KCE REPORT 331

Federaal Kenniscentrum voor de Gezondheidszorg
Centre Fédéral d'Expertise des Soins de Santé
Belgian Health Care Knowledge Centre

HOW TO BETTER TACKLE ELDER ABUSE IN BELGIUM?





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COLOPHON

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LIST OF ABBREVIATIONS

ABBREVIATION	DEFINITION
ADMR	Aide à Domicile en Milieu Rural
ANESM	Agence Nationale de l'Evaluation et de la qualité des Etablissements et Services sociaux et Médico-sociaux
APS	Adult Protective Services
ARS	Agence Régionale de Santé
ASA/APA	Agression sur Personne Agée
ATDEA	Assessment tool for Domestic Abuse
AU	Austria
AVIQ	Agence pour une Vie de Qualité
AWHIP	Agence wallonne pour l'intégration des personnes handicapées
BASE	Brief Abuse Screen for the Elderly
BBT	Bijzondere Beroepstitel
BI	Barthel Index
BILOBA	Projet innovant et global pour les personnes âgées
BOT	Brussels Overleg Thuiszorg
BtT1	Break the Taboo 1
BtT2	Break the Taboo 2
Bru-Nord	Police Department of Brussels North
BTZ	Beratungs- und Therapiezentrum (advice and therapy center)
CAD	Centra voor alcohol- en andere drugproblemen
CAJ	Centre d'accueil de jour
C.A.P.A.M	Centre d'Aide aux Personnes Âgées Maltraitées
CASE	Caregiver Abuse Screen for the Elderly

CAW	Centrum Algemeen Welzijnswerk - Center General Welfare
CCCA	Conseil Consultatif Communal des Ainés
CEBAM	Centre Belge pour l'Evidence-based Medicine
CFA	Confirmatory factor analysis
CGG	Centrum voor Geestelijke Gezondheidszorg
CHSLD	Centre d'hébergement de soins de longue durée
CIPP	Context, Input, Process, and Product
CLPQS	Commissaire Local aux Plaintes et à la Qualité des Services
CNBD	Comité National pour la bientraitance et les droits des personnes âgées et des personnes handicapées
CNSA	Caisse Nationale de Solidarité pour l'Autonomie
CO3	Permanente overlegstructuur voor de meest complexe en chronische situatie van intrafamiliaal geweld, waarbij de interventie van één dienst onvoldoende is
COCOF	Commission communautaire Française
COCOM	Commission communautaire commune
COL	Circulaire du Collège des procureurs généraux
CPAS	Centre Public d'Action Sociale
CPEABS	Caregiver Psychological Elder Abuse behaviour Scale
CRA	Coördinerend en Raadgevend Arts
CSJ	Centre de soins de jour
CUP	Centre Universitaire Psychiatrique
CZ	Czech Republic
DETECT	Detecting Elder Abuse by Emergency Care Technicians
DM	Domus Medica

DNA	Deoxyribonucleic acid
DPSB	Politiedienst voor slachtofferbejegening
DSS	Department of Social Services
EA	Elder Abuse
EADSS	Elder Abuse Decision Support System
EAI	Elder Assessment Instrument
EARAE	Elder Abuse Risk Assessment and Evaluation©
EASI	Elder abuse suspicion index
EASI-ltc	Elder abuse suspicion index adapted for long-term care
EASI-leo	modified version of Elder Abuse Suspicion Index for use by law enforcement officers
EC	European Commission
ED	Emergency department
ED Senior AID	Emergency Department Senior Abuse Identification
EHPAD	Etablissement d'hébergement de personnes âgées dépendantes
E-IOA	Elderly Indicators of Abuse
EL	Greece
EMS	Emergency medical services
ENEO	Mouvement social d'aînés, d'action citoyenne et collective, guidé par la solidarité et la justice sociale, d'inspiration mutualiste et chrétienne
EPAS	Elder Psychological Abuse Scale
EPO	Enquête Policière d'Office
ES	Ecoute Seniors
EU	European Union
FAMHP	Federal Agency for Medicines and Health Products

FF	Family and Friends scale
FIAPA	Fédération Internationale des Associations de Personnes âgées
FJC	Family Juctice Center
FMS	Federatie Medisch Specialisten
FNIS	Framework Note Integral Safety
FORAP	Fédération des Organismes Régionaux et territoriaux pour l'Amélioration des Pratiques et organisations en santé
FPS	Federal Public Service
FOD	Federaal Overheidsdienst
FTE	Full-time equivalent
GGZ	Geestelijke Gezondheidszorg
GP	General practitioner
HCP	Health Care Professional
H-S/EAST	Hwalek-Sengstock Elder Abuse Screening Test
IFV	intra-familial violence - violence intra-familiale – intrafamiliaal geweld
IMC	Interministerial Conference
INAMI	Institut National d'Assurance Maladie-Invalidité
INPEA	International Network for the Prevention of Elder Abuse
IOA	Indicators of Abuse
IR	Ireland
KR-20	Kuder-Richardson technique
LFDRS	Lichtenberg Financial Decision making Rating Scale
LFDSS	Lichtenberg Financial Decision-making Screening Scale
LGBT	Lesbian, gay, bisexual, transgender

LINK	Limburgse INtrafamiliaal geweld Keten
LSRI	Loi spéciale de réformes institutionnelles
LTC	Long Term Care
MEDIANTE	Code of Criminal Investigation for the French speaking part of Belgium
MODERATOR	Code of Criminal Investigation for the Dutch speaking part of Belgium
MS	Member State
MMS	Mini mental status
MMSE	Mini-Mental State Examination
MEEM	Mini examen de l'état mental
NAP	National Action Plan
NGO	Non-governmental organization
NICE	National Initiative for the Care of the Elderly
NIHDI	National Institute for Health and Disability Insurance
NL	The Netherlands
NSP	National Safety Plan
OAFEM	Older Adult Financial Exploitation Measure
OAMA	Older Adult Mistreatment Assessment
OAPAM	Older Adult Psychological Abuse Measure
OCDE	Organisation for Economic Co-operation and Development
OCMW	Openbaar centrum voor maatschappelijk welzijn
OKRA	vereniging voor 55-plussers in Vlaanderen & Brussel
OMB	Ouderenmis(be)handeling
OP	Older person
PA	Personne âgée

PASV	Police assistance service to victims
PCS	Plan de Cohésion Sociale
PCSA	Public Centre of Social Action
PICO	Patient (Population, or Problem) Intervention Comparator Outcome
PL	Poland
PTSD	Post-Traumatic Stress Disorder
REAMI	Risk on Elder Abuse and Mistreatment-Instrument
RITI (scale)	Korte en op de praktijk gerichte vragenlijst die het risico op ouderenmis(be)handeling meet
RIZIV	Rijksinstituut voor Ziekte- en Invaliditeitsverzekering
ROC	Receiver operating characteristic
RS	Respect Seniors
SAPV	Service d'Assistance policière aux victimes
SDG	Sustainable Development Goal
SEL	Samenwerkingsinitiatief Eerstelijnsgezondheidszorg
SEPAM	Service d'Ecoute pour Personne Agée Maltraitée
SK	Slovakia
SL	Slovenia
SOLIDARIS	Mutualité Socialiste
SPMSQ	Short Portable Mental Status Questionnaire
SR	Systematic review
SRE	Structure régionale de santé
SSM	Services de Santé Mentale
SSMG	Société Scientifique de Médecine Générale

THV	Tijdelijk huisverbod
ULB	Université Libre de Bruxelles
UN	United Nation
UNCRPD	United Nation Convention of the Rights of Persons with Disabilities
VASS	Vulnerability Abuse Screening Scale
VGC	Vlaamse gemeenschapscommissie
VLOCO	VLaams Ondersteunings Centrum Ouderenmis(be)handeling
VOS	Verontrustende opvoedingssituatie
VVVS	Vlaamse Vereniging Verpleegkundigen Spoedgevallenzorg
VZW	Vereniging Zonder Winstoogmerk
WHO	World Health Organization
WMO	Wet Maatschappelijke Ondersteuning
ZBI	Zarit Burden Interview

SCIENTIFIC REPORT

CHAPTER 1: INTRODUCTION

1 CONTEXT AND PROBLEM DESCRIPTION

Elder Abuse is a form of mistreatment of older people. It is one part of a spectrum of violent or neglecting behaviour that occurs in relationships where trust exists. A difference exists between 'intentional' and 'unintentional' elder abuse. But although unintentional abuse is easier to understand, it remains unacceptable.[1] In an aging population, the vulnerabilities that may accompany the aging process (e.g. dependency due to different pathologies, social isolation, etc.) increases the risk for elder abuse.

Elder abuse can take place in a family/domestic context as well as in a patient/resident professional relationship and can take many forms including financial, psychological/emotional, social, physical, sexual abuse and neglect.[2] The denial of civic rights, discrimination on the ground of age and ageist attitudes can also be considered to be forms of elder abuse.[2] Each type of abuse can result in behaviour changes that may indicate to others around the older person that something is not going right. Yet, although we know that elder abuse is prevalent in every society (see 9), it is usually a hidden form of violence that often goes **undetected and thus unreported and unresolved**.[2]

Interviewed older people report that they may be ashamed for the situation or reluctant to report it because of fear for loss of social contact with the author of the abuse, fear of worst consequences or loyalty to the family. They also may just not be aware of the abuse or of the options for help or experience a lack of physical, mental or emotional capacity which can impair a reporting[a].

[a] https://maltraitancedesaines.com/wp-content/uploads/2020/01/2018_DAMIA-FR_animateurs_V-janv2019.pdf

In addition, detection and reporting may affect the care relation of professionals with the elder as well as relatives, friends and society at large. Various reasons underlie the lack of detection and reporting by each of these protagonists. Professionals may be inadequately trained to recognize abuse, they may lack knowledge on how to handle a case, fearing the loss of trust in the patient-professional relationship, struggle with the application of their professional secrecy, etc.[3] The reasons for under-detection and underreporting are not only related to individuals but are societal as well. The perception whether a situation is categorised as abuse depends of the cultural context in which it has occurred. In western societies there appears to be a general negative attitude towards ageing and older people, devaluating older people and creating a context that is conductive to elder abuse, without labelling it as "abuse".[1, 4] There is a link between elder abuse and the denial of seniors' fundamental rights, with the lack of understanding of the social value of older people and with the lack of services that can support dignified aging.[1] The older persons themselves explain the occurrence of abuse mainly as a consequence of societal changes, a societal problem. This understanding of, and explanation for, elder abuse may influence the detection and reporting behaviour of older people, as they may tend to acknowledge only severe cases of intentional physical violence that leave clear and therefore physically detectable evidence.[5]

An appropriate intervention and prevention of elder abuse start with the identification of risk factors. Although the causes of elder abuse are complex and type- and case-specific, risk factors for authors (e.g. mental health problems, substance abuse, financial stress), for victims (e.g. dementia, social isolation, physical dependency), and for context (e.g. lack of caregiving support and history of conflict) can be identified.[3, 6, 7] This **compilation of multiple problems** makes appropriate tackling of elder abuse very challenging and demands for joint actions of actors in the sectors of health care, policy and finances, social services, and police and justice.

Today, many of these sectors face problems in the proper **early management of elder abuse**. For instance, (health)care professionals from different settings in Belgium (emergency department, GPs, residential setting, home care…), who are typically well placed to detect elder abuse, encounter problems in the detection, reporting and follow-up of (presumed) elder abuse. Some of these problems are related to the lack of supporting tools or policy in the setting they work in (lack of a decision-making step plan, no tool for risk detection, etc.). Although initiatives and tools (RITI scale, step plan SEL Waasland…) exist, they vary between communities and regions, are not adapted to all or specific settings, are often unknown by healthcare professionals and are not systematically implemented in the different help and care settings where elder abuse may take place. Other problems concern the (health)care professional's feeling of incapacity to properly handle the situation (lack of training on detection, lack of good communication skills, poor knowledge on existing network of supporting services, no support from a team in solo practices, hesitations about the limits of their professional secrecy …). Furthermore, shortcomings can also be situated on a system level (little sensitisation, shortage in residential places, etc.).

Overall, elder abuse is also an issue that struggles to rise to prominence on the **political agenda** of the national, regional and local governments although there is a growing consensus that elder abuse is a human rights issue.[1] The topic is often grouped with other forms such as domestic violence and it remains rather low on the list of public priorities in favour of other concerns. Moreover, as the (non-judicial) management of elder's issues falls within the competence of the communities/regions and the local governments, the offer of services and the service providers involved in the management of elder abuse and the overall policy with regard to the topic varies a lot. Finally, only a few scientists are working on topics specific to elderly and the level and quantity of evidence about those topics are low.[1, 8]

So, the underlying reasons for the under-detection and suboptimal management of elder abuse situations are multi-layered and interconnected. Tackling the complex phenomenon of elder abuse will thus only be effective if all these layers are (en)able(d) to function optimally themselves but also as part of a chain in which each element impacts the other.

2 SCOPE, OBJECTIVES AND RESEARCH QUESTIONS

The initial research question originated from healthcare professionals working in an emergency room setting and was limited to the identification of a detection tool adapted to this setting. As detection is only one part of the chain in the management of elder abuse, KCE took the opportunity to address a larger scope. Our study addresses all types of elder abuse committed by another person to an elder in all kinds of settings (residential, domestic, hospital,..), includes abuse by relatives as well as by professionals (all called 'authors' for this report) and involves actors from all sectors concerned by all steps of the fight against EA, i.e. prevention, detection, intervention (definition see chapter 10). The scope of the study excludes self-neglect and harm to an older person in a non-trusted relationship, for example, like pickpocketing in the street. So the original research question is withheld but the scope was enlarged.

The overall objective of the study is to provide a general framework for all steps and actors to tackle elder abuse in Belgium.This study will identify the current gaps in the different steps (= prevention, detection, intervention) and the needs of the main actors and will suggest solutions/good practices to come forward to these gaps and needs.

More specifically, the following research questions (RQ) will be addressed.

- RQ 1: What is the actual state of affairs in Belgium regarding elder abuse management from a legal and from an organisational point of view?
- RQ 2: What are the barriers and facilitators encountered by the main actors involved in the fight against elder abuse in Belgium?
- RQ 3: What can we learn from other countries regarding the prevention of elder abuse and the existence of step-by-step plans for detecting and reporting EA?
- RQ 4: What tools are used to detect elder abuse, adapted to different settings of care?
- RQ 5: Which solutions can be drawn to improve all steps of EA management in Belgium?

Each research question is analysed in one or more chapter(s) of this report. Chapter 2 answers RQ1. It includes a description of the actual state of affairs related to the institutional and legal framework related to elder abuse. Moreover, an overview of the offer of services involved in the management of elder abuse in Belgium and the existing action plans and good practices related to elder abuse prevention and management are summarised. Chapter 3 answers partly RQ3 and is divided in 3 parts. The first one described the International and European plans, institutions and projects aiming to prevent elder abuse. The second part gives an overview of preventive actions done in a selection of countries (the Netherlands, Canada-Québec and France). The third part compares the preventive actions held abroad with those done in Belgium.

Chapter 4 answers the other part of RQ3. It gives illustrations of step-by-step plans used in foreign countries (Canada, France, Australia, UK, USA and the Netherlands) from which a step-by-step plan developed for Belgium could be based. Chapter 5 answers RQ4. It gives the results of a systematic literature review related to the detection tools for elder abuse. Chapter 6 and 7 answer RQ2 by identifying the perceived barriers, facilitators and good practices in EA management. Chapter 6 includes the opinions of formal and informal caregivers, resulting from a stakeholder opinion survey. Chapter 7 summarises the view of stakeholders in the police and justice sectors obtained via exploratory interviews. Finally, chapter 8 summarizes the input of major stakeholders and academic experts on controversial or difficult aspect of some findings in the previous chapters. Their opinion was collected through focus groups and on-line survey. This last consultation aim to bring new solutions and to analyse their acceptability and feasibility.

3 METHODOLOGY

The global methodology used in the all study is based on a multimodal and triangulation process. First, different methodologies are used to collect data and answer research questions: grey literature review, scientific literature review, systematic and narrative reviews, qualitative methodology (discussion groups, exploratory interviews and online surveys). Then, the triangulation process allows to integrate the data and lead to conclusions. The methodology for the different parts is described in the respective chapters.

The KCE team leading the study was composed of legal experts, a geriatrist and experts in Health Service Research. Punctual help was given by the KCE communication cell for languages concerns in French and Dutch, by the KCE expert in evidence search strategy and by the qualitative research cell for advices in qualitative methodologies.

The data included in this first chapter, which works as an introduction, was collected through a quick search in grey and scientific literature and after individual meetings and phone calls with major actors and politicians involved in elder abuse or elders' well-being: VLOCO, Respect Seniors, Ecoute Seniors, Brussels meldpunt ouderenmis(be)handeling, a member of the Walloon health minister, a member of the COCOF, a member of the COCOM and a member of the Flemish health minister.

4 DEFINITIONS

There is no unique and uniform definition of the concept of elder abuse and of older person. Depending on the context (research, legal aspect, care setting, regions…), different nuances are reflected in the existing definitions.

4.1 Elder abuse

A focus on the definitions of elder abuse developed by international organisations, found in scientific articles and used in Belgium is made in this section.

- WHO (World Health Organisation)

By far the most used, here is the definition of elder abuse developed by the WHO: "Elder abuse (EA) 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.[9] For instance, the European Charter on older people rights and responsibilities uses this definition.[2]

- European Council

The European Council definition of an abuse is as following: "any act or omission committed by a person, if it violates the life, physical or mental integrity or freedom of another person or seriously compromises the development of his or her personality and/or harms his or her financial security". For instance, France ministry of health and solidarity uses this definition in his national policy.

- Literature

A narrative review of the literature highlights a variation in the definition of elder abuse with a predominance of the WHO definition (see Appendix 1).

- Belgium

There is no uniform legal definition of the notion of elder abuse in the Belgian (federal) law although both criminal and civil codes cover situations which are considered as elder abuse according to the WHO definition.

In the Walloon Code of Social and Health Action (decree part), elder abuse is defined as : “any act or omission committed by a person or group of persons who are in a personal or professional relationship with an elder and which physically, morally or materially harms or could harm that person”. [a] This definition is used to define the mission of the organisation recognized and subsidized by the Walloon authorities to fight against elder abuses, named “Respect Seniors” (see Chapter 2). The service involved in the management of elder abuse in Flanders, the VLaams OndersteuningsCentrum Ouderenmis(be)handeling (VLOCO) uses a more operational definition: "By elder (person of 55 years or older) abuse we mean all the acts or omissions of all those who are in a personal and/or professional relationship with the older person, as a result of which the older person (repeatedly) suffers or is likely to suffer physical and/or psychological and/or material damage and where on the part of the older person there is a form of partial or total dependency"[b]. The VLOCO definition stresses the fact that the abusive act is not always conscious or intentional. Sometimes a too high burden of care, lack of knowledge or incapacity are underlying reasons for the “abuse”. Therefore VLOCO explicitly uses the notion ‘ouderenmis(BE)handeling (mistreatment).

The notions of (different kinds of) harm and a relationship of trust are key in all definitions. Other elements are the fact that abuse can be active or passive, single or repeated.

For this study, we use the definition of the WHO as determined during the scope of the study. We assume that the non-intentional ‘ouderenmisBEhandeling’ (skip medication by a partner, lack of staff in nursing homes…) is included in this definition.

4.2 Older person

Although the notion of ‘elder’ is used in all definitions, the age limit is not always specified as in the WHO definition. In the Walloon Code, elder is defined as a person aged of sixty years or over[c] while VLOCO defines an elder as a person aged 55 years and older. Those age cut-offs reflect important practical changes in life (early retirement, children moving out of the house, beginning of health problems…).

However, defining ‘older adults’ remains an issue of debate. Most developed countries accepted the age of 60 (or 65) years as a threshold of older age[d]. But this might be misleading as older people are a very heterogeneous group: some very old persons remain vigorous while others, even younger and without any apparent disease, fail to rebound following illnesses or stressful events. Still, ageing is a risk factor of decrease in functional reserves with higher levels of comorbidities leading to increased vulnerability often described as ‘frailty’.[10] So, for some experts, frailty is a better way than age to define the population at risk of elder abuse. But others highlight that elder abuse never occurs when the environment of an elder, no matter how frail he or she may be, is free of potential maltreating persons. According to the WHO, many physiological changes occur in a lifetime, but only part of them are related to age. Some 80+ers have the same physical and mental capacities as 30 years old individuals.[11] Therefore no age limit was determined for the scope of this study.

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[a] article 378 of the Code Wallon de l’action sociale et de la santé (partie décrétale - décret du 29 septembre 2011)

[b] https://www.besafe.be/nl/veiligheidsthemas/geweld/ouderenmis-be-handeling

[c] https://wallex.wallonie.be/contents/acts/0/117/1.html?doc=21579 : see article 378

[d] https://www.who.int/news-room/fact-sheets/detail/mental-health-of-older-adults

5 DIFFERENT TYPES OF ELDER ABUSE

The two forms of elder abuse are on the one side related to violent behaviour (active form) and on the other side related to neglecting behaviour (passive form). Active forms include committing acts, in particular disproportionate use of freedom restrictors whereas passive abuse of the elderly involves the omission of acts. Those two forms can include different types of elder abuse which vary amongst informations sources. The following forms of abuse are often differentiated: physical, psychological, sexual, financial, societal, organisational or civic. There might be some overlap and several types of abuse can be present at the same time. One example of categorization is illustrated in Table 1.

Table 1 – Types of elder abuse and neglect, adapted from Rosen et al, 2018 and the "Guide pour lutter contre la maltraitance des aînés du Québec"

Types	Definition	Examples
Physical abuse	Actions, words or attitudes that constitute a harm on physical well-being or integrity as intentional use of physical force that may result in bodily injury, physical pain, or impairment.	Pushing, bullying, hitting, burning, forced feeding, inadequate administration of medication, inappropriate use of restraints (physical or chemical), slapping, kicking, pulling hair, use of household objects as weapons, use of firearms and knives, etc.
Psychological/emotional abuse	Actions, words or attitudes that constitute a harm on psychological well-being or integrity as intentional infliction of anguish, pain, or distress.	Emotional blackmail, manipulation, humiliation, insults, infantilization, denigration, verbal and non-verbal threats (of punishment or deprivation), disempowerment, excessive supervision of activities, verbal berating, harassment, intimidation, isolating from others; etc.
Sexual abuse	Actions, gestures, words or attitudes with a sexual connotation that are not consented to, that affect the well-being, integrity or sexual identity.	Suggestive comments or attitudes, jokes or insults with a sexual connotation, promiscuity, indecent exposure (exhibitionist behaviour), sexual assaults or battery (unwanted touching, forced sexual relation), coerced nudity, sexually explicit photographing, etc.
Material or financial abuse	Fraudulent, illegal, unauthorized or dishonest obtaining or use of the person's property or legal documents, lack of financial or legal information or misinformation.	Pressure to change a will, banking transaction without consent (use of a credit card, Internet, etc.), excessive price charged for services rendered, misappropriation of funds or property, identity theft, stealing money or belongings, forcing older adult's signature, coercing an older adult into signing contracts, assigning durable power of attorney against his or her wishes etc.

Neglect	Refusal or failure to fulfil any part of a person's obligations or duties to an elder, which may result in harm – may be intentional or unintentional	Withholding of food, water, clothing, shelter, medications; failure to ensure elder's personal hygiene or to provide physical aids, including walker, cane, glasses, hearing aids, denture; failure to ensure ender's personal safety and/or appropriate medical follow-up, non-information or misinformation about one's rights, not to assist in the exercise of rights, not managing assets in the person's interest or providing the necessary assets when responsible; not questioning a person's ability, understanding or financial literacy, rejection, indifference, social isolation, etc.

Rosen T, Stern ME, Elman A, Mulcare MR. Identifying and Initiating Intervention for Elder Abuse and Neglect in the Emergency Department. Clin Geriatr Med. 2018;34(3):435-51. Partenaires multisectoriels. Guide de référence pour contrer la maltraitance envers les personnes aînées. Centre d'expertise en santé de Sherbrooke; 2016. Available from: https://ciusss-ouestmtl.gouv.qc.ca/fileadmin/ciusss_oim/Infos_pour_les_usagers/Maltraitance_envers_les_personnes_agees/Guide_reference_pour_contrer_la_maltraitance_envers_les_personnes_ainees.pdf

Unlike financial and sexual abuse which are always intentional, unintentional abuse often results from a lack of understanding of the older person's needs and feelings and the carer's difficulty in reconciling the older person's needs and wishes with one owns private and professional demands."[2]

6 INFORMAL CAREGIVERS AND DERAILED CARE

Many older people sooner or later make use of informal care. Informal care is the help that a person gives voluntarily and unpaid to another person with a need for care in their immediate environment. It concerns care that is more than it is usual in a personal relationship[a].

According to a survey conducted by the King Baudouin Foundation in 2016 on informal caregivers to elders[b], informal caregivers are mainly spouses (73%) and adult children (23%). Most of them are women (71%). Another survey conducted by the 'Ligue des familles' in 2015 also indicated that more than 45% of informal caregivers are over 50 years of age, and that approximately 55% have a monthly income below 2000 euros[c]. The King Baudouin Foundation estimates that the average time of support provided is 4.2 hours per day. This data, which must certainly be revised upwards, is a good indicator of the impact of this role on the informal caregiver's daily life[d].

Being an informal caregiver has psychological, social, and of course professional and financial consequences, especially since 60% of the informal caregivers works (according to available figures). Indeed, the help and support provided by the caregiver often affects his or her professional life. About 30% of family caregivers had to leave their work in order to devote themselves to this activity, and 25% had to significantly reduce the time spent on it. Moreover, still according to the King Baudouin Foundation, the financial benefit of the informal caregiver's efforts for the society amounts to 267 to 1197 euros per month.

Good care can surreptitiously turn into neglect, wrong treatment or compassion fatigue. This would be called 'off the rails' or derailed or degenerated care and could sometimes be seen as elder abuse, because it can lead to psychological or physical abuse, or neglect. But derailed informal care is not a question of bad will. It is often a result of overburdening, powerlessness, incompetence or ignorance. Virtually nothing is known about the extent of derailed care. What is clear, however, is that it happens to everyone, regardless of education, age or origin[e]." In the case of derailed informal care, the informal carer exceeds the boundary of good care.

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a https://www.aanpak-ouderenmishandeling.nl/ontspoorde-mantelzorg

b Fondation Roi Baudouin (2016), « Les aidants proches des personnes âgées qui vivent à domicile en Belgique : un rôle essentiel et complexe. Etude de données. » - www.kbs-frb.be/fr.

c La Ligue des familles, « Aidants proches. Après la loi, on fait quoi ? », Actes du colloque du 21 avril 2015, Bruxelles – www.laligue.be.

d La Ligue des familles, « Aidants proches. Après la loi, on fait quoi ? », Actes du colloque du 21 avril 2015, Bruxelles – www.laligue.be.

e https://www.aanpak-ouderenmishandeling.nl/ontspoorde-mantelzorg

7 CAUSE AND RISK FACTORS OF ELDER ABUSE

Elder abuse is a multi-layered problem which must be appreciated in its context. There are many theories that explain elder abuse, and there is not one single theory that can explain all elements of elder abuse. Sometimes elder abuse can be (partly) explained on an individual level of the author: personality traits or psychopathological behaviour, or frustration and stressful structural circumstances. Also, theories of family systems and care dependency relationships can explain part of the elder abuse. Theories about violence as an intergenerational pattern are also used, as are theories about power and gender. Theories about dignity are also given, many experts refer to a prevailing depreciation of older people. And, finally, social developments as individualism, an ageing population and economic developments are another explanation for elder abuse. This leads to many risk factors.[2]

In epidemiology, a risk factor is a variable associated with an increased risk of a negative event. Risk factors that may increase the potential of an abuse against an older person were summarized by the WHO in a fact sheet in 2018. It classifies the risk factors in 4 different levels, at individual (victim or authors), family, society, and institution levels.

7.1 Risk factors related to the person

- The risks at the individual level of the victim, also called vulnerability factors,[12] include advanced old age; illiteracy; personal characteristics that may predispose to prejudice (odours, appearance…); disruptive or violent behaviour towards carers (agressiveness, reluctance or resistance to care…); substance dependence (alcholism, drug addiction, medication overuse); dependence on others for business management (budget, bill, payment, finance); dependence for basic care (food, hygiene, medication, transfer, etc.); difficulty or inability to express oneself, attitude of submission, excessive trust in others; behavioural or emotional difficulties; financial difficulties; social and geographical isolation; lack of knowledge of official languages; lack of knowledge of the rights and resources at its disposal; mistrust of public services (health and social services, police…); **poor physical and mental health** (cognitive losses, depression…); and **female gender**. Some of those risk factors increase the dependence on caregivers.

    - Health problems: the exemple of dementia

      Older adults with dementia are thought to be at greater risk of abuse and neglect than those of the general elderly population. On the one hand, increasing dependency on others and deteriorating social networks leave the person more isolated, creating a context that is ripe for becoming abusive. Simultaneously, cognitive difficulties interfere with the ability to take action. For example the person may have difficulty organizing to leave the place where the author is or to seek support. Three international studies found overall rates of abuse of people with dementia by their caregivers ranging from 34 to 62%.[13-15] In another US study, 14% of caregivers reported that they were neglectful in caring for loved one with dementia.[16] Lachs and Pillemer suggest this may be due to disruptive behaviours demonstrated by the person with dementia.[17]

    - Gender

      While older men have the same risk of abuse as women, in some cultures where women have inferior social status, elderly women are at higher risk of neglect and financial abuse (such as seizing their property) when they are widowed. Women may also be at higher risk of more persistent and severe forms of abuse and injury.[9]

Risks at the individual level of the author include physical and **mental disorders** (illness and distress) and **alcohol and substance abuse**, as well as work, family or financial troubles. An author's emotional or financial dependency on the older person also increases the risk of abuse. In one U.S. study, 20% of caregivers expressed fears that they would become

violent with the people for whom they cared for[a]. Lack of knowledge about the diagnosis and the correct care to give as well as lack of external support also increase the risk of elder abuse. To be the principal caregiver, to have the feeling of a burden or to have been forced to be the elder caregiver can worsen the situation.[12]

7.2 Risk factors related to the family environment

A **shared living situation** is a risk factor for elder abuse, although it is not yet clear whether spouses or adult children of older people are more likely to perpetrate abuse. In some cases, a long history of **poor family relationships** may worsen as a result of stress when the older person becomes more care dependent.[9] Intergenerational transmission of violent behaviour is also a plausible risk factor.[8]

Loneliness of caregivers and older persons, and the ensuing **lack of social support**, is a significant risk factor for elder abuse by caregivers. Many elderly people are isolated because of loss of physical or mental capacity, and/or through the loss of friends and family members.[9]

7.3 Risk factors related to the society system

Socio-cultural factors that may affect the risk of elder abuse include:[9]

- depiction of older people as frail, weak and dependent (ageism);
- erosion of the bonds between generations of a family;
- systems of inheritance and land rights, affecting the distribution of power and material goods within families;
- women entering the workforce have less spare time, caring for older relatives becomes a greater burden, increasing the risk of abuse;[9]
- migration of young couples, leaving elderly parents alone in societies where older people were traditionally cared for by their offspring;
- lack of funds to pay for care;
- community with a high crime rates, a social disorganisation, a lack of social resources and networks, and poverty;[18]
- significant value place, in occidental culture, to productivity, cognition and reason.[17]

Ageism in particular is a societal risk factor of abuse, to the extent to which older people do not fit the perceived social norm, and are treated as “less” (which may include being less valued and less visible). Seniors become relegated to a second class status; their needs and their lives are treated as if they do not matter as much.[17]

[a] From Elder Abuse Ontario ppt presentation at the 13th annual geriatric emergency management conference-Reference of the publication not known

7.4 Risk factors related to the institution

Within institutions, abuse is more likely to occur where:[9]

- standards for health care, welfare services, and care facilities for elder persons are low;
- where staff are poorly trained, supervised, remunerated, and overworked;
- where the physical environment is deficient; and
- where policies operate in the interests of the institution rather than the residents.

The WHO World report on ageing and health[11] gives a summary of evidences underlying the risk factors of EA (see Appendix 2).

7.5 Protective factors

Protective factors are characteristics specific to the person or to his or her environment that tend to reduce the incidence of a problem. They are not the opposite of risk factors and their presence does not indicate the absence of risk factors. Although the scarcity of studies on protective factors, the 'Guide de référence pour contrer la maltraitance envers les personnes aînées', developed in Quebec, proposes a number of protective factors specific to the individual or its environment.[a]

Protective factors specific to the individual are self-esteem, the ability to ask for help, understanding of emotions, social participation, the ability to learn about oneself and one's society and the maintenance of good lifestyle habits.

Protective factors related to the environment are an appropriate network, a suitable living environment and financial capacity.

8 CONSEQUENCES OF ELDER ABUSE

Elder abuse can lead to serious physical injuries; long-term psychological consequences; increased mortality; diminution of quality of life; and decrease of general health status[b].[9] Physical injuries range from minor scratches and bruises to broken bones, wounds and head injuries leading to disability while psychological consequences can be serious, sometimes long-lasting, as depression, delirium, post-traumatic syndrome disorder and anxiety. Physically restraining patients or insufficient care allows older people to develop pressure sores.[9] A 13-year follow-up study found that victims of elder abuse are twice more likely to die prematurely than people who are not victims of elder abuse.[19] In 2011, the WHO reported that EA was responsible of 2500 deaths in Europe.[8]

Because older victims usually have fewer support systems and reserves, the impact of abuse and neglect is magnified, and a single incident of mistreatment is more likely to trigger a downward spiral leading to loss of independence, serious complicating illness, and even death[c].[9] For example, the consequences of broken bones can be especially serious because their bones may be more brittle and convalescence longer.

Moreover, emerging evidence shows that EA has great economic costs.[8, 20] Maltreated elderly have longer hospital stays and higher rates of utilisation of emergency departments compared to non-maltreated persons.[21] As they sense a growing insecurity feeling (fear) and a withdrawal into oneself (shame, culpability), the received protection and care by the legal and social system have also an important cost (at least USD 500 million in 2004).[22]

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a https://www.inspq.qc.ca/sites/default/files/publications/2380_chapitre-6.pdf

b http://www.respectseniors.be/

c http://www.respectseniors.be/

9 PREVALENCE OF ELDER ABUSE

9.1 In general

Elder abuse is an important public health problem. Estimations on the extent of the phenomenon exist but this will probably always represent the tip of the iceberg, as many elder abuse situations remain unreported or are not uniformly registered.

A 2017 study based on the best available evidence from 52 studies in 28 countries from diverse regions estimated that, over the past year, 15.7% of people aged 60 years and older were subjected to some form of abuse.[23] This is likely to be an underestimation, as only 1 in 24 cases of elder abuse is reported, partly because older people are often afraid to report cases of abuse to family, friends, or to the authorities. Although rigorous data are limited, this systematic review coupled to a meta-analysis[23] provides pooled prevalence estimates of number of older people affected by different types of abuse **in community settings.**[9, 23]

- psychological abuse: 11.6%
- financial abuse: 6.8%
- neglect: 4.2%
- physical abuse: 2.6%
- sexual abuse: 0.9%

Rates of abuse may be higher for older people living in institutions than in the community[9] but data on the extent of the problem **in institutions** such as hospitals, nursing homes, and other long-term care facilities are scarce. A survey of nursing-home staff in the United States of America, however, suggests that rates may be high. Of all nursing-home staff surveyed:[24]

- 36% witnessed at least 1 incident of physical abuse of an elderly patient in the previous year;
- 10% committed at least 1 act of physical abuse towards an elderly patient;
- 40% admitted to psychologically abusing patients.[24]

Another source identify that the international figures from the United Nations indicate a prevalence of 3 to 8 percent of elder abuse in the world. This group of victims grows to 1 in 5 (20%) in vulnerable elderly people[a].

9.2 In Belgium

The only national prevalence figures for Belgium estimating the phenomenon of elder abuse date from 1998. It is extracted from the study "Violence and feelings of insecurity among the elderly"[25] and states that one in five elderly people (over 65 years of age, cohabiting or isolated), or 20%, will ever be the victim of abuse (all types of abuses included) and that one in eight (1/8) elderly people were confronted with one or other form of psychological, physical or sexual violence.[b]

Later, a study done **in community setting** in Wallonia (2010) concludes to 21.4% of elderly neglect, 18.1% of psychologic abuse, 7.8% of financial abuse and 6.4% of physical abuse.[26] A report about Belgium data collected in the frame of the DAPHNE II EU project about violence against older women highlights the fact that 70% of the victims in Belgium are female, in general between 70 and 89 years old, with a peak between 80 and 84 years.

In addition to scientific publication, prevalence of elder abuse data in **Belgium** should be found in several sources: specialised organisations (VLOCO, Respect Seniors, Ecoute Seniors, 1712, CAW), the Belgian Health Interview Survey (HIS) which includes a section about violence, and police and the department of justice databases. However, no centralized register of EA exist in Belgium.

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a http://www.vzwzijn.be/wat-is-geweld/themas/ouderenmisbehandeling

b Doc. Parl., Senate, sess 2010, n°5-191, p.2.

9.2.1 Data from specialised services

In the Brussels region, the SEPAM (recently renamed **Ecoute Senior**) recorded 660 calls concerning elder abuse situations in 2019 which led to 262 dossiers. [27] In 2018, 750 calls were recorded concerning 304 EA cases.[28] Sixty-four percent stemmed from a situation in an institution, probably due to the tie links between Ecoute Seniors and Infor-Home which is, firstly a specialized organisation giving advices about institutions for the elderly. The Brussels Meldpunt Ouderenmis(be)handeling responded to 149 calls, which led to 34 dossiers in 2019.[29]

The regional association against elder abuse in Wallonia, **Respect Seniors** (which accepts calls from professionals and non-professionals) got 2007 calls in 2018 and followed up 835 cases of confirmed elderly abuse with 65% of the cases occurring in private households.[30] Around a third of the calls concerned psychologic abuse while financial abuse occurs in one fifth of the calls. The physical abuse seems to be more frequently discussed on the phone than before (1/8 instead of 1/10 in previous years).

In 2018, **VLOCO** (which collects only reports by professionals) recorded 444 cases. Most of VLOCO cases related to psychological and physical abuse, closely follows by financial abuse. Sixty-three percent of the victims lives together with the abuser. For most of the cases, organised assistance was ongoing.[31]

Via the **hotline 1712** (reporting by society at large), only 9 cases were reported and were related to a rest/care home context.[32]

In 2018, 82 assistance trajectories related to elder abuse were started in all **CAWs** in Flanders.

9.2.2 HIS database

The Belgian Health Interview Survey (HIS) is a cross-sectional survey which is repeated every 4-5 years and is coordinated by Sciensano. It aims to include 10.000 respondents nested in 6.000 households in the French, Dutch, and German speaking households. The purpose of the HIS is to assess the health status of the Belgian population aged 15 years and older, and to identify the main health problems as well as the determinants and behaviours that could influence them. The first wave of the HIS was launched in 1997 and repeated in 2001, 2004, 2008, 2013, and 2018. At the moment of writing current chapter, all data of the 2018 wave were not yet available or published (in particular the one about violence).[33]

The part of the HIS concerning violence combines written questionnaire and interviews but the answers to open questions of the 2013 wave are not yet analysed. Info available in the HIS about violence are: age of the victim, actions taken after violence issue (who has been contacted: police, family, friends, none), type of violence (verbal or psychological or physical), location where the violence occurred (at home or elsewhere or in a public place), familiarity with the author (the victim personally know the offender and/or member of the household).

Even if the HIS presents a certain will to figure out intra familial violence, the data, in its actual form, are not usable to estimate elder abuse prevalence in Belgium. Indeed, in the HIS report, abuse is included in the violence concept and it is not possible, according to the type of questions and analyses, to identify the difference between violence and abuse. Indeed, this limitation is related to the lack of information about the degree of trust in the relationship. A proxy factors potentially related to trust could be the location of violence (at home rather than in street) and the familiarity with the author (personally know the author or the author is a member of the household) but without any certainty. An additional limitation is the lack of information about the vulnerability of the elder in this section of the HIS. Again a potential proxy should be to focus on 75+ but again, as explained before, age is a risk factor of vulnerability but not a certainty factor. So currently, no specific analysis or conclusion is possible on elder abuse prevalence estimation

Moreover, the question in the HIS targets the "victim of violence in the past 12 months", so not in a lifetime but once in a recent issue. Finally, elder abuse is a delicate topic which could imply false negative answers and thus an underestimation of the real prevalence. So a careful interpretation is needed about the recognition of violence/abuse by the respondent and the fear of reporting as well as the absence of follow-up of reported cases. On an evolution aspect, a comparison between 2004, 2008 and 2013 is not possible because not every question was included in all years round.

However, a note can be taken. Indeed, the authors of the conclusions based on the HIS 2013 results recommend that the role of care professionals in the identification and documentation of violence should be highlighted and that the awareness of policymakers about violence is needed, notably, by collaboration within international projects (e.g. WHO Economic dimensions of interpersonal violence).

9.2.3 Data from police

Police offices collect data according to code related to the type of offence. During this study, more details on two police zone data were obtained. One in Brussels and one in Flanders. The data only concern the initial offence report (PV) on the territory of the zone. Information about the date of birth of the victims are available. One report can include several issues, several persons can be victims of a single issue and a same person can be the victim of several issues.

One main limitation of the data is that a labelling/code of the offence is never "elder abuse" as this concept is not recognized as an offence by itself. A long list of offences can however be considered as an elder abuse and within the codes for crimes there is a subdivision for intrafamily violence. But again the vulnerability of the victims and the trust in the relationship with the author are not known. Hence, it is impossible to reveal if it is a case of elder abuse or another type of intrafamily violence.

So, the use of the database as such is not possible to estimate the prevalence of elder abuse in each police zone.

9.2.4 Data from justice

No comprehensive database (containing all judgments) is available in Belgium but even though, similar to the data at the level of the police, the lack of "elder abuse" label would make impossible to have a clear view on the number of cases related to elder abuse. This absence of labelling is the main barrier to epidemiological data collection in the police and justice sectors.

9.2.5 Data in the context of BELRAI[a]

BelRAI is an in-progress large database concerning vulnerable people developed by the Belgian authorities. All healthcare professionals can or will can access, via the BelRAI system, to a specific screener tool[b] and assessment tools according to certain settings (home care, long-term residential care…) and certain topics (mental health, dependency…). Those tools do not aim to assess situation of elder abuse but can contribute to prevention of such abuse by guiding or alerting health care professionals of certain circumstances that may influence the vulnerability of the elder. They can also lead to anonymised extraction of data about vulnerable older people (more details in Appendix 1).

a https://www.etaamb.be/fr/protocole_n2018030846.html

b https://www.belrai.org/fr.

10 DIFFERENT STEPS IN THE TACKLING OF ELDER ABUSE

10.1 Prevention

Prevention is the action to prevent occurrence or development of a problem and/or its complications. In general, prevention corresponds to any action taken to avoid or remove the cause of a problem in an individual or a population before it arises. Primary prevention is concerned with preventing the onset of a situation, while secondary prevention tries to intervene and hopefully put an end to a situation before it fully develops. **In this report, the word "prevention" will only encounter primary prevention.** In the case of EA, primary prevention relates to the actions which prevent the abuse from occurring. It consists, as described in chapter 3, of professionals' awareness and training, public information campaigns, support to caregivers, improvement of policies and practices in nursing homes and home services for elderly, programmes to decrease societal ageism attitudes and set up of policies and laws which support the combat against EA[a].

10.2 Detection

Detection is defined as the action or process of identifying the presence of something concealed. It refers to the observation and (clinical) evaluation of patients suspected of being abused or having risk factor of abuse. It includes direct detection through direct contact with an older person, but also indirect detection through contact with a family member or a third party. The detection tools analysed in the chapter 5 only concern situations where a suspicion of abuse is present. It does not include a systematic search (screening) in all the older adult population.

10.3 Intervention

After the detection, an intervention is always required. This step is named the **early management** step or early intervention in this study and consists in giving an account of an observation or a suspicion to a person or a service, in order to protect the older person, help the family or intervene and stop the abusive situation. The early intervention can be a request for advice to a specialised service, a discussion with colleagues as well as an official reporting to a specialised service or to judiciary authorities. So early management is a comprehensive term that groups different actions (possibly) leading to different procedures. Chapter 4 analyses different step-by-step plans to guide professionals in early interventions.

Interventions occurring after early management relate to the actions led by specialised services, judiciary authorities and services or professionals that were referred to in the trajectory after early management. It merely concerns the stopping of elder abuse and ensuring (acute and long term) safety of the older person, treatment of physical/psychological injuries and prevention of recidivism for the author. This part of the process to tackle elder abuse is named '**long-term management**' in this report. However no in-depth analysis of this step was made in a particular chapter although it was discussed in the stakeholder consultations (Chapters 6, 7 and 8).

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[a] In 2010, the Canadian Ministry for families and seniors highlighted the meaning of elder abuse prevention by the following declaration: « La prévention [de la maltraitance] vise à réduire, voire à éliminer l'incidence de ce phénomène dans tous les milieux de vie des personnes aînées. Elle repose sur la promotion de valeurs telles que le respect de la dignité humaine, sur une connaissance des causes et des facteurs associés à la maltraitance et sur la responsabilisation de tous les acteurs sociaux dans la lutte pour réduire cette problématique sociale. Elle a pour effet d'augmenter le degré de sensibilité collective et de contribuer à l'acquisition d'attitudes et de comportements respectueux envers les aînés. Elle crée un climat où les personnes concernées se sentiront plus à l'aise pour briser le silence et faire les gestes nécessaires afin que cesse la maltraitance ». (Ministère de la Famille et des Aînés, 2010, p. 49).

11 EVIDENCE ON ELDER ABUSE INTERVENTIONS

Globally, too little is known on how to tackle elder abuse. Many risk factors remain contested, and the consequences and evidence for what works is limited.[8, 9, 34] A review of evidence on all issues related to elder abuse is kept up-to-date by the research chair on elder abuse in Québec. It is availablie in Appendix 4. Evidences on interventions are of interest for the set-up of policy. At the current state of the knowledge, efforts to respond to abuse include interventions such as:[9]

- mandatory reporting of abuse to authorities
- self-help groups
- safe-houses and emergency shelters
- psychological programmes for authors
- helplines to provide information and referrals
- caregiver support interventions.

Evidence for the effectiveness of most of these interventions is limited at present and can be summarized like this: (i) caregiver support, after abuse has occurred, reduces the likelihood of its reoccurrence; (ii) evidence suggests that adult protective services and home visitation by police and social workers for victims of elder abuse may in fact have adverse consequences, increasing elder abuse; (iii) multidisciplinary and inter-sectoral collaborations can also contribute to reducing elder abuse[9] by including the social welfare sector (through the provision of legal, financial, and housing support); the education sector (through public education and awareness campaigns); and the health sector (through the detection and treatment of victims by primary health care workers).[9]

A recent Cochrane review (2016) shows that there is inadequate trustworthy evidence to assess the effects of elder abuse interventions on recurrence of abuse although there is some evidence to suggest that EA interventions may decrease the anxiety and depression of caregivers. The authors of the Cochrane review conclude to the need for high-quality trials to determine whether specific intervention programmes are effective in reducing abuse episodes among the elderly, and to include in all future research a component of cost-effectiveness analysis, implementation assessment and equity considerations of the interventions.[8]

A Canadian researchers' team performed similar systematic review in 2017, analysing peer-reviewed literature between 2009 and December 2015 about the efficacy of community-based elder abuse interventions. Again the evidence is scarce what can be explained by the difficulties to study or reach the outcome 'decreased elder abuse and neglect'. However, this review highlight types of interventions currently under studying around the world. Among the 9 articles selected for inclusion, 2 'very high-evidence' level (level 1) were in favour of psychological interventions (like the START intervention). Four 'low evidence level' studies (level 4) support (i) conservatorship, (ii) an elder abuse intervention/prevention program named ECARE, and (iii) a multidisciplinary intervention. The remaining three included studies were classified as 'very-low evidence level' (level 5) and were about elder mediation and multidisciplinary interventions.[34]

How to better tackle elder abuse in Belgium: path of improvement from chapter I:

The collection of epidemiological data could be much more increased and improved:

- Specialised organisations could be better supported in their work of data collection
- Police and justice sectors could improve the labelling of cases in specifying that the offence is made against vulnerable adult, within a trust relationship
- Sciensano could include in HIS section about violence a question about trust in the relationship between the victim and the author; and the analysis of the results from the violence section could be merged with the data from the section about vulnerability/frailty.

- Data from the different sectors could be centralised, for example by Sciensano

The BelRAI database could be used by care professionals, relatives and older people to identify risk factors of elder abuse

Much more high-quality evidences could be collected about the efficacy of interventions against elder abuse. Incentives to the topic could be given to researchers. Types of interventions which need more evidences are the impact of mandatory reporting, the feasibility of self-help groups, the needs of safe-house or emergency shelters, efficacy of psychological programs for authors, the impact of helplines which inform and refer, and the efficacy of caregivers support programs.

CHAPTER 2: BELGIAN CONTEXT

1 INTRODUCTION

In this chapter the current state of affairs in Belgium regarding the tackling of elder abuse from a political, legal and organisational point of view will be described.

The following research questions will be addressed:

1. Who are the **political authorities** in charge of tackling elder abuse in Belgium?
2. What are the existing **repressive and preventive legal frameworks** to address individual elder abuse cases?
3. What are the **main specialized and non-specialized services** that may **provide aid** in the management of elder abuse?
4. Which **action plans, guidelines and good practices** were identified in Belgium to improve the tackling of elder abuse?

It should be stressed at the outset that elder abuse, as defined for this study, can be of very different types and occur in a wide variety of circumstances. Depending on the type of abuse and the severity, the concrete response(s) to an individual case can be judicial, social, medical or a combination of different solutions. Currently, a large range of services and actors can be involved but their actions are not necessarily coordinated. Consequently, it was not possible to present one unique and structured description for the management of all elder abuse cases.

First an overview of the **competent political authorities** involved in different policies against elder abuse will be described (see 3). Then an overview of the legal framework for elder abuse situations is given. In that part we will zoom in to the **repressive and preventive measures** (on an organisational level as well measures directly protecting persons) that can be applied by the competent actors (see 4.1 and 4.2). A specific section is devoted to the description and discussion of **legal rules applicable to professional secrecy** and to **the duty to provide aid to persons in danger (see Chapter 5)** as according to the consulted stakeholders (see Chapter 6, Chapter 7 and Chapter 8) these two issues can constitute major challenges for the persons facing an elder in an abusive situation. The overview of the steps in a criminal procedure can be found in appendix 2 of this chapter. In part 6 an overview is given of the non-judicial **actors involved in the management of (presumed) elder abuse cases**. Moreover **policy actions** related to elder abuse, **plans and protocols** and **good practices** in the field are described.

2 METHODOLOGY

To describe the legal framework, the research team consulted the following sources in the following order:

- **Latest coordinated versions of the Federal and Federated Belgian legislation[a].**

  Parliamentary works (preparatory discussions before the Parliament) of these legislations were also checked in order understand their rationale and to identify the ongoing debates or reform proposals.

- **Relevant case law** (jurisprudence).

  Judicial decisions were only used to understand the concrete application of the legislation. It was not possible to use these decisions for quantitative analysis of all elder abuses situations handled by the judges because only a very small part of the case law decisions are published[b].

- **Belgian legal literature** (doctrine) was also consulted, mainly with a view to provide a critical analysis of the relevant legislation.

  To complete the description of the institutional and organisational parts, official websites and documents of the public and private actors involved were consulted.

3 POLITICAL AUTHORITIES INVOLVED IN POLICIES AGAINST ELDER ABUSE

Elder abuse takes various forms, occurs in various contexts and has harmful impacts at different levels of our society, affecting public health but also social and democratic values. Therefore political responses involve different authorities, in particular those in charge of health, welfare and justice which makes the political response to this problem particularly complex. Moreover, in Belgium, those three competences are shared between the Federal, the community/regional and the local levels.

In contrast to what exists for child abuse management or for some specific types of violence (violence between adult partners), there are currently no joint political plan or joint operational protocols defining specific procedures between the justice, health and social sectors regarding elder abuse.

3.1 Health care and social security competences

Elder abuse impacts health policies at different levels not only because the consequences on the elder's health status can have a significant impact on care expenditure[35] but also because health care professionals and institutions could be, because of their regular contacts with elders, witness but also authors of such abuses. Both the Federal and the Federated health authorities are competent to tackle these issues[c].

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[a] Website of the Belgian Official journal. http://www.ejustice.just.fgov.be/loi/loi.htm.

[b] Only 0.5% of the judgments and arrests issued since 1945 are published on Juridat, the official database of the Ministry of Justice. https://www.lecho.be/economie-politique/belgique/general/les-arrets-et-jugements-seront-publies-sur-internet-en-2020/10128551.html. To improve this rate, the Belgian Law of 5 May 2019 amending the Code of Criminal Procedure [Code d'instruction criminelle] and the Judicial Code [Code judiciaire] with regard to the publication of judgments and decisions was enacted.

[c] Article 5 of the special law of 08.08.1980 on institutional reforms, *O.J.* 15.08.2980.

The **Federal State's health competences** regarding elder abuse may include:

- the suspension or withdrawal of the individual health care professionals' license to practice (visum) if the care delivered to the elder does not meet the quality requirements for health care practice (see infra, section 4.1.4).
- the provision of general information or guidance documents to support healthcare professional's decision regarding the detection and management of elder abuse[a] (see infra 7.2.1 and Chapter 4).
- data collection of elder abuse situation in health care contexts regulated by the federal (mainly hospitals)
- the enactment of specific social security rules to grant informal caregivers social special leaves (see infra 7.3).

The **Community's health competences**[b] include, among other things, elder's care in residential, long-term and rehabilitation settings as well as the organisation of primary care. They may for instance define organisational or qualitative rules for the care delivered by these settings and services. In case of serious abuses against elders, Federated entities may withdraw the licences of these services (see infra 4.1.5).

3.2 Justice competences

Elder abuse response may require the intervention of judges, either to sanction the author, or to protect the victim. The criminal prosecution and sanction of certain behaviours perpetrated against elders (see 4.1) as well as the definition of maintenance obligations (for instance of children's towards their parents) and guardianship procedures to protect incapacitated elders (see infra 4.2.2 and 4.2.5) fall within the Minister of Justice's competence. A large majority of the justice competences are therefore in the hands of the **Federal level.**

However, **Federated entities** are competent regarding victim's support services and justice houses (see infra section 4.1.5).

3.3 Security competences

The **Federal Minister for Security and Internal Affairs** is competent to define national policies against violence (national plans, awareness campaign, data collection etc.), including against elders[c], and for the training and organisation of the police services (Federal and local). Together with the Federal Minister of Justice, he sets, every 4 years, in a "Framework note of integral safety"[36], the security priorities at a national level. This plan is then translated in a "National safety plan"[37] containing specific measures to handle the security priorities (see infra 7.6.3).

The **municipalities** are also indirectly concerned by elder abuse as part of their local security competence[d]. In this context, municipalities may apply for financial support from the Federal Ministry of internal affairs if they set up a specific prevention plan that fit within the Federal program. Combating violence against elders is one of the possible issues (among about 20 others) mentioned by the Federal authorities in order to receive a Federal

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a https://www.health.belgium.be/fr/sante/professions-de-sante/thematiques-multidiciplinaires/violence-familiale/violences-familiales-1.

b See Appendix 5 for a description of the concrete exercise of these community competence in Belgium.

c https://www.besafe.be/fr/themes-de-securite/violence/la-maltraitance-envers-les-seniors.

d https://www.avcb-vsgb.be/fr/subsides.html?sub_id=320.

budget[a]. We found some examples of municipalities using this Federal amount to offer a subsidy to seniors in order to install tele vigilance systems at home[b] or to train elders against scams.

3.4 Welfare competences

General aid and help services for elders, not specifically related to care, is part of the welfare competences of the **Federated entities**[c]. This include, for instance, the creation of help and support services dedicated to elders (specific services providing aid to tackle abuses) of social services, services providing help at home etc. (see infra 0). The **municipalities** are indirectly concerned by the topic of elder abuse as part of their local welfare policies[d]. Depending on the priorities of each municipality, some of them chose to have specific services for elders. For instance, some municipalities offer (limited) financial support or advice for informal caregivers or propose psychological or social support to elders living on their territory. Additionally, centres for general welfare (OCMW/CPAS) are in charge of providing social and financial support to the persons who need material, medical, social or psychological aid and who are not able to pay for it. Since there are more than 500 municipalities in Belgium, it was not possible to examine for each of them which local initiatives are in place to support the welfare of elders. It should be stressed, however, that the proximity of municipal agents and social workers to the elders is a valuable weapon in the detection and reporting of situations of abuse of the elderly.

4 LEGAL FRAMEWORK PROTECTING ELDERS AGAINST ABUSE

The current Belgian legal framework contains several possible responses to elder abuse situations. Repressive responses focus mainly on the sanction of the author while preventive measures mainly intend to protect the elder before he or she is abused or to prevent the occurrence of new abuses.

Preventive measures with a more collective objective, such as improvement of the policies and practices in residential care facilities, awareness campaigns for the public and programmes to decrease societal attitudes and stereotypes towards older people are presented in section 7.4.

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[a] Royal Decree of 7 November 2013 on strategic security and prevention plans and neighborhood officers article 7, *O.J.* 29.11.2013. See also Ministerial Decree of 27 December 2017 determining the modalities of introduction, monitoring, evaluation and determining the modalities of granting, using and controlling the financial allocation relating to the strategic security and prevention plans 2018-2019, *O.J.* 05.02.2018.

[b] See for instance: https://www.quaregnon.be/ma-commune/securite/prevention

[c] See article 5 § 1 II, 2° of the special law of 08.08.1980 on institutional reforms, *O.J.* 15.08.1980.

[d] Decree of 9 February 2018 related to the local social policy, *O.J.* 26 February 2018 https://codex.vlaanderen.be/PrintDocument.ashx?id=1029068&datum=&geannoteerd=false&print=false#H1085079.

4.1 Repressive responses

4.1.1 Criminal sanctions against the author

The Criminal Code does not contain specific offenses that qualify as such because they are committed against elders. However, the most severe types of elder abuse described in chapter 1 will usually be covered by the Criminal Code. For instance:

- **Intentionally hitting, slapping or pushing an elder** could qualify as battery and assault (art. 398). If the intent was to kill the victim it could qualify as murder (art. 393) or aggravated murder (art. 394). If the murdering is committed against mother or father or ascendant it qualifies as parricide and is even more severely sanctioned (art. 395).
- **Severely mistreating elders (physically or psychologically)** may qualify as torturing (art. 417*ter*) or treating inhumanely or in a degrading way (art. 417*quater* and 417*quinquies*).
- **Giving an elder too many drugs** to harm him/her or to keep him/her calm without any medical need may be qualify as poisoning with (art. 397) or homicide or physical harm with (art. 402) or without intent (art. 421).
- **Neglecting an elder** could be sanctioned under manslaughter (art. 418) or abandonment (art. 423). A specific family abandonment offense (art. 424) sanctions children who abandon their parents or who refuse to pay for their maintenance after placing them under the watch of a third party or after they have been entrusted to a third party by court order. Voluntarily not feeding or caring for someone who is unable to provide for his/her own maintenance or not providing him/her with the necessary medical care is punishable under deprivation of food or care of a vulnerable person (art. 425) or neglect of maintenance obligations (art. 426 and 427).
- **Refusal to give aid** to an elder in case of great danger is also sanctioned (art. 422*bis*).
- More "psychological" and less visible abuses, such as **threatening** or **repeatedly put pressure** on an elder could be sanctioned under threat (art. 327 et seq.) or stalking (442*bis*).
- **Financial abuse** against elders can include scam and deceit fraud (art. 496), theft or racket (art. 461 and seq.). Using funds entrusted by the elder for personal purpose (e.g., bank investment) could be prosecuted under steal and breach of trust (art. 491 or 493).
- **Untruthfully and intentionally misusing someone's physical or psychological weakness to make him or her do things or omit things that affect his/her physical or psychological integrity or his/her assets** is specifically sanctioned under abuse of weakness (article 442*quater*). The abuse must be committed by the offender with the intention of causing harm, knowing the state of weakness that seriously impairs the victim's capacity to decide, in order to lead him/her to an act or abstention that seriously damages the physical or mental integrity or property of the victim.
- **Sexual abuse** of elder can be categorised and sanctioned under indecent assault (art. 373) or rape (art. 375).

Since 2011, several of the above mentioned offences are more severely sanctioned if they are perpetrated against *"persons in situation of vulnerability due to their age, pregnancy, illness, infirmity or physical or mental disability*" (see Box 1). In other words, the Criminal Code considers, for a very large number of offenses, the fact that they are committed against an elder as an aggravating circumstance. Those circumstances are evaluated at the end of the criminal procedure, when the judge decides on the sanctions. The evaluation of the vulnerability of the victim due to his/her age is not made on basis of a specific age or on basis of a medical expertise but on a case-by case basis by the judge. A very old age in itself is not sufficient evidence of vulnerability and must generally be corroborated by other evidence, evaluated by the judge.

Box 1 – The law of 26 November 2011 on abuse of people's position of weakness and protection of vulnerable persons against abuse under the criminal law

The law of 26 November 2011 is the first law explicitly aiming to tackle elder abuse in criminal law. This law pursues a double objective[a]. On the one hand, it introduces a new offence in the Penal Code by criminalising the abuse of a person's weakness (not only elders). On the other hand, it aims to provide a criminal response to the problem of abuse of vulnerable persons in general and the elders in particular[b] [c].

To that end:

- it provides for new aggravating circumstances, rendering sanctions more heavy, when certain offenses are commited against persons in situation of vulnerability "*due to their age, pregnancy, illness, infirmity or physical or mental disability*"
- it broadens the exceptions to professional secrecy to allow the holder of this secret to lift it in case of serious offenses committed against vulnerable persons (article 458bis see 5.4.2), and
- it abolishes criminal immunity for financial abuses committed within the family

In case of mistreatments or abuse of weakness, article 43 of this law also contains the legal ground to enable associations acting in the field of prevention against violence and abuse against vulnerable persons **to act in justice alongside the victim**, with his/her consent or the consent of his/her representative[d]. This procedural support was specifically intended to encourage vulnerable persons to report and fill a claim since these persons would often refrain from reporting ill-treatment or violence against themselves or their property because they fear for reprisals, of for being permanently abandoned or robbed[e]. This remains however theoretical because to implement this ground, a specific royal Decree needs to be enacted, setting the requirement to authorise these associations.

The parliamentary discussions of this law already highlighted the main problems related to the fight against elder abuse: the reluctance of the victims to report this type of offenses, the limitation of available data and the complicated context linked to the close relationships between the victim and the author.

In the context of the law of 26 November 2011 protecting vulnerable persons (including elders) against abuses, many of the experts auditioned before the Parliament indicated that for this new legal protection to have a real impact, **concrete and specific circulars from the General Public prosecutors and the Ministry of Justice were needed**. Among the proposed measures to improve elder abuse management, the specialists also proposed the appointment of a reference magistrate in elder's matters and the insertion of a specific nomenclature into the registration system of prosecutors' offices[f].

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[a] Law of 26 November 2011 on abuse of people's position of weakness and protection of vulnerable persons against abuse under the criminal law, *O.J.* 23.01.2012. See also parliamentary discussions, DOC., House of Representatives, 2010-2011, n° 53 0080/007, p. 4.

[b] This law is the result of several parliamentary initiatives in both the House of Representatives and the Senate. See different law proposals, DOC. Senate, n° 3-777/1(2007), nº 4-239/1 (2007), n° 5-191/1, n° 5-146/1, n°5-156/1, n°5-196/1 et nº 5-1023/1. See also arrest of the Constitutional Court n°146/2013 of 07.11.2013.

[c] The current reform of the Criminal Code also confirm this. *À la suite de l'avis du Conseil d'État, il est précisé que le renvoi dans la définition de personne vulnérable à "toute personne dont la vulnérabilité en raison de son âge" vise les personnes âgées »* Advice of the Council of State n° 64121/1, n°23.

[d] Article 43 of the law of 26 November 2011 on abuse of people's position of weakness and protection of vulnerable persons against abuse under the criminal law, *O.J.* 23.01.2012.

[e] DOC., House of Representatives, 2009-2010, n°52 0493/004.

[f] DOC., House of Representatives, 2009-2010, n°52 0493/004.

Despite these recommendations, no specific circular (binding guidelines for the police and justice sectors) was adopted on the criminal policy regarding elder abuses. At the time of writing this report, a COL related to elder abuse is drafted.

Yet, elder abuse partly falls in the scope of several circulars regarding intrafamily violence. In 2006, two circulars on criminal law policy were drawn up regarding intrafamily and partner violence. The first circular (COL3/2006 of the Minister of Justice and the College of General Public Prosecutors on criminal policy regarding **intrafamilial violence[38])** concerns the management of domestic violence in general and extrafamilial child abuse and focuses on **definitions** and the importance of **uniform identification and registration** by the police and the public prosecutor. The second circular (COL4/2006 of the Minister of Justice and the College of General Public Prosecutors on criminal policy regarding **violence between partners)** concerns violence between couples[39]) and elaborates on the importance of **the concrete approach** to partner violence and the coordination between police and judicial actors on the subject.

- **COL 3/2006** is an administrative (binding) guidance that indirectly covers part of the scala of elder abuse situations, namely violence between family members, including between spouses, violence against parents or grand-parents. The purpose of this circular was to set up specific data checks by the public prosecutor's offices and the police in order to make up for the lack of such data concerning violence within the couple or, more broadly, within the family. This violence may be physical (e.g., assault and battery voluntary), sexual (e.g. indecent assault or rape), psychological (e.g. harassment,slander, libel, slander, insults) or even economic (e.g. family abandonment). This guidance obliges the Prosecutor's offices to register several offenses or behaviours with a specific focus on partner violence and child abuse. Where before 2006 solely the code IFV was available, 3 new codes were added in 2006, i.e. IFV against descendents, IFG against other family members and extra family child abuse. An evaluation of the implementation of the COLs related to the registration practices showed that since the introduction of COL3 and COL4, for the year 2006 in about 56% no relationship between perpetrator and victim was registered.[40]

- The joint circular **COL 4/2006** of the Minister of Justice and the College of General Public Prosecutors on criminal policy regarding **violence between partners** concerns violence between couples and thus further limits it's application to elder abuse.

  The objectives of this circular were to 1° define the main lines of the criminal policy related to violence between partners; 2° establish a uniform system enabling the identification and registration of situations of violence between partners by the police services and the public prosecutors' offices; 3° define the minimum measures to be applied in all judicial districts of the country (arrondissement) and encourage specific local actions; 4° provide the judicial and police services with the tools and references on which they can base their action. It is foreseen that an action plan related to violence between partners is elaborated per judicial district by the Public prosecutor. This plan shall take into account the possibilities for reception of victims and perpetrators in the district and, where appropriate, outside it, by public institutions and services and private associations active in the social, psychological, medical and judicial fields. The plan is also concretised by cooperation protocols, which specify the modalities of the cooperation. Another particular measure in the COL is the assignment of a reference magistrate for violence between partners who is the first contact point related to IFV and is amongst other responsible for the sensitization of police and magistrates about the COL and the action plan. At the police level, it is foreseen that a reference police officer is appointed.

  It is stated in the COL that the elaboration of the intervention model described in the circular should be the target within all districts of the country. However, their implementation may depend on the specific situation in each district, in particular of the human and material resources and services available. During an evaluation of COL 4/2006 in 2009 by the College of Prosecutors-general, assisted by the service

for judicial policy,[a] the fact that collaboration protocols had been concluded in most of the districts was welcomed and it was recommended that they be extended to all districts in order to meet the objectives of the circular. However, the restructuring of public prosecutor's offices, in parallel with changes in the personal careers of magistrates, had led in a number of the districts to a blurring of the criminal policy for combating domestic violence: the magistrates of reference did not really fulfill the role of coordinating criminal policy and acting as interlocutors with other actors and, consequently, protocols that had not be renewed have fallen into disuse. For some, even though intra-family violence is considered a priority, the years that have passed since the circular came into force have in fact become routine. Finally, at that time, there was a call for the creation of multidisciplinary chain approaches on the model of the "CO3" project in Antwerp, the LINK project in Limburg, arguing that only such an approach makes it possible to achieve the policy objectives of combating domestic violence in the most serious cases. In the meantime almost all provinces in Flanders have such a chain approach or Family justice houses (see section 6.1.5).

- The joint circular **COL 18/2012** of the Minister of Justice, the Minister of Internal Affairs and the College of General Public Prosecutors on the **residence ban in case of domestic violence**[41]. A Law of 15 may 2012 introduced the temporary prohibition of residence in cases of domestic violence (see for more details on the law 4.2.1). The circular intends to have a uniform application of the law[b] and defines the modalities and the roles of all parties (prosectors's office, police and service for aid to victims) concerned. The COL also includes templates for the decision at the level of the prosecutor's office, the notification to the police and the notification of the banned party.
- The **COL 4/2018** of the College of Prosecutors-General at the courts of appeal on **case concertation and professional secrecy**[42]**:** Article 458ter of the Criminal Code provides new possibilities for organising so-called case consultations between the various holders of professional secrecy and thus for interdisciplinary cooperation, for instance by aid services, police and justice (see also 5.4.5). The circular contains guidelines on the actions of the Public Prosecutor's Office in the context of these case consultations. As there is a diversity of possible consultation structures, ad hoc cases or pilot projects that can be created and the far-reaching powers offered to the prosecution service, it is necessary to define a unified vision that can serve as a guideline for the prosecutor's office. As a guideline, the public prosecutor participates in the case consultations within the framework of a protocol. The Public Prosecutor may become aware in the case consultation meeting of information that constitutes a breach of professional secrecy and that relates to offences for which the consultation is organised. It is important for the public prosecutor to point out to the participants in the case consultations, that only "secret" information relating to offences for which the consultations are organized can be discussed. The Public Prosecutor then decides, in a joint consultation with the other participants in the consultations, on the most appropriate actions, *which will not necessarily be legal actions*, that can be taken. In that scope it is important to note that the aim of case consultation is prevention.[c] An actor that is holder of the professional secrecy can have alarming information on a situation and feel the need to share it with other actors.

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a K. BERTELOOT Salih SIVRI, Marie-Rose BROUCKER, « Evaluation de la circulaire commune COL4/2006 du Ministre de la justice et du Collège des procureurs généraux relative à la politique criminelle de violence dans le couple : rapport de synthèse », Service de la politique criminelle, décembre 2009 ; http://www.dsb-spc.be/doc/pdf/EVA_COL4_synthese_091216_NL_def.pdf

bb Law of 15 may 2012 on the temporary prohibition of residence in cases of domestic violence, *O.J.* 1 01.10.2012

c DOC House of Representatives 54 2259/001, bill related to the simplification, harmonisation, informatisation and modernisation of dispositions of civil law and civil process law, as well as notaria and related to diverse dispositions regarding justice, p. 218.

This does not hinder however, the legal missions of the public prosecutor defined in the criminal code.

4.1.2 Professional ban against the author in case of sexual offenses

In case of sexual offenses the judge may prohibit the offender, temporarily or permanently, from directly or indirectly managing a nursing home, a service flat or any residential structure for vulnerable persons, or from being a member, as a volunteer, statutory or contractual staff member or as a member of the administrative and management bodies, of any institution or association whose activity mainly concerns vulnerable persons (art.378 of the Criminal Code).

It should also be noted that the regime of professional ban provided for in cases of sexual abuse against minors is more robust (382bis) since it allows much broader prohibitions namely:

1. to participate, in whatever capacity, in education for minors;
2. to be a member, as a volunteer, statutory or contractual staff member, or as a member of the administrative and management bodies, of any legal person or de facto association whose activity mainly concerns minors;
3. to be assigned to an activity which places the convicted person in a relationship of trust or authority with minors, as a voluntary member, member of statutory or contractual staff or as a member of the administrative and management bodies of any legal person or de facto association;
4. to live, reside or hold himself/herself in a specified area.

Very serious offences other than sexual may have been committed by professionals against elders that would certainly justify a professional ban. It is therefore questionable whether it would not be legitimate for a professional ban to be imposed by the judge seized rather than waiting for the professional orders (which exist only for doctors and pharmacists) or the administrative authorities to do so[a].

Another weakness is that this sanction does not apply (except for minors) to help or care professionals working solo or under independent collaborative contracts despite the fact that many elders care and support services at homes are provided by self-employed people.

4.1.3 Specific but limited support during the criminal procedure

All victims and their relatives shall be treated in a correct and conscientious manner, in particular by providing them with the necessary information and, where appropriate, by putting them in contact with specialized services and, in particular, with victims support services (article 3bis of the Preliminary title of the Criminal Investigation code).

Very often the police and the prosecutors' offices adapt themselves to the profile of the victims, for example by hearing the victim in his/her residence or seeking the help of victim support services. It should be noted, however, that not all are specially trained in elder abuse, which can sometimes prevent either a successful prosecution or an effective reorientation towards non-contentious avenues.

Moreover, vulnerable persons such as elders may encounter additional difficulties thorough the different steps of the criminal procedure[b].

Therefore, since 2019, article 91bis of the Code of Criminal Investigation allows vulnerable person to be accompanied by a person of his or her choice during his or her hearing by the judicial authorities. This allows an elder to ask someone he or she trusts (it can be anyone) to **support him or her**

[a] License withdrawal may be decided by public health authorities but in separate procedures and deontological bodies may take deontological measures (only for physicians and pharmacists).

[b] See Appendix 6

during the hearing unless Public Prosecutor or the Investigation judge is of the opinion this could impair the interest of the vulnerable person or the discovery of the truth. Unfortunately, the list of offenses for which this right to be accompanied is applicable only covers certain offenses[a] against elders but does not include abuse of weakness for instance.

In addition, **victim's support services** can also play a very important role in providing elders with an appropriate support during the criminal procedure. However aid to the victims covers a large number of different services with different missions:

Short-term police support

Within the police zones (and the Federal Judicial Police of each arrondissement), the **police victim assistance service provides** emergency assistance and short-term support. It can intervene even if the victim does hesitate to file a complaint, for example in the event of domestic violence.

Houses of justice

The **service for victims of the Houses of Justice** collaborate with members of the public prosecutor's office and the court in the context of judicial procedure. It offers a range of services and support at any stage of the proceedings and acts as an interface with the judiciary, but only with the agreement of the judge in charge of the case. Since the 6th State reform these services were transferred to the Communities. These services mainly orient the victims to the house of justice victims help service.

Non-profit organisations

In addition, **private non-profit organisation** financed and licenced by the Communities, provide aid to the victims independently of the police and judicial authorities. They provides social, administrative and psychological support in the short, medium and long term. They can focus on specific type of victims (domestic violence, sexual violence etc.[b]). Examples of those services are presented in section 6.1.4. Some victim's support services organised by the municipalities have also an agreement of the Communities for their services.

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[a] This article refers to the following offenses:

- article 347bis (prise d'otage)
- articles 371/1 to 377 and 377quater (voyeurisme, attentat à la pudeur et viol)
- articles 379, 380, 380bis and 380ter (corruption de la jeunesse et prostitution)
- articles 383, 383bis, 385, 386 and 387 (outrages publics aux bonnes moeurs)
- articles 398 à 405ter, 409 and 410 (homicide volontaire non qualifie meurtre et des lésions corporelles volontaires)
- articles 422bis 422ter (défaut d'assistance à personne en danger),
- article 423 (délaissement d'enfant ou de personne vulnérable) – abandonment (article 424) is not refered to.
- article 425 (privation d'aliments)
- article 426 (négligence)
- article 428 (enlèvement),
- article 433quinquies to 433octies (traite des êtres humains)

[b] http://www.victimes.cfwb.be/ou-trouver-aide/services-aide-victimes/ (Wallonia and French-speakers in Brussels); https://www.caw.be/ (Flanders and Dutch-speakers in Brussels), http://www.ostbelgien.be (German-speaking region).

4.1.4 Administrative or deontological sanctions against individual health care professionals

If the author of an abuse against an elder is an individual health care practitioner, he/she might (in addition to potential criminal / civilian prosecutions) be sanctioned by a withdrawal of his/her license to practice by the Federal public health authorities. Currently, **specific provincial commissions within the FPS Public Health** are competent to control the exercise of health care professionals' licences. If there is serious and consistent evidence that the continuation of the practice raises serious concerns for the patient's health, medical provincial commissions may suspend the licence to practice of any healthcare provider (including physicians, midwives and physiotherapists) or impose certain conditions for pursuing the practice[a]. If a health care professional is convicted for a criminal offence threatening healthcare provision[b], medical provincial commissions may withdraw or suspend the licence to practice or impose certain conditions for pursuing the practice.

In the future, the competencies of the medical provincial commissions will be transferred to a Federal Commission for the Control of Health Care Practice. This Commission will still be part of the FPS Public Health but it will centralize the control on all health care professional. Unlike the current medical provincial commissions, investigation powers will be granted to this Federal Commission (articles 44 to 63). Moreover, the competences of this Commission will be extended: it will assess the physical and mental capacity of all health care professional but also the quality of the care provided by them (on basis of the new quality requirements enshrined by the Law on the Quality of Healthcare Practice)[c].

In addition to these administrative sanctions, **deontological bodies** (when they exist, namely for physicians and pharmacists) may withdraw the deontological membership (which in practice leads to a withdrawal of the right to practice).

Those procedures are complementary to other procedures and do not involve reparation for the victim. In both cases, the claim may be filed by anyone including the patient, by a member of the patient's family, by another health care professional or by a public body (e.g. NIHDI, FAMHP, Federated entity).

Complaints related to quality of care delivered by a healthcare professional in a hospital or an infringement of other patients' rights (see Patients' Rights Act of 22 August 2002[d]) can be directed to the mediation service of the respective hospital. Complaints related to the quality of care delivered by a professional in the ambulatory sector (e.g. a general practitioner, a specialist in a private practice, an independent nurse, a physician providing care in a residential setting,…) can be launched by patients, their representative or their close relatives to the federal mediation service "patients' rights".[e] When patients or relatives launch a complaint to a mediation service, the mediator will attempt to solve the incident via mediation in collaboration with the professional and the patient. If parties do not get to a solution via mediation, the mediator informs the complaining party on the alternatives to solve the problem.

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[a] Article 119 2° i of the Law of 10 May 2015 regarding the exercise of health care professions, *O.J.,* 18.06.2015

[b] Article 119 2° h of the Law of 10 May 2015 regarding the exercise of health care professions, *O.J.,* 18.06.2015

[c] Article 45 of the law of 22 April 2019 regarding the quality of health care practice, *O.J.* 14.05.2019.

[c] Articles 44 to 63 of the law of 22 April 2019 regarding the quality of health care practice, *O.J.* 14.05.2019

[d] Patients' Rights Act of 22 August 2002, *O.J.* 26 September 2002

[e] https://www.health.belgium.be/en/federal-ombudsman-service-patients-rights

4.1.5 *Administrative sanctions against services and residences for elders*

Residential settings as well as care or help services at domicile for elders must comply with **quality and organisational rules (accreditation norms)** issued by the competent federated entities[a]. These entities are exclusively competent to regulate, organise, finance[b] and control all nursing homes, residential settings, rehabilitation or day care centres, short stay centres, integrated home care and help services and first line health care associations.

In all federated entities, those quality rules include staff requirements, training requirements, and requirements regarding the respect of the fundamental rights, autonomy and dignity of the elders. Common registration obligations concern registration of decubitus, falls and contention measures. However, these rules do not treat elder abuse as a specific topic except in Brussels where the COCOM foresees general training and information obligation (see infra). Furthermore, in Flanders, the residence and care facilities ("woonzorgvoorziening" = a local services centre, a home care service, a group of assistance flats or a residential care center) and the informal caregiver associations need to have a written procedure for each type of unappropriate behaviour towards the users of the respective services.[c] This procedure needs to be integrated in the quality manual. The procedure needs to include prevention, detection and appropriate reaction to unappropriate behaviour and anonymised registration of situations of unappropriate behaviour. Residence and care facilities and informal caregivers also need to report each case of unappropriate behaviour to the Agentschap zorg en Gezondheid via a standardised template. It is not defined in legislation what is meant by "unappropriate behaviour". Whereas in an earlier version of the legislation only sexual unappropriate behaviour was targeted at, the new version focusses on all types of unappropriate behaviour which suggests a large concept including all types of elder abuse as well. On top of the procedures related to unappropriate behaviour, the law foresees that serious events impacting the care and support, the health, safety, dignity or integrity of the users of the services, need to be immediately reported to the Agency. At the moment of the writing of the report it is not clear which measures can be taken by the Agency. The law foresees that more explicit rules can be formulated.

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[a] As described in appendix 1, the Flemish Community is competent for institutions in Flanders and for institutions and services exclusively organized in Dutch in Brussels, the Walloon Region (exercising the competence of the French-speaking Community) is competent in Wallonia. The COCOM is competent for bilingual institutions and services in Brussels and for the French speaking rest-and nursing homes in Brussels. The COCOF is competent for The COCOF remains competent for the service flats, day centers and home care services organized in French and the German-speaking Community is competent for the German-speaking services in Wallonia.

[b] The Communities fund the construction, functioning, nursing staff and acts of daily living but the reimbursement of pharmaceuticals and of fees for medical care remains federal.

[c] Art. 10 of the Decree of the Flemish government of 28 June 2019 related to the programming, accreditation criteria and the subventioning of residence and care facilities and informal caregiver associations, *O.J.* 21 november 2019

Flanders

With regard to the quality of care, residence and care facilities ("woonzorgvoorziening" = a local services centre, a home care service, a group of assistance flats or a residential care centre) and the informal caregiver associations need to carry out a self-evaluation[a]. This self-evaluation contains a periodic evaluation of the following aspects:

1. the functioning of the residential and care facility or the informal caregiver association;
2. its objectives.

For each evaluation, the following steps are completed, each time for a period of three years:

In this self evaluation the facility demonstrates at least:

1. how data related to quality of care are collected in a systematic way;
2. how data are used to formulate quality goals;
3. which step plan + timing is drafted to reach the goals;
4. the method and frequency of evaluation whether the goals are reached;
5. which steps are undertaken if one of the goals were not reached.

The residence and care facilities and the informal caregiver associations need to keep the annual report of the previous working year and the quality planning for the current year at disposal of the Agency Zorg en Gezondheid from 15 April each year. The annual report contains the registration data on the general policy and the quality policy. It also contains an evaluation of the quality planning. The quality planning contains a description of the activities undertaken to achieve the objectives, the quality requirements and the quality management system. Furthermore, a right of complaint has to be guaranteed and it has to be ensured that complaints are dealt with adequately and objectively. The residential care facilities and the informal caregiver associations also needs to measure the satisfaction of its users at least every three years and make adjustments accordingly.

The Vlaamse Zorginspectie controls organisations working in different domains: health, welfare, care for the disabled, home care... Its inspection services lead inspections, publishes the criteria applied, the general reports of its inspections and its control policy on its website[b]. For residential care centers (woonzorgcentra), the Flemisch care inspection intends to perform unannounced inspections every 3 years. Furthermore there are also thematic inspections (for instance regarding hand hygiene). **The inspectors check the quality norms[c] and indicators (see further) and compliance with accreditation standards[d] but there is no particular focus on elder abuse apart from the duties related to the reporting and registering of unappropriate behaviour against users of the services and an obligation for residential care centers to display the contact data of the Woonzorglijn.** The residential care centers, centers for short stay and day care, service flats and residential complexes with services are also subject to **sectoral quality requirements**.[e] These requirements concern respect for

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[a] Art. 8 of the Decree of the Flemish government of 28 June 2019 related to the programming, accreditation criteria and the subventioning of residence and care facilities and informal caregiver associations, *O.J.* 21 november 2019

[b] https://www.departementwvg.be/home-zorginspectie-organisaties.

[c] Decree of 17 October 2003 related tot he quality of health-and welfare services

[d] See annex XI of the Decree of the Flemish government of 28 June 2019 related to the programming, accrediation criteria and the subventioning of residence and care services and informal caregiver associations, *O.J.* 21 november 2019; The goals, the general principles and the missions of the residence and care facilities are integrated in the Decree of 15 Februari 2019 related to 'woonzorg' but this decree will only enter into force on 1 January 2021.

[e] Ministerial decree of 10 December 2001 regarding quality of care in rest homes, centers for day care, centers for short stay, service flats and facilities with service provision, *O.J.* 28.03.2002

privacy, dignity, autonomy, participation, freedom of choice, integration, security, right of complaint, information and rights of the elder.

Via the **Flemish quality indicators project** that started in 2013[a] in all Flemish residential care centres for +65, a number of **indicators** in residential care centres that are important in the context of quality care and its follow-up are also measured. Objective indicators such as decubitus cases, fall incidents, medication incidents and physical restrictions on freedom are controlled. Moreover, subjective indicators are also controlled regarding the patient's feelings and satisfaction[b].

If a non-compliance is identified with the accreditation standards, the quality norms or indicators reveal problems in residential care centers, centers for short stay and day care, service flats and residential complexes with services, the Agenschap voor Zorg and Gezondheid can propose a remedial plan. If no improvement is noted, a negative (sanction/ withdrawal of the license) procedure is initiated. Since March 2019 some residential care services where recurrent complaints were registered are submitted to more intensive inspection and follow-up.[c] If residents or other parties involves have a complaint related to care or organisational issues in a residential care service, they can address a complaint to the Woonzorglijn (see 6.1.2). The Woonzorglijn informs the Zorginspectie of complaints.

Home care services also need to comply with accreditation standards[d] and quality norms[e]. Thematic supervision with a short, specific inspection each year in a sample of services is carried out. In addition, follow-up inspections are also carried out in which the Zorginspectie checks the general operation. These inspections do not take place with a fixed regularity. The frequency and content of inspection visits are determined in consultation with the agency Zorg en Gezondheid. A model report has also been developed for these inspections. Inspections can be announced or unannounced depending on the theme and purpose of the inspection visit. The emphasis of the inspection lays on demonstrating that the work complies with the standards (accreditation criteria and quality system) and on testing the functioning on the work floor.

Wallonia

The Audit and Control Department of the AVIQ controls and possibly sanctions institutions and services for elders. As in Flanders, those institutions are subject to **sectoral quality requirements**. These requirements concern respect for privacy, dignity, autonomy, participation, freedom of choice, integration, security, right of complaint, information and rights of the occupant[f]. The compliance with these requirements is part of the care inspections. Each residential care facility is obliged to put in place minimum procedures and to register falls and containment measures.

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a Zorg en Gezondheid cooperates with elderly care and umbrella organisations on quality policy and quality improvement for the Flemish residential care centres. Thanks to the Flemish Indicators Project Residential care centres support these partners in a continuous process of quality improvement. This happens based on data on the care and **experiences of residents**, which are specifically related to aspects of quality of care and quality of life. https://www.zorg-en-gezondheid.be/vlaams-indicatorenproject-voor-woonzorgcentra-vip-wzc; https://www.zorgkwaliteit.be/

b https://www.zorgkwaliteit.be/woonzorgcentra.

c https://www.zorg-en-gezondheid.be/verscherpt-toezicht-bij-woonzorgcentra-met-aanhoudende-en-ernstige-kwaliteitsproblemen

d See annex II of the Decree of the Flemish government of 28 June 2019 related to the programming, accrediation criteria and the subventioning of residence and care services and informal caregiver associations, *O.J.* 21 november 2019

e Decree of 17 October 2003 related tot he quality of health-and welfare services

f See Walloon Code of Social Action and Health (decree and executive decree).

The audit and control department will ensure that residential settings comply with the relevant standards by carrying out periodic and unannounced checks and inspections, or following a complaint, of the establishments in question. The aim of the Audit and Control Department is to find solutions by acting in conciliation. Decision against the institution may range from the suspension of the license with a time limit for the establishment to comply with the regulations to the withdrawal of license (either for certain activities or for the whole). In most serious cases where urgent measures are required, the establishment may be temporarily or definitively closed.

Complainants may request the inspection service to keep his/her identity confidential.

In addition to the above-mentioned service, complaint regarding the operation and organization of a facility for the elderly (notice, meals, lack of care, hygiene, staff, etc.) can be relayed to the Mayor of the municipality where the establishment is located.[43] The Mayor is competent to "act in conciliation and formulate recommendations which seem likely to him to bring a solution to the difficulties of functioning"[a].

Brussels

In the Brussels Hoofdstedelijk Gewest the programmation, accreditation and control falls within the competence of the COCOM[b] for he bilingual facilities for care for elders and the French speaking rest-and nursing homes (that were transferred to the COCOM since 1 january 2016). Iriscare is the executing instance. The Flemish Community is competent for the Dutch speaking facilities for care for elders and the Agentschap Zorg en Gezondheid is the executing instance. The COCOF remains competent for the French speaking service flats, day centers and home care services. Each authority has its own rules regarding to accreditation norms including quality requirements for the respective settings and the inspection of these norms.[c]

Regarding **residential institutions** for elders that are under the jurisdiction of COCOM, the legal rules include an **obligation to place the phone numbers of the services specializing in combating elder abuse in a place where it is accessible for elders**. This apply to all “services where older persons are living/staying”[d].

There are also specific obligations to **train staff and directors in these matters** (but only in rest- and nursing- homes, institutions for short stay and stay during the day). These obligation do not apply to other services such as services for home care or aid at home. Moreover they do not apply to settings depending on the VGC or COCOF in Brussels.

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a Article 43 of the Walloon Code of Social Action and Health.

b Ordonnance of 24 April 2008 related to facilities for day care and short term stay and residence of elderly, *O.J.* 16 May 2008

c For the residential facilities and facilities where elderly can stay, falling within the competence of the COCOM: Decree of the Unitied College of 3 December 2009 setting the accreditation criteria the residential facilities and the facilities where elderly can stay need to comply with and the description of the grouping and fusion and the special norms they have to fulfill, for home care services falling within the compentence of the COCOM Ordonnance of 7 Novermber 2002 related to centers and services offering assistance to persons, *O.J.* 27 November 2002; for facilities falling within the competence of the VGC see supra regulation for Flanders; For the French speaking home care services. – Decree of 5 March 2009 related to the offer of ambulatory services in the domain of social action, family and health care, *O.J.* 8 May 2009

d Decree of 3 December 2009 of the United College setting the accreditation norms for elderly facilities organising day care, short stay and housing and describing the grouping and fusion and the specific norms that need to be accomplished, *O.J.* 17 December 2009.

Complaints with regard to care or organizational aspects in Brussels can be addressed to Infor-Home (for the French speaking) and Home-Info (for the Dutch speaking). If an amicable settlement is not possible, the complaint can be directed to the inspection services. Complaints related to elder abuse in bilingual facilities for elderly or French speaking rest-and nursing homes in Brussels can be addressed to the mentioned specialized services but also to Iriscare. In case of a complaint, an inspection will take place and non-anonymous complaints will get an answer.

Box 2 – Specific obligation for residential settings in France

In France, the Code of Social Action and Families obliges the residential settings and services to report to the public authorities any serious dysfunction in their management or organisation likely to affect the care of users, their support or respect for their rights, and any event that threatens or compromises the health, safety or physical or moral well-being of the persons being cared for or helped (Article L 331-8 of the Social Action and Family Code)[a].

This includes, for instance, disruptions in the organisation of work and human resources management, accidents or incidents related to an error or a lack of care or supervision, situations of disruption in the organisation or functioning of the structure related to recurring relational difficulties with the family or relatives of a person being cared for, **or situations of mistreatment of persons cared for or helped** (Article 1 of the Order of 28 December 2016 on the obligation to report social and medico-social structures)[b].

4.2 Preventive measures

4.2.1 Temporary ban from the residence

If an adult sharing the residence of an elder seriously and immediately threatens the elder's safety, the Public Prosecutor may order a temporary residence ban during 14 days maximum[c]. This measure needs to be confirmed by the Family Tribunal (Tribunal de la famille – Familie Rechtbank) that may lift the ban or extend it for maximum three months. This measure can also be applied preventively before an offence is committed but is limited to threats to the physical or psychological safety. Threats that are solely related to material or financial security are excluded according to the COL 18/2012[41].

In 2019, the law was completed and strengthened the sanction in case of non-compliance with a residence ban aimed to introduce more monitoring of the banned person. Moreover the law stipulated that the public prosecutor shall immediately communicate his or her decision of temporary ban of residence to the **competent service of the communities** so that those services may **assist and inform the victims**[d]. It is also foreseen that the public prosecutor shall immediately communicate his or her decision of temporary ban of residence to the **competent service of the communities** so that those services (i.e. the houses of justice) may **assist and follow up the banned person**.

At the time of writing the report it is not clear how this aid and follow-up is implemented. A tricky issue is **housing** for the banned person during the

a https://www.legifrance.gouv.fr/affichCode.do;jsessionid=A3185E4EB9A33FC93A497EF0EC2476F4.tplgfr23s_1?idSectionTA=LEGISCTA000006157636&cidTexte=LEGITEXT000006074069&dateTexte=20200409

b https://www.legifrance.gouv.fr/affichTexte.do?cidTexte=JORFTEXT000033749053&categorieLien=id

c Article 3 of the Law of 15 may 2012 on the temporary prohibition of residence in cases of domestic violence, *O.J.* 1October 2012

d Law of 5 May 2019 related to diverse dispositions in penal matters and matters of cultes and modifying the law of 28 May 2002 regarding euthanasia and the social penal code, *O.J.* 24 May 2019 (art. 165-169)

ban and control of the respect of the ban. Many other countries have also adopted the measure of banning from residence but there is a lot of variation in the implementation (see for the example of the Netherland Box 3). In some countries housing is foreseen, in others it was foreseen not to provide organized housing to make actors more responsible[44]. Several countries have an **electronic monitoring system** to control the respect of the ban[44].

Box 3 – Example of the Netherlands: Crisis aid in the first ten days of the ban

In the Netherlands for instance, crisis aid is organised for the persons involved for the primary duration of the measure (the 'ten-day track')[44]. During this period, no actual aid has been provided yet since ten days is too short for that. The intention is to get a good knowledge of the situation and then to hand over the persons involved to other aid services after ten days. The coordination of the aid, which can be of a very diverse nature, is provided by case managers. The experience in the Netherlands is that mobilising the emergency services during the crisis time has positive consequences for the acceptance of the aid by those involved. The displaced person, the victim and the person(s) left behind are more open to a conversation and are less resistant to aid.

4.2.2 Placement of the elder under guardianship (the incapacity regime)

When someone's decision-making capacity is impaired, protective measures can be decided by a judge in order to protect this person and his/her property. This regime was not solely or particularly designed to prevent elder abuse but is of course particularly important for elders since older people with mental problems can be more susceptible of financial abuse and other types of abuse.

A guardian (this might be a member of the family or a relative as well as a professional, such as a lawyer) will be assigned to manage the individual's rights related to person (for instance patients' rights) and/or to property.

The provisory guardianship may be requested by the person self, his/her family or any other interested party (neighbour, nurse or social worker, etc.) or by the King's Prosecutor (article 488bis Civil Code). The judge of peace will always evaluate the situation on a case by case basis (unusual expenses, unusual behaviour, etc.)

In addition, the judge may take constraint measures in a certain number of cases (**observation in a hospital, internment,** etc.).

A medical certificate ('detailed medical certificate') is only necessary if the requested measure will affect the person's autonomy. This certificate is not required when the request concerns a prodigal (person who wastes his income on unnecessary expenses).

The actors involved in this protection regime (justice of peace, administrators) are also particularly well placed to prevent, identify and redress problematic situations. However, sometimes the guardian is also particularly well placed to become the author of (financial) abuse. To avoid this, the law foresees a periodic evaluation by the judge of peace of the work of the guardian.

The law with regard to guardianship is currently under revision; the medical certificate will have to be drafted by psychiatrist or recognised physicians

and could no longer be drafted by a GP.[a] This was designed to improve the evaluation of incapacity but will cost a lot of money and is likely to increase waiting lists. Paradoxically, while the current reform aims to avoid unfairly depriving a person of his or her right to decide for himself or herself, these new amendments could also increase uncertainty and thus hinder or delay prompt action against other types of abuse.

4.2.3 Extra-judiciary mandate (article 489 to 490/2 Civilian Code – article 1984 to 2010 civilian code)

Adults who are still capable can write a mandate to organize their future protection for the day they will no longer be capable to take their own decisions.

This is called the **extra-judicial mandate**. This warrant can be written by the person self or with the help of a notary.

The person must designate the person who will be responsible for managing his/her property and/or person (the trustee). It can be a close friend, a family member. Some restrictions apply to members of the staff of residential settings for elders. In addition, the National Order of Physicians considers that, “from an ethical point of view, it is not advisable for a doctor to accept to be appointed as a trustee of a patient's property or as a representative of his or her person in the context of extrajudicial protection. Whether the doctor acts as the treating doctor or as the coordinating doctor of the nursing home where the patient resides is irrelevant here[45].”

The warrant must describe the exact powers given to the trustee (paying invoices, managing bank accounts, filing the tax return, choosing the residence, exercising the patient's rights, etc.).The person can also indicate how she/he wants his/her property to be managed (sell this property, rent this property, etc.) and more personal aspects, such as organising a move or a placement in a nursing home.

The decision of the elder is then registered in a specific register.

If one day, the person becomes incapable of managing his or her assets, the mandatary then implements the mandate and carries out the mission as provided for in the mandate.

During the execution of the mandate, any person may at any time ask the judge of peace to check the exercise of the mandate. The judge then checks whether the trustee correctly executes the mandate, and whether the actions he or she takes are in the interest of the elder.

If the justice of the peace finds that the warrant is not the best protection, he or she may convert the warrant into a measure of administration of property and/or person (guardianship). He then appoints an administrator, who takes over management under the supervision of the justice of the peace.

Since 1 March 2019, the scope of the extrajudicial mandate has been extended: one can now give a mandate covering personal decisions. For example, an extra judicial warrant can explicitly state that the persons want to live in his/her home (and be cared for there) as long as possible, designate the rest or care home in which he/she wants to reside, specify the patient's rights that the representative can exercise, etc. There are, however, some exceptions. Indeed, certain extremely personal acts listed in the Civil Code (for instance marriage) cannot be performed by the trustee and the mandate cannot derogate from the specific legislation relating to certain declarations of will (in particular with regard to euthanasia) which continue to prevail.

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[a] Art. 1241 § 1 Judicial Code

4.2.4 Nullity or prohibition of certain financial transfers

The civil Code foresees that when a person grants or legates something, his/her decision may be revoked in case of **ingratitude**. There is ingratitude in case of refusal to fulfil maintenance obligations or in case of serious abuses, offence or insults committed by the grantee against the donor or testator[a].

Thus, **if an elder is victim of such abuse (for instance an abuse of weakness[b] or other serious mistreatments) by a person to whom he or she has granted or bequeathed something, this donation may be declared null and void by a judge upon request of the elder or his/her inheritors**.

Moreover, in order to protect vulnerable persons against financial abuse by individuals who may particularly influence their judgment, civil law provides for **certain prohibitions to inherit or receive any benefit by will or donation act**.

The first category encompasses **doctors, health officers and pharmacists** who have treated a person during the illness from which he or she dies[c]. Those persons cannot receive any advantage either by donation act or by will if those acts were established for their benefit during the course of this illness[d].

The incapacity to receive gifts or inherit depends on several conditions: the caregiver must belong to one of the categories mentioned in the list of article 909; he must have treated the person for a specific illness; and the donation or testament must occur during this illness from which the person dies.

The condition of the disease is very restrictive. Moreover, the terms “doctors”, “health officers” and “pharmacists” no longer perfectly match the current legal terminology and are not defined in the legislation.

When this article was revised in 2003[e], the legislator considered that these terms should nevertheless be maintained since they **were general terms covering all health professionals who, in one way or another, treat or provide care to ill persons**[f].

However, in practice, courts do not always apply such a broad reading. For example, the Ghent Court of Appeal ruled in 2012 that an independent nurse providing care at home cannot be considered as a health officer[g]. A few years later, the same Court of Appeal considered that the term "health officers" may also refer to nurses, physiotherapists or psychologists, because they care for patients and can, depending on their knowledge and skills, alleviate suffering and perhaps even prolong life. However, the same Court considers that article 909 C. civ. does not apply to domestic home services without nursing character[h]. The Brussels Court of Appeal ruled that home nurses who provide medical care and domestic help to a terminally ill

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a Articles 955, 2°, and 1046, paragraph 1, of the Civil Code.

b The abuse of weakness constitutes an offence referred to in article 442quarter of the Penal Code.

c Art. 909. « Physicians, surgeons and gynaecologists, officers of health and the pharmacists who have treated a person for the ilness the latter died of, cannot benefit from gifts or testaments that were drafted during the period of illness ».

d Article 909 of the Civil Code.

e Law of 22 April 2003 related to the modification of article 909 of the Civil Code, O.J. 22 May 2003

f *Doc. parl*. 50-0150/004.

g Ghent (11e ch.) 13 December 2012, *NJW* 2013, afl. 284, 510, noot VANDENBERGHE, K.; *Rev.trim.dr.fam*. 2014 (samenvatting DANDOY, N., FONTEYN, J., VAN HECKE, A.), afl. 1, 219; *Rev.trim.dr.fam*. 2016 (samenvatting DANDOY, N., FONTEYN, J.), afl. 1, 223; *TBBR* 2015, afl. 7, 368, noot MAES, E.

h Ghent (11e ch.) n° 2016/FA/0590, 29 mars 2018 *Not. Fisc. M*. 2018, liv. 3, 73; *TEP* 2018, liv. 2, 345; *T. Not*. 2018, liv. 6, 485

patients are legally disqualified to inherit or receive any benefit by will or donation act[a].

The **doctrine also seems to hesitate regarding the scope of this article**: some authors include nurses and professional caregivers[b] and others do not[c].

Even when the patient dies from a cause other than the illness for which he or she is being cared for by a doctor, the National Council of the Order of Physicians recommends that all donations (gifs) should in principle be refused. Under no circumstances can a doctor encourage a patient to make a donation that directly or indirectly benefits him or her. He/she cannot create or encourage the feeling that the patient is morally indebted to him/her. The practice of his profession by a doctor does not justify any other reward than the payment of his honoraria[d].

Since 2003, managers and staff members of nursing homes, care and nursing homes and any other collective accommodation for the elders may not receive any advantage either by donation act or by will that a person staying in their institution may have made for them during their stay[e]. This prohibition applies to the above mentioned persons but not to the institution itself[f].

Moreover, the same prohibition apply to the HCP's taking care of an elder in the context of euthanasia procedures (article 15 of the law of 28 may 2002) and to the religious counsellor as well as with regard to delegates of the Central Secular Council.

Various reform proposals were made in order to clarify the scope of this prohibition for professional care and help givers but none of them suceeded[g].

The third category encompasses, since 2018[h] **the administrator (trustee) and any person appointed by the judge** to exercise guardianship. They cannot receive any benefit from the protected person or the person in respect of whom the mandate is exercised during the course of judicial protection or the mandate. This provision shall not apply to the person designated by the elder as preferred trustee when the elder was still capable and to close family members, spouses and person living with the elder as cohabitant[i].

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a Ghent (11e ch.) 31 May 2018, *RW* 2019-20, afl. 15, 585 en http://www.rw.be/ (20 januari 2020); *TEP* 2018, afl. 4, 924; *T.Not*. 2018, afl. 10, 797

b J. Sace, *op. cit*., p. 123, no 92; « Les libéralités - Dispositions générales », *Rép. not.,* 1993, p. 213, no 193

c M. E. de Wilde d'Estmael (*op. cit*., no 83) et par M. L. Raucent, (*op. cit*., no 103)

d Advice of the National Order of Physicians nr. A160006 (Bull. 160) - 24/02/2018.

e Article 909, al 2. The managers and members of the personnel of rest and nursing homes and care homes as well as every other structure for collective habitation for older persons cannot benefit from gifts during life or testamentary gifts that a person living in their facility would have done during his/her stay.

f Civ. Eupen (3e ch.) 15 juin 2009, *JLMB* 2011 (samenvatting), afl. 6, 284 en http://jlmbi.larcier.be (17 februari 2011)

g Doc. Parl., S., 2010-2011, 5-395/1. Also Doc. Parl ; Ch., 200-2001, 1287/001, on de loi modifiant l'article 909 du Code civil (DOC 500150/004). DOC 50 1175/001, DOC 50 0150/004

h Art. 908 « The administrator as mentioned in book 1, title XI, chapter II/1, and any other person executing a legal mandate cannot benefit from any gifts during life or testamentary gifts that the protected person or the person for which the mandate was done could have done during the legal protection or mandate. This does not apply to persons in article 496, alinea 1, and in article 909, alinea 3, 2° et 3°. »

i Law of 21.12.2018 related to diverse dispositions regarding social affairs, *O.J.* 17 January 2019

In view of the ageing of the population, current policies increasingly favour home care and professional networks supporting elder's autonomy.

The lack of clear rules on the granting of financial benefits to certain actors is a gap in the protection afforded to elders against financial abuse. We could actually think of all the people who take care for the elder in his daily lives, such as home nurses, nurses' aides, senior aides, paramedics, dentists, physiotherapists, therapists, social workers, but also psychologists, CPAS/OCMW staff members, notaries, lawyers, employees of banking organizations, insurance companies, savings banks, etc.

It is even more important to clarify these rules since many of these persons are self-employed and are not subjected to the control of their employer.

In general, consideration should be given to a system of integration of independent carers either in a coordinated network around the elderly person or in a professional association that would have an obligation to come and ensure that there is no abuse and that no pressure is put on the elderly person.

The working rules of a home care and help service may of course contain a prohibition on accepting donations or legacies from caregivers. Violation of this prohibition is then a contractual fault and may constitute a reason for immediate dismissal[a]. However, the accreditation standards for home care associations do not require this.

4.2.5 Imposition of care and maintenance obligations

The maintenance obligation applicable to parents for their children is reciprocal (Articles 205, 207 and 353-14 of the Civil Code). Children therefore have a maintenance obligation towards their father and mother if they are in need[b].

There are situations where family solidarity is not self-evident. However, the duty of aid to his parents is an obligation enshrined in the Civil Code since the Napoleonic era. Given the current ageing process and the amounts granted under the statutory pension scheme, this maintenance obligation could become more and more important in the coming years.

If cases where elders use this right themselves are rare, most of the Centres for general welfare use this provision in court to force family members to fulfil their obligation towards elders helped by the centres in the first place.

To impose a maintenance obligation to the concerned family members, the justice of peace will appreciate two things.

1. The parent's state of need and the resources available to him/her.

The state of need differs in each situation depending on the parent's age, standard of living, environment and state of health. The judge will assess the amount necessary to enable the person to lead a decent life *in relation to his or her usual lifestyle.*

But his behaviour will also be taken into consideration: if he has recklessly squandered his money or if he has been inactive out of laziness, he may be refused aid from his children. The state of need must therefore be **"involuntary".**

If the judge considers that the parent's resources are insufficient, he or she may ask his or her children to help. But they must also have the means to help their parents.

[a] Gent (11e ch.) n° 2016/FA/0590, 29 mars 2018 *Not. Fisc. M.* 2018, liv. 3, 73; *TEP* 2018, liv. 2, 345; *T. Not*. 2018, liv. 6, 485

[b] Various articles of the Civil Code concern maintenance obligation between parents and their child's (see articles 205, 207, 208, 209, and 210).

2. The means available to children. To assess the situation, the judge will weigh the children's income against their (incompressible) expenses. If there is a margin available, children will be required to contribute. The calculation will be made on a case-by-case basis. The basic idea is that everyone contributes in proportion to their means, even if they are limited.

It is the family court that is responsible for ordering this type of contribution (may even authorize an attachment of salary).

In case someone was civilly condemned to pay pension to his parents and voluntary decide not to during more than two months, it can be sued (article 391bis of the Penal Code).[a]

5 DUTY TO PROVIDE AID AND PROFESSIONAL SECRECY

Elder abuse or presumption thereof often raises numerous questions for both professionals and non-professionals who ask themselves if they are allowed or obliged to share information or doubts in order to protect the elder or to take other actions.

In this regard, no one is deemed ignorant of the law. Therefore every citizen should in principle be aware of the rules in relation to his or her duty to provide aid. In addition, professionals and in particular health care professionals or professionals providing aid should be familiar with the rules applicable to professional secrecy.

However, as illustrated in the following section, the practical application of these rules is not always easy.

5.1 Everyone has a duty to assist a person in great danger…

There is a **legal general duty for any citizen (professional or not) to help a person in great danger**. Articles 422*bis* and 422*ter* of the Belgian Criminal Code indeed punish under "guilty abstentions" (with prison sentences up to 2 years):

- "*anyone who refrains from helping or providing aid to someone exposed to a serious risk when he or she could have intervene without serious danger to himself or others*"(article 422bis)
- "*anyone who refuses or neglects to provide someone in danger with the legally required aid when he or she could have intervene without serious danger to himself or others*

[a] https://www.actualitesdroitbelge.be/droit-de-la-famille/obligations-alimentaires/les-obligations-alimentaires/la-pension-alimentaire-fondee-sur-un-etat-de-besoin; https://e-justice.europa.eu/content_maintenance_claims-47-be-maximizeMS_EJN-en.do?member=1

This article punishes the deliberate inertia or a selfish refusal to provide aid[a]. It entails a positive obligation to provide aid for all citizens, including judges, social workers, and healthcare practitioners, even when they are holders of a professional secrecy[b].

This obligation arise when the following circumstances are met[c]:

- Someone is in a **life-threatening situation** or is facing **threat to his/her integrity or safety. However** an offense does not necessarily need to be commited.
- The person required to intervene has knowledge of this great danger either because he/she **has ascertained the danger** him/herself or because the **situation has been reported** to him/her by the person(s) calling for help or seeking for an intervention
- The danger is **real** and actual
- Helping the victim does **not cause a serious danger** to the person required to intervene or to others

The victim's consent is not necessary and action can even be taken against his/her will. Moreover, the help provided does not need to be successful. Therefore one cannot justify inaction by saying that it would have been useless, inefficient or inadequate[d].

Article 422*bis* of the Criminal Code does not define which action is needed to be taken. The person requested to intervene has to provide the help that he /she thinks is most appropriate. Consequently article 422bis does this not impose any obligation to report. However, a professional who hides behind professional secrecy, without taking any measures to help persons in danger, risks to be guilty for violation of the duty to assist.[e]

Box 4 – Can obligation of aid apply to psychological abuse?

According to the data of the specialized associations (see 6.1.3, 6.2.1, 6.3.3 and 6.3.4), one of the most frequent types of abuse against elder is psychological. Therefore, one can ask whether the intended danger can be a danger to psychological integrity. Unfortunately, this question does not receive a clear answer. Article 422bis of the Criminal Code does not explicitly regulate this point because it only refers to "a serious risk" for the victim and the case law is divided[f].

In any case, when the danger is solely of a psychological nature, a particular attention must be paid to its gravity.[g] A mere situation of stress does not constitute a danger within the meaning of Article 422bis of the

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a Cass. 7 november 2012, Pas., 2012, 2162, *Rev. dr. Santé – Tijd.Gez. Recht.*, 2012-2013, 310 ; Cass., 9 novembre 1964, *Pas.*, 1965, I, 242.

b T. OPGENHAFFEN and J.PUT « Wegwijzers Beroepsgheim », https://www.law.kuleuven.be/isr/wegwijzers-volledig.

c T. OPGENHAFFEN and J.PUT « Wegwijzers Beroepsgheim », https://www.law.kuleuven.be/isr/wegwijzers-volledig

d Cass., 9 novembre 1964, Pas., 1965, I, 242.

e N. COLETTE-BASECQZ, "La violation du secret professionnel dans une situation de maltraitance d'enfant. La justification par l'autorisation de l'article 458bis du Code pénal ou par l'état de nécessité", *T.Gez.* 2009-10, (22) 27.

f For the Cour d'appel de Liège (25 juin 1986) the answer was no (see https://www.compsy.be/fr/422bis#_ftn4) but more recent decisions include psychological abuses. (see Tribunal correctionnel d'Anvers du 24 novembre 2000 (*R.W.*, 2000-2001, p. 1423). Tim OPGENHAFFEN and J.PUT « Wegwijzers Beroepsgheim », https://www.law.kuleuven.be/isr/wegwijzers-volledig.

g DE LA SERNA, I. (2010). Chapitre IX – Les abstentions coupables. In Bosly, H.D., et De Valkeneer, C., (dir.). *Les infractions. Volume II. Les infractions contre les personnes*. Bruxelles : Larcier, p. 553. (quoted by https://www.compsy.be/fr/422bis#_ftn4).

Criminal Code[a]. However, a threat on mental health can have repercussions on the physical level. These potential consequences are undeniably taken into account when assessing the seriousness of the danger.[b]

5.2 ….even holders of a professional secrecy

In some cases, the most appropriate help will involve an obligation to breach professional secrecy because it is the only way to protect someone form a great danger. The decisions are left to the professional him/herself. Article 422bis requires the professional to provide the aid that he or she feels is most appropriate either by intervening himself or herself or referring to a third party[c].

Legal literature considers that social workers or health care professionals (bound by a professional secrecy) should in principle and unless urgency, provide aid themselves. If this is not enough, an appropriate third party can be called upon, in the first instance, in the same profession. Only if no suitable solution can be found within the same profession, a report to the social services, the police or the judiciary may be necessary to fulfil the obligation to provide aid[d].

For physicians, article 29 of the Medical code of ethics[e] states that a physician who *suspects* that a vulnerable person is being mistreated, abused, exploited, harassed or subjected to negligence shall immediately take the necessary steps to protect that person. The physician has the deontological obligation to discuss the problem with the concerned person to the extent of his or her capacities and encourages him or her to take the initiative. If the concerned person gives his/her consent, the physician shall consult a competent healthcare provider or refer the case to a multidisciplinary structure. The physicians shall inform the person's relatives of this fact only in his or her interest and with his or her consent. A physician who suspects that a vulnerable person is threatened by a serious and imminent danger or that there are indications of a serious and real danger that other vulnerable persons may be victims of mistreatment or negligence ***may,*** according to the legal provision of the Penal Code (458bis), inform the public prosecutor when he cannot himself or with the help of others protect the person's physical or psychological integrity.

5.3 Professional secrecy …

Article 458 of the Penal Code imposes a duty of professional secrecy on medical professionals and on necessary confidents who due to their status or profession obtain knowledge or secrets entrusted to them. The persons bound by a professional secrecy are defined by law, tradition or custom. Professional secrecy concerns however only professions where confidentiality is considered by the society to be more important than other values such as the truth finding, the efficient flow of information within the help services or communication with the patient/client's network.

This obligation of non-disclosure applies not only to information acquired directly from the person concerned, but also to person related information which the professional learns from other sources in his character as the

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[a] DE LA SERNA, I. (2010). Chapitre IX – Les abstentions coupables. In Bosly, H.D., et De Valkeneer, C., (dir.). *Les infractions. Volume II. Les infractions contre les personnes*. Bruxelles : Larcier, p. 555. (quoted by https://www.compsy.be/fr/422bis#_ftn4).

[b] https://www.compsy.be/fr/422bis#jur6.

[c] Vanderstraete, I. et Put, J. (2005). *Beroepsgeheim en hulpverlening*. Brugge: Die Keure, p. 150; Traest, P. (2011). Enkele aspecten van schuldig verzuim. *Tijdschrift voor onderwijsrecht en onderwijsbeleid, 2011* (12), p. 8. And Traest, P. (2011). Enkele aspecten van schuldig verzuim. *Tijdschrift voor onderwijsrecht en onderwijsbeleid, 2011* (12), p. 8.

[d] Tim OPGENHAFFEN and J.PUT « Wegwijzers Beroepsgeheim », https://www.law.kuleuven.be/isr/wegwijzers-volledig.

[e] https://www.ordomedic.be/fr/code-2018/contenu/.

confident of the person concerned. Anonymized information's are however not secret if the concerned person is not possible to identity.

Box 5 – Content of professional secrecy is a political choice

It is important to recall that the boundaries of professional secrecy are a political choice in each democratic society. Legislators may modify the limits of professional secrecy depending to what is appropriate in their democratic society. All countries did not make the same choices in that regard. It is therefore not an untouchable concept[a].

As recalled by the Belgian constitutional Court, professional secrecy is **not a value in itself** but a "**process for defending certain values**". When these values are in conflict, a hierarchy is necessary, although this is not always a comfortable solution for the holder of professional secrecy because sometimes he/she has no other guide than to "listen to the voice of his/her conscience".

Under Belgian law, various exceptions exist to professional secrecy, in the Criminal Code itself, in specific laws and in the case law of the highest court (Cassation court).

Regarding those exceptions, the belgian Constitutional court ruled (regarding derogation to professional secrecy under article 458bis)[b] that « vulnerable persons are entitled to State protection, in the form of effective prevention, protecting them from serious forms of violation of the rights set out in articles 3 and 8 of the Convention (ECHR, 15 December 2005, Georgiev v. Bulgaria; 2 December 2008, K.U. v. Finland, § 46). Consequently, regarding vulnerable persons, the authorities must pay particular attention and provide victims with increased protection because of their ability or willingness to complain, which is often weakened (ECHR, 10 May 2012, R.I.P. and D.L.P. v. Romania, § 58)".

5.4 ….and exceptions thereto

5.4.1 A legal obligation or authorization

Article 458 of the Criminal Code states that there is no breach to professional secrecy when :

- A professional is obliged to disclose confidential information during a testimony before a court (judge) or before a parliamentary Committee
- A professional is obliged or authorized by a law to divulge such information. In this regard, some legal provisons of the federated entities forsee an obligation to report. For instance the Madrane Code regarding Youth help **obliges** the **social worker** to inform the Public prosecutor when a minor's physical or psychological integrity is in great danger or when is health or safety is severely compromised.[c] In Flanders, professionals under professional secrecy **can** provide information to the mandated services (i.e. a mandated service decides whether the government should intervene in the aid for youngsters and their family[46]) without consent of the person involved if this is necessary to intervene in a problematic sitation ('verontrustende situatie).[d]

[a] Doc. Parl. 2000-2001 - 50-0695/0009 parliamentary hearing p.16 presentations by Mr Lambert and Hutsebaut.

[b] Constitutional Court, case 163/2013, B18.

[c] Article 35 § 5 of the Decree of 18 January 2018 (Madrane Code on prevention, youth help and youth protection), O.J. 3 April 2018

[d] Article 76 in fine, Decree of 12 July 2013 on integral youth help, *O.J.* 13.09.2013

5.4.2 A right to report under article 458bis

The right to report has been explicated for certain circumstances and specific categories of persons in art. 458bis of the Criminal Code. According to article 458bis of the Criminal Code, holders of a professional secrecy who are aware of certain abuse[a] against a vulnerable person *are allowed to* inform the public prosecutor. This article was initially introduced as a consequence of the Dutroux case and concerned the report of severe abuses against minors.[b] In 2011 (see supra Box 1 on the law of 26 November 2011), the scope of this article was extended to other categories of vulnerable persons. These persons must be vulnerable as a result of pregnancy, **age**, **illness or physical or mental infirmity or inadequacy**. In 2012, the scope was further extended to victims of partner violence.[c]

The right (it is not an obligation) to report to the public prosecutor exist the following circumstances are met[d]:

- An offence has been committed against a minor or vulnerable person
- This offence is one of the offences included in the list established by article 458bis of the Penal Code
- One of the two situations arises:
  - there is a serious and imminent danger to the physical or mental integrity of the victim
  - there are indications of serious and real danger that minors or vulnerable persons, other than the victim of the acts already committed, may be the subject of one of the offences referred to in Article 458bis of the Penal Code.
- The holder of professional secrecy is not able, alone or with the help of third parties, to protect the integrity of the person in danger
- This holder of professional secrecy cannot protect the integrity of the victim himself or with the help of others (by means of shared professional secrecy for instance) in order to preserve the confidential patient-care professional relationship.

Box 6 – Practicability of article 458bis to cases of elder abuse?

The criminal offences listed in art. 458bis only cover sexual assault, rape, murder, parricide, voluntary manslaughter, physical violence, genital mutilation, abandonment, deprivation of care and minor's kidnapping. This implies that the professional is able to identify this specific list of offenses (which is not easy). This also misses other frequent offenses against elders such as abuse of weakness or financial abuse. Yet, for these offences the figure of 'state of necessity' can be applied (see infra).

Purely preventive reporting of possible harm to the direct victim cannot be done based on this article since serious and imminent danger to the physical or mental integrity of the victim is one of the conditions.

Additionnaly, this article only allows the report to the Public prosecutor and not to the police or administrative services.

[a] Article 458bis Criminal Code refers to various offences

[b] Law of 28 November 2000 regarding penal protection of minors, *O.J.* 17.03.2001.

[c] Law of 23 Februari 2012 modifying article 458bis in order to extend it to offences of intrafamily violence, *O.J. 26.03.2012*

[d] T. OPGENHAFFEN and J.PUT « Wegwijzers Beroepsgeheim », https://www.law.kuleuven.be/isr/wegwijzers-volledig.

5.4.3 State of necessity

A state of necessity is a legal principle of law, which is not expressly enshrined in law, but which is unanimously accepted by case law and doctrine. A state of necessity is an objective ground for justification which allows facts to be revealed when they are a priori covered by professional secrecy. When applying the 'state of necessity' the violation of a legal provision (in this case professional secrecy) is the only way to protect an interest of a higher value (e.g. a person's life). A state of necessity will succeed if there is an **imminent certain and serious danger** to the victim, the holder of professional secrecy can **only safeguard the victim's interests by breaching his professional secrecy** (this is the necessity requirement) and if the **interest of professional secrecy does not outweigh the interest of the victim** (this is the proportionality requirement). There is no state of emergency if a holder of professional secrecy provides information of which he has been aware for more than a year. After all, in this case there is no imminent harm.[a]

The state of necessity as a justification created legal uncertainty for the holders of professional secrecy. In view of its non-statutory nature and its casuistic interpretation, it was not always clear whether the requirements for disclosure have been met.[b] The legislator responded to these objections by introducing article 458bis of the Criminal Code (cfr. Supra). Yet, article 458bis Criminal code have set more restrictive conditions, such as the limited list of offences for which it applies.

Box 7 – What in case of doubts/suspicion?

Both art. 458bis of the Criminal Code and the state of necessity require an imminent and serious danger as one of the conditions to lift professional secrecy. An imminent danger implies an immediate need to intervene. Serious danger refers to the extent and the far-reaching nature of the facts. A situation that drags on over a certain period of time and in which there is insufficient progress within the voluntary aid, can also acquire a threatening and serious character.[c] It is up to the holder of professional secrecy to make this assessment. The same goes for art. 422bis of the Criminal Code where the notions of life-threatening situation or serious breach of integrity are open for interpretation by professionals bound by professional secrecy.

5.4.4 Patient's consent

The Belgian jurisprudence remains divided regarding the possibility to allow that a professional can be released from the obligation to keep information confidential if the patient consented. Initially the Court of Cassation had the opinion that a physician cannot be released from the duty to secrecy because the patient has consented to the disclosure of confidential information. In the Court's opinion the duty of medical secrecy is of public order and thus it is not to the disposition of the patient. Article 64 of the medical deontological code is in line with this opinion. Yet, **in the meantime the same Court of Cassation recognised that professional secrecy**

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[a] Luik 25 mei 2009, *T.Gez.* 2009-10, 44; A. DE NAUW, Inleiding tot het bijzonder strafrecht, Mechelen, Kluwer, 2010, 300, nr. 380

[b] A. DIERICKX, "Misdrijven gepleegd ten aanzien van een minderjarig of kwetsbaar persoon. Een commentaar bij de wet van 30 november 2011", *NC* 2013, (33) 34, nr. 4. Zie ook: I. VANDERSTRAETE en J. PUT, *Beroepsgeheim en hulpverlening*, Brugge, die Keure, 2005, 161, nr. 325

[c] Amendementen, *Parl.St.* 1999-2000, nr. 2-280/2, 3-4; A. DE NAUW, *Inleiding tot het bijzonder strafrecht*, Mechelen, Kluwer, 2010, 298, nr. 379; V. DE SOUTER, "Het beroepsgeheim en de invoering van een spreekrecht door de wet van 28 november 2000 betreffende de strafrechtelijke bescherming van minderjarigen. Een nadere analyse van het artikel 458bis van het Strafwetboek", *TJK* 2001, afl. 5, (184) 192; F. GOOSSENS en F. HUTSEBAUT, "De wet van 28 november 2000 betreffende de strafrechtelijke bescherming van minderjarigen", *R.W.* 2002-03, (1361) 1374, nr. 51; A. TANS en J. PUT, "Het beroepsgeheim uitgehold? Een versoepeld meldrecht voor geheimplichtigen", https://steunpuntwvg.be/images/rapporten-en-werknotas/het-beroepsgeheim-uitgehold, 9, nr. 15; P. TRAEST, "Enkele aspecten van schuldig verzuim", *T.O.R.B.* 2011-12, (83) 88.

serves the interest of the client/patient[a]. Lower tribunals, courts of appeal and more recent doctrine have recognized that the consent of the patient may release a physician / social worker of his duty of medical secrecy if consent relates to a clearly defined part of the information and an identified receiver[b]. Furthermore, consent needs to be free, informed and explicit[c]. Consent of the patient/victim for disclosure of an abusive situation is often problematic in elder abuse cases, since older persons are often ashamed of the situation or do not want the abuse to be tackled because they are loyal with the offender who is often a family member.

5.4.5 Individual case discussion and management (458ter)

In case of abuses, multidisciplinary approach is often recommended. Cooperation and exchange of information between social workers and judicial and police actors can therefore contribute to a more effective and accurate approach of the problem[d]. A number of initiatives, such as chain approach (structural collaboration of aid services, police and justice) and the Family Justice Centers (see 6.1.5), in which cooperation takes place in a structural manner, illustrates this trend. A legal basis has been created for a specific form of cooperation when security or integrity is at stake: the case consultation. This resulted in a new article 458ter in the Criminal Code. Article 458ter of the Criminal Code recognizes the principle that different actors (police, justice and social services) who do not share the same objective, can however exchange information's in a structured case concertation in order to take a common decision.

This article is a general provision that needs to be further operationalised in a law, decree or ordonnance or in an argumented decision from the Public Prosecutor, either in a specific case or in the context of a specific protocol. One cannot therefore invoke Article 458ter of the Criminal Code directly. As no regulations have yet been issued for the operationalisation of article 458ter of the Criminal Code, currently the case consultation can only be organised with the permission of the public prosecutor. In some provinces in Flanders, a protocol setting the modalities for this kind of case concertation between aid services, police and justice was elaborated (yet, it was not public at the time of writing of the report). The legal text of the prosecutor's decision or protocol must at least determine ***who can participate*** in the case consultation, ***for what purpose***, and ***according to which modalities*** the consultation will take place. The consultation must be organised with a view to (1) protecting the physical or psychological integrity of the victim or of third parties, or (2) preventing terrorist offences or offences committed within the framework of a criminal organisation. A circular (COL 4/2012, see 4.1.1) contains guidelines on the actions of the Public Prosecutor's Office in the context of these case consultations.

Article 458ter does not require all participants in the consultation to be bound by professional secrecy. Both secretaries and non-bound persons may be associated with the consultation. For those who are bound, article 458ter is important because it allows them to share secrets with third parties. For the non-bound parties, article 458ter is important because it imposes on them a special obligation of secrecy with regard to the secrets learned in the course of the consultation.

At the time of the writing of this report, Wallonia submitted a Decree implementing article 458ter regarding the publics services involved in youth

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[a] Cass., 30 octobre 1978 ; Cass., 9 février 1988; Cass., 18 juin 2010. Nys, H. (2016). *Geneeskunde. Recht en medisch handelen*. Mechelen: Wolters Kluwer, p. 515.

[b] Tim OPGENHAFFEN and J.PUT « Wegwijzers Beroepsgeheim », https://www.law.kuleuven.be/isr/wegwijzers-volledig

[c] Tim OPGENHAFFEN and J.PUT « Wegwijzers Beroepsgeheim », https://www.law.kuleuven.be/isr/wegwijzers-volledig

[d] https://www.caw.be/locaties/co3/), ketenaanpak (https://www.departementwvg.be/justitiehuizen/ketenaanpak-intrafamiliaal-geweld), casusoverleg,

protection[a]. The Council of State[b] asked the government to clarify the intent and the conditions, blocking the adoption of this text for the moment. In addition, a new decree was adopted in Flanders regarding justice houses[c] adding the possibility for justice houses to participate in such concertation. The parliamentary discussions underline that justice's houses "may play a role in case concertation". This text does not however organise itself such concertation.

5.4.6 Shared professional secrecy

Under certain conditions the sharing of confidential patient information between professionals bound by professional secrecy is accepted.This is not as such an exception to professional secrecy and it is different from the multidisciplinary case concertation mentioned above (article 458ter). This is called the 'shared professional secret'. According to jurisprudence the application of the shared professional secrecy needs to meet the following conditions[d]:

- The information transfer is **necessary and pertinent** for the task of the professional concerned
- The professionals need to '**treat' the same person and with the same objective**

Doctrine added the requirement that the person concerned also needs to have **priory consented (at least implicitly)** to the information exchange or needs to be at least informed on the information transfer[e]. In order to facilitate collaboration in team, doctrine further adapted the conditions defined by jurisprudence. As such all patient related information **relevant** for the professional treatment or aid can be shared between professionals (subject of professional secrecy) of the **same team**.[f]

The idea of shared professional secrecy was also inserted in the legislation of the Communities. In art. 74 of the Flemish Decree integral youth help for instance the actors of the Intersectoral Access Gate, the mandated services, the social services, the pupil guidance centers, the providers and other persons and services providing youth care can share personal data of the person for whom help was organised. The sharing needs to be necessary for the care providing, in the interest of the person(s) for whom the care is organised and as much as possible with the consent of the person concerned.

It is important that professionals that share confidential information act within the same purpose. Police officers for instance are on the one hand submitted to professional secrecy, but on the other hand, they have a duty to report according to their mandate. The sharing of confidential information between professionals in the sector of health and social aid, police and the judiciary context cannot take place within the application of the shared professional secrecy as parties serve another finality.

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[a] Bill related to the modalities of the participation to concertation as in article 458ter of the Criminal Code.

[b] C.E., Avis 65512/4 du 15/04/2019 http://www.raadvst-consetat.be/dbx/adviezen/65512.pdf. See also Avis 66217/2 du 17/06/2019 ; Avis 66032/4 du 20/05/2019, Avis 64879/4 du 04/02/2019.

[c] Decree of 26 April 2019 regarding the houses of justice and the legal first line assistance, *O.J.* 17.06.2019 – not entered into force yet

[d] Cass. 13 maart 2012, *NJW* 2012, 597, noot C. CONINGS, *T.Gez.* 2012-13, 144, noot A. DIERICKX en J. BUELENS en *T. Strafr.* 2012, 333, noot T. BAUWENS.

[e] T. BALTHAZAR, *Arts, werknemer en sociaal verzekerde: de taak van de arts bij de toepassing van het sociaal recht*, Gent, Faculteit Rechtsgeleerdheid Universiteit Gent, 2000, 641; F. BLOCKX, *Beroepsgeheim*, Antwerpen, Intersentia, 2013, 99.

[f] I. VAN DER STRAETE en J. PUT, *Beroepsgeheim en hulpverlening*, Brugge, die Keure, 2005, 234-239.

Table 2 – Summary table professional secrecy

	Obligation to act (art.422bis Penal Code)	Article 458bis Penal Code	State of necessity	The patient/client is the victim : supreme court case law	Case concertation (article 458ter)	Shared professional secrecy
Purpose of the exception to professional secrecy?	Any citizen has an obligation to provide aid to a person in danger. The facts covered by professional secrecy must be disclosed only if such communication constitutes in concreto the only way to provide aid to the person in danger. There is, however no obligation to report. Other ways of providing help are possible.	Article 458bis of the Penal Code allows facts covered by professional secrecy to be disclosed to the King's Prosecutor if there is a risk that certain offences listed (particularly severe) may be committed against minors or vulnerable persons.	The violation of a legal provision (in this case professional secrecy) is the only way to protect an interest of a higher value (e. g. a person's life). A state of necessity is an objective ground for justification which allows facts to be revealed when they are a priori covered by professional secrecy.	The Court of Cassation has ruled in several cases that professional secrecy does not extend to offences against the patient of which he/she is the victim.	Article 458ter allows different parties such as aid services, police and justice to share information in the scope of case concertation aiming at the protection of the physical or psychological integrity of a victim.	Under certain conditions the sharing of confidential patient information between professionals bound by professional secrecy is accepted by jurisprudence and doctrine.
Legal basis for the exception to professional secrecy?	Article 422bis of the Penal Code.	Article 458bis of the Penal Code.	A state of necessity is a principle of law, which is not expressly enshrined in law, but which is unanimously accepted by case law and doctrine.	Article 458 of the Penal Code as interpreted by the Court of Cassation.	Article 458ter of the Penal Code	The shared professional secrecy is a construction of jurisprudence and doctrine
Person concerned by the exception?	Anyone	Persons bound by professional secrecy (and who are therefore obliged to comply with article 458 of the Penal Code).	Anyone	Persons bound by professional secrecy and whose clients are victims of an offence.	Parties involved in the case concertation (most often aid services, police and justice)	Professionals bound by professional secrecy treating the same person with the same objective
Cumulative conditions to be met in	• A living person is in danger • The danger is:	• An offence has been committed	• Two duties or interests, one of which is the	There are no specific conditions to which the invocation of this	Case concertation can only be organised with the permission of the	• The information transfer is necessary and pertinent for the

order to reveal the facts covered by professional secrecy?	• life-threatening situation; or serious breach of integrity You are aware of the danger or you are reasonably expected to be aware of the danger • The danger is real and present • Rescue does not pose a serious danger to you or others	against a minor or vulnerable person • This offence is one of the offences included in the list established by article 458bis of the Penal Code • One of the two situations arises: - there is a serious and imminent danger to the physical or mental integrity of the victim - there are indications of serious and real danger that minors or vulnerable persons, other than the victim of the acts already committed, may be the subject of one of the offences referred to in Article 458bis of the Penal Code. • You are not able, alone or with the help of third parties, to protect the integrity of the person in danger	obligation of professional secrecy, are in conflict • The interest in safeguarding (e. g. a person's life) is of equal or greater value than the respect of professional secrecy • The interest to be safeguarded is threatened by a serious, imminent and certain danger • There is no choice but to violate professional secrecy to protect the interest to be safeguarded	exception is subject. Nevertheless, it is important to consider a number of things when considering disclosing facts.	public prosecutor, either in a specific case or in the context of a specific protocol. The legal text of the prosecutor's decision or protocol must at least determine ***who can participate*** in the case consultation, ***for what purpose***, and ***according to which modalities*** the consultation will take place	task of the professional concerned • The professionals need to 'treat' the same person and with the same objective • The person consents (at least implicitly) or is informed of the information transfer

Obligation to disclose facts covered by professional secrecy?	You must provide the help that you think is most appropriate. If revealing facts covered by professional secrecy is the only way to rescue a person in danger, then you have an obligation to breach professional secrecy.	No. This is a faculty and not an obligation.	No. This is a faculty and not an obligation.	No. This is a faculty and not an obligation.	No. This is a faculty and not an obligation.	No. This is a faculty and not an obligation.
Person to whom the facts covered by professional secrecy may be disclosed?	This issue is not specifically regulated by a legal text. The facts covered by professional secrecy must be disclosed to the person or body most appropriate in concreto to effectively assist the person in danger. In this respect, you should favour solutions that least damage the trust relationship established with the client.	The facts can only be revealed to the Public prosecutor.	This issue is not specifically regulated by a legal text. The facts covered by professional secrecy must be disclosed to the person or body most appropriate in concreto to effectively assist the person in danger. In this respect, you should favour solutions that least damage the trust relationship established with the client.	Facts can only be disclosed a priori to disciplinary and judicial authorities who have the possibility to prosecute the authors of these acts (e.g. the competent disciplinary authorities or the public prosecutor's office).	Only necessary information related to the respective case can be shared between the parties that take part in the case concertation.	Amongst professionals that treat the same person for the same objective.

Note. This table is a KCE adaptation of the original table provided by the Ethics Commission of Psychologists[47]

5.4.7 *Need for more explicit dispositions on possibilities to lift professional secrecy*

The state of emergency, art. 422bis and article 458bis of the Criminal Code provide useful grounds for information sharing or reporting in **acute cases**. However, it remains unclear and difficult for professionals to be sure on the interpretation of notions such as 'great and imminent danger'. De facto, professional secrecy always leaves a large 'scope for assessment and action'. Within this scope, an appeal is made to the responsibility of the healthcare provider, who weigh up the interests themselves. To this end, they can call on personal assessment, training, experience, ethics, the deontological context…Yet, especially in situations where there is no clear imminent or great danger for the victim but where relatively minor but often recurrent facts are occurring or where informal care is derailing without any clear offence, it is often difficult for professionals to find a justification to lift professional secrecy and seek help. Whereas the shared professional secrecy allows to share necessary and pertinent information between professionals 'treating' the same patient, consent of the patient or at least informing the patient that information was shared is requested. This is often problematic as many older persons in a situation of abuse will often refuse to reveal the problems. Furthermore it is not clear what is meant by a professionals that treat the same patient. Is this limited to colleagues or a multidisciplinary team or is it possible to apply the theory of shared professional secrecy to report a case to specialized organisations? Although it is possible for healthcare professionals to contact specialized services or the prosecutor for an anonymous advice or to organize help themselves, professionals may feel the need to report suspicion or doubts to police, justice or specialized services. A more explicit formulation of the possibility to report to a case to these actors would be in favour of legal certainty for professionals and for victims of a situation of abuse. This is already the case in Flanders for instance for youngster in a problematic situation. Professionals under professional secrecy can provide information to the mandated services (i.e. a mandated service decides whether the government should intervene in the aid for youngsters and their family) without consent of the person involved if this is necessary to intervene in a problematic situation ('verontrustende situatie).[a]

As stated above the content of professional secrecy and the possibilities to lift it vary from country to country. In the scope of elder abuse, the decision to provide explicit legal grounds to report goes hand in hand with the vision on the status of a person's autonomy and the level of protection by society that can be imposed on an older adult person. In contrast with youngsters who, because of their young age are legally incapable, older persons stay capable adults until there is a decision of the judge declaring them incapable. In some of our neighbouring countries (see Box 8), a more interventionist approach has been adapted and the right to report in situations of abuse or violence has been explicated in legislation (and supported by guiding documents provided by the government cfr. Chapter 3 The Netherlands). It is obvious that when such a right is explicited, successful implementation highly depends on the construction of a reliable network of services involved in the management of (elder) abuse.

[a] Article 76 in fine, Decree of 12 July 2013 on integral youth help, *O.J.* 13 September 2013

Box 8 – Right to report cases of abuse or violence in the Netherland and in France

Professional secrecy in The Netherlands

Social workers who offer help, care, support or any other form of guidance often have a professional secrecy.

Nevertheless, it may be in the client's/patient interest if a social worker or a health care professional does exchange confidential information with others. That is why a **right to report domestic violence and child abuse was introduced in the legislation**. Professionals with a professional secret may report (suspected) domestic violence to a one single point of contact even without the consent of those involved under certain conditions (such as going through the step-by-step plan in the reporting code).

The Government has issued a basic model reporting code for domestic violence and child abuse[48]. Every sector involved in help and care is obliged to adapt this code to its own field.

Artikel 5.2.6 of the Wet maatschappelijke ondersteuning (Wmo 2015) state that "*third parties who professionally possess information that may be deemed necessary to terminate a situation of domestic violence or child abuse, or to investigate a reasonable suspicion thereof, may provide this information to an AMHK (Advice and Reporting Centre for Domestic Violence and Child Abuse) on request or on their own initiative without the consent of the person concerned and, if necessary, by breaching the duty of confidentiality on the grounds of a statutory regulation or on the grounds of their office or profession*"[a].

Professional secrecy in France

Professional secrecy is not applicable to any person (including doctors) who has knowledge of ill-treatment (deprivation or physical or psychological abuse) committed against persons who are vulnerable because of their age (elders, minors), or because of their physical or psychological disability and who informs the judicial, medical or administrative authorities (article 226-14 of the Criminal Code).

Any person (including doctors) who does not denounce such a situation may be punished by 3 years imprisonment and a fine of €45,000 for failure to assist a person in danger (Article 434-3 of the Penal Code).

The denunciation to the competent authorities made under these conditions shall not give rise to civil, criminal or disciplinary liability of the person who made it, unless it is established that he or she did not act in good faith.

Moreover, there is an additional protection for employees or agents who report ill-treatment or deprivation against a person taken in or cared for by social and medico-social institutions and services: the Code of Social Action and Families states that this cannot be taken into consideration when deciding on unfavourable measures concerning him/her (article L313-24 of the Code of Social Action and Families).

Key points

- **Several political authorities are concerned by elder abuse**
- **At the Federal level, the competences of the minister of Justice, the minister of security and internal affairs and the Minister for health care are affected by elder abuse.**
- **Communities (or Regions exercising the competences of the communities) are the main actors for the management of elder abuse because they are in charge of the whole welfare and wellbeing policy for elders. In addition, they are also in charge of elder health care and in this context are in charge of the entire**

[a] Wet Maatschappelijke Ondersteuning 2015 https://wetten.overheid.nl/BWBR0035362/2020-01-01.

organisation of all residential care for elders (MR – MRS – day care centres and short stay – isolated geriatric hospitals) and of first line health care (integrated home care services, palliative multidisciplinary teams and palliative networks).

- Municipalities are also concerned by the topic because they offer social and proximity services. Depending on their local priorities, municipalities chose to have specific social or health services for elders or to put in place specific security rules for them.
  - In contrast to what exists for child abuse management or for specific type of violence (intra family violence, gender-based violence), there are no specific joint approaches and strategies between the justice, health and social services for the management of elder abuse.
  - Criminal law provides for the punishment of the author of certain abuses against elders. This cover the most severe cases of misbehaviours threatening of affecting the physical or mental integrity of the elders. Certain procedural protection exist to encourage and protect elder to have the courage to file a claim but they are rarely used in practice because of the lack of implementation or lack of training of the services in the justice and police sector or because of the work overload.
  - Civil law essentially provides for guardianship measures and the nullity of certain donations in order to protect elders against abuse, particularly financial abuses. It also foresees an obligation for close family members to take care of their parents.
  - Quality rules (i.e. accreditation norms, quality norms and indicators) applicable to health care professionals and institutions provide for rules to prevent certain types of abuse in the context of health care but there are only few rules that directly concern elder abuse.
  - In case an elder proves that Belgium infringed one of the fundamental human rights by structurally failing to protect elders from abuses, Belgium could face international condemnation by the European Court of human rights.
  - The Belgian legal framework punishes any citizen who refuses to give aid to a victim in great danger. This rule only implies an obligation to act for the most severe and evident cases of elder abuse and is very person- and circumstance-dependant.
  - The Belgian legal framework does not include a general obligation to report elder abuse cases or suspicion thereof for professionals.
  - Unless they have an obligation to act, only certain circumstances (where the physical or psychological integrity of the elder is being seriously threatened) allow professionals who are bound by professional secrecy to report elder abuse case.
  - The current rules on professional secrecy and derogation thereto result in a very important responsibility for professionals who do not always have the time or training to evaluate these rules in complex cases of abuses.
  - The current legal framework applicable to professional secrecy was recently modified to add the possibility to organise multidisciplinary individual case concertation when the security or security of someone is threatened. To implement this, a law or a specific authorisation of the Public prosecutor are required.

6 DESCRIPTION OF THE SERVICES INVOLVED IN ELDER ABUSE MANAGEMENT

The following sections intend to give on the one hand an overview of the **actors involved in different (mainly non judiciary) steps of the management of (presumed) elder abuse cases**. On the other hand **policy actions** related to elder abuse, **plans and protocols** and **good practices** in the field are described.

As the measures of judges and judicial services were already mentioned (see 4), they are not considered here as services.

As mentioned earlier, elder abuse is a complex issue with (often) many underlying and interconnected problems such as addiction, financial problems, complex relational issues, mental problems, etc. The victim as well as the author can experience these problems. Hence, the services involved in the management of elder abuse cases, are not limited to the services that handle the 'single' problem of elder abuse. An integrated approach of the problem implies that all underlying problems are tackled as well. This might need the intervention of organisations or professionals specialised in the particular problem (e.g. centers dealing with addiction problems, psychologist specialised in the treatment of specific traumas…). As their intervention is very case-specific, we will not go into a detailed description of all these 'supporting' services managing the underlying reasons. We also limit ourselves to policy and plans directly related to elder abuse.

Actors involved in the management of situations of elder abuse can be distinguished according to the **phase(s)** in which they intervene. Some actors are involved in prevention (e.g. setting up campaigns or giving training to professionals,..), others are operational in receiving calls for help or organising care for the elder or his/her environment. Moreover there are also services that are involved in different steps of the process or that have a coordinating role. Typically, after a situation of abuse is detected, (possible) further action consist either in the organisation of a help trajectory (=aid, voluntary), the involvement and close follow-up by Justice (chain approach or family justice center; see 6.1.5) or in the direct referral to a judiciary trajectory. The judiciary trajectory is described above.

Actors involved in the management of elder abuse can also be characterised according to their **specificity**. Some services **specifically focus on elder abuse** (e.g. Respect Senior in Wallonia, VLOCO in Flanders) but many services (especially in Flanders) are embedded in structures tackling intra family violence or organising support/wellbeing services in general (e.g. CAW). In addition, non-profit, private organizations and local initiatives exist that include care for elderly amongst their concerns. A detailed description of these last type of services is not included in this report.

As mentioned earlier, the Communities/Regions are in charge of the policy related to elderly, as part of their welfare and wellbeing competence but also as part of their competence regarding health care. Their welfare competences include, for instance the creation of aid services. Consequently the organisation of aid services for elderly is different in Flanders, Wallonia and Brussels. In Brussels-Capital, one can opt for French speaking or Flemish speaking aid services. The Flemish speaking services in Brussels are regulated by the Decrees of the Flemish Community and the French speaking services by the Decrees of the 'Fédération Wallonie-Bruxelles'. As such the organisation of these services in Brussels will be the same as in the respective Community. For bilingual institutions (either public institutions which are bilingual by definition, such as public hospitals, or private institutions which have not opted for either), specific ordonnances of the Joint Community Commission are applicable.

In the next sections the main actors involved in different phases of the management of elder abuse and the policy actions will be described according to their geographic location (Flanders, Wallonia and Brussels).

6.1 The main actors involved in the management of elder abuse in Flanders

To have a good comprehension of the actors involved in the management of elder abuse, it is necessary to understand the global policy vision of the Flemish government with regard to elder abuse. In Flanders, it was decided to have an integrated approach where all types of violence are managed by the same main players (i.e. CAW, social services, OCMW,..) and not by one specific organisation per type of abuse (except for child abuse). In the scope of that approach, it was chosen not to create a specific access point for elder abuse but a central access point for all types of violence (1712), where delegated personnel of the existing services involved in the management of all types of violence are present.

The Flemish strategy for elder abuse is based on three main objectives: increasing the sensibility and the expertise of professionals, the creation of a risk-taxation instrument for professionals and making sure that institutions, for instance a nursing home, develop agreements and procedures for their internal well-functioning. In order to realise these objectives, several actions were taken by several parties. Campaigns and other means for sensitisation were set up by 1712 and VLOCO, financing was granted to Domus Medica to elaborate an on line tool for general practitioners, a risk taxation instrument was developed (RITI) and VLOCO in collaboration with the SEL Waasland created a booklet as an example of a procedure how to handle elder abuse. This material is not only targeted at individual institutions and/or professionals but also for networks of organisations such as the 'geïntegreerd breed onthaal' (= collaboration of CAW, OCMW and the social services of the sickness funds) or the eerstelijnszones.[a]

6.1.1 1712 Meldpunt "abuse, violence and child abuse": hotline for citizens

In 2012, the Flemish authorities established a **hotline** (Meldpunt voor misbruik, geweld en kindermishandeling - 1712) for all types of abuse, violence and child maltreatment. This hotline is organised in each Flemish province and is staffed by personnel of the Child Abuse Confidence Centers and the centers for general welfare (see 6.1.4.1). The number 1712 is followed by a call forwarding system that connects the citizen to the hotline in his province. Every citizen involved in or confronted with any kind of violence or abuse or who has questions regarding violence or abuse, can call 1712 (for free and anonymously) for information, advice or referral to the respective relevant service. The hotline is **not involved in the treatment of individual cases.** Moreover, there is no policy of recontacting or following up the caller. As such, all callers are free to follow up the advice and to contact the service they were referred to. Each contact with the hotline is (anonymously if requested) registered in an electronic file. 1712 operates during working days from 9 a.m. to 5 p.m. 1712 is also accessible via email, facebook or via chatboxes. There is a permanence scheme; people who call outside opening hours receive the message that they can contact teleonthaal on the toll-free number 106.

Part of the **website** is dedicated to the topic of elder abuse.[b] The information is addressed to victims as well as authors and an explicit 'no – guilt approach' is used in the set-up of the website to get the topic out of the taboo sphere. The heading of each page contains the sentence 'it is not your fault'.

Several **campaigns** were set up to inform the citizens on the existence of the hotline. Each year, information on 1712 are advertised on 100 public busses of "De Lijn" in Flanders. On top of the generic campaigns, other campaigns target specific population groups, e.g. in 2017 a campaign focussed on domestic violence in elder couples.[c] A phased approach was

[a] Vraag Om uitleg over ouderen(be)mishandeling, DOC 2254 (2017-2018), 26.06.2018 https://www.vlaamsparlement.be/commissies/commissievergaderingen/1266322/verslag/1267413

[b] https://1712.be/geweld/ouderenmisbehandeling

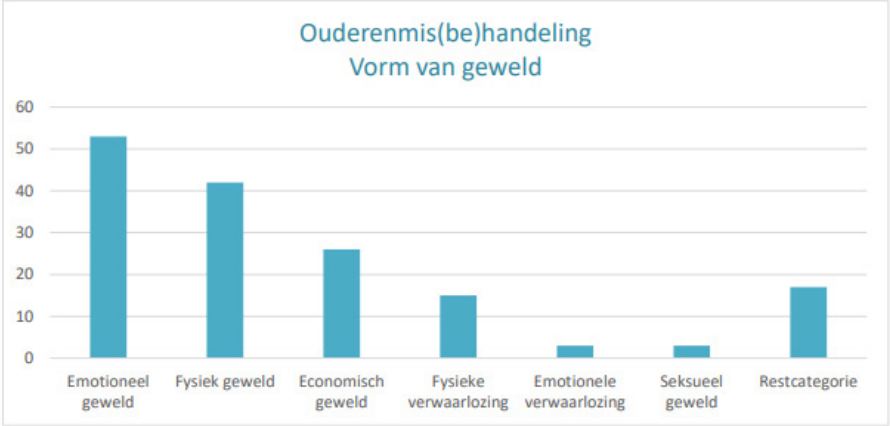
[c] https://1712.be/pers/id/365/nieuwe-campagne-1712-tegen-partnergeweld-bij-ouderen

opted for because of the strength of the effect of repetition. The campaign was introduced via a press article and a press conference. Posters and a short movie were published on the 1712 website and the facebook page. Directly after the launch of the campaign different channels were used to target the elderly population: social media, newsletters and webpages of associations for seniors, day centers and member associations of the Flemish Elderly Council (Vlaamse ouderenraad). Moreover a TV spot was broadcasted on regional TV chains during 1 month and posters were distributed in CAWs, OCMWs/CPAS, and associations for seniors, hospitals, residential care centres and local service centres. The primary aims of this campaign were to inform elderly about the existence of 1712 and to draw the attention on the topic of domestic violence in elderly couples. There was no formal assessment on the effectiveness of the campaign but a raise in the number of contacts with the hotline in June (709 in June 2017 versus 585 in May and 576 in July 2017 – the same trend can be observed in the previous year) may suggest the impact of the campaign which was also held in June in the scope of the International day of sensitization to elder abuse[49]. In 2018 these campaigns were not repeated. At the time of writing, there are no data yet for the year 2019.

In 2018, 5126 calls to the 1712 (for all types of violence) regarding 7218 persons were registered[50]. A majority of all callers (65%) wants to remain anonymous. Most of the calls come from the victim or his/her environment. Although the hotline does not target professionals, 181 calls came from services involved in aid to adults, e.g. Family Help, OCMW/CPAS, etc. Six calls stem from Justice.

Only **159 calls (or 3% of all calls) related to elder abuse**. Although this number seems very low, it represents 40% of all EA registrations **(n=444) in Flanders (sources: 1712, CAW, VLOCO and the registration of the use of the RITI scale**).[51] Overall, the calls mainly concern emotional and physical abuse (see Figure 1).

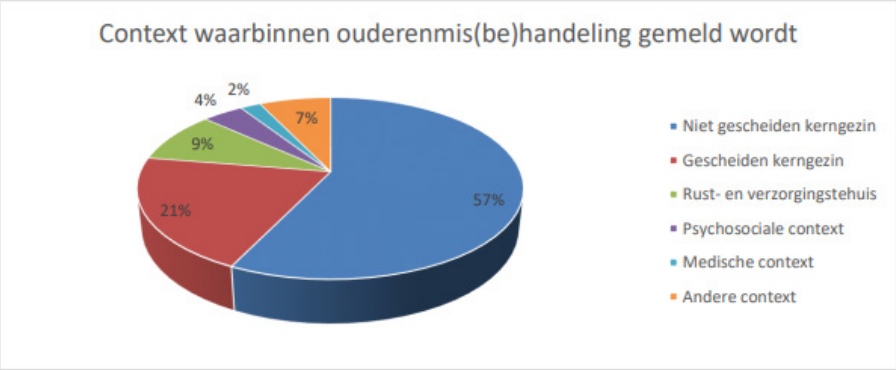
Figure 1 – Types of elder abuse



Source: annual report 1712 – 2018

Most situations relate to a home situation (78%). Only 9% relates to abuse in residential settings (see Figure 2).

Figure 2 – Setting where elder abuse takes place



Source: annual report 1712 – 2018

In 64% of the calls, transfer to the most relevant aid services or police or justice is proposed to the caller. In almost 7% the situation is actively reported to an appropriate service or police or justice because of the seriousness of the case.

6.1.2 Residential care line (Woonzorglijn)

If the abuse does not occur in the private/home situation, one can contact the residential care line. In this case, complaints relate to the care offered in the residential care sector (residential care center, a rest and care home, a service flat, a center for short stay, a day care center). Depending on the situation, a suitable answer will be sought. The residential care line is available every working day, from Monday to Friday by telephone from 9 a.m. to 12 a.m. on 02/553.75.00. One can also use the residential care line question or complaint form. The Woonzorglijn cooperates with the Woonzorg and Eerste Lijn department of the Agency for Care and Health (Agentschap Zorg en Gezondheid) and with the Care Inspectorate (zorginspectie – cfr. 4.1.5) who can follow-up complaints.[a]

6.1.3 Services specialised in elder abuse

From Vlaams Meldpunt Ouderenmis(be)handeling to Vlaams Ondersteuningscentrum Ouderenmisbehandeling (VLOCO)

The "Vlaams Meldpunt ouderenmis(be)handeling" has been created in 2002 following a call from WHO to increase attention to the phenomenon of elder abuse. Originally the **Vlaams Meldpunt** served as an **umbrella organisation** providing information and advice, treating calls from **all kinds of individuals** confronted to a case of (presumed) elder abuse and providing the intake meetings. If further intervention was needed the case was transferred to a local contact point **"Steunpunt"** of the respective Flemish province or Brussels. Furthermore the local contact points were also the direct contact points for professionals confronted to situations of elder abuse.

In 2007 the Government of Flanders made a covenant with the aim of arranging the cooperation between the Flemish government, the 5 Flemish provinces and the Flemish Community Commission in Brussels. This covenant was signed by all parties on 30 January 2008. A bottleneck in this respect was the fact that there were no clear commitments for the provinces in the covenant. This allowed the provinces to give their own interpretation as regards to their role in consultation and intervention questions, awareness campaigns, training, etc.... In practice, some provinces opted for a minimal interpretation.

In 2012, the above mentioned hotline 'Abuse, Violence and Child Abuse' was established (see 6.1.1). For that reason, the Vlaams Meldpunt ouderenmis(be)handeling has been converted to the **Vlaams**

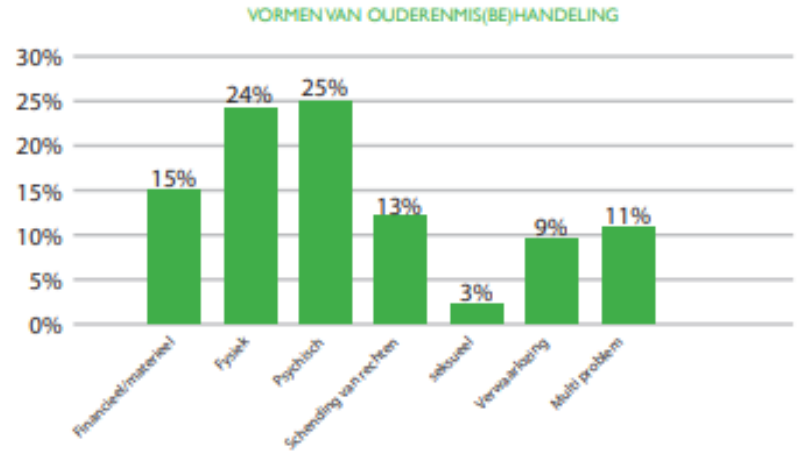
[a] https://www.vlaanderen.be/organisaties/administratieve-diensten-van-de-vlaamse-overheid/beleidsdomein-welzijn-volksgezondheid-en-gezin/agentschap-zorg-en-gezondheid/afdeling-woonzorg-en-eerste-lijn/woonzorglijn

Ondersteuningscentrum Ouderenmisbehandeling (VLOCO[a]) with a focus mainly on the support, i.e. information, advice (for instance via consultations where the situation is discussed with the professional) and training of **care providers and other intermediaries** such as police, justice, social workers... VLOCO has not the mandate to intervene in situations. VLOCO also created a discussion platform related to elder abuse in Oost-Vlaanderen with representatives of OCMW/CPAS, home care, rest homes, etc. VLOCO also cooperated with the SEL Waasland (= samenwerkingsinitiatief eerstelijnsgezondheidszorg Waasland - (see 7.6.8) to **elaborate a step plan and guidance related to elder abuse**. Another particular mission of VLOCO was the elaboration of **a risk taxation instrument**. Together with the Vrije Universiteit Brussel the RITI scale, a risk evaluation scale for the detection of elder abuse (cfr. Chapter 5) has been drafted. VLOCO also works on **visibility** by means of press articles and interviews. In 2017, a cartoon referring to VLOCO was printed and distributed via 50.000 bread bags.

At the time of writing this report, VLOCO is part of the CAW Oost-Vlaanderen and has only sufficient financial means to pay 1 FTE. Consequently, some of the activities such as providing training for healthcare professionals needed to be cut: instead of training healthcare professionals, training is now provided to one key person, who transfers the knowledge to peers ("training the trainer").

In 2018, (only) **99 requests for a consultation/advice** were registered at VLOCO. Most of the requests relate to psychological abuse, physical abuse and financial abuse (see Figure 3).[51]

Figure 3 – Types of elder abuse



Source: annual report VLOCO 2018

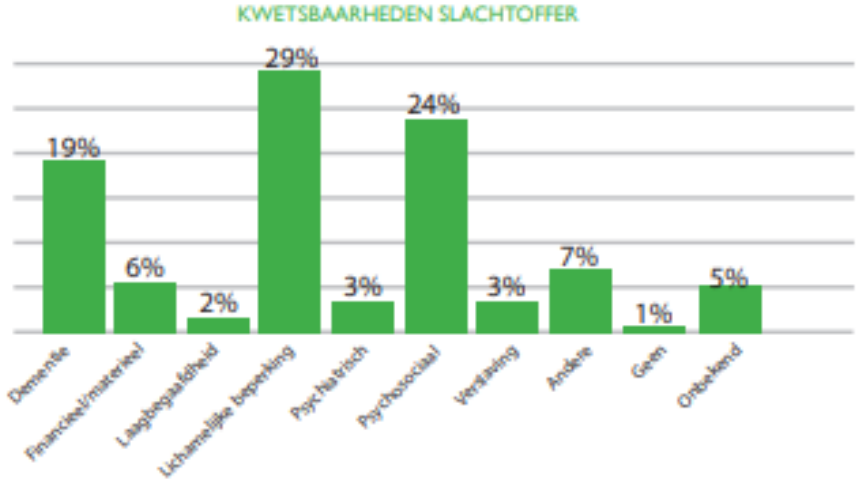
In most of the cases, some kind of aid (by social services, general practitioners, home aid...) is already involved. This is not surprising since those who contact VLOCO are professionals.

Most of the victims are older than 75 years old and 71% are **women**. The high age can be explained by the fact that dependency increases. According to VLOCO, the large % of women is possibly due to the fact that demographically there are more women or by the fact that men are more ashamed to reveal abuse. In 63% of the cases, the victim lives together with the offender. Offenders are mostly men and in most of the cases the partner or the son.

Most victims have a vulnerable status, in particular a physical limitation or dementia (See Figure 4).

[a] http://www.ouderenmisbehandeling.be/VLOCO/Index.aspx

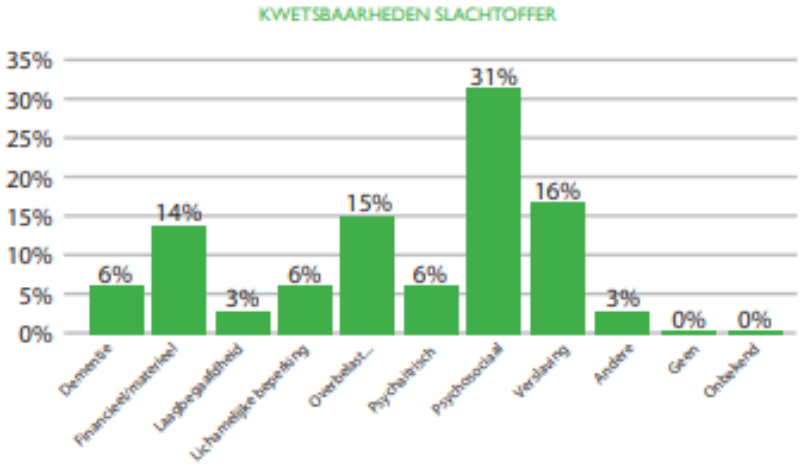
Figure 4 – Vulnerabilities of the victim



Source: annual report VLOCO 2018

Another striking observation is that the authors often have a vulnerable profile as well. In the top 3, we find psychosocial problems, addiction and overburdening (see Figure 5).

Figure 5 – Vulnerabilities of the author



Source: annual report VLOCO 2018

6.1.4 Non-specialised services involved in the management of elder abuse

In Flanders, the organisation of care/aid after the detection (and reporting) of elder abuse or as a preventive measure when one or more risk factors for elder abuse are present is not centralised in one service and not specific for elder abuse. Several services offer complementary and sometimes overlapping aid services that can be useful to tackle problems related to situations of elder abuse. Depending on the particular needs and the first contact with a service, referral to other services or collaboration between different services is possible.

In most of the respective services, there is no registration of the cases that are related to elder abuse.

6.1.4.1 Center for General Welfare (CAW)

Centers for General Welfare (Centrum voor Algemeen Welzijnswerk - CAW) have three core tasks: reception ("onthaal"); general prevention; and psychosocial guidance. There are 10 CAWs in Flanders and 1 in Brussels, all with their own geographical area (see Figure 6). Adults can go to a CAW when they encounter difficulties in one or more themes:

- wellbeing;
- health;
- relation, family and environment;
- administration and money;
- autonomy;
- victims and offenders (from violence, abuse, traffic accidents and crimes);
- living;
- work and leisure
- migration

CAWs have no specific section related to elder abuse, but elder abuse and the underlying reasons can be embedded in one or more of the above mentioned themes. Some CAWs have a specific a specific section for intrafamily violence.

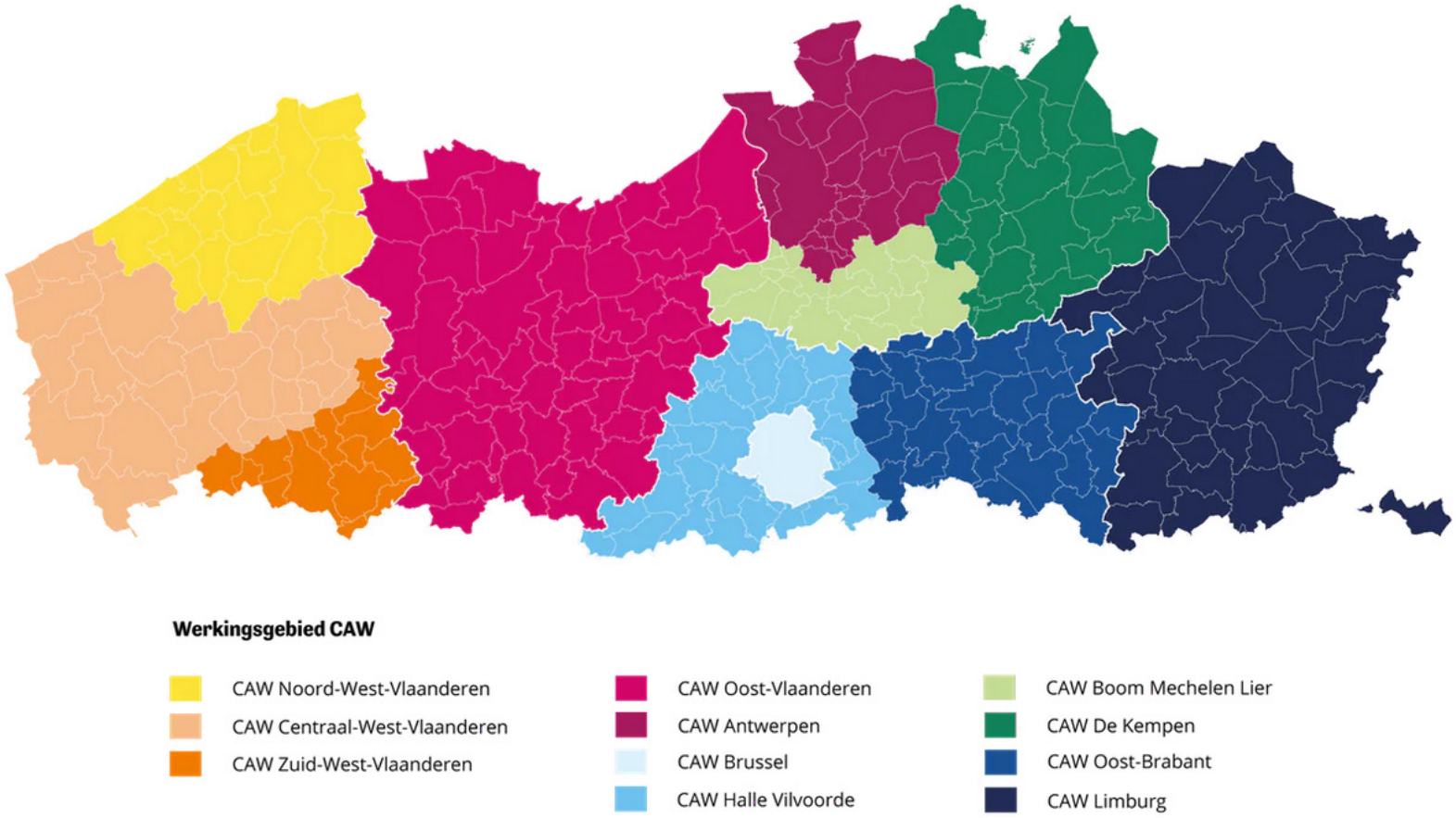
In practice, aid provided by the CAWs ranges from information and advice to practical help (e.g. accompanying a person to the police, court, a physician,…), mediation, crisis help and aid in finding or organising the appropriate help for the respective problem(s). CAWs also offer different kinds of secured shelter, e.g. crisis shelter, shelter for women or men solely, shelter for families, shelter with secret address, shelter for youth, winter shelter, etc. These secured shelters are spread all over Flanders and Brussels.

A CAW-team consists of a variety of specializations, e.g. social workers, psychologists, educators, sociologists and pedagogues, depending on the specific situation. Referral to other specific services is very common, such as for instance to the "Services de Santé mentale - Centrum voor Geestelijke Gezondheidszorg" (SSM-CGG) for psycho-medico-social help. In 2018, 82 aid trajectories related to elder abuse (OMB) were started in all CAWs in Flanders (of which 31 in East Flanders)[51]. This is a remarkable decrease of 40% compared to 2017.

Access to a CAW is open and free for all citizens, on their own initiative or by referral. For shelter an amount per day needs to be paid. For persons with a low income, the public centre of social action (OCMW-CPAS) covers the cost.

CAW have incomes from different sources. The Flemish government funds CAW through global financial envelope to provide an agreed range of care. Local authorities offer additional income for specific tasks. The CAW can get also temporary funding for projects.

Figure 6 – Geographic area of the CAWs



6.1.4.2 OCMW/CPAS

The OCMW/CPAS are public services that organise social aid in each municipality of the country. Their mission is to provide individuals and families with the help (material, social, medical, medico-social or psychological) due by the community. In addition to individual aid, the law provides that the OCMW/CPAS may establish and manage social, curative or preventive services (e.g; debt mediation service, transit housing, social restaurant, rest home, etc.).[a] The services of CAW and OCMW/CPAS are complementary.

6.1.4.3 Social service of the sickness funds

All (unless very limited exceptions) Belgian citizens are affiliated to a sickness fund. Each sickness fund in Belgium integrates a social service providing several services that may be very useful in the management of elder abuse:

- Immediate help and support
  - Information about options and support in home care.
  - Information and advice on social benefits and provisions.
  - Coordination of home care services.
  - Discussion of needs in the long(er) term.
  - Strengthening the autonomy/independency of the individual through mediation and the deployment of home care services, aids or adapting the home.
  - Relieving the informal caregiver by calling on, among other things, a housesitter, personal alarm or short stay.
  - Searching for solutions together with the individual and his relatives if home care becomes difficult or no longer possible....
- Guidance in complex home care situations
  - Aid over a longer period of time that monitors the care organised for the individual and his/her environment.
  - Discussing of problematic issues.
  - Help with drawing up an "action plan".
  - Support and step-by-step management of the care situation, monitoring of limitations, processing of loss experiences, early care planning.

Social services of the sickness funds also often have a coordinating role regarding the care and aid services for elderly.

6.1.4.4 Social service of the hospital

Persons involved in situations of elder abuse can be hospitalised for different reasons, related or not to the abuse. Some patients may be admitted with acute physical problems due to the abuse; for other patients the hospital serves as a crisis shelter solution (for instance on referral of a general practitioner), where further psycho-medical observation is needed and sometimes abuse is just detected during a 'regular' hospital stay.

In all these situations, the social service of the hospital can play an important role. Their tasks can consist in[52]:

- Psychosocial aid, including support, mediation, counseling, treatment and/or crisis intervention. This is primarily aimed at influencing the interaction between the patient (his self-image, subjective experience, behavior and thinking) and his social environment (relationship and communication patterns). Psychosocial aid pays a lot of attention to the necessary conditions for the patient to live as well as possible in accordance with his social environment, so that his chances of healing are optimal.

[a] http://www.ocmw-info-cpas.be/, last accessed 27/03/19

- Exploring and mapping the social situation of a patient, forming the basis for further aid to the patient. An be drawn up based on this information.
- Coordination of care which involves the preparing of hospital discharge for patients at risk of complicated discharge and / or a risk of fundamental relapse. This can be achieved by preparing a high-quality referral to an adapted home or home replacement environment or to the services and facilities that the patient needs. For this purpose, interdisciplinary collaboration processes must be worked out in the hospital, as well as between the hospital and the extramural structures. The social worker as care coordinator ensures that all the care actors involved regularly consult and check whether the services are tailored to the demand for help.

6.1.5 Collaboration between aid services, police and justice: chain approach and Family Justice Centers (FJC) in Flanders

Some situations of elder abuse are very complex and multiproblematic. Typically, many efforts are invested to organise voluntary aid and police intervention may be recurrent. In these more difficult (and often more severe) cases, it may be beneficial that partners of aid services, police and justice collaborate and jointly follow-up a case (under the direction of a casemanager). This was the guiding idea for the set-up of the chain approach (ketenaanpak). Characteristic of the chain approach is that it is a total approach, whereby the perspectives of providing aid services (CAW, OCMW/CPAS, Centers Mental Healthcare…) the police and the judiciary services are brought together. In concrete terms, in a chain approach, the case goes through a process of (relevant) information sharing, drawing up a customized approach and case management (follow-up, implementation and continuity). The Flemish region has been working with a chain approach for some time in several regions (e.g. project CO3 in Antwerp, de ketenaanpak in Mechelen, LINK in Limburg) and it is also starting up in East and West Flanders.

A chain approach initiative usually ends up in the creation of a Family Justice Center (FJC). In a FJC different partners of aid services (e.g. CAW, OCMW, Center Mental Health…), the police and the judiciary are physically together under one roof, so that they can tackle domestic violence jointly. This enables collaboration between the respective partners, but it also centralises the necessary services for the victim and his/her relatives. Not all FJC have all partners under one roof. An intermediate solution is that a case manager can refer the a case to other more specialised services and further follows up and coordinates the trajectory. Limburg, Mechelen and Antwerp are at the moment of writing the report the 3 regions with a Family Justice Center. Until today FJCs are not structurally embedded in legislation. They started as pilot projects and local initiatives of collaboration between the sectors of police, justice and aid. As such there is no specific financing for the operational functions of these centers. The participating parties finance the center from their own budgets and depending on the region there is additional financing of the respective cities or municipalities.

Each FJC has its own specificities. There is no common policy between the different initiatives of chain approach and FJC. An exercise to align the policies has been done in 2018 and is to be implemented.

Individuals cannot directly access to the services of the FJC. The center receives dossiers from families in high-risk, problematic situations via the police, aid services, a care provider, the public prosecutor's office or via the emergency services. Then the team makes a risk assessment. What is needed on which life domain? Should new housing be sought? Is there a debt? After the assessment of the situation a trajectory is set up.

Box 9 – The example of Limburg

In the province of Limburg, the FJC is a pilot project in the two largest police zones of Limburg, Carma and Limburg Capital Region. Currently, the FJC is not yet directly accessible to clients nor professionals. The main access point is the police reports. All reports notices from those police zones that relate to domestic violence end up in the FJC. Other organizations can only register very complex and serious files for the time being. The files that are registered with the FJC are first screened. This

risk taxation is done by police and justice via a risk taxation instrument. This instrument was specifically constructed for the FJC based on a scientific study and completed with criteria stemming from the expertise and experience of police and the public prosecutor. Based on information from the databases of police and justice on antecedents and a global assessment of the situation, a risk classification (red, orange, green) is done. Depending on the nature, the severity of the domestic violence and the level of risk, the family is closely monitored or aid is started. At a low risk level (green code), this is a voluntary and easily accessible range of aid. In this case, a letter from the public prosecutor is sent to the persons involved: "a police intervention has been made, we are worried, seek help." Furthermore, a brochure of the Family Justice Center brochure informing people where they can get help in the first line services, on “What does violence mean?", " What does this imply for the children?” is sent as well. In some files, the police will recontact the respective individuals after a month to check whether they sought help. Systematic follow-up of green code dossiers is not foreseen because of a lack of capacity. Priority is given too more severe dossiers.

Where there is more concern, action is taken quickly at a high level of risk. If a dossier is orange or red, interaction of the Family Justice Center partners (OCMW/CPAS, CAW, justitiehuizen, het CAD, GGZ, Vertrouwenscentrum Kindermishandeling, Jongeren Welzijn and Kind&Gezin) and not just from the police and the public prosecutor is necessary. If it is orange, the police will contact the adult involved to request permission to work with their file from the FJC. It is clearly communicated which services are part of the Family Justice Center and the FJC asks whether it is allowed to share personal information. Most of the people agree because they know that even if collaboration is voluntary a refusal is communicated to police and the public prosecutor, which may not be very beneficial for the case.

In the dossiers with code red no consent is needed; people are informed of the fact that information will be shared between police, justice and aid. This can legally be done based on article 458ter of the Belgian Penal Code. The general prosecutor allows the partners in the chain to share info. In theory all partners are still allowed to refuse the sharing of information, but in the FJC a structural framework for information sharing is established. The content of the conversations between the services involved and the individuals are never shared. It solely concerns the info necessary to evaluate the context of the case (e.g. if services are already familiar with the respective individuals, if there is already a trajectory of help, if this goes well or not, who is the contact person etc.) and if the partners of the FJC need to intervene or not. Information is shared via SharePoint (a shared platform). Once a week there is a multidisciplinary concertation with all services concerned. For each code orange or red dossier, the FJC organises aid, as far as there is no already existing help trajectory. Since representatives of the aid services are delegated to the FJC, it is quite easy to find out whether there is already an existing trajectory. The aid services have decided themselves to delegate representatives and finance it from their own budget. Before 2018, the FJC were financed by the provinces, but in 2018 the competence was shifted to the Flemish Community who decided not to take up the financing. In Antwerp, the ‘city’ Antwerp co-finances the FJC.

Mostly families are seen 3 times by the FJC. The first meeting is an intake, where the problems are mapped. A first concern is to guarantee safety for all persons concerned. In the next meetings, aid is organised. Often, the FJC refers to other services. Depending on the underlying problem this may be the OCMW (financial), mental health services, addiction services (CAW)…

All proposed care is based on the voluntary participation of the individuals. The FJC cannot impose measures but they are charged with the surveillance and follow-up of the case. After 2 weeks and 6 weeks, the respective individuals are contacted to control whether a care trajectory is started. After 6 weeks the respective organisations are contacted as well. In the code red dossiers, a recontact takes place after 3 months because feedback to the police and the prosecutor is foreseen. If the respective individuals do not want to collaborate the case is referred to police and justice who can take measures or follow the judicial trajectory. Since there is a regular concertation with police and justice, coordination of the case is optimal. Only 3% of the cases in the FJC Limburg relates to elder abuse.

At the moment of the writing of the report, a study was commissioned by the Flemish governement related to intersectoral, multidisciplinary and directly accessible FJC in Flanders. The aim is to develop an intersectoral and multidisciplinary model on how to handle intrafamily violence, based on the current practice of 'chain approach'. The following topics will be developed in the study:

- Making an overview of the current situation related to information and help for intrafamily violence.
- Reflection on how to set up a low profile open door policy for situations of intrafamily violence?
- Developping an ideal model of an intersectoral, multidisciplinary and directly accessibe FJC for Flanders.
- Developping a step-by-step plan for a fluid, phased implementation per region.

Key Messages for Flanders

- **As the compentences related to the management of elder abuse are primarily exercised by the Federated entities, the organisational landscape is different in the respective geographical parts of the country.**
- **In Flanders, the policy related to elder abuse is integrated in a generic approach on intrafamily violence.**
- **There is a hotline, generic for all types of intrafamily violence. The target population of callers is the general public, including the victim and his/her relatives and except for professionals. The hotline is a.o. staffed with employees from the CAWs, who are not necessarily experts in elder abuse. Only a marginal number of the calls relates to elder abuse. The hotline does not intervene in situations; it can give advice or information or refer to other services. There is no follow-up on wheter the callers contacted the services referred to.**
- **Professionals can call VLOCO for advice or feedback on a specific situation where elder abuse is suspected. As VLOCO is integrated in the CAW of one Flemish Province (Oost-Vlaanderen), most of the callers stem from that area. Moreover, although VLOCO has been very active in developing material for professionals to support them in the detection and management of elder abuse, in the visibility of the topic, providing training to professionals, etc. there is only 1 employee at the moment of writing the report due to financial restrictions. VLOCO does not intervene in situations.**
- **The practical management of situations of elder abuse and the organisation of help for a particular problem is not centralised within one organisation specialised in the topic of elder abuse. The organisations competent for first line, low treshold support for all kinds of problems related to wellbeing of individuals, such as the CAWs, OCMWs, social services of the sickness funds… manage situations of elder abuse.**
- **As elder abuse is managed by different organisations, data are not centralised. Another complicating factor is that the management of elder abuse is integrated in a global approach on intrafamily violene which makes that little specific data on the characteristics of elder abuse cases is available. Moreover registration of elder abuse is not done in a uniform way in all organisations, which hampers a reliable overview of the extent of the problem.**
- **A striking observation in the data collected by VLOCO is that in almost all cases not only victims but authors as well (who are also considered as victims) have one or more vulnerabilities (dementia, physical limitations, poverty, alcoholism, overburdening…).**
- **In some provinces Family Justice Centers are set up. Multiproblem and complex sitations where voluntary help does not seem to be sufficient and where often recurrent police**

interventions are necessary can be transferred to FJCs. Collaboration between aid services, police and justice enables to observe closely and react rapidly. Only a minority of the cases treated by FJCs relate to elder abuse.

- **The Woonzorglijn cooperates with the Woonzorg and Eerste Lijn department of the Agency for Care and Health (Agentschap Zorg en Gezondheid) and with the Care Inspectorate (Zorginspectie) who can follow-up complaints.**

6.2 The main actors involved in the management of elder abuse in Wallonia

In contrast with the situation in Flanders where the management of elder abuse is done by several services that (often) are not exclusively specialised in elder abuse, management of elder abuse is centralised in one organisation that is specialised in elder abuse. Additionally non-specialised services such as the social services of the sickness funds, social services of the hospitals and CPAS (see higher 6.1 for a description of these services can also be involved in the management of elder abuse).

6.2.1 Respect Seniors

The A.S.B.L. Respect Seniors was created following the Walloon decree of July 3 in 2008[a] relating to elder abuse and was recognized as the Walloon agency for the fight against elder abuse by in 2009. This decree was adopted to combat the various forms of abuse against older persons, whether they are living in their homes or in institutions. The A.S.B.L. takes over the activities of two older A.S.B.L.: the C.A.P.A.M and the Libr'âgé network.

The **missions** of Respect Seniors are:

- The accompanying of each person confronted to a situation of elder abuse
- the organisation of actions, information and awareness-raising;
- the organisation of training courses;
- the exchange of information, statistics and good practices.

Any person confronted to a situation of elder abuse can contact a **free hotline** 0800 / 30.330 available every working day from 9am to 5pm. **Six 'antennes' cover the entire territory of Wallonia**. Psychosocial workers offer in particular a first listening, a clarification of the situation, information and orientation towards an adequate service. All the information exchanged with the callers is encoded in a common database. Each Respect Seniors staff member has access to it, which facilitates sharing and transmission between the 'antennes', within the respect of professional secrecy. Depending on the particular situation, further follow-up of a case is necessary.

If further **follow-up** is needed, the 'antenne' of the province where the person lives, can propose to the person(s) involved to take up this task. To understand, analyze and reflect on the needed support or intervention (e.g. organising aid), the involved persons will have to make an evaluation of the situation in order to identify the type of support. In this, different axes will be considered: the physical and mental health of the elder, the person's history and the history of aid already offered. Questions relating to daily life, habits, lifestyle, available resources and network in the immediate environment and at the professional level, and emotional/relational issues are raised. Respect Seniors uses a systemic approach, taking into account the point of view, the feelings and the experience of each of the involved persons. As such, it is important not to judge or stigmatize but take into account the complexity of

[a] In 2011 the Walloon region adopted the Code Wallon de la santé et de l'action sociale in which the articles 378 to 388 of the decree of 3 July 2008 related to the battle against elder abuse of older persons is integrated

each situations. It is also important to consider the decision-making possibilities of the elder so that everyone is treated with dignity and respect. Respect Seniors also stresses that the consent of the elder is primordial (except in dangerous or very severe situations) and that protectionist interventions should be avoided.

In 2019, Respect Seniors received **3318 contacts**[53]. After the first contact, different scenarios can emerge. An "abuse file" is created when there is a feeling of abuse or a fear of mistreatment of an elder aged 60 and over. For this type of files, there were 3138 global contacts. Of these, psychosocial workers received 2007 contacts, made 1131 contacts and conducted 220 field visits throughout Wallonia. Most of the interventions made by employees of respect seniors in “abuse files” related to information and listening. A total of 855 situations were accompanied in 2019, with some situations already in progress in previous years.

In the majority of the cases **the caller** was a member of the family of the elder, the elder him/herself or a professional (see Table 3). The victim is not always aware of the call. Employees of Respect Séniors always try to get contact with the older person him/herself or try to convince the caller to talk to older person about the situation and about the existence of Respect Séniors. Over time, the older persons call more and more themselves, which is a positive sign in a context where elder abuse is seen as a taboo. Almost 70% of the victims are women and most of the victims are over 80 years old.

Table 3 – Identity of the caller

		N = 855 fiches
Famille	322	37,7%
Aîné qui appelle lui-même	220	25,7%
Professionnel	172	20,1%
Entourage (amis, voisins)	95	11,1%
Autre	43	5,1%
Non spécifié	3	0,3%

Source: annual report Respect Seniors 2019

Most of the cases relate to abuse in the home situation (see Table 4).

Table 4 – Place where the elder abuse takes place

		N = 855 fiches
Domicile	563	65,8%
Institution	215	25,1%
Non spécifié	77	9,1%

Source: annual report Respect Seniors 2019

In most of the cases the author is a family member (65,8%). In almost 14% of the cases the author is a professional in an institution and in 7,4% another professional.

Most of the cases relate to psychological or financial abuse, although other forms of abuse are also prominently present (see Table 5).

Table 5 – Type of abuse

N= 1453 formes rencontrées dans les 855 fiches maltraitance		
Psychologique	428	29,4%
Financière	333	22,9%
Civique	272	18,7%
Négligence	239	16,4%
Physique	168	11,7%
Non spécifié	13	0,9%

Source: annual report Respect Seniors 2019

Respect Seniors is also involved in:

- The **prevention and sensitization** of the population on elder abuse issues through colloquia, forums, conferences, congresses… The recourse to the media contributes to a fast public awareness on a large scale. Respect Seniors teams organize information and awareness sessions at the request of any interested person, (professional or not). These sessions are flexible according to the available time. They also organize training for professionals: home care services, nurses, doctors, carers, staff of the judicial world... And finally they broadly inform on the existence of the service itself, its values and its functioning.
- The **exchange of information, statistics or good practice** with associations or similar organizations in neighbouring regions or communities or in other countries. They aim to establish or help building networks. They also collect and publish data.

The annual report 2019 of Respect Senior highlights the **different means used by the ASBL to prevent elder abuse**. The Table 6 extracted from this report shows different actions aimed at prevention and sensitisation used by Respect Senior in 2019.

Table 6 – Number of sessions, spent hours and participants by type of preventive action (2018)

	Nombre de séances	Nombre de personnes
Ciné-débat	6	182
Théâtre	16	1345
Stand	19	2154
Prise de parole en public et action diverses	20	971
Information	28	986
Sensibilisation	124	1789
Total	**213**	**7427**

Source: annual report Respect Seniors 2019

Respect Seniors holds stands during fairs targeting professionals, elderly or all public. It allows to start sensitization. Cartoons are sometimes used to open the discussion. Public speaking are usually under invitation triggered by the networking of Respect Senior teams. The themes are as broad as Alzheimer disease, autonomy loss, ageism or maltreatment of course. For example, a symposium on the 15th of June entitles: “Do our good practices develop the autonomy of the elderly?”

Some parts of the actions target professionals (pharmacists, GPs, police agents, solicitors, mayors…) which relay the information about Respect Senior to the elderly they meet. Information is also given to elderly consultative councils of town (Conseil consultatif des Ainés de la commune), to coordination platforms and to professionals federations (GPs, informal caregivers…). The vulnerable elderly are usually reached through folders given at home by home services and in nursing homes or revalidation centres by intern senior advisory councils. Sensitization occurs in secondary schools, advanced schools and universities, mainly targeting future professionals. Respect Senior also sensitizes the health care professionals

of nursing home and home care. Volunteers are also in demand of sensitization.

Two specific tools of sensitization were developed by Respect Senior team based on a Canadian experience and are ready to be used but are waiting for publication and printing. The first one is a Quiz targeting the all population. It is composed of 16 questions helping to distinguish myth and reality. The second one is a card game for elderly on the theme of the intergenerational discussion. The game is entitled "thinking our choices earlier for later". According to Pascale Broché, psychologist at Respect Senior, the best way to prevent elder abuse and to increase elder respect is that everyone questions himself on what maltreatment is.[a]

In 2018, Respect Senior launched a campaign with pictures on busses, posters in station and pins distribution at the entrance of grocery stores. In the future, Respect Senior would like to increase their visibility through the radio and the television to, at least, better make known the free phone number of the association.

6.2.2 Complaints about abuse in residential care settings

Any person concerned may lodge a complaint about the operation of a rest home, a service residence or a day centre. Any interested person means the elderly person, his or her entourage, as well as the staff of an establishment. The operation of the nursing home includes the residents' council, activities, cleanliness, organisation of care, food, costs... This primarily relates to accreditation standards. This types of complaints can be directed to the **Walloon Region, the inspection services of the Walloon Region, General Directorate of Social Action and Health - Directorate of the Third Age, or the Mayor of the municipality where the establishment is located**. Any complaint will be examined by the administration and by the inspectorate.

When the complaint is within the competence of the Walloon Region and is not anonymous, receipt is acknowledged and the applicant is informed that action is taken. When the investigation is successful, the applicant shall be kept informed of the conclusions.

Senoah (former Infor Homes Wallonia) receives all complaints relating to the care of the elderly in nursing homes, rest and care homes, service residences and day centres with a view to mediation or reorientation. Senoah takes on the role of conciliator and tries to re-establish the dialogue between the parties by means of a possible agreement. Senoah can also be mandated by the Mayor to deal with a complaint.

6.2.3 No chain approach at individual case level

At the time of writing there is no chain approach or FJC in Wallonia. Two antennes of Respect Seniors participated to information sessions on Family Justice Centers in Liège and Namur. There is collaboration between police, justice and aid services in anonymous cases. At the time of writing the report, a draft COL related to elder abuse is drafted. The collaboration between justice, aid and police would be one of the issues that will be structurally imbedded by the COL.

Key Messages for Wallonia

- **In Wallonia, there is a centralised and specific approach for the management of elder abuse. Elder abuse is managed by a specialised organisation, "Respect Seniors". "Respect Seniors" provides information, analyses the situation, gives advice, coordinates the involved professionals and if necessary, refers cases to the relevant services. Furthermore they are also involved in sensitization, prevention and analysis of the issue of elder abuse in general.**

[a] http://www.informationsmedicales.be/les-maladies-rares/la-maltraitance-des-aines-parlons-en?fb_comment_id=1416715201784588_1428265237296251

- **Additionally, non-specialised services such as the social services of the sickness funds, social services of the hospitals and CPAS can also be involved in the practical organisation of help in situations of elder abuse.**
- **Respect Seniors has set up a hotline, specific for situations of elder abuse. This hotline is accessible for all callers (included professionals) during restrictive day hours.**
- **If further follow-up is needed, the 'antenne' of the province where the person lives, can propose to the person(s) involved to take up this task and manage the case. Home visits are also regularly done. Consent of the person(s) involved is primordial.**
- **Much more situations of elder abuse are registered in Wallonia than in Flanders. This is not surprising, as central management by a specialised organisation enables a more centralised and accurate registration.**
- **At the time of writing there is no chain approach or FJC in Wallonia. Yet, there is collaboration between police, justice and aid**
- **Complaints related to accreditation standards of residential setting can be directed to the Walloon Region, the inspection services of the Walloon Region, General Directorate of Social Action and Health - Directorate of the Third Age, or the Mayor of the municipality where the establishment is located. Senoah (former Infor Homes Wallonia) receives all complaints relating to the care of the elderly in nursing homes, rest and care homes, service residences and day centres with a view to mediation or reorientation.**

6.3 The main actors involved in the management of elder abuse in Brussels

As mentioned earlier, in Brussels-Capital, one can opt for French speaking or Flemish speaking aid services or residential settings.

6.3.1 Home-Info/Infor-homes

In the Brussels region, both the Flemish and the French-speaking competent authorities have their own organisation to inform the citizens of Brussels on residential care and its related aspects: Home-Info is financed by the Vlaamse Gemeenschapscommissie and Infor-Homes is financed by COCOF. Both organisations are gathered in a centralized organisation (vzw Home-Info/asbl Infor-Homes), financed by the COCOM/GGC.

Each organisation has similar missions, i.e. **providing information** to the elderly, his family and/or care providers on residential care (different settings, quality of provided care in these settings and the legal and administrative aspects such as financial aspects), **pointing out potential barriers and/or lacks in current practice to the dedicated policymakers and organisations, and providing information on elderly care to the general public**.

Of particular interest are the **site visits** to the elderly care settings in Brussels. The live encounter with the collaborators of Home-info/Infor-Homes allows the elderly and the care professionals **to mention a suspicion of elderly abuse**. Home-info/Infor-Home plays a mediating role between the different persons involved.

Although there is a close collaboration between the Home-info and Infor-homes (supervision, joint visits to institutions, exchange of data, same training for both teams), different approaches in regional policies lead to differences in the field. For example, Infor-home has planned a public campaign on the early detection of elderly abuse, whereas the more restricted financial resources of Home-info do not allow the set-up of such a campaign (cited in a phone interview with Belgian stakeholders), nor to enlarge the hours of **phone attendance** (Monday – Friday between 9 a.m. and 4 on Mondays and Fridays or 5 p.m.), or to increase the number of

training sessions for the care professionals, due to lack of financial and human resources.

6.3.2 Steering Committee elder abuse

A Steering Committee elder abuse was set up in 2009 with the aim of establishing cooperation between the various aid partners active in the Dutch-speaking Brussels field. This guarantees an interdisciplinary approach and increases the support for dealing with problems of elder abuse.

In the Steering Group there is a wide representation of actors both within and outside the care sector including BOT, ZorgPlus, Family Aid, Brussels Elderly Platform, Victim Support CAW Brussels, Police Victim Support Service, Expertise Center Dementia Broes, House for Health, Mederi, a provisional administrator, Federation Socialist Mutualities, Independent Health Insurance Funds, Federation of Christian Mutualities, VGC.

A protocol was developed in which the commitments made by the various partners regarding the aid method were described. The Steering Committee has quarterly consultations and met 3 times in 2018.

6.3.3 Brussels Meldpunt Ouderenmis(be)handeling

Within Home-Info, a specific service, Brussels Meldpunt Ouderenmis(be)handeling, has been set up focused on elderly abuse (since 2009). This service aims to be the contact point **for elderly** living in a residential care setting or at home, but also for **care providers** who are involved in a case of (suspected) elderly abuse. This contact can be via a unique phone number (during restricted day hours), or via the website. The Meldpunt provides information, analyses the situation, gives advice, coordinates the involved professionals and refers cases to the relevant services. In principle the Meldpunt does not organise specific aid, but helps the persons concerned to find the appropriate aid via networking.

The **methodology** that Home-Info uses for handling complaints/conflicts **depends on** whether the problem is situated in a **residential or** in a **home setting**.

Within residential care settings the steps to be taken depend on the nature / seriousness of the problem. There is differentiation in the provision of aid, namely:

- conversation with caller and/or conversation with the relevant residential setting
- providing information, advice: general, legal
- contac /consultation with competent inspection service
- consultation with and between the various persons involved: namely victim / staff / management
- possible referral to another service / organization eg. victim support

A specific aid process was elaborated for the reports regarding abuse/mistreatment in **a home situation**.

This methodology differs depending on the nature of the problem and the presence or absence of aid/network.

A "step-by-step plan" for intervention was drawn up. Each of the steps are briefly explained here.

- The data is recorded on the basis of a registration form. At the request of the reporter, anonymous registration is possible. The following information is registered:
  - all steps taken in the counseling process,
  - all activities related to training, prevention, awareness-raising,
  - all questions, gaps, bottlenecks that cannot be answered.
- Determining the request for help from the reporter is a first important step. If it concerns a request for information and / or advice, it will be provided immediately. If an intervention appears necessary, the situation will be explored further.

- In a conversation with the reporter, the situation is assessed further. Mapping existing aid and support is an important point of attention in this regard. The Brussels Meldpunt strives for a way of working in which the available help is encouraged to tackle the situation and this with the necessary support.
- In the next phase, the aim is to consult with the other persons involved.

The purpose of these consultations is to look at the situation from different angles and to arrive at an action plan. This action plan is used as a guideline and is evaluated on a regular basis. In addition, the consultation aims to facilitate communication and cooperation between the various care providers. Within the network of available aid, a key figure is sought who can coordinate the care (e.g. care mediator). If no key figure is found, the Brussels meldpunt will proceed to the effective implementation of the action plan.

- The situation is regularly monitored by the Brussels Meldpunt. The file is completed after all the objectives of the action plan have been achieved. An emergency plan can be drawn up with clear agreements should problems arise again.

An action plan has been elaborated how to assess the risk on elderly abuse (mainly based on the RITI scale and on the experience of the collaborators), which interventions are needed after notification of a case of abuse and how to inform and to listen to the concerned persons. Within the detection of signals of abuse, aspects of the elderly are considered, such as untended appearance of the elderly, perception of anxiety, but also signals in the (informal and formal) caregiver, such as “ontspoorde zorg”, lack of knowledge how to handle certain diseases (e.g. dementia). Similar to the Flemish region, the RITI scale is recommended to assess the potential risk for abuse. Next to the **follow-up of the call**, **data is also registered** for descriptive purposes on the current situation in the Brussels region.

Another important role of the Meldpunt, is raising **awareness and sensitization of the general public, the professional field and the authorities**. This is done by giving lectures, organising an annual colloquium in the scope of the international day against elder abuse[a], organising workshops, developing projects, participating in events with an info stand, an extensive website and distributing promotional material. For the further training and education of the team the Meldpunt participated in several seminars, colloquia and seminars.

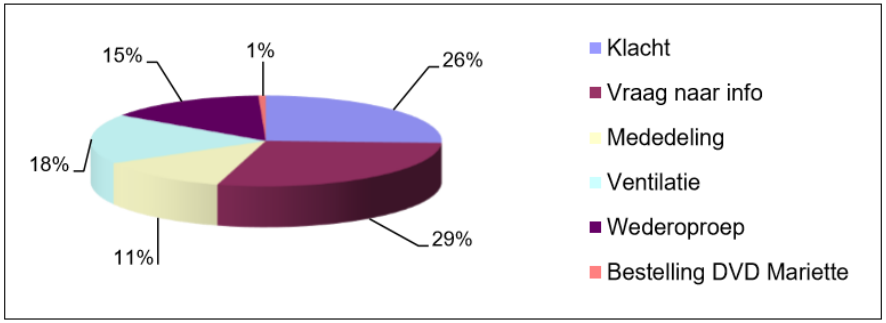
Every contact is registered. According to the most recent annual report of the Home-Info Brussels Meldpunt Ouderenmis(be)handeling (2019)[54], **149 calls** were received, which is comparable to 2018. The complexity of the calls increased, however, requiring more follow-up. 114 calls related to a residential situation, 28 to a home situation and 7 contacts concerned a request for information, training or other. **Of the 149 calls, 34 cases required intensive follow-up.**

Contacts are mostly taken by the family (36% - in particular in residential settings) and external professionals (29%). In 20% of the cases, the elderly calls him/herself. Most of the contact takers are women (76%). A majority of the victims are women as well (in the residential as well as in the home setting) and most of them are older than 80 years old.

Most of the reasons for contacts relate to a request for information (29%), a complaint (26%), and chat with someone who listens (18%) (see Figure 7).

[a] In 2019, the theme chosen was 'the field of tension between the care of the health care provider, the informal caregiver and the older self: everyone's expectations that sometimes may give rise to certain forms of non "well-being.

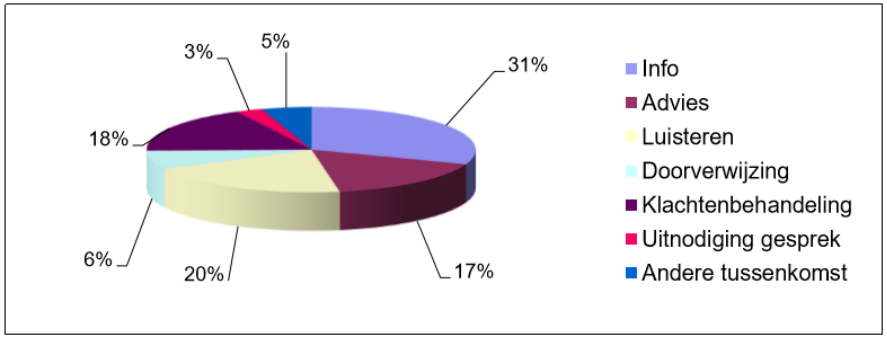
Figure 7 – Reasons for contact



Source: annual report Home Info – Brussels Meldpunt Ouderenmis(be)handeling 2019

The actions following the contacts mostly consist in informing (31%), advising (17%) and listening (26%). In 18% further management of a complaint is done (see Figure 8).

Figure 8 – Actions following the contact



Source: annual report Home Info – Brussels Meldpunt Ouderenmis(be)handeling 2019

Characteristics of the cases where intensive follow-up was necessary

In 2019, 34 cases needed intensive follow-up. 19% is related to the **home situation** whereas 76% relates to a **residential setting**. Most of the victims are mostly over 80 years old.

In 7 cases the **contact takers** for abuse in a home situation were care providers providing care at home. In 3 cases, the older person called him/herself. For cases in residential settings is was most often a family member who took contact. In 71% of the reported cases in a **home situation** it concerns a **request for advice without any further intervention** of the Meldpunt. In 2 cases registration of the complaint was asked for. For cases in a **residential setting**, **intervention of the Meldpunt** is asked for in 22%. 52% of the contacts are requests for advice.

Psychological abuse and violation of the rights are the most frequent types of abuse in both a home setting and a residential setting. In home settings 17% relates to derailed informal care and in residential settings 19% concerns problems with care provision (see Table 7).

Table 7 – Type of abuse per setting

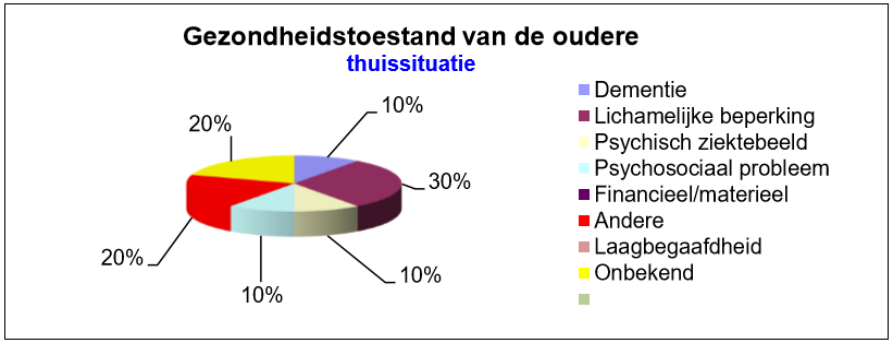
	Thuissituatie		Residentieel	
Fysiek	1	*8%*	6	*12%*
Psychisch	3	*25%*	13	*25%*
Financieel/materieel	1	*8%*	7	*13%*
Schending van rechten	4	*34%*	11	*21%*
Ontspoorde zorg	2	*17%*	0	*0%*
Verwaarlozing	0	*0%*	5	*10%*
Verzorging	1	*8%*	10	*19%*
Seksuele mishandeling	0	*0%*	0	*0%*
Totaal	**21**	***100%***	**52**	***100%***

Source: annual report Home Info – Brussels Meldpunt Ouderenmis(be)handeling 2019

30% of the reports concerning the **home situation** concern a victim with a physical disability who is dependent on external help and who is in a dependent position vis-à-vis the persons providing care. In some situations derailed care can lead to elder abuse (see Figure 9).

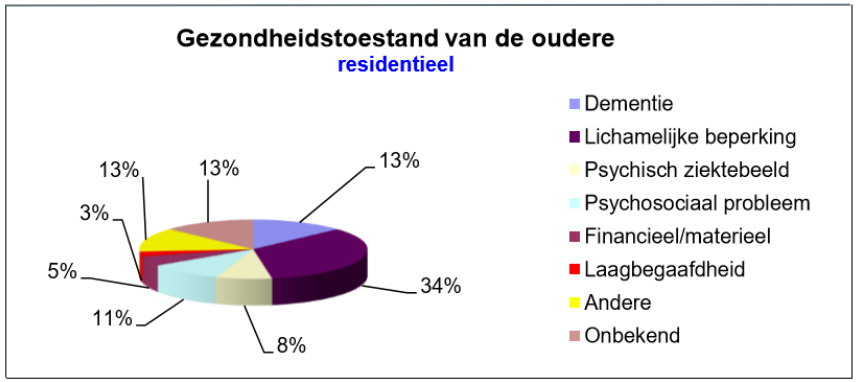
At the **residential facilities** we see that the victim has a physical disability in 34% of the reports. The elderly stay at home as long as possible and do not go to a residential care centre until they become dependent on (heavy) care. Because of this dependence on care, the elderly person is more vulnerable and can more easily become a victim of elder abuse. An overview of the vulnerabilities is given in Figure 10.

Figure 9 – Vulnerabilities of the victim in a home situation



Source: annual report Home Info – Brussels Meldpunt Ouderenmis(be)handeling 2019

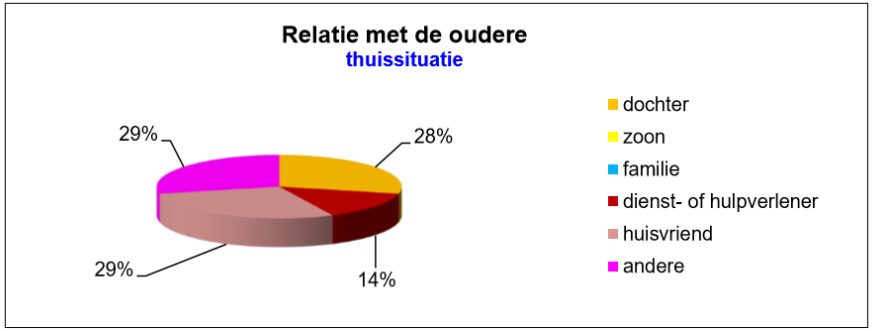
Figure 10 – Vulnerabilities of the victim in a residential setting



Source: annual report Home Info – Brussels Meldpunt Ouderenmis(be)handeling 2019

In 64% of the complaints related to elderly in the **home situation**, a **family member is the (presumed) author** (see Figure 11).

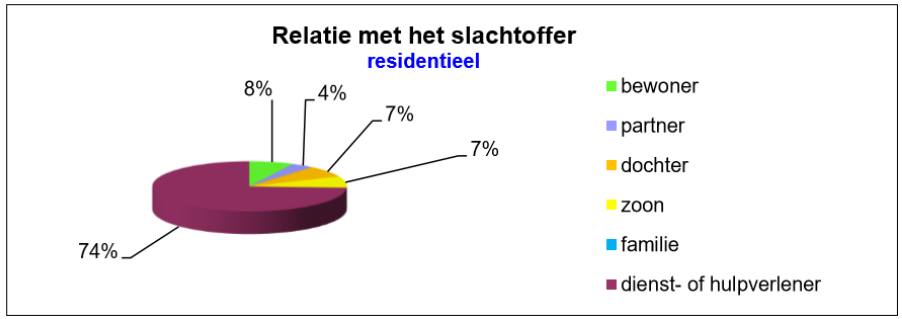
Figure 11 – Relation of the author with the victim in a home situation



Source: annual report Home Info – Brussels Meldpunt Ouderenmis(be)handeling 2019

In the **residential setting**, the (presumed) author is most often a **care provider** (see Figure 12)

Figure 12 – Relation of the author with the victim in a residential situation



Source: annual report Home Info – Brussels Meldpunt Ouderenmis(be)handeling 2019

6.3.4 Ecoute seniors

An equivalent service to the Meldpunt Ouderenmisbehandeling exists for the French-speaking citizens of Brussels: Ecoute Seniors, 'La maltraitance parlons-en', formerly known as SEPAM.

According to the annual report **1195 calls related to (presumed) elder abuse** were received in 2019 (this number includes calls from Infor-Home and Ecoute Séniors)[30]. **660 calls** related to situations of (presumed) abuse, which led to 262 dossiers, implying a further clarifications and follow-up of the situation.

In Table 8, it is shown that 262 dossiers (concerning one unique person/situation) have led to 882 complementary interventions.

Table 8 – Number of calls, opened files and complementary interventions per setting

	Domicile	Institution	TOTAL
Dossiers ouverts en 2019	92	166	**262***
Appels reçus	168	492	**660**
Interventions complémentaires	274	608	**882**

Source: annual report Ecoute seniors 2019

36% of the dossiers stemmed for (presumed) abuse in a home situation, 64% from a residential setting (rest- or nursing home, hospital…). According to Ecoute seniors this majority in a residential setting is due to the fact that ecoute seniors is perceived to be linked to InforHomes (which targets residential settings). Therefore efforts have been made in 2018 to inform personnel involved in aid at the domicile and professionals of the social sector and to advertise via radio. In 2019 there was a significant rise of the calls related to situations of abuse in the home situation. Although it is possible to call anonymously, only 2% of the callers chooses to stay anonymous. Most of the callers ask for an intervention of Ecoute seniors, be it a contact with the direction of the residential setting or a complaint to the inspection service.

- **Relation of the caller with the elder**

  If the case relates to the **home situation**, half of the callers have a family link with the elder (children 33%, husband/wife (1%) other members of the family (6%). Friends and neighbours count for 8% of the calls and 16% are physicians and external services like domestic aid services, community services, OCMW/CPAS, hospital services. In 36% of the cases, the older person called him/herself.

  If the case relates to a **residential situation**, the elder calls him/herself in 19% of the cases. More than half of the calls come from the family of the elder: children (41%), husband/wife (4%), and other family members, like brothers or sisters, nephews, grandchildren (7%). Friends, neighbours, visitors count for 9%, social workers and other

professionals from outside the institution (6%) and professionals working in the residential setting (4%).

- **Gender of the victim**

  The majority of the victims are women.

- **Age of the victim**

  The majority of the victims is older than 70 and most of the victims are older than 80.

- **State of dependency of the victim**

  The state of dependency of the victim is not known in approximately half of the cases. In cases related to the home situation as well in a residential setting, approximately 45% of the victims is **physically** dependent.

  The **mental/psychological** status of the victim is not known in approximately half of the case. Dementia and loss of memory are the most important mental problems (+/- 12%) in victims.

- **Subject of the call**

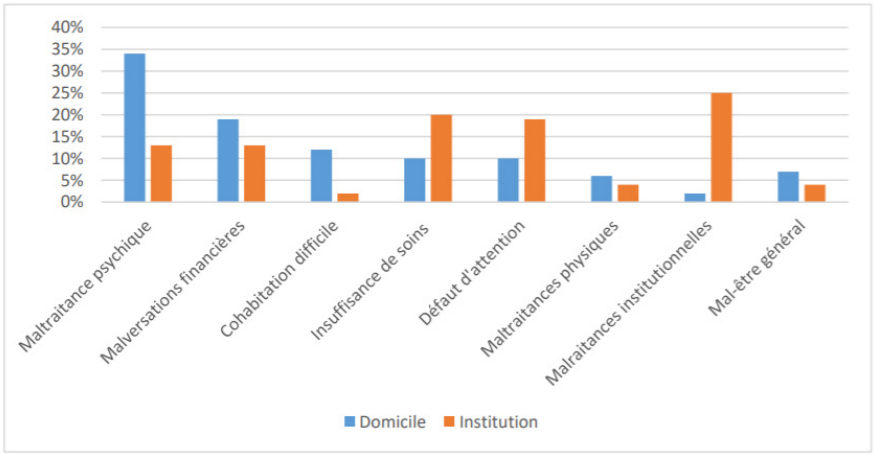
  In a home situation, the subject of the call relates primarily to difficulties in the relation with the family, in particular with the children and children in law (44% of the cases), the husband/wife or the partner (8%), grandchildren, nieces and nephews (7%). Problems with the place where the elder live (10%) and problems with external services (aid at the domicile or CPAS) and problems with friends and neighbours are also mentioned In the **residential setting**, organisational problems (64%) and problems with a care professional (8%) are the primary causes of the calls.

- **Types of abuse**

  In a **residential setting**, institutional abuse is occurring the most frequently, followed by insufficient hygiene and lack of attention. Institutional abuse includes the misorganisation or the malfunctionning of the residence, the lack of personnel, the high turnover of the personnel.

  In a home setting psychiological abuse (threatening, aggressive behavior, etc…), difficult cohabitation, fincancial abuse, lack of attention and insufficient hygiene are the most occuring types of abuse (see Figure 13).

Figure 13 – Types of abuse according to the setting



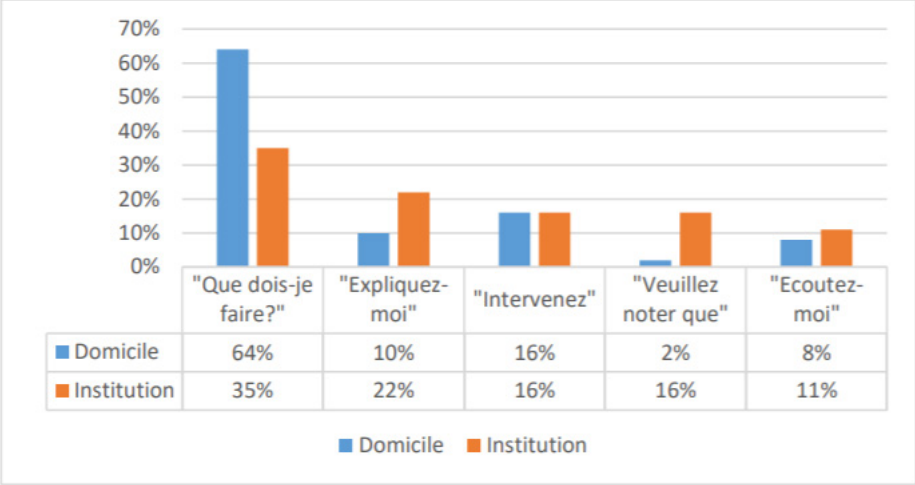
Source: annual report Ecoute seniors 2019

- **Type of intervention following the call**

  Most callers call for advice (“what do I have to do”), although this is slightly more the case for abuse in a home situation than in an institutional setting. The number of requests for **intervention are equal** for situations in a residential setting and those stemming from the home setting. Other types of intervention are **providing information, listening and registration (**see Figure 14**).** As the latter goes for each call, it was only taken into account as a separate category when it was the explicit demand to ‘just listen’ or when no other types of intervention

were asked for**.** For cases in the institutional setting, callers sometimes ask to **register** the complaint.

Figure 14 – Types of interventions per setting



Source: annual report Ecoute seniors 2019

The interventions of Ecoute Seniors vary according to the specific case: an advice, a simple clarification, referral to an appropriate service, such as services for victim aid, the police office, a mental healthcare professional, judge of peace, the competent inspection service, etc. All data related to the call are registered. If a simple orientation is not sufficient or the person cannot take action him/herself, other proposals will be done or – with the consent of the older person- Ecoute Séniors can start actions such as the research for (legal) information, proposal for mediation, proposal to change the domicile, contact with other actors such as: social service, healthcare professional, a legal guardian, a coordinator for home care, judge of peace,…, direct contact with the direction of the institution where the elder person lives or visit of this place, referral of the case to the competent inspection service, recurring contact with the family of the older person, direct contact with the older person if the case was reported by a third party. In very difficult situations Ecoute Séniors can coordinate the intervention of diverse professionals. A particular service used by Ecoute Séniors is "senior mediation". This mediation is done by recognised mediators that intervene independently for Infor-Homes. The mediators have signed a partner convention with Infor-Homes. Persons participation to the mediation pay 20 euro per person per session.

- **Promotion, sensitization and training**

Ecoute Seniors is also involved in promotion, sensitization and training. In 2018, Infor-Homes organised a 'matinée de réflexion' at the department of Sociology at the ULB and a sensitisation campaign on the radio. Moreover several sensitization and training activities were organised for students, professionals in contact with older persons, informal caregivers. Furthermore folders and posters are regularly sent to interested parties. There are regular contacts with the political field and the media. Moreover training is given to students, directors and personnel of rest-and nursing homes.

Key messages for Brussels

- **In the Brussels region, there are separate organisations for the Flemish and the French-speaking citizens to inform them on residential care and its related aspects: Home-Info financed by the Vlaamse Gemeenschapscommissie and Infor-Homes financed by the French Community Commission (COCOF). Both organisations are gathered in a centralized organisation (vzw Home-Info/asbl Infor-Homes), financed by the Common Community Commission (COCOM/GGC).**
- **Each organisation has similar missions, i.e. providing information to the elderly, his family and/or care providers on residential care (different settings, quality of provided care in these settings and the legal and administrative aspects such as financial aspects), pointing out potential barriers and/or lacks in current practice to the dedicated policymakers and**

organisations, and providing information on elderly care to the general public.

- **Of particular interest are the site visits to the elderly care settings in Brussels. The live encounter with the collaborators of Home-info/Infor-Homes allows the elderly and the care professionals to mention a suspicion of elderly abuse. Home-info/Infor-Home plays a mediating role between the different persons involved.**
- **Within Home-Info, a specific service, Brussels Meldpunt Ouderenmis(be)handeling, has been set up focused on elderly abuse (since 2009). This organisation aims to be the contact point for elderly living in a residential care setting or at home, but also for care providers who are involved in a case of (suspected) elderly abuse. This contact can be via a unique phone number (during restricted day hours), or via the website. The Meldpunt provides information, analyses the situation, gives advice, coordinates the involved professionals and if necessary, refers cases to the relevant services . Furthermore they are also involved in sensitization and prevention and analysis of the issue of elder abuse in general.**
- **An equivalent service exists for the French-speaking citizens of Brussels, écoute Seniors, La maltraitance parlons-en, formerly known as SEPAM.**

6.4 The main actors involved in the management of elder abuse in German-speaking community

In the German speaking Region, the German-speaking Community has legislative and executive power in persons related matters, including health care, social welfare and victims support.

- With regard to elders, the German-speaking community:
  - sets the standards for the recognition, finances and control residential and accompanying structures as well as domestic help services
  - subsidizes the financing of home emergency call systems;
  - subsidizes services offering home help, such as family and senior care;
  - subsidizes services supporting informal cargivers.

The administration in charge of those matters is the Dienststelle für Selbstbestimmtes Leben der Deutschsprachigen Gemeinschaft Belgiens .

In addition, family support services were created such as the SOS-Hilfe service, the Familien- und Seniorenhilfsdienst Verviers and the advice centre "Eudomos- Ihr häuslicher Begleitdienst".

A specific hotline is available for emergency calls under the national number 108. Approximately 40 volunteers work for this hotline. Call remain anonymous and respondent are bound by professional secrecy. The service is available around the clock, including weekends and holidays.

The trained and trustworthy staff are available to assist those seeking help; they take the needs of those seeking advice seriously and listen to them.

They also provide information about existing counselling and aid facilities and - if the caller so wishes - forward the call to specialist institutions or services.

A meeting house was founded by volunteers from the 3 parishes of Kettenis, Eupen-Unterstadt and Eupen-Oberstadt. The aim of the founding members was to open a discussion place for people seeking help, especially those living in great isolation, where volunteers could listen to them, give them a little security, prepare a cup of coffee and pastries, inform them, advise them and, if necessary, refer them to other services.

This houses can also organise information, awareness-raising and further training measures.

Finally, a counselling and therapy Centre (BTZ) is open since 1 January 2018, the German speaking Community organizes a specific counselling and therapy center named “BTZ”.

The BTZ offers the following services:

- general multidisciplinary therapy and counselling for children, young people and adults. These include psychological, social, medical and psychiatric support.
- an extended multidisciplinary therapy for children up to 14 years of age. This includes psychological, social, medical, psychiatric, pedagogical, occupational therapy, speech therapy, kinesiotherapy, psychomotor therapy, psychomotor and curative education.

The BTZ is open to all residents of the German-speaking Community.

The BTZ offers help in various areas related to family, health care (including stress, addiction, depressio,), violence, victim’s support etc.

Table 9 – Overview table: Services involved in elder abuse management in Flanders, Wallonia and Brussels

	FLANDERS	WALLONIA	BRUSSELS	German speaking region
Hotline	Generic for violence 1712 (not for professionals)	Specific EA Hotline of respect seniors): 0800/30330	Specific EA NL: Brussels Meldpunt OMB (part of Home-info): 02/511 91 20	Generic for violence 108
			Specific EA FR: Ecoute séniors (part of Infor-Home): 02/223.13.43	
Help For Professionals	VLOCO	Respect Seniors (not exclusive)	NL: Brussels Meldpunt OMB	
			FR: Ecoute Séniors	
Management of EA	No centralised management; no specialised service CAW, social services sickness funds, social services hospitals	Respect Seniors (not exclusive)	NL: Brussel Meldpunt OMB	
			FR: Ecoute séniors	
Complaints related to residential settings	Woonzorglijn Zorginspectie	Senoah Inspection services of the Walloon Region (AVIQ)	NL: Brussels Meldpunt OMB	
			FR: Ecoute séniors	
Collaboration justice-police-aid services	Chain approach or Family Justice Centers	Anonymous case discussion between justice and aid services organized on informal basis (no public protocol)		

7 ACTION PLANS, GUIDELINES AND GOOD PRACTICES RELATED TO THE PREVENTION OF ELDER ABUSE IN FLANDERS, WALLONIA AND BRUSSELS

In the next section, plans and good practices related to the prevention of elder abuse are listed. As elder abuse is often related to many interconnected problems such as poverty, isolation, addiction, etc., it is obvious that plans, policy and good practices to encounter these problems also play a role in the prevention and management of elder abuse. It is not our mission however, to give an exhaustive overview of all existing measures and good practices in these connected domains. We will only zoom in to the most important ones.

7.1 Awareness campaigns for the public

Different kinds of awareness campaigns for the public are organised by many of the above described organisations that are involved in the management of elder abuse.

7.2 Professional awareness and training

7.2.1 Trainings for professionals are not systematic and offered by different players in the field

Different kinds of professional awareness initiatives and training is provided for **professionals in contact with elderly** by several organisations involved in the management of elder abuse. These trainings are not systematically included in their curriculum and are often on demand of the professionals or the setting the professionals work in themselves. Apart from the organisations involved in the management of elder abuse (such as for instance Respect Seniors, VLOCO...) other players such as universities, professional associations, private parties etc. organise trainings for different kinds of students or professionals. For example, the faculty of psychology at the University of Liège gives the opportunity to students in psychology and speech therapy to learn about elder abuse and its prevention. The SSMG (Société Scientifique de Médecine Générale) organizes training about maltreatment for GPs about once a year.

For the staff of **nursing homes**, specific training, financed by the RIZIV/INAMI exists to become a resource person on dementia.[a] The full-60 hours training included at least 4 hours spent on the ethico-deontologic aspect of the dementia with among others, the theme of the well-treatment culture promotion. The law which set the prerequisites of the initial and continuous training does not formally include prevention of abuse.[b]

Training for professionals **in hospitals** is not systematically foreseen. In some hospitals ad hoc information sessions are provided. In 2012, training session on the early detection and management of domestic violence were provided in 9 hospitals (Flanders + Wallonia) as part of a research project financed by the FOD Volksgezondheid[55]. The training was targeted at

[a] See traning programme in Flanders for 2020 https://infocentrum.dementie.be/opleiding-referentiepersoon-dementie-20/

[b] Ministerial Decree of 4 May 2010 regard the modification of the ministerial decree of 6 November 2003 setting the amount and the conditions for the financing, as described in article 37, § 12 of the law regarding the compulsory health insurance, coordinated 14 July 1994, in rest-and nursing homes for older people.

physicians, nurses, midwives, psychologists, social assistants at the emergency department and the departments of paediatrics, geriatrics, gynaecology, the social service,…and consisted in a basic and an advanced part and in the aid in the development of a protocol for the respective hospital. Although the output of the training sessions was positively evaluated by the participants, several success factors and conditions for the effective implementation of actions plans and protocols on domestic violence were formulated. The involvement and engagement of the hospital management, the physicians and nurses were judged as primordial. Furthermore, external as well as internal financing were found to be necessary, with a focus on the financing of the social service that could function transversally as case managers for domestic violence. Moreover targeted awareness-raising and training for physicians was mentioned as another important action point. Finally, the recognition of urgent social intervention within hospital legislation was judged to be a must, even more if the social services would function as case managers for domestic violence.

7.2.2 Practice guideline "elder abuse in domestic environment" SSMG and e-learning module Domus Medica

Domus Medica (DM) vzw represents the interests of **general practitioners** and the general practitioners in Brussels and Flanders on a scientific, social and syndical level through democratic decision-making and scientific support. Furthermore DM promotes the development and realization of a good patient-oriented healthcare and care policy.

In 2013 a **practice guideline on elder abuse** in domestic situations was elaborated by the Société Scientifique de Médecine Générale (SSMG)[56], the French counterpart of Domus Medica. This guideline was certified by the CEBAM and was translated by Domus Medica to the situation in Flanders[57]. The guideline was commissioned by the FOD Public Health in the scope of the National action plan against all types of gender related violence. It describes the risk factors and signals, recommends the use of a tool for the detection of elder abuse (Elder Abuse Suspicion Index - EASI) and describes the steps to take in case of presumed abuse. It also includes a summary on the most important legal issues (annex 1 of the guideline), tools for the assessment of financial competency (annex 2 of the guideline), template medical certificates for the diagnostics of physical abuse (annex 2 of the guideline) and a list of references to the supporting services.

Since January 2018, physicians can subscribe to an **e-learning module on domestic violence** available on the website of Domus Medica.[a] The module includes type cases, instruction material and test questions for the participant on the different steps in the management of elder abuse. The different steps deal with recognising signals and the actions to take. Furthermore tools supporting the different steps and references to literature are included. Although the e-learning tool targets general practitioners, all physicians that have a RIZIV-INAMI number can subscribe and follow the course for free.

7.3 Informal caregiver support

Some situations of elder abuse are related to an overburdened caregiver. Moreover it was shown that authors of elder abuse frequently suffer from mental disorders or physical disabilities. Therefore the availability of homecare services and the support of informal caregivers is of an utmost importance in the prevention of elder abuse.

Support measures for informal caregivers

Different types of measures to provide informal caregivers with support are foreseen on different political levels (either by the Federal level through the legislation referred to underneath, by the Communities/regions or by the municipalities) and are scattered in different sectors of the social security system. Moreover, non-financial support is also foreseen by several non-

[a] https://www.domusmedica.be/vorming/e-learning/7371-aanpak-van-huiselijk-geweld-in-de-huisartsenpraktijk.html

profit organisations. In the next sections, we list the main interventions and summarise the main key findings from the 2014 KCE report 233 “Support for informal caregivers – an exploratory analysis”.[58]

Legal recognition as “informal caregiver” and specific thematic leave for informal caregivers

Since 2014, a Federal law[a] enshrines the principle that, under certain conditions, a person who, on a continuous or regular basis, dedicates part of his or her time to help a dependent person in a non-professional context and without being paid can be recognized as an informal caregiver. One of the conditions is that this person must have a trusted or close relationship with the person being cared for. This informal support must respect the life project of the person being cared for and must be completed by at least one professional support. The person cared for also needs to comply with several conditions, such as for instance the degree to which the person is self sustainable.

To be legally recognised as an informal caregiver, an application needs to be submitted to the sickness fund.

From the 1st of September 2020[b], employees recognised as informal caregivers can get a "thematic" and specific (paid) leave of 1 month full (this period can be extended to 6 months by Royal Decree) time (or 2 months half time) per person cared for.

Moreover, there a possibility for some workers to combine informal caregiver activities with another (social) statute. For instance, people who are on sickness leave will not loose their benefits when combining informal caregiver activities. Unemployed informal caregivers can continue to receive the unemployment allocations without being available on the labour market.[c] Self-employed persons cannot benefit from the above menitioned thematic leave for informal caregivers. Yet, they can benefit from a paid leave if they want to care for a servely ill or palliative family member (partner, sibling till the second degree or a person that lives officially at the address of the self-employed person). They are granted with a lump sum for maximum 12 months, an exemption of the social contributions for maximum 4 months and pension rights are retained.[d]

Other leaves

Besides the thematic leave for informal caregivers, informal caregivers (employees and civil servants) can benefit from other types of paid leaves which all have distinct conditions:

- Time credit or career break

Employees or civil servants can interrupt their professional career completely or partially for a certain period of time to take care of a sick person. They can then make use of the time credit if they work in the private sector and the normal career break in the public sector.[e]

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a Law of 12 May 2014 related to the recognition of the informal caregiver, *O.J.* 16 June 2014

b Royal Decree of 16 June 2020 executing the law of 12 May 2014 related to the recognition of the informal caregiver and the granting of social rights to the informal caregiver, *O.J.* 26 June 2020. Originally, this leave was foreseen for implementation from the 1st of October 2019, but a Royal Decree executing the recognition of the employee as informal caregiver was lacking.

c Royal Decree of 15 April 2015 modidying the articles 63, 114 and 116 of the Royal Decree of 25 November 1991 related to the rules of unemployment and repairing of the articles 90 and 125 in the same decree in the scope of informal care, *O.J.* 22 April 2015

d Royal Decree of 27 September 2015 related tot he granting of a financial compensation for self-employed persons interrupting temporalily the professional activity to care for another person, *O.J.* 5 October 2015

e https://www.belgium.be/fr/emploi/conges_et_interruption_de_carriere/credit_temps_et_interruptions_de_carriere

- Leave for medical aid

Employees or civil servants who want to take care of a seriously ill family member (the persons with whom the person lives, family members up to the second degree: children, parents, siblings, grandparents, grandchildren...) can benefit from a leave for medical aid.

During this leave for medical aid people will receive a replacement income from the RVA/Onem (Rijksdienst voor Arbeidsvoorziening/Office National de l'Emploi).[a] In addition, they may also be entitled to a Flemish incentive bonus.

- Palliative leave

Palliative leave is a paid leave that can be requested for by employees and civil servants to take care of terminally ill or uncurable person.

Financial support

- Flemish care allowance (Zorgbudget voor zwaar zorgbehoevenden)b

Each citizen in Flanders older than 25 years old contributes each year a premium of 53 or 26 euro (amount 2020) for the Flemish care allowance, which is a kind of a solidarity insurance for people with severe care needs. Citizens living in Brussels can freely opt to contribute and benefit from it. This allowance is meant to help people with severe care needs. They receive a fixed amount of 130 euro per month to cover their care needs. The allowance is granted to the person who needs help, not directly to the informal caregiver. Yet, the allowance can be used to pay the informal caregiver.

One can be entitled to 3 premiums via the Flemish care allowance. Each premium has its own conditions:

  - The care budget for severely dependent people.
  - The care budget for elderly people in need of care.
  - The care budget for persons with a handicap.

- Municipal care premiums in Flanders

In addition to the Flemish care allowance, many cities and municipalities also provide what is known as a 'municipal informal care allowance'.[c]

A municipal informal care premium is an amount that is granted monthly or annually to an informal caregiver. The conditions for receiving a premium vary from one municipality to another. The municipal informal care premium is granted to the person in need of care or to the informal caregiver. It is the local authority that chooses to whom the amount is given and when this is done. Unlike the Flemish Care Allowance, which may only be spent on the non-medical costs of the person in need of care, the informal care premium may be freely spent.

- Allocation pour l'aide aux personnes âgées (Wallonia and Brussels)/zorgbudget voor ouderen met een zorgnood (Flanders)

The allowance for a dependent older person, attributed to individuals aged 65 years or older who suffer from a disability or from an age-related illness is dependent on the degree of disability and the income level.[d]

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a https://www.belgium.be/fr/emploi/conges_et_interruption_de_carriere/credit_temps_et_interruptions_de_carriere.

b https://www.vlaamsesocialebescherming.be/

c Via this link, informal caregivers can check whether their municipality grants such an allowance: https://www.mantelzorgers.be/Pages/Opzoeken%20gemeentelijke%20mantelzorgpremie.aspx.

d allocation pour l'aide aux personnes âgées: https://handicap.belgium.be/fr/nos-services/allocation-aide-personnes-agees.htm/ zorgbudget voor ouderen met een zorgnood https://www.vlaamsesocialebescherming.be/het-zorgbudget; Other allowances and premiums for persons with care needs can be found here :

Respite care

Respite care is available in residential care facilities and by other initiatives from different actors, such as sitting home-respite care provided by the sickness funds. Arrangements to cover the cost of respite care depend from specific reimbursements from health care authorities, the cost itself of respite care alternatives (e.g. provision via non-profit institutions) and of the criteria to access short-term facilities.

Subventions for **services to relieve caregivers** such as "**nursing aid**" (oppashulp) and "**hosting care**" (gastopvang), are foreseen by the Flemish government. In 2019, these services cost maximally 2.87 Euro/h. The maximum amount of hours of this type of support that is eligible for subsidies has been extended every year since their introduction.[a] A list of all home care services and their cost can be found via the Agentschap Zorg en Gezondheid.[b]

Flanders has also taken important steps in the field of **respite care**, e.g. the initiatives for Collective Autonomous Day Care (Collectieve Autonome DagOpvang)[c], centers for day care, centers for short stays in elderly care.

Yet, a 2016 study of the Koning Boudewijnstichting shows that very few informal caregivers find the way to respite care.[59]

Information, training and psychological support

Support for informal caregivers is fragmented between the regions and even between municipalities in the same region. Different regional and local organisations and institutions (social services of the sickness funds, social services of the hospitals, public municipal welfare centres, etc.) provide information to informal caregivers and provide training and hobby activities for the elderly, but also for informal caregivers and volunteers.

In Wallonia, the AVIQ participates to an Interreg V project (European research funding program) which aims to train professionals to care for informal caregivers, to support informal caregivers and to create a network of professionals between Belgium and France. Psychological counselling is organised to help the informal caregiver and the recipient of care on how to better know the disease, how to react effectively, how to identify each other needs, how to understand the relation to each other, how to take time to respite,…

Furthermore, caregiver associations distribute information to dependent individuals and their caregivers, organise activities and represent the caregivers' interests. Currently, six non-profit associations (Steunpunt Mantelzorg Liever Thuis LM Ziekenzorg van de Christelijke Mutualiteiten Ons Zorgnetwerk OKRA-ZORGRECHT van OKRA, trefpunt 55+ and S- Plus Mantelzorg) active in Flanders and Brussels have been accredited. In Wallonia, the non-profit organization Aidants proches, created in 2005, is the sole caregiver's association. The Walloon government financially supports the "asbl aidant proche" in Brussels (co-subventioned by the COCOM) and Wallonia. This A.S.B.L. organises training of professionals to sensitize them to the importance of the role of the informal caregiver in the care and the necessity to collaborate with each other. The association provides information to informal caregivers and has developed an inventory on the available initiatives providing support to informal caregivers and formal services for the dependent person. In 2019, Aidants proches formulated several action points for politics related to informal caregivers.[60]

https://www.mantelzorgers.be/Pages/Tegemoetkomingen%20voor%20zorgvragers.aspx

[a] https://www.zorg-en-gezondheid.be/urencontingent-diensten-voor-oppashulp

[b] https://www.zorg-en-gezondheid.be/hoeveel-betaalt-een-gebruiker-voor-thuiszorg

[c] http://www.woonzorgbrussel.be/node/485

Vlaams expertisecentrum Mantelzorg

The Vlaams expertisecentrum Mantelzorg is an online meeting point for informal caregivers and those who work with them. Moreover up-to-date knowledge and information about informal care is centralised.[a]

Bien vivre chez soi

The Platform Bien Vivre Chez Soi depends on the AVIQ.[b] The aim of this platform is to enable people with restricted capacities to continue living at home in good conditions. The mission is to inform people, via the website, about advice, help and services that promote autonomy in Wallonia. Moreover people who request it can receive a free visit from an advisory service. This service will propose solutions for to enable a qualitative life of the person and the informal caregiver.

Mantelzorgplan in Flanders

In the mantelzorgplan 2016-2020 several action points have been formulated to improve the situation of informal caregivers[61].

Dementia plan Flanders

Support actions for caregivers are also included in the **dementia plan Flanders[62]**. This includes strengthening the informal caregivers and working with dementia experts, facilitating the access to the social worker in complex or novice care situations... The psycho-education, elaborated by the Expertise Center Dementia Flanders and spread through informal care and client associations helps the informal caregiver to increase his or her capacity.

Conclusions from the KCE report "Support for informal caregivers – An exploratory analysis[58]

In 2014, the KCE drafted a report on the support measures for informal caregivers in Belgium. We list the main conclusions. In Belgium, financial compensation for informal caregivers is limited, as social security benefits are not necessarily covered during care periods and the cash-for-care allowances (*Vlaamse zorgverzekering (now Zorgbudget voor zwaar zorgbehoevenden and the Allocation pour l'aide aux personnes – zorgbudget voor ouderen met een zorgnood*) are seldom used for compensating the informal caregiver. A caregiver allowance *(mantelzorgpremie)* is granted to informal caregivers in some municipalities and provinces in Flanders but is rather seen as a form of recognition for the informal caregiver's work than being a financial compensation at the level of a salary. A well-established system of leaves from work exists. However, there is little information on the extent to which work leaves provide a long-term solution for people who want to combine work and care responsibilities. Moreover, while respite care and psycho-social support is available from different sources, informal caregivers do not necessarily have access to those services.

a https://www.mantelzorgers.be/

b http://bienvivrechezsoi.be/qui-sommes-nous.php

7.4 Policies and practices in residential care facilities and home care

Centres providing residential care for Elderly in **Flanders** (e.g. residential care centers , day care centres,..) are legally held to have a **quality manual**[a] **justifying how the respective centre fulfils the sectoral minimum requirements of the Quality Decree**[b]. There is also the Ministerial Decree of 10 December 2001 on quality care in rest-and nursing homes (now 'residential care centers'), day care centres, short-stay centres, service flats and housing complexes with services for the elderly with sector-specific quality criteria and minimum requirements.[c] Although the minimum requirements foresee these kind of centres should provide measures to guarantee respect for privacy, autonomy, the right to complain for the resident, etc. there is no explicit requirement to have a procedure for situations of (presumed) elder abuse. Some facilities spontaneously have included a procedure related to elder abuse, but in practice this was not often used or not known by the care providers working in the centre[d]. Inspections of the quality norms and the accreditation norms in residential care settings is done by the Vlaamse Zorginspectie (see 4.1.5).

For all **home care facilities and the associations of users and informal caregivers** the Quality Decree stipulates that they need to:

- pursue a quality policy;
- draw up and use a quality manual;
- evaluate themselves periodically (self-evaluation);
- draw up an annual quality plan;
- also have to draw up an annual report in which they describe, among other things, the quality policy they have pursued in the past year.

Furthermore, the Decree related to 'Residential care' (woonzorg) (applicable to residential and/or care facilities = a local services center, a home care service, a group of aid habitations or a residential care center and associations for informal caregiver or users) stipulates principles related to well treatment and respect for the users of the services (i.e. the elderly) and the informal caregivers that must be guaranteed in all the "Residential and/or care facilities and associations". [e] All these residential care facilities and associations also have to guarantee users a right of complaint and ensures that complaints are dealt with adequately and objectively. Moroever they have to monitor the satisfaction of its users and adjusts accordingly. A responsible user satisfaction measurement shall be carried out at least every three years.[f]

"Residential and/or care facilities" and informal caregiver associations are held to draft a frame of reference for inappropriate sexual behaviour towards inhabitants/users and need to have a procedure for the prevention, detection and appropriate response **to inappropriate sexual behaviour towards inhabitants/users**.[g] This procedure includes a registration system that keeps anonymised data on cases of inappropriate sexual behaviour towards inhabitants/users. The facility will report, in an anonymised manner,

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a https://www.zorg-en-gezondheid.be/een-kwaliteitshandboek-en-kwaliteitsplanning-opstellen-in-een-ouderenzorgvoorziening

b Decree of 17 October 2003 related tot he quality of health- and wellbeing services, *O.J.* 10 November 2003

c Ministerial Decree of 10 December 2001 related to quality care in rest homes, centers for day care, centers for short stay, service flats and housing complexes with services for elderly, *O.J.* 28 maart 2002

d Information stems from local survey - Communication by Hans Debeule

e Art. 3 Decree of 15 Februari 2019 related to "woonzorg", *O.J.* 3 May 2019

f Art. 8, § 3 and 4 Decision of 28 June 2019 of the Flemish government regarding the programmation, the accreditation conditions and the subventioning of residential settings and associations for informal caregivers and users, *O.J.* 21.11.2019

g Art. 4 of the Decision of 9 May 2014 of the Flemish government related to the policy regarding prevention of and handling transgressive sexual behaviour in health care facilities and woonzorgvoorzieningen, *O.J.* 02.07.2014

inappropriate sexual behaviour towards users to the Health and Care Agency (Agentschap Zorg en Gezondheid). The task of the Healthcare Inspectorate (Zorginspectie) consists of checking the presence and correct application of procedures that have been worked out. It also examines whether the rights of the users are respected. These checks can be planned checks or can be initiated by reporting an incident. The inspection report describes possible points of attention or shortcomings in the approach to the incident and in the established and implemented procedures. This goes beyond the incident itself. These reports are provided to both the health care institution and the Health and Care agency for further follow-up. Until 2018 (the most recent year), there were no reports in home care. In elder care, the number of reports is limited (4 in 2015, 7 in 2016, 5 in 2017 and 6 in 2018).[a]

In 2010, the AWHIP published a report within the scope of the well treatment plan, part of a **Walloon** prevention protocol against abuse of people with handicap. The document includes several tools also used in nursing homes. Those tools are:

- The well treatment booklet[b]
- Together against maltreatment[c]
- Risk factors of maltreatment[63]

Wallonia government has elaborated a decree specifically addressing the wellbeing of the residents in institutions. In the chapter 3 of the "code wallon de l'action sociale et de la santé" (CWASS), the article 337 says that the nursing homes have:

- 1 ° to respect the individual rights of the residents;
- 2 ° to guarantee respect for their private, emotional and sexual lives;
- 3 ° to promote the maintenance of their autonomy;
- 4 ° to promote their participation in social, economic and cultural life;
- 5 ° to ensure an environment conducive to their personal development and their welfare;
- 6 ° to ensure their safety while respecting their individual rights and freedoms.

The previous article 338 of this code stipulated that nursing homes can freely ratify a charter about the needs, the expectations and the respect of the residents[d]. But following procedural difficulties, the ratification of the charter was not done by any Walloon nursing home till now.[e] The past Walloon minister of health had planned to elaborate a new decree making mandatory the ratification of the charter but a decree of February 2019 mofified the article 338 in a different way. Instead of a charter, the government must take the mesures allowing the continuous improvement of the quality in elders' residential facilities.

The article 334 of the CWASS defines **the life project of an elders' residential facility** as all actions and measures designed to ensure the social integration and quality of life of residents, both inside and outside of

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a Flemish Parliament, written question n° 447 of 13 April 2018, http://docs.vlaamsparlement.be/pfile?id=1398886

b Le Livret de la bien-traitance, 152 avenue de Malakoff, 75116 PARIS, MEDIDEP

c Ensemble contre la maltraitance – Résidence Santé Cousin de Méricourt et Résidence Service l'Aqueduc (Paris). Prix spécial du jury Initiatives de la bientraitance – Ville de Paris, 2005.

d Arrêté du Gouvernement wallon portant exécution du décret du 30 avril 2009 relatif à l'hébergement et à l'accueil des personnes âgées ; 15 octobre 2009, annexe 1

e http://www.senoah.be/wp-content/uploads/2016/03/Le-label-%C2%AB-qualit%C3%A9-%C2%BB-des-maisons-de-repos-et-des-maisons-de-repos-et-de-soins.pdf

the seniors' institution. This life project is one of the mandatory condition required for a seniors' institution to receive an agreement (pt 10 of article 359 of the CWASS). The life project of the establishment enables residents to preserve a meaning to their life in the establishment and for the professionals to give a meaning to their work (...). It is advisable to allow residents to evoke their wishes, their difficulties, their habits, their values through committees and debates. On the basis of the establishment's life project, the work teams define operational objectives in their daily practice, as well as indicators to evaluate them. The manager and the director make the necessary means for the implementation of the Life Project available (pt 5.1 and 5.2 of annex 120 of the CRWASS).

This life project should include at least six main issues:

- (a) arrangements for the reception of residents made with a view to respecting their personality, alleviating the feeling of rupture experienced by them and their families on entry and identifying the elements which will enable their aptitudes and aspirations to be developed during their stay;
- (b) provisions relating to the stay enabling residents to return to a living environment as close as possible to their family environment, in particular by encouraging their participation in decisions concerning community life and by developing occupational, relational and cultural activities with a view to opening up the nursing home to the outside world;
- (c) provisions relating to the organisation of care and hotel services, with the aim of preserving the autonomy of residents while providing them with well-being, quality of life and dignity;
- d) provisions organizing teamwork in an interdisciplinary spirit and in a spirit of ongoing training, requiring the staff to respect the resident's person and individuality in deeds and words, and granting the staff the means, particularly in terms of time, to facilitate the collection and transmission of observations that will make it possible to achieve the objectives of the life project;
- (e) provisions allowing for the participation of residents, each according to his or her abilities, in order to foster dialogue, welcome suggestions, evaluate as a team the achievement of the objectives contained in the institutional life project and offer activities that meet the expectations of each person.
- (f) provisions to ensure respect for the emotional, relational and sexual life of residents, regardless of their sexual orientation or gender identity.

In addition, the new decree of February 2019 introduces the mandatory filling in of four criteria if a seniors' institution wants to ask to the resident a rental price for his/her room in the institution. One of those criteria is to have at disposal and to maintain a quantity and the quality of the employment, and a ratio of staff of which the threshold is determined by the Walloon Government.

The coordinator GPs of nursing home is in charge to elaborate with the management of the nursing home and the nurse in chief the program of quality. The quality standard in the program include at least that the care and services warrant the respect of dignity, the respect of private life, the respect of ideology, religion or philosophy, the right to complain, the right to be informed and the right to participate. It also includes a specific support to persons with dementia and the effectiveness and continuity of the care and services.

Only establishments approved by the AViQ (Walloon Region) benefit from the protection and guarantee measures in the interests of both the establishments themselves and their residents offered by the AViQ. If an establishment does not comply with the rules laid down in this respect, the AViQ can be informed by means of a written complaint, so that the AViQ can instruct inspectors on site to verify the facts denounced in the complaint and, if necessary, sanction the establishment in question. Sanctions can range from a simple warning with possibly an administrative fine, to a decision to suspend or withdraw the operating permit and thus to a provisional or

definitive closure of the establishment in question.[a] Also, the AVIQ plans to control the quality of the nursing homes not only on the architectural rules respect but also on the respect of each resident's life project.[b]

In Brussels, the Decree of the COCOM (03 December 2009) asks in its article 13 that a life project should be defined in each institution by the manager and the director, in collaboration with the staff and the participatory council, with a view to promoting the development and well-being of older people, both inside and outside the institution. On the basis of the life project, the manager, director and staff will define operational objectives to be implemented in daily practice and indicators to evaluate them. The life project is evaluated annually by the manager, director, staff and participatory board. If necessary, the life project is modified. The life project is communicated to each member of staff on recruitment and to each elderly person on admission and whenever it is modified. The life project as well as the documents relating to its elaboration and evaluation, with any amendments, must be able to be checked by staff members. Inspections are performed by the COCOM, on an unplanned way when complains were filed.

7.5 Programmes to decrease societal attitudes and stereotypes towards older people: empowerment of older people.

In Belgium, several initiatives exist to combat ageism and to empower the older people.

Be.Source is a private initiative which aims to support and federate actions improving the living conditions of vulnerable seniors[64]. This project is based on 5 areas of solidarity: the fight against loneliness, combatting cognitive decline, improving mobility, managing elders' free time and organising intergenerational activities. In 2018, more than 6,000 elderly people benefited from more than 55,000 services: home visits, "well-being" care or minor work at home, singing workshops, activities in a day-care centre….

In Plombières, 13 apartments in a residential nursing home setting are co-managed by residents and staff, according to an innovative model that aims to preserve the autonomy of each, while establishing a collective dynamic that is conducive to the well-being of all. This philosophy corresponded to an innovative project developed in Sweden.[c] This model is based on the needs of the resident: the resident is active in the organization through committees that are composed of both staff members and residents. Organisation of care, purchasing decisions, collective activities and even staff recruitment: this covers all areas. Co-management makes it possible to enhance the value of the elderly person and his or her abilities. A project of this type is able to reassure the residents as the main fear when entering the community is precisely the loss of autonomy. As the staff is in demand for more contact with the residents, this new form of organisation is received very favourably. Thanks to the King Baudouin Foundation and in collaboration with the AVIQ, several pilot projects of this type will be developed in Flanders and Wallonia. The King Baudouin Foundation will grant 10,000 euros per year to finance community decision-making, while

[a] http://www.senoah.be/questions-juridiques-a-la-loupe02/

[b] Personal communication of Miss Lore Poncin Cabinet Greoli

[c] https://www.jmhospitals.be/dossiers/les-seniors-en-mode-participatif/article-normal-29327.html?cookie_check=1583164858

the AVIQ is making a coach available to the institution. In this context, the King Baudouin Foundation supports similar project in Lontzen en Steenokkerzeel.[a]

Age Platform, a European organisation based in Brussels and aiming to voice and promote the interests of the older European citizens, has developed several initiatives to **decrease societal attitude and stereotypes toward older people**.[b] This organisation considers that the demographic change is an opportunity, that a comprehensive approach to aging is needed and that older women and men should be seen as self-advocates. An example is a sensitisation campaign led in Brussels in 2018 : “Les droits humains ne diminuent pas avec l'âge”[65]. On the Age Platform website, different good practices all around Europe are listed.[c] In Belgium, the labolobo project aims to fight against the isolation of seniors; to enhance their role through transmission; to strengthen the social ties of all; and to transform our vision of old age.[d] In the same mind, Atoutage is an association for those who want intergenerational responses to various social issues: project management, methodology, conferences, animations, consulting. [e] Similarly, the entr’ages association aims to be a social and political actor on the issue of ages in our society.[f]

The **Flemish Elderly Council** is the advisory and participatory body of older people in the Flemish government.[g] The non-profit association is a consultative platform of various organisations of and for the elderly. Through awareness-raising campaigns, the organisation wants to make people aware of the added value of older people in society, create more attention for their needs and requirements, stimulate realistic perceptions of older people and encourage the elderly themselves to (continue to) play an active role in their environment.

Another topic concerns the **employment of older people and the active ageing.** Several initiatives illustrates this aspect of the empowerment of older people: (i) Road67[h], more 50+'ers at work' is a trajectory to promote the employment rate of 50+'ers in Flanders; (ii) “Les compagnons dépanneurs”[i] are volunteers between the ages of 15 and 99 who help people in financial difficulty; and (iii) the project “Nursing home Witte Meren: Making exercising fun for the elderly”[j] works to improve the well-being and good health of older people in an original challenging practice of physical exercises.

Some initiatives concerns the **accessibility of services to older people** like in Mons with the “Service administrative à la maison” offered to people older than 75 or with reduced mobility.[k] At a larger scale, project like “Atingo”[l] or “Global aged-friendly cities”[66] contributes to improve the mobility of older people in Belgium.

Digitalisation is for many older people a major issue, leading to social isolation and lack of access to several services. Yet, knowledge with regard to digital services, such as for instance digital banking can be an important

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a https://www.kbs-frb.be/fr/Activities/Themes/Health/99642; https://www.kbs-frb.be/fr/Activities/Grants?theme=0fde20237bbb4457ad6be29b9558227d&themeName=Personnes%20C3%A2g%C3%A9es&amount=43

b https://www.age-platform.eu/about-age

c https://www.age-platform.eu/good-practice-introduction

d http://labolobo.eu/fr/project/

e http://www.atoutage.be/

f https://www.entrages.be/wp/

g https://www.vlaamse-ouderenraad.be/wie-zijn-we/in-het-kort

h https://www.road67.be/

i http://compagnonsdepanneurs.be/Qui-sont-les-Compagnons-Depanneurs?lang=fr

j https://www.eurisy.org/good-practice-activ84health_204

k https://www.mons.be/annuaire/administration-communale/etat-civil-population/service-population/service-administratif-a-la-maison

l https://www.atingo.be/qui-sommes-nous/presentation-datingo-facile-a-lire-a-comprendre/

facilitator to avoid financial abuse. In that scope, Febelfin, the Belgian federation of the financial sector, is collaborating with Gezinsbond on the **'Digitalisation and Senior Citizens'** campaign. The aim is to encourage senior citizens to do more digital banking. It appears that half of the over-55s do not do so.

Last topics concerns **social inclusion**: (i) the “Pens(i)ons quartier” project[a] aims to create a new neighbourhood dynamic to take older people out from isolation and fostering bonds of solidarity; (ii) the project and website 'Forget dementia. Remember people'[b] is part of the implementation of Dementia Plan Flanders 2016-2019: 'Building together on a dementia-friendly Flanders'. This project invites to build an inclusive society for people with dementia and everyone who cares for them; (iii) the association “The "Angry Old People's Gang"[c] is an independent citizens' movement that fights so that future generations can grow old in dignity with decent access to health care and a guaranteed minimum retirement pension, equal for all women and men; and (iv) the ‘maison-Biloba-huis’ project[d] is a meeting place/anchor point and a supportive dwelling/home for senior citizens. BILOBA strives to ensure that the senior citizens who live in the neighbourhood.

Sickness funds and organisations related to the authorities are deeply involved in this societal concern: Vlaamse ouderenraad[e], LUSS[f], Conseil consultatifs des ainés[67], ENEO[68], SOLIDARIS[69] and OKRA[g]. For example, on the website of OKRA, the empowerment aspect is well highlighted: “OKRA is an association of, for and by people over 55. In OKRA you will find plenty of opportunities to meet peers and do activities together. You get the chance to develop your talents, stay active and participate in the ever-evolving world. The ultimate goal is to create a warmer society for everyone. And every member of OKRA contributes to this. OKRA draws its inspiration for this from its Christian vision of man and society. This means that the following values are very important to OKRA: solidarity, justice, equality and solidarity. Vulnerable groups get extra attention.”

The Social Cohesion Plan (Plan de Cohésion Sociale-PCS)[h] is a project proposed by the Walloon Region since April 2009 and is developed by 147 municipalities. It is a communal, social, generalist, front-line service that relies on a network and favours a participatory methodology.

The plan aims to provide access to fundamental rights for the entire population, through four axes: socio-professional integration, housing, health and treatment of addictions, and reworking of social, intergenerational and intercultural bonds. This is a. o. a programme to decrease societal attitudes and stereotypes towards older people by promoting the reworking of intergenerational links (=activities which mix older people and younger people/children). The PCS team is in charge of setting up and supporting activities and projects in order to better integrate people from different generations in their village and neighbourhood. The intergenerational approach is thus always present in each of the projects.

In Philippeville, as an example, the constant concern with the links between generations is expressed in the partnerships forged with the schools, the Advisory Councils of the Elders, the Hestia project of the Red Cross (home support for isolated elderly people), the system of local exchange PhiSel and intergenerational spaces in which different workshops and events allow exchanges and meetings.

Another good practice in Wallonia illustrates in the same time the possible improvement in nursing home as well as the empowerment of older people. In the frame of the European project “WE DO 2” and the realization of the

a http://www.villesamiesdesaines-rf.fr/files/partages-experience/200/277-peok-pens-i-ons-quartier-bruxelles-1.pdf

b https://onthoumens.be/

c https://gangdesvieuxencolere.be/

d http://www.maisonbilobahuis.be/

e https://www.vlaamse-ouderenraad.be/wie-zijn-we/in-het-kort

f https://www.luss.be/thematique/personnage-agee/

g https://www.okra.be/over-okra

h http://www.intergeneration.be/carnet-seniors.php?dossier=91

"European Charter of rights and responsibilities of older persons in need of long-term care and aid", the "Domaine des Rièzes et Sarts" in Couvain was visited, in 2013, by several European delegations as an example of good practice in Europe on wellbeing and respect of the elderly. The functioning and the values of this house of solidarity for older adults are modelled as much as possible on the specific needs and desires of its inhabitants. At the Domaine, professionals commit themselves to be guarantors of values such as respect for the autonomy, citizenship and freedom of the inhabitants. They take into consideration the habits of the elderly before his admission. The Domaine offers a real space of freedom where the right to express his wishes is respected. Disoriented residents live freely and are never contained or held in a chair. They live like the others, with the others. No unit is reserved for them. The doors are open to the outside and walking is encouraged. This choice raises the problem of risk management. The Domaine considers that life is risky and that there is no greater risk than that of not taking it! To allow people to take risks is to acknowledge them the right to still be alive.[a]

Several political declarations were made underlining the importance to take measures against elder abuse. For instance, in 2018, a joint political declaration was made by the Federal and Federated authorities in the context of the adoption of **a new mental health care landscape for elders**. This declaration acknowledges that in the context of drafting this new landscape, authorities in charge should pay attention to the particularly negative impact of elder abuse on the (mental) health of elders[b].

7.6 National, subnational or local policies and/or action plans related to elder abuse

7.6.1 No operational protocols for elder abuse between the Federal and the Federated level

Regarding elder abuse, there is (in contrast with child abuse for instance) no formal joint approach nor any specific agreement or protocols between the **justice, health care and social services on a policy level**. There are however several policy notes and plans that include the topics of safety and intrafamily violence. Although there is most often no specific attention to elder abuse, the targets and action points defined can often also be applied to elder abuse or could easily be extended to this topic (see next section).

Regarding the management of child abuse, the Federal minister of justice (Federal) and Flemish Minister in charge of Family, health and welfare signed (2010) a joint protocol to tackle this specific type of abuse in a coordinated manner[70]. This protocol contains commitments to train the professionals involved, to appoint reference persons in the network and includes a general "stappenplan" (step by step plan) and list of all possible offenses against children. This plan is not mandatory but serves as code of conduct for quality interventions to handle child abuse cases. The protocol has primarily had a major impact in the operationalisation of a policy for elder abuse in Flanders. A similar protocol was signed by the Federal justice minister and the (Federation Wallonie-Bruxelles) minister for Youth, welfare and health care.[71]

a http://www.espace-seniors.be/Sante/Projet-europeen-WeDO/Pages/wedo-bien-etre.aspx

b https://organesdeconcertation.sante.belgique.be/fr/documents/declaration-conjointe-pour-la-realisation-dune-nouvelle-politique-de-soins-de-sante.

7.6.2 National Action plan against all types of gender related violence

Since 2001, Belgium has pursued its policy to combat gender-based violence by means of a national action plan (NAP) coordinated by the Institute for the Equality of Women and Men. The NAP strives for a coherent and coordinated approach and relies on the close cooperation between the Federal government, the communities and the regions to convert this plan into 235 new measures to combat gender-based violence. Although the focus of the plan is gender-based violence, it is foreseen in the National Action plan against all types of gender related violence 2015-2019[72] that specific campaigns will be set up for fragile groups, such as elderly. Whereas the national action plan 2010-2014 foresees to integrate training for general practitioners on child abuse, elder abuse and partner violence in the continuous training process, elder abuse is no longer specifically mentioned in measures on training the professionals in the 2015-2019 plan. As gender-related violence is defined in the plan as violence between partners, sexual violence, genital mutilation, forced marriages, and honour-related violence, elder abuse is only partly included (elder abuse by another person than the partner, such as for instance in residential settings by a healthcare professional,…does not seem to be addressed) and does not seem to be part of the main focus of the plan. This is a missed opportunity as many proposed measures in the 2015-2019 plan such as integrating aspects of gender related violence in the basic education of health care professionals also apply to elder abuse. In order to prepare a new Action Plan, the Institute for the Equality plans to draft a document listing problematic issues and recommendations related to violence related themes. Based on this document a new plan 2020-2024 will be drafted (not published yet in April 2020).

7.6.3 National safety plan and Kadernota

The National Safety Plan (NSP)[37] is a document that is published every 4 years by the ministers of Safety and Internal affairs. It serves as a guideline for the functioning of the Police. The NSP is the basis of safety plans per police zone. The current NSP includes the topics of intrafamily violence, sexual violence on adults and minors and discrimination but does not explicitly mention elder abuse. In the plans per police zone, specific topics can be focussed on, depending on the particular situation in a zone and the affinity of the chief superintendent. In the 2018 plan of the zone Schaarbeek, Evere, Sint-Joost-Ten-Node for instance, the elaboration of a 'seniorenproject' adressing a.o. the issue of elder abuse is foreseen[73].

For the elaboration of the national safety plan 2020-2023 attention will be paid to the further approach to radicalisation, violent extremism and terrorism, including the updating of the Radicalism and Channels Action Plan, the development of a global concept for training with a needs plan, training catalogue and reference persons in each police school, and the creation of new training courses such as risk assessment, polarisation management and information officer. It is not clear if elder abuse will be included in the training catalogue.

The Framework Note Integral Safety (FNIS) is the basic document of the Belgian Security Policy. The FNIS determines the conceptual and substantive content of all other policy documents, both in terms of the basic principles and in terms of security policy priorities. The power to shape the FNIS is herein assigned to the Federal Ministers of Justice and the Interior. They lay down a draft framework note, prepared by a working group of experts, to the Interministerial Conference (IMC) 'Veligheids- en handhavingsbeleid'. The Ministers of the deFederated entities participating in this IMC formulate on the basis of their competences responsibilities adaptation proposals or new initiatives. Intrafamily violence is part of the nota and several useful action points have been formulated. Although it rather focusses on violence between young adults and families with children, the action points could also apply to elder abuse[36].

7.6.4 Circulars from the General public prosecutors and the Ministry of Justice

Several circulars from the General Public prosecutors and the Ministry of Justice with regard to intrafamily violence have been drafted (see 4.1.1). At the time of writing of the report, a circular related to elder abuse is under construction.

7.6.5 Flemish policy for older persons

The Flemish policy on the elderly is an inclusive policy. It does not require a categorical approach to all people above a certain age, but just to have a policy that covers attention for people's needs as they get older. In each of the domains concerned involvement of older people is aimed at. The Flemish Elderly Policy Plan outlines the framework for realising this ambition[74]. The plan is drafted with the participation of the elderly and the Flemish Elderly Council, and describes the planning of short and longer term policy measures, as well as the modalities of evaluation of the policy pursued, as laid down in the decree “decreet houdende de stimulering van een inclusief ouderenbeleid en de beleidsparticipatie van ouderen”. At the time of writing of the report, the Flemish government has announced a new Flemish Elderly Policy Plan for the period 2020-2025. The topics in the former plans address topics that related to prevention of elder abuse in an indirect way (for instance optimalisation of (health)care for elderly) but elder abuse is not included in the plan as such.

7.6.6 Walloon policy for older persons

The Walloon government has included a section on seniors in its 2019-2024 political plan[a]. This does not specifically mention the fight against abuse. It does, however, insist on the development of the elderly population and on keeping people with a loss of autonomy at home if they so wish. Priority will be given to reception and accommodation establishments that respect the living habits of residents. This plan also supports the development of the Silver Economy. The round tables organised on this subject to define with stakeholders the needs of elderly people in Wallonia have notably led to the conclusion that raising awareness against the discrimination and even abuse of which the elderly are victims is recommended[b].

7.6.7 Brussels region policy for older persons

In 2019, the Brussels government developed and published the Brussels Health Plan which, among other things, defines how to age in good health by proposing to adapt the residential offer to the needs of tomorrow and to organise local care in order to prevent dependency and to keep older people in their place of residence. However, the subject of abuse is not addressed[c].

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a https://www.wallonie.be/sites/default/files/2019-09/declaration_politique_regionale_2019-2024.pdf

b https://spw.wallonie.be/sites/default/files/silver%20%C3%A9conomie.pdf

c https://www.ccc-ggc.brussels/fr/observatbru/publications/plan-sante-bruxellois-grandir-et-vivre-en-bonne-sante-bruxelles

7.6.8 *Good practice on the local level of Samenwerkingsinitiatief EersteLijnsgezondheidszorg (SEL) Waasland: "Stappenplan & Leidraad Ouderenmis(be)handeling"*

Box 10 – Stappenplan en leidraad ouderenmis(be)handeling

A step-by-step plan and guidance related elder abuse, including the information on how to prevent, detect, report and deal with elder abuse is elaborated by the SEL (samenwerkingsinitiatief eerstelijnszorg) Waasland in collaboration with different partners from aid services, police and justice. The plan targets (care)organisations as well as individual care providers. It is not a step-by-step plan that can sequently be followed from step 1 to step X, but it offers professionals information and guidance for all the steps that might be taken in the management of elder abuse. It defines the different types of elder abuse, lists the signals for elder abuse, explains the legal framework related to professional secrecy, refers to several tools and techniques and gives practical information (contact data) of the respective instances that might be able to help (police, justice, aid services…). The step-by-step plan is generic and can easily be adapted to other provinces in Belgium.[a]

With regard to prevention, the necessity to sensitize at different levels (citizens, caregivers, care providers, police and justice) is stressed. Furthermore, the plan recommends municipalities to be more involved in the topic of elder abuse and integrate it in their local social policy plan.

This recommendation fits in the agenda of 'First line zones' (eerstelijnszone) in Flanders. In order to better align healthcare and welfare and to enhance an optimal cooperation between local governments, healthcare professionals and aid providers, 'first line zones' were created in Flanders[b]. The "first line" are the local care- and aid providers that are the first point of contact for persons with care and welfare questions. Examples are general practitioners, pharmacists, physiotherapists, home nurses, psychologists, social workers ... Overall a first-line zone is formed by all partners from the care and welfare landscape in a geographically defined area formed by 1 or more municipalities.

The required partners are:

- Healthcare users and informal care associations
- Medical and paramedical professions
- Local authorities and OCMWs
- Family care services and additional home care
- Babysitting services
- Local service centers
- Residential care centers, day care centers and home care actors
- Social work services of the health insurance funds
- General Social Work Centers
- Houses of the child
- Mental Health Actors

The first-line zones are managed by the Care Commission ('Zorgraad'), composed of representatives from (at least) the mandatory partners.

Other recommendations of the SEL WAASLAND are addressed to organisation, namely to elaborate a strategic vision related to elder abuse and to implement a protocol defining how to deal with elder abuse. Moreover a reference person within each (care)organisation should be appointed. This reference person is the central contact point and can help and support the

a https://www.selwaasland.be/system/files/stappenplan_omb_generiek_v2_1.pdf

b https://www.eerstelijnszone.be/wat-is-een-eerstelijnszone

personnel in the interpretation of signals of elder abuse and the further steps to take. Other tasks such as evaluating and keeping up to date the protocol, serving as a contact person for other organisations, registering reports of elder abuse via RITI or transferring this to VLOCO… can also be assigned to the reference person.

7.6.9 Decision tree for professionals developed by the Federal Public Service health care, food chain safety and environment

In 2006, in the context of a more global policy against intra-familial violence, the health care federal authorities (Federal Public Service health care, food chain safety and environment) issued a generic step-by-step plan (decision-tree) for elder abuse presumption for health care professionals. For more details on this tool see Chapter 4.

8 CONCLUSION

In Belgium there is no national policy related to elder abuse. This is partly because the competences related to the prevention and management of elder abuse are mainly situated with the defederated entities and the local governments. Several competences related to healthcare for older persons belong to the federal state, such as reimbursement of medical costs related to abused older persons or the suspension or withdrawal of the individual health care professionals' license to practice (visum) if the care delivered to the elder does not meet the quality requirements for health care practice. Moreover, Elder abuse response may require the intervention of judges, either to sanction the author, or to protect the victim. The criminal prosecution and sanctioning of certain behaviour perpetrated against elders as well as the definition of maintenance obligations (for instance of children's towards their parents) and guardianship procedures to protect incapacitated elders fall within the Minister of Justice's competence. Federated authorities are the main players for the (organisation of) the management of (non criminal cases of) elder abuse since they are in charge of welfare and wellbeing for older persons. Moreover they are also in charge of health care for older persons and the organisation of all kinds of residential and first line healthcare. The topic of elder abuse also affects the municipalities since they offer social and proximity services at a local level.

Although the fragmentation of responsibilities amongst the different political authorities of the relevant domains should not hinder the option of cooperation, there is no common approach related to elder abuse. Yet, there are some national plans regarding safety and violence in general. In these plans, the topic of intra-family violence is often included, but there is no focus on elder abuse. Although most of the action points and recommendations that count for intra-family violence in general are also applicable for elder abuse, there are some particularities for situations of elder abuse. Financial abuse for instance is one of the topics that is common in elder abuse situations but not addressed by national plans.

On the level of the federated entities, there is a major difference between Flanders and Wallonia and Brussels. In Wallonia and Brussels the management of elder abuse is centralised in services that are specialised in elder abuse. These services offer a first contact point (hotline for elder abuse) as well as the full management and follow-up of a situation. In Flanders all types of violence are integrated and managed by services that are not specialised in (elder) abuse, but provide first line help in several domains of life (relations, finances, addiction, overburdened caregiver,…). There is a centralised contact point for all types of violence (1712 hotline) that is accessible for the general public (not for professionals). When relevant, the caller is referred to the respective services, but there is no follow-up as to whether the caller has taken the initiative to contact the services referred to. The underlying idea for the integrated approach of management of all types of violence is that the reasons for elder abuse often relate to domains (relations, finances, addiction, overburdened caregiver, etc.) in which several existing first line services such as CAW, OCMW/CPAS…have a good know-how. For professionals dealing with (suspicion of) elder abuse situations, there is a specialised service that offers advice and help (VLOCO) but due to financial restrictions this organisation is currently a practice of 1 FTE.

Elder abuse also concerns the local social/welfare policy of the municipalities. Depending on the priorities of each municipality, some of them chose to have specific services for elders. For instance, some municipalities offer (limited) financial support or advice for informal caregivers or propose psychological or social support to elders living in their territory.

As many services involved in the management of elder abuse act on a local level, it seems obvious that collaboration between local actors in different domains (police, justice, first line health care providers, home services, residential services, CAW, OCMW/CPAS…) would enhance a common approach without losing the local specificities. A good example of such a collaboration is the booklet of the SEL Waasland. The booklet includes a step plan elder abuse, providing information on how to prevent, detect, report and deal with elder abuse. It defines the different types of elder abuse, lists the signals for elder abuse, explains the legal framework related to professional secrecy, refers to several tools and techniques and gives practical information (local contact data) of the respective instances that might be able to help (police, justice, aid services,…). According to the makers of this booklet, the sole act of creating such a booklet allowed to participating parties to get to know each other and get familiar with the topic. A valuable recommendation of the SEL Waasland, in that scope, is to give this mission to Eerstelijnszones in Flanders.

Prevention in the domain of elder abuse covers a wide scale of actions and interventions. There are regular campaigns and initiatives to inform the general public on elder abuse. These efforts are mainly taken by the specialised organisations but also by all kinds of associations that are active for seniors. Once a year, there is increased attention for the topic of elder abuse due to the international day against elder abuse. Although this is a nice opportunity to organise different kinds of initiatives in a systematic and recurrent way, some specialised services were not able to pay a lot of attention to this day due to financial restrictions. The types of material or action that is used to inform the public varies, but is often audiovisual. The information that is diffused mainly relates to informing the public on the existence/contact data of the specialised services and illustrating situations of elder abuse. Information on how a situation will/can be solved/managed is rarely given.

Another branch of prevention is the informing and training of professionals. Elder abuse is a topic that is not included in the basic training of professionals. Some sectors or (care) institutions provide trainings on intrafamily violence or elder abuse for their professionals but this is rather occasional and not systematic. Training is given by the specialised organisations or by other parties. For some categories of professionals, specific information or training is developed, for instance the guidelines and e-learning tool of SSMG-DOMUS Medica. Moreover, for justice and police there are circulars related to intrafamily violence that give guidance on how to manage cases. Yet, there are still many remaining categories of professionals that are well placed to detect (and manage) elder abuse but that not have any systematic specific training or information on the detection and management of elder abuse.

In Flanders as well as in Wallonia and Brussels, there are quality norms for (residential)care facilities. These norms do not impose facilities to have a procedure/action plan for situations of elder abuse. Quality norms address organisational issues but also aspects of wellbeing. In Flanders, residential care facilities and home care services need to have a quality handbook in which they confirm their quality policy and demonstrate that they comply with the norms. In Wallonia such a handbook can be drafted on a voluntary basis.

Overall there are many channels where citizens can launch a complaint against a professional or the quality of care delivered by a professional (e.g. Woonzorglijn, Federal Mediation Service Patients' Rights, Zorginspectie, provincial councils of the order of physicians, specialised organisations elder abuse,…). All these services operate on different levels (federal, regional, local) with all their own specificities. This leads to confusion and unclarity for the general population on which channel to contact and may hamper the willingness to launch a complaint. An integrated policy where complaints are centralised in 1 instance at the level of the ELZ, SISD, BRUSANO can come forward to these problems.[a] This instance can dispatch the complaints to specialised (local) channels for the respective complaint.

A particular type of elder abuse is the situation where the underlying reason for abuse is an overburdened or exhausted informal caregiver. It is clear that (part of the) prevention of this kind of situations lays in the organisational and financial support. There is a law recognising the statute of 'informal caregivers'. From the 1st of September 2020 , employees recognised as informal caregivers can get a "thematic" and specific (paid) leave. At the time of writing the report direct "financing" of informal caregivers only exists in Flanders in municipalities that grant a premium on a voluntary basis. This amount is rather symbolic than a real remuneration. Furthermore there are different types of allowances for persons with a high care need in all regions but these are paid to the elder him/herself. Furthermore, apart from the thematic leave for informal caregivers, there are several other systems of (paid) leaves but these do not cover the normal wage of the informal caregiver. On top of these measure, several respite options exist and information, training and hobby activities are organised by various (informal caregiver) associations and institutions.

As mentioned higher, elder abuse is a complex issue because there are often many underlying reasons in different domains of life. Particular for elderly is that on several domains they are more vulnerable than younger populations. Because of the loss of autonomy, they are more exposed to isolation and depend more often of others. Moreover society has a rather negative image of elderly, which hampers a full integration of elderly in the society. Several initiatives and plans from different parties try to come forward to this and formulate actions to integrate elderly as much as possible.

In, conclusion one can state that one the one hand there are many existing initiatives and structures involved in the management of elder abuse and that various preventive actions are available. On the other hand, there is a lot of fragmentation and little systematisation. Compared to other types of violence such as child abuse or violence between younger adults, elder abuse seems to be not that high on the political agenda.

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a http://vlaamspatientenplatform.be/_plugin/ckfinder/userfiles/files/2018_03_12%20Klachtrecht%20standpunttekst.pdf

CHAPTER 3: ELDER ABUSE PREVENTION

1 RATIONALE AND CONTEXT

This chapter answers the research question 3 - part1: "What can we learn from a selection of foreign countries with regard to the prevention of elder abuse?"

Prevention is the action to prevent occurrence or development of a problem and/or its complications. In general, prevention corresponds to any action taken to avoid or remove the cause of a problem in an individual or a population before it arises. Primary prevention is concerned with preventing the onset of a situation, while secondary prevention tries to intervene and hopefully put an end to a situation before it fully develops. Tertiary prevention groups the actions aiming to manage the consequences after abuse has occurred. This chapter focuses on primary prevention of EA defined as any interventions related to prevent the abuse from occurring.[8]

Since the years 2000's, several international organizations insist on the prevention aspect in the combat against EA: the United Nation (UN),[75] the World Health Organisation (WHO[a] and WHO-Europe[11]), the European Union (EU)[2], etc.. Many stakeholders all around the world, including in Belgium, expressed that prevention of elder abuse is in everybody's hands and that the promotion of well treatment is the best way to combat maltreatment.[12, 76] Also numerous references[b] from scientists and from practitioners described strategies that have been implemented to prevent elder abuse (see Appendix 7 for details).[8, 76] Elder abuse prevention was, at the beginning of this project, set as the main priority by specialized organisations in elder abuse management in Belgium.

As abuse occurs in a variety of contexts (homes, community, and institutions) and takes a variety of forms, prevention needs to be comprehensive and general in order to deal with the complexity of elder abuse by targeting several audiences: the elder person, the relatives, institutions and their staff, professional stakeholders, authorities, society as a whole and the media. Each of these actors can help and get involved in this issue of the society[c]. In some countries, the health sector has taken a leading role in raising public concern about elder abuse, while in others the social welfare or the justice sector has taken the lead.

The chapter is divided in 3 parts. The first one described international and European plans, institutions and projects aiming to prevent elder abuse. The second part gives an overview of preventive actions in three different countries (the Netherlands, Canada-Québec and France). The third part compares the preventive actions led abroad with those existing in Belgium. This comparison aims to get input to the Belgian situation from abroad concerning good practices in EA prevention.

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a https://www.who.int/violence_injury_prevention/violence/global_campaign/en/chap5.pdf?ua=1

b https://www.ucp-asbl.be/spip.php?article1245

c https://www.ucp-asbl.be/spip.php?article1245

2 METHODOLOGY

In September 2019, a non-systematic review of scientific articles, reports, and websites (of organizations and associations) on the thematic "prevention of EA" was done by one KCE expert. First, a quick search of websites and reports from major international organisations and of review articles in the scientific literature allow to identify 6 main categories of prevention's actions. Then detailed data about those preventive actions were collected for international institutions like the WHO, UN, EU and Council of Europe. Next the same preventive actions were identified in 3 different countries/regions: the Netherlands, Canada (Québec) and France. France and the Netherlands were chosen because of the proximity with Belgium and the language. Québec was chosen for his leader position in the field according to Belgian stakeholders. The collection of data was completed with the support of Marie Beaulieu. Finally a comparison between the categories of the EA prevention's actions was made between the foreign countries overviews and the Belgian data on prevention described in and extracted from Chapter 2.

3 LIMITATIONS

The main limitation of this chapter is the lack of strong evidences regarding the efficacy of EA prevention interventions. This phenomenon can easily be highlighted by recent scientific reviews[77] of which extracts are available in Appendix 8.

Globally, little is scientifically known on how to prevent and manage EA. The scope and nature of the problem is only beginning to be delineated. Many risk factors remain contested, and the consequences and evidence for what works to prevent elder abuse is limited.[9, 78] The quality of the collected data are not always robust on a scientific point of view. This is notably due to the multiple and complex aspects of EA issue and that EA occurrence is very difficult to measure. First, there is a huge black number related to EA due partially to the unwillingness of older people to talk or confirm an abuse, to the lack of knowledge of HCP and/or relatives to detect and report, to the absence of official and centralized registration of EA cases, and many other reasons. This prevents a good evaluation of the direct outcome "EA occurrence". Second, an increase in EA reporting, which can be an indirect outcome, can be interpreted in two different ways: the apparition of new EA situations (what is a negative trend for the outcome) or an increase of the number of EA situations which are at last reported (what is a positive trend for the outcome).

However, increasing concerns emerge since the 2000's years about EA and notably among international institutions. Awaiting for more scientific data and in the hypothesis that this expectation is realistic, the publications and websites of international institutions will serve as the skeleton of the actual knowledge on elder abuse prevention.

4 CATEGORIES OF PREVENTIVE ACTIONS

Based on data from the WHO on violence prevention[79], on the “guide de reference pour contrer la maltraitance des aînés”[12], and on a recent Cochrane review on preventive interventions of elder abuse[8], the first quick search allows to identified six categories of preventive strategies: (1) existence of international, national or subnational policies and/or action plans and/or laws on EA matters; (2) improvement of policies and practices in residential care facilities; (3) professionals’ awareness and training; (4) support to caregivers to avoid burden; (5) awareness campaigns for the public; and (6) programmes to decrease societal attitudes and stereotypes towards older people, including theempowerment of older people. Some examples illustrating the preventive actions for each category are given in next chapter.

5 PREVENTIVE ACTIONS AT THE INTERNATIONAL AND EUROPEAN LEVEL

5.1 Elder abuse preventive strategies worldwide

International organisations such as the OECD (Organisation for Economic Co-operation and Development), the United Nations (UN) and the WHO (World Health Organization) are increasingly involved in fighting elder abuse.

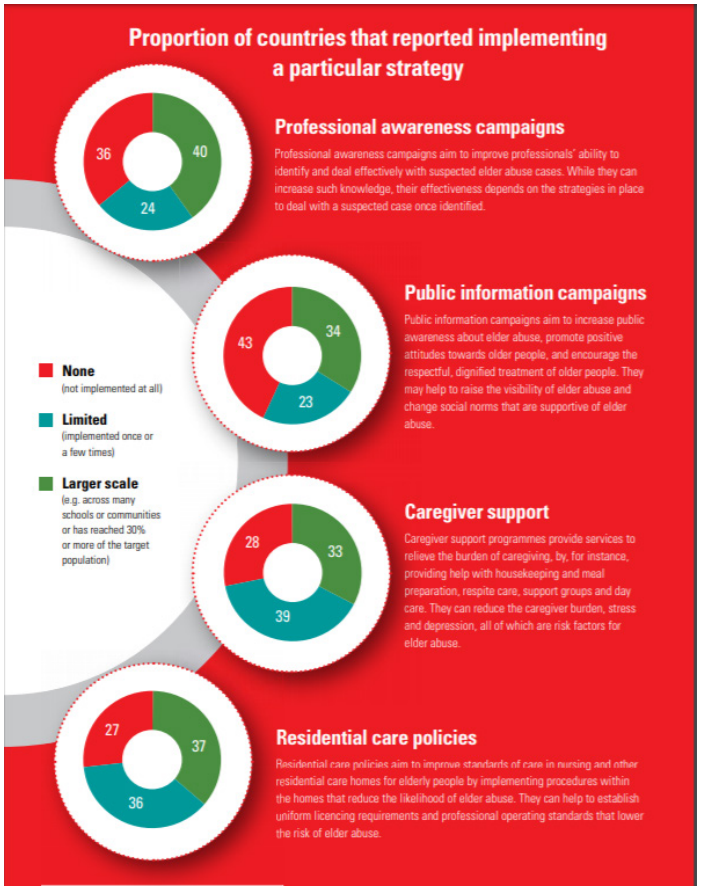
5.1.1 The World Health Organization (WHO)

In 2014, the WHO published “The **Global status report on violence prevention 2014**”.[79] This report presents the progress that countries all over the world have made in implementing the recommendations about violence prevention given in the “2002 World report on violence and health”[78] (see Appendix 1 for Belgium data). By giving an assessment of global violence prevention efforts and a snapshot of these efforts by country, the report aims to provide a starting point for tracking future progress and offers a benchmark that countries can use to assess their own progress in prevention. An entire chapter is devoted to elder abuse in the “2002 report” and the data snapshot by country in the “2014 report” includes several items about EA: the existence of a National Action Plan (NAP) on EA, of an EA prevention programme and of the data collection on EA.

Different strategies usually included in EA prevention programmes are listed in the “2014 report”. They concern the efforts made to raise professional awareness and train practitioners; the information given to the public about how to identify the signs and symptoms of elder abuse and where help can be obtained, the support offered to caregivers to relieve their burden and the improvement in policies and practices in residential care facilities for elderly people.

Although public and professional information campaigns to raise awareness about elder abuse are reported in many countries, elder abuse is one of the least investigated types of violence in national surveys, and one of the least addressed in national action plans. Moreover there is very little research on the effectiveness of any such programmes in preventing elder abuse, and this is, according to the report, a critical gap to fill. The Figure 15 illustrates the proportion of countries that has reported the implementation of each preventive strategy.

Figure 15 – Proportion of countries that have reported the implementation of each preventive strategy



World Health Organization (2014). Global Status report on violence prevention. Geneva.

In May 2016, the World Health Assembly adopted a **global strategy and action plan on ageing and health**[80] that provides guidance for action in Member States (MS) on healthy ageing. In this plan, WHO calls MS to implement evidence-based elder abuse prevention and response programmes. In the same time, WHO and partners commit to collaborate on elder abuse prevention through initiatives that help to identify, quantify, and respond to the problem. The WHO secretariat decides to perform itself several actions focused on EA prevention. For example, the WHO will develop, for MS, technical guidance on EA prevention. The WHO also commits to provide a database[a] of available evidence on prevalence, risk factors, consequences and interventions in EA.[80] Finally, the WHO will disseminate information and support efforts to prevent elder abuse.[9]

Practically, at the moment of the redaction of this chapter (fall 2019), the WHO website[b] proposes (i) an information tool targeting the professionals as an info graphic entitled "Elder Abuse: The health sector role in prevention and response"[c] (technical support); (ii) a Fact Sheet[d] last-updated in June 2018 giving a summary of definition, general concepts and numbers (database summary); (iii) a link to the webpage "violence info"[e] of the WHO which includes a specific chapter on elder abuse describing 71 studies among which two are about prevention strategies for EA[81, 82](evidence-based data); and (iv) all WHO reports on EA in open access (information dissemination). The WHO fact sheet explains the impact of school-based intergeneration programmes to decrease negative societal attitudes and stereotypes towards older people as well as caregiver support to prevent elder abuse before it occurs [9].

In 2014, the WHO published "The Global status report on violence prevention 2014" which gives an assessment of Member States (MS) efforts to prevent global violence, providing a starting point for tracking future progress. Four types of preventive strategies are analysed in the report: (1) efforts to raise professional awareness and train practitioners; (2) effort to inform the public about how to identify the signs and symptoms of elder abuse and where help can be obtained, (3) effort to support caregivers in providing services to relieve the burden of caregiving and (4) effort to improve policies and practices in residential care facilities for elderly people. Since 2016, the WHO website offers practical support to EA prevention for MS (info graphic to print; numbers databases, evidence-based data).

5.1.2 The United Nation (UN)

Political declaration and Madrid international plan of action on ageing[75]

This political declaration and plan of action was adopted by the United Nations General Assembly in 2002. In the part on recommendations for actions, the plan develops several directions, which include several issues, which itself include several objectives. Elder abuse topic is addressed in the priority direction III about "ensuring and enabling a supportive environments [to older people]". Three issues are related to the prevention of EA: issue 2 about the care and support for caregivers, issue 3 about neglect, abuse and violence, and issue 4 about images of ageing. Within the third issue, sensitization of professionals and education of the general public are highlighted, in using media and other awareness means, and in adressing

a https://apps.who.int/violence-info/elder-abuse/

b https://www.who.int/health-topics/elder-abuse#tab=tab_1

c https://www.who.int/violence_injury_prevention/violence/elder_abuse/EA_infographic_EN_Jun_18_final.pdf?ua=1

d https://www.who.int/news-room/fact-sheets/detail/elder-abuse. Since June 2020, a new version of the fact sheet is available: https://www.who.int/news-room/fact-sheets/detail/elder-abuse

e http://apps.who.int/violence-info/studies?area=elder-abuse&aspect=prevention

the various characteristics and causes of EA. To enact legislation and strengthen legal efforts to eliminate elder abuse are also mentioned.

In this plan, research into the causes, nature, extent, seriousness and consequences of all forms of violence against older people is encouraged as is also the widely dissemination of the findings of research and studies.

Suggested actions in the plan concerning the image of ageing are: (i) to develop and widely promote policy in which there is an individual and collective responsibility to recognize the past and present contributions of older persons, seeking to counteract preconceived biases and myths and, consequently, to treat older persons with respect and gratitude, dignity and sensitivity; (ii) to encourage the mass media to promote images that highlight the wisdom, strengths, contributions, courage and resourcefulness of older women and men; (iii) to encourage professors to recognize and include in their courses the contribution made by persons of all ages, including older persons; (iv) to encourage the media to move beyond portrayal of stereotypes and to illuminate the full diversity of humankind; (v) to recognize that the media are harbingers of change and can be guiding factors in fostering the role of older persons in development strategies; (vi) to facilitate contributions by older people to the presentation by the media of their activities and concerns; (vii) to encourage the media and the private and public sectors to avoid ageism in the workplace and to present positive images of older persons; and (viii) to promote a positive image of older women's contributions to increase their self-esteem.[75]

International convention

The United Nations Convention for the rights of persons with disabilities (UNCRPD[83]) is the more recent international human rights treaty. Whereas the UNCRPD does not address the full range of challenges faced by older persons in need of care, and in particular those situations related to ageism and age discrimination, it still covers many important aspects of older persons' lives, including access to disability benefits, health services, support for independent living, fight against violence and abuse, accessibility and others[a].

Unlike other population groups such as women and children, no comprehensive international convention, at the UN level, exists specifically in relation to the rights of older persons[b]. The International Covenant on Economic, Social and Cultural Rights does not contain any explicit reference to the rights of older person. Nevertheless, in view of the fact that the Covenant's provisions apply fully to all members of society, it is clear that older persons are entitled to enjoy the full range of rights recognized in the Covenant. However, as stressed out by the U.N. Committee on Economic, Social and Cultural rights[c], the respect for the rights of older persons may requires special measures to be taken[d].

Still, since 2012, the General Assembly has established an open-ended working group on ageing by resolution 65/182 named "Towards a comprehensive and integral international legal instrument to promote and protect the rights and dignity of older persons. The working group has considered the existing international frameworks of the human rights of older persons and identified possible gaps and how best to address them[e]. In June 2019, the U.N. department of Economic and Social Affairs expressed

a http://publications.age-platform.eu/opcare-toolkit/chap1.php#chap01-01-03

b Such convention exist in other part of the World (Inter-American Convention on Protecting the Human Rights of Older Persons).

c The Committee on Economic, Social and Cultural Rights (CESCR) is the body of 18 independent experts that monitors implementation of the International Covenant on Economic, Social and Cultural Rights by its States parties.

d General comment n°6 (1995) The economic, social and cultural rights of older person. https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/TBSearch.aspx?Lang=en&TreatyID=9&DocTypeID=11.

e https://social.un.org/ageing-working-group/index.shtml

the opinion, based notably on data collected by the working group, that elders should be recognized a specific right to "freedom from all forms of violence, abuse and neglect". The scope of this right should include all types of abuse as well as intentional or unintentional neglect. The right should be upheld irrespective of where this happens and irrespective of the nature of the relationship and the type of perpetrator.[84]

The U.N. Department of Economic and Social Affairs stressed out several State's obligations to prevent elder abuses as the obligation to adopt legislative, administrative and other measures to prevent violence, abuse and neglect of older persons through all appropriate means.[84] The following examples are given:

- Raise **awareness** and sensitize society (public prevention campaigns) about the different forms of violence, abuse and neglect in older age and how to identify and prevent them
- Adopt **legislation and policies** that include the duty to prevent, identify, investigate and redress for acts of violence, abuse and neglect. Ensure these measures are compatible with the right to autonomy and independence. Allocate resources for implementation.
- Provide **training of professionals** like judiciary and law enforcement workers, care providers, and healthcare and social workers
- Develop effective independent **monitoring mechanisms** of situations of care and support provision
- Take measures to **protect people who report** abuse from any form of retaliation

World Elder Abuse Awareness Day

Since 2011, the United Nations General Assembly, in its resolution 66/127, designated June 15 as World Elder Abuse Awareness Day[a]. The purpose of this day is to raise awareness on this global social issue which affects the Health and Human Rights of millions of older persons around the world. It represents "the one day in the year when the whole world voices its opposition to the abuse and suffering inflicted to some of our older generations". The theme in 2018 was "Moving from Awareness to Action through a Human Rights based approach". The theme in 2019 is "Access to Justice: Legal, Social and Economic Services for Older Victims of Sexual, Physical and Financial Crimes"[b].

Sustainable development goals of the UN

EA issue can be approach by one of the sustainable development goals (SDG) set by the UN to achieve a better and more sustainable future for all in the world[c]. Indeed, the tenth goal of the UN aims to reduce inequalities, including those related to age: **"**By 2030, empower and promote the social, economic and political inclusion of all, irrespective of age, sex, disability, race, ethnicity, origin, religion or economic or other status (target 10.2)"

Although no specific covenant exists for older people, the United Nations Convention for the rights of persons with disabilities (UNCRPD) still covers many important aspects of older persons' lives, including access to disability benefits, health services, support for independent living and fight against violence and abuse. In 2019, the UN department of Economic and Social Affairs stressed out notably the States' obligation to adopt legislative, administrative and other measures to prevent violence, abuse and neglect of older persons through society awareness, right to autonomy and

a https://www.un.org/development/desa/ageing/world-elder-abuse-awareness-day.html

b https://www.un.org/development/desa/ageing/world-elder-abuse-awareness-day/2019-2.html

c https://www.un.org/sustainabledevelopment/sustainable-development-goals/

independence, professionals training, service monitoring, and protection of people who reports. UN also support EA prevention through the 'World Elder Abuse Awareness Day' and the sustainable development goal which expresses the empowerment and promotion of the social, economic and political inclusion of all, irrespective of age.

5.1.3 OECD

"A good life in old age" is a report published in 2013 by the OECD in collaboration with the European Commission. It focuses on the monitoring and on the improvement of the quality in long-term care (LTC) which is defined like following: "Good quality of LTC maintains or, when feasible, improves the functional and health outcomes of frail, chronically ill and physically disabled old people. Three aspects are generally accepted as critical to quality of care: effectiveness and safety; patient-centeredness and responsiveness; and care coordination." The policy brief looked at data and policies in the different countries to measure quality in long-term care and drive up standards of care.[85]

Few countries systematically measure whether LTC is safe, effective, and centred around the needs of care recipients but according to the report, indicators of health care quality should focus on quality outcomes and not on processes; be constructed from administrative data using standardised coding systems; and be built on a single item, not on a multi-item scale. Examples of indicators are: elderly falls and related fractures, bed-sores, medication use, weight loss, or depression.[85]

Standardised need-assessment tools should also be used by providers to monitor quality and/or to generate quality indicators. Responsiveness is also a mean to evaluate quality: user experience in LTC, waiting times for LTC services or avoidable hospital admissions for chronic conditions. As well as quality of life of resident: consumer choice, autonomy, dignity, comfort, security, relationships or social activity. Regulatory means (licensing, accreditation and minimum standards in nursing homes; staff qualification requirements) can also help but with certain limits: leniency about standard controls, high cost of monitoring, and focus on what is regulated, rather than on broader quality issues. Care coordination can be evaluate by (i) good case management or primary-care coordinators; (ii) interdisciplinary care; (iii) availability of integrated information system linking data through the continuum of care and portable across health and care settings; or (iv) multidisciplinary assessments teams, single entry points.[85]

All countries have legislation setting principles of adequate and safe care, or protecting against abuse such as mandatory reporting of neglect or improper care (e.g., in Israel; Ireland; Alberta, Ontario and Nova Scotia, Canada; Germany; Japan; Korea; Norway), or mandatory criminal reference checks for care workers as in Canadian provinces and the United States. National-level campaigns, including training for professionals and older people on responding to elder abuse have been broadly successful in Ireland, Canada, Israel, and the United States. Ombudsmen to act as advocates of old people exist in some provinces in Canada, Finland, and the United States, among others. Adult guardianship and trusteeship arrangements have been established in Australia, Canadian provinces, and the United States, for example. Multidisciplinary teams trained to prevent and intervene exist in Israel. Decentralised bodies are often responsible for quality control.[85]

They conclude that governments must prioritize the delivering of quality long-term care services for three reasons: "First, users of care services demand more voice and control over their lives. Second, as the cost of care services keeps on growing from 1.6% of GDP across the OECD to at least double this figure by 2050, LTC services are under pressure to improve their accountability. Third, governments have the responsibility to protect vulnerable older people from potential abuse." Three main approaches to drive LTC quality improvement are highlighted in the report: Regulatory standards, typically focused on setting minimum standards on inputs (labour, infrastructure) and enforcing compliance; Standards to normalise care practice in desirable ways, and to monitor that quality indicators match objectives; and Market incentives for providers and users, including financial incentives and the grading of providers' performance. To succeed, OECD suggests to use standardised assessment tools and to develop protocol of care. It asks to test the impact of public reporting, of quality grading systems,

of choice and direction set by the consumer, and of paying providers for high quality.[85]

The OECD published in 2013 a report entitled "A good life in old age" in collaboration with the European Commission, which focuses on the monitoring and on the improvement of the quality in long-term care (LTC), one of the preventive strategy highlighted by the WHO. According to the OECD report, indicators of health care quality should focus on quality outcomes, not processes; be constructed from administrative data using standardised coding systems; and be built on a single item, not on a multi-item scale. Regulation means can be licensing, accreditation and minimum standards in nursing homes; staff qualification requirements. The report concludes that governments must prioritize the delivering of quality long-term care services for three reasons: (i) users of care services demand more voice and control over their lives; (ii) as the cost of care services keeps on growing, LTC services are under pressure to improve their accountability; and (iii) governments have the responsibility to protect vulnerable older people from potential abuse.

5.1.4 *International Network for the Prevention of Elder Abuse (INPEA)*

The International Network for the Prevention of Elder Abuse[a] (INPEA) was established in 1997 at the 16th World Congress of the International Association of Gerontology (IAG) in Australia. INPEA aims to increase society's ability to recognize and respond to the mistreatment of older people in whatever setting it occurs. Their objectives are: to stimulate international collaborations, to increase public awareness and knowledge, to promote education and training of professionals in identification, treatment and prevention, to further advocacy on behalf of abused and neglected elders, and to stimulate research into the causes, consequences, prevalence, treatment and prevention of EA and neglect[b]. INPEA functions as a Non-Governmental Organization with Special Consultative Status with the United Nations (UN) and as an active member of the Stakeholder Group on Ageing, promoting older persons' in the Sustainable Development Agenda of the UN.

The International Network for the Prevention of Elder Abuse (INPEA) is a NGO with a consultative status with the UN which aims to increase society's ability to recognize and respond to the mistreatment of older people in whatever setting it occurs.

5.2 Elder abuse preventive strategies in Europe

5.2.1 *WHO Europe*

In 2011 was published 'The European report on preventing elder maltreatment'.[86] At that time, in the WHO European Region, at least 4 million older people experience EA in any one year. The ageing of the population increases the demands on family caregivers and the need for a trained health and social care workforce, particularly in supporting people with dementia and multiple problems. EA was thus considered as an important public health problem and preventing elder maltreatment, an issue of human rights and social solidarity. Indeed, the rights of older people may be eroded by ageism in the form of negative societal attitudes towards older people and stereotypes. To overcome this, the report suggest that social cohesion and solidarity across generations were strengthened and prevention programmes put in place on a public health approach informed by evidence.

Yet in 2011, numerous interventions have already been implemented across Europe to prevent and protect older people and to improve risk factors related to elder maltreatment, which indicate that governments and nongovernmental organizations were giving this health and social problem greater priority than before. But the lack of high-quality evaluation studies of

a http://www.inpea.net/

b http://www.inpea.net/filemanager/cms/img/user_files/source/INPEA_Membership_Brochure_May2016_draft1_3_.pdf

interventions specifically designed to reduce or prevent elder maltreatment substantially limits conclusions about which interventions may be most effective.[86]

However, some data highlight the potential efficacy of professionals' awareness and education courses; legal, psychological and educational support programmes; and restraint reduction programmes. Indeed, psychological programmes for authors have been associated with a reduction in self-reported abusive behaviour. But, additional high-quality evaluations of these programmes were needed to provide a better understanding of the effects. Promising evidence supports programmes aiming to change attitudes towards older people or to improve caregiver mental health, but their effects on reducing elder maltreatment as an outcome have not yet been measured. Further research is also needed on the costs related to implementing elder maltreatment interventions.[86]

Finally, the 2011 report gives a set of 9 actions for Member States, international agencies, nongovernmental organizations, researchers, practitioners and other stakeholders. There are: (i) to develop and implement national policies and plans for preventing elder maltreatment; (ii) to take action to improve data on and surveillance of elder maltreatment; (iii) to undertake evaluative research in priority; (iv) to strengthen responses for victims; (v) to build capacity and exchange good practices across the sectors; (vi) to address inequity in the maltreatment of older people; (vii) to raise awareness and target investment for preventing elder maltreatment; (viii) to set up a protective factors-based, life-course and intergenerational approach; and (ix) to develop ethics and quality culture in the community services and in institutions.[86]

In 2011, WHO-Europe published 'The European report on preventing elder maltreatment'. The report suggested that social cohesion and solidarity across generations were strengthened and that prevention programmes were put in place on a public health approach informed by evidence. However, the report highlights the lack of high-quality evaluation studies of interventions specifically designed to reduce or prevent elder maltreatment. Finally, the report gives a set of 9 actions for Member States which are: (i) to develop and implement national policies and plans for preventing elder maltreatment; (ii) to take action to improve data on and surveillance of elder maltreatment; (iii) to undertake evaluative research in priority; (iv) to strengthen responses for victims; (v) to build capacity and exchange good practices across the sectors; (vi) to address inequity in the maltreatment of older people; (vii) to raise awareness and target investment for preventing elder maltreatment; (viii) to set up a protective factors-based, life-course and intergenerational approach; and (ix) to develop ethics and quality culture in the community services and in institutions.

5.2.2 Council of Europe

The Council of Europe[a] aims to develop, throughout Europe, common and democratic principles based on the European Convention on Human Rights and other reference texts on the protection of individuals. **The European Convention on Human Rights**[87], applicable in Belgium, enshrines the most fundamental human rights such as the right to life (article 2), the prohibition of torture and inhuman or degrading treatment or punishment (article 3), the right to liberty and security (article 5), the right to the protection of private and family life (article 8), the freedom of expression (article 10), and the prohibition of discrimination (article 14). These international human rights standards apply to persons at all stages of life and the provision of this

a https://www.coe.int/en/web/sarajevo/objectives-mission

convention do not specifically refer to the situation of older persons. However, due to the particular vulnerability of older persons, effective protection of their rights may require additional measures.

The revised European Social Charter[88] enshrines the right of elderly persons to social protection in its article 23 which states that:

"With a view to ensuring the effective exercise of the right of elderly persons to social protection, the Parties undertake to adopt or encourage, either directly or in co-operation with public or private organisations, appropriate measures designed in particular:

- to enable elderly persons to remain full members of society for as long as possible, by means of:
  a. adequate resources enabling them to lead a decent life and play an active part in public, social and cultural life;
  b. provision of information about services and facilities available for elderly persons and their opportunities to make use of them;
- to enable elderly persons to choose their life-style freely and to lead independent lives in their familiar surroundings for as long as they wish and are able, by means of:
  c. provision of housing suited to their needs and their state of health or of adequate support for adapting their housing;
  d. the health care and the services necessitated by their state;
- to guarantee elderly persons living in institutions appropriate support, while respecting their privacy, and participation in decisions concerning living conditions in the institution."

However, Belgium does not consider itself bound by this article[a]. Indeed, the Belgian government signs all other articles of the revised social Charter except the one concerning older persons.
In various cases, the European Court of Human rights condemned Member States for having failed to take the elder's particular vulnerability into account in the protection of the human rights enshrined by the European Convention on Human Rights. Examples of cases are available in Appendix 1. The common idea in all cases is that States are obliged to make additional efforts in order to guarantee the effectivity of elder's right (and other vulnerable persons).

In 2014, the Committee of Ministers of the Council of Europe issued a specific recommendation on the promotion of human rights of older persons[b]. The Committee listed various recommendations and highlighted good practices with regard to effective protection of the human rights of elder persons.

"IV. Protection from violence and abuse

16. Member States should protect older persons from violence, abuse and intentional or unintentional neglect. Such protection should be granted irrespective of whether this occurs at home, within an institution or elsewhere.

a https://www.coe.int/en/web/conventions/full-list/-/conventions/treaty/163/declarations?p_auth=J0ZDQ2GW&_coeconventions_WAR_coeconventionsportlet_enVigueur=false&_coeconventions_WAR_coeconventionsportlet_searchBy=state&_coeconventions_WAR_coeconventionsportlet_codePays=BEL&_coeconventions_WAR_coeconventionsportlet_codeNature=10.

b Recommendation CM/Rec(2014)2 of the Committee of Ministers to member States on the promotion of human rights of older persons - 19 February 2014. https://search.coe.int/cm/Pages/result_details.aspx?ObjectID=09000016805c649f.

17. Member States should provide for appropriate awareness-raising and other measures to protect older persons from financial abuse, including deception or fraud.

18. Member States should implement sufficient measures aimed at raising awareness among medical staff, care workers, informal carers or other persons who provide services to older persons to detect violence or abuse in all settings, to advise them on which measures to take if they suspect that abuse has taken place and in particular to encourage them to report abuses to competent authorities. Member States should take measures to protect persons reporting abuses from any form of retaliation.

19. Member States shall carry out an effective investigation into credible claims that violence or abuse against an older person has occurred, or when the authorities have reasonable grounds to suspect that such ill-treatment has occurred.

20. Older persons who have suffered from abuse should receive appropriate help and support. Should member States fail to meet their positive obligation to protect them, older persons are entitled to an effective remedy before a national authority and, where appropriate, to receive adequate redress for the harm suffered in reasonable time."

Several European institutions work on the protection of the rights of older people which is a way to prevent EA. The Council of Europe checks that the Member States comply with the European Convention on Human Rights. The European Court of Human rights can condemn Member States for having failed to take the elder's particular vulnerability into account in the protection of the human rights. And the Committee of Ministers of the Council of Europe gives recommendations and highlights good practices to effectively protect the human rights of elder persons. Belgium does not consider itself bound by the article 23 of the revised European Social Charter that enshrines the right of elderly persons to fundamental and social protection.

5.2.3 European Union

An extract from the 'European charter on the right and responsibilities of older people in need of long term care and assistance' published in 2010 highlights the global orientation of the EU position on EA: "EU health care and long-term care services should be based on solidarity between generations as reflect in the Lisbon Treaty which state that the EU shall combat social exclusion and discrimination, and shall promote social justice and protection, equality between women and men, solidarity between generations and protection of the rights of the child".[2]

European Parliament

In 2010, the European parliament adopts a text on long term care for older people[a]. Among the 26 resolutions, here under are the most related to the prevention of elder abuse, the others being more general about long term care for older people.

The European Parliament:

- Recognises the importance of both the quality and continuity of care, calls on Member States to improve, facilitate, and encourage specialist training, education and reinsertion measures for all those people, including informal carers and those requiring professional qualifications, with long-term care responsibilities for older people; such training may also help improve the status of this important work. Urges Member States to tackle the issues of poor payment of care work, shortage of personnel, lack of training or inadequate training, which all put a strain on care provision. […] (resolution 3);

[a] https://www.europarl.europa.eu/sides/getDoc.do?pubRef=-//EP//TEXT+TA+P7-TA-2010-0313+0+DOC+XML+V0//EN&language=EN

- Calls on the Commission and Member States to take into account the needs of informal carers, who provide a significant proportion of care for older people, and to take concrete measures to support and safeguard this resource via training, respite and measures to reconcile work and family life (resolution 5);
- Maintains that guarantees should be in place in all Member States to protect the fundamental rights of persons receiving long-term care and to that end calls on the Member States to bring greater attention than hitherto to bear on the enforcement of, and compliance with, quality criteria for service provision (resolution 6)
- Notes that the EU policy on older people is based on the principle of 'society for all', requiring Member States to guarantee that people of different ages have a full opportunity to participate actively in community life, irrespective of their age (resolution 15);
- Calls for a Green Paper to be produced by the Commission on elder abuse and safeguarding older people in the community and in all care settings, […](resolution 17)
- Calls, through the Open Method of Coordination, for an exchange of information, policy ideas and best practice between Member States on the provision of long-term care for older people and, in particular, measures and minimum professional standards in order to (resolution 19):
  a. reduce health inequalities and safeguard older people in the community and in care settings,
  b. tackle elder abuse,
  c. adopt human resource strategies to fight against staff shortages;
  d. help disseminate information and communications technologies to promote the (care within families and) independence of older people;
- Calls for the exchange of best practices in finding the most effective ways of developing intergenerational relations, so as to increase the involvement of family members in long-term care arrangements, resulting in a number of benefits and making it possible to meet more successfully the individual needs of care recipients (resolution 22);
- Calls on the Member States to reduce the burden on those who care for older people or people with disabilities and – to enable carers to take up employment – set up integrated care systems (resolution 26).

The resolutions of the European parliament in 2010 about long term care for older people are in close relation with EA prevention strategies like professionals' training, informal and formal caregivers support, protection of fundamental rights and new policies specifically on elder abuse.

European Commission

Despite the fact that the European Union has no direct competence to take action to prevent and combat elder abuse, there is an increasing concern around how to ensure the sustainability of health and social protection systems[a]. The European Commission financed several projects and structures to tackle and prevent elder abuse and to reconnect health and social systems with the dignity of older people in need of care, ensuring an access to quality care to all and supporting informal carers

[a] http://www.age-platform.eu/policy-work/quality-long-term-care-fight-against-elder-abuse

Age Platform Europe (AGE)[a]

This organisation is the voice of older persons at EU level. It was created in 2001 and is located in Brussels. The members of Age Platform are organisations of older people or non-profit organisations providing services to older people or active in the ageing field. Those members comes from Europe. Age Platform is financed by EU-DG Justice for 80%. One of their executive collaborator is specifically in charge of elder abuse and long-term care.

The main task of the Age Platform staff is to defend older people's rights at the European Commission while AGE members are important in lobbying to the representatives at the European parliament and European Council from their own country. Since 2014, AGE has built its action around the 9 main WHO-Europe actions. One of it is about quality of long-term care and fight against elder abuse[b].

Since its creation, AGE has led several initiatives for the development of quality long-term care and the prevention of elder abuse. These include most notably:

- The coordination of the development and the diffusion of the European Charter of the rights and responsibilities of older people in need of long-term care and assistance[2] and its accompanying guide[89]. Those tools are the main outcomes of the EUSTaCEA project (2008-2010)
- The European Quality framework for long-term care services, delivered by WeDO (2010-2012)[90], a European Partnership for the Wellbeing and Dignity of Older people made of national coalitions of a wide range of stakeholders and a European Coalition[c].
- The co-organisation with the European Commission of several conferences on the topic of fighting against elder abuse to mark the World Elder Abuse Awareness Day (2009, 2011, 2013, 2014, 2015, 2016).
- A task force on Dignified Ageing and on quality long-term care and elder abuse.
- An involvement in several European research project always financed by the EC.
- A website highlighting a selection of examples of good practice in diverse areas of interest around older people within the European Union.
- A comprehensive tool box to the attention of decision-makers and stakeholders.

AGE platform Europe is the voice of older persons at EU level since 2001. It groups a large numbers of organisations involved in ageing and care to seniors. One of their executive collaborator is specifically in charge of elder abuse and long-term care and their website offer a comprehensive access to documents and tools around elder abuse. AGE participated to European projects about elder abuse (EUSTaCEA); wellbeing and dignity (We DO); and violence against older women (Break the Taboo).

a www.age-platform.eu

b http://www.age-platform.eu/policy-work/quality-long-term-care-fight-against-elder-abuse

c https://www.age-platform.eu/project/wedo-wellbeing-and-dignity-older-people

EUSTaCEA project

This project was a European Strategy to Combat Elder Abuse[a] which took place between 2007 and 2010 in Belgium. The project aimed to develop recommendations for policymakers and specifically to create a "*European Charter of the rights and responsibilities of older people in need of long-term care and assistance*".[2] The Charter was published in 2010 and translated in 13 languages. A practical guide was also developed (toolkit).[89]The accompanying guide of the Charter explains how the rights of the Charter can be implemented, providing recommendations and examples of good practices. In proposing a European Charter "of the rights and responsibilities of the older people requiring assistance and long-term care", the EUSTACEA partners want to launch a discussion within the EU Member States on how best to recognise and affirm the rights of the most vulnerable older people. Their objective is to give a voice to older people and ensure that they are heard by the whole society.

The EU charter is a reference document setting out the fundamental principles and rights that are needed for the wellbeing of all those who are dependent on others for support and care due to age, illness or disability. So this is a clear tool of prevention of elder abuse.[2] The charter begins with the following words: "*Human dignity is inviolable. Age and dependency cannot be the grounds for restrictions on any inalienable human right and civil liberty acknowledged by international standards and embedded in democratic constitutions. Everybody, regardless of gender, age or dependency is entitled to enjoy these rights and freedoms and everybody is entitled to defend their human and civil rights*." The Charter recognises that the vast majority of frail and vulnerable older people are women and more than a third of them suffer from Alzheimer's disease or dementia. The Charter aims to enable everyone to facilitate older people's access to their fundamental rights, to raise awareness among a wider public, to stress the rights of the increasing number of people receiving long-term care, and to foster best practices in Member States and beyond. The articles and recommendations stipulated in the Charter as well as related quotes and examples of good practices are given in Table 59 in the Appendix 12.

The European Charter of older persons' rights and responsibilities[2] stressed a preventive measure targeting important risk factors of EA: the support to formal and informal carers. It says about that: "*Although there are huge discrepancies in eldercare among European Union countries, (…) the majority of older dependent people are still cared for by informal carers (i.e. relatives, friends, neighbours). Informal carers often face a high risk of burn-out and social exclusion due to the physical and psychological demands put on them. Professional carers are also often put under huge pressure and are not always offered the training and support they need to perform their work under good conditions. Actions to tackle elder abuse must therefore take on board carers' needs and the difficult challenges faced by all those – formal and informal carers - who devote significant parts of their lives to care for dependent elders, as their needs and the challenges they face constitute important risk factors. It is the duty of public authorities - together with the care providers - to protect all those who become dependent on others for their daily needs and to enable them to live a dignified life until the very end of their lives. Such measures must go hand in hand with measures to protect and support both formal and informal carers by offering them decent working and living conditions and acknowledging and valuing the huge contribution they make to the community*".[2]

The EUSTaCEA project members have elaborated the "European *Charter of the rights and responsibilities of older people in need of long-term care and assistance*". An accompanying guide explains how the 9 rights of the Charter can be implemented, providing recommendations and examples of good practices. The objective was to give a voice to older people and ensure that they are heard by the whole society. As the EU charter set out the fundamental principles and rights that are needed for the wellbeing of all those

[a] https://www.age-platform.eu/project/daphne-eustacea-european-strategy-combat-elder-abuse

who are dependent on others, this is a clear tool of prevention of elder abuse. It also highlights preventive strategy about the support to formal and informal carers.

WeDO projects

The project WeDO[a] "Wellbeing and Dignity for Older people" was the continuity of the EUSTaCEA project. It was financed by the EC and coordinated by AGE Platform Europe, gathered 18 partners coming from 12 different member states and occurred from 2010 to 2012. The project's objective was to develop a persistent European partnership of organisations committed to work together. They follow the aim to promote the wellbeing and dignity of vulnerable and disabled older people and prevent elder abuse through the promotion of quality long-term care. This project enables all interested stakeholders to discuss, exchange experiences and good practice both at national and EU level, and to develop together an approach to elder care based on commonly agreed fundamental principles. It led to the redaction of a *European Quality Framework for Long-Term Care services*[90] (LTC) adapted for institutional, community and home care settings. This tool for professionals offers principles and guidelines for the wellbeing and dignity of older people in need of care and assistance. It is available in 10 different languages including French, German and Dutch. It is aimed at any stakeholder who would like to improve the quality of life of older people in need of care and assistance and contribute to a more efficient long-term care system. The framework lists the principles necessary to deliver a good quality service. So long term care to older people services should be respectful of human rights and dignity; person-centred; preventive and rehabilitative; available; accessible; affordable; comprehensive; continuous; outcome-oriented and evidence-based; transparent; and gender and culture sensitive. It also lists the actions to perform in the aim to reach a high quality level: preventing and fighting elder abuse and neglect; empowering older people in need of care and creating opportunities for participation; ensuring good working conditions and working environment and investing in human capital; developing adequate physical infrastructure; developing a partnership approach; developing a system of good governance; and developing adequate communication and awareness-raising.[90]

In 2013, the next step, named the WeDO2 partnership and funded by the Grundtvig programme, included 8 organisations from 7 different countries (Austria, Belgium, Germany, Greece, Poland, Netherlands and UK), and one European organisation (Age Platform Europe)[b]. Each partner engaged to strengthen stakeholder's (e.g. older people, formal and informal care providers, volunteers and professionals) ability to participate in the process of long term-care and consequently in combating elder abuse. The WeDO2 partnership developed and tested an innovative train the trainer toolkit about quality care[c]. This training is flexible and can be adapted and used for various groups (older people, formal and informal caregivers, policymakers and practitioners).

The We DO project's objective was to develop a persistent European partnership of organisations committed to work together to promote the wellbeing and dignity of vulnerable and disabled older people and prevent elder abuse through the promotion of quality long-term care. Further, the WeDO2 partnership developed and tested an innovative train the trainer toolkit about quality care.

a https://www.age-platform.eu/project/wedo-wellbeing-and-dignity-older-people

b http://www.belgianageingstudies.be/index.php?p=8

c http://publications.age-platform.eu/opcare-toolkit/

DAPHNE II and III projects: breaking the taboo 1 and 2

Violence against older women in the family is a taboo and is less visible in society than violence against younger women. Professionals who work in community health and social services are often the only persons who have access to this target group. It is thus very important that these professionals have the sensitivity and skills to detect and assess problematic situations and the knowledge and competence to act accordingly[a]. The projects Breaking the Taboo I and II (see Appendix 1 for more details) was financed by the EU-DG Justice between 2004 and 2013 and resulted in the development of several tools for professionals:

- A brochure of 17 pages for health care professionals available in Dutch, German or French,
- A training handbook which can be ordered in English on the website[b]. The handbook provides a two-day training course for health and social service staff members who work in older people's own homes, and is designed to help them to recognize violence against older women within families and to take action.
- A recommendations' book in German, Dutch and French[c] which provides an overview on strategies at organisational as well as policy level in order to combat violence against older women within the family.(more details up there)
- Reports about awareness[d]: a European one which summarises the most important results of the national reports and points out the differences and similarities between European countries and individualised report for Belgium, Austria, Finland, France, Italy, Poland and Portugal.
- Reports about training whose the Belgian one overviews existing train-the-trainer-courses dealing with violence and abuse against older women in the field of community-based health and social services in Flanders.[91]

"Breaking the Taboo 1" is a European project aiming to empower health and social service professionals to combat violence against older women within families. The final report concludes that many health and social service providers do not have clear organisational procedures dealing with abuse against older women. Hence, organisations working with older people need to develop standards and procedures, and to train staff members as peer advisors. The report also recommended to strengthen cooperation and networks between victim protection organisations and community health and care organisations. Further, five tools for raising awareness were developed by the "Breaking taboo II" project.

EuROPEAN project:

Starting in 2010, the European Reference framework Online for the Prevention of Elderly Abuse and Neglect[1] (EuROPEAN) project compiles good practices across Europe to develop a reference framework to prevent elder abuse. This project was funded by the European Commission. The project partners consist of voluntary/community organisations across nine European countries but not Belgium. The EuROPEAN project aimed to spread information and to link relevant stakeholders and experts (researchers, policy makers, NGO's, advocacy and interest groups) in an interactive way. The project was designed to allow any European experts and stakeholders (and not only partners in the project consortium) to contribute actively in the development of the reference framework through the use of the "preventelderabuse.eu" website but it is not working anymore. However, a Background and Position Paper summarizes information collected by questionnaire.[1]

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a http://www.btt-project.eu/

b http://www.btt-project.eu/index.php?id=29

c http://www.btt-project.eu/index190a.html?id=17

d http://www.btt-project.eu/indexa9bc.html?id=19

In all participating countries, elder abuse is not receiving enough attention, causing problems for the recognition and prevention. This problem can be related with the general image of ageing in a culture or country. A negative image of old age might trigger (or allow) forms of abuse and discrimination and prevents elder abuse of being recognized as a serious problem. So, more awareness needs to be raised to address elder abuse efficiently. The questionnaire analysis highlights that research, awareness raising campaigns as well as legislation and policy measures are important to improve recognition of and sensitivity to elder abuse. In participating countries (NL, AU, CZ, EL, IR, IT, PL, SK, SL), there is no specific legislation on elder abuse, although the respondents think legislation could be important in preventing elder abuse from happening. In all participating countries, there have been awareness campaigns about elder abuse. And in many countries, NGO's and social services provide information and support. Finally, in all countries there are professional workers to help victims. It was concluded that more attention should be given to elder abuse by a broader range of actors.[1]

The European Reference framework Online for the Prevention of Elderly Abuse and Neglect (EuROPEAN) project compiles good practices across Europe based on a webquestionnaire in the aim to develop a reference framework to prevent elder abuse through the use of the "preventelderabuse.eu" website. But the website is not working at the moment of this report redaction. Respondents to the questionnaire consider research, awareness raising campaigns as well as legislation and policy measures important to improve recognition of and sensitivity to elder abuse.

MILCEA project

Occurring from 2009 to 2012, the 'Monitoring Elder Abuse in Long-term Care' (MILCEA) project aimed to contribute to the prevention of elder abuse. It has developed a monitoring system that allows the assessment of elder abuse in long term care as a precondition for prevention.[92] MILCEA was funded by the European Commission and was coordinated by the German Medical Advisory Service of Health Insurance (MDS) and subsidised by funds from the EC-DG Employment, Social Affairs and Equal Opportunities. The project partners were the Austria, the Netherlands, Luxembourg and Spain. The Phase 3 of the MILCEA project aimed to develop a framework usable by all EU Members 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 long-term care structures. This framework described the prerequisites for each of the four elements of the monitoring system: awareness, identification, action and evaluation.[92]

As this chapter focuses on primary prevention, only the part about awareness is developed. The general conclusion of the MILCEA project about awareness is: "*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."* The prerequisites are: (i) EA topic must be included as part of the training of all healthcare professionals and social workers; (ii) continuous training for formal and informal caregivers (and even older people), including ageing, older people's rights and stereotypes must be implemented (financial and logistic support); (iii) law protecting older people against elder abuse and enforcing quality of life as an explicit goal of LTC; and (iv) nationwide public awareness campaigns must be launched in mass media, including topic as empowerment of older people, information on older people's rights and on whom to turn to in case of elder abuse.[92]

The Monitoring Elder Abuse in Long-term Care (MILCEA) project contributed to the prevention of elder abuse by developing a monitoring system that allows the assessment of elder abuse in long term care as a precondition for prevention. The Phase 3 of the MILCEA project aimed to develop a framework usable by all EU Members States to put a monitoring system in place. Again, awareness campaigns, professionals' training, legislation enforcing the quality of life are highlighted.

IPVoW and Mind the Gap projects

Initiated by the police sector, the intimate partner violence against older women (IPVoW) research project[a] ran from 2009 to 2010 and was followed by a second part between 2011 and 2013, the 'Mind the Gap' project[b] which developed material for practitioners and led to recommendations[c] to help the implementation of the IPVoW conclusions[d]. This research was led by stakeholders from the police sector and summarizes a law enforcement file analysis from Austria, Germany, Hungary, Poland, Portugal and the UK.[93] The available materials is appropriate to use in this sector as the instrument for data collection of police/public prosecutor/court files[e], campaign materials (poster, business card, postcard); brochure targeted older women victims of intimate partner violence; and manuals and guidance for social support services and/or law enforcement agencies.

The police sector also led a project on intimate partner violence against older women and developed material to practitioners and help to implementation.

5.3 Summary of the international data about the preventive strategies

For recall, six categories of preventive strategies of elder abuse has been identified at the beginning of the research. There are: (1) existence of international, national or subnational policies and/or action plans and/or laws on EA matters; (2) improvement of policies and practices in residential care facilities; (3) professionals' awareness and training; (4) support to caregivers to avoid burden; (5) awareness campaigns for the public; and (6) programmes to decrease societal attitudes and stereotypes towards older people, including empowerment of older people. For each above analysed organisation or project, described strategies or recommendations could most of the time be related to one of those categories. However, some described actions can be more related to the management of elder abuse or to registration or evidence collection. The following summary lists the strategies or recommendations in line with the categories (between brackets, the number related to a preventive strategy category or the not related cases).

5.3.1 International general plans

1. European parliament took resolutions (2010) about long term care for older people close to EA prevention strategies:
   a. professionals' training, (4)
   b. informal and formal caregivers support, (2 and 3)
   c. protection of fundamental rights (6) and
   d. new policies specifically on elder abuse(1)

a http://www.ipvow.org/en/

b http://www.ipvow.org/en/description-of-projects/mind-the-gap

c http://www.ipvow.org/images/ipvow/reports/recommendations/Shared_Recommendations.pdf

d http://www.ipvow.org/en/research-reports/ipvow

e http://www.ipvow.org/images/ipvow/reports/MTG_instrument_for_case_file_analysis.pdf

2. EU specifically focuses on EA prevention (2011) and reports that
   a. social cohesion and solidarity across generations should be strengthened (6)
   b. prevention programmes should be put in place on a public health approach informed by evidence (evidence /register)
   c. but high-quality evaluation studies are lacking (evidence /register)
3. EU report (2011) suggests 9 “preventive” actions to MS:
   a. (i) to develop and implement national policies and plans for preventing elder maltreatment; (1)
   b. (ii) to take action to improve data on and surveillance of elder maltreatment; (evidence/register)
   c. (iii) to undertake evaluative research in priority; (evidence/register)
   d. (iv) to strengthen responses for victims; (management)
   e. (v) to build capacity and exchange good practices across the sectors; (4)
   f. (vi) to address inequity in the maltreatment of older people; (management)
   g. (vii) to raise awareness and target investment for preventing elder maltreatment; (4)
   h. (viii) to set up care approaches based on a protective factors, a life-course model and an intergenerational point of view; (2) and
   i. (ix) to develop ethics and quality culture in the community services and in institutions (2)
4. OECD focuses on the monitoring and on the improvement of the quality in long-term care (2013). The report concludes that governments must prioritize the delivering of quality long-term care services for three reasons:
   a. users of care services demand more voice and control over their lives;(6)
   b. as the cost of care services keeps on growing, LTC services are under pressure to improve their accountability (2); and
   c. governments have the responsibility to protect vulnerable older people from potential abuse (1).
5. The WHO has a specific focus on violence prevention including EA: global status report (2014) with comparative table by MS and a website with practical tools (2016) (1)
6. The WHO suggests 4 types of prevention action field for EA:
   a. efforts to raise professional awareness and train *practitioners*; (4)
   b. effort to inform the *public* about how to identify the signs and symptoms of elder abuse and where help can be obtained; (5)
   c. effort to support *caregivers* in providing services to relieve the burden of caregiving (3)
   d. effort to improve policies and practices in *residential care facilities* for elderly people(2)
7. UNCRPD covers many important aspects of older persons’ lives(1)
8. UN department of Economic and Social Affairs stressed out the States’ obligation to adopt legislative, administrative and other measures to prevent violence, abuse and neglect of older persons (Key elements in the fight against EA-2019):
   a. society awareness, (5)
   b. right to autonomy and independence, (6)
   c. professionals’ training, (4)
   d. service monitoring, (2)
   e. protection of people who reports(1)
   f. ‘World Elder Abuse Awareness Day’(5)

g. sustainable development goal(1)

5.3.2 Specific international institutions and projects

1. Several European institutions works to the protection of the rights of older people (Council of Europe and European Court of Human Rights)
2. AGE platform Europe is the voice of older persons at EU level since 2001. AGE participated to/coordinated European projects about elder abuse (EUSTaCEA); wellbeing and dignity (We DO); and violence against older women (Break the Taboo).
3. The EUSTaCEA project led to the elaboration of the"*European Charter of the rights and responsibilities of older people in need of long-term care and assistance*". The EU charter:
   a. set out the fundamental principles and rights that are needed for the wellbeing of all those who are dependent on others(6) and
   b. highlights preventive strategy about the support to formal and informal carers (2 and 3).
4. The We DO 1 and 2 projects have
   a. developed a European partnership of organisations committed to promote the wellbeing and dignity of vulnerable and disabled older people (6) and prevent elder abuse through the promotion of quality long-term care (2); and
   b. developed and tested an innovative train the trainer toolkit about quality care(4).
5. "Breaking the Taboo" projects aimed to empower health and social service professionals to combat violence against older women within families. They conclude to the need of:
   a. standards and procedures (2)
   b. training staff members as peer advisors (4)
   c. strengthening cooperation and networks between victim protection organisations and community health and care organisations (management)
6. The EuROPEAN project compiles good practices across Europe based on a web questionnaire. Respondents to the questionnaire consider research (evidence/register), awareness raising campaigns (5) as well as legislation and policy measures (1) important to improve recognition of and sensitivity to elder abuse.
7. The MILCEA project contributed to the prevention of elder abuse by developing a monitoring system that allows the assessment of elder abuse in long term care as a precondition for prevention. Awareness campaigns (5), professionals' training (4), legislation enforcing the quality of life (1 and 2) are highlighted.
8. The IPVOW and Mind the gap projects done by the police sectors, giving practical tools to manage abuse against older women. (management)

6 OVERVIEW OF PREVENTIVE ACTIONS IN 3 DIFFERENT COUNTRIES

6.1 The Netherlands

In the Netherlands, it is estimated that 200,000 older people over the age of 65 are mistreated every year, including all types of EA (physical and psychological abuse, sexual abuse, neglect and financial exploitation)[a].

6.1.1 Defining national or subnational policies and/or action plans and/or laws

In the Netherlands, domestic violence is high on the political agenda of the Dutch national government since 2002 after the publication of the report 'Privé geweld, publieke zaak'[b]. In 2007, a law [c]resulted in the creation of the 'steunpunten huiselijk geweld' (center against domestic violence). In 2009, the law about a temporary ban[d] of access to the domicile was implemented. This law makes possible to prohibit access to the domicile for 10 to 28 days to (potential) authors of violence. During this period, measures should be sought to ensure safety for the victims and to prevent recidivism.

In 2013, the law 'verplichte meldcode huiselijk geweld en kindermishandeling" was published. According to this legislation, organisations in the sectors of health care; education; early childhood; social support; youth care; and justice are obliged to have a Meldcode.

The prevention and management of elder abuse was particularly focussed on in the national action plan (NAP) entitled 'Ouderen in veilige handen'[94] (Elderly in safe hands). This NAP started in March 2011 and stopped at the 1st of July 2018. It included 10 action points among which six were related to prevention. One action of the NAP specifically targeted the duty to report abuse committed by professionals and a mandatory reporting protocol for domestic abuse. Other actions concerned the steps of detection, interventions and epidemiological registration.

From July 2018, the topic 'elder abuse' was included in the overall domestic violence action programme 'Geweld hoort nergens thuis'[95] (Violence doesn't belong anywhere) (2018-2021). This programme provides few preventive actions.[95]

In 2015, the municipalities became responsible for the prevention and management of domestic violence by all actors in the chain (police, health care providers, care institutions…). Since then, every four years, municipalities of each region in the Netherlands are held to draft a strategic plan on prevention and management of elder abuse for their region.[94]

Two more general laws on elder care and help exist in the Netherlands. First, the Social Support Act (Wmo) aims to help citizens as they can continue to live independently at home and participate in society for as long as possible; municipalities are responsible for implementing the Wmo. Second, the law about the quality, complaints and disputes in the frame of care (Wkkgz Act) stipulates that incidents must be reported (see next section).

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a https://www.aanpak-ouderenmishandeling.nl/

b https://www.canonsociaalwerk.eu/2002_privegeweld/BELEID_prive_geweld_publiek_zaak.pdf

c https://wetten.overheid.nl/BWBR0017020/2007-12-23

d https://www.huiselijkgeweld.nl/dossiers/huisverbod/publicaties/publicaties/2008/11/04/staatsblad-2008-421-wet-tijdelijk-huisverbod

6.1.2 Improving policies and practices in residential care facilities

On the official Dutch website on elder abuse[a], it is explained that overburdening and team culture can play an important role in the emergence of elder abuse in care institutions. The Dutch law Wkkgz Act support the report of active and passive abuse to the management or to the Health Care Inspectorate."

According to the NAP 'Ouderen in veilige handen'[94], a compulsory Certificate of Good Behaviour (Verklaring Omtrent Gedrag, VOG) for professionals in long-term care services and a manual for screening new staff members should be implemented. Within the same NAP, several elements were elaborated e.g. the "safe care relationship guide" (Leidraad Veilige Zorgrelatie[b]) designed for the directors of care organisations. This document includes guidelines helping directors of care organisations (hospitals, home care organisations, rest homes, care for disabled persons…) to elaborate and implement a policy/step plan on sensitization, prevention and intervention in case of elder abuse in their organisation. This guide primarily focuses on elder abuse in a professional relationship. This tool was evaluated in 2015 by 9 long-term care organisations. The overall conclusion was that it is a useful tool to sensitise a care organisation and to prevent elder abuse. Yet, continuous effort is needed to keep the prevention of elder abuse "alive" in a care organisation as there is not always enough time or staff to give work out a good care approach. It was also mentioned that directors rather tend to react when an incident took place than acting preventively.

6.1.3 Professional awareness and training

Within the national action plan (NAP) 'Ouderen in veilige handen'[94], several products were developed to raise awareness (campaigns and information) and knowledge (training) of volunteers and professionals. First, the plan suggests an e-training module for professionals called 'ouderen in veilige handen' which is available since December 2014. This training targets 3 different groups of care professionals and students: physicians, nurses and auxiliary nurses. The module includes a session on how to recognise signals for elder abuse and gives instructions on what care professionals need to do according to the Meldcode (see Chapter 4). The module costs 35 euro[c]. Second, Movisie offers the training 'Signaleren en bespreekbaar maken van ouderenmishandeling en ontspoorde mantelzorg bij ouderen' (Identifying and discussing elder abuse and derailed informal care for the elderly). This training teaches professionals and volunteers how to communicate on difficult situations of possible elder abuse and how to get it out of the taboo sphere. Third, the product called 'Handreiking vrijwilligers tegen ouderenmishandeling'[d] (helping volunteers against elder abuse) (2012, Updated 2015), targets volunteers. This last product contains 3 packages:

1. Practical guidelines for *volunteers* including information on how to detect and handle elder abuse and tips and tricks on how to communicate with the victim;
2. Guidelines for *local coordinators of volunteers* including facts and figures, the signal of elder abuse, background info on risk factors, links to movies, theatre and other audio-visual material, a template code of conduct, a model for the organisation of a workshop, 2 type cases and tips on how to communicate with the victim; and
3. Relevant background information

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a https://www.aanpak-ouderenmishandeling.nl/geweld-in-zorginstellingen

b http://www.veiligezorgrelatie.nl/downloads/Leidraad%20Veilige%20zorgrelatie,%20overzicht%20wijzigingen%20door%20actualisatie%20april%202016.pdf

c https://www.noordhoff-health.nl/nl/webshop/ouderen-in-veilige-handen

d https://www.verwey-jonker.nl/publicaties/2015/vrijwilligers-tegen-ouderenmishandeling-2015

According to the NAP 'Ouderen in veilige handen'[94], a guide on preventing EA for municipalities was developed to guide municipality's officers in the development of preventive policies on elder abuse. It is available since 2016.[96]

For bank employees, an e-learning tool was developped on how to recognise signals for financial abuse.

6.1.4 Support to informal caregivers to avoid burden

Official Dutch State website[a] explains that "'off the rails' (derailed) informal care for the elderly is sometimes - wrongly - seen as elder abuse, because it can lead to psychological or physical abuse, or neglect. But derailed informal care is not a question of bad will but the result of overburdening, powerlessness, incompetence or ignorance. Only when this is done intentionally do we speak of elder abuse. Combating derailed informal care starts by talking about it openly. Discuss the situation with each other. Make sure it is not taboo."

A step plan for situations with a risk for or where elder abuse takes place because of an overburdened caregiver is proposed on the web site "aanpak-ouderenmishandeling". This web site includes the steps to be taken, references to relevant instances and tools.[97]

Some tools that help informal caregivers to detect derailed care or to come back to balanced care are particularly interesting to mention. The 'mantelscan'[b] is a tool aiming to map the caregiver and professional network surrounding a person and to identify possible gaps and/or risks of overburden. It also includes a set of questions for the caregiver to assess the burden of care.

The organisation Markant, in Amsterdam, has several tools related to situations with a risk for elder abuse because of caregiver exhaustion. The self-assessment folder "3 minute check for caregivers"[c] tries to analyse the burden and the care situation for caregivers in 10 questions with a final score. Tips and contact data of helping instances are referred to. Another tool is entitled "Informal care to the elderly: attention for a good balance". This guide aims to support professionals in and provide insight into the prevention, detection and action of overburdened and derailed informal care of the elderly.[98]

The project 'Met mentorschap in veilige handen' promote the elaboration and implementation of a possible role for mentor in the detection and further approach of elder abuse. Mentors are persons that can legally represent elderly if the latter are mentally incapable. Mentors in the broad sense are confidents.[99]

6.1.5 Awareness campaigns for the public

The Hotline and public campaign "Een veilige thuis, daar maak je je toch sterk voor" (A safe home, that's what you're fighting for) is composed of radio and television commercials and was first launched in 2012. The aim of the commercials was to raise the public awareness and contained the following message: "Elder abuse is not always clear. A presumption is enough to share your concern. Want to know how? Go to deeljouwzorgen.nl or call 0800 2000". This is a central contact telephone number, free of charge and accessible 24/7.

A DVD 'Je ziet het pas als je het gelooft' with 5 type cases of elder abuse[d] (2013) is available for 10 euros and can be used for awareness raising and training. It shows type cases on elder abuse and how problems can be tackled.

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a https://www.aanpak-ouderenmishandeling.nl/ontspoorde-mantelzorg

b https://www.movisie.nl/sites/movisie.nl/files/publication-attachment/MantelScan%20%5BMOV-177655-0.2%5D.pdf

c http://www.markant.org/assets/2015/12/3_minuten_check.pdf

d https://www.movisie.nl/sites/movisie.nl/files/publication-attachment/Flyer%20DVD-pakket%20ouderenmishandeling%20%5BMOV-835001-00%5D.pdf

According to the NAP 'Ouderen in veilige handen'[94], a tool to prevent financial exploitation[a] was planned as a part of the first action of the NAP. The government and the Dutch association of banks, notaries, mentorship NL, the municipalities and the associations of elderly have agreed on a common approach related to financial abuse. There is for instance a training for elderly 'how to safely arrange financial affairs"[b] in the form of a checklist to be filled in by the elderly to check the state of the organisation of their own administration and finances. This tool is available since 2016 and is a part of a toolkit[c] which is aimed at professionals, the elderly and informal carers. The kit also contains conversation and signal tips. Also, specific campaigns related to the prevention of financial abuse were organised as pilot projects in different municipalities of the Netherlands: Almere, Den Bosch, Ede, Gouda, Groningen, Haarlem and Rotterdam.

On the Official State Website of the Dutch authorities, an interactive webpage works as an awareness tool[d]. It offers to visitors different means to identify the signs of EA and the different available actions that should be done. The Ministry of Health, Wellbeing and Sports and the Ministry of Justice and Safety have jointly set up the campaign 'Huiselijk geweld'[e]. The aim is to make it easy and accessible for the overall population to act in case of suspicion of domestic violence. In 2019, a campaign specifically focussing at elder abuse has been launched. Specifically for elder abuse, several products such as posters, video's[f], texts to share on social media, factsheets, audio material are available at a central website: https://www.campagnetoolkits.nl/huiselijk-geweld/ouderenmishandeling.

Awareness campaigns are also organised by senior associations: ANBO, Netwerk van organisaties van Oudere migranten (NOOM), PCOB and UnieKBO.[94]

6.1.6 *Programmes to decrease societal attitudes and stereotypes towards older people and empowerment of older people*

EA responsibility was shift to the municipalities in 2015 following the global idea that prevention and management of elderly abuse should be integrated in the local policy of societal support and safety. The overall idea of societal support is that elderly should be stimulated and supported to be self-sufficient (zelfredzaam) and to stay as long as possible in their own familial environment. They should participate to and be integrated in the society, instead of being isolated. Within this idea, the municipalities are responsible to focus on prevention and management of elder abuse inter alia by enhancing elderly's ability to stay independent and integrated in society. In addition, tools of awareness are directly targeting older people to empower them to act in case of an abuse.

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a https://www.aanpak-ouderenmishandeling.nl/doc/Checklist-ouder-voorkomen-van-financiele-uitbuiting.pdf

b https://seniorenveiligonline.wordpress.com/

c https://www.aanpak-ouderenmishandeling.nl/kennisbank/toolkit-voorkom-financiele-uitbuiting

d https://www.ikvermoedhuiselijkgeweld.nl/ouderenmishandeling

e https://www.rijksoverheid.nl/actueel/nieuws/2019/06/12/campagne-tegen-ouderenmishandeling-van-start

f https://www.rijksoverheid.nl/onderwerpen/ouderenmishandeling/documenten/videos/2019/06/11/campagne-ouderenmishandeling-klaverjas

https://www.rijksoverheid.nl/onderwerpen/ouderenmishandeling/documenten/videos/2019/06/11/campagne-ouderenmishandeling-kapper

6.2 Québec (Canada)

6.2.1 *Defining national or subnational policies and/or action plans and/or laws*

At the national level, the Canadian Charter of Rights and Freedoms[a] (the Charter) guarantees the right to equality. It protects from all forms of discrimination, including age discrimination. At the provincial level of Québec, the Québec Charter of Rights and Freedoms[b] is a fundamental law that takes precedence over all laws in Québec. Its main purpose is to foster harmonious interactions between people in Québec and between individuals and their institutions, including the Government.

On the Canadian scene, the only common mechanism to combat abuse is the Criminal Code. Even if abuse is not in itself a crime, it can be dealt with through various crimes such as common or aggravated assault, fraud, etc. The Canadian Criminal Code includes a specific section that reminds judges that they can (not must) take the age of the victim into account when sentencing. All other provisions are specific to the 10 provinces and 3 territories that make up Canada. As a result, there is no unified Canadian model for addressing abuse. In order to respect provincial jurisdiction over health and social services, the Canadian government plays a primary role in the prevention of abuse. The problem of elder abuse is seriously taken into account by the Canadian and Québec authorities.

Canada's New Horizons for Seniors Program held a major initiative to provide $750,000 in funding for projects on elder abuse. This unique initiative notably allowed the Canadian Network for Prevention of Elder Abuse to restructure itself into a hub and the Research Chair on EA of the Sherbrooke University to develop, in partnership with the Service de police de la ville de Montréal, the IPAM model (Police Intervention with Abused Older Adults).

All Canadian provinces have reporting systems for abuse in residential care settings. Reporting of abuse in other group living settings for seniors (e.g. private residences for seniors without health care) varies widely across provinces and states. It varies even more for seniors living at home. For example, the mandatory reporting law in Quebec specifically targets all seniors living in long-term care centres (living and geriatric care settings) and all other adults under protection, regardless of where they live.

Protection plans for adults (where persons have been declared unfit), whether for property or for the person, vary according to the 13 jurisdictions. They are called: curatorship, guardianship, homologation of a mandate of protection, etc. Those are protection mechanisms used in the fight against abuse.

Several provincial and national plans exist in Canada. Some provinces are much more structured than others in terms of public policies, action plans, specific mechanisms, etc. In the province Quebec, two governmental action plans were set up. The first one covered the period from 2010 to 2015[100], and the second one from 2017 to 2022.[101] Both are entitled “Plan d’action gouvernemental (du Québec) pour contrer la maltraitance envers les personnes âgées » (Gouvernmental action plan to tackle abuse against seniors). The second plan explains that the elaboration of laws, policies and protocols are a necessary step to prevent elder abuse.[101]

The first plan of the Quebec government benefited from an evaluation report published in 2016.[102] Ninety pourcent of the 39 measures stipulated in the plan had at least already started in April 2015. Only 4 were not yet initiated. The measures of the plan were, in addition, reinforced and completed by four successful transversal actions according to the evaluation report: (i) the sensitization campaigns, (ii) the spreading of knowledge by the Chair of research (iii) the financing, flexibility and training of the Elder Abuse line, and (iv) the coordination between private and public partners.[102]

a https://laws-lois.justice.gc.ca/fra/const/page-15.html

b http://www.cdpdj.qc.ca/en/droits-de-la-personne/vos-droits-au-quebec/Pages/charte.aspx

In Québec, the specific Act aiming to fight abuse against elders or any adult in situation of vulnerability[a] provides for 6 measures to combat elder abuse and abuses against any other adult in a vulnerable situation. In Appendix 14, tables summarizing the legal frame in Québec are given[b]. A summary of all laws existing in Canada and Québec concerning elder abuse is also available in Figure 39 in Appendix 15. The law on adult protection in Quebec will be changing soon to move towards a more adapted and modulated protection according to the needs of each person (Marie Beaulieu, personal communication).

Canadian and more specifically Quebec government regularly establish a plan to fight against elder abuse. The Canadian authorities are deeply concerned by this issue. Institutional policy against EA, professional secrecy lifting and EA reporting are mentioned in a specific Act about EA in Quebec.

6.2.2 *Improving policies and practices in residential care facilities*

The interest of the Quebec government about elder abuse in residential care facilities is quite recent (personal communication from Marie Beaulieu-2018). One observation is that organisational maltreatment are frequently present as the staff is not sufficient to assume the tasks. The well-treatment approach is promoted as a positive approach to fight abuse. But other ways are also used as mandatory reporting (see Appendix 14), control policy, concertation meeting with families, etc. The manager of the residential facilities is in charge to the application of the measures of protections.

In the second government actions plan against elder abuse, objectives are set up to adapt some settings in a way to fight against abuse: (i) to implement policy to address abuse of residents in residential and long-term care centres (CHSLDs); (ii) to promote well-treatment in private seniors' residences through outreach activities and tools; and (iii) to disseminate and promote the regulation on the use of cameras and other technological means for surveillance purposes in CHSLDs. This second plan gives a central place to the well-treatment and the conditions which favours it: (i) to place the person in the centre of the actions; (ii) to favour the decisional autonomy and the empowerment; (iii) to respect the person and his/her dignity; (iv) to intervene with know-how and interpersonal skills; and (v) to offer a concerted support.[101]

As explained in the previous section, in Quebec, an Act aims to fight abuse against elders or any adult in situation of vulnerability[c]. Amongst the 6 measures to combat abuse of elders and any other adult in a vulnerable situation[d], one concerns the prevention in residential facilities: *Mandatory adoption and implementation, in all institutions in the health and social help sectors, of a policy to combat abuse of persons in vulnerable situations.* The policy must be posted in public view and published on the institution's website.

In the Quebec province, a very detailed reference guide[12] can be used by anyone wanted to fight against elder abuse. This guide supports the collaborative inter-sectoral approach of the governmental plan 2010-2015.[101] In this guide is highlighted the need to elaborate in each care institution a charter on sensitisation, prevention and intervention of elder abuse, and to make it known and understandable to the elderly and his family.[12]

In October 2018, the INESSS (Institut National d'Excellence en Santé et Services Sociaux) of Québec published a report about the quality of the life environment within CHSLD for people with a lack of autonomy.[103] Through a scientific approach, the authors succeed to determine the essential characteristics of a high-quality life environment in CHSLD, to illustrate the

a http://legisquebec.gouv.qc.ca/fr/showdoc/cs/L-6.3

b https://www.quebec.ca/famille-et-soutien-aux-personnes/aide-et-soutien/maltraitance-aines/loi/

c http://legisquebec.gouv.qc.ca/fr/showdoc/cs/L-6.3

d https://www.quebec.ca/famille-et-soutien-aux-personnes/aide-et-soutien/maltraitance-aines/loi/

consequences of a higher quality life environment and to identify how to evaluate this quality.

6.2.3 *Professional awareness and training*

A particularity of the Québec in EA prevention means is the unique existence of a university chair on abuse of older adults, named the Research Chair on Elder Abuse of the Sherbrook University[a].[100] On its website, numerous pedagogic tools and practical guides. The practical guide 'En Mains' which allows to enrich the ethical reflexion of professionals specialized in elder abuse care. Also policemen can find on this website the practical guide targeting the police which helps policemen to better identify elder abuse situations and to intervene in collaboration with other sectors 'professionals. Then, a practical guide aims to support inter-sectorial duo interventions between police and social or community workers. And finally, three quiz on knowledge about elder abuse and ageing allow anyone to test his/her skill.

In the second government actions plan against elder abuse, one objecyive is to inform, train and tool actors about elder abuse. It stipulates that the quality of the initial and ongoing training of the various stakeholders (eg: social workers, nurses, nursing auxiliary, police officers, managers, volunteers, etc.) to the concepts of ageing and the fight against abuse is crucial because it can help to avoid some abusive behaviours. Trainers can also teach the stakeholders to identify indices who can testify to a situation of abuse or indicators who confirm the presence of a maltreatment because identifying a situation of, or at risk of, abuse allows to prevent the aggravation of the situation.[101]

Numerous actions are suggested to reach this objective. The ones concerning **the financial sector** are: (i) to develop and distribute to financial sector stakeholders a checklist to help identify situations of financial abuse of seniors; (ii) to develop and offer to financial sector stakeholders an information session on prevention, identification and intervention in situations of abuse against seniors; (iii) to continue to offer lectures on the prevention of financial fraud among senior clients, through associations of seniors, as well as to stakeholders in the financial sector who work with this clientele; (iv) to develop and publish a guide for the financial sector setting out guidelines on good practices for persons in vulnerable situation; (v) to organize a forum on financial abuse that brings together financial sector stakeholders; and (vi) to develop and make available web content on the prevention of financial abuse for seniors and their families, as well as of the financial sector stakeholders working with seniors.

The actions concerning **the police and justice sector**s are: (i) to disseminate information about elder abuse in the police sector; (ii) to update the Police Practices Manual with respect to techniques for identification, intervention and investigation on elder abuse; (iii) to update the senior abuse training components in the initial training of police patrol; (iv) to develop a directive for prosecutors in criminal and penal prosecutions covering all of their obligations and responsibilities to victims of crime and vulnerable witnesses, including the elder abuse victims; (v) to add a section about the offences against older persons to the training of prosecutors on economic crimes; (vi) to contribute to the development of mediation training in the context of protection regimes and mandates; and (vii) to update the newsletter on police statistics on crime against seniors.

The actions concerning **the health and social help sectors** are: (i) to develop and implement a deployment strategy of the various training courses concerning the abuse of seniors with the stakeholders of the health and social services; (ii) to update and deploy the training designed by the Help Line Elder Abuse on elder abuse to professionals in the health, social help and community sectors; (iii) to organize meetings in order to perfect the practice of workers in seniors' facilities allowing them to exchange on their interventions and to identify "good" practices in context of care, combining know-how and interpersonal skills of well-being; (iv) to develop and implement a national strategy for the dissemination of the 'Reference Guide against elder abuse'; (v) to educate community agencies about elder abuse

[a] http://maltraitancedesaines.com/fr/2014-10-29-16-39-26/outils-pedagogiques-et-guides-de-pratique

and the role they can play in the prevention of elder abuse; and (vi) to develop an awareness tool and training content specific to the realities of LGBT seniors to health care professionals and social services and institutions.[101]

Finally few actions are also targeting **the education sector and the housing sector**: to disseminate the tools and training available on elder abuse and eldercare in the educational institutions; to support the Research Chair on Elder Abuse of the Sherbrook University; and to carry out awareness-raising activities with the agents and partners of the 'Société d'habitation du Québec' to prevent and identify elder abuse.[101]

The second government actions plan against elder abuse also stipulates several actions done in the past by the Quebec government to facilitate the knowledge about elder abuse situations: (i) the dissemination of training content in the justice network on the provisions of the legislation permitting the disclosure of confidential information; (ii) the use of the Info-Aidant service, a telephone line for listening, information and support to professional, which is confidential and free; and (iii) the contribution of the Research Chair on EA of the Sherbrook University to the development, dissemination and outreach of the knowledge as well as to the initial and continuing training of the concerned professionals, to maintain networking and dissemination of knowledge and good practices through a Forum, and to disseminate the Quebec Report on Violence and Health, including the section on elder abuse. One example is the reference guide[12] based on the collaborative inter-sectoral approach of the governmental plan 2010-2015.[101] This guide allowed to more than 2,500 stakeholders and managers from different backgrounds to participate in the appropriation workshops of the first edition of the reference guide and/or to take training inspired by the guide[a].

In the future, others actions should be accomplished in Québec as: (i) the revision of certain programs depending on the practice evolution, (ii) the release of staff to take part in professional development activities, and (iii) the creation of specialized teams to promote the transfer of knowledges to the peer.[101]

Sensitization principles, tools and actions are described in details in plans and reference guide in Québec. Many tools already exist and are grouped in the "trousse SOS abus".

6.2.4 *Support to informal caregivers to avoid burden*

In 2018, Marguerite Blais, Minister responsible for Seniors and Close Caregivers of Québec, met with numerous stakeholders to lay the groundwork for the first National Policy for Caregivers in the history of Québec[b]. A first consultation with 200 people in the field of caregiving was held on December 11, 2018 and then, the health and social help Ministry has begun work on drafting this policy, which will mainly aim to consolidate the recognition of family caregivers, promote their role and provide them with the necessary support. It will be tabled in the National Assembly in early 2020. According to the Minister, this plan will help to take care of a family caregiver before he or she becomes exhausted.

In the meanwhile, some laws in Quebec highlights some aspects of the informal caregiving[c] as the family and personal leave; the care consent; the access to the medical file; the planning of the future by the elder; the rights of vulnerable people; and housing aspect development. In addition, some taxes can be adapted in case of informal caregiver profile. But specific protection for caregivers of older vulnerable person are not obvious.

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a www.maltraitanceaines.gouv.qc.ca

b https://www.journallenord.com/2020-marquera-la-mise-en-place-de-la-premiere-politique-au-quebec/

c https://www.educaloi.qc.ca/proches-aidants-comment-la-loi-vous-outille

Some services are also available to older people's informal caregivers as 'l'Appui', locally present in all regions of Quebec. It offers information, training, psychological support and respite. Its hotline and its website give a valuable help to informal caregivers. The RANQ (Regroupement des aidants naturels du Québec) groups local and regional associations aiming to improve the quality of life of informal caregivers, to raise awareness of the realities and needs of natural caregivers in Quebec and to promote their interests. Its website[a] offers information and a toolbox for family caregivers themselves.[104]

6.2.5 *Awareness campaigns for the public*

Yet, the first government actions plan to combat elder abuse included national awareness campaigns as measures to prevent maltreatment and to promote well-treatment.[100] In this frame several actions were led in Québec by different stakeholders: (i) the deployment of the "Ce n'est pas correct!" program which aims that neighbours, friends and families present for seniors recognize the signs of elder abuse in their community and accomplish simple and practical gestures to help with respect and in a safe manner (CIUSSS Centre-Ouest-de-l'Île-de-Montréal); (ii) the update and reissue of the pamphlet 'Sexual Assaults against Seniors exist and make a deep scars...Let us be vigilant', within the framework of the Governmental Strategy to Prevent and Address Sexual Violence 2016-2021 (SCF); (iii) the conduct of information sessions on abuse and fraud for individuals and seniors' organizations, offered through the Aîné-Avisé program (FADOQ, Sûreté du Québec); (iv) the publication of the guide 'Seniors and Consumption. Rights to be asserted to avoid worries' whose main objective is to inform seniors of their rights and to help them to prevent problems they might experience in various areas of consumption that particularly affect them (Office de la protection du consommateur).[101] The evaluation of the first governmental plan showed that the people reached by the awareness campaigns showed a higher level of knowledge and that the number of calls to the elder abuse helpline increased over the course of the campaigns.[102]

In the second government actions plan against elder abuse (2017-2022), different objectives were recently set up on population sensitisation through (i) dissemination of information on the rights of victims and on the services and recourses available to them in the justice network; (ii) updating of the regional resource directory offering services or accompaniment related to situations of elder abuse; and (iii) the availability of the 'Direction des services aux personnes handicapées et à leur famille', of the 'commissaire local aux plaintes et à la qualité des services' and of the 'Ligne Aide Abus Ainé', which offers to the population a listening and referral service specialized in elder abuse.[101]

Additional measures for the future are also given in the second government plan: (i) to develop and disseminate a societal campaign to denounce elder abuse; (ii) to design and make available different means and tools raising awareness about abuse, including on material and financial abuse, as well as on the well-treatment for the elderly; (iii) to raise awareness among family caregivers of seniors about the phenomenon of abuse, including incorporating information on abuse in different communication tools and activities; (iv) to raise awareness and mobilize the population on the well-treatment of people unable to decide for themselves; (v) to produce tools and facilitate information sessions on rights and remedies and on the role of the Commission on the elder abuse; and (vi) to establish, strengthen and disseminate the main trajectories of services to borrow in situations of elder abuse.[101]

Also in the reference guide against elder abuse, sensitisation's means are highlighted[12]:

- To give prevention tools and information about EA resource services to the elderly and relatives during professionals practice or volunteering.
- To highlight the 15th of June, international day of sensitisation to elder abuse.

[a] https://ranq.qc.ca/en/

- To spread information in the media, including local media like church mass folder, local newspapers or town bulletin.
- To elaborate in each care institution a charter on sensitisation, prevention and intervention of elder abuse, and to make it known and understandable to the elderly and his family. As usual the respect of a charter is not mandatory.

So, in Quebec, numerous sensitisation tools have already been disseminated on the subject of abuse. Those tools have increased the level of vigilance of older adults and of the general population on the multiple forms of elder abuse.[102] The wide variety of tools which has been developed includes folder, games, theatre play, movies, training, books, ads, mostly targets the elderly but also the volunteers and the caregivers. They sensitise about the types of maltreatment, good practices of self-protection and resource services. Better tools are dynamic, close to hands and elaborated by elderly in collaboration with the education sector. The use of tools has to be effective and focus in the aim to avoid waste of time and material. A certain attention is needed to check the comprehensibility of the vocabulary and to reach the most vulnerable and isolated persons.

One of the main prevention mean is “Trousse SOS abus”[a] which exist in English as well. It groups 80 different tools mainly created in the Quebec but which not only target prevention. Multiple websites are also listed there with the aim to aware seniors about the different type of abuse. Financial abuse are particularly focused.

The reference guide is a tool itself as it gives advices to seniors on knowledges and behaviours which help to be secure, to be aware and to secure one’s possessions. Explanations about how to grant proxy to somebody, to give advanced care/end of life instructions, to write a testament and to ask a protection mandate are given in the reference guide. Television and radio are definitely good means to reach the most vulnerable and isolated persons.[12]

Practical details about the organisation of sensitisation meetings are even given in the reference guide: “Several specialists and resource persons can carry out sensitisation meetings to social worker, police officer, doctor, lawyer, notary, volunteer, intervener of community organizations, etc. Co-facilitation by stakeholders with complementary skills is encouraged as it greatly enriches the content of the presentation. The involvement of a senior is a clear added-value to the sensitisation process. The time after the meeting is important to offer prevention tools and to collect personal experiences. Themes of the presentation have to be chosen carefully tackling a broader and less delicate subject as quality of life, well-being or security. To reach isolated or less mobile persons, presentations can occur inside nursing homes or in place where frail people must go (pharmacy, polyclinics, bank…). Games and exercises are very good icebreaker to open the discussion after the presentation.”[12]

6.2.6 *Programmes to decrease societal attitudes and stereotypes towards older people and empowerment of older people*

In Québec, some documents show a will to change societal attitudes and to empower older persons.

In the reference guide, the section on prevention starts with the description of three concepts amongst which two are related to societal attitudes. First, the promotion of active aging, and then the combat against ageism.[12] Also private initiative, as the website[b] of the Canadian researcher Louis Plamondon, aims to develop on internet a set of references and documents promoting the dignity and the respect of the elderly; helping to defend human rights of the elderly in communities; helping to protect the vulnerable older persons and favouring the plurality of visions and practices. This website can contribute to the exchange of data between French speaking communities and countries on vulnerable elderly and also offer an easy access to a tool of evaluation of maltreatment risk.

a www.troussesosabus.org

b http://www.rifvel.org/presentation/rifvelcest.php

The department of Justice of Canada offers a good model through its guide intended for older people susceptible to be abused by a trusted person (or for anyone knowing this kind of situation).[105] In this guide published in 2011, advices are given for each type of abuse in a way which empowers the older person. Each advice is given in the 'should' form. The document ends with a global advice: "If you're being abused, or if you know anyone who's a victim, talk to someone you can trust. And continue to talk about it until someone listen to you. You definitely can get help. There are people who can help you, provide information on what to do. In general, abuse is only gets worse when it remains hidden."[105]

Also, on a Québec website[a] summarizing and explaining the laws to the public, actions to do by an older person to prevent abuse empowering senior is highlighted like in the following extract: "While you are in good health, create a Mandate of Protection (formerly called a Mandate in Case of Incapacity). This is a legal document in which you appoint one or more people you trust to make decisions on your behalf if you become incapable of doing so on your own. If you have given someone a mandate (also called a power of attorney) and you have reason to believe it could be misused, you can cancel it at any time. A Power of Attorney is a document that gives someone you designate the authority to do things on your behalf. For example, withdrawing money from a bank account. Unlike a protection order, a warrant is only valid while you are still able to make decisions. If you decide to cancel a power of attorney, be sure to notify the people or institutions involved, such as the person you have designated to act on your behalf and your bank. While you are in good health, prepare a will to determine who will inherit your assets upon your death."

On the website of the research chair on elder abuse is a practical guide named DAMIA available. This guide targets trainers which aim to develop and maximise the sensitization's approaches about elder abuse. It was built on a study which explored the reasons for which older people did not ask help when there are maltreated or they witnessed it.[b]

6.3 France

6.3.1 Defining national or subnational policies and/or action plans and/or laws

In France, a national policy targets abuse against vulnerable people.[106] So on the website of the 'Ministère des Solidarités et de la Santé', people at risk of elder abuse are assimilated to vulnerable people. Since the early 2000s, the state policy is organized around three main lines: (i) facilitating the reporting of acts of abuse, (ii) reinforcing controls within institutions and (iii) preventing and identifying the risks of abuse.[107] The 'bureau de la protection des personnes' within the 'direction générale de la cohesion sociale' is in charge of the application of this policy at the national level. More locally, the 'directions régionales et départementales de la cohesion sociale' and the regional health agencies (agences regionales de santé-ARS) follow the setup of the programmes, procedures and products according to the three priorities. Seven main actions were suggested by the national policy including the implementation of the law n°2002-2[c]. This law reforms the social and medico-social action and aims in particular at developing the rights of users attending institutions and social and medico-social services.

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a https://www.educaloi.qc.ca/capsules/les-aines-et-la-protection-contre-lexploitation-et-les-abus

b https://maltraitancedesaines.com/realisations/guide-de-pratique-damia/

c https://www.legifrance.gouv.fr/affichTexte.do?cidTexte=JORFTEXT000000215460&categorieLien=id

This law is completed by two circulars (DGCS/SD2A n° 2011-282[a] and DGCS/SD2A n° 2014-58[b]) which reinforce the fight against abuse and the development of well-treatment in institutions and services.[106]

In 2007, a national plan to promote the well-being of and to combat the maltreatment against older people and person with handicap was adopted.[108] The same year, a decree stipulated the creation of a specific commission, the 'Comité national de vigilance et de lutte contre la maltraitance des personnes âgées et des adultes handicapés'. Then, in 2013, two decrees were adopted about the creation of a new commission, the 'comité national pour la bientraitance et les droits des personnes âgées et des personnes handicapées'(CNBD)[c] The establishment of this last commission should improve the knowledge on EA and put in place means to facilitate the identification, reporting and treatment of situations of abuse, promote treatment and support for caregivers involved in daily life.[107]

In 2015, the law n° 2015-1776[d], called the ASV law, enacted the need to adapt the French society to the ageing of the population. This law was adjusted recently (2019). The objectives of this law are threefold: anticipating the loss of autonomy; adapting society to ageing, and improving the care of people in loss of autonomy. Also in 2015, a law attempted to clarify a report protocol in case of abuse perpetrated by health professionals[e].

French laws concerning the medical secret[f] define that facts known during the activities of health professionals are in principle subject to secrecy (Article 226-13 of the Penal Code) but this does not apply to deprivation or abuse inflicted on a minor or on a person who is unable to protect himself or herself because of age, physical or psychological condition (article 226-14 of the Criminal Code and article 434-3). This law allows health professionals to inform the authorities if they observe acts of ill-treatment without the risk of punishment for breach of professional secrecy.

Concerning the failure to assist a person in danger[g], the article 223-6 of the Penal Code stipulates that "anyone who, by his immediate action, without risk to himself or to third parties, can prevent either a crime or an offence against the physical integrity of the person refrains from doing so shall be punished by five years' imprisonment and a fine of 75,000 euros. The same penalties shall be imposed on anyone who voluntarily refrains from giving a person in danger the assistance which, without risk to himself or to third parties, he could have given him either by his personal action or by inducing assistance".

To ensure that "all men are born and stay free and equal in rights", different charters exist in France according to settings or subgroups[h].

- The charter of the hospitalized person is an official document. Its purpose is to make known to every sick person hospitalized in a health facility its essential rights and the rules of life in the hospital. Its latest version dates from 2006.
- The charter of Rights and Freedoms of the elderly person with disabilities or dependence.

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a https://solidarites-sante.gouv.fr/fichiers/bo/2011/11-10/ste_20110010_0100_0045.pdf

b http://circulaires.legifrance.gouv.fr/index.php?action=afficherCirculaire&hit=1&r=38073

c https://solidarites-sante.gouv.fr/IMG/pdf/2013_decret_creation_du_CNBD.pdf

d https://www.legifrance.gouv.fr/affichTexte.do?cidTexte=JORFTEXT000031700731

e https://www.legifrance.gouv.fr/affichTexte.do?cidTexte=JORFTEXT000031424650&categorieLien=id

f https://3977.fr/temoin-ou-victime-que-puis-je-faire/

g https://3977.fr/temoin-ou-victime-que-puis-je-faire/

h http://www.agevillage.com/article-4129-1-Vieillissement-et-citoyennete-les-chartes.html

- The charter of Human Rights and Freedoms in long-term care facilities. The Charter of Human Rights and Freedoms is published in the appendix to the decree of September 8, 2003 and referred to in Article L. 311-4 of the Social Action and Family Code.
- The charter of professionals in gerontology. Established by the Institute of Gerontology of Limousin in April 2004, it defines the specific skills needed for professional help, care and support for the elderly.
- The Charter of Rights and Freedoms of the major person under protection.

In France, the national policy targets abuse against vulnerable people. People at risk of elder abuse are thus assimilated to vulnerable people.

Since the early 2000s, the state policy is organized around three main lines: (i) facilitating the reporting of acts of abuse, (ii) reinforcing controls within institutions and (iii) preventing and identifying the risks of abuse.

First, a law reforms the social and medico-social action and aims in particular at developing the rights of users attending institutions and social and medico-social services.

Then, a national plan and two specialised commissions were set up to promote the well-being of and to combat the maltreatment against older people and person with handicap.

Next, the ASV law enacted the need to adapt the French society to the ageing of the population. The objectives of this law are threefold: anticipating the loss of autonomy; adapting society to ageing, and improving the care of people in loss of autonomy.

And also, laws attempted to clarify a report protocol in case of abuse perpetrated by health professionals, the exception to the professional secrecy and the duty to assist someone in danger.

Finally, numerous charters ensure that “all men are born and stay free and equal in rights”

6.3.2 *Improving policies and practices in residential care facilities*

Concerning this topic, three main actions are suggested by the national policy against vulnerable people’s abuse: (i) implementing an active policy of good treatment in institutions, (ii) developing a culture of analyse and risk management in institutions; and (iii) diffusing good practices and guidelines.[106]

The ‘Agence nationale de l’évaluation et de la qualité des établissements et services sociaux et médico-sociaux’ (ANESM) has developed a number of recommendations for good professional practice, and internal and external evaluation procedures to support the improvement of the quality of care and the promotion of good treatment in the social and medico-social sector.[107] In addition, it assists institutions and departments in a regular self-assessment of their practices in terms of proper treatment, in order to raise awareness of this approach and measure progress.[109]

The HAS has also published in collaboration with the FORAP (Fédération des Organismes Régionaux et territoriaux pour l’Amélioration des Pratiques et organisations en santé)[a] a guide for professionals of care residential institutions proposing tools which allow to spread well-treatment.[110] The guide includes well treatment principles, points of awareness and strategies to diagnose EA, to develop and implement well-treatment plan and to evaluate the results of the changes. The guide listed 7 tools suggested by different ‘regional supportive structure in evaluation of the health sector’[b]

[a] The FORAP is the association of 14 regional and territorial organisms aiming to improve the practices and organisations in the health sector.

[b] http://www.ccecqa.asso.fr/sites/ccecqa.aquisante.priv/files/u46/2.outilscpp.pj-bientraitance.0.pdf

(SRE- structure régionale d'appui en évaluation-santé et médico-social). Training tools are used by SRE along a process of teaching in which first the professionals listed their needs, after the training is given and finally an evaluation of the training is done. Details about the characteristics of each tool are given in the Table 60 in Appendix 1.

The evaluation of the different tools was done through a questionnaire sent to institutions and professionals. One hundred twenty-seven questionnaires were filled. The conclusion of this evaluation is that the global perception of the tools is in favour of the implementation of them; that the development of the tools is mainly centred on the paramedical staff; and that the residents seem paradoxically forgotten.[111]

Another action suggested by the national policy against vulnerable people's abuse is strengthening the controls carried out within the institutions Indeed the actual policy in France ensures a regular presence of State services inside institutions to inspect and control care and security of vulnerable people. They also support the institutions in their approach to assessing and managing the risk of maltreatment.[106] The 2013-2017 program[a] stipulates that the control will (i) verify that the conditions and arrangements for the hosting or care of persons respect their health, safety, integrity, dignity and physical and moral well-being; (ii) identify situations of abuse and neglect that go unreported, but also prevent risks by identifying critical points in the functioning and organisation of the structures; (iii) propose solutions to improve the quality of the hosting and daily care of residents; and (iv) sanction, if necessary, the inadequacies and abuses observed.

In 2019, the commission CNCPH (Conseil National Consultatif des Personnes handicapées) suggested to the French government to structure professional time by inserting, in a mandatory way, in medico-social establishment, spaces for questioning practices (supervision, practices analysis, etc), (for example, Article D.312-7-1 of the Code de l'action social services for home help services) . It also suggests to introduce, for medico-social establishments and services, the obligation to reflect within them on the ethics of reception and accompaniment, as it already exists for health establishments (article L.6111-1 of the Public Health Code).

Three main actions are suggested by the national policy against vulnerable people's abuse about the situation in residential care facilities: (i) implementing an active policy of good treatment in institutions, (ii) developing a culture of analyse and risk management in institutions; and (iii) diffusing good practices and guidelines.

Several knowledge institutions have developed internal and external evaluation procedures to support the improvement of the quality of care and the promotion of good treatment in the social and medico-social sector.

The same knowledge institutions have also developed recommendations for good professional practice and tools for self-assessment, to spread well-treatment, to raise awareness, to diagnose EA and to measure progress. The evaluation of the different tools concluded that the global perception of the tools is in favour of the implementation of them.

Another action suggested by the national policy against vulnerable people's abuse is to strengthen the controls carried out within the institutions Indeed the actual policy in France ensures a regular presence of State services inside institutions to inspect and control care and security of vulnerable people. They also support the institutions in their approach to assessing and managing the risk of maltreatment.

It is finally suggested to insert in medico-social establishment, spaces for questioning practices and for reflecting on the ethics of reception and accompaniment.

[a] https://solidarites-sante.gouv.fr/fichiers/bo/2014/14-04/ste_20140004_0000_0060.pdf

6.3.3 Professional awareness and training

The first main action suggested by the national policy against vulnerable people's abuse[a] is informing and educating the public and professionals to improve reporting and knowledge of abuse.

The MobiQual programme[b], financed by the CNSA (Caisse nationale de solidarité pour l'autonomie), aims to support the improvement of the care quality in nursing homes, hospitals and at home services. It focuses on the sensitization of professionals about well-treatment, pain, palliative care, depression, infection risks, nutrition and Alzheimer disease. Between 2010 and 2013, 31 000 training kit were used freely by professionals. Additionally, the CNSA supports cursus leading to the professional qualification of nurse's assistants, medico-psychological assistants, educational instructors, special educators and nurses.

In 2019, the commission CNCPH (Conseil National Consultatif des Personnes Handicapées) suggests to the French government to develop practical training on site and by case study in institutions and medico-social services. Those lessons should involve the whole staff and should position vulnerable people and their caregivers as trainers through role-playing games about abuse of people vulnerable. The commission also suggests to mobilize professional federations to inform their members about the obligations of reporting. Finally, it suggests to integrate awareness of abuse in the initial and continuous training of professionals in the social and health care sectors. Continuous training of professionals should be provided on a mandatory regular base like for fire safety training courses in an adapted periodicity to the audience.[112]

One action suggested by the national policy against vulnerable people's abuse is informing and educating the public and professionals to improve reporting and knowledge of abuse.

The MobiQual programme focusing on the sensitization of professionals to support the improvement of the care quality in nursing homes, hospitals and at home services was freely used by thousands French professionnals.

Specialised commission also suggested to develop practical training on site and by case study in institutions and medico-social services

6.3.4 Support to informal caregivers to avoid burden

In 2015, the HAS service in charge of persons with chronic disease which need help, elaborated a guide to evaluate their health route. In this guide, a chapter is devoted to the prevention of exhaustion in caregiving and of elder abuse. As explain in the guide: "Informal caregivers who are deeply involved in caring for a family member with a disability or loss of autonomy, may be victims of exhaustion, and gradually neglect their own health. Caregivers, particularly those which care of relative with neuro-degenerative diseases, have a very high morbidity and mortality, often underestimated by themselves and by professionals. Following this exhaustion, they can slip insidiously toward abuse of the person they help, named derailed informal care. Health care professionals should give special attention to them (annual consultation dedicated to their state of health, reiterated if necessary), and specific services must be offered to them: support groups, telephone or internet support, structures respite, information, etc".[113]

In France, several decrees concern the training and support to informal caregivers[c]. The HAS has recently published the recommendations from the ANESM about the support to informal carers. Those recommendations are

a https://solidarites-sante.gouv.fr/affaires-sociales/personnes-agees/maltraitance-des-personnes-vulnerables/article/orientations-prioritaires-de-la-politique-nationale

b http://www.mobiqual.org/portail/

c https://www.has-sante.fr/portail/upload/docs/application/pdf/2018-03/bibliographie_soutien_aux_aidants_non_professionnels.pdf

addressed to professionals from the care and the health sectors to guide the support which has to be given to informal caregivers. The recommendations focus on four different main topics: the recognition of the complementarity between professionals and informal caregivers; the mobilisation of the local resources specific for informal caregivers; the prevention, identification and management of the exhaustion risks; and the management of the derailed situations. A list of questions about the 4 topics is available and allows that professionals can question themselves on how to support informal caregivers.[114]

Seven objectives in relation to support for loss of autonomy have been set in the law n° 2015-1776 supporting the adaptation of the society to ageing[a]: (i) to revalue and improve the personal autonomy allowance (APA) at home, (ii) to redesign home care; (iii) to support and enhance the value of family caregivers; (iv) to define the methods for compensating the departments for the new expenses resulting from the improvements to the APA; (v) to support foster care; (vi) to clarify the rules on the rate for accommodation in residential facilities for dependent elderly people (EHPAD); and (vii) to improve the medico-social offer on the territory. As explained in a report of the DREES (Direction de la recherche, des études, de l'évaluation et des statistiques), the APA allows to finance the right to respite for informal caregivers or to finance care relay when informal caregivers are hospitalised.[115]

In 2019, the commission CNBD asks to prevent the occurrence of EA through, notably, a better centralisation on support to caregivers.[112]

The focus on informal caregivers is quite recent (2015) in France.

The HAS, in a guide evaluating the health route of persons with chronic disease which need help devoted a chapter to the prevention of exhaustion in caregiving and of related elder abuse. Recommendations about the support to informal carers are addressed to professionals from the care and the health sectors to guide them in the support to informal caregivers.

The law supporting the adaptation of the society to ageing asks to support and enhance the value of family caregivers.

The APA (allocation personnel autonomie) allows to finance respite for informal caregivers or to finance care relay when informal caregivers are hospitalised.

6.3.5 *Awareness campaigns for the public*

In 2007, the President of the FIAPA (Fédération Internationale des Associations de Personnes Agées), an international federation of associations of elderly from France, Belgium, Italy and Spain, has recommended to the minister of Solidarity and Health to fight against financial abuse on vulnerable elder persons by, for example, leading, via typical media alerts, a communication campaign on this issue[b].

In 2008, the French government launched a national campaign against abuse and created a national phone number (3977) targeting maltreatment against elder and disabled persons. This call center aims, through listening, to improve the detection and treatment of abuse situations[c].

In 2018, at the occasion of the International day for the sensitization to elder abuse, the FIAPA diffuses advertisement on the television. The objective was to sensitize the population to recognise in his/her environment a

a https://www.legifrance.gouv.fr/affichTexte.do?cidTexte=JORFTEXT000031700731

b https://www.fiapa.net/rapport-maltraitances-financieres-a-legard-des-personnes-agees/

c http://www.agevillage.com/n3-L-essentiel-sur-la-maltraitance-8

situation at risk of maltreatment and to call the 3977. The current awareness campaign of the 3977 organisation is about “The courage to see, the choice to talk about: victim or witness, call 3977”. Folders, posters and press contact are available on the 3977 web site[a].

In 2019, the commission CNBD suggests to the French government to install a recurrent communication process for the large public (such as "anti-abuse week") to raise awareness of abuse, and inform on the right ways to react, and to create and widely disseminate tools for identifying situations or behaviours, revealing - or revealing with a high probability - the existence of a maltreatment. It also suggests to elaborate and disseminate simple, synthetic and regularly updated documents which clearly summarise the obligations and rights of any person - professionals or third parties - faced with a worrying fact.[112]

The French government launched a national campaign against abuse and created a national phone number (3977) targeting maltreatment against elder and disabled persons. This call center aims, through listening, to improve the detection and treatment of abuse situations. The specialised commission also suggests to install a recurrent communication process for the large public and to elaborate and disseminate simple, synthetic and regularly updated documents.

The FIAPA (Fédération Internationale des Associations de Personnes Agées) diffuses advertisement on the television to sensitize the population to recognise in his/her environment a situation at risk of maltreatment and to call the 3977. It also insists on the fight against financial abuse on vulnerable elder persons through communication campaign via the media.

6.3.6 *Programmes to decrease societal attitudes and stereotypes towards older people and empowerment of older people*

In 2019, the commission CNBD published its first report which position the fight against maltreatment as the key stone of all help to support autonomy, and therefore of all policies supporting people autonomy. Well-treatment paves the way to any accompaniment to autonomy. So the commission specifically targets abuses in a relationship of help. Three axes are considered to establish a comprehensive policy to support elder autonomy: (i) to understand situations and elder abuse issues; (ii) to better respond to elder abuse events collectively ; and (iii) to prevent the occurrence of EA through a profound transformation of the current approaches.[112]

The website France-victimes[b] is a resource for older persons suffering from elder abuse as are the different websites Alma[c] (Allô maltraitance des personnes âgées, majeures et/ou handicapées) and the Age Village website[d] which collects and diffuses information for seniors and informal caregivers. In parallel, books also diffuse information to the public as the book entitled “Alerte maltraitance” published by the Administrator of the national federation to fight against abuse (3977 phone number institution). He has collected and analysed the press article about maltreatment during two years and gives answers to the EA issues at the individual and collective level, notably in fighting against ageism.

The evaluation report made by the HAS and the FORAP in 2015 highlights that “well-treatment is a new, dynamic and multidimensional concept which aims to support a major evolution, the irruption of the patient as the actor of his own health and thus the paradigm shift in the caregiver-care receiver relationship. There is now a rebalancing of the relationship in favour of the user, to whom we recognize not only rights but also knowledge that feeds into a shared medical decision-making process.” [111]

a https://3977.fr/presse-et-kit-media/

b http://www.france-victimes.fr/

c http://www.alma-paris.org/

d http://www.agevillage.com/

In France, since 2015, a specific law[a] aimed at "anticipating the consequences of the ageing of the population and making this period of life part of a journey that meets people's expectations as far as possible in terms of housing, transport, support and care in the event of loss of independence, social and civic life...". Practically, this law provides, in addition of the examples already given previously, financing through the CNSA to actions of prevention of autonomy loss, financing means against isolation and adaptation of the society to ageing as the establishment of senior civic volunteering; collective housing for the elderly; territories, housing and transport; and definition of the rights, the need of protection and the commitments of the elderly; and the creation of a High Council of Ageing. The law on the adaptation of society to ageing enhances the rights and freedoms of the elderly (both in terms of physical integrity and personal safety), particularly in the EHPAD (Etablissement d'hébergement de personnes âgées dependants).[107] This law strengthens the procedure for obtaining consent to enter a retirement home and enables elderly people to designate a trusted person in the event that they encounter difficulties in knowing and understanding their rights.

In a similar way, the commission 'comité national pour la bientraitance et les droits des personnes âgées et des personnes handicapées'(CNBD)' promotes, in particular, the full representation and expression of the persons (elderly and disabled persons). And the CCNE (Comité Consultatif National d'Ethique) has published in February 2018 its 'Advice number 128'[b] concerning the ethical issues about ageing in which they question the sense of concentrating the elder persons in institution and ask for leviers for an inclusive society for the elderly.

According to the French specialised commissions, well-treatment paves the way to any accompaniment to autonomy. So in the aim to prevent the occurrence of EA, a profound transformation of the current approaches are needed, promoting the full representation and expression of the older and disabled persons.

This is in line with the law on the adaptation of society to ageing which enhances the rights and freedoms of the elderly particularly in the EHPAD, and with the conclusion of evaluations made by knowledge institutions: "well-treatment is a new, dynamic and multidimensional concept which aims to support a major evolution, the irruption of the patient as the actor of his own health".

a https://www.legifrance.gouv.fr/affichTexte.do?cidTexte=JORFTEXT000031700731

b https://www.ccne-ethique.fr/fr/actualites/avis-ndeg-128-du-15-fevrier-2018-enjeux-ethiques-du-vieillissement-quel-sens-la

7 INTERNATIONAL COMPARISON

This last section aims to give a comparison of data issued from international organisations and from the three analysed countries with the Belgian data from chapter 2 concerning the prevention. Data collected about preventive actions in France, the Netherlands and Québec are summarised in Table 61 available in 0. Belgian data regarding the 6 categories of preventive actions extracted from chapter 2 are summarised in Table 62 available in the Appendix 18.

7.1 EA prevention: power levels and action plans

In Belgium, competence concerning EA prevention present an overlap between different levels of authorities. Sensitisation of the population, training of the professionals and policy/practice in nursing homes are only managed at the federated level while policies/laws about violence, program to decrease ageist attitude and behaviour, and support to informal caregivers are also treated by the federal level. Compared to Belgium, France and the Netherlands have a much more centralised authority which delegates implementation of decision at a regional (France) or local (the Netherlands) level. In Canada, all the EA prevention matters are decentralised to provinces/territories.

Globally, the situation of EA prevention in France seems to progress on a similar pace than in Belgium but is more focussed on well-treatment and older people empowerment. The Netherlands put the focus on the 'out of taboo sphere' while Québec is in a more advanced phase of the preventive approach encompassing comprehensive action plans, plenty of tools and regular awareness campaigns.

Since 2002 and still recently, United Nations stressed out the obligation for countries to adopt **legislative and administrative measures to prevent violence, abuse and neglect of older persons**[75, 84] as does the WHO Regional Office for Europe.[86] According to an OECD report on Long-Term care for older people[85], all OECD countries have adopted legislation setting principles of adequate and safe care, or protecting against abuse such as mandatory reporting of neglect or improper care, or mandatory criminal reference checks for care workers.

In Belgium, the situation evolved with the sixth state reform concerning the set-up of policies, action plans or laws specifically targeting elder abuse. Before the 6th state reform, a global policy against intra-familial violence was developed by the Federal Public Service of health (2006). It included a step plan to guide health care professionals in the management of elder abuse coupled with several tools (see Chapter 4). Also at that time, the National Action Plan against gender related violence stipulated specifically the topic 'Elder Abuse' in suggesting to train all GPs about EA (see Chapter 2). Since the 6th state reform, different regional decrees create specialised organisations in every region/community to deal with elder abuse situations and launched numerous prevention initiatives. However, no overall vision on how to prevent elder abuse exists in Belgium nor national or regional action plan/policy. Still, the more recent National Plan against gender related violence suggests to lead specific campaigns for frail groups like the elderly but elder abuse is not anymore mentioned. Till now, the Security and Justice competences are still on the federal level and an increasing concern emerges from the Justice about the violence against older people. A Circular of the College of the General Prosecutors on violence against older people is in preparation since months and would include a section about elder abuse (see Chapter 2, Chapter 7 and Chapter 8).

Compared to Belgium, the Netherlands pursues a strict policy against intra-familial violence since 2002. Moreover, between 2011 and 2018, a specific national plan was led on elder abuse.[94] Since 2018, elder abuse was again incorporated in the intra-familial violence national plan.[95] Although the politic vision is centralised, the Dutch federal authorities have delegated the implementation of actions, including the preventive actions, to municipalities. In France, a national plan on the development of well-treatment and reinforced combat against maltreatment was adopted in 2007. Specific councils and a specialised organisation were created in 2007, 2013 and 2014 but all those decisions are included in a more global vision than elder abuse. It always concerns all the vulnerable adults' population, i.e. the elderly and the people with a handicap. In Québec, the provincial politics about elder abuse is clear since years and results from a collaboration

between all concerned ministries. It leads to the development of two specific action plans on elder abuse (2010-2015 and 2017-2022) and the adoption of an Act[a] (law) to fight abuse against elders or vulnerable adults in 2017.[100, 101] The Québec started with a specific vision targeting elder abuse to extend it to vulnerable adults in a second time.

7.2 EA prevention: policies in residential care facilities

In the WHO-2014-World report on violence prevention[79], programmes to improve standards of care within nursing and other residential care homes were only reported by about 36% of countries. However, already in 2010, the European Parliament recommended that European member states bring greater attention to the enforcement of, and compliance with, quality criteria for service provision. In 2012, a European Quality Framework for Long-Term Care (LTC) services[90] which offers principles and actions for quality long-term care to people in need of care and assistance was developed.

The OECD report on LTC quality[85] deplored that few countries systematically measure whether LTC is safe, effective, and centred around the needs of care recipients. This report explains that indicators of health care quality should focus on quality outcomes (e.g. elderly falls and related fractures, bed-sores, medication use, weight loss, or depression) and not on processes.

In Belgium, the improvement of policies and practices in residential care facilities (RCF) depends on the regional authorities and local initiatives. In Flanders, quality standards are mandatorily defined in a quality handbook. Self-evaluations are also included in an annual quality plan. The standards concern at least falls prevention, restraints use and complaint procedure. Recently, a new interest emerged about subjective indicators like older people satisfaction monitoring and global well-being. The Walloon Code on health and assistance insists on the well-being but keeps free the ratification of the Walloon quality charter. At the time of data collection for this report, none RCF has yet adopted the Walloon quality charter, and only restraint use and fall events must be recorded. In Brussels Region, the COCOM legally imposes to improve the visibility of the regional EA helpline “Ecoute Senior”. Information about it must be present in residential care establishments and on their website.

Quality controls of RCF in Flanders are made by the ‘Zorginspectie’ with a high transparency policy about the results of the inspections. In Wallonia, RCF quality controls are performed by the Audit and Control department of the AViQ and lead to conciliation or sanctions. Results remain confidential. In France, one of the priorities on the improvement of RCF quality is to strengthen the controls through a specific strategy by verifying hosting and care conditions and identifying abuse and risk factors in the aim to suggest solutions and then to sanction the persistent default. In the Netherlands, the efforts of the authorities are more focussed on RCF managers to fulfil the quality requirements. For example, tools are available to managers to support them in the selection of the staff members. Any incident in Dutch RCF has to be reported to the RCF management or to the Dutch Health Care Inspectorate. In Québec, the new Québec Act to combat abuse obliges RCF to adopt and implement policy to combat abuse and to diffuse it (poster, website). Moreover, any abuse in RCF must be reported by professionals from the health and social sectors. Every RCF must also implement a procedure to intervene in case of abuse. In France, the focus is placed on the well-being. Any organisational concern that could potentially impact the well-being of residents must be reported to the administrative authority. The actual French action plan is oriented on the implementation of well-treatment RCF policy and on the development of a new culture of risk analysis and management.[110] France and the Netherlands opt to go out the taboo sphere while Québec choose a more legal approach in the RCF completed by a training approach through the adaptation of training tools to the practice in RCF, the release of the staff for training purpose and a ‘train the trainer’ approach to spread the knowledge to peers.

In Belgium, researchers have participated to three European projects (EuSTACEA, WeDO and WeDO[2]) focussing on quality of care and including

[a] http://legisquebec.gouv.qc.ca/fr/showdoc/cs/L-6.3

the development of a train-the-trainer toolkit adapted to all types of stakeholders allowing to understand and implement the content of the European Quality Framework in their daily practice[a].

The United Nations Department of Economic and Social Affairs recently suggests to develop effective independent monitoring mechanisms of situations of care and support provision.[84] Belgium seems to have already open the way of this suggestion. In Brussels Region, Infor-Home is a very active organisation which advices older people and their relatives about residential care facilities. It also offers a senior mediation service and collect updated data about RCFs' quality and characteristics. Home-Info is its Dutch-speaking counterpart. In Wallonia, the organisation Senoah plays the role of Infor-Home while, in Flanders, it is the 'Woonzorglijn'. All those organisations mix role of advises and complaint handling.

7.3 EA prevention: training professionals

According to the OECD report[85], national-level campaigns, including training for professionals and older people on responding to elder abuse have been broadly successful in Ireland, Canada, Israel, and the United States. In Belgium very few resources are deployed to **raise awareness and train professionals** and future professionals in the prevention, detection and care of elder abuse. In comparison, the Netherlands and Quebec have developed numerous training and awareness-raising tools for workers and volunteers in all the concerned sectors (police, justice, health, social assistance, finance, education and housing). In Belgium, sensitisation and professional training is only done by the four organisations specialised in elder abuse management, except for the GPs who benefit from training module and guidelines developed by their professional organisations (Domus Medica and Société Scientifique de Médecine Générale). But those training sessions seem to reach an interested public that is already aware of the problem. In France, the situation seems somewhat similar to Belgium in the light of the latest CNBD[b] report calling on the French government to develop practical training for care and assistance professionals. In contrary, the existence of a university chair in Quebec dedicated to elder abuse apparently gives them a head start on the development and deployment of training tools. Indeed, while others focus on health and assistance personnel, Quebec is now targeting other sectors or specific issues such as the abuse of LGBT seniors. On a larger scale, the WHO-2014-World report on violence prevention[79] highlights that only a quarter of countries (26%) reported having implemented campaigns aimed at educating professionals to recognize the signs and symptoms of elder abuse and improve their problem-solving and case management skills. This shortcoming was however recently highlighted by the UN and the Committee of Ministers of the Council of Europe.[84, 88]

7.4 EA prevention: sensitisation campaigns for a broad public

Amongst the countries which participate to the world survey on violence prevention organised in 2014 by the WHO[79], only 23% of the countries report having implemented public information campaigns although an International Day on awareness about elder abuse is established since 2011 by the United Nations. In Belgium, only specialised organisations in elder abuse management lead **sensitisation campaigns and events**. Abroad, the Canadian province of Québec has develop plenty of public EA sensitisation actions, multiplying means, targets and subjects since years. In the Netherlands, although the EA topic is included in the intra-familial violence topic, a large sensitisation campaign on EA was led in 2019 with video spot on TV and several other means. In France, few public campaigns have occurred triggered by seniors' association calls. Interestingly, EA specialists in Québec have analysed the best way to sensitise through meeting and tools.[12] Internationally, the UN highlights the need to educate the public in using media and other awareness-raising campaigns since 2002.[75,84]

[a] http://www.belgianageingstudies.be/index.php?p=8

[b] CNCPH= comité national pour la bientraitance et les droits des personnes âgées et des personnes handicapées

Success of national-sensitization campaigns is mentioned in the OECD report[85] for Ireland, Canada, Israel, and the United States.

7.5 EA prevention: support to informal caregivers

The Madrid International Plan of Action on Ageing insists to support caregivers as early as 2002[75]. And the European Parliament did the same in 2010, recommending that member states take concrete measures to support and safeguard informal caregivers via training, respite and measures to reconcile work and family life and to reduce their burden. In the WHO-2014-World report on violence prevention[79], nearly 40% of countries reported implementing caregiver support programmes to prevent abuse of older adults like programmes helping informal caregivers to deal with the emotional demands and stresses involved in providing care to an older person. In Belgium, an important step is the recognition of the status of informal caregiver since 2014. Thanks to this status, Belgian unemployment benefits are maintained with unavailability on the labour market and a royal decree is pending to concretise a specific right of leave. Till then, certain rights to stop work for caring a sick person are already possible. Respite care is organised by sickness funds and independent organisations as "aidants proches".

In Flanders, the Flemish government subsidises them in the form of 'oppashulp' and 'gastopvang'. The growing interest in Flanders in the situation of informal caregivers is reflected in the existence of a Flemish centre of expertise and an action plan 2016-2020 specifically dedicated to this issue. In addition, recent Flemish decrees strengthen the financial assistance granted to dependent elderly persons and their caregivers. In Wallonia and the Brussels region, the allowance for the elderly is still managed by the federal government. The orientation taken by the AViQ in Wallonia concerns more the training of healthcare professionals on the needs of and care for informal caregivers.

In France, the focus is also on the care and follow-up of informal caregivers, while in the Netherlands, the government's energy is more focused on getting 'derailed care' out of the taboo sphere. To this end, a number of tools are available, such as the 'Mantelscan' or the self-assessment 3-minute-check for caregivers. In Quebec, an action plan is being developed by the government to consolidate the recognition of informal caregivers, promote their role and take care of them before they decompensate. Organizations like 'l'Appui' and the 'RANQ' are participating in it through practical assistance for one and political support for the other. A recent report by the CNDB in France emphasizes the need to centralize support organized around informal caregivers.

7.6 EA prevention: fighting ageism and empowering elders

When the UN, the WHO, the EU and the Council of Europe highlight the need to reduce inequalities related to age and the need to change the image of ageing, Belgian authorities sign all articles of the revised European social Charter except the one concerning older persons. In the same time in Belgium, numerous independent organisations highlights the need **to fight ageism**[a] as ENEO and OKRA and Age platform organises sensitisation campaigns about the respect of the Human Rights of older people and diffuses the messages of the European Charter on the rights and responsibilities of older people. This Charter results from a joint action from different European countries and aims to enable everyone to facilitate older people's access to their fundamental rights, to raise awareness among a wider public and to stress the rights of the people receiving long-term care. Identically in Québec, the first pages of the reference guide to combat EA are focussed on active ageing and combating ageism. In France, the CNBD, the CCNE and the HAS as well as the websites Alma, Age village and France-victims confirm the importance to fight ageism. And also in Belgium, Flemish, Walloon and Brussels initiatives exist in this aim through different ways like intergenerational projects or age-friendly city involvement. In France, the law on the adaptation of the French society to ageing aims

[a] Ageism = negative attitude and stereotype about ageing

notably to fight ageism and the CCNE insists on the need to not concentrate older people in RCF and favour their inclusion in the society. In the Netherlands, the inclusion of the elderly in the society is strongly supported.

The will **to empower older persons** is present in all studied countries/regions but seems less prominent in the Netherlands. In Québec, advices are given to older person in a way which keeps them in the position of the decider, e.g. about the creation of a Mandate of Protection, the preparation of a will or talking about elder abuse.[105] In France, institutions like CNDB, HAS and FORAP go a step further in advising to change the whole care approach to a shared decision making process between the caregiver and the care receiver what represents a shift in the care relationship between the old person and his/her caregiver. In France again, the advice is given to the authorities to strengthen the consent of older person when they enter a RCF. In Belgium, Elderly Council in municipalities and at regional level, and residents 'council (code wallon art 341) in residential care facilities open the ways to more empowerment and inclusion in decisional process of the elder population. FOthers examples are the financial support given by the King Baudouin Foundation on projects of co-management of RCF with the residents and the service of a coach offered by the AVIQ to help in the realisation of those co-management projects. Other ways to empower older people range from the possibility to establish extra-judicial mandates to the existence of documents and campaigns specifically addressed to the elderly in the aim to give them the leading role in case of EA by detecting and reporting it themselves.

CHAPTER 4: INTERNATIONAL OVERVIEW OF STEP-BY-STEP PLANS IN CASE OF SUSPICION OF ELDER ABUSE

1 INTRODUCTION

This chapter concerns the second part of the RQ3: “What we can learn from a selection of other countries with regard to the existence of step-by-step plans to detect and/or report Elder Abuse?”. This part participates to the fulfilment of the third objective of the study i.e. to propose a framework to Belgian stakeholder allowing them to tackle elder abuse and including the steps about detection and reporting by professionals.

2 METHOD

Official sources of government and specialized organisations (grey literature) were searched about step-by-step plans in case of suspicion of elder abuse in Canada, the Netherlands, USA, UK, Australia and France.

The choice of the countries arises from the proximity of and language similarity with Belgium (France and the Netherlands) and from a leader position in health services organisation and language accessibility (Canada, Australia, UK and USA).

Search terms were “decision tree/algorithm/step plan + elder abuse’ followed by the country’s name (Australia, Canada, France, Netherlands, UK, USA).

As we focus precisely on how each step-by-step plan is built to support the realisation of a step-by-step plan for Belgium, a copy-paste with reference of figure and/or text related to the step plans was made on purpose. Those are available in the appendix 18 to 54 of this report.

When a first quick search made on the terms “decision tree/algorithm/step plan + elder abuse” followed by the country’s name did not identified any hit, other search terms were used. It was the case for France and the Netherlands. For the Netherlands, the search term “Meldcode” was used. For France, search terms were: “algorithme”, “arbre décisionnel” and “plan” and also “personne vulnerable” instead of “personne âgée”.

A systematic analysis was made on the basis of questions concerning specific topics which could help to build a Belgian framework. These questions are:

- Is the step-by-step plan elaborated by the government or by an association (of professionals/other)? Is it developed at the local or national level?
- Is the use/elaboration of the step-by-step plan and its implementation (financially) supported by a government?
- Is there any evaluation of the impact of the use of a step-by-step plan on elder abuse handling?

- Has the country/region a centralised entrance point, specific for elder abuse and how is it organised?
- Does the step-by-step plan take into account the decision- making capacity of the older person?
- Does the step-by-step plan take into account the consent of the older person?
- Is it a collaboration between health care and justice sectors within the step-by-step plan?
- Is the step-by-step plan general (for all types of violence) or specific to elder abuse?
- Does the step-by-step plan include a discussion with the author in case of derailed care?
- Does the framework include a mandatory reporting and/or an obligation to have a plan?

3 CONTEXT OF STEP-BY-STEP PLANS IN CASE OF ELDER ABUSE SUSPICION IN FOREIGN COUNTRIES

3.1 Australia

In February 2016, a research report[116] providing an overview of elder abuse policies and guidelines[a] in Australia about understanding issues, frameworks and responses was published (see Figure 41 in Appendix 19). This report revealed that, in Australia, responses to elder abuse were complicated because of multiple layers of legislative and policy frameworks across health, ageing and law at Commonwealth, Australia and states/territories level. For example, a law[b] makes it mandatory that elder abuses occurring within 'Commonwealth Government-funded aged care facilities' have to be appropriately addressed to the Aged Care Complaints Service (Australian Government Department of Health) while there is no unique law concerning powers of attorney and guardianship. Each state and territory has its own laws and follows his own policies and guidelines to handle elder abuse.

In Australia, policy frameworks and practice guidelines vary in scope and details between states and territories but similar limitations have been identified:

- The difficulty to reach vulnerable victims of elder abuse
- The lack of emphasis on service improvement, on development of expertise, and on facilitating collaborative practices

[a] It is important to notice that, in Australia, the term "elder abuse" is less used than the term "abuse of older Australians". Indeed, in Aboriginal or Torres Strait Islander culture, the term elder does not necessarily refer to a person of advanced age but to "community representatives with responsibilities".

[b] Section 63-1AA and 96-8 of the Aged Care Act 1997 (Commonwealth)"

- The lack of clarity around the relevant primary point of contact in cases of elder abuse

In the 2016 report[116], calls for a national policy of elder abuse are highlighted even if experts in the field recognize that existing knowledge about elder abuse and measures to prevent, identify and manage it, are limited. In 2017, a report from the Australian Law Reform Commission[a] recommends that the Australian government and all the eight states and territories' governments work together to develop a national plan against elder abuse. On the 19th March 2019, the Attorney-General of Australia launches the national plan entitled: "**National Plan** to respond to the Abuse of Older Australians (Elder Abuse) 2019-2023"[117]. The aim was to provide a national strategic framework for the next 4 years to address the abuse of older Australians without removing existing mechanisms. This National Plan was developed in collaboration with states and territories' governments and provides an overview of the issues on which all regional governments need to act as a priority. The presented plan is punctuated by concrete cases of different forms of abuse. Five priority areas are established to achieve the objective of reducing the prevalence of maltreatment. Each of these priorities can be achieved through several initiatives and within a certain time frame (see Figure 42 in Appendix 20). In this National Plan, no national step-by-step plan has been found. Nevertheless, several local step plans exist in every state/territory (except for the Northern Territory). Each of these step-by-step plans are different.

Australian Capital Territory (ACT)

The ACT Elder Abuse Prevention Program was created in order to reduce and prevent elder abuse through actions like (i) community awareness raising, (ii) accessible information and referral systems, (iii) **service response guidelines,** and (iv) staff training. This program is coordinated by the Office for Ageing within the Community Services Directorate and two others agencies, the Elder Abuse Prevention Network and the ACT Ministerial Advisory Council on Ageing. More details about roles and responsibilities of each agencies are available in the report "Elder Abuse Prevention Program Policy"[118]. This report includes a step plan (see Figure 43 in Appendix 21) developed for ACT Government agencies and funded community partners, to respond to abuse of older people.

New South Wales (NSW)

The NSW Ageing Strategy 2016-2020[119] has set out the policy and the framework to prevent and respond to abuse of older people in the NSW. According to the policy, "there are essentially five stages to identifying and responding to abuse. In all cases, individuals should follow their agency's policies and procedures." The NSW Government funds an Elderly Resource and Helpline Unit (EAHRU) which acts as a central point for information, advice, guidance and data collection. This unit provides services, information and advice to older people and carers, friends, family, support workers and service providers. It may also refer individuals to support's agencies or service's providers. In 2016, EAHRU had developed a step-by-step plan to identify and respond to abuse of older people in 5 steps (see Figure 44 in Appendix 22). This tool was created to help agencies "that have staff, including volunteers, in positions where the abuse of an older person may be suspected, witnessed, or disclosed" in line with the NSW Interagency Policy. It is not a mandatory report but in some cases, agencies are required to report abuse to the NSW Police.

[a] https://www.alrc.gov.au/publication/elder-abuse-a-national-legal-response-alrc-report-131/3-a-national-plan-to-combat-elder-abuse/a-national-plan-to-combat-elder-abuse/

Queensland

In the Queensland Government website[a], a page is dedicated to health professionals to help them to assess and respond to abuse. Six steps are defined but without a graphic support (see Appendix 1 for details). Those steps are:

- Identify the abuse
- Provide emotional support
- Assess risk
- Safety planning
- Document
- Refer

Information about the mandatory nature of the reporting cannot be found on the website.
For other people (non-health professionals) who experienced or who knows someone who experienced abuse, the Government gave information's on how to get help (see Appendix 24).

Victoria

The Victorian Government has developed the Elder Abuse Prevention Strategy (EAPS) in order to protect and safeguard the rights of older Victorians. Victorian health and community services had developed a framework for agencies. The content of this framework has to be incorporated into the local elder abuse policy and procedure of each agency (for an example, see Figure 45 in Appendix 25). If several agencies are involved, interagency protocols are used (see Figure 46 in Appendix 26).

Western Australia

The Western Government has a protocol to help responding to elder abuse (see Figure 47 in Appendix 27). This protocol is a five-step approach. It notably cites the 1997 Act on the duty to report physical and sexual abuse of older persons in residential care facilities[b]. Such reporting can be made to the police for a suspicion or to the Ministry of Health for a presumption and within 24 hours by telephone or by downloading a report form.

South Australia

The Office of Ageing of South Australia has developed a fact sheet[c] (see Figure 48 in Appendix 28) to help workers to respond to elder abuse. Workers and professional can choose the action best suited to his or her role, responsibilities and organisation.

Tasmanie

In a document from the Department of Health and Human Services of the Tasmanian government[120], guidelines to respond to elder abuse are given to government and non-government employees. This guide is an adaptation of the work from the State of Victoria on elder abuse. It is not a mandatory procedure but an information's guide: at the beginning of the document, it is mentioned: « *This guide is provided on the basis that all persons undertake responsibility for assessing the relevance of the guide and its suitability for their own needs*. ». As in other Australian states, an inter-agency response framework, adapted from the New Wales one, is proposed to professionals working with elder people (see Figure 49 in Appendix 29). Another protocol from the Tasmania guideline suggests that professionals should adapt their behaviour according to the patient's state of health (*capacity or lack of capacity*) and according to the patient's consent (*consent or no consent*) (see Figure 50 in Appendix 30).

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a https://www.qld.gov.au/seniors/safety-protection/discrimination-abuse/elder-abuse/info-health-professionals

b https://www.legislation.gov.au/Details/C2017C00241

c https://www.sahealth.sa.gov.au/wps/wcm/connect/4e48e3004a1e18088993e990d529bdaa/Workers+-+Response+to+concerns.pdf?MOD=AJPERES&CACHEID=ROOTWORKSPACE-4e48e3004a1e18088993e990d529bdaa-mN5HcN1

KEY POINTS

All Australian states/territories (except Northern Australia) have developed protocols for responding to suspected elder abuse; some under the form of step-by-step plans, others under the form of decision trees, fact sheets or frameworks.

Most of these protocols have been agreed to through inter-agency cooperation.

None of these protocols are mandatory (no obligation to have/use a protocol or to report an abuse), except for institutionalized older people, for which there is a legal obligation to report in specific circumstances or places (in Commonwealth government funded aged care facilities and in Western Australia under the 1997 Act[a].) which ask to report physical and sexual abuse of older persons in residential care facilities.

In several states, protocols integrate the dimensions of incapacity and consent of the elderly so that professionals can adapt their decision to the senior's situation.

Usually in Australian states or territories, step plans are addressed to professionals of agencies and mainly concern the first stage of response to a (suspicion of) elder abuse (= early management). The protocols collected in this section about Australia are mainly made of 4 to 6 steps and always target specifically older Australians. First steps are nearly always about identification of suspected, disclosed or witnessed abuse. The second and third steps share between each other the safety assessment step (and the contact of the emergency service) and the step of emotional support (and discussion with the older person). In the third step, time to evaluate the decision capacity of the senior or to talk with supervisor/peers can also be taken. The fourth steps are more about safety planning, the fifth steps is usually about reporting and recording, and the sixth steps about referral and follow-up.

Globally, step plans in Australia gives a large place to safety assessment, to discussions with the older persons and the management, and to older people consent. Some plans are clearly oriented to ensure the legal adequacy of the professionals' decisions while others are more practical even though none are precise and comprehensive enough to totally guide professionals through detailed concrete actions and ethic reflexions, except maybe in the South Australia fact sheet.

[a] https://www.legislation.gov.au/Details/C2017C00241

3.2 Canada

The Canadian Charter of Rights and Freedoms (the Charter) provides that everyone has the right to life, liberty and security of the person. This includes the right to choose where one lives, to make basic personal decisions and to be free from physical restraint. In the Canadian Criminal Code, there is no single crime called elder abuse. However, many types of elder abuse are crimes[a]. The law on the protection of older people in Canada stipulates that vulnerability due to age is considered as an aggravating factor in sentencing[b].

In Canada, a document published by the Canadian Centre for Elder Law's and entitled "A Practical Guide to Elder Abuse and Neglect Law in Canada"[121] groups the laws of the 13 territories or provinces about elder abuse. This document also includes general principles to help professionals and volunteers understand and effectively respond to the rights of older adults who are abused, neglected or at risk. The Box 11 lists those principles.[121]

Box 11 – Principles to help professionals and volunteers to respectfully care older adults who are abused, neglected or at risk

1. Talk to the older adult

Ask questions. Talk to the older person about his or her experience. Help the person to identify resources that could be helpful.

2. Respect personal values

Respect the personal values, priorities, goals and lifestyle choices of an older adult. Identify support networks and solutions that suit the older adult's individuality.

3. Recognize the right to make decisions

Mentally capable older adults have the right to make decisions, including choices others might consider risky or unwise.

4. Seek consent or permission

In most situations, you should get consent from an older adult before taking action.

5. Respect confidentiality and privacy rights

Get consent before sharing another person's private information, including confidential personal or health information.

6. Avoid ageism

Prevent ageist assumptions or discriminatory thinking based on age from affecting your judgment. Avoid stereotypes about older people and show respect for the inherent dignity of all human beings, regardless of age.

7. Recognize the value of independence and autonomy

Where this is consistent with the adult's wishes, assist the adult to identify the least intrusive way to access support or assistance.

8. Know that abuse and neglect can happen anywhere and by anyone

Abuse and neglect of older adults can occur in a variety of circumstances from home care to family violence.

9. Respect rights

An appropriate response to abuse, neglect, or risk of abuse or neglect should respect the legal rights of the older adult, while addressing the need for support, assistance, or protection in practical ways.

a https://www.cliquezjustice.ca/vos-droits/mauvais-traitements-a-l-egard-des-personnes-agees

b https://laws-lois.justice.gc.ca/fra/loisAnnuelles/2012_29/page-1.html

10. Get informed

Ignorance of the law is not an excuse for inaction when someone's safety is at stake .If you work with older adults you need to educate yourself about elder abuse.

A guide intended for older people susceptible to be abused by a trusted person (or for anyone knowing this kind of situation) was also published in 2011 by the department of Justice of Canada[105]. In this guide, advices are given for each type of abuse in a way which empowers the older person. (see Appendix 1 for details)

In Canada, a federal program called "New Horizons for Older Adults" has strongly supported provincial/territorial anti-abuse initiatives in the past. Currently, a non-profit, charitable organization (the Canadian Network for the Prevention of Elder Abuse - CNPEA) strives to be the Canadian leader in the field of elder abuse prevention by sharing information, coordinating resources, and connecting professionals involved in the prevention and management of abuse at the local, regional and national levels.[a]

In all Canadian provinces/territories, legislation makes reporting elder abuse mandatory when a person is in a residential care facility. However, there is no obligation for facilities to follow an intervention procedure. In the balance between respect for self-determination and protection, the emphasis is always first and foremost on the former, that is to say, respect for the autonomy of the elderly person (marie Beaulieu, personal communication).

No generic step plan was found on federal Canada website[b].

3.2.1 Quebec

In Quebec, the Act already described in chapter 3 aims to fight abuse against elders or any adult in situation of vulnerability [c] (see summary in Figure 39 in Appendix 14 and details on the content of the law in Appendix 32). In this law, the mandatory or voluntary aspect of elder abuse reporting depends on the situation. Reporting is mandatory when it concerns users of residential and long-term care centres and protected unfit persons, regardless of their place of residence. Mandatory reporting must be made to the CLPQS (local commissioner for complaints on services' quality) of an institution if the abused person is receiving services there or, in other cases, to the police force. The Act encourages voluntary reporting of abuse at all times. The report may be made, among other things, to the police; to the integrated health and social services centre in their region; to the local 'Centre intégré universitaire de santé et de services sociaux'; to the CLPQS of an institution if the victim of abuse is receiving services there[d]." The professional secrecy is also addressed by the ability to waive confidentiality or professional secrecy where there is a serious risk of death or serious injury. The second governmental action plan of Québec (2017-2022) follows 4 general orientations whose orientation 2 states to encourage early identification and appropriate intervention.[101]

In Québec, an extensive, comprehensive and multidisciplinary reference guide[12] (see also chapter 3) gives the full procedure in case of elder abuse including recognition, prevention, detection, intervention, coordination, legislation and solutions. Two step-by-step plans were proposed in this guide. The first one is addressed to any person which question himself about the need to intervene where a concern about an elder abuse occurs. It is a mix between a step plan and a decision tree (see Figure 51). The second

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a https://cnpea.ca/en/about-cnpea/who-we-are

b https://www.canada.ca/en/employment-social-development/campaigns/elder-abuse.html

https://www.bcli.org/project/practical-guide-elder-abuse-and-neglect-law-canada

https://www.canada.ca/en/employment-social-development/corporate/seniors/forum.html

c http://legisquebec.gouv.qc.ca/fr/showdoc/cs/L-6.3

d https://www.quebec.ca/famille-et-soutien-aux-personnes/aide-et-soutien/maltraitance-aines/loi/

one is addressed to police agent confronted to a clear situation of elder abuse and is composed of a double decision tree (see Figure 52 in Appendix 34).

In Québec, in case of abuse, the abused person or someone knowing this kind of situation can contact the 'commission des droits de la personne et des droits de la jeunesse'. This organization ensures that the protections guaranteed by the Quebec Charter of Human Rights and Freedoms are respected. The Commission's services are free of charge. The Commission has a special team that deals with situations of elder abuse. The consent of the victim is not required to report the situation to the Commission[a].

In the aim to help the ethical discussion around elder abuse situations, the tool 'En Mains' was developed. This tool is mainly intended to professionals involved in the psycho-social management of the abused senior (see Figure 53 in Appendix 1). This decision tree was adapted by Respect Senior to the Wallonia situation.

3.2.2 British Columbia (BC)

In BC, the Government asks for the creation of the BC Council to Reduce Elder Abuse (CREA) which is made up of representatives from 15 agencies that deal with EA. Their website, "Reduce elder abuse BC"[b], proposes an easy-to-use decision tree (see Figure 54 in Appendix 36) with videos and explanations. The Council insists on the fact that any service or professional should be ready with step plans and documents before an EA case occurs. Five videos illustrate the decision tree[c].

Organisations like 'Seniorsfirst' which hosts the EA helpline, proposes a procedure addressed to the elderly. The one entitled 'Understanding and responding to elder abuse'[122] does not include a step plan even if it includes all information needed by an older person to report an abuse. Other procedures having the form of a step plan/decision tree are addressed to service providers assisting older adults (see an example in Figure 55 in Appendix 37).

3.2.3 Ontario

'Elder Abuse Ontario[d]' has developed plenty of tools regarding each type of abuse and adapted to different kinds of elder at risk of being abused. Forty-two tools are available about intervention and response in case of suspected EA. In Ontario, the law says that the abuse of an older adult living in a long-term care home or retirement home must be reported immediately by anyone who has reasonable grounds to suspect that a resident has been harmed or will be harmed (Retirement Home Act s.75. (1) and Long-Term Care Homes Act, 2007 s.24(1)). Videos and discussion guide are available to help ethical discussion related to reporting suspected abuse and neglect in long-term care structure[123]. Examples of step plans grouped in a training tool[e] of the 'Elder Abuse Ontario' specialised organisation are given: the first step plan is general (see Figure 56 in Appendix 38), the second one concerns emotional abuse (see Figure 57 in Appendix 39) and the third one physical abuse (see Figure 58 in Appendix 40).

3.2.4 Alberta

No specific step plan was identified but several fact sheets are available on the Alberta government website[f].

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a https://www.educaloi.qc.ca/capsules/les-aines-et-la-protection-contre-lexploitation-et-les-abus

b http://reduceelderabusebc.ca/report-elder-abuse/

c http://seniorsfirstbc.ca/for-professionals/responding-elder-abuse-neglect/

d http://www.eapon.ca/

e https://socialhealthpracticeottawa.files.wordpress.com/2018/12/EATraining_SWAG_Nov222018-1.pdf

f https://www.alberta.ca/get-help-elder-abuse.aspx

3.2.5 Manitoba

In Manitoba, two organisations are in charge of elder abuse: PEAM (Prevent Elder Abuse Manitoba) and A&O support services with Older Adults. Only a step plan is given on a regional website[a], the Winnipeg regional health authority (see Figure 59 in Appendix 41). An advice is given with the step plan: "it is important to be familiar with your program/organization's policy and procedures regarding elder abuse. In addition, if you are concerned that the older adult is being mistreated by a co-worker/staff person, please contact the appropriate RHA (retirement home (regulatory) authority) program. The Seniors Abuse Support Line is available for further information about resources and supports at 1-888-896-7183."

3.2.6 Saskatchewan

No step plan or decisional tree was identified on any of the websites related to elder abuse in Saskatchewan[b] which rather offer a list of help and support services and prevention advices.

3.2.7 Newfoundland and Labrador (NL)

NL defines a provincial strategic plan to address elder abuse in 2010. Then, the Newfoundland and Labrador Network for the Prevention of Elder Abuse (NLNPEA) was created to raise public awareness, serve as resource for information, promote the implementation of recommendations, liaise regional, provincial and national organisations, identify gaps and act in advisory capacity[c]. On the website of the NLNPEA[d] , a full guide is available named 'Looking Beyond the hurt: a service providers guide to elder abuse'.

In the chapter 6 of this guide, decision trees are proposed related to the different types of abuse: physical, psychological, financial and neglect (see Figure 60, Figure 61, Figure 62 and Figure 63 in Appendix 42)

3.2.8 Nova Scotia:

Toolkit, fact sheets and slides show are available on the website of the department of seniors of the Government of Nova Scotia[e] but no step plan/decision tree was identified.

3.2.9 Prince Edward Island

A guide addressing issues specific to seniors gives some contact info in case of elder abuse but does not include any step plan[124].

3.2.10 New Brunswick

A guide on preventing abuse and neglect of Seniors is available in New Brunswick[125] but it does not include a step-by-step plan. However a clear list of concrete actions to do is given to the senior himself and another one addressed to any concerned friend or neighbour (see Figure 64 and Figure 65 in Appendix 43). Reporting of an abuse is not mandatory by the law but it is said that anyone can help.[125] The Department of Social Development is a centralised contact point.

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a https://wrha.mb.ca/support-services-to-seniors/community-resources/abuse-towards-older-adults/

b https://skseniorsmechanism.ca/resources-programs/seniors-neglect-abuse-response-line/

https://skseniorsmechanism.ca/publications/elder-abuse/

https://sk.211.ca/

https://cnpea.ca/en/what-is-elder-abuse/get-help/saskatchewan

c http://www.nlnpea.ca/Who_We_Are#introduction

d http://www.nlnpea.ca/LBH

e https://novascotia.ca/seniors/stopabuse/pockettools.asp

3.2.11 Yukon

On the Yukon government website[a], information sheets are collected. Tips for helping the abused older person and to build a safety planning[bcd] are given (see details in Figure 66 and Figure 67 in Appendix 44).

3.2.12 Nunavut

On the website of the Nunavut government[e], no step plan was found in the section about family violence in the department of family services nor about financial abuse in the department of justice.

3.2.13 Northwest Territories

The help and social services of the Northwest Territories website[f] proposed a list of contact data for getting help in case of elder abuse. An explanation on how to identify Elder Abuse presented on the NWT network website is inspired of the following link: https://www.wikihow.com/Identify-Elder-Abuse. A list of principles but no step plan is also given on the same website[g].

Key messages about step plans in Canada

Mainly all provinces or territories in Canada have plans about EA but only some proposes a step-by-step plan. Most of the time, this step-by-step plan is merged with a decision tree resulting in a mix (between step-by-step and decision trees).

Although main step plans are addressed to health and assistance professionals, federal and provincial authorities also proposes guides or decision trees to older people, entourage or policemen.

In Québec and Ontario, a law makes reporting of EA mandatory in certain circumstances: the hosting of the abused older person in a long-term residential care settings for both provinces and, in Québec only, the older person incapacity (to decide).

Except in British Columbia, the step plans are specifically targeting older people.

The step plans available in Québec, BC, Ontario, Manitoba and NL are highly practical and precise. Their number of steps varies from 4 to 6. The first or second step is usually on danger assessment. The next step is more about the mental capacity of the senior. After, the step is quite different from one plan to another like the financial aspect of the abuse, the timing to intervene, or the acceptability of an intervention by the older person. Last steps are more about support to the older person, intervention and follow up.

Globally, Canadians empower the older person and favour precise step plans.

a http://www.hss.gov.yk.ca/seniorabuse.php

b http://www.hss.gov.yk.ca/pdf/2_Responding_to_abuse_neglect_and_self_neglect_of_older_adults.pdf

c http://www.hss.gov.yk.ca/pdf/3_Safety_planning_and_the_older_adult.pdf

d http://www.hss.gov.yk.ca/pdf/elderabuseb.pdf

e https://www.gov.nu.ca/family-services/information/family-violence

https://www.gov.nu.ca/finance/news/protecting-elders-against-financial-abuse

f https://www.hss.gov.nt.ca/en/services/protecting-elders-abuse-and-neglect/getting-help-elder-abuse

g http://www.nwtnetwork.com/?page_id=822

3.3 France

In France, the programme '157' aims, amongst others, to protect the vulnerable persons because of their age or disability, by making it easier to report the facts of abuse[126]. This program funds the single national elder abuse helpline 3977. A national platform is relayed by local networks made up of branches responsible for analysing alerts and following up situations in relation, where appropriate, with the local administrative authorities (state services and the departmental council) or even judicial authorities.

No step plan was identified by a quick search in grey (Google the 08/11/2019 and the 30/01/2020) or recent scientific (Google Scholar 2015-2020) literature concerning elder abuse management in France. However, EA response tools in the form of written procedures are available on the website of the French ministry of solidarity and health, on the website "Pour les personnes âgées" which is related to the French ministry of solidarity and health and on the website of the specialised organisation against elder abuse "3977".

On the website of the French ministry of solidarity and health[a], two links are given: one to a guide about the management of the risks of elder abuse at home[127] and another one about the management of the risks of elder abuse in residential institutions[128]. The first guide includes two feedback documents to collect information about EA concerns, which should be filled by professionals on the one hand, and by relatives on the other hand. Those documents are not step plans but includes a large range of possible situations of elder abuse under the form of check list.

On the website "Pour les personnes âgées »; a full page described literally (and not by a diagram) what to do in case of elder abuse. The last update was made in March 2017. The text of the web page[b] is given in the Appendix 1.

The third website which offers a procedure about elder abuse is the one of the specialised organisation 3977[c]. Again, the procedure is not like a full diagram but like a three steps written procedure guiding victims and witnesses. The first step concerns the identification of an elder abuse and is accompanied by an online test. The second step describes the actions to do. It includes general principles about EA management, legal advices on professional secret and the law of non-assistance to person in danger, and specific tips related to the witness profile (informal caregiver, professionals or citizen). The third step is about the follow up by the specialised organisation as shown by the Figure 69 in the Appendix 46.

Key messages about step plans in France

No early stage step plan is available in French grey literature. However, official websites (French government, specialized organisation 3977) give a list of action to do in case of suspicion of elder abuse.

a https://solidarites-sante.gouv.fr/affaires-sociales/personnes-agees/maltraitance-des-personnes-vulnerables/article/orientations-prioritaires-de-la-politique-nationale

b https://www.pour-les-personnes-agees.gouv.fr/exercer-ses-droits/en-cas-de-maltraitance

c https://3977.fr/le-3977-en-quelques-mots/

3.4 The Netherlands

In the Netherlands the use of a step plan to detect and report domestic violence is obligatory for professionals and institutions in several sectors.

Indeed, since 2002, domestic violence is high on the political agenda of the Dutch national government. The reports 'Privé geweld, publieke zaak'[129] and 'de volgende fase[a]' resulted, inter alia, in the enactment of the law 'Obligatory Meldcode domestic violence and child abuse'[b]. Between 2011 and 2018, a national action plan 'ouderen in veilige handen'[94] specifically focussed on the prevention and management of elder abuse. This plan includes the duty to report abuse committed by professionals, the mandatory reporting protocol for domestic abuse, and a guideline on elder abuse. More details about the main actions defined by this plan are available in Appendix 1. Since 2018, however, the management of elder abuse is integrated in the action programme 'Geweld hoort nergens thuis'[95] (2018-2021) which is not specific for elder abuse but includes all types of domestic violence.

Meldcode domestic violence and child abuse

In 2013 the law related to the compulsory 'Meldcode huiselijk geweld en kindermishandeling' (named Melcode in the text) was enforced[c]. According to this legislation, organisations in the sectors of health care, education, early childhood, social support, youth care and justice are obliged to have a Meldcode. The overall aim of the Meldcode is that professionals are able to early detect and act appropriately in case of a suspicion of abuse. Research learned that professionals disposing of such a Meldcode intervene more often than those without a Meldcode[130]. The Meldcode does not impose to report. Professionals are obliged to act according to the 5 steps foreseen in the Meldcode and have the right to report to 'Veilig Thuis' (see box here under) in certain circumstances (even if the persons involved do not agree), but the trajectory of the steps does not necessarily leads to reporting. The right to report to 'Veilig Thuis' also implies that professionals can transfer personal data regarding the persons involved to make it possible for 'Veilig Thuis' to start an investigation related to the family situation. Moreover professionals are allowed to provide additional information on the request of 'Veilig Thuis'.

"Veilig Thuis" is the contact point for advice and reporting of domestic violence and child abuse. These regional organisations help victims, perpetrators, professionals and others persons concerned with help, advice and/or referral. There is a central contact telephone number, free of charge and accessible 24/7. A caller will be asked for the postal code and will then be redirected to the respective local contact point[d].

The National government provides a generic model of the Meldcode. This model has been adapted to the specific sectors. Individual institutions and organisations need to further fine-tune the model to their particular practice: they explicitly need to describe who will take which action in case of a suspicion of abuse. As each Meldcode contains the same basic steps as in the basic model, it enables the collaboration between professionals and organisations.

Employers in concerned sectors are not only requested to adapt the steps of the Meldcode to their particular situation, they are also requested to implement it in their organisation and train their employees to use it. Standard presentation material on the Meldcode (for managers) and other tools enabling the use of the Meldcode are available on a website managed by the federal government[e]. Those tools are (i) assessment frameworks; (ii) information for municipalities and organisations; and (iii) a question & answer document on the (changes in the) 'Meldcode'.

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a https://zoek.officielebekendmakingen.nl/kst-28345-185.html

b https://zoek.officielebekendmakingen.nl/stb-2013-142.html

c https://www.rijksoverheid.nl/onderwerpen/huiselijk-geweld/meldcode

d https://www.ikvermoedhuiselijkgeweld.nl/

e https://www.rijksoverheid.nl/onderwerpen/huiselijk-geweld/documenten/publicaties/2018/07/01/toolkit-meldcode-huiselijk-geweld-en-kindermishandeling

Since the 1st of January 2019, professionals are obliged to also use a decision frame ('afwegingskader') in steps 4 and 5 of the Meldcode (see Figure 70 in Appendix 48) and organisations are obliged to elaborate and implement a decision frame that is adapted to their practice. The frames help professionals to assess whether a situation is so serious that reporting is necessary. The decision frames were elaborated in 2018 by the professional categories for which the Meldcode applies[a].

A new element is that reporting to 'Veilig Thuis' is always necessary if there is suspicion of acute or structural intra-family violence, even if assistance was successfully organised by the professional him/herself. The underlying idea is that 'Veilig Thuis' can monitor the situation and follow-up safety once assistance has stopped. 'Veilig Thuis' also has a national register, which allows to link reports in one region to reports of the same case in another region.

Two adaptations of the Meldcode done by KNMG[b] for general practitioners are given in Figure 71 and Figure 72 in Appendix 49. Even if the persons involved refuse the offered care (see step 4 Stroomdiagram), it is a professional norm for general practitioners to report even in non-acute or structurally unsafe situations if the general practitioner cannot organise him/herself sufficient or effective care.

Specificities for informal caregivers

A specific step plan for situations with a risk for/where elder abuse takes place because of an overburdened caregiver was elaborated by Movisie. It includes the steps to be taken, references to relevant instances and tools[97]. The working group 'Meldcode' also pleads for the inclusion of a 'mantelzorgverleningscheck' (caregiver check) in step 1 of the (generic) step plan. This check includes that professionals confronted to adults in a (medical) condition which may cause harm to potential adults/elderly they care for, need to check whether the adult is an informal caregiver. This can be the case when the informal caregiver has a severe physical or psychological disease (e.g. dementia).

Key points

In the Netherland, professionals and institutions in the sectors of health care, education, early childhood, social support, youth care and justice are obliged to use a step plan (called Meldcode) in case of suspicion of domestic violence or child abuse. Employers need to make sure that the plan is adapted to and implemented in their daily practice.

The government has invested in the drafting of a generic model of the step plan and in tools and material for employers to enable the implementation in their institution.

Moreover the professional associations were involved in the fine-tuning of the step plan according to the specificity of their sector.

To help professionals to make a decision to report, the step plan has been improved with a decision frame (again to be fine-tuned to the specific sector).

The use of the step plan is closely linked to the well-functioning of 'Veilig Thuis', the organisation to which professionals can report or ask for advice.

The generic step plan aims at each step to orientate professionals to 'Veilig Thuis' if a secure and effective help is not ensured.

[a] https://www.augeo.nl/nl-nl/meldcode/afwegingskader

[b] Koninklijke Nederlandsche Maatschappij tot bevordering der Geneeskunst

3.5 UK

In UK, no step plan has been identified. Nevertheless, several institutes/ initiatives exist and the main one (Action on elder abuse), a charity association, seems to be the most important organization specialized in elder abuse.The UK government has a page on his website[a] dedicated to abuse of older person. Examples of abuse and possibilities to report abuse are given:

- If it is an immediate danger, the website advise to call emergency service (999)
- In other cases, contacting the local council[b] is recommended.

The website also advises the public to contact the charity "Action on Elder Abuse" to discuss their concerns and get advice.

The National Health Service (NHS) also provides on his website[c] information on elder abuse. They give advice when somebody thinks to have been abused (all the steps and the contact information). They also give advices for carers (spotting signs of abuse in older people), they promote dialogue with a professional (GP or social worker) and they address to specialized agencies like Age UK or Action on Elder Abuse (except in immediate danger: call 999). See Appendix 1 for details.

Key messages about step plans in UK

No early stage step plan are available in grey literature but official websites (NHS, Charity 'Action on EA', UK government) give a list of action to do in case of suspicion of elder abuse.

3.6 USA

In USA, no national step-by-step plan has been identified although several national department and administration are involved in elder abuse management.

- National Institute on Aging[d]

The National Institute on Aging (NIA) is a federal agency seeking to understand the nature of aging and the ageing process, and diseases and conditions associated with growing older, in order to extend the healthy, active years of life. This agency provides information on elder abuse (definitions, signs, where to find help) and also talks about caregiver stress and the long-term consequences of elder abuse but it's not a specialized agency on elder abuse.

- National Center on Elder Abuse[e]

The National Center on Elder Abuse (NCEA) is a national resource center dedicated to the prevention of elder mistreatment. It is a program of the U.S. Administration on Aging.

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a https://www.gov.uk/report-abuse-of-older-person

b Below the region level and excluding London, England has two different patterns of local government in use. In some areas there is a county council.County councils are very large employers with a great variety of functions including education (schools and youth services), social services, highways, fire and rescue services, libraries, waste disposal, consumer services and town and country planning

c https://www.nhs.uk/conditions/social-care-and-support-guide/help-from-social-services-and-charities/abuse-and-neglect-vulnerable-adults/

d https://www.nia.nih.gov/

e https://ncea.acl.gov/

The NCEA provides elder abuse information to professionals and the public, and also technical assistance and training to states and community-based organizations.
For citizen, information and steps of prevention are given:

- "Report suspected mistreatment to the local APS (Adult Protective Service) agency or to the law enforcement service (except if it is an immediate danger (Call 911)). A specially trained operators will refer you to a local agency that can help (Eldercare Locator)
- Plan ahead to protect against financial exploitation (How to protect yourself or a loved one).
- Be aware of the possibility of abuse. Look around and take note of what may be happening with your older neighbours and acquaintances (Red Flags of Abuse).
- Keep in contact. Talk with your older friends, neighbours, and relatives. Maintaining communication will help decrease isolation, a risk factor for mistreatment.
- Join 'Ageless Alliance[a]: United Against Elder Abuse!' 'Ageless Alliance' connects people of all ages, nationwide, who stand united for the dignity of older adults and adults with disabilities and for the elimination of abuse and neglect. "

- The National Domestic Violence Hotline[b]

The 'National Domestic Violence Hotline' is a non-profit organization established in 1996 as a component of the 'Violence Against Women Act' (VAWA). Available 24/7/365, confidential and free of cost, the 'National Domestic Violence Hotline' (1-800-799-SAFE) provides lifesaving tools and immediate support to enable victims to find safety and live lives free of abuse. The personal of that Hotline are highly trained, experienced advocates offering compassionate support, crisis intervention information, educational services and referral services in more than 200 languages. Visitors to the website can find information about domestic violence, online instructional materials, safety planning, local resources and ways to support the organization. Callers could be survivors of abuse, some as abusive partners and some as concerned family members and friends seeking help for someone else.

- The US Department of Justice: Elder Justice Initiative[c]

The mission of the 'Elder Justice Initiative' (EJI) is to support and coordinate the Justice Department's enforcement and programmatic efforts to combat elder abuse, neglect and financial fraud and scams that target US nation's seniors. This 'Elder Justice Initiative' focused on:

- Building federal, state and local capacity to fight elder abuse: training and resources to elder justice professionals
- Promoting justice for older Americans
- Supporting research to improve elder abuse policy and practice
- Helping older victims and their families

The EJI provides several scenarios and "red flags" (warning signs) to help the public understand the five types of abuse. In so far as, an elder abuse case has many stages from the incident through investigation, prosecution, and victim recovery, the EJI seeks to improve outcomes at each stage by providing resources, training and information, and by promoting a multidisciplinary response to elder abuse.

The Department of Justice provides training, toolkits and resources to assist law enforcement in their mission to combat elder abuse and financial exploitation (see website).

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[a] Ageless Alliance is a new national elder justice campaign which anyone can join. This campaign gives a voice to those who have been affected by elder abuse and abuse of adults with disabilities.

[b] http://www.thehotline.org/blog/get-help-today/

[c] https://www.justice.gov/elderjustice

- Ageless Alliance[a]

It is the nation's first 'Elder Abuse Forensic Center' hosted in Orange County, California by a group of professors in Geriatric Medicine. The aim was to bring the perpetrator to justice and safety to the victim. Each week a multidisciplinary meeting is held to evaluate cases, make intervention plans and follow-up (law enforcement, social workers, doctors, and attorneys).

This initiative has served over 1100 older adults who have been financially exploited, neglected, degraded, and physically battered. The 'Elder Abuse Forensic Center' has shown to be effective in addressing cases of elder abuse and has been replicated across the county, nevertheless it only addresses cases of elder abuse that have been reported to government agencies and research shows that it is not the majority (less than 1 in 23 cases) and 'Elder Abuse Forensic Centers' address abuse after it occurs rather than preventing abuse in the first place. In 2016, the research team related to the Center published the Abuse Intervention Model which can be used to study and intervene in elder mistreatment.[131]

In March 2015, 'Ageless Alliance: United Against Elder Abuse!' became national, non-profit charity organization. The mission of Ageless Alliance is to eliminate elder abuse, neglect, and exploitation through awareness and advocacy. For those reasons, the website provides:

  - an advocacy letter template with current elder justice priorities that everybody can send to his/her congressional representatives in order to help make elder justice a national priority;
  - a space for people to share their experience and bring these stories to light;
  - information on the 'World Elder Abuse Awareness Day' in June which has been created to bring heightened attention to this issue.

No step plan has been found from that organizations but several ones were created by Adult Protective services.

- National Adult Protective Services (NAPSA)[b]

The National Adult Protective Services Association (NAPSA) formed in 1989 is a national non-profit organization with members in all fifty states. His goal is to provide to APS a forum for sharing information, solving problems, and improving the quality of services for victims of elder and vulnerable adult mistreatment. Its mission is to strengthen the capacity of APS at the national, state, and local levels, to effectively and efficiently recognize, report, and respond to the needs of elders and adults with disabilities who are the victims of abuse, neglect, or exploitation, and to prevent such abuse whenever possible.

- Adult Protective Service (APS)

An 'Adult Protective Services (APS)' is a social services program provided by state and/or local government nationwide serving older adults and adults with disabilities who are in need of assistance. APS workers investigate cases of abuse, neglect or exploitation, working closely with a wide variety of allied professionals such as physicians, nurses, paramedics, firefighters and law enforcement officers.

Every state has their own distinct APS system and programs which vary from state to state in respect to served populations, provided services and scope of the program. APS helps by assessing each individual's unique needs, then developing a service plan to maintain his/her safety, health and independence. As an example, the step plan of the state of California[c] is presented in Figure 73 in Appendix 51.

What happens when a report is made to an APS[d] is illustrated by the comprehensive flow chart given in Figure 74 in Appendix 52 and by the summary given below.

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a https://agelessalliance.org/

b https://www.napsa-now.org/about-napsa/

c https://www.sccgov.org/sites/ssa/daas/aps/Pages/info.aspx

d http://www.napsa-now.org/

1. A concerned citizen contacts his/her local APS office to report concerns about the welfare of a senior or adult with disabilities.
2. The details provided in the report will be screened by a trained professional to evaluate if it meets the statutory requirements for APS services in the state and/or municipality receiving the report.
3. If the situation meets criteria for abuse, neglect or exploitation, an APS worker will initiate face-to-face contact with the adult needing assistance.
4. The APS worker will assess the adult's safety, need for assistance, and determine what services, if any, would be beneficial to maintain his/her well-being and independence.
5. While APS workers help thousands of vulnerable adults every day, individuals always have the right to decline services.

Confidentiality policy differs in each state: each of them has regulations and policies governing it. In some states, a report of abuse can be submitted anonymously.

A person making a good-faith report of suspected abuse or neglect can be assured he/she has:

- A right to confidentiality of his/her identity, with a disclosure of identity only with the reporter's written consent or by the order of a court
- Protection from civil and criminal liability, as well as professional disciplinary action
- Protection for providing information, records or services related to a report of suspected mistreatment
- Protection against retaliation by an employer

All information APS comes in contact with is kept confidential in accordance with the law. When APS workers meet with seniors or adults with disabilities, the APS worker will describe:

- How personal information will be handled and stored
- How long the information will be kept
- Who is allowed access to the information
- Whether confidential information may be shared with others

The personal safety of all individuals receiving APS services is a paramount concern. APS will work with the adult to keep him/her as safe as possible.

On the NAPSA website, APS map provides easy access to information on reporting suspected abuse nationwide.

The location of states' adult protection administrative structures varies. In two thirds of the states, the agency responsible for state administration resides with the Department of Social Services. The remaining one third are State Units on Aging with a sprinkling of Departments of Health and Rehabilitation. In the majority of states Adult Protective Services has a role in investigating abuse reports in long term care facilities. Sometimes this role is shared with the long-term care ombudsman and/or other regulatory agencies (APWA Report).

Key messages for USA

Several national structures are in charge to tackle EA in USA: the national centre on EA, the elder justice initiative, the ageless alliance, and the national domestic violence hotline. So the Aging US Administration and the US Department of Justice are involved. Some initiatives empower the older person while others target professionals.

In some states, a separation between residential and domestic abuse exists but not in all. In this case, the long Term Ombudsman can be called.

Reporting tools are different for financial institutions and the involvement of professionals from the justice sector is important: advocates take the call of the hotline about domestic violence.

The analyzed step-by-step plan is very specific as it only aims to describe the report of an abuse to dependent adult or elder adult to the APS of California, Orange County.

3.7 Belgium

In Belgium, there is no obligation for professionals to develop a step plan in case of elder abuse. But some informative documents exist to guide certain professionals in their decisions. Some, like the guideline developed by the SSMG, does not include step plans. Others do.

3.7.1 The federal approach plan in case of elder abuse presumption (Federal Public Service Heath)

In 2006, in the context of a more global policy against intra-familial violence, the health care federal authorities (Federal Public Service health care, food chain safety and environment) issued a generic step-by-step plan (decision-tree) addressed to health care professionals in case of elder abuse presumption (see Figure 75 in Appendix 53).

The use of this document was not mandatory and did not concern abuses committed by health care professionals in elder's residential settings. No specific follow up of its use has been set up by the authorities.

The approach suggested by this decisional tree do not require the victim's consent. However, communication and transparency with the victim is strongly promoted in the accompanying documents which advice the HCP to not promise total secrecy. Simple sentences adapted to the dialogue with elders are also proposed.

This generic step plan for health care professionals is not sufficient to take an appropriate decision. Therefore, it has to be used in combination with 3 other documents:

- An elder abuse approach sheet on intra familial violence against elders describing, with more details, the decisional/evaluation steps of the step by step plan[a]
- A guide containing a definition of the different type of abuses, associated factors, clinical considerations, advice regarding the diagnostic and useful interventions, legal framework and advice regarding prevention of abuses[b].
- A psychiatric assessment sheet describing the neuropsychological aspects in case of elder abuse[c].

As the legal framework and specialized organizations considerably evolved since 2006, this documents need to be updated.

3.7.2 Sexual Violence reporting code (Order of Physicians and National Institute for Gender Equality)

The National Order of Physicians and the National Institute for Gender Equality had drawn up a Code for Reporting Sexual Violence (see Figure 76 in Appendix 54). This decision-making tool provides doctors with information on how to best assist victims of sexual violence, without losing sight of the code of ethics. This tool focus on sexual violence and provides rather general advices on the behaviour doctors should adopt to support victims of sexual violence.

The document is not mandatory and no specific follow up of its use has been set up.

It does not contain specific contacts or references to legislation.

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a https://www.health.belgium.be/sites/default/files/uploads/fields/fpshealth_theme_file/violence_personnes_agees_fiche_8292411_fr.pdf.

b https://www.health.belgium.be/sites/default/files/uploads/fields/fpshealth_theme_file/guide_fr_violence_contre_les_personnes_agees_7864422_fr.pdf.

c https://www.health.belgium.be/sites/default/files/uploads/fields/fpshealth_theme_file/annexe_3_evaluation_psychiatrique_7866412_fr.pdf.

This plan does not refer to the decisional capacity of the patient but rather to its “psychological incapacity to handle the situation”. However, it is clear that if the HCP must first try to convince the victim to fill a claim her/himself, his/her consent is not required. In last resort, if there is a threat to the security or integrity of the victim or other persons or if the victim is psychologically incapable to handle the situation, it underlines the necessity to refer the case to judicial and help services.

An important point of this plan is the discussion and the transparency towards the victim.

3.7.3 Decisional tree on professional secrecy (National commission of Psychologists)

The website of the National Commission provides extensive information to help psychologist to decide if they can or must report abuse or presumed abuse in general (not only committed against elders)[a]. Amongst available documents, a decisional tree is provided with all legal references and explanations on professional secrecy (see Figure 77 in Appendix 55).

These documents are purely informative, and their use is not mandatory (however, compliance with the legislation referred to, including references to professional secrecy provision and provision on obligation to provide assistance is well mandatory).

[a] https://www.compsy.be/fr/client-victime-sp

4 SYSTEMATIC ANALYSIS OF THE STEP-BY-STEP PLANS ON SPECIFIC TOPICS

In this chapter, mainly step-by-step plans are described but some other types of tools allowing to respond to EA like written procedures, fact sheets, frameworks and decision trees are also mentioned. So the global wording of “EA early management tool” or “EA response tool” will be sometimes used in this conclusion. From the different EA early management tools analysed in this chapter, different topics are identified as important to develop a tool for handling EA in Belgium: the target population of the step plan/tool, the target users of the step plan/tool, the level of authority in charge of the step plan/tool development, the centralised or decentralised aspect of the early management present in the step plan/tool, the multi-sectoral aspect of the early management present in the step plan/tool, the global organisation of the steps within the step plan/tool, the inclusion of the step plan/tool within a global plan, the impact of the implementation of the step plan/tool, the mandatory aspect of and within the step plan/tool, and the empowerment of the older person in the step plan/tool. The relevant elements concerning those topics within the identified foreign step plans are summarised here under.

4.1 Australia

In Australia, the first national plan to respond to EA is from 2019 and follows calls from scientific and justice experts. But at the states’ and territories’ level, early management tools to respond to EA are available since years. Most of them are **elaborated by their respective state/territories government**. However, local agencies also design and use their own policies to report EA. Some EA response tools are included in global governmental plans/strategies/programmes and all are **specific to elder abuse**. **Almost all states/territories provide a helpline** which seems **not be the central contact point**. Indeed, in each tool, a list of several available contact point is given instead of a unique one. Those **multiple contact**

points are **originated from diverse sectors** like health, assistance, justice, police, and administration. No data are identified about financing and evaluation of the EA response tools.

Decisional autonomy is taken into account in the majority of the identified EA response tools but is rarely evaluated. T**o seek the consent of the older person is a recurrent item** in the actions to do in response to EA. Several decision trees include a direct question about the capacity and the consent of the older person. However, no tool include a discussion with the author.

Collaboration between the sectors of healthcare, police and justice is not directly cited but is indirectly present through the type of contact points suggested in the tools. The contact outside the health and assistance sector are the police, the Public Advocate, the Public Guardian, legal services, and power of Attorney. Collaboration between health and assistance agencies is illustrated by inter-agency protocols.

The **mandatory aspect** of using an EA response tool or to report is absent of the identified information except the report of EA in **Commonwealth-funded residential institutions**, applicable **all over Australia**, and the report of **physical and/or sexual abuse in residential structures in West-Australia**.

4.2 Canada

In Canada, a national guide is addressed either to professionals or elders; a national program called 'New Horizons for Seniors' supports provincial/territorial initiatives; and a charity organisation called Canadian Network for the Prevention of Elder Abuse connects people involved in EA prevention and management at local, regional and national levels.

At regional level, **governments are involved** in the elaboration of EA response tools in most of the provinces/territories. Those tools are **specific to elder abuse** except in two places (Québec and Yukon). Data about financial support by government and efficacy evaluation of the tools are lacking. As in Australia, **most of the provinces/territories have a helpline** which seems **not be centralised.** Indeed, in all described tools, a list of **contact points from the different involved sectors** is given. Where a step plan is available, it includes a step **taking into account the decision capacity and the consent** of the senior. A discussion with the author is suggested in a tool addressed to Senior themselves but this is not the case in the tools addressed to HCP.

Report of EA in long-term residential facilities is mandatory in Québec and Ontario but there is no obligation to use an EA response plan.

4.3 France

In France, no step-by-step or decision tree was identified. However, EA response tools are still available in the form of written procedure on official websites: of the solidarity and health ministry, and of the specialized organisation financed by the **government**, called the 3977 federation. This federation is the **centralized contact point**, welcoming concerns about **older or disabled persons**. The **evaluation of its impact is foreseen** by the governmental funding. The **autonomy** of the older person is **shortly evoked** on the ministry website while the **consent is indirectly** mentioned in the written procedure of the 3977 website. **Sectors of the police and the justice are listed** in the contact points. No discussion with author or **mandatory report** or procedure use is noticed on the studied sources.

4.4 The Netherlands

In the Netherlands, the **use of a step plan** is **mandatory** according to the law. This step plan is a part of a **global governmental plan** to tackle **every type of abuse,** including elder abuse. A generic step plan was elaborated by the government. Regional and local structures adapt the generic tool to their practices. The step plan guides professionals to a secure and efficient case management but it **does not take into account the capacity and the consent** of the abused person. 'Veilig Thuis', specialised organisations handling domestic violence, are the **centralised contact points**. A large part of the professionals sectors is concerned by the mandatory step plan on domestic violence reporting: education, early childhood, health, assistance …

4.5 UK

In UK, no step plan are available. Tips are given to vulnerable people and relatives to respond to abuse on the NHS website but no info was found on a mandatory aspect, the older people decisional capacity evaluation or the consent of the abused person. Charities seem to be the centralised contact points for victims.

4.6 USA

In USA, step plans are available in local APS (Adult protection services) but not at the national level where several governmental institutions are in charge to tackle EA. Information about implementation's financing and impact's evaluation is lacking. The collaboration with the justice sector is present in all described initiatives. The example of the APS step plan from California, Orange County, does not include a step about decisional capacity or consent of the vulnerable adult. As already said, the organisations are not specific to elder abuse but concerned all adults requiring protection. It is possible that the mandatory aspect vary from one state to another.

4.7 Belgium

In Belgium, in the frame of a global and national plan against violence in 2006, a step-by-step plan specifically targeting elder abuse has provided a detailed procedure to health care professionals. Since then, only specific tools were developed, for example, on sexual violence, on professional secrecy….Initiatives in Belgium are either local, regional or national depending of the authorities' competences. No mandatory aspect is present except for the obligation to help someone in danger. The inter-sector approach is lacking from the available tools with a centralisation around the non-specialised health and assistance services. The decisional capacity of the older person is included in the step-by-step plan but the consent of the older person is not sought. No data are identified about financing and evaluation of the EA response tools.

5 CONCLUSION AND DISCUSSION

Step-by-step plans or similar tools to response to EA are available almost everywhere in the countries and regions analysed in this chapter. The exceptions are the region of Northern Australia, and Prince Edward Island and Nunavut in Canada. Most of the described EA response tools are **addressed to professionals**. In Canada, step plans are equally addressed either to HCP or non HC professionals or to the elders themselves. In the Netherlands, the Meldcode is addressed to different types of professionals in charge of vulnerable people. And in Belgium, the tools are only addressed to HCP.

Globally, EA response tools target only older people (Australia, 11 regions of Canada) or vulnerable adults (France, Québec, Ontario, USA) or vulnerable people including children (the Netherlands). In Belgium, it is the option of targeting only older adults which was rather chosen. However, in the definition of the elder abuse, the concept of vulnerability of the abused person is crucial (see Chapter 1) and, in the Belgian law, and particularly in the not-yet-approved new criminal code, more and more importance are given to the vulnerability of the victim, because of his age but also of his state of pregnancy or disability… (see Chapter 2)**.** The question of the target population of a future Belgian step-by-step plan tools is open.

Abroad, EA response tools are either **developed** locally, regionally or nationally. Indeed, in some analysed countries, EA response policies and tools prevail at the local or regional level and reach timely the national level (Australia, Canada) while in other countries (France, the Netherlands), a governmental centralisation system of early response to abuse with a decentralised system of abuse practical management is present. In USA, national and local organisations seem to co-exist equally, while in Canada and Australia, regional territories seems much more in charge to respond to EA. In UK, the central organisation seems be done by charities. In Belgium, a step-by-step plan to respond to EA was developed at the national level in 2006. Since then, few tools were developed at the regional and local level which do not specifically concern the EA early management: the learning tool of Domus Medica (see Chapter 2), the specific intervention decision tree

(e.g. adaptation of the tool 'En mains') (see Chapter 2), and the SEL Waasland comprehensive plan to tackle EA (see Chapter 2).

Except in France and the Netherlands where a more **centralised** system for abuse matters is proposed, several entry doors are generally provided for reporting and/or receiving help and advices in case of abuse. Most of the countries and regions have a general hotline for all types of violence and a specific helpline for EA, with wide open hours. The step-by-step plans and other EA response tools from abroad provide the hotline/helpline numbers; emergency numbers and legal support numbers. In Belgium, studied tools do not provide clearly contact number or do not show inter-sector approach except the local tool created by SEL Waasland. Foreign step-by-step plans always include contact point in the justice, police, assistance and health sectors and this is common to all analysed countries and regions.

The **involvement of the justice sector** is high in USA and the Netherlands in the elaboration of EA response tools. And professionals from the police and the justice sectors are in all countries included in the contact persons list in case of abuse. In Australia, cooperation is highly developed between agencies through inter-agency protocols.

Step-by-step plans generally includes 4 to 6 **steps** whose the main issues are EA identification; safety assessment and emergency call; emotional support; decision capacity evaluation; discussion with supervisor/peers; safety planning elaboration; reporting; data recording; referral to specialists; and follow-up. A general tendency is also to delegate, as the final step, specific interventions to specialised organisations. However, in Belgium, the step-by-step plan does not mention specialized organisation, nor refer to new offenses or new development regarding professional secrecy and concertation. For HCP, the support and advice of the specialized organizations with legal knowledge is very helpful and very important as even if no one can ignore the law, the legal provisions and procedure may be complex and time consuming for HCP.

A **global action plan** for Belgium on elder abuse or abuse against vulnerable people is lacking in Belgium. But this kind of plans is also missing in UK where the responsibility is given to charities or was only developed very recently in Australia. The repeated institutional reforms are probably part of the cause in the delay in Belgium (see Chapter 2). Indeed, in 2006, EA guide and tools were developed by the Federal Public Service Heath but was finally not updated probably because the competences about elders care and assistance were transferred to the federated entities. However, police and justice competences remained at the federal level. So, now, Belgium is confronted to different priorities and financing devoted to EA matters in the regions but with a part of the issues still federal (see Chapter 2).

Data about the **impact of the implementation** of abuse response tools, only available in the Netherlands, shows that professionals intervene more often with a step plan than those without a step plan.[130] In France and Belgium, collection of data by specialised organisations are done but not as an impact study of tools implementation and it is likely that data collection is also done in Canada, Australia, USA and UK but no report about impact were identified. Data about funding of step-by-step plans implementation was neither clearly identified.

In Canada, Belgium and Australia, the **empowerment of the older person** is at the forefront. For example, safety plans built by the senior himself are a crucial step. A part of the provinces/territories government (or related organisations) addresses EA early management tools directly to seniors. Several decision trees include a step in which the HCP seeks the consent of the older person. In Australia, Canada and Belgium, the capacity evaluation is present in the step of the step-by-step plans and tools. Places where professionals can evaluate decisional capacity are also sometimes provided in some tools. Empowerment and older person consent seem less prevailing in the Netherlands or France where the decisional capacity is sometimes take into account, sometimes not.

The **mandatory aspect** vary a lot from one country to another. In the Netherlands, it is the use of the step-by-step plan in case of domestic violence which is mandatory while, in Australia and Canada, it is the reporting of abuse in long-term facilities which is mandatory. In Belgium and France, there is nothing mandatory except the assistance to person in danger.

CHAPTER 5: CLINICAL TOOLS FOR THE DETECTION OF ELDER ABUSE

1 INTRODUCTION

The initial research question behind this KCE project on elder abuse was introduced by a health professional who asks KCE to identify a tool for the "early detection of elder abuse and neglect in an emergency department ". Although this initial research question identified a need in emergency departments, it seemed more relevant to provide an overview of clinical tools to detect all types of elder abuse in different care settings (primary care, emergency departments, home care, non-emergency hospital units and residential facilities) with a description of the psychometric properties of the detection tools. This chapter presents the different tools identified in the literature for detecting elder abuse.

Before the presentation of the tool, a clarification of terminology must be made between detection, screening and diagnosis.

A **screening** test is performed to detect a disease (or a negative event) in an asymptomatic population, i.e. a population that shows no signs of the disease a priori. The screening test identifies, among the people screened, those for whom additional tests (called **diagnostic** tests) are needed to confirm or to infirm the presence of the disease.[a]

Detection is defined in this chapter as the action or process of identifying the presence of something hidden through the observation and assessment of older people suspected of being abused or having risk factors of abuse. As mentioned earlier (see Chapter 1), the detection tools discussed in this chapter only concern situations where there is a real suspicion of abuse or risk factors and do not include a screening (systematic search) for abuse in the elderly population.

In the literature, several terms related to detection are used, such as identification, screening, assessment and evaluation. But although the variable terms used in the different papers, the authors' definitions of these terms are all consistent with what we refer to as detection. In this chapter, whatever the term used by the authors, we will use the term ‘detection’ and ‘detection tools’.

Several types of tools have been found:

- Tools for identifying risk factors for abuse (see definition of risk factors for abuse and risk of abuse in Chapter 1)
- Tools to detect abuse itself (including detection of physical signs) when the health care professional has a doubt.

These tools are used either by health professionals (doctors, nurses) or social workers. No specific search on self-detection has been done but self-detection tools were still identified by the systematic study.

[a] This definition is mainly based on the information retrieved on the WHO website (https://www.who.int/cancer/prevention/diagnosis-screening/screening/en/)

2 METHODOLOGY

This overview of the literature regarding detection tools was developed using a standard methodology based on a systematic review of the evidence. We applied a stepwise approach starting with a search for systematic reviews and after selection of the most recent and highest quality review, an update of the review with primary studies was done. We also contacted the tool's authors in order to know if their tools were available in one of the three Belgian languages.

2.1 Search for systematic reviews

The search strategy was elaborated by our information specialist, including following keywords and their combinations: 'elder abuse', 'aged', 'mistreatment', 'maltreatment', 'neglect', 'screening', 'assessment'. The search strategy was slightly adapted per database and restricted to the time period from 2009 up to the 8th of February 2019. Following databases were searched for: Embase, CINAHL, Medline, PsycINFO, Cochrane and sociological abstracts. All search strategies per database can be found in Appendix 56.

The selection on title and abstract was mainly based on the scope of this chapter, i.e. only references regarding the detection of elder abuse were retained. An overview of the in- and exclusion criteria can be found in Table 10.

Table 10 – Selection criteria

Selection criteria	Included/excluded
Population	Elderly (no age limit) Excluded: children and adolescents
Intervention	Detection, diagnosis Detection of risk factors Excluded: follow-up, treatment, management
Comparison	Tool versus another tool
Outcome	User-friendliness, psychometric properties
Design	systematic reviews Excluded: narrative reviews with no clear description of methodology, other study designs

Further details about KCE and the systematic review methodology are available at https://kce.fgov.be/content/kce-processes.

2.2 Search for primary studies

After selection of the systematic review with the highest quality, an update with primary studies was performed, starting from the search date of the systematic review.

The same search strategy was applied, rather in this case a search for primary studies and starting from 2015 onwards. The same selection criteria were used (see Appendix 56), adapted for the search for primary studies (without exclusion on any type of design).

2.3 Psychometric assessment

One objective of this chapter is to provide an overview of the existing evidence behind the retrieved detection tools. Therefore, only tools with a description of the psychometric properties were included in our analysis. So for every selected tool, the author (and often the developer of the tool) have described a psychometric assessment of the performance of the tool.

For the theoretical background behind the psychometric assessment of detection tools, we refer to the Oxford handbook of clinical Geropsychology.[132] As stated in this handbook, reliability and validity are the most important scientific properties a tool should show as a proven scientific guarantee. **Reliability** refers to the extent to which a score on a certain test is free from measurement errors, such as the degree of diversity of items included in the test (internal consistency), the extent to which test administration at different times and on different occasion yields different results (test-retest reliability) and the extent to which different raters, observers, interviewers, or test administrators obtain different results (inter-rater reliability). Internal consistency is often assessed through the Cronbach alpha's coefficient, with a coefficient superior to 0.60 (or 0.7) as an indicator of good internal consistency. Another measure for internal consistency is the Kuder-Richardson technique (KR-20), which is more used in dichotomous answers whereas Cronbach's alpha is more recommended for measuring instruments with a Likert or multiple choice scale.[133] **Validity** of an instrument is defined as the degree to which it measures what it claims to measure. The best validity indicator to arrive at a clinical diagnosis, is a high sensitivity (i.e. tool detecting the relevant clinical problem if present, very few false negative results) and specificity (i.e. tool not detecting other diagnoses, very few false positive results). The construct validity is also an important measure to assess the validity of an instrument (see Appendix 60).

In accordance to the Oxford handbook for Geropsychology,[132] the psychometric assessment in our analysis covers the different psychometric properties, such as the different types of validity and reliability. The data provided by the authors are literally mentioned in the descriptive tables. For some of the tools, additional studies were found on the reliability or the validity of the tool in another country (and language) or in another setting (e.g. a tool for home care tested in a long-term care setting). These data were also included in the description of the tool.

The psychometric assessment is only one part of the critical analysis, which also takes into account other aspects related to the use of a detection tool in clinical practice, for example the way of formulation of the questions, the time required for completion of the tool, etc. All these related aspects are presented per tool in a descriptive table.

3 SEARCH RESULTS

3.1 Systematic reviews

The search strategy of systematic reviews (SRs) allows to identify 277 SRs about detection tools of elder abuse. A sort based on the inclusion and exclusion criteria (see Figure 79 in Appendix 57) resulted in 192 selected abstracts. After the critical appraisal of each selected reviews, 26 SRs were assessed as being of good quality. The systematic review of Gallione et al. (2017)[3] was finally chosen among all the good quality SRs reviews because it was the most recent (see table 17 of the selection of systematic reviews in Appendix 58).

Table 11 is a critical appraisal of the systematic review of Gallione et al. (2017).[3] A flow diagram on the selection of the systematic reviews can be found in Appendix 58.

Table 11 – Evidence table of systematic reviews regarding the detection tools for identification of elder abuse

Title: Detection tools for identification of elder abuse: a systematic review	
Methods	
• **Design**	Systematic review
• **Source of funding and competing interest**	University of Eastern Piedmont (Italy) No conflict of interest declared
• **Search date**	1980–2015
• **Searched databases**	MEDLINE, Cochrane database of systematic review, Embase, Scopus and Other resources (American Psychological Association, Centers for Disease Control and Prevention, The National Center of Elder Abuse, National Centre for the Protection of Older People and the World Health Organization)
• **Included study designs**	Prospective and retrospective observational cohort studies
• **Number of included studies**	11 studies
Patient characteristics	
• **Eligibility criteria**	Individuals aged 60 and older
• **Exclusion criteria**	Patients out of range age
• **Patient & disease characteristics**	Elder abuse: physical, psychological, financial, sexual or neglect
Interventions	
• **Intervention group**	Detection tools to detect elder abuse
• **Control group**	No control group
Results	

• **Outcome**	11 tools identified: H-S/EAST, VASS, EASI©, CASE, BASE, E-IOA, EAI, EPAS, CPEABS, OAPAM and OAFEM
Limitations and other comments	
• **Limitations identified by the author**	Databases missing in the search strategy : CINAHL and PsycInfo Questionable methodological quality of the highly variable tools Detection tools not adapted to people with cognitive impairment No evaluation of the possible adverse effects of detection on older adults or caregivers Acceptability of detection tools by older adults has not been evaluated
• **Limitations identified by the researcher**	No tools were compared to a gold standard No definition of what the authors consider as a validated tool Some existing tools used in current practice have not been mentioned

3.2 Primary studies

Among the 54 primary articles identified by the literature update, 31 were selected (see in Appendix 59 of Chapter 5 for reasons for exclusion). Those primary articles were (i) adaptation from tools mentioned by Gallione et al. (2017)[3] (e.g. CASE, VASS, HS-EAST, EASI©), (ii) or tools developed in the Belgian context (RITI), (iii) or other tools not mentioned by Gallione et al. (2017)[3] (ZARIT, QUALCARE scale, etc.).
Next paragraph is a critical appraisal of those tools. No critical appraisal of the methodological quality was performed, due to the few number of studies per tool and it was decided not to exclude studies based on their study design.

4 CLINICAL TOOLS FOR THE DETECTION OF ELDER ABUSE

The literature search revealed a list of existing detection tools, either more comprehensive covering all types of abuse, either more specific on one type of abuse (e.g. financial abuse, psychological abuse) or in a specific setting (e.g. emergency care) or in a detection procedure (e.g. developed for Adult Protective Services programs).

The SR of Gallione et al. (2017)[3] included 11 original studies describing 11 tools: 8 prospective cohort studies,[134-141] 2 longitudinal observational studies,[142, 143] and one transversal study.[144] When additional studies are available, Gallione et al. (2017)[3] mention it. Their goal was to evaluate detection tools in terms of their **efficacy and accuracy**. All these tools assess the risk factors for abuse (either the risk of being abused or the risk to abuse an older person (see tool CASE for example)) and are intended for healthcare professionals. No tools for self-detection by the perpetrator of abuse were identified by Gallione et al. (2017)[3] but a tool for self-detection by the elder of psychological abuse (OAPAM see discussion part) was identified. The detection tools were developed in different countries: USA, Canada, Israel, Taiwan, and Australia.

The update search of primary studies revealed (i) a Belgian tool used in practice (RITI), (ii) additional studies on tools mentioned by the SR of Gallione et al. (2017) (such for VASS and CASE), other tools not mentioned by Gallione et al. (2017)[3] (such for ZARIT, QUALCARE scale) and interesting experimentations of tools mainly developed for Adult Protective Services (APS) programs.

A differentiation is made in the appraisal of literature between **comprehensive tools versus more specific tools** (regarding to type of abuse, setting, etc.).

4.1 Comprehensive detection tools

Gallione et al. (2017)[3] identified 4 comprehensive detection tools (see Table 12): VASS, HS-EAST, EASI© and E-IOA (which is derived from the tool IOA). The additional search revealed 1 article describing another tool (REAMI called in Dutch RITI) from De Donder et al. (2018)[145] developed in the Belgian context, 3 additional studies on VASS and 1 additional study on IOA. Also one newly developed tool (Assessment tool for Domestic Abuse (ATDEA[146]) was found in the update search, but no data on reliability and a very few data on validity were reported on the article of Yi et al. (2019)[146]) therefore it was decided to exclude it from the comparison with the other comprehensive tools, due to its limited information about its psychometric properties.

Table 12 – Overview of comprehensive detection tools

TOOLS	VASS	HS-EAST	EASI©	E-IOA	REAMI (RITI)
Country	Australia	USA	Canada	Israel	Belgium
Date of creation	2002	1987	2008	1998	2017
Setting	Home care	mixed	Ambulatory care Long-term care	Hospital	Home care
Cognitively intact or not severe cognitive decline population	yes	yes	yes	yes	yes
Number of items	12	15	6	7	22
Administration time	5 min	5-10 min	≤2 min	2 hours	2-15min
Psychometric assessment	yes	yes	partly	yes	yes

Psychometric assessment means the authors had evaluate the reliability (through the internal consistency with Cronbach alpha's scoring or KR-20 scoring and/or the test-retest reliability and/or the inter rater reliability) and the validity (through the sensitivity/ specificity and/or the construct validity). If either reliability or validity were lacking, this item was scored with "partly".

Hwalek-Sengstock Elder Abuse Screening Test (H-S/EAST)

The original study on the H-S/EAST[134] and a further validation study[147] are described in the SR of Gallione et al. (2017).[3] The search for primary studies revealed two additional studies, both called by their authors "validation studies": both about the Turkish version of this detection tool.[148, 149] No additional studies on the H-S/EAST in other care settings were found. Moreover, according to one of the tool's author contacted, HS-EAST was listed as one of the validated tools in the Elder Maltreatment Screen and Follow-Up Plan, led by the U.S. Agency for Healthcare Research and Quality.[150] Details on H-S/EAST are presented in Table 13.

Table 13 – Hwalek-Sengstock Elder Abuse Screening Test (H-S/EAST)

Detection tool	Hwalek-Sengstock Elder Abuse Screening Test (H-S/EAST)
Aim	Detection tool to identify older people at high risk of need for adult protective service (APS)
Types of abuse	All types of abuse

Setting (care setting/country)	Original study:[134] nursing homes / USA but suitable for different care settings according to Gallione et al. (2017)[3]
	• Additional studies:
	  ○ Ozmete et al. (2017):[148] home / Turkey
	  ○ Ozcakar et al. (2017):[149] home / Turkey
	Both came to the same conclusion: the Turkish version of the H-S/EAST can be used as a reliable, valid clinical tool for the detection of elder abuse.

Administration	• Type of items (original version of H-S/EAST):
	  ○ 15 dichotomous questions asked to the elder person ("Yes/No/did not answer")
	  ○ Covering 3 domains: violation of personal rights or direct abuse, characteristics of vulnerability, potential abusive situations
	  Abuse is associated with a response of "no" to items 1,6,12 and 14; the response "someone else" to item 4 and the response "yes" to all other items.
	• Completion time: 5-10min

Target population	Not clearly stated

Psychometric assessment	• *Reliability*:
	  ○ Internal consistency: Cronbach's alpha: 0.29 (low due to different types of abuse)[134]
	• *Validity*:
	  ○ construct validity: suggested cut-off ≥3 (potentially higher risk of abuse)[147]

Open access	Yes

	• link to the H-S EAST: https://static1.squarespace.com/static/545020a5e4b06fcbba6b1d78/t/5ef9dbcba7500b669548c243/1593433035997/H-S_EAST_UPDATED_06-27-2019.pdf • for the Sengstock-Hwalek Comprehensive Index of Elder Abuse https://static1.squarespace.com/static/545020a5e4b06fcbba6b1d78/t/55d78104e4b0feb04b6212a7/1440186628707/Sangstock-Hwalek-Report-of-Scale.pdf
Validated in one of the three national belgian languages	No but a non-validated version is available in Dutch.
Critical analysis	+: direct questions to the older person, questionnaire available in several languages (but not all validated) -: cognitive abilities not mentioned in studies, but the direct questions of the tool require a certain level of cognition; acceptability of the tool by older persons not tested; difficult to discriminate between situations of abuse and non-abuse; no further validation studies

Vulnerability Abuse Screening Scale (VASS)

The Vulnerability Abuse Screening Scale (VASS) tool was developed as part of a 20-year Australian longitudinal study (see Table 14). The tool was tested at home in a cohort of women aged 70-75 years. It is an adaptation of the H-S/EAST tool:[134] 10 of the 12 items were from the H-S/EAST and 2 items were from the Conflict Tactics Scale.[151]

The VASS covers the following 4 areas: vulnerability, dependence, dejection and coercion, with three questions for each area. The administration time is very fast (5 minutes). At the time of the SR of Gallione et al. (2017),[3] there were not yet other studies for this tool. With the update through primary studies search, three additional studies were found: one study evaluating the VASS in Brazilian population,[152] another evaluating a Turkish version of the original tool[153] and third evaluating a French one.[154]

These additional studies[152-154] (see Table 14) also tested the tool on a mixed population (women and men) which was not the case in the original study[142] where only women were tested.

Table 14 – Vulnerability Abuse Screening Scale (VASS)

Detection tool	**Vulnerability Abuse Screening Scale (VASS)**
Aim	Originally, to quantify the phenomenon of abuse in older women
Types of abuse	All types of abuse

Setting (care setting/ country)	• Original study:[142] home/ Australia
	• Three additional studies:
	  ○ Dantas et al. (2017):[152] home/ Brazil
	  ○ Duru et al. (2017):[153] home/ Turkey
	  ○ Grenier et al. (2016):[154] hospital/ France

Administration	• Type of items (original version of VASS):
	  ○ 12 items, ("Yes/No" questions)
	  ○ Covering domains: vulnerability, dependence, dejection and coercion
	  ○ Mainly based on Hwalek-Sengstock elder abuse-screening test
	• Completion time: 5 minutes

Target population	• Original study:[142] 10 421 women aged 70-75 years old • Dantas et al. (2017):[152] 151 elders aged 60 years and older • Duru et al. (2017):[153] 140 elders aged 65 years and older • Grenier et al. (2016):[154] 200 elders aged 65 years and older

Psychometric assessment	• Reliability:
	  ○ *Internal consistency (Cronbach alpha or KR-20): α=0.31-0.74[142]; KR-20=0.69[152]): α= 0.819[153];*
	  ○ *Test-retest reliability: no difference between test and retest mean scores[153]*
	• Validity:
	  ○ *Construct validity: Low construct validity for the area coercion (due to non specific formulation/generic questions) [142]*
	  ○ *Sensitivity: 90.9% for a threshold of 1[154]*
	  ○ *Specificity: 49.7% for a threshold of 1[154]*

Open access	Yes https://medicine.uiowa.edu/familymedicine/sites/medicine.uiowa.edu.familymedicine/files/wysiwyg_uploads/VASS.pdf
Validated in one of the three national belgian languages	Yes, in French
Critical analysis	+: direct questions to the older person, questionnaire available in several languages (but not all validated) -: cognitive abilities not mentioned in studies, but the direct questions of the tool require a certain level of cognition; acceptability of the tool by older persons not tested; complementary studies[152, 153] obtained more effective results than the original study

Elder Abuse Suspicion Index© (EASI)

In the SR of Gallione et al. (2017),[3] the original study on the development of the EASI© has been critically discussed.[143] Next to this information source, the search for primary studies revealed two other studies: Ballard et al. (2017)[155] have adapted the EASI© questionnaire for use in long term care settings and Kurkurina et al. (2018)[156] have adapted the questionnaire for use by law enforcement officers.

The tool consists of 6 items, of which 5 items are questions directly posed to the elder and one observational item for the health professional. The directquestions require sufficient cognitive abilities from the elder, which could be seen as the main limitation of this detection tool. More details on EASI© are presented in Table 15. One of the authors contacted stated that there is also the EASI-sa which is a modified version of EASI© in English and French for self-administration. Since the EASI-sa is simply the EASI© with the last question removed[143] and since there was 100% acceptability in a sample of over 200 older adults, the authors did not feel it necessary to repeat their validation study for this modification.

Table 15 – Elder Abuse Suspicion Index© (EASI)

Detection tool	**Elder Abuse Suspicion Index© (EASI)**
Aim	Confirmation of a reasonable level of suspicion of (any type of) abuse in order to justify referral to an appropriate community service for more in-depth assessment
Types of abuse	All types of abuse
Setting (care setting/country)	• Original study:[143] ambulatory care (general practitioners, general internists, geriatricians)/ Canada • Other studies: ○ Adapted for long-term care (EASI-ltc) (Canada):[155] addition of “do not know” to answer options, 2 additional questions (to further address psychological abuse and neglect) and a context-specific preamble to orient responders, not yet validated in LTC settings ○ Modified version for use by law enforcement officers (EASI-leo) (USA):[156] separation of multipart questions, inclusion of checkboxes, addition of clear instruction for use, incorporation of the Fairfield Department of Social Services’ (DSS) Elder Outreach form (on older person’s condition and additional needs), addition of questions on social isolation, home safety and how the older person can access emergency services when needed and a section for notes, not yet validated in practice
Administration	• Type of items (original version of EASI©): ○ 5 dichotomous questions asked to the elder person (“Yes/No/did not answer”) ○ 1 question for the general practitioner himself: observation of findings of abuse (patient’s appearance and behaviour) (“Yes/No/ not sure”) ○ A response of “Yes” on one or more of questions 2-6 may establish concern. • Completion time: 1-10min (generally <2min)
Target population	Subjects over 65y, without not severe cognitive decline (score ≥24 Mini-Mental Status Exam), language spoken English or French

Psychometric assessment	• Validity: ○ *sensitivity: 0.47 (range 0.03-0.28)*[143] ○ *specificity: 0.75 for at least one positive EASI item (range 0.72-0.99)*[143]
Open access	Yes: www.mcgill.ca/familymed/research/projects/elder
Validated in one of the three national belgian languages	Yes, in French and German
Critical analysis	+: concise questionnaire; combination of direct questions and observation; short completion time; adapted for different care settings (ambulatory care and long term care) and for different observers (physicians and law enforcement officers) -: only for cognitively intact subjects; no further validation studies

Indicators of Abuse (IOA) 1998

Another comprehensive tool analysed in the SR of Gallione et al. (2017)[3] is the E-IOA from Cohen et al. (2006).[138] The E-IOA comes from the original instrument, the IOA ("indicators of abuse") from Reis et al. (1998)[157] and was examined in a large cohort of patients admitted to two hospitals in Jerusalem. The search of primary studies revealed a Portuguese version of the IOA developed by Touza et al. (2018).[158] The IOA had not been analysed by Gallione et al. (2017)[3] but other sources such as the National Initiative for the Care of the Elderly (NICE) includes that tool in their set of available detection tools for elder abuse[a]. Gallione et al. (2017)[3] state that the use of E-IOA/ IOA is most effective in combination with the BASE or CASE tool. Details on IOA and E-IOA are presented in Table 16. In French, IOA is called LISA for “Liste des indices de situations abusives”. One of the authors of E-IOA contacted stated that this tool can be also used in ambulatory care and home setting.

[a] Website: http://www.nicenet.ca/tools-ioa-indicators-of-abuse

Table 16 – Elderly Indicators of Abuse (E-IOA) and Indicators of Abuse (IOA)

Detection tool	Elderly Indicators of Abuse (E-IOA)	Indicators of Abuse (IOA)
Aim	Develop and assess an instrument to identify older people at high risk of abuse based of IOA	Identify elderly people who may be at risk of domestic abuse by their caregiver.
Types of abuse	All type of abuse	Domestic abuse (physical abuse, economic exploitation, emotional abuse, abandonment and neglect)
Setting (care setting/country)	Original study: hospital/ Israel	Original study: home/ Canada Other study: home/ Spain
Administration	• Type of items (original version of E-IOA): ○ 7 items, (Likert scale from 1"to a great extent" to 5"not at all" or "not possible to receive information") ○ Covering domains: demographic and personal data, lifestyle and possible kinship with caregiver, number of hospitalisation in previous year, albumin levels (mg/dl) in the blood, functional state, financial situation • Completion time: 2 hours	• Type of items (original IOA): ○ 27 items: 15 items regarding the elderly person and 12 items regarding the caregiver. For answer, 5-degree scale (from 0 = non-existent to 4 = yes/severe and two other possible answer: not applicable and don't know) ○ 3 covering domains: (1) caregiver intrapersonal problems/issues (e.g., mental health, behavioural, and alcohol or other substance abuse difficulties); (2) caregiver interpersonal problems (e.g., marital and family conflict and poor relationships, generally and with the care receiver); and (3) care receiver social support shortages and past abuse of the care receiver • Completion time: 2-3 hours
Target population	Subjects over 65y, cognitively intact with caregiver actively present in personal care, language spoken Hebrew	Original study:[157] 341 elders aged 55 and older Other study:[158] 231 elders aged 63 and older
Psychometric assessment	• Reliability: ○ *Internal consistency:* α=0.78–0.91[138] • Validity: ○ *Sensitivity: 92.9%*[138] ○ *Specificity: 97.9%*[138]	• Reliability: ○ Internal consistency: α = 0.91[157] ; α = 0.94 at the cut-off point given by score 16[158] • Validity: ○ *Sensitivity : 0.94*[158] ○ *Specificity : 0.85*[158]
Open access	No	No
Validated in one of the three national belgian languages	No	Yes in French

Critical analysis	+: good validity and reliability; easy to score; analyses the functional and nutritional status of the elder -: only for cognitively intact subjects; no further validation studies ; weak in identifying areas of financial abuse; long to administer Requires trained personals for administration	+: good discrimination between cases of abuse and cases of non-abuse; good validity and reliability -: Long completion time; requires trained personals for administration

Risk on Elder Abuse and Mistreatment-Instrument (REAMI/RITI)

The literature search has revealed only one Belgian tool which is currently used in Flanders.[145] The VLOCO is responsible for the further implementation of the Risk on Elder Abuse and Mistreatment-Instrument (REAMI) tool in Flanders, particularly in services and organisations that frequently visit the homes of elderly people, such as home care services, home nurses, social work services of the sickness fund, CPAS, etc.

REAMI (see Table 17) is an oriented health professional detection tool used in home setting which asks their feelings (questions begin by "To which extent do you feel that…") in different domains such as risk factor related to the older person, risk factors related to the environment/possible perpetrator and signals of elder abuse.

Table 17 – Risk on Elder Abuse and Mistreatment-Instrument (REAMI)

Detection tool	**Risk on Elder Abuse and Mistreatment-Instrument (REAMI)** **In Dutch Risicotaxatie-Instrument (RITI)**
Aim	Detection of the risk of elder abuse and mistreatment (signs and risk factors)
Types of abuse	All type of abuse
Setting (care setting/country)	Home care/ Belgium (Flanders)
Administration	• Type of items (original article) ○ 22 items (from completely disagree (1) to completely agree (4)) ○ Covering domains: "risk factors related to the older person" (6 items), "risk factors related to the environment/possible perpetrator" (10 items) and "signals of elder abuse" (6 items) • Completion time: between 2 and 15 min (for some 2 to 3 minutes and for others 10 to 15 minutes)
Target population	1920 elders
Psychometric assessment	• Reliability: ○ *Internal consistency: α= respectively 0.74; 0.89 and 0.84*[145] • Validity: ○ *Construct validity (Confirmatory factor analysis (CFA)): 0.41-0.81*[145]

Open access	No: restricted to MD, access via the website of VLOCO https://www.ouderenmisbehandeling.be/RITI/Index.aspx
Validated in one of the three national belgian languages	Yes in Dutch and French
Critical analysis	+: rapid administration, clear -: Training is necessary; more studies needed to test the applicability in different countries and settings; more studies needed to test validity.

4.2 Tools on specific types of abuse

The majority of the tools identified in the literature search, assessed the risks for all types of abuse. However, some tools focused on more specific types of abuse such as financial and psychological abuse.

Financial abuse

In daily clinical practice, a healthcare provider might be less frequently confronted with financial abuse compared to the other types of abuse. However, as mentioned in the introduction of this report, often an older adult is victim of different types of abuse at the same time and financial exploitation could have adverse consequences on the general health condition of the older adult.

Two different (sets of) detection tools were identified throughout the literature search:

- the set of Financial Decision-making Assessments (see Table 18), consisting of:
  - the Financial Decision Tracker, also known as the Lichtenberg Financial Decision-making Screening Scale (LFDSS)[159, 160]
  - the Financial Vulnerability Assessment, also known as the Lichtenberg Financial Decision making Rating Scale (LFDRS)[161, 162]
  - the Family and Friends Interview, also known as The Family and Friends scale (FF)[163]
- the Older Adult Financial Exploitation Measure (OAFEM) (see Table 18) (Conrad et al. (2010),[141] mentioned in the SR of Gallione et al. (2017)[3] and Phelan et al. (2017)[164]

One of the authors contacted stated that the set of Financial Decision-making Assessments (LFDSS, LFDRS and FF) has been validated in social service settings (Adult Protective Services in the U.S), legal settings, financial advisor settings and psychological and social work mental health practice settings. Currently, the authors are testing the tools in geriatric memory and primary care settings.

Table 18 – Set of Financial Decision making Assessments (LFDSS, LFDRS, FF) and Older Adult Financial Exploitation Measure (OAFEM)

Detection tool	Financial Decision making Assessments	Older Adult Financial Exploitation Measure (OAFEM)
Aim	Assessment of financial decisional abilities in older adults - By informant (Family and Friends Scale) - By professionals trained in assessment	The detection of financial exploitation
Setting (care setting/country)	No specific settings	Original study:[141] Ambulatory care/ USA
Administration	*Financial Decision Tracker (or Lichtenberg Financial Decision-making Screening Scale (LFDSS))* • Type of items: ○ An 10-items interview (short version of the LFDRS) examines a specific financial decision made by the older adult, to assess his financial judgment, vulnerability to theft and scams, and whether financial predation may have taken place (multiple choice answers) Assessors: professionals who often work with older adults making significant financial decisions (including attorneys, financial planners, bankers, investment brokers, insurance agents, accountants, law enforcement officers, and Adult Protective Service case workers) • Completion time: 10min *Financial Vulnerability Assessment (or Lichtenberg Financial Decision-making Rating Scale (LFDRS))* • Type of items: ○ An in-depth interview with 34 questions (77 items in LFDRS), covering 4 domains (financial situational awareness, pscyhological vulnerability, susceptibility to undue influence, and intellectual factors) Assessors: mental health professionals who are well-trained in administering standardized tests (including psychologists, psychiatrists, physicians, therapists, counselors, nurse practitioners and pastoral counselors) • Completion time: 25min *Family and Friends Interview (or FF scale)* • Type of items:	• Type of items (original version of OAFEM): ○ Direct questions: 79-, 54-, 30-items measures ("Yes/No/Suspected/Unknown") ○ Covering 5 areas: possible suffered fraud, victimisation, financial coercion, signs of possible financial exploitation, money management ○ Administered by experienced staff ○ A raw score of 12 on 60 is indicative of financial abuse. Validation of the 25-items version for use by the national safeguarding older person services (Ireland):[164] OAFEM could be shortened to 6 items, with a trigger to complete the remaining 19 items when a positive response was obtained in any of the first six items. • Completion time: not stated

	○ Interviews (14 items) with trusted relative, friend or professional acquintance of the older adult (someone who would not benefit from the older adult's financial decision) (multiplie choice answers) on risk perception Assessors: not clearly stated • Completion time: 10min	
Target population	Subjects over 60y, cognitively intact (no formal score stated)	Subjects over 60y, cognitively intact (score > or = 24 Mini-Mental Status Exam)
Psychometric assessment	*Financial Decision Tracker (or Lichtenberg Financial Decision-making Screening Scale (LFDSS))* • Reliability: ○ *Item response theory analysis: the overall average reliability ranged from 0.78 for model with 7 binary items to 0.85 for model with 10 ordinal and binary items, indicating that this instruments performs well as brief screen for financial decision making capability*[160] • Validity: ○ *No sensitivity and specificity stated (only differences between 2 assessors groups)*[159] *Financial Vulnerability Assessment (or Lichtenberg Financial Decision making Rating Scale (LFDRS))* • Validity: ○ *No sensitivity and specificity stated*[161] ○ *Clinical utility by ROC curves: good to excellent range for decisional capacity scoring and fair to good range for financial exploitation*[162] *Family and Friends Interview (or FF scale)* • Validity: ○ *Sensitivity and specificity calculated at each potential cut-off point*[163]	• Reliability: ○ *Internal consistency: α= 0.93*[141] • Validity: ○ Good *construct* validity[141]
Open access	No, access via the website: https://olderadultnestegg.com	Yes https://academic.oup.com/gerontologist/article/50/6/758/630082

	Login needed	
Validated in one of the three national belgian languages	No	No
Critical analysis	+: focus on (risk of) financial abuse, direct questions to the elder; -: only for cognitively intact subjects; well-trained professionals needed for assessment, no further validation studies	+: focus on financial abuse, direct questions to the elder; shorter version (with 6 items) possible -: only for cognitively intact subjects; only tested in seniors with at least one report of abuse; need pairing to a general detection tool for all types of abuse; long completion time; capacity detection needed, no further validation studies

Psychological abuse

Three specific psychological abuse detection tools have been identified in the SR of Gallione et al. (2017):[3]

- an Elder Psychological Abuse Scale (EPAS) (see Table 19) ;
- a Self-report Measure of Psychological Abuse of Older Adults (OAPAM) (see Table 19) which come from a three-dimensional study (OAMA, Older Adult Mistreatment Assessment) like OAFEM (financial abuse);
- and a Caregiver Psychological Elder Abuse behaviour Scale (CPEABS) (see Table 22) which will be presented later in so far as it's a caregiver's assessment and not a patients' one.

Table 19 – Older Adult Psychological Abuse Measure (OAPAM) and Elder Psychological Abuse Scale (EPAS)

Detection tool	OAPAM	EPAS
Aim	Self-report Measure of Psychological Abuse of Older Adults	Risk and risk factors
Setting (care setting/country)	Home setting/ USA	Institutional care/ Taïwan
Administration	• Type of items (original version of OAPAM): ○ 31 ITEMS (0 = No, 1 = Suspect, 2 = Yes) ○ Areas detected: isolation, insensitivity and disrespect, shaming and blaming, reported ○ threats and intimidation, and other trusted risk factors. Stratified by risk category • Completion time: not indicated	• Type of items: ○ 32 items (Yes/No) ○ Domains: discussion (Q1-7) active observation (Q8-13) interview with the caregiver (Q14-32). • Completion time: 5-10min
Target population	226 elders who have already suffered at least one episode of violence and have at least a MMSE (Mini-Mental State Examination) of 17	195 elders aged 60 years and older, communicating ability; partially dependent on a caregiver
Psychometric assessment	• Reliability: ○ *Internal consistency : α=0.92*[140] • Validity: ○ *Construct validity:* good *construct validity*[140]	• Reliability: ○ *Internal consistency :* KR-20= 0.82[139] • Validity: ○ *Concurrent validity was obtained comparing it with the BI and SPMSQ, with an overall correlation of 0.32 (p < 0.001)*[139]
Open access	No	No
Validated in one of the three national belgian languages	No	No
Critical analysis	+: Good psychometric construct validity and inter-item correlation in defining the risk of psychological abuse; Useful in screening for potential psychological abuse of older people reported to social services -: Need additional external validation studies in other populations ; Population tested: only in the Chicago area	+: This demonstrated that older people with cognitive impairment or with functional dependency were at a higher risk of psychological maltreatment. -: culturally limited to the country in which it was developed and tested.

4.3 Tools detecting the caregiver as abuser

Five tools detecting the caregiver as potential abuser had been identified by the literature search: the SR of Gallione et al. (2017)[3] revealed three of them: BASE, CASE and CPEABS and the search for primary studies revealed the others: ZARIT and QUALCARE scale.

The Caregiver Abuse Screen for the Elderly (CASE) and the Brief Abuse Screen for the Elderly (BASE) both take part of a national project called "Project Care" which the aim was to tackle neglect and abuse by caregivers in Canada. CASE[135] is an 8-items questionnaire where the yes/no questions are asked in a way that the participant becomes aware that his/her behaviour is or is at risk of becoming abusive (e.g., "Do you sometimes find it difficult to put patient x to rest? », Do you think you should ignore patient xx's behaviour?"). BASE[136] is a rapid questionnaire (only 5 questions with an administration time of 1 minute) completed by trained health professional covering three domains: level of suspicion, the type of abuse and the immediacy of response. When they are combined, the tools BASE, CASE and E-IOA/ IOA are more effective.[135, 136, 138]

The Caregiver Psychological Elder Abuse Behaviour Scale (CPEABS)[144] aim to identify psychological abusive behaviour by the caregiver. This 20-items questionnaire has a rapid administration time (5-10 minutes). According to Gallione et al. (2017),[3] CPEABS is "culturally limited to the country in which it was developed and tested".

The two last tools identified were the ZARIT[165] and the QUALCARE scale.[166] Curiously, those tools hadn't been identified in the SR of Gallione et al. (2017)[3] although they exist since 1980 for ZARIT[167] (with revised versions after that date) and 1990 for QUALCARE scale.[168] According to the Belgian stakeholders, the ZARIT has often been used in clinical practice and is also mentioned in the guideline of the GP's professional associations (Domus Medica and SSMG)[a].

[a] see the website: https://www.ssmg.be/avada_portfolio/violences-conjugales/?portfolioCats=107%2C108%2C183%2C109

CASE

In the SR of Gallione et al. (2017)[3], the original study on the development of the Caregiver Abuse Screen for the Elderly (CASE) has been critically discussed.[135] Next to this information source, the search for primary studies revealed three other studies: Perez-Rojo et al. (2015)[169] and Rivera-Navarro et al. (2018)[170] have adapted the CASE questionnaire in the context of dementia caregiving in Spain and Melchiorre et al. (2017)[171] in the context of dementia caregiving in Italy. Details on CASE are presented in Table 20. In French, CASE is called DACAN as "Questionnaire de dépistage de l'abus chez les aidants naturels ».

Table 20 – Caregiver Abuse Screen for the Elderly (CASE)

Detection tool	CASE
Aim	Assess if an informal caregiver is a potential abuser (the risk of abuse)
Types of abuse	All types of abuse

Setting (care setting/country)	• Original study:[135] Home care / Canada
	• Three additional studies:
	  ○ Melchiorre et al. (2017):[171] home / Italy
	  ○ Rivera-Navarro et al. (2018):[170] home / Spain
	  ○ Perez-Rojo et al. (2015):[169] home care/ Spain

Administration	• Type of items (original version of CASE):
	  ○ 8 questions asked to the caregiver ("Yes/No")
	  One point by answer 'yes'. From 4 or more points, the caregiver is considered "abuse likely". The higher the score, the greater the risk of abuse.
	• Completion time: 2 min

Target population	• Original study:[135] 139 informal caregivers • Melchiorre et al. (2017):[171] 438 caregivers of older people with Alzheimer's disease • Rivera-Navaro et al. (2018):[170] 326 informal caregivers of people with different types of dementia • Perez-Rojo et al. (2015):[169] 211 informal caregivers who take care of elders with dementia

Psychometric assessment	• Reliability:
	  ○ *Internal consistency : α=0.71 for six of the eight items*[135]; α=0.86[171]; α=0.713[170]; α=0.84[169]
	• Validity:
	  ○ Construct validity: good[169-171]

Open access	No
Validated in one of the three national belgian languages	Yes in French
Critical analysis	+: the questionnaire is a non-blaming approach to make caregiver confident; rapid administration; it's one of the few tools to evaluate abuser; risk of false-positives (unresolved familial conflicts) -: more efficient when combined with E-IOA/IOA (or BASE)

BASE

The Brief Abuse Screen for the Elderly (BASE) (see Table 21) has been identified in the SR of Gallione et al. (2017):[3] it had been developed by Reis et al. (1995).[136] The search for primary studies didn't revealed additional study on that tool. In French, BASE is called DESIA for "Grille de dépistage des sévices infligés aux aînés ».

Table 21 – Brief Abuse Screen for the Elderly (BASE)

Detection tool	BASE
Aim	Assess the risk of abuse
Types of abuse	All type of abuse
Setting (care setting/country)	Home care / Canada
Administration	• Type of items : ○ 5 items, ("Yes/No") ○ Covering domains: level of suspicion, the type of abuse and the immediacy of response • Completion time: 1 minute
Target population	492 elders aged 60 years and older
Psychometric assessment	• Reliability: ○ Inter-rater reliability: good[136]
Open access	No
Validated in one of the three national belgian languages	Yes, in French
Critical analysis	+: rapid administration -: Specific training needed; more efficient when combined with E-IOA/IOA

CPEABS

The Caregiver Psychological Elder Abuse Behaviour Scale (CPEABS) (see Table 22) has been identified in the SR of Gallione et al. (2017):[3] it had been developed by Wang et al. (2006).[144] The search for primary studies didn't revealed additional study on that tool.

Table 22 – Caregiver Psychological Elder Abuse Behaviour Scale (CPEABS)

Detection tool	CPEABS
Aim	Focused on the identification of psychological abusive behaviour by the caregiver himself
Types of abuse	Psychological
Setting (care setting/country)	Long-term care community and home setting/ Taiwan
Administration	• Type of items : ○ 20 items, (Likert scale) ○ Covering domains: not clearly stated • Completion time: 10 minutes
Target population	92 caregivers
Psychometric assessment	• Reliability: ○ *Internal consistency:* α=0.85 ○ *Test-retest reliability:* 0.64 (p<0.001) over a two-week period • Validity: ○ *Content validity:* 0.95
Open access	No
Validated in one of the three national belgian languages	No
Critical analysis	+: good reliability; rapid administration -: tested on a small sample; culturally limited to the country in which it was developed and tested.

Zarit Burden Interview (ZBI)

The search for primary studies revealed an article about an adaptation of the Zarit Burden Interview. The original Zarit Burden Interview (ZBI) is a 29-item questionnaire developed in 1980 by Zarit et al. (1980)[167] used for the assessment of caregiver burden who care elder person with a chronic illness or mental problem. The ZBI was developed in an outpatient clinical setting.Two revised versions (a 22-item in 1985[172] and a 12-item ZBI)[173] had been developed in different settings. Ojifinni et al. (2018)[165] wanted to test the 12-item ZBI among elderly persons with no clinical diagnosis of illness in Nigeria (see Table 23). The SR of Gallione et al. (2017)[3] didn't selected neither the original tool (ZBI) nor the revised versions.

Table 23 – The ZARIT Burden Interview 12 items

Detection tool	12-item ZBI
Aim	To validate the12-item version of the ZBI for use among informal caregivers of elderly persons irrespective of level of cognition within the Nigerian cultural context.
Types of abuse	All types of abuse
Setting (care setting/country)	Community-dwelling/ Nigeria
Administration	• Type of items: ○ 12 items, (Likert scale from 0 never to 4 nearly always) ○ Two covering domains: personal strain and role strain • Completion time: not stated
Target population	80 informal caregivers
Psychometric assessment	• Reliability: ○ *Internal* consistency*: α*=0.90 • Validity: ○ Construct *validity:* strong
Open access	Yes:https://eprovide.mapi-trust.org/instruments/zarit-burden-interview
Validated in one of the three national belgian languages	Yes in Dutch and French
Critical analysis	+: easier administration due to the short version of ZBI; good internal consistency; good construct validity -: small sample; requires trained personals for administration

QUALCARE scale

Another tool which hadn't been identified by the SR of Gallione et al. (2017)[3] is the QUALCARE scale. This tool was developed by Phillips et al. (1990)[168] in order to assess the quality of caregivers' care to an older person. The search for primary studies revealed one article[166] which estimated the sensitivity and the specificity of the QUALCARE scale (see Table 24).

Table 24 – QUALCARE scale

Detection tool	QUALCARE scale
Aim	Measure the quality of caregivers' care to an older person
Types of abuse	All abuse
Setting (care setting/country)	Home/ USA
Administration	• Type of items : ○ 52 items, (Likert scale from "Best possible care" (1) to "Worst possible care" (5)) ○ Covering domains: environmental, physical, medical maintenance, psychosocial, human rights, financial • Completion time: 1-3 hours

Target population	36 nurses and social workers who provide care to elders at home
Psychometric assessment	• Validity: ○ *Sensitivity:* 0.811-0.977 ○ *Specificity*: 0.167-1.00
Open access	No
Validated in one of the three national belgian languages	No
Critical analysis	+: high sensitivity; possibility to identify the specific caregiving acts the abuse is related to (personal hygiene care, feeding, respecting choices, etc.) -: virtual reality platform with scenarios; long administration time

4.4 Tools for specific settings

Emergency setting

The Elder Assessment Instrument (EAI) (see Table 25) is the only tool selected by the SR of Gallione et al. (2017)[3] to detect abuse in emergency department setting.[174] Another particularity is that this tool has been developed for nurses unlike the other tools analyzed by Gallione and al. (2017),[3] which were mainly addressed to physicians. Moreover, a physical assessment of the older person is done in addition to the EAI questionnaire. One of the authors contacted stated that EAI is also convenient in nursing homes and ambulatory care.

Table 25 – Elder Assessment Instrument (EAI)

Detection tool	**Elder Assessment Instrument (EAI)**
Aim	Detect elder abuse in emergency departments (abuse)
Types of abuse	All types of abuse
Setting (care setting/country)	Emergency departments/ USA
Administration	• Type of items: ○ 41 non scoring items (5-point Likert-type scale) ○ Covering domains: general assessment, possible indicators of abuse, neglect, financial exploitation, abandonment, final assessment, comments and follow-up • Completion time: 12-15 minutes
Target population	501 older adults presented in an emergency department setting
Psychometric assessment	• Reliability: ○ *Internal consistency:* α= 0.84[174] ○ *Test-retest reliability:* 0.83 (p<0.0001)[175]. • Validity: ○ *Sensitivity:* 0.71[137] ○ *Specificity: 0.93*[137]
Open access	Yes:https://hign.org/sites/default/files/2020-06/Try%20This%20General%20Assessment%2015.pdf
Validated in one of the three national belgian languages	No
Critical analysis	+: physical exam of the elder; -: no existing cut-off and non-scoring

Because emergency departments (EDs) play a major role in identifying elder abuse (EA), several authors have developed specific tools used in EDs.

Cannel et al. (2016, 2019)[176, 177] conducted a preliminary pilot study to develop a detection tool called Detecting Elder Abuse by Emergency Care Technicians (**DETECT**) in collaboration with Texas Adult Protective Services (APS) and others.

The DETECT tool was designed specifically to help paramedics identify potential abuse among older adults living in the community during an emergency response. DETECT is based entirely on observations of the older adults' physical and social environment: there is no direct questionnaire to either the older adult or their caregivers.

The long-term goal of the DETECT project is to refine the tool and validate its effectiveness in helping first responders connect seniors potentially living with EA to needed programs and services.

The DETECT detection tool has not been developed to definitively determine whether or not EA is occurring. Rather, it was designed to assist ambulance attendants in determining whether they should contact the APS (as per the current Texas mandate) for further investigation and assistance. Therefore, a positive test should not be interpreted as a confirmed case of EA.

Platts-Mills et al. (2018)[178] aimed to validate a tool called Emergency Department Senior Abuse Identification (**ED Senior AID**), including a brief cognitive assessment (using the Abbreviated Mental Test 4 (AMT4)), questions to detect several domains of EA, and a physical examination. This comprehensive tool is intended to be used by nurses to screen all emergency department older patients for elder abuse and can be completed quickly (i.e., <1-3 min) in most patients with good sensitivity. For all patients who test positive, the assessor would contact the GP prior to possible referral to authorities and/or APS services.

This study is noteworthy because it is one of the few tools (like EAI) to incorporate a physical examination into the detection of abuse. Moreover, the authors even considered evaluating the usefulness and acceptability of the initial detection tool from the point of view of assessors and patients. The usefulness and acceptability of the tool was determined by administering the tool to 20 elderly people receiving care in the emergency department of a large university medical centre in an effort to refine the instruments. Assessing the acceptability of a detection tool is virtually unheard of among all the tools identified.

Furthermore, according to Namboodri et al. (2018),[179] studies assessing the attitude of emergency medical services (EMS) towards elder abuse have shown that while caregivers express a desire to identify and report elder abuse, they often feel that they do not have sufficient guidance on how to do so. The authors also conclude that clearer protocols need to be implemented across the country, although they acknowledge that there is a lack of primary research in this area and that there is no evidence of the effectiveness of tools in any setting.

Primary care setting

Emergency departments are not the only place where elder abuse can be detected. According to Ries et al. (2018),[180] general practitioners (GP) are well placed to identify elderly patients at risk of or experiencing various forms of abuse. They need to be aware of the detection tools available and consider how best to integrate them into their own practice. They also play an important role in the multidisciplinary care of abused older people. Ries et al. (2018)[180] stated that detection should be carried out by community-based service providers including GPs, nurses, home workers and lawyers.

The authors summarized the detection tools (EASI, HS-EAST, VASS, OAFEM, and LFDSS) for various forms of elder abuse available in the primary care setting. According to them, improved detection can be a valuable first step towards improving detection of and response to elder abuse. And while there is a lack of evidence for detection and follow-up strategies, these detection tools offer standardized approaches that can help physicians, but physicians should be aware of their limitations such as the fact that no studies have examined their acceptability for older adults or the fact that most tools have not been validated with older adults with cognitive impairment - a group that may be particularly vulnerable to abuse.[180]

Ries et al. (2018)[180] concluded that systematic, community-based detection in general practices (and other settings) could be a first step towards improving detection of elder abuse. They consider that further work is needed to identify a reliable detection tool that is acceptable to primary care practitioners and their patients.

4.5 An example of a full detection procedure

In the USA, various experiments were developed recently. As explained in Chapter 4, elder abuse is dealt with by charities and mostly by Adult Protective Services (APS). APS agencies are responsible for receiving reports of suspected abuse and neglect, investigating the validity of these reports, and are also responsible for providing a range of services to eliminate or reduce cases of abuse and neglect. People working in APS therefore need tools to help them conduct their investigations and identify risks, while guiding them in the development of appropriate interventions and monitoring of outcomes for situations involving several stakeholders (general practitioners, social workers, psychologists, sometimes justice and police).

Many tools have been developed to assist APS workers in investigating suspected cases of elder abuse. Some of them have already been mentioned in the tools on specific settings section such as DETECT or ED Senior AID but also the HS-EAST which originally aim to identify older people at high risk of need especially for APS. Due to the large number of studies (see Appendix 59), only a few of them are presented in order to get an little overview of that type of full detection procedure.

According to Conrad et al. (2017),[181] various web-based computer systems are being used by APS programs in several states to improve case management processes and workflow. However, very little research has published the results of their use: the Elder Abuse Decision Support System (EADSS) system is one example for which the authors report the results. For this system only an internet connection is required. All detection steps are computerized and centralized. The intake form has been designed to be able to identify all forms of abuse and there is a detailed client information form (including questions on mental status, risk behaviours, substance abuse), an information form on the alleged abuser and an interview with the alleged abuser, as well as recommended interventions, i.e. services, programmes, actions, based on the specifics of the abuse recorded in the abuse and abuser detection forms. Staff can update the form as interventions are implemented. Statistical reports can be generated "as needed", by individual, agency, region and state. The detection of abuse is done using the OAMA tool referred to in the SR of Gallione et al. (2017).[3] The Older Adult Mistreatment Assessment (OAMA) includes published measures of financial abuse (OAFEM), emotional assessment (OAPAM), and neglect, as well as physical and sexual abuse that have been used for more than a decade in Illinois. These measures have been field-tested to reduce the time required by using filters that skip questions that are not applicable to the case in question. However, since the purpose of the study was not the validity of the OAMA, no psychometric values were presented in the SR of Gallione et al. (2017).[3] However, this experience is reported in our discussion as it provides an example of integrating the detection tool into a more comprehensive process.

The Elder Abuse Risk Assessment and Evaluation© (EARAE) is another example of an abuse detection tool, this time designed for social workers working in the field of elder abuse services outside of APS. There was a need to also develop tools for assessments taking place outside of APS when APS is unable to substantiate an allegation of abuse, or if the allegation of abuse does not meet APS criteria for service provision. The objective of the Dauenhauer et al. (2017)[6] was to describe the development, implementation and preliminary results of the EARAE©. This tool is of particular interest, although the authors stressed the need to establish its validity, as it demonstrates once again the importance of embedding abuse detection in a process that includes monitoring and decision-making, all of which are computerized to form empirical evidence

5 DISCUSSION

The literature review showed that tools for detecting elder abuse have not sufficient evidence of their effectiveness:

- The US task force paper[182] concluded in its recommendation that there is insufficient evidence to assess the balance between the advantages and disadvantages of detection tools or should we detect or not.
- The SR of Gallione et al. (2017)[3] concluded that it is not possible to recommend one tool over another, indicating that the quality and performance of psychometric tools is variable and that the detection methods studied had been reviewed and/or validated in a specific population and/or setting, and therefore its applicability for other populations or settings was unknown.
- In a report of the "Federatie Medisch Specialisten",[183] the quality of evidence of the studies presented in the SR of Gallione et al. (2017)[3] is classified as "very weak".

However, although the critical appraisal did not permit to find the best tool to detect elder abuse, the authors [3, 184] agree that the detection tools can be useful in detecting elder abuse because their use raises awareness among health care professionals.

Because the studies did not use a reference test or gold standard (which is not (yet) available for the identification of suspected elder abuse), it was not possible to compare the psychometric characteristics of the different instruments.[183]

Articles identified in the literature studied a tool in a specific setting and/or population. In almost all cases, when additional studies were identified for an existing tool, the aim was to test the tool in another setting or population. The SR of Gallione et al. (2017)[3] selected some tools but not all the existing one whereas some of them are used in current practice. For example, the ZARIT is recommended by the SSMG.

Depending on the context (living place; type of abuser (family, caregiver)) it will be more relevant to use one tool over another. Due to the methodological limitations of the identified tools, no ranking could be made which tools is the most reliable or sensitive to detect elder abuse. Also most of the authors mentioned that a detection on itself will only give an indication of an abusive situation, but may not be considered as a decision tool. Therefore a more comprehensive assessment of the elder and his context is needed, ideally in a multidisciplinary approach, and in combination with other detection tools (for example on cognitive abilities, social context, etc).

Three different **types of detection tools** could be distinguished:

- The risk of elder abuse is evaluated by a direct questionnaire to the elder (self-report)
- The risk of elder abuse is evaluated with a questionnaire addressed to an informant reported (Family and Friends skill)
- The risk of elder abuse is evaluated by identifying potential abusive behaviour from caregivers (informal or not).

The majority of the tools consisted of questions, asked to the elder or his relatives, or an observation of the elder in his social context. An extensive physical examination, to detect physical abuse was only mentioned in two tools (ED Senior AID and EAI).

Very vulnerable people, and in particular people with cognitive disabilities, are particularly exposed to abuse. Paradoxically, even though they should be particularly well followed, this population is under-detected. One of the reasons is that detection tools are not adapted for people with cognitive disabilities. It can be seen that only a few tools include elders with cognitive impairment like the VASS for example. The tests traditionally used to assess the cognitive status of older people are mini mental status of Folstein (MMS)[154, 178] and the MMEEM performance.[153] Under a certain threshold, people were considered to have a cognitive impairment. All these studies conclude that it is difficult to assess elder abuse in this population.

On the other hand, there is **no tools for other types of vulnerability** such as cultural barriers (language) or patients with chronic diseases. Moreover, what about isolated people who, very rarely, visit a health professional? How can they be detected? The objective of the study of Mahmoudian et al.

(2018)[185] was to design and evaluate the psychometric properties of a questionnaire on elder abuse by family caregivers in elderly persons on haemodialysis (in hospital setting). However, no other study was carried out.

Implementation of a detection tool in clinical practice

Based on our critical analysis of the existing detection tools, it seemed impossible to choose the most suitable tool for the detection of elder abuse, which takes also into account the complexity of the situation. In the study of Brijnath et al. (2018),[186] the authors were confronted with the same problem, i.e. none of the tools were deemed suitable by a panel of Australian health professionals for use in their practice. After selection of 5 detection tools based on their internal rigor (VASS, EASI©, EAI, CASE, BASE) (based on the SR of Gallione et al. (2017)),[3] these tools were discussed in focus groups with health professionals about the reliability, the time required for completion and the acceptability to older people of those 5 selected tools. Main findings from these focus groups were the following:

- the current lack of use of a detection tool by the health professionals, instead rather using red flags or even risk assessment tools from other sectors (such as family violence)
- the perception of inappropriateness of the 5 selected tools, referring to the designs and layout of the tools, not considering the cognitive status of the older person nor the influence of cultural diversity on the presentation of elder abuse nor the wishes of the older person regarding the further management of the case

The participants described following conditions for an ideal tool:

- regarding design and layout: rather than binary yes/no questions, a tool should be straightforward, concise, ask one question at a time, avoid technical jargon and judgmental language.
- regarding the cognitive status of the older person: a detection tool should consider cognitive impairment. The participants reflected also on intimate partner violence, in which the abused partner by loosing cognitive inhibitions, starts abusing in response to previous experienced violence. Another issue raised by the participants was the potential abusive behaviour by the overburdened caregiver
- regarding sociocultural confounders: the participants mentioned the issue of language barriers and in an ideal situation a professional interpreter should be present rather than a family member. Also cultural differences were mentioned as potential barriers in the detection of elder abuse, such as immigrant-related abuse which is not considered in the selected tools
- regarding the wishes of the older person: A detection tool should not only rely on clinical observation but the older person should also be involved in their screening and the further management. Participants were reluctant regarding mandatory reporting but preferred building rapport and trust with the older person.

Taking into account these different aspects, the participants preferred open, non-confrontational questions which facilitate building trust. Also the detection tool should be suitable for use in different clinical settings and should be administered by a variety of health professionals. And most importantly the tool should be embedded in a referral pathway on when to report, who to contact and how to involve the older person in the referral process.

The need for a detection tool in Belgian clinical practice was discussed during a meeting with the Belgian stakeholders and the findings of this discussion can be found in Chapter 8.

Other authors searched for other related aspects which could influence the detection and reporting of elder abuse. For example, Garma et al. (2017)[187] found that the knowledge and attitude of health professionals play an important role, thereby referring to the importance of consensus on operational definitions to guide the professional in their interpretation, also personal characteristics of the health professional which could act as barrier or facilitator (e.g. empathy with the abuser, ethical dilemmas posed by reporting, etc.), the need for organizational procedures for the further management of a suspected case of elder abuse, and the need for training

to improve the competences of the health professionals to detect and report elder abuse.

Silva et al. (2017)[188] focused on the detection of elder abuse by dentists and found, based on a systematic search in literature, that the lack of knowledge to identify properly suspicious cases (due to a lack of training on elder abuse) was identified as the major barrier in the detection of elder abuse. Also the variety in attitudes towards the management of a case of elder abuse indicates a lack of standardization and makes the dentist less confident for managing elder abuse cases in their dental practice.

The above-mentioned references related to the implementation of a detection tool in clinical practice were found 'accidentally' in our search for systematic reviews on the efficacy of detection tools. Therefore the results of these studies are presented in the discussion of this chapter, rather than in the results section, which would imply a more comprehensive and in-depth analysis of the current evidence on the factors related to the implementation of a detection tool in clinical practice.

6 BELGIAN PERSPECTIVE

The presentation of the tools for detecting abuse available in the literature aimed to identify one or more tools that could be used in the Belgian context. Many health professionals told us, during the interviews, stakeholders meeting, or Lime Survey, that some tools were already used in Belgium.

The Domus Medica's recommendations about elder abuse[189] refer to the tool EASI©[a] which is a rapid administered tool with questions adapted for the primary care setting according to a feasibility field study and the website of the SSMG refer the EASI© and the ZARIT burden interview.

The RITI is also used in Flanders and the VLOCO is responsible for the further implementation of the instrument in Flanders.

In the report of the Federatie Medisch Specialisten (FMS)[183] some conditions were mentioned to optimize the detection of elder abuse, such as the cross-cultural qualities of a detection tool. This means that a detection tool should be applicable in different cultural settings within a multicultural society, by translations of the questions for example. However, the current tools are not yet tested in different cultural settings nor in different languages (and especially not in Dutch). Also the lack of tools developed for persons with cognitive problems could be a major barrier in the clinical use of detection tools.

The report of the FMS also questioned if the tools were capable to distinct between neglect by others and self-neglect. The aspect of self-neglect is considered as out-of-scope in this report, but remains an important issue in the comprehensive assessment of the elder.

Although there is not sufficient evidence to prove the effectiveness of detection tools, the aspect of awareness, induced by detection tools, should not be underestimated and could be an important objective for Belgian policymakers in the set-up of a more global policy around elder abuse.

[a] https://domusmedica.be/sites/default/files/Richtlijn%20Ouderenmisbehandeling_0.pdf

Awareness around elder abuse should not only be focused on the care providers but also on the elder persons themselves and the general public. The need for training of the care professionals is one of the implementation conditions to increase the awareness around elder abuse and in particular in the correct use and interpretation of the detection tools.

Within the set-up of a step-by-step plan, also potential disadvantages should be taken into account, such the risk for detection-fatigue (an overload of tools) and the currently restricted methodological quality of the instruments (e.g. limited data on psychometric properties) which hampers the roll-out of a more systematic detection approach. Therefore a detection method should be affordable, reliable, simple in use and low burden.

Due to the insufficient evidence of the existing tools, the FMS[183] recommends the use of alarming question “Is here a suspicion of elder abuse”, the so-called “niet-pluis-gevoel”. If so, the care professional should support this suspicion with observed signals or risk factors and further explore the situation. And if needed, further action should be taken.

In addition, a detection tool alone is not sufficient to reduce the phenomenon of abuse and that it must be part of a more global multidisciplinary approach in which detection is only the first step. A positive test should not be interpreted as a confirmed case of EA.

In this respect, the literature raises the fact that health professionals do not know what to do once the detection process has begun: to whom should it be referred? Should specialized organizations take over?

A step-by-step plan, as exists in many countries (see Chapter 4), would enable health professionals to be guided in their detection process and to work in a multidisciplinary manner to ensure optimum care for the elderly person and also for the author.

Key points

- The literature review showed that tools for detecting elder abuse have not sufficient evidence of their effectiveness. Because the studies did not use a reference test or gold standard (which is not (yet) available for the identification of suspected elder abuse), it was not possible to compare the psychometric characteristics of the different instruments.
- However, the authors agree that the detection tools can be useful in detecting elder abuse because their use raises awareness among health care professionals.
- Depending on the context (living place; type of abuser (family, caregiver)) it will be more relevant to use one tool over another.
- Many detection tools are not adapted for very vulnerable people like people with cognitive disabilities, people with cultural barriers (language), with chronic diseases or isolated people whereas they also can be exposed to abuse.
- There is a huge need for organizational procedures for the further management of a suspected case of elder abuse, and for training to improve the competences of the health professionals to detect and report elder abuse.
- A detection tool alone is not sufficient to reduce the phenomenon of abuse and that it must be part of a more global multidisciplinary approach in which detection is only the first step. A positive test should not be interpreted as a confirmed case of EA.
- A step-by-step plan, as exists in many countries, would enable health professionals to be guided in their detection process and to work in a multidisciplinary manner to ensure optimum care for the elderly person and also for the author.

CHAPTER 6: LIME SURVEY

1 INTRODUCTION

The aim of this chapter was to collect the perception of the Belgian health professionals and informal caregivers on the actual detection and management of elder abuse (EA) and how the ideal detection and management of EA should look like. In this way, this chapter participates to answer the second research question on what the barriers and facilitators are experienced by the main actors involved in elder abuse. This survey was a first step to generate the topics with potential bottlenecks and solutions. In a later stage of this project, these topics were further elaborated with more detailed statements and were discussed during a stakeholders meeting.

The aim was to collect the variety of perceptions on the same problem, for example which procedure should be followed to report a case of elder abuse, therefore representativeness of each profession was not searched for. Within the questions, some results will provide new information on topics not yet elaborated in the other sections of this report, other answers serve as more in-depth description or clarification of certain topics already discussed in other sections.

2 METHODOLOGY

For the elaboration of the questionnaire, several methodological options were balanced and finally following decisions were made:

- Content of the questionnaire

  It was decided to cover the different steps on how to handle with a case of elder abuse, starting with the detection of a (suspicion of) an abusive situation (including the need for a detection tool, the characteristics of such a tool, who should detect and the barriers and facilitators related to detection), the determination of the urgency to intervene, the interventions after detection (mainly focused on the reporting procedure, who should report and the barriers and facilitators related to these interventions), the existence of a good clinical practice, the role of a reference person, which organisations could be contacted and how the elder can be involved in decision-making. Furthermore an additional section was foreseen for personal stories and the final section probed for ideas to improve the current situation. These topics were discussed within the KCE research team and with external experts. The questionnaire has a common trunk for all respondents but differs then according to professionals or informal caregivers. The house keepers were labeled also as informal caregivers. Some sections were only accessible for the professionals (e.g. urgency of intervention, the interventions).

- Development of the questionnaire

  An online survey tool was chosen for the set-up of this questionnaire (Lime Survey). An electronic form of a questionnaire facilitates the dissemination towards the target population and afterwards the data can easily be analysed with the help of the software program. The data analist of the KCE performed the more in-depth analyses. A combination of closed an open questions was used. The closed questions were in most cases a bullet list in which the respondent had to tick his preferences. Open questions were provided so that the respondent could clarify his answer or give additional comments to the topic. The online questionnaire was available both in French and in

Dutch. Also informed consent of the respondent was obtained before entering the questionnaire. Before launching the official version of the survey, a draft version was tested by a panel of experts in the field of elderly abuse. The full version of the questionnaire can be received on request (via mail: info@kce.fgov.be).

- Target population

  The questionnaire was intended for all types of health professionals who were involved in elderly care. It was decided to cover a very broad spectrum of domains, including the medical sector (physicians, nurses, auxiliary nurses, physiotherapists, occupational therapists, psychologists, speech therapists, medical imaging technologist, ambulance man, pharmacists), the social sector (social workers, spiritual advisors, mediation services), aid sector (housekeeper, cleaning aid, family help), educators, researchers, and managers/coordinators. Both individual health professionals as professional associations were contacted to complete the questionnaire and to distribute it to their members. 'Clinical practice' was used throughout the text, but could refer to different care settings, such as hospital department, nursing homes, ambulatory care practice, care at home, etc. No linkages were made between the care setting and the answers, due to the potential selection bias of participants and the non-representativeness of the sample. It was decided not to use a specific token per respondent, wereby the link to the questionnaire could be forwarded to colleagues or other persons interested in the topic. The sectors of police and justice were purposely excluded for this questionnaire. Within the KCE team, it was decided to perform more in-depth interviews with representatives of these sectors.

- Timing

  The online survey was launched on the 15th of March 2019 and was open until the 10th of April 2019. A reminder was send to all participants after 2 weeks.

- Data analysis

  All answers are anonymised, and where needed, places or names were left out to avoid to recognize certain care settings.[a] The analysis itself was a combination of quantitative results (frequency that answers were given or linkages made between different variables, and figures and tables) and qualitative results. The qualitative answers were either analysed in NVivo or on paper. The main purpose of this qualitative analysis was to classify the answers per theme (these themes emerged from the data and were not predefined) and to end up with an overall analysis across the different themses per section. Both types of results (quantitative and qualitative) were used in a complementary manner, i.e. often the open questions gave more clarification on the quantitative results. Where possible a comparison was made between the professionals and the informal caregivers. In some sections a comparison was made between the different types of health professions. For feasibility reasons, all health professionals were divided in 5 groups: the physicians (GPs and specialists), the psychologists, the managers, the paramedics (including physiotherapists, auxiliary nurses, occupational therapists, speech therapists, nurses) and the psychosocial sector (including educator, ambulance man, social worker, spiritual advisor). In the analysis these 5 groups were compared to each other. The analyses were performed by one researcher with the help of a data analist for the quantitative part.

[a] For the sake of easy readability, only male form is used in this chapter.

- Limitations

  The answers are subjective interpretations by the respondents, with a potential bias. The analysis of these answers is therefore a representation of the respondent opinions and knowledges and are not representative of all situations in Belgium. In addition, the method does not allow for the factual verification of the accuracy of all the information, for example, the analysis on the trainings on elder abuse is fully based on the description the respondents gave in the open question.

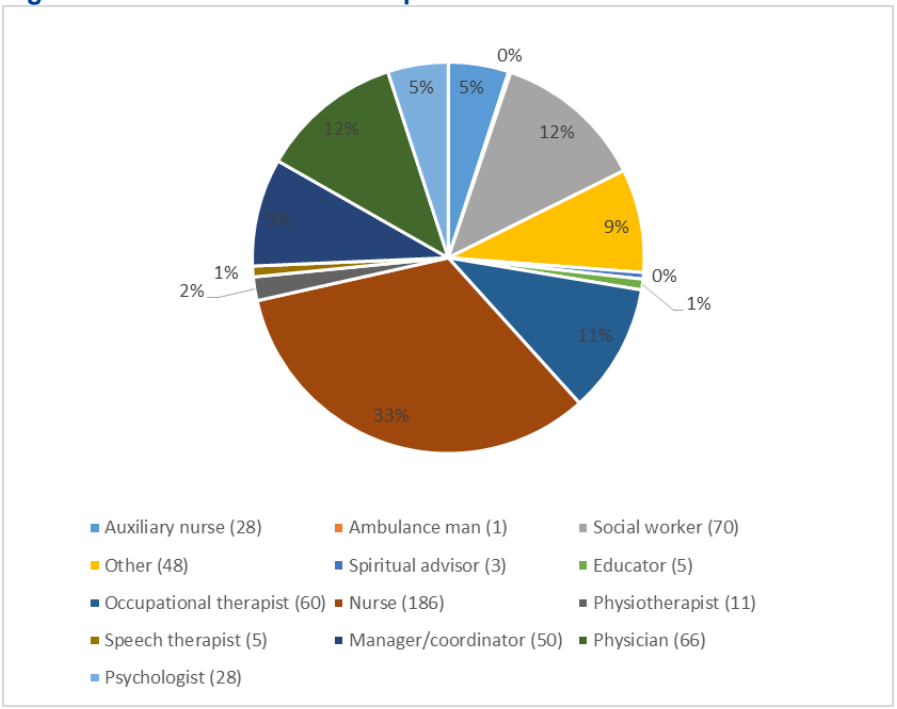
3 RESULTS

3.1 Characteristics of the respondents

The online survey was sent to more than 4000 health professionals and informal caregivers involved in elderly care and potentially confronted with elder abuse. In total 1189 responses were registered of which 625 complete responses. In the analysis of the results, only these complete responses were used (n=561 professionals and n=64 informal caregivers).

The majority of the respondents were women (80.8% vs 19.2% men), in the age group 41-65y old (52% vs 42% 18-40y vs 6% >65y) and working as a health professional (83.08% vs 14.4% in social sector and 1.5% in service sector, 0.5% in education, 0.33% in authorities and 0.16% in parish). Only 9.76% of the total respondents identified themselves as informal caregivers. Geographically, professionals from Flanders and Wallonia were equally represented (37.4% vs 41.2%), with a smaller representation of Brussels region (12.64%). Most professionals were either working in a hospital (30%) or in a residential care setting (e.g. nursing home) (35.5%) or in home setting (23.6%). Only a minority worked in an ambulatory care setting (10.24%). Within the hospital-based care professionals, the majority was working in the geriatric department (17.6%). Also social services and more mobile functions were found, which are not linked to one department but are working across different departments in the hospitals. Nevertheless the wide-spread communication about this online survey towards all professional organisations, some professions were not represented among the respondents, for example family helpers, technicians in medical imagery, pharmacists, and mediators. In Figure 16 a distribution of the different care profiles is presented.

Figure 16 – Distribution of care profiles



3.1.1 Training on elder abuse

Half of the respondents indicated to have followed a training on elder abuse (50.72%), of whom only a minority received a training on elder abuse during the formal education (16.32%). The respondents could specify at which moment they've got the training and the answers could classified in following categories: either a training was organised by a specialised organisation (e.g. VLOCO or a professional organisation, like SSMG) or by the employer (e.g. the residential care setting) or at a conference (e.g. VVVS conference), or during a specialisation within geriatrics (BBT Geriatrics, CRA, reference person for dementia). Some people mentioned also that they did some self-learning about the topic, often driven by their experience with elder persons.

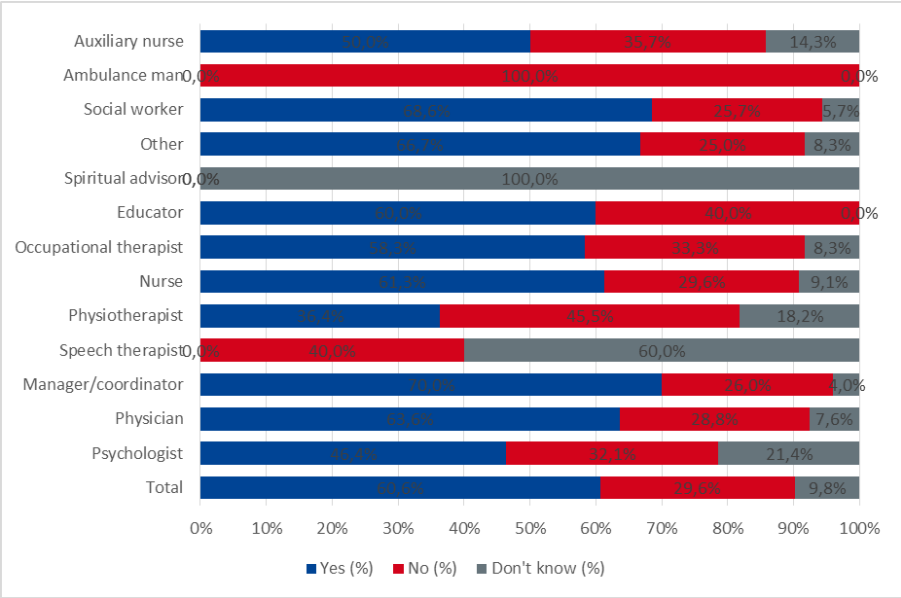
Some respondents have given a short description of their training. The following themes were identified, varying from theoretical courses on awareness, definitions of abuse, detection (with some respondents mentioning the RITI scale), and management towards more practical sessions with for example a theatre play or a video with examples. Specialised organisations, such as Respect Senior, VLOCO and Vlaamse Ouderenraad were often mentioned as initiators of these courses. Next to the more general topics, such as detection and management, more particular aspects were mentioned, for example focus of some training were put on the well-being and good practices in elderly care with specific attention for empathy, free choice for the elder, empathy, communication and respect. Another example was the attention for the burden for the (informal) caregiver and the related potential risk for abuse. Occasionally across the 272 open answers about the training, more organisational aspects, such as collaboration between different organisations and juridical procedures, were mentioned. A respondent mentioned that next to trainings organised by the employer, also a budget was foreseen for the creation of a hospital-based multidisciplinary working group in which cases of abuse could be discussed. Another example was the set-up of a detection system which could be filled in after a suspicious home visit.

Within the responses, not only descriptions were given but also the need for more information and training about elder abuse was pointed out. Some respondents mentioned that the training they've got, was only an eye-opener, but they still miss practical information on who to contact and which actions should be taken.

3.1.2 Particular attention for elder abuse in clinical practice

In Figure 17 a linkage was made between the profession of the respondent and his answer if particular attention was given to elder abuse in his clinical practice. The questions of this sections were only addressed to the health professionals. This figure is not representative for all professions, but gives an impression in which types of care professionals more or less attention for elder abuse is perceived. In general could be stated that more than half of the respondents (60.6%) answered positively (i.e. a particular attention was paid to elder abuse) on this question.

Figure 17 – Particular attention for elder abuse per profession



In the survey more detailed questions were asked to clarify how the topic of abuse was brought to the attention in their setting. In Table 26 the different kinds of particular attention are presented per type of care setting, varying from an individual clinical practice to a more general institutional level. In general could be stated that the three most often cited types of interest were training, a procedure and a discussion group.

The respondents could also fill in their own type of attention in their clinical practice (10% of the respondents) and the most cited categories were: multidisciplinary consults within the clinical care setting or even transmural with other services (e.g. police, specialised organisations, etc.), no formal procedure but rather a more case-specific approach, in which the care professional can also contact his supervisor, a deontological code with emphasis on the values of good care practices and in contrary the lack of procedures.

A fairly similar distribution was found between the different aspects of the attention given to EA issue in respondents' practice:

- Detection of a situation of elder abuse via a test or criteria: 21.6%
- Evaluation of the urgency to intervene: 20.16%
- Psychosocial interventions: 20.96%
- Notification to a specialised organisation: 20.96%
- Concept of well-being and prevention of abuse: 36%

The declaration to the police or to justice was clearly less cited as part of the attention in clinical practice (10.56%).

Table 26 – Particular attention for elder abuse, per type of care setting

	Organisation (n=235)	Service/team (n=186)	Group practice (n=91))	Solo practice (n=107)
Discussion group	15.1%	16.7%	23.5%	18.3%
Charter	8.8%	7.8%	7.4%	10.0%
Procedure	16.5%	19.3%	12.3%	11.6%
List of criteria	5.6%	7.8%	6.4%	6.0%
Training	24.1%	19.0%	21.6%	19.1%
Regulations	7.8%	7.2%	9.8%	10.0%
Quality handbook	14.1%	11.0%	13.2%	16.7%
Leaflet	5.8%	6.9%	4.4%	5.6%
I don't know	2.2%	4.3%	1.5%	2.8%

3.2 Detection of elder abuse

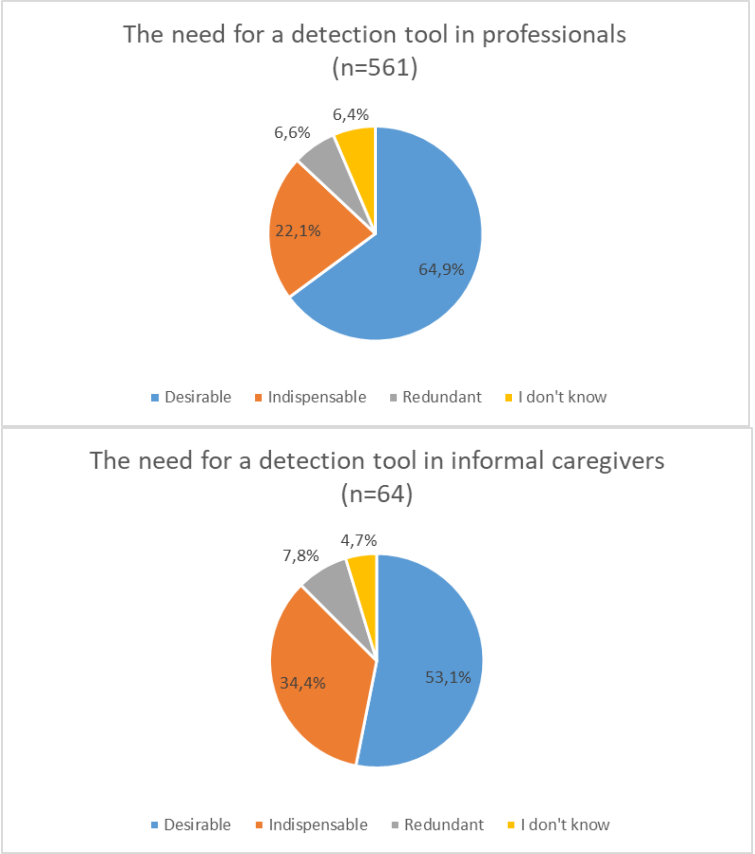
The questions in this part of the online survey were focused on the potential need for a detection tool and how this tool could best fit in clinical practice. These questions were asked to both the professionals and the informal caregivers and in the analysis a comparison between both groups is made where possible.

In a subsequent section of the survey, the participants were questioned about the barriers and facilitators related to the detection of elder abuse. These results were incorporated in this analysis, to gather all information related to detection in one chapter.

3.2.1 The need for a detection tool

The majority of the professionals indicated that a detection tool (consisting of a test or criteria) would be desirable (63.68%) (see Figure 18). Almost a quart of them (23.36%) found it indispensable and only a minority found it redundant. A similar result was found in the informal caregivers, with somewhat more respondents who indicated the indispensable need for a detection tool (34.4%), whereas 53.1% found it more desirable (see Figure 18).

Figure 18 – The need for a detection tool, by professionals and informal caregivers



If the respondent answered that a detection was redundant, then he could further explain his answer in an open question. Following reasons, related to the use of a detection tool, were mentioned:

- Need for a detection tool is dependent on the care department: some contradictory answers were given in which department a detection should be used. A respondent indicated that in the geriatric department such a tool should be indispensable whereas in other departments, such as surgery, its use seemed less applicable. Another respondent saw the need for a detection the other way around: in geriatric care the care professionals have enough experience and clinical sense to detect elder abuse without a detection tool whereas in other departments, such a tool could facilitate the detection.
- Insufficiency of a tool on its own: Several respondents mentioned that a tool seemed insufficient to detect the complex situation of an abuse or to confirm a suspicion of abuse. A more comprehensive assessment, including observation, communication and a trust relationship with the elder, is needed to confirm a suspision of abuse. Even if the tool has pointed out that there are signs of abuse, often the elder person will refuse any further help, often induced by fear for the consequences (e.g. isolation, reprisals, etc). Also the importance of open communication with the GP, who is considered as the confidential advisor of the elder and his environment, was emphasized by the respondents.

  A respondent revealed that in most cases the professionals are looking for the perpetrator in the family of the elder, but often abuse by care professionals is neglected and should also be taken into account in the detection process. Some other respondents pointed out that next to the detection of abuse, also the risk factors should be handled, such as exhaustion of the caregiver, the routine and the aggravating care for the elder.
- Methodological limitations of a tool: High sensitivity of such a test is considered as a necessity for its use in clinical practice, however this could also imply a potential risk for overdetecting cases of abuse due to its use by less experienced care professionals. Avoiding false accusations are one of the main concerns mentioned by the health professionals. Also trying to objectify a suspicion of abuse, could hamper further follow-up, by over- or underestimating the impact of a maltreatment differently as perceived by the elder.
- Burden for the caregiver: Several respondents mentioned the already existing oversupply of procedures and another tool would drown in the high amount of tools which are not frequently used in clinical practice.

Also more general reasons, linked to the care for the elderly, were mentioned:

- Power of decision of the elderly: a respondent mentioned the importance of autonomy of the elder person and his decisional capacities about his own life
- No abuse: some respondents mentioned that elder abuse did not happen in their clinical practice or in their family

3.2.2 *Characteristics of a detection tool*

In the online survey a list of (desirable) characteristics of a detection tool was provided, in which the respondent could tick all items they considered essential for its use in clinical practice. No restriction in number of ticks was given.

Figure 19 (in professionals, n=488) and Figure 20 (in informal caregivers, n=56) give an overview of the characteristics for a detection tool. In both groups the item on the ease of the use was the most frequently ticked (86% in the professionals and 70% in the informal caregivers). The next most frequently ticked items differ between both groups: whereas the professionals prefer a tool with clear instructions (70%) and could be completed in a very short time of notice (less than 10 minutes) (67%), the informal caregivers preferred that the tool could be used at home and in an institutional care setting (70%) and a tool which is adapted to the linguistic, cultural and social lifestyle of the elderly (63%). Other items which were clicked by more than half of the respondents (per group) were: its applicability in home and institutional setting (58%) and the objective indicator of the risk (50%) in the group of the professionals. In the group of informal caregivers, clear instructions (61%), part of the global medical file (54%) and ease the moral pressure to declare a potential case of abuse

(50%). The latter was only indicated in 38% of the professionals. In both groups was the utility for data collection the least clicked on (27%).

In the subsequent open question when the respondent wanted to add additional characteristics, following aspects were mentioned: such a detection tool has already been developed (the RITI scale), the detection tool could be developed in line with the Dutch detection tool for child abuse (Sputovamo tool), the tool should be evidence-based and the tool should be embedded in an action plan which clearly states which steps should be taken after the detection of abuse. Next to characteristics related to the tool itself, some respondents mentioned also the importance of prevention of abuse by increasing the time of care for the elder. This aspect is revealed several times through the questionnaire.

Figure 19 – Characteristics of a detection tool, by the professionals

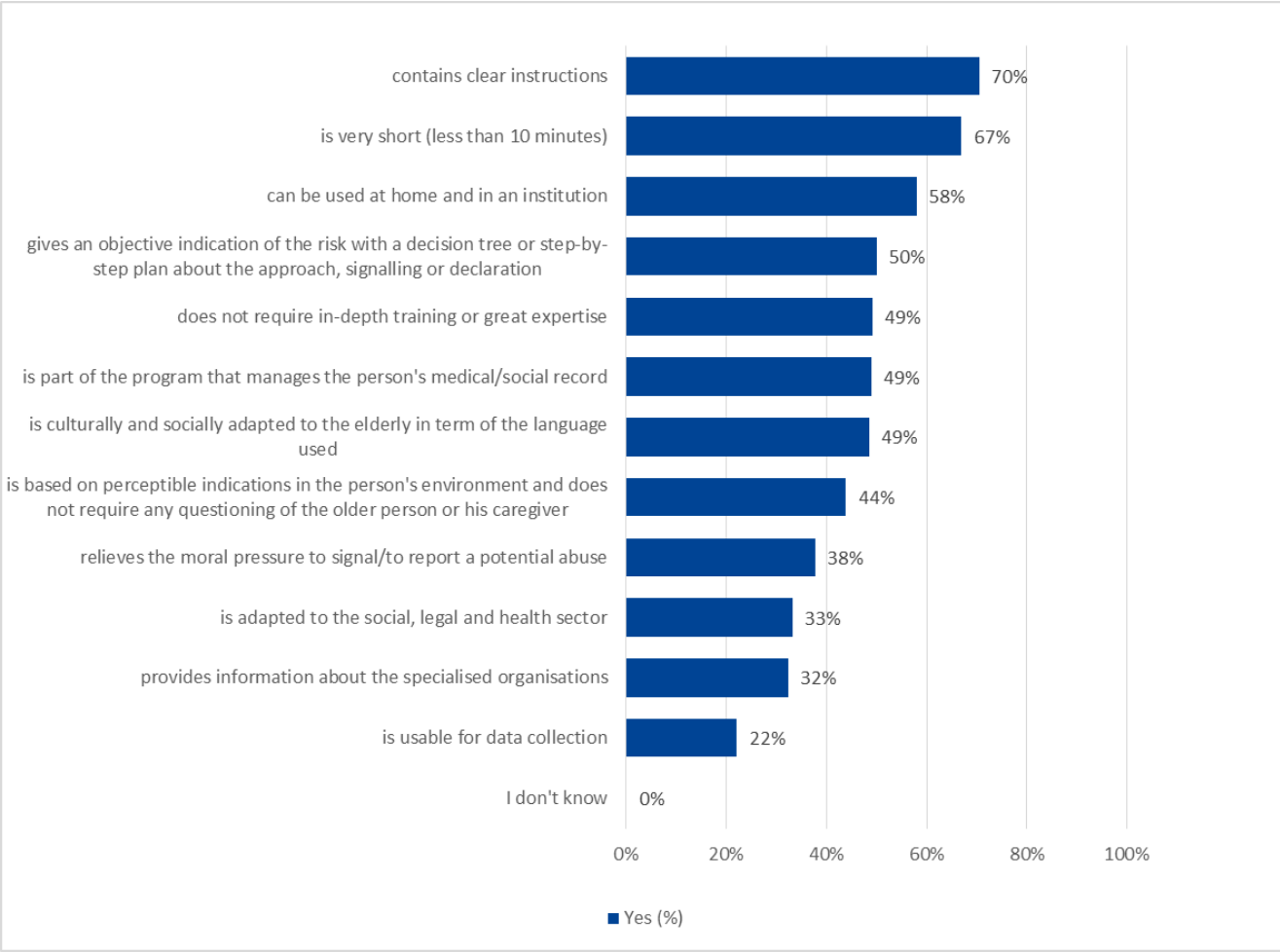
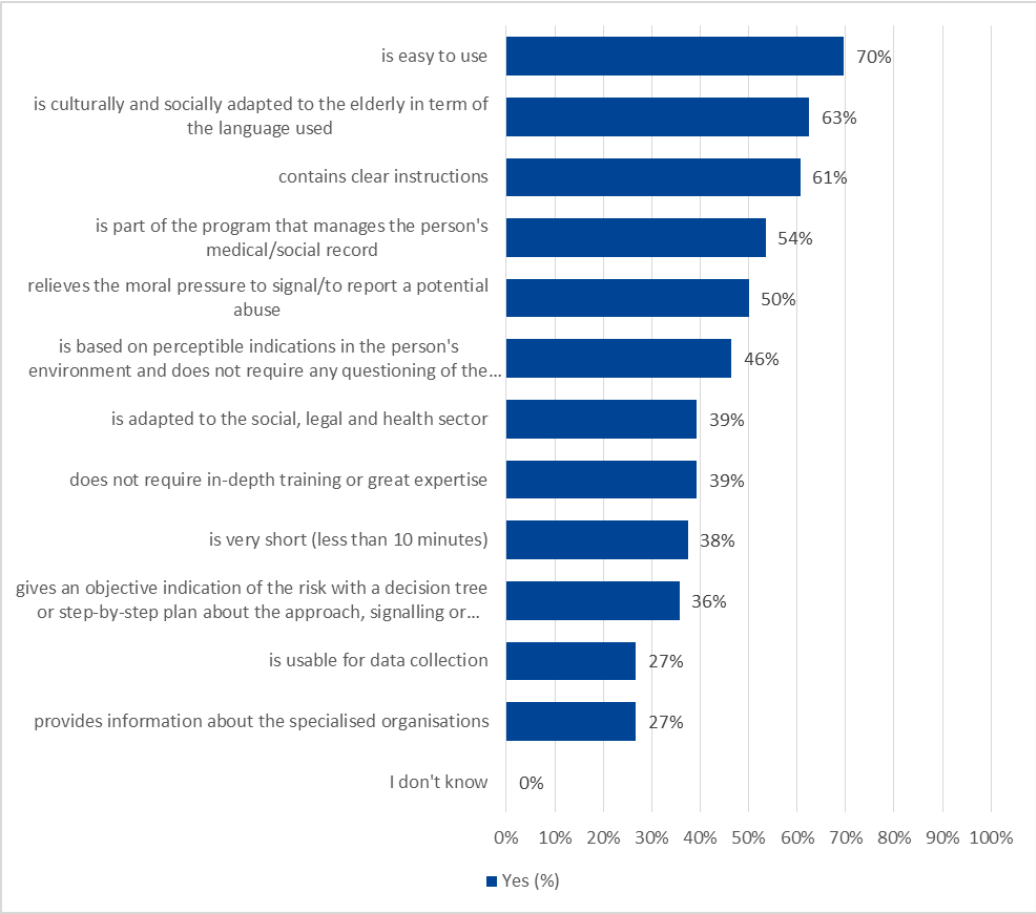


Figure 20 – Characteristics of a detection tool, by informal caregivers



3.2.3 Who should detect for abuse?

The respondents could indicate which care professional should detect abuse. A non-exhaustive list of different types of professionals was provided and the respondent could tick as many answers as he wanted. Also an open question was available to add other types of professionals or other comments related to this question who should detect for abuse.

In the analysis a comparison was made between the answers given by the professionals versus the informal caregivers. In Figure 21 (for the professionals, n=561) the 5 most cited care providers who should detect elder abuse are the nurse (82%), the physician (81%), the nursing auxiliary (74%), the social worker (72%) and the persons around the elder (71%), equally mentioned with the family helper (71%). In the informal caregivers group (n=64) the physician (83%) and the nurse (81%) were the most cited, similar to the group of professionals. However, the persons around the elder were equally cited as the nurse (81%), indicating that detection of abuse is not exclusively a task for the health professionals but also for the environment of the elder. The other most cited persons who should detect abuse, were the nursing auxiliary (78%) and the home help (75%). There were none of the answers options which were not chosen by the respondents. In Figure 22 the ranking given by the informal caregivers is presented. The results were quite similar to those from the health professionals, with a more important role for the persons around the elder (81%, second most cited like the nurses).

Figure 21 – Who should detect elder abuse, by total of professionals

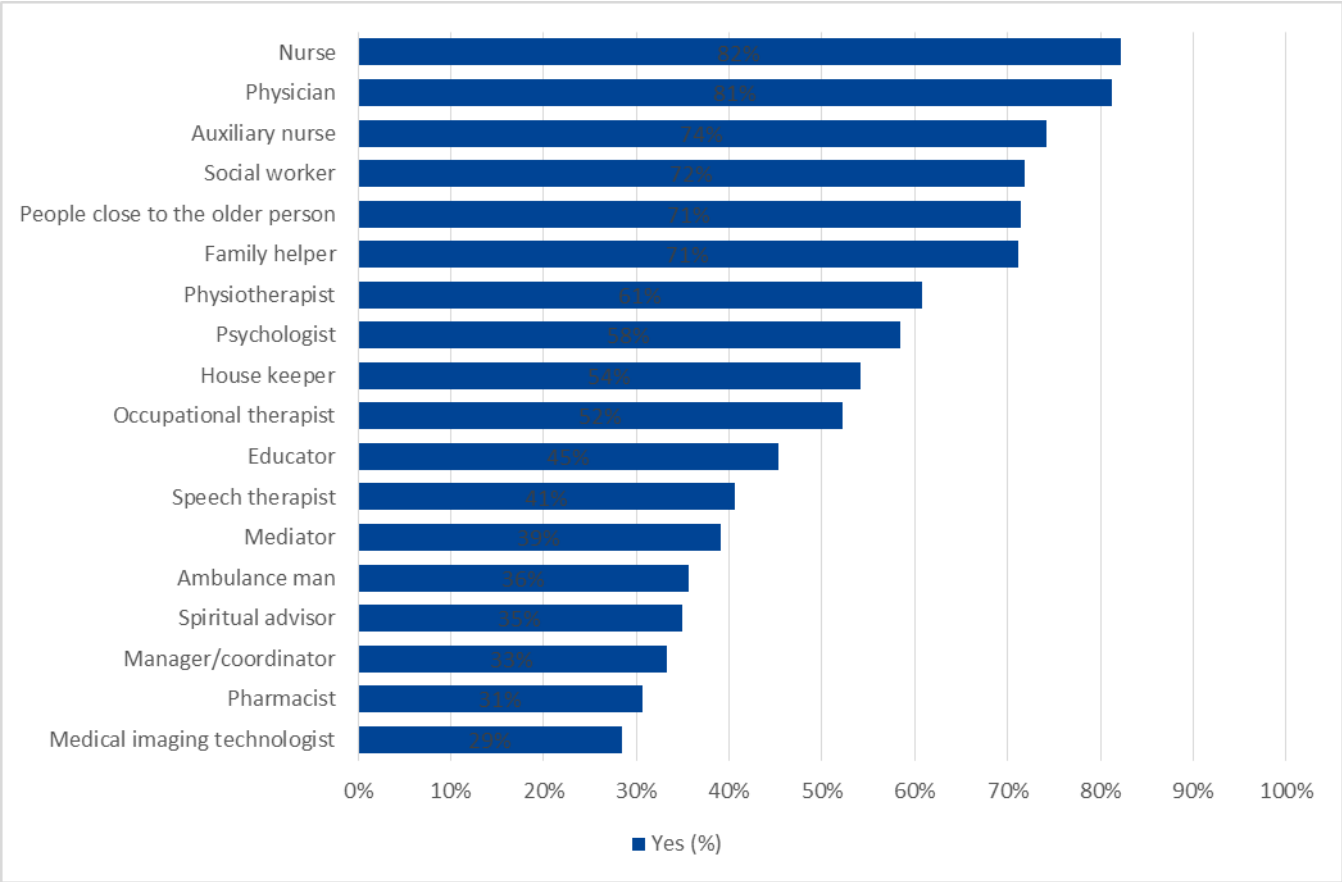
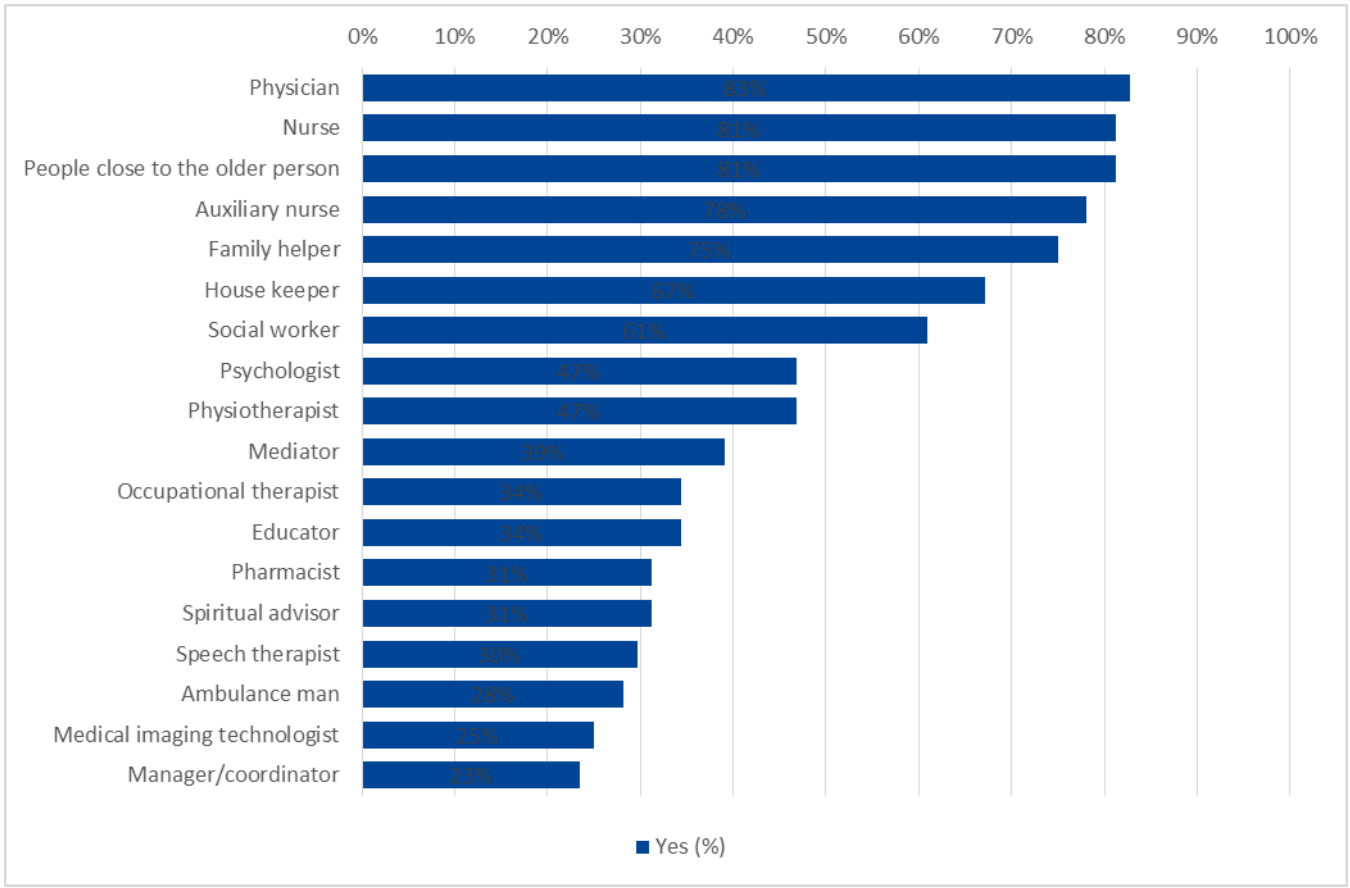


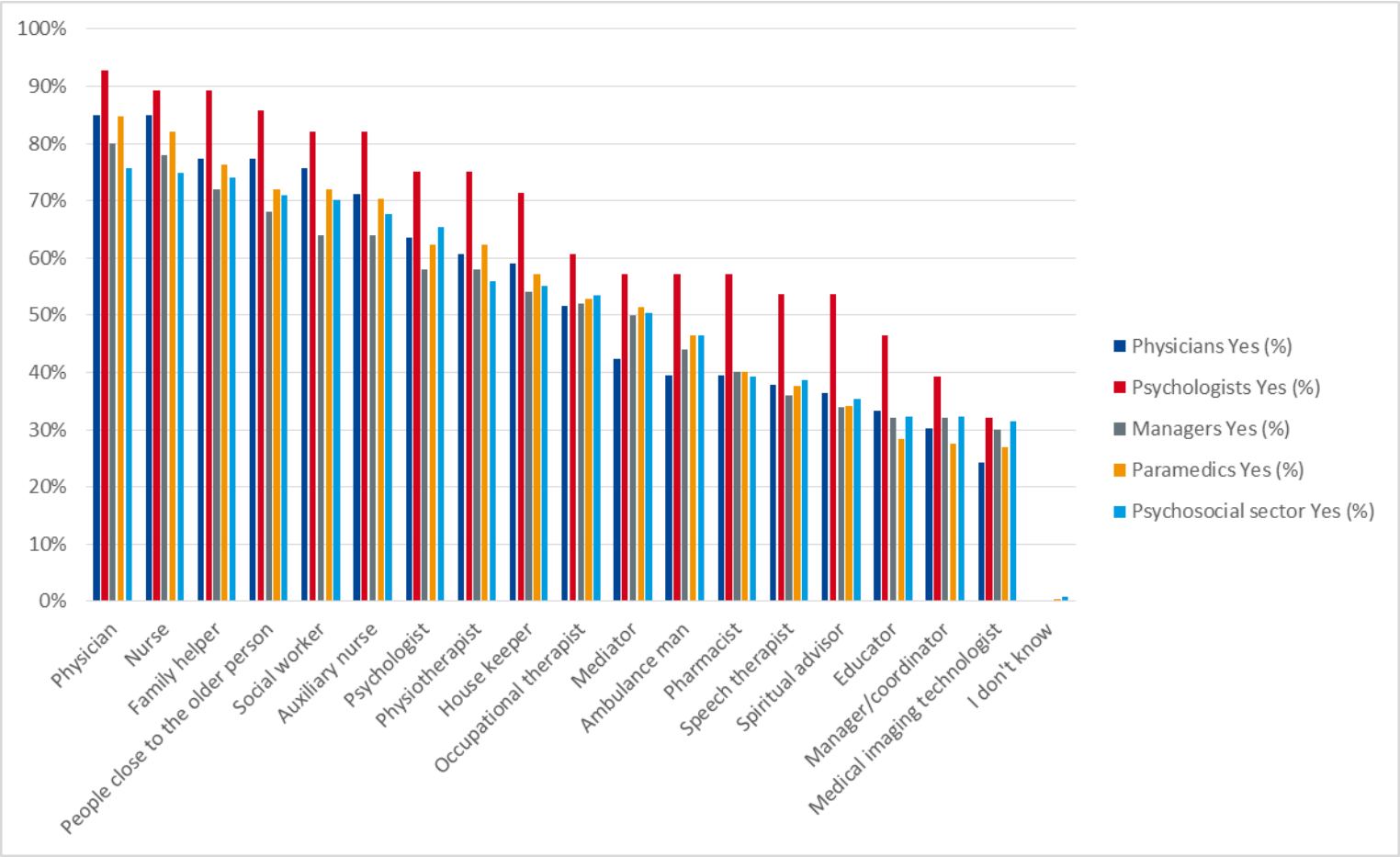
Figure 22 – Who should detect elder abuse, by informal caregivers



In a sub analysis, the health professionals were divided in 5 groups: the physicians (GPs and specialists), the psychologists, the managers, the paramedics (including physiotherapists, auxiliary nurses, occupational therapists, speech therapists, nurses) and the psychosocial sector (including educator, ambulance man, social worker, spiritual advisor). The ranking on who should detect elder abuse does not differ much between these 5 groups (see Figure 23) (physicians, n=66; psychologists, n=28; managers, n=50; paramedics, n=290; psychosocial sector, n=127). In all groups the physicians and the nurse were the highest ranked professionals, either followed by the environment of the elder (according to the group of physicians) or by nurse auxiliary or family help (according to managers and the paramedics). Some particularities were found, such as in the group of psychologists, the psychologist was identified as one the highest ranked professionals to identify elder abuse, whereas in the other groups the psychologist was lower placed in the ranking. In the contrary, the group of managers identified themselves not as one of the most important professions to detect elder abuse. Also the medical imaging technologist appeared in the top 5 of most cited professions (in the group of the psychosocial sector) whereas in the other groups this profession was rather low ranked. Overall, could be stated that even the small differences between the groups, a similar ranking can be found, in which the physician and the nurse were the highest ranked, and that all the figures show that all professions were ticked, indicating that all respondents were convinced that all health professionals should feel responsible to detect elder abuse.

The open question revealed some supplementary information about who should detect elder abuse. All 123 respondents emphasised that everybody should be concerned and should (also) be aware of the risk for abuse. Other, less frequently cited answers were the role of a multidisciplinary team or other professionals who were not mentioned in the list, such as animator in a home for the elderly or the spiritual advisor. Also the elder themselves were mentioned as potential detectors of abuse. A respondent mentioned also the minister of health, indicating the importance of this topic not only on care level but also on policy level.

Figure 23 – Who should detect elder abuse, by the 5 different professional groups



3.2.4 Barriers and facilitators related to detection

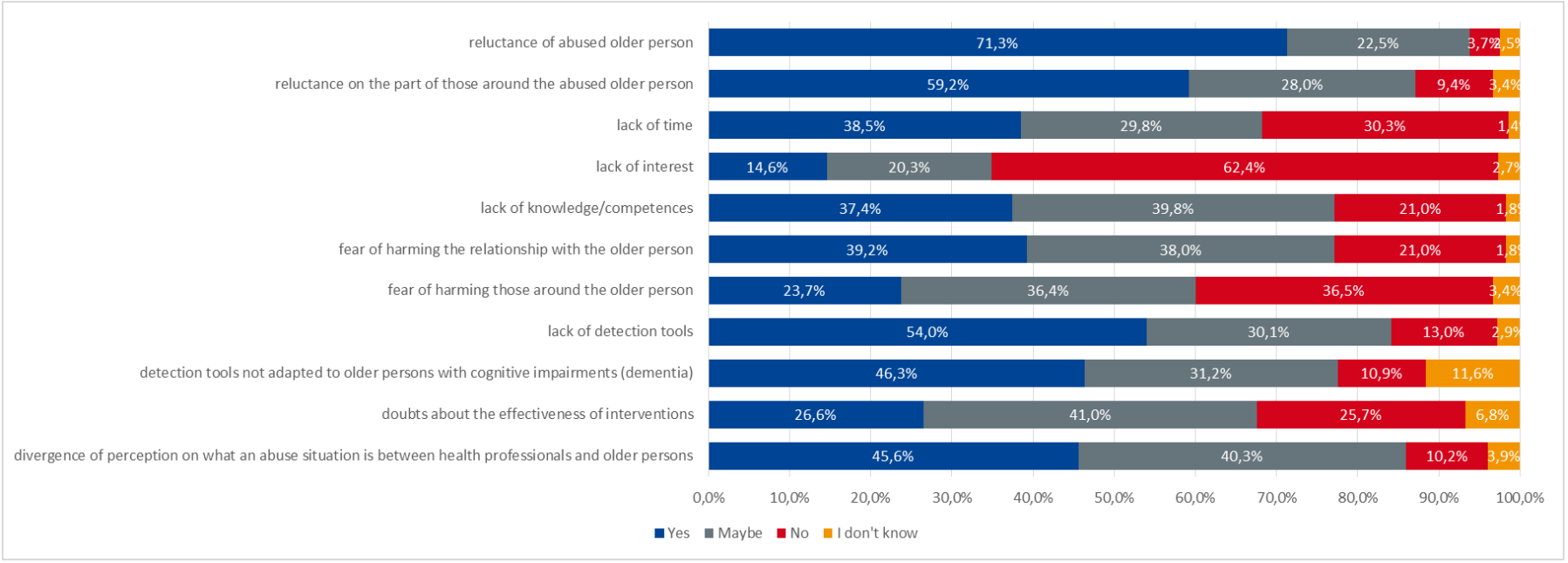
3.2.4.1 Barriers for detection

Both professionals and the informal caregivers were questioned about their perceived barriers in the detection and management of elder abuse. In both groups a list of barriers was suggested and in first instance all potential barriers could be indicated. The respondent could tick 'yes', 'no', 'maybe' or 'I don't know', every item had to be answered. In the next question the respondent had to choose the three most important barriers derived from the list of indicated items. There were separate lists for detection and for management of elder abuse (see section on intervention).

Barriers cited by the professionals

The first graph (Figure 24) shows the distribution of frequencies across all barriers, perceived by the professionals (n=561). The most cited barrier for the detection of elder abuse was the reluctance either by the elder (71.3%) or by the entourage of the elder (59.2%). Another highly cited barrier was the lack of detection tools (54.0%). Remarkable in the answer options, is the high rate of 'maybe' responses, indicating the doubts of the professionals. Lack of interest was the less cited as a barrier. For other barriers a similar distribution of answer options was found, for example for lack of time 38.5% indicated this as a barrier, whereas 30.3% as 'not' and 29.8% as 'maybe'.

Figure 24 – Barriers for detection, by professionals



In Table 27 two analyses were combined, i.e. the analysis of the three most important barriers and a clustering of results per profession group. As in previous analyses, the health professions were divided in 5 groups: the physicians (GPs and specialists), the psychologists, the managers, the paramedics (including physiotherapists, auxiliary nurses, occupational therapists, speech therapists, nurses) and the psychosocial sector (including educator, ambulance man, social worker, spiritual advisor).

Whereas in the overall analysis, the reluctance of the elder of his environment was highly cited as a main barrier in the detection of elder abuse, this barrier was less often cited in the top three of barriers (except in the psychosocial sector). Common barriers across the groups were the lack of detection tools and the lack of knowledge. The paramedical group mentioned also the lack of time as an important barrier. Only the group of physicians ranked the fear of harming the relationship with the elder as a main barrier. The divergence of perception between caregivers and older persons on what an abusive situation is, was ranked as one the main barriers for detection in the group of the managers, the psychologists and the psychosocial sector.

Table 27 – Barriers per group of professions

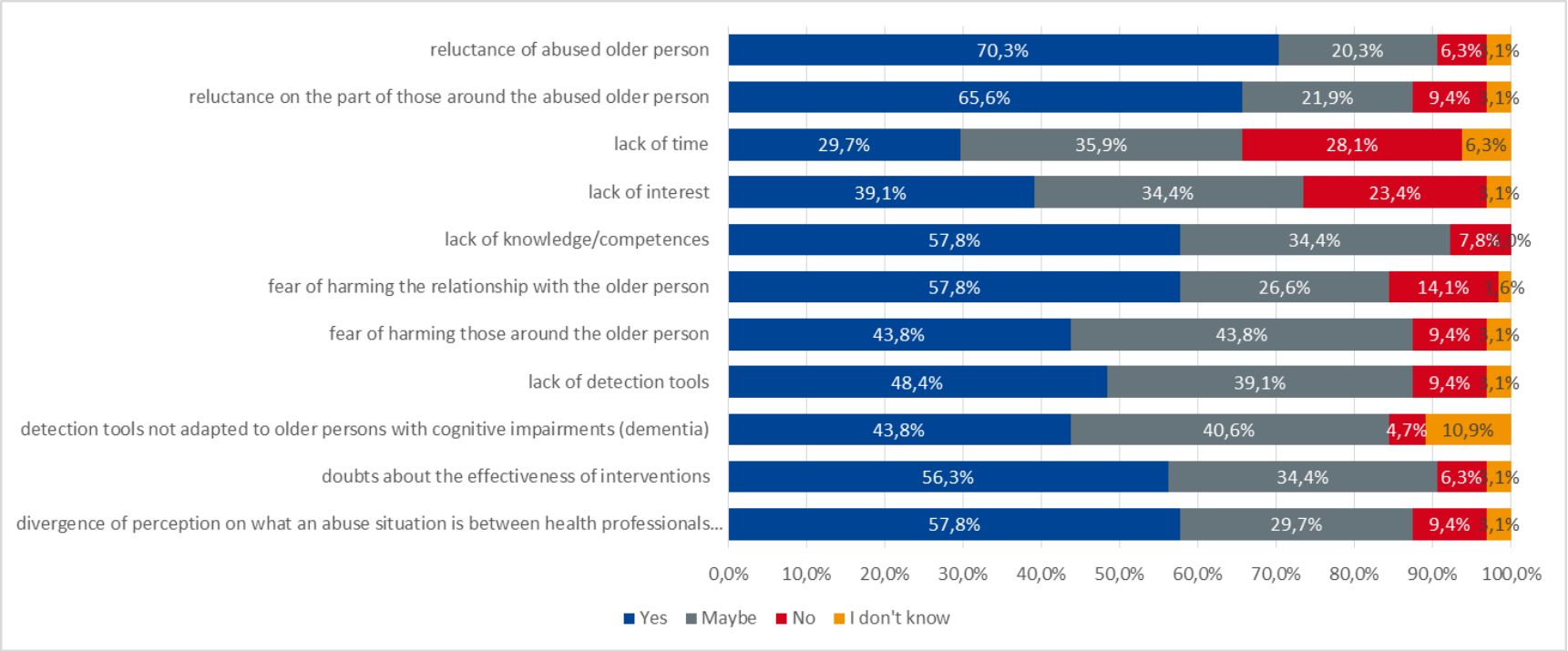
	Managers	Physicians	Paramedics	Psychologists	Psychosocial sector	Total (n=561)
Reluctance of abused older person	57.6%	63.6%	61.2%	65.2%	**72.5%**	64.0%
Reluctance on the part of those around the abused older person	39.3%	28.1%	39.0%	70.6%	43.8%	40.7%
Lack of time	47.1%	54.2%	**63.3%**	66.7%	47.4%	58.3%
Lack of interest	0.0%	12.5%	21.4%	66.7%	19.0%	19.5%
Lack of knowledge/competences	**70.0%**	**87.0%**	**61.3%**	**87.5%**	47.9%	62.9%
Fear of harming the relationship with the older person	55.0%	**68.0%**	43.4%	50.0%	42.1%	47.3%
Fear of harming those around the older person	20.0%	6.7%	15.9%	0.0%	10.8%	13.5%
Lack of detection tools	**73.3%**	**73.1%**	**62.1%**	**75.0%**	**56.8%**	63.4%
Detection tools not adapted to older persons with cognitive impairments (dementia)	39.1%	36.0%	40.4%	46.2%	46.0%	41.5%
Doubts about the effectiveness of interventions	35.7%	57.1%	37.2%	0.0%	38.5%	38.3%
Divergence of perception on what an abuse situation is between health professionals and older persons	**68.4%**	50.0%	58.0%	**77.8%**	**57.4%**	58.6%

Barriers cited by the informal caregivers

Similar to the professionals, the informal caregivers could indicate in the first question all perceived barriers, followed by the three most important barriers in the second question.

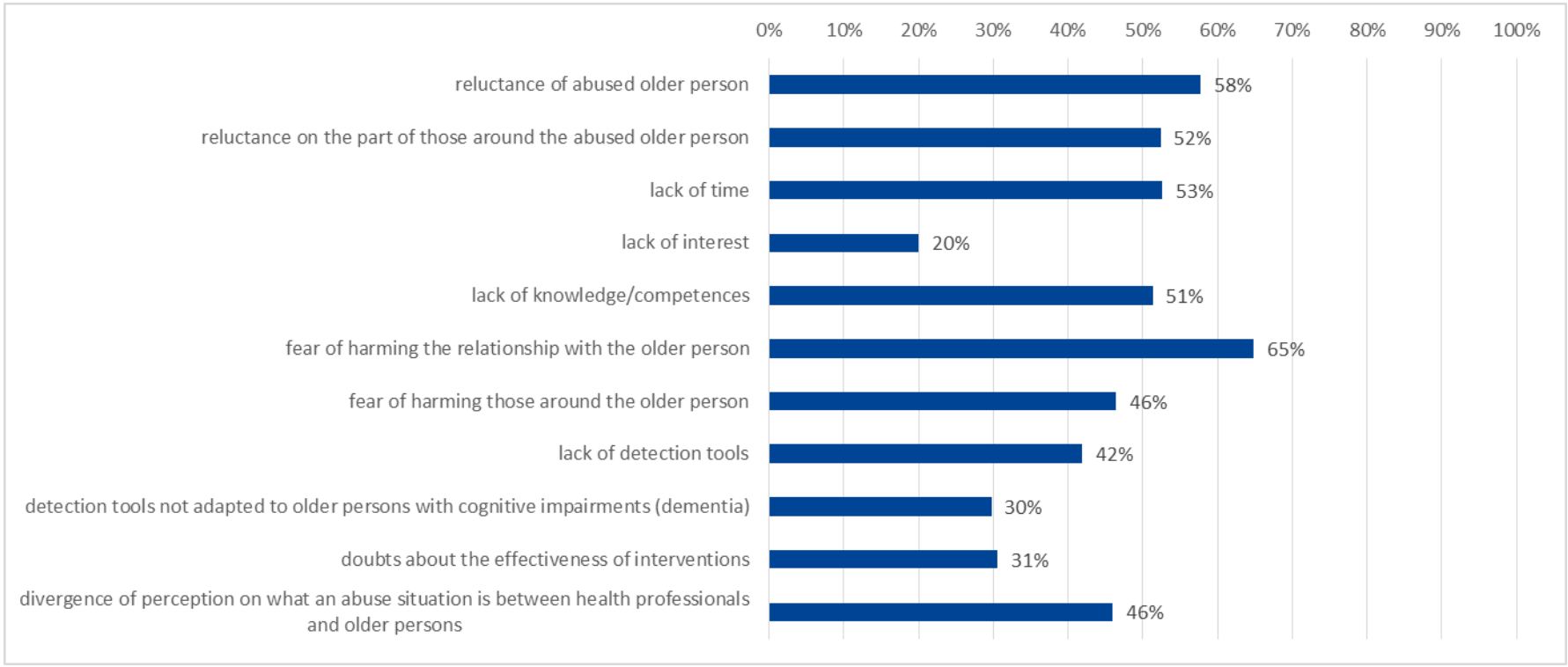
Figure 25 shows the distribution of barriers, cited by the 64 informal caregivers. In line with the group of professionals, the reluctance by the elder or by the entourage were the most cited barriers (70.3% and 65.6%). Also different perception on the definition of abuse, fear to cause harm to the relationship with the elder and lack of knowledge/skills were frequently cited (57.8% in the three cases). Overall can be stated that the informal caregivers less frequently stated if an item was considered as a barrier. The percentages of 'no' responses is clearly lower compared to the group of professionals. However, in both groups a lot of respondents used also the 'maybe' answer option.

Figure 25 – Barriers for detection, by informal caregivers



In Figure 26 the distribution of the three most important barriers is presented. Common to the barriers mentioned by the professionals, is the reluctance of the elder also one of the main barriers mentioned by the informal caregivers. In this group, more emphasis was put on the fear to cause harm to the relationship with the elder and the lack of time as barriers for detection. The lack of detection tools as barrier was less present in this group compared to the professionals.

Figure 26 – Top 3 of barriers for detection, by informal caregivers



In an open question, all respondents could add other barriers related to the detection of elder abuse. Following barriers could be identified:

- The lack of support by the management (of residential care settings) for the set-up of a procedure for the detection and management of elder abuse
- The so-called 'law of silence': The person who detected the abuse, is reluctant to report this case for personal reasons (fear for reprisals by management or colleagues) or out of fear for reprisals towards the elder victim.
- Neglect by the elder: in persons with a history of abuse, new situations of abuse will less quickly be noticed and handled
- Ignorance by the health professionals or the management
- The medical condition of the elder: often cognitive problems (e.g. caused by dementia or polymedication) hamper the detection of abuse
- Cultural or linguistic barriers: in some cultures home care services are less accepted. The need for a third person (often a family member) to translate between the elder and the health professional could hamper the trust-relationship between both and the detection of abuse.
- Very short hospital stays whereby less time is foreseen for a comprehensive geriatric assessment and to build a trust-relationship with the elder.

'Pas de solidarité au sein de l'Equipe - Proche d'un membre du personnel - désintérêt de la direction - Obligation pour certains services que la personne maltraitée doive obligatoirement prendre elle-même contact!'

'La négligence, plus longue ou plus difficile à percevoir notamment par la personne concernée. Surtout si " elle a toujours connu cela".'

'Vaak heb je een vermoeden dat relatie of manier van behandelen van de oudere door de mantelzorger niet oké is, maar de oudere wordt 'streng bewaakt' / in ogen van mantelzorger, goed verzorgd.'

'La méconnaissance du personnel et des résidents sur ce qu'est la maltraitance'

3.2.4.2 *Facilitators for detection*

The questions about the facilitators were slightly different compared to the questions on the barriers related to detection of elder abuse. Both professionals and informal caregivers had to tick the three facilitators with the highest impact to improve detection. A predefined list of facilitators was suggested and in an open question the respondents could add facilitators or comment on the list.

Facilitators cited by the professionals

Table 28 shows that across the 5 groups of professionals, good communication between health professional and informal caregiver is one of the main facilitators to improve the detection of elder abuse. In the group of the managers, the paramedics and the psychosocial sector, the knowledge about and the access to a detection tool were highly cited facilitators. In the group of the physicians and the psychologists, the efficacy of the management after detection was a more important facilitator than a detection tool itself. The group of physicians and paramedics indicated also that the possibility to contact specialised teams to confirm a suspicion of elder abuse, could be a major facilitator to improve the detection. Other facilitators were less often ticked as the main factors to improve the detection of elder abuse.

In the open question following additional facilitators could be identified:

- Multidisciplinary meetings in residential care settings to discuss suspicion of cases of elder abuse
- Multidisciplinary trainings, including, next to the medical sector, also the juridicial and social sector
- The use of cameras in residential care settings: This facilitator was mentioned by several respondents

- A role for the social worker of the sickness funds as contact point for the elder and a more auditing role towards the health professionals
- The possibility to report anonymously, to avoid reprisals

  'Possibilité de déposer une plainte anonyme (pour la personne maltraité ou famille ou même membre du personnel) car souvent peur de représailles (surtout si la maltraitance est commise par un membre du personnel)'

- A standardized (short) screening questionnaire, which is posed with every admission or change of care setting, to avoid missing a potential case of abuse. Other examples of such screening questionnaires are the short questions on malnutrition or fall risk
- A more elaborated legal framework for the protection of the older persons, similar to child protection.

Table 28 – Facilitators for detection of elder abuse, by groups of professionals

	Managers (n=50)	Physicians (n=66)	Paramedics (n=290)	Psychologists (n=28)	Psychosocial sector (n=127)
Knowledge about the existence of detection tool/instrument	**50%**	30%	**46%**	32%	**46%**
Easy access to a detection tool/instrument	**52%**	30%	**38%**	21%	**45%**
Effectiveness of interventions after detection	38%	**45%**	37%	**39%**	39%
Good communication between the professionals involved	**40%**	**41%**	**44%**	**57%**	**40%**
Existence of a shared file between the professionals involved	14%	14%	18%	4%	17%
Good communication between professionals and informal caregivers	36%	27%	31%	32%	22%
Raising the awareness of the elderly about the risk factors for elder abuse	16%	23%	16%	29%	28%
Raising the awareness of the elderly about the existence of support services	18%	27%	23%	**46%**	26%
The possibility to contact teams specialised in elder abuse to confirm a suspicion of abuse	34%	**55%**	**38%**	29%	35%

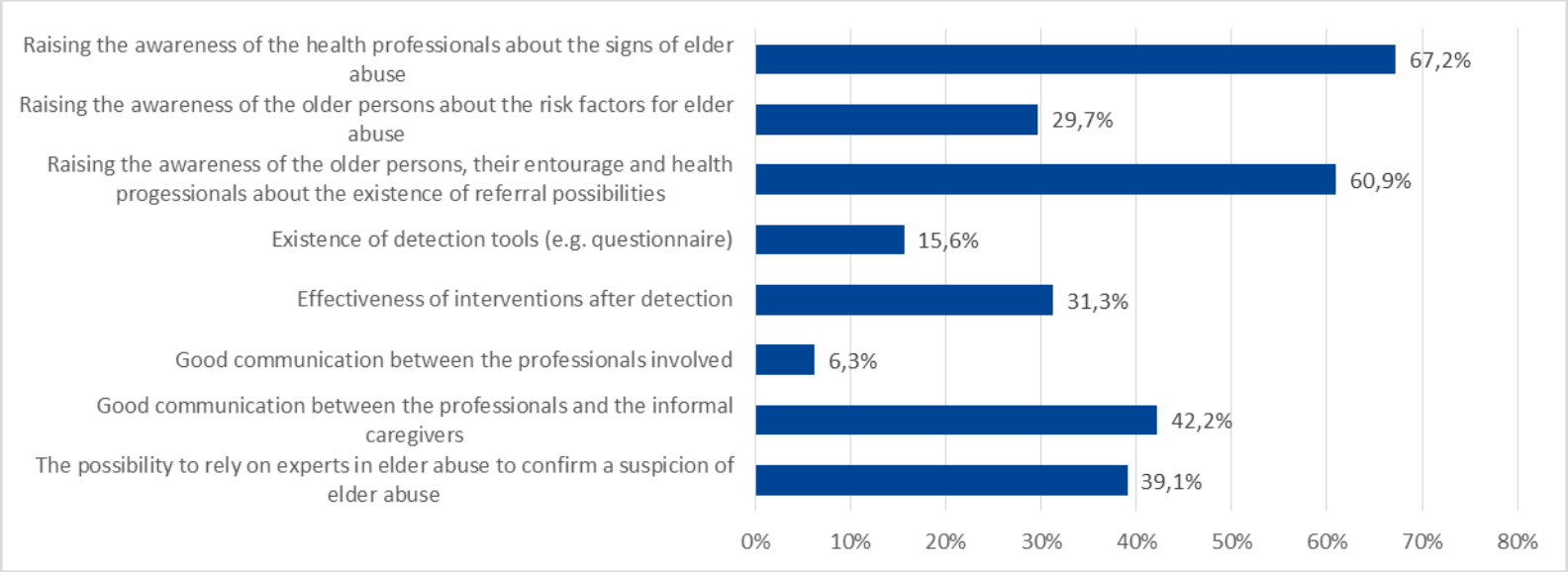
Facilitators cited by the informal caregivers

A similar list of facilitators was presented to the informal caregivers and the three most important facilitators could be ticked. Figure 27 shows that sensitization of the health professionals and the elderly were the most cited facilitator to detect elder abuse. The third most often cited facilitator was the good communication between the health professionals and the informal caregivers.

In the open question, the respondents could mention additional facilitators or comment on the list. Following additional facilitators were identified in the answers:

- A confidant within the family or in the residential care setting
- Compulsory training for all health professionals
- Support for informal caregivers
- Home visits by social workers or by trained volunteers

Figure 27 – Facilitators for the detection of elder abuse, by informal caregivers



Key-points for detection of elder abuse

- Both the professionals and the informal caregivers agreed that a detection tool would be desirable to improve the detection of elder abuse.
- Conditions for the implementation of a detection tool in clinical practice, mentioned by the respondents, are:
  - Most cited characteristics of a detection tool were ease of use, with clear instructions and a short completion time. In addition the informal caregivers preferred a tool suitable for different care settings and adapted to the linguistic, cultural and social lifestyle of the elder.
  - A detection should be evidence-based, this means the psychometric properties (sensitivity, specificity and reliability) should be assessed and the tool should be able to detect accurately cases of abuse without false accusations
  - The administrative burden related to the use of an instrument should be restricted to a minimum
  - The use of a detection tool should be incorporated in a comprehensive assessment of the elder and in step-by-step which stipulates the further management of the EA case.
- The Belgian RITI scale was mentioned by the respondents as the detection tool for use in Belgian clinical practice.
- All respondents agreed that everybody should be aware and should be able to detect elder abuse. Most frequently cited professions were GP, nurses, social workers and the persons around the elder, indicating that detection of abuse should not exclusively be a task for the health professionals, but for everybody in the environment of the elder.
- Frequently cited barriers were: the reluctance by the elder and his environment, the current lack of a detection tools and lack of knowledge about elder abuse (and how to tackle it). Also the fear to harm the trust relationship between the professional and the elder was often mentioned. Some respondents dared to speak about the law of silence, which implies that often the professional who detects EA will be reluctant to report this case, afraid of reprisals by colleagues or by management.
- Facilitators to improve the detection of elder abuse were: good communication between the health professional and the informal caregiver, knowledge about and access to a detection tool and sensitization for the elderly and the health professionals about elder abuse and multidisciplinary consultation.

3.3 Evaluation of the urgency

This section in the online survey was focused on the need for criteria to determine the urgency to act immediately in case of EA. The majority of the respondents indicated that this kind of criteria would be indispensable (35.5%) or desirable (56.9%). Only a minority indicated that these criteria would be redundant (3.36%). In the open question, in which the respondents could further explain their choice for the redundancy of the criteria, following aspects were mentioned:

- The complex situation of abuse: the respondents are very clear on the need for an urgent intervention in case of severe physical abuse, but were less convinced of the urgency of an intervention in other types of abuse due to the complexity of each individual case. Also before taking any action, the elder should be consulted and should agree on the proceeding interventions.
- Risk for harm: Linking further action to a list of criteria to determine the urgency, without taking into account the individual situation of the elder, seemed too restrictive and could potentially be harmfull for the elder, e.g. with loss of confidence in the care providers, etc. Rather applying a list of criteria, contact with specialised organisations seemed more useful and reliable, according to a respondent. However, another respondent was rather convinced that the intervention should not

depend on the urgency but immediate action is always needed in case of abuse.

- Professional experience and clinical feeling versus list of criteria: This comment, mentioned by some respondents, is also related to the complexity of the situation and refers to the need for professional experience to detect elder abuse. A list of criteria seemed not sufficient to fully identify the need for an intervention in case of suspicion of abuse.
- Need for integration in daily practice: some respondents found that additional criteria were redundant because their way of taking care for the elderly already included the detection of abuse, including determining the urgency of intervention.

Key-point for the evaluation of the urgency

- All respondents agreed that criteria to determine the urgency to act immediately in case of elder abuse were desirable.

3.4 Intervention

In this section, the ideal procedure for intervention was questioned, starting with a question if such a procedure, which describes the different interventions, is needed or not, which characteristics should this procedure (and specifically the procedure for reporting) have and who should report a case of abuse.

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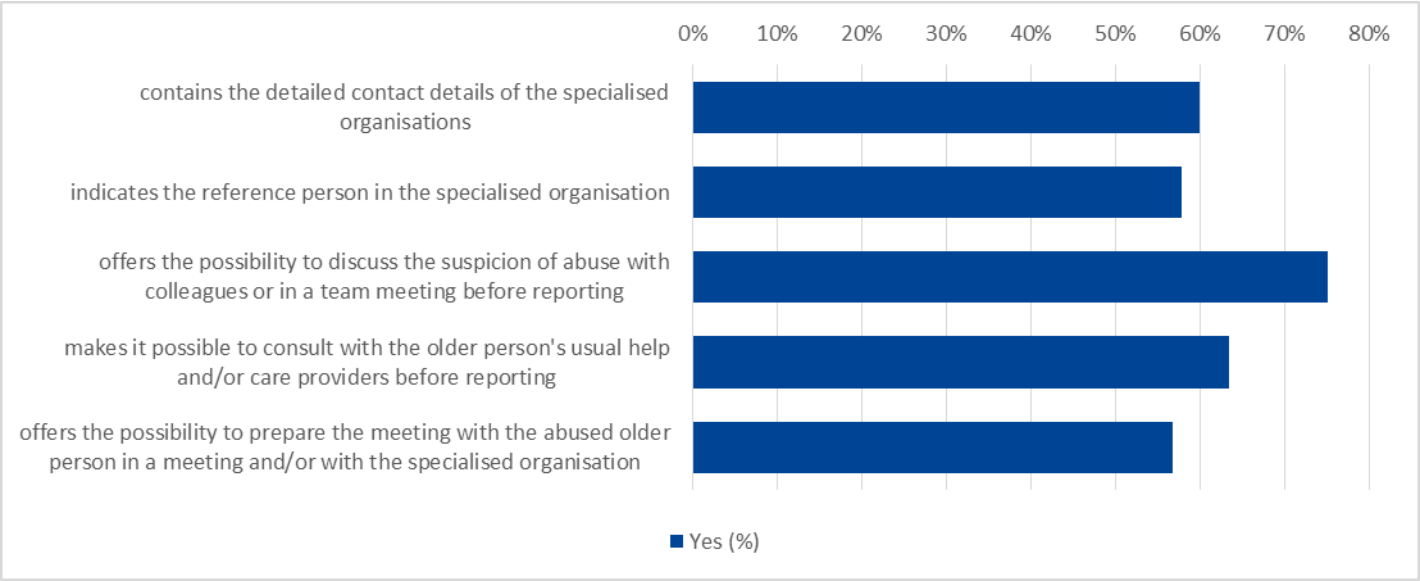
3.4.1 The need for an interventional procedure

The majority of the respondents found that a procedure for the management of abuse, is indispensable (35.8%) or desirable (59.0%). A minority indicated that such a procedure would be redundant (2.6%). Within the group of respondents who indicated the redundancy of such a procedure, the main reason was the limitations linked to a procedure, for example the rigidity of a written procedure which is less adaptive to an individual case of abuse, but also organisational issues (e.g. inefficiency of social services and justice).

3.4.2 Characteristics of a reporting procedure

A list of 5 characteristics on the procedure for reporting was provided in the survey, and the majority of respondents agreed on the need for all 5 characteristics with the highest rate for the characteristic on the possibility to discuss the suspicion of abuse with colleagues or in a team meeting before reporting it (75%). Other frequencies of answers can be retrieved in Figure 28

Figure 28 – Characteristics of a procedure for reporting elder abuse



Next to the 5 characteristics mentioned above, the respondents could also list up some other characteristics. Within these answers, following themes could be identified regarding interventions in the procedure:

- Importance to discuss with the elder (and/or his relatives): next to discussion with colleagues, also the elder (and/or his relatives) should have the possibility to give his point of view on the situation
- Contact with the police: the procedure should also mention when and how to contact the police
- Team discussion: the organisation of a regular (multidisciplinary) team meeting should be one of the main interventions in the procedure
- Centralised contact point: a reference person or a registration centre (meldpunt) is needed in every organisation to facilitate the collection and follow-up of all notifications

Also characteristics were mentioned regarding the procedure itself:

- Anonymity: a respondent mentioned the importance of anonymity in the procedure, but without further detailing who or when this anonymity is indispensable.
- Applicability of the procedure in the clinical practice: Aspects, such as efficiency of the interventions but also a rapid and simple procedure were mentioned by the respondents.

One answer could not be subdivided in one of the above-mentioned categories, but represent an important feeling among the respondents, i.e. that abuse is not an individual problem but could also be induced by societal choices regarding respect and care for the elder persons.

> *'La maltraitance des personnes âgées est structurelle càd qu'elle est généralisée à tous les milieux de soins aux personnes âgées. Pour le répondant, il y a une volonté de la grande majorité des soignants et décideurs de négliger les soins aux personnes âgées dans un but financier. Le répondant identifie un manque de formation, d'éthique et un système de soins basé sur la peur et sur le mensonge au sein des équipes soignantes.'*

3.4.3 Who should report a case of elder abuse

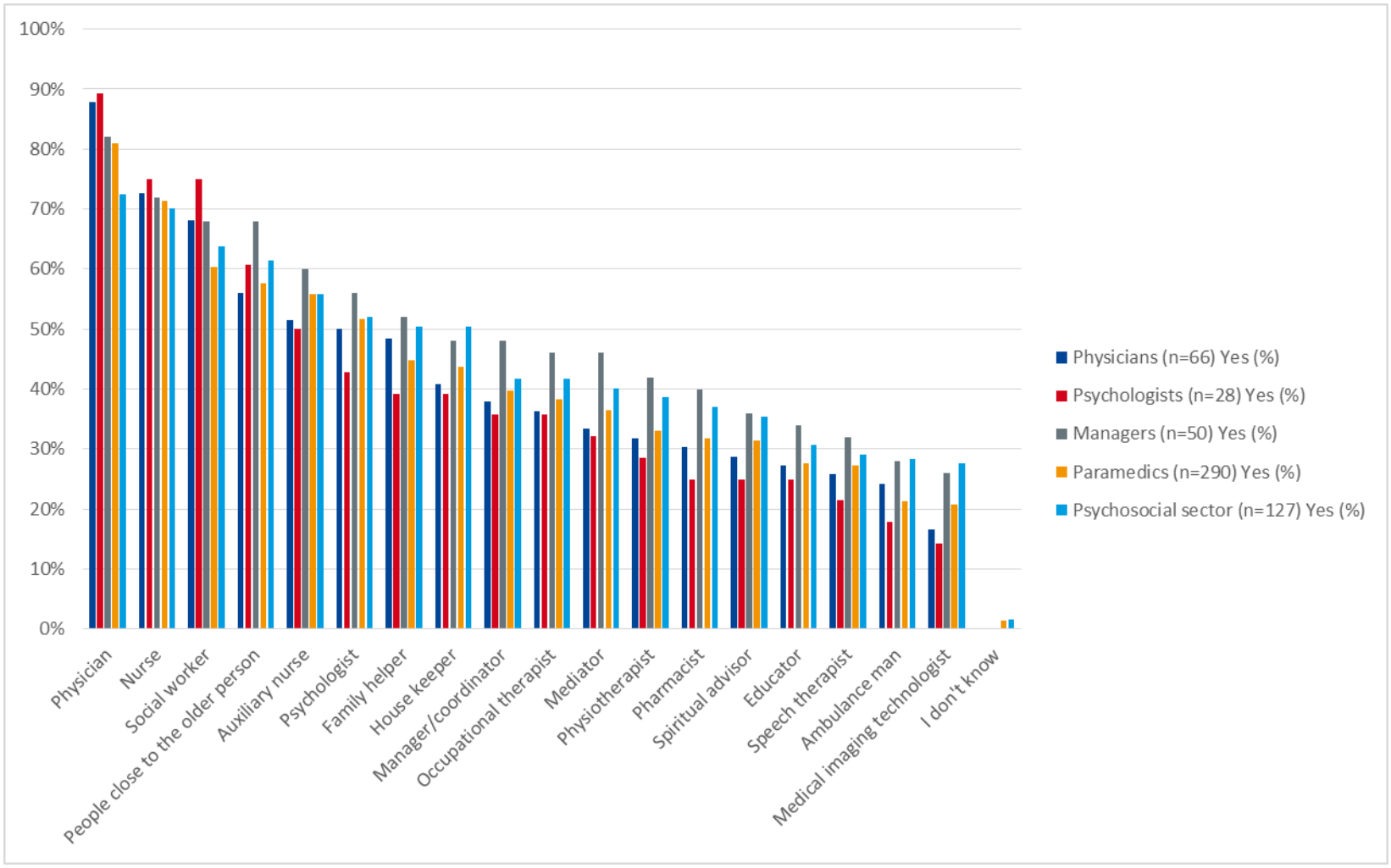
An important step in the procedure after detection of a case of elder abuse, is the notification or reporting to external organisations and/or police and justice. In the online survey, the respondents could indicate who should take this responsibility.

The majority of the respondents indicated that the GP should take the responsibility for the notification or reporting of a case (81%). Other most cited types of care providers were: nurses (70%), social worker (66%), persons around the elder (59%), nurse auxiliary (57%) and home help (53%). None of the answer options was not chosen by the respondents.

The respondents could also mention other professionals who should report a case of elder abuse. Almost everybody emphasised the importance that everyone should be concerned in the notification or reporting of a case and that it should not be restricted to one type of professional. Other suggestions that were made, were regarding other types of professionals which were not mentioned in the list (e.g. director of a home for the elderly, multidisciplinary team, mediation services). Only one respondent was not convinced that everyone should report a case but wrote down that one reference person per organisation/care setting should be made responsible in order to have a more structured approach. Another respondent mentioned the responsibility of the victim himself.

In following figures (Figure 29) an analysis was made on the linkage between the type of health professional and who should report a case of abuse. The health professionals were divided in 5 groups (see similar analyses in previous sections). Across the 5 groups, similar results could be retrieved and those were in line with the overall analysis: the physician, the nurse and the social worker were the most cited who should report a case of elder abuse. The group of psychologists and managers indicated also their own profession as responsible for reporting elder abuse, whereas these professionals were less cited by the other groups of professionals.

Figure 29 – Who should report elder abuse, by the 5 different professional groups



3.4.4 Barriers and facilitators in the management of elder abuse

Both professionals and the informal caregivers were questioned about their perceived barriers in the detection and management of elder abuse. In both groups a list of barriers was suggested and in first instance all potential barriers could be indicated. The respondent could tick 'yes', 'no', 'maybe' or 'I don't know', every item had to be answered. In the next question the respondent had to choose the three most important barriers derived from the list of indicated items. There were separate lists for detection and for management of elder abuse.

3.4.4.1 Barriers for the management of elder abuse

Barriers cited by the professionals

Due to a technical problem with the online survey, the question with the list of barriers related to the management of elder abuse was not activated and therefore only the responses in the open question on possible other barriers could be analysed. Nevertheless this methodological flaw, the 170 responses on the open question confirmed our list of suggested barriers and even additional barriers were mentioned. However, a quantitative analysis of the number of cited barriers was not possible.

Following themes could be identified:

- Related to the elder himself:
  - Health status: frailty
  - Perception by the elder: fear for the consequences, perception on definition, relationship with the family
  - Social context of the elder: cultural or language barriers, financial situation, isolation, neglect
- Role of the family:
  - Absence of family support
  - Manipulation by the relatives
  - Perception by the family on which interventions are needed
- Organisational issues:
  - Lack of time by justice
  - Lack of policy in care settings
  - Lack of support by specialised organisations
- Perception by the care professional
  - Lack of knowledge on the definition of abuse and its different types
  - Fear for false declaration
  - Fear to cause harm to the trust relationship with the elder
  - Lack of interest or solidarity
  - Reluctance to report, often induced by the above-mentioned factors, such as fear for false declaration or fear to cause harm
- Work conditions
  - Presence of an inappropriate procedure
  - Lack of detection tools
  - Lack of follow-up by care professional
  - Lack of knowledge on management
  - Lack of staff
  - Lack of time
  - Lack of training

In the personal stories (see section 3.9), the respondents reported following reasons for not reporting the case or not taking further action in the management of the elder abuse:

- Refusal by the elder

  The respondents mentioned some examples in which the elder feels guilty about the situation, due to dependent position of the elder towards the author of the abuse (often family). Of sometimes the elder is not aware of the abusive situation.

  'C'était son fils, elle se culpabilisait même de ne pas avoir su bien l'élever'

- Reluctancy to report

  In line with the other sections of the survey, the lack of knowledge to whom and how to report was mentioned as one of the reasons not to report a case of elder abuse. Also uncertainty about the situation if this case was a real case of abuse, lead to underreporting.

  In other personal stories however, the respondents mentioned more personal reasons why they hesistated to report a case. The reluctance to report was mainly driven by a fear for their own position as a consequence of the reporting. Fear for reprisals by colleagues when a base of abuse by one of the colleagues has been reported, or even fear to be licensed after reporting a case of abuse (even whithout being the author). Also being in a lower position (for example a student) could lead to more reluctancy to report a case of abuse by a health professional. Another aspect in the decision-making to report or not a case of elder abuse, is the attitude of the management of the residential care setting. Respondents mentioned that even if they would report a case, the management would deny and ignore the situation or the abuse or neglect was considered as normal practice.

  'Cela s'est déroulé lorsque j'étais étudiante. La maltraitance venait de la part d'un soignant et je n'ai pas osé le signaler'
  'Peur des représailles que cela engendrerait pour moi'

  'La peur d'être licencié pour avoir terni l'image de l'institution'

  'geen hoop op structurele verbeteringen in bepaalde zorginstellingen waar de verwaarlozing plaatsvond'

- Change in living conditions of the elder

  The situation of abuse by a family member was considered as resolved as the elder was moved to a nursing home.

Barriers cited by the informal caregivers

A list of barriers was suggested to the informal caregivers, in which he could thick as many answer options as wanted. Figure 30 shows that the most cited barrier to intervene was the fear for aggravating the situation by reporting the case (in 78.1%), followed by fear to harm the trust relationship with the elder (73.4%) and refusal by the elder (71.9%). Lack of time was the least cited barrier (31.3%). The results show also that most informal caregivers were in doubt if a suggested barrier was really perceived as a barrier (based on the high percentages of 'maybe' responses).

In a subsequent question, the informal caregiver was asked, within the ticked list of the first question, to indicate the three barriers which should be eliminated primordially to improve the management of elder abuse. Half of the respondents indicated that the fear for aggravating the situation by reporting and refusal by the elder were main barriers which should be eliminated to improve the management of elder abuse. Also the improvement of the knowledge or competences could have its beneficial effects on the management of elder abuse. The restricted contact hours of the specialised organisations was not perceived as an important barrier. All results are presented in Figure 31.

In the open question, respondents could mention additional barriers. Two additional barriers were identified:

- Financial impact of the management of elder abuse: in some cases the financial implications of for example more home care services, could be a barrier
- Lack of psychological support: currenlty no financing is foreseen for psychological support for the older persons

Figure 30 – Barriers related to the management of elder abuse, by the informal caregivers

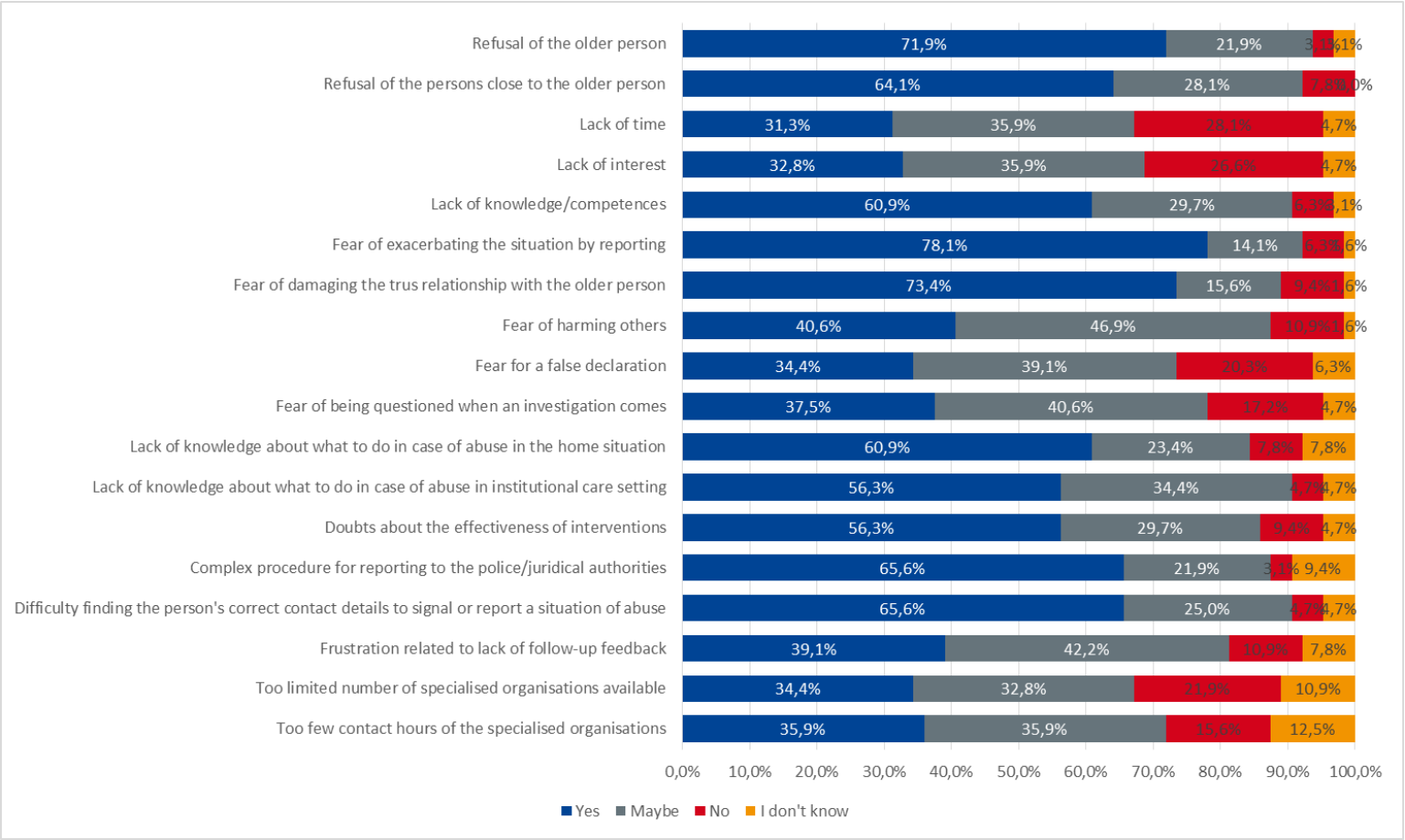
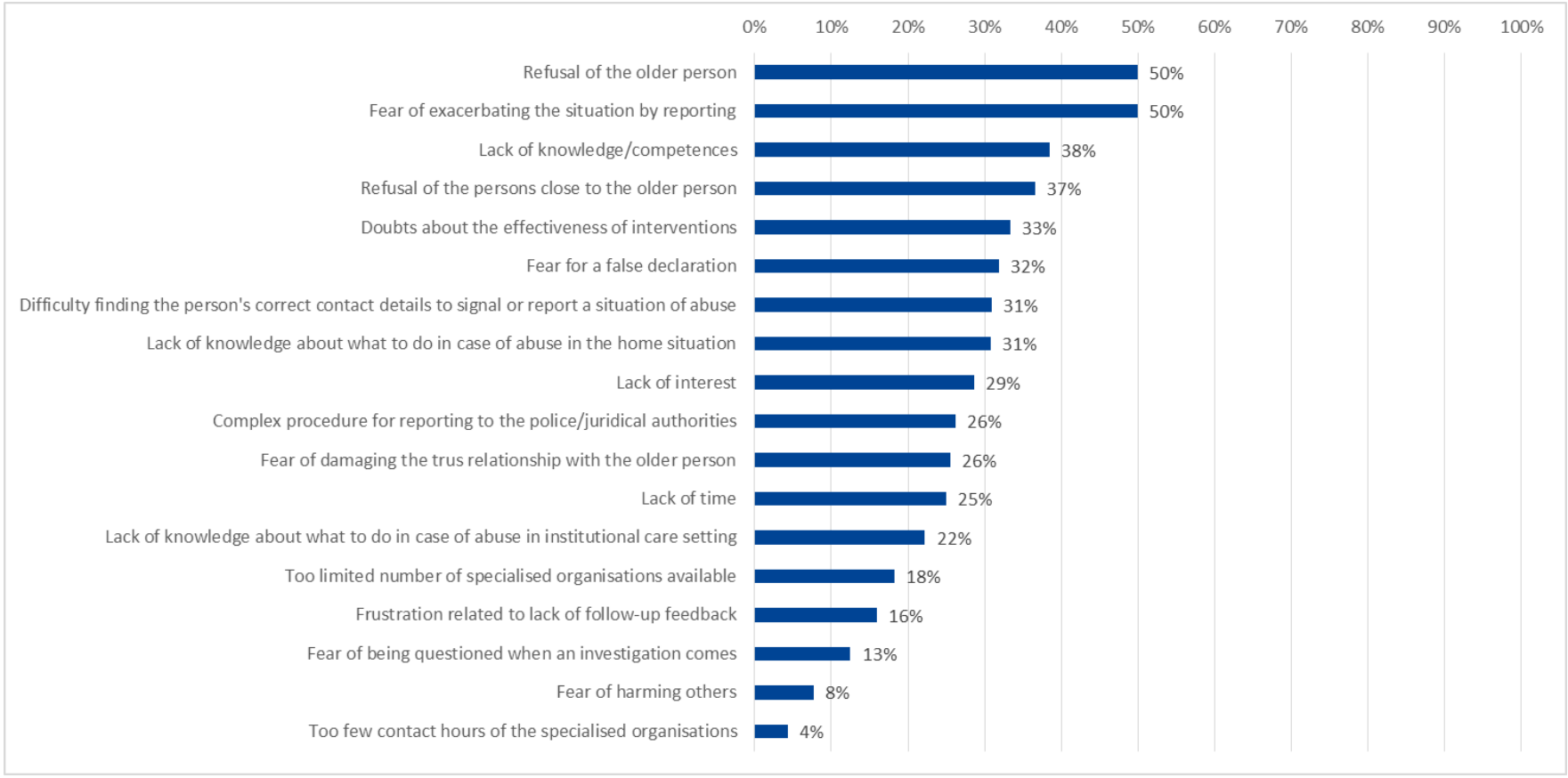


Figure 31 – Top three of barriers for the management of elder abuse



3.4.4.2 *Facilitators for the intervention for elder abuse*

Both professionals and the informal caregivers were questioned about their perceived facilitators in the management of elder abuse. In both groups a list of facilitators was suggested and the respondent had to choose the three facilitators with the highest impact to improve the management of elder abuse. In the open question the respondent could add additional facilitators related to management.

Facilitators cited by the professionals

Table 29 shows, per group of professionals, the highest percentages for three facilitators, which are closely linked to each other. In order to facilitate the management of elder abuse, a detection procedure should be incorporated in a more comprehensive procedure, covering (next to a detection procedure) also an efficient step-by-step plan for the reporting of a case and the further management. In addition to the existence of such a comprehensive procedure, specialised organisations should be available. Other facilitators were less often ticked as the main factors to improve the management of elder abuse.

Table 29 – Facilitators for management of elder abuse, by groups of health professionals

	Managers (n=50)	Physicians (n=66)	Paramedics (n=290)	Psychologists (n=28)	Psychosocial sector (n=127)
The existence of a procedure in your professional context	**54%**	**42%**	**45%**	25%	**39%**
An efficient step-by-step plan to signal/report a situation of abuse	**44%**	**42%**	**53%**	**43%**	**46%**
Effectiveness of interventions after signalling/reporting	**34%**	**47%**	**38%**	**50%**	**38%**
Possibility of obtaining legal advice in your professional context	24%	21%	10%	18%	24%
Availability of specialised organisations	30%	36%	16%	**36%**	27%
Training in social and legal problems and solutions in case of elder abuse	30%	21%	27%	18%	28%
Good understanding of professional secrecy	10%	11%	12%	7%	6%
Good communication between professionals and informal caregivers	16%	11%	21%	29%	18%
Good communication between involved professionals (specialised organisations, health professionals and police and justice)	22%	32%	21%	25%	24%
Raising the awareness of the elderly about the risk factors for abuse	2%	2%	10%	14%	10%
Raising the awareness of older persons about the existence of support services	2%	8%	14%	14%	16%
The existence of a reference person and/or support when the situation is emotionally difficult	22%	9%	22%	21%	18%

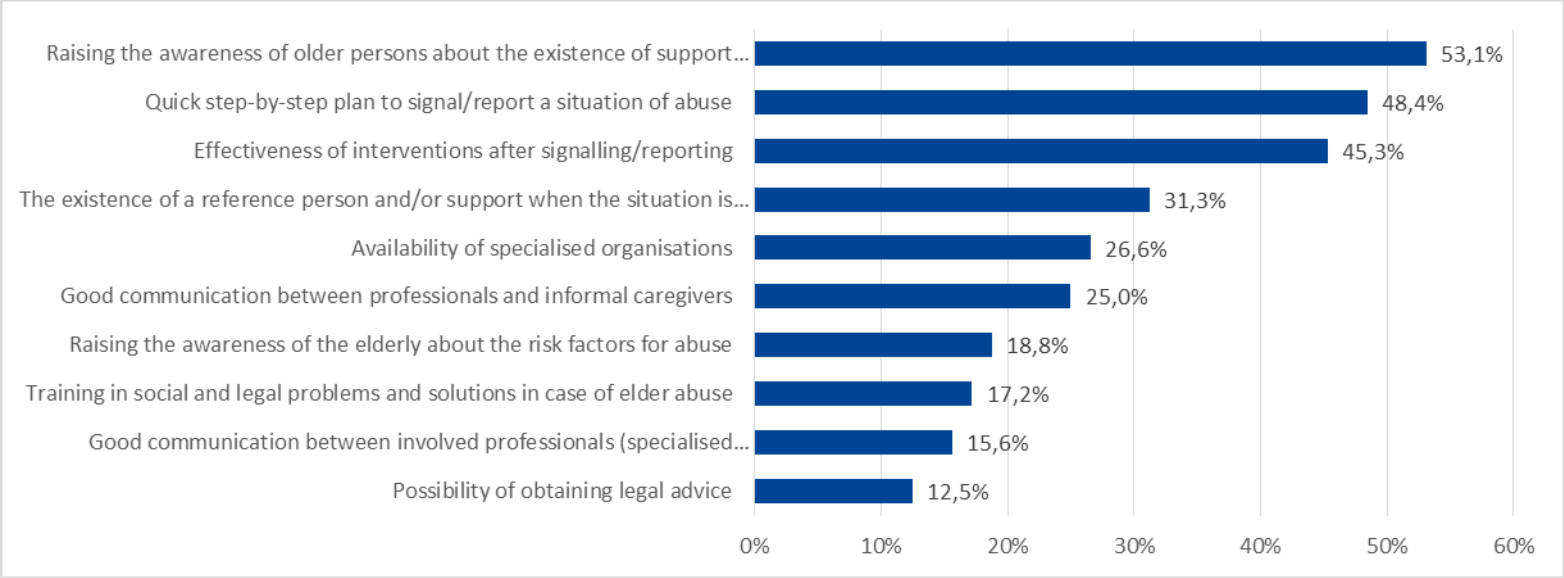
Following additional facilitators for the management of elder abuse were found in the open question:

- Informal caregivers: more support is needed for the informal caregiver
- Intervention: an easy to follow procedure, including the facilitation of self-reporting, a contact procedure with a crisis centre if needed and follow-up of the case could improve the management of elder abuse. Also multidisciplinary meetings (in residential care) were deemed necessary. Another suggestion was to increase the reimbursement of psychological support for the elder.
- Supervision: Several suggestions were made regarding the supervision, e.g. by independent organisations or neutral inspection. Supervision could also be done via a social worker or even by cameras.
- Work conditions: More human and financial resources are needed to improve the care for the elderly. This would imply that the health professional could spend more time to take care of the elderly (and could be more aware for the detection of elder abuse). Also more support for the health professional, from the management was identieified as one of the conditions to improve care for the elder.
- Legal framework: a more elaborated legal framework is needed for the protection of the elderly. Other suggestions were the modification of the juridical definition of elder abuse and the need for more protection of the reporter

Facilitators cited by the informal caregivers

A list with facilitators for the management of elder abuse was suggested to the informal caregivers and the three main facilitators, which are primordially to improve the management, had to be chosen. In Figure 32 can be seen that sensitization of the elder about existing help services was identified as an important facilitator, by the majority of the respondents. Also a quick step-by-step plan for reporting of an abusive situation and the efficacy of the interventions were identified as key facilitators to improve the management of elder abuse.

Figure 32 – Facilitators for the management of elder abuse, by informal caregivers



Key-points for intervention

- Within intervention two main procedures can be distinguished: the reporting of a (suspicion of a) case of elder abuse (the so-called early manegement) and the further management (actions undertaken to stop and prevent further abuse) (the so-called longterm management).
- The procedure of reporting (early management) should give the opportunity to discuss the suspicion of abuse with colleagues or in a team meeting before reporting. Other characteristics mentioned by the respondents were the importance to discuss with the elder (and/or relatives), to have a centralised contatc point (e.g. reference person) and that the reporting could occur anonymously.
- Similar to who should detect elder abuse, the respondents also agreed that everybody should report a case of EA. The Gp was the most cited type of profession who should be responsible to report a case of EA, followed by a nurse, social workers and the persons around the elder.
- The majority of the respondents agreed that a procedure describing the different interventions for the long-term management of elder abuse, would be desirable in their clinical practice.

- Barriers related to the management of elder abuse were related to personal aspects of the elder and/or relatives (e.g. poor health, fear to signal abuse, lack of family support, etc), or personal aspects of the health professional (e.g. fear for false declaration, lack of knowledge, etc), or due to organisational issues, such as lack of clear policy in the care setting, lack of support by specialised organisations, etc. Also the current work conditions with a lack of human and financial resources were often cited as barriers in the care for the elder.
- Main facilitators to improve the management of elder abuse were: the need for a comprehensive procedure including a detection procedure and an efficient step-by-step plan on the early and long-term management and the availability of specialised organisations. In the open question, respdondents mentioned also the need for better work conditions and the need for a better elaborated legal framework for the protection of the elder.

3.5 Good practices

This section in the online survey aimed to describe the existing charters on good clinical practice in a residential care setting, service or in an ambulatory practice. However, the interpretation of the results was hampered by the misinterpretation of the questions by the respondents.

In the first question, the respondent had to indicate if a charter on good clinical practice would be indispensable, desirable or redundant. More than a quarter of the respondents (27.04%) indicated that a charter on good practices would be desirable, 15.2% of the respondents found it indispensable and only a minority indicated that it would be redundant (5.76%). In the open question the latter could explain why such a charter would be redundant in their clinical practice. The reasons for redundancy could not further be analysed, due to the different interpretations the respondents made on what a charter for good clinical practice was. Some of the respondents perceived this as a kind of quality handbook on well-being and good practice in elderly care, adapted to their clinical practice, others thought the questions were about a specific step-by-step plan for elderly abuse.

It was decided to stop the analysis of this section and discuss this topic during the stakeholders meeting.

3.6 Reference person

This section contained questions on the current presence of a reference person, his tasks and what the ideal situation would be. In the first question the respondent had to indicate if there was already a reference person present in their clinical practice. If so, then the respondent could thick in the second question what the tasks were of that reference person and an open question was available to add other tasks. The respondents who indicated not to have a reference person currently in their practice, were referred to the questions on the ideal situation. The respondent had to indicate if such a reference person was indispensable/desirable/redundant and had to tick in a pre-defined list what the tasks would be. Also two open questions were foreseen, one to explain why a reference person would be redundant and one to comment on the list of tasks.

In our sample of professionals, 33.12% of the respondents confirmed the current presence of a reference person in their clinical setting. In 44.64% no reference person was available and in 22.24% the respondents was not sure of such a person was present in their clinical setting. The current tasks of such a reference person are (ranked per highest rate): counselling (24.8%), mediation (16.69%), inspection (11.20%) and/or training (11.04%).

Six respondents (0.96%) reported not to know what the tasks were of their reference person. All respondents could also mention other tasks in an open question. Following themes could be identified:

- Follow-up of cases of abuse, including the organisation of the managament of the abuse
- Support and providing information towards the care professional who reported the case

- Specialised organisation, such as Ecoute Senior, play the role of reference person
- In some clinical settings, no particular reference person is appointed, but this role has been taken up by colleagues, supervisor per department, coordinating physician, social worker, or management.

In the respondents who indicated in the previous questions not to have access to a reference person, 43.2% pointed out that such a person would be desirable, 16.48% found this indispensable and only 4% found this redundant. A similar ranking of the tasks was found, compared to the tasks of the current reference persons: counselling (55%), mediation (43.52%), training (41.28%) and/or inspection (30.08%). Following additional tasks were suggested in the open question: reporting to the competent authorities, reporting to the Ministry of Health on the reasons for abuse, and coordinating the interventions in the management of the case of elder abuse.

The respondents who found a reference person as redundant, could explain their choice in an open question. Main reasons were:

- Every health professional should be trained and should be able to perform the tasks of a reference person
- The respondents were reluctant to involve a third party who could disrupt the trust relationship between the health professional and the elder.
- The fear for additional administrative burden due to the involvement of a reference person was also mentioned as one of the reasons not to opt for such a function.

Key-points for reference person

- The majority of the respondents mentioned that the presence of a reference person would be desirable.
- Main tasks for the reference person would be counselling (including support and providing information to the elder or the health professional), mediation and training. Specialised organisations could play the role as reference person.
- Some respondents were less convinced about the need for such a reference person, quoting that every health professional should be able to perform the tasks of a reference person or that a third party could disrupt the trust relationship between the health professional and the elder.

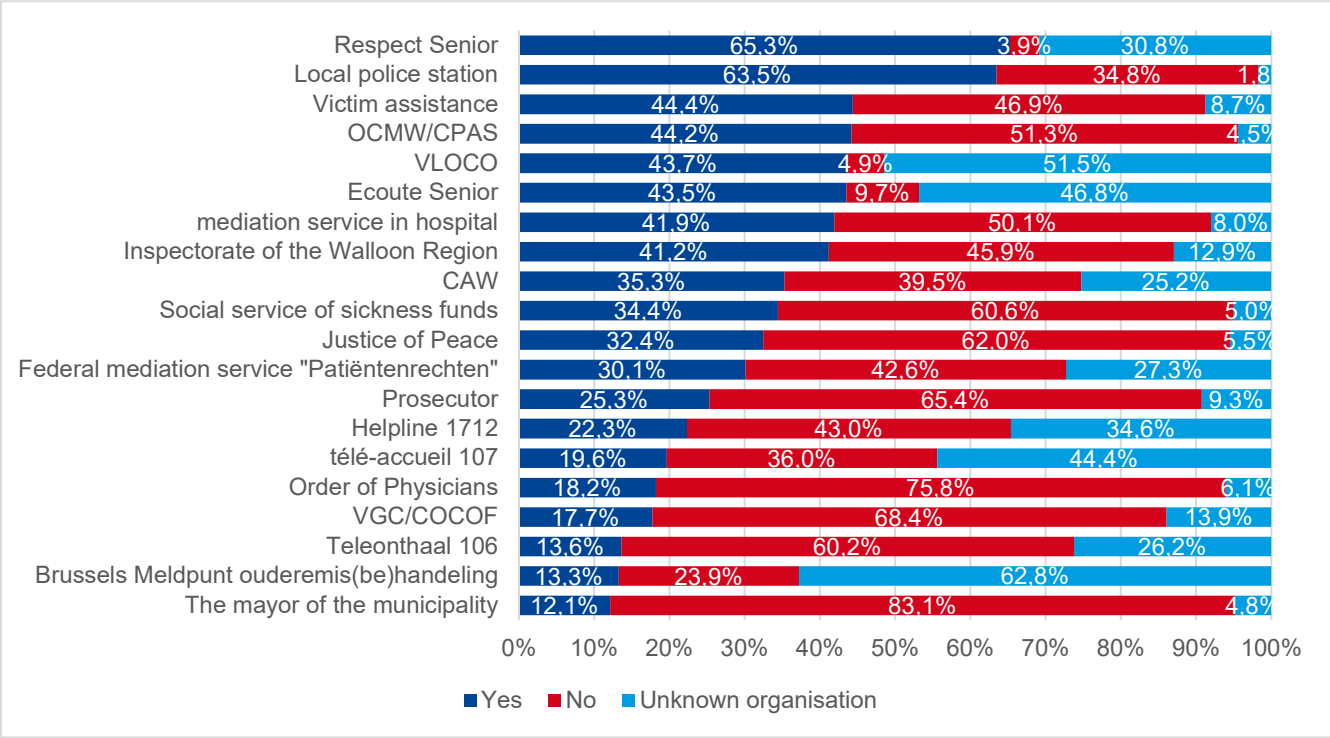
3.7 Contact

All respondents (both professionals and informal caregivers) could thick in a suggested list which organisations they would contact to report a case of elder abuse or if the suggested organisation was unknown for them. In a subsequent question, the respondent could explain why he would not contact an organisation.

In the analysis, the professionals were divided in 5 groups (see previous sub analyses), in order to look at differences between these groups. Additionally a comparison was made between the Dutch- and French-speaking professionals.

Overall could be stated that the majority of the **professionals** would contact specialised organisations (such as Respect Senior, VLOCO), the police, victim assistance or OCMW/CPAS (Figure 33). Particular to the specialised organisations, was that either the respondent knew the specialised organisation and would then contact them, or either the respondent did not know at all these organisations. For the other suggested organisations, the lack of knowledge on the existence of these organisations came less clearly out of the results.

Figure 33 – Which organisations would be contacted to report a case of elder abuse, by all health professionals



Looking at the answers per profession group (Table 30), the following findings were noticed:

- The top three most cited organisations by the physicians were Respect Senior (a specialised organistion), the police and the local prosecutor.
- The psychologists preferred to contact specialised organisations (Respect Senior and Ecoute Senior) and/or the inspectorate of the Walloon Region.
- The managers preferred to take contact with the police, Respect Senior and OCMW/CPAS.
- The majority in the group of paramedics would contact specialised organisations, such as Respect Senior and Ecoute Senior, or the police.
- Similar to the group of paramedics, the psychosocial sector would contact specialised organisations, such as Respect Senior and victim assistance, or the police.
- The regional differences came out clearly in all five groups. Whereas one specialised organisation (Respect Senior) seemed to be known, other specialised organisations are less known by the respondents, probably due to regional differences. For example Brussels Meldpunt OMB is only accesible for citizens of Brussels.

Table 30 – Which organisations would be contacted to report a case of elder abuse, by profession group

	Physicians (n=66)		Psychologists (n=28)		Managers (n=50)		Paramedics (n=290)		Psychosocial sector (n=128)	
	Yes	**Unknown**	**Yes**	**Unknown**	**Yes**	**Unknown**	**Yes**	**Unknown**	**Yes**	**Unknown**
VLOCO	28.6%	*68.6%*	57.1%	*38.1%*	50.0%	*50.0%*	40.2%	*56.1%*	53.7%	35.8%
Respect Senior	**54.5%**	40.9%	**90.0%**	0.0%	**72.2%**	22.2%	**60.0%**	36.4%	**76.3%**	21.1%
Ecoute Senior	15.9%	*79.5%*	**80.0%**	10.0%	25.0%	*58.3%*	**49.7%**	39.4%	50.0%	*43.4%*
Brussels Meldpunt ouderemis(be)handeling	11.4%	*68.6%*	4.8%	*52.4%*	18.2%	*50.0%*	12.8%	*70.1%*	16.4%	*49.3%*
Local police station	**48.5%**	3.0%	57.1%	0.0%	**76.0%**	0.0%	**60.0%**	2.8%	**75.6%**	0.0%
Prosecutor	**47.0%**	6.1%	21.4%	10.7%	32.0%	2.0%	17.9%	12.4%	29.1%	6.3%
Helpline 1712	2.9%	42.9%	23.8%	*28.6%*	27.3%	31.8%	26.2%	37.8%	20.9%	25.4%
Teleonthaal 106	2.9%	34.3%	9.5%	14.3%	22.7%	22.7%	15.9%	29.9%	11.9%	17.9%
Télé-accueil 107	18.2%	52.3%	30.0%	20.0%	19.4%	30.6%	15.8%	*50.3%*	27.6%	*36.8%*
CAW	34.3%	25.7%	57.1%	9.5%	45.5%	22.7%	30.5%	28.0%	43.3%	17.9%
OCMW/CPAS	43.9%	4.5%	32.1%	0.0%	**62.0%**	0.0%	38.3%	5.9%	53.5%	3.9%
Social service of the sickness funds	25.8%	4.5%	28.6%	0.0%	28.0%	4.0%	36.6%	6.2%	37.8%	3.9%

Victim assistance	33.3%	12.1%	53.6%	0.0%	40.0%	6.0%	39.7%	11.0%	**60.6%**	4.7%
Justice of peace	39.4%	3.0%	25.0%	0.0%	54.0%	0.0%	24.1%	9.3%	40.9%	1.6%
The federal mediation service "Patiëntenrechten"	12.1%	30.3%	25.0%	21.4%	30.0%	18.0%	36.2%	27.6%	26.8%	29.9%
Mediation service in hospital	34.8%	7.6%	28.6%	3.6%	32.0%	2.0%	46.9%	10.3%	40.9%	6.3%
Order of Physicians	22.7%	1.5%	17.9%	3.6%	24.0%	0.0%	15.5%	9.0%	19.7%	4.7%
De Vlaamse Gemeenschapscommissie (VGC) or COCOF (Commission Communautaire Française)	0.0%	15.4%	0.0%	0.0%	57.1%	0.0%	17.5%	20.0%	18.8%	6.3%
The mayor of the municipality	3.0%	3.0%	3.6%	7.1%	20.0%	0.0%	11.0%	7.6%	18.1%	0.8%
The Inspectorate of the Walloon region	25.8%	22.6%	**62.5%**	0.0%	55.2%	0.0%	36.5%	14.3%	49.2%	13.1%

The above-mentioned results could be biased by **regional differences**, for example French-speaking specialised organisations, such as Respect Senior, are only accessible for the French-speaking citizens. In order to erase the potential influence of regional difference, a distinction was made between the Dutch- and French-speaking respondents.

In Figure 34 the results are resented for the French-speaking respondents (n=360). The three most cited organisations were Respect Senior, the social service of the sickness funds and the mediation services of the hospital. As expected, the Flemish specialised organisations (VLOCO, helpline 1712, Tele-onthaal 106) were the least chosen (next to the mayor of the municipality) and the most unknown. In the analysis of the Dutch-speaking respondents, a flaw in the analysis of the results was found. For example, based on the results in Figure 35, one could conclude that all respondents agreed that télé-accueil 107 should be contacted to report a case of elder abuse. However, this is a French-speaking organisation (and the Flemish equivalent exists). Looking at the raw data, only one respondent ticked this organisation and none of the other respondents ticked on the other answer options (‘no’ or ‘unknown organisation’). This kind of misinterpretation is probably due to a default in the set-up of the questionnaire, in which the respondent was not obliged to answer one of the three options for each of the organisations. Based on the raw data, it could be concluded that the Dutch-speaking respondents preferred to contact the OCMW/CPAS, victim assistance and CAW or social services of the sickness funds. The mayor of the municipality, the Order of Physicians and the peace judge were the most cited organisations which should not be contacted. The specialised organisations, such as Brussels Meldpunt OMB and VLOCO, and the federal mediation services for patient rights were the most unknown organisations.

The analysis per region indicate that the regional specialised organisations are not well known by the health professionals.

Figure 34 – Which organisations would be contacted to report a case of elder abuse, by the French-speaking respondents

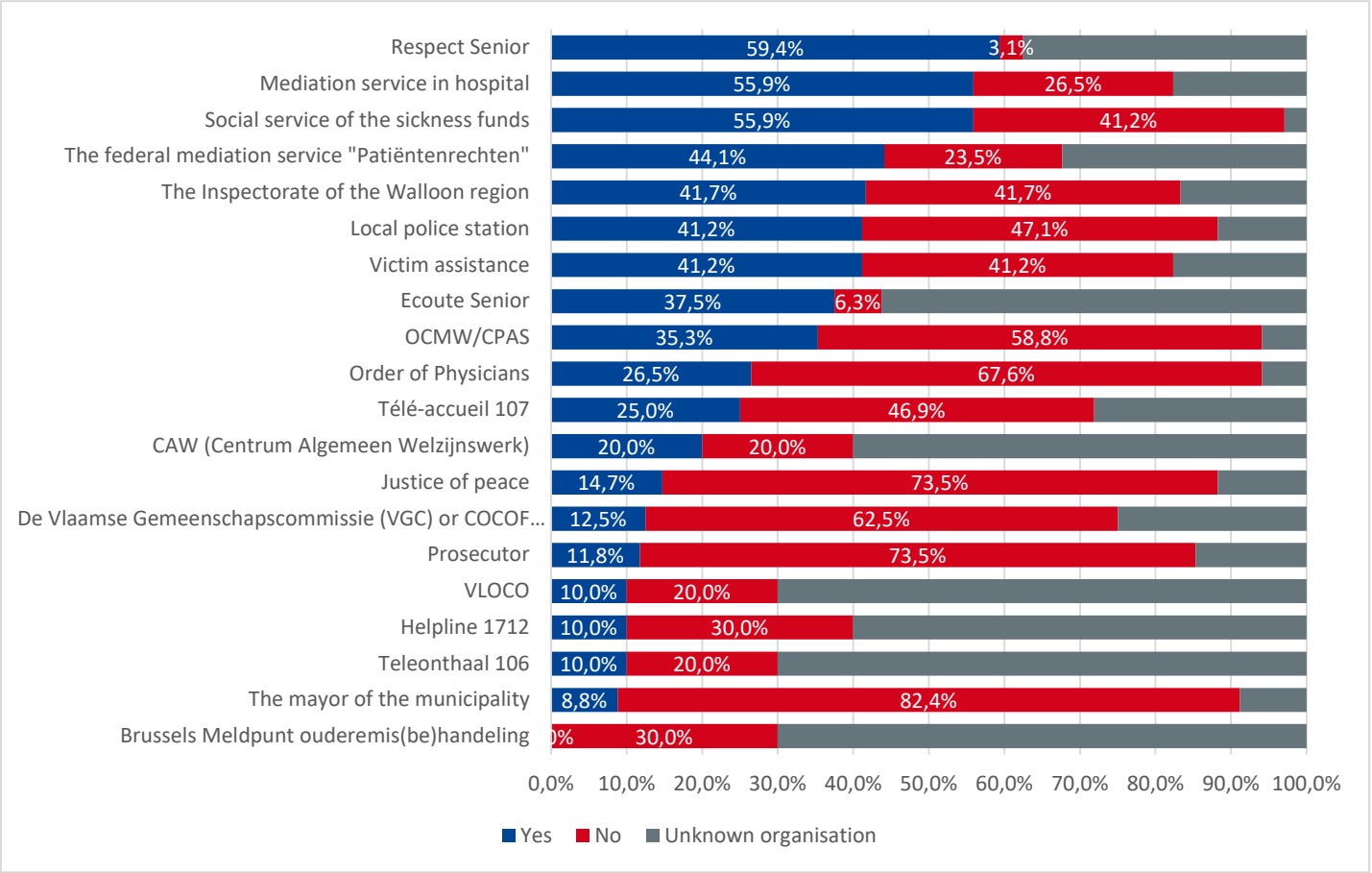
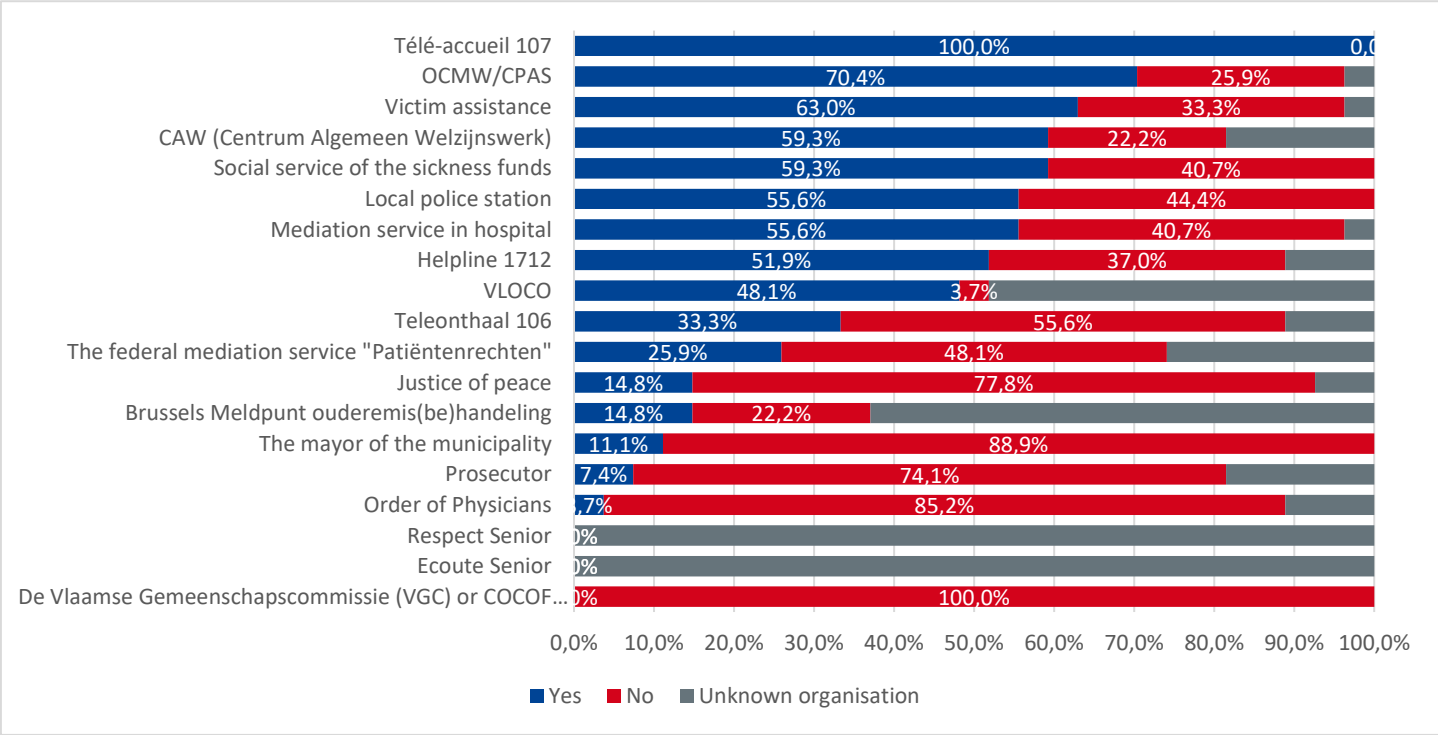


Figure 35 – Which organisations would be contacted to report a case of elder abuse, by the Dutch-speaking respondents



Regarding the **informal caregivers**, the most chosen organisations were the social service of the sickness funds, the mediation service of the hospital and OCMW/CPAS. The most cited unknown organisations were Brussels Meldpunt OMB, VLOCO and Ecoute Senior. All three are organisations specialised in elder abuse.

In a subsequent question, the respondents could clarify per organisation why they would not contact this organisation. Following **main barriers** were found per organisation:

- Specialised organisations (e.g. VLOCO, Ecoute Senior, etc)
  - (Perceived) restricted operation (e.g. only advisory role, only accessible for care professionals, restricted contact hours, not accessible in the region of the respondent)
  - Reluctance to contact them to protect privacy of the patient and fear for undeserved accusation
  - Lack of confidence in role of these organisations
  - 106, 1712: not specialised enough, variable contact persons (preference for one contact person)

- Police:
  - Fear for undeserved accusation
  - Perception that other organisations are more appropriate to mediate or to act
  - Fear to break the confidential relationship with the elder
  - Reluctant to the more intrusive approach
  - Professional secrecy that hampers to contact the police and to discuss about a case of elder abuse
  - (perceived) need for proof of accusation
  - In first instance, conversation with the elder (and relatives), contact with police only in later stage (if needed)
  - Unnecessary because victims will be admitted in hospital
  - Slow procedure before action is taken
- Prosecutor: (note: only negative reactions)
  - Unknown role
  - Only in later stage, firstly searching for an internal solution (within the local situation of the elder)
  - Too drastic step
- CAW/CPAS/OCMW
  - Unknown role
  - Takes no action
  - Professional secrecy that hampers to contact the organisation and to discuss about a case of elder abuse
  - Not specialised in elder abuse
- Social services of sickness funds:
  - Unknown role
  - Not accessible
  - not appropriate organisation
- Victim assistance:
  - unknown role
- Peace judge: similar to procureur (unknown role, too slow procedure, too drastic, professional secrecy)
- Federal mediation service for patient rights
  - unknown role
  - restricted contact hours
  - other organisations are more appropriate
- Mediation service in hospital
  - preference for social service of hospital
  - other organisations are more appropriate
  - restricted to hospital
- Orde der artsen
  - unknown role
  - other organisations are more appropriate
  - only accessible for physicians
- VGC/COCOF
  - Rather role of control on the care settings, not a direct role in reporting of a case of abuse
- Mayor of the municipality
  - Unknown role



- Will be alerted by other organisations (police, social services)
- Takes no action
- He has no professional secrecy, therefore difficult to discuss with him about a case

- Inspectorate
  - Will redirect to other organisations, so waste of time to contact them
  - Unknown role

From the **personal stories**: The results on which organisations are contacted in case of elder abuse, show that the majority of the professionals will attempt several approaches (e.g. discussion with colleagues) before reporting to the police or justice.

The reluctance to report the case of elder abuse to the police of justice, can be caused by several reasons. In the section on personal stories, the respondents could explain in which cases they would report to the police or justice. A frequently mentioned reason was the urgency to act. When the professional judged that the elder person is in danger, then the police would be contacted immediately. This kind of danger is not only restricted life-threatening situations, but also financial abuse or persistent situations. Also when the professional has no doubt about the fact that the elder person is victim of any type of abuse, is a trigger to contact the police. Some respondents mentioned also the added value of the police/justice in the multidisciplinary approach, including a good collaboration with the social services of the police.

> *'Omdat je licht opsteken bij de plaatselijke wijkagent soms erg verhelderend kan zijn!'*

Other respondents consider reporting to police or justice as a last option, after all other attempts (with social services or specialised organisations) failed.

Key-points for contact organisations

- The majority of respondents would contact specialised organisations (e.g. Respect Senior, VLOCO, Brussels Meldpunt OMB, etc.), the police or social services (such as OCMW/CPAS or victim assistance).
- The role of the specialised organisations as contact organisations is still ambiguous: either the respondent knew the organisation and would then prefer to contact this organisation, or either the health professional didn't know the organisation at all. The results show a clear lack of knowledge about the existing organisations.
- Regional differences were clearly present in the results. Sub analysis with differentiation between the French-speaking and the Dutch-speaking respondents show that mainly in the French-speaking part of Belgium, the preference was given to contact specialised organisation.
- Informal caregivers would prefer to contact social services, such as the social service of a sickness funds, or the mediation service in a hospital or OCMW/CPAS.
- Main barriers not to contact an organisation were related to lack of knowledge about the function of the organisation, fear to break the confidential relationship with the elder, lack of shard professional secrecy between the health professional and the organisation. Often several attempts were made to find a solution for the abusive situation in consultation with the colleagues before contacting the police.

3.8 Involvement of the elder in decision-making

In this section, the respondents were questioned on how the elder (and his relatives) is involved in the decision-making about the management of his case of abuse.

In the first question, the respondent could indicate if the elder is **involved in the decision-making** related to the further management of his case of abuse. In more than 60% the elder will be involved in decision-making (35.1% always and 30.5% occasionally). Almost one third of the respondent could not answer on this question (27.3%). Only in a minority of the cases, the elder was rarely (4.8%) to never (2.3%) involved.

The subsequent questions handled on the **decisional capacity** of the elder. The respondents had to indicate how often the decisional ability of the elder is evaluated, in case of suspicion of elder abuse. In the majority of cases this evaluation was always done (69.3%) and in 16.6% only occasionally. A minority of respondents indicated that this kind of evaluation was only rarely done (in 2.7%) or even never (3.3%). Almost 10% of the respondents could not answer this question.

In an open question the respondent could clarify which criteria were used for the evaluation of the decisional capacity of the elder. Following main criteria could be identified:

- A variety of scales are used in practice, such as the mini mental health status exam (MMSE), Katz, BelRAI, or an own-developed scale
- Even if an instrument has been used, the assessment of the elder will be discussed in team
- Sometimes the role as evaluator has been designated to one person, e.g. psychologist or GP
- Some respondents mentioned that this evaluation should be a clinical assessment (incldуing an observation) without clear-defined criteria
- Other respondents mentioned very clear-cut criteria, e.g. person has dementia or not and this will determine if he will be further involved in decision-making or not

The final questions in this sections handled the issue if an abused older person refuses any intervention. The respondents had to indicate what their attitude would be. The majority of the respondents ticked the option that they don't know what their attitude would be in that case. Within the group of respondents who choose one of the two answer options (n=220), more than half of them (60%) indicated that the wish of the elder would be followed, the other respondents would ignore the refusal and intervene though. In the open question, the respondents could clarify their answer and following additions were found:

- The elder decides for himself, unless physical integrity is compromised or if a staff member has been identified as author of the abuse
- Even if it was decided to follow the wish of the elder, the professionals will remain vigilent and will keep up the discussion with the elder in order to understand his motives for refusal
- Often social control will be installed by altering the social services (of OCMW/CPAS or sickness funds) and (more) home care services will be organised
- Other respondents quote that case by case will be discussed, often in multidisciplinary consult

In case that the family of the elder refuses further intervention, following solutions were identified (in an open question):

- If a case of abuse is presumed, the family should not have a directive role in the decisionmaking to intervene or not
- Some respondents mentioned that they would ignore this refusal by the family and still intervene
- Other respondents emphasised the need for open communication with the family, to explore their motives for refusal
- If communication is not anymore possible, specialised organisations will be contacted or even justice will be alerted

Key points for involvement of the elder

- The results show that in most cases the elder will be involved in the decision-making about the management of his case of abuse
- However, the cognitive status of the elder will determine the decisional capacities.
- The evaluation of the decisional capacities is often done by an instrument and a multidisciplinary assessment.
- Even in case of refusal to intervene by the elder or by his family, the health professional will keep up the communication in order to understand the motives for refusal
- The refusal by the elder or by the family will often be ignored in case the physical integrity of the elder is in danger

3.9 Personal stories

The main focus of the online survey was on the perception of the professionals and informal caregivers on the optimal approach to encounter elder abuse. In one of the final sections, the focus was rather on the personal experiences of the respondents.

The quantitative analysis of this survey is only an indication, and should not be considered as representative for the Belgian population. For example, in the survey 50% of the professionals indicated to be personally confronted with a case of elder abuse. It would be unreliable to extrapolate this number for the whole population of professionals in Belgium. This number tells more about the specific characteristics of the respondents, i.e. it is more probable that people with an interest for elder abuse have responded to these questions.

For anonymity reasons, the stories will not be reported as a whole but rather as more in-depth information of certain aspects and are added in the different sections of this chapter.

Within the group of professionals, 50% of the respondents indicated to be confronted personally with a case of (suspicion of) elder abuse in their professional or personal life, 20% of the respondents heard about it and 17% was never confronted with a case of elder abuse. Similar numbers were found for the informal caregivers. The most cited actions undertaken were report to colleague or chef, talked with the elder and talked with his/her treating physician. More personal stories related to the issue of reporting a case of elder abuse are presented in the section on reporting.

3.10 Ideas to improve the management of elderly abuse

The final section in the online survey questioned the participants about their primordially ideas (max 3) as 'Minister of Health' to improve on a short term the management and/or the prevention of elderly abuse. Across the large number of responses on this question, several themes could be identified related to the prevention, the detection and the management of elder abuse. Also ideas on a more political level, e.g. a modification of the financing system, were mentioned as important tipping point to improve the current practice to handle an abusive situation. In the analysis no differentiation was made between the answers of the health professionals and the informal caregivers.

3.10.1 Prevention of elder abuse

Three main themes identified within prevention of elder abuse, were sensitization by awareness campaigns, the improvement of knowledge about elder abuse by the organisation of trainings on this topic and support for the informal caregiver.

According to the respondents, **awareness campaigns** about elder abuse should be oriented towards the elderly themselves, the health professionals and the informal caregivers. Not only to break the taboo, but also to make more publicity about the existing care services, such as the specialised organisations or social services. Next to more general information about elder abuse, also more attention should be given to more specific topics, like the frequent occurrence of elder abuse in the context of interfamilial violence, or about the more "hidden" types of abuse, such as financial or

psychological abuse, or the role of solitariness in the arise or maintaining of the abusive situation. Next to the more specific target populations, such as the health professionals, also the general public should be informed about the occurrence of elder abuse and how to tackle this kind of situation.

> *'Campagne de sensitization aux agissements qui peuvent être considérés comme de la maltraitance et rappelez que la maltraitance n'est pas celle d'un professionnel vers une personne âgée, elle est essentiellement intrafamiliale'*

> *'Meer bekendmaking onder maatschappelijk werkers, diensten thuiszorg, mutualiteiten… elke dienst die maar in aanmerking komt met ouderen'*

Awareness campaigns could have an impact on the **societal perception** by altering the current (more negative) image of the society on the elder person. Moreover, awareness about the prevention of elder abuse implies also more awareness about the current living conditions of the elder, e.g. lack of financial means, dependence on (abusive) family members, but also about the (revalorisation of the) status of the elder as an adult with his own decision-making capacities.

> *'Action principalement à l'échelle sociétale: campagnes de sensibilisation, lutte contre l'âgisme et les stéréotypes (la méconnaissance!) du vieillissement qui mènent à la plupart des attitudes "non bienveillantes" non-intentionnelles'*

> *'Je pense que le gros problème vient du fait que les personnes âgées perdent leur statut d'adulte en vieillissant et sont infantilisées. On ne leur reconnaît plus le droit (la capacité) de prendre des décisions concernant leur propre vie. C'est pour moi la maltraitance la plus répandue. Il faudrait leur redonner un rôle dans la société (le rôle de sage qui conseille), il faut les revaloriser, il faut faire leur publicité.'*

> *'une qualité de vie générale meilleure qui éviterait que l'on garde une personne âgée au domicile pour avoir accès à sa pension ou à l'inverse l' "obligation" de la garder à domicile par manque financier pour couvrir les frais d'hébergement'*

Awareness campaigns could be via media (television, radio) or information leaflets oriented to the health professionals or to elderly or even by organising information evenings across the country. For the set-up of these awareness campaigns, an adequate financing is needed and these campaigns should also be regularly repeated.

The need for more **training** of the health professionals and the informal caregivers is often cited by the respondents. A specific training on elder abuse should not only be organised as continuing training but also be incorporated in the basic training of each concerned health professional. Objective of such a training session is to make the professional more aware of the problem and to improve clinical practice on the detection and management of elder abuse. Similar to the awareness campaigns, should the training on elder abuse regularly repeated and supported by an adequate financing.

> *'mogelijkheid tot opleidingen voor hulpverleners om de beste zorg te kunnen bieden aan patiënten (Versus huidige trend tot besparen: zo weinig mogelijk opleidingen)'*

> *'meilleure formation des professionnels à domicile, en MRS, en hôpital aux soins des personnes âgées fragiles'*

The demand for more **support for the informal caregivers** was often mentioned by the respondents. This kind of support should focus on the wellbeing of the informal caregiver, by offering free training on elderly care, but also financial support for respite care, and/or psychological support to prevent burn-out of the informal caregiver, and/or automatic allocation of the right for special care services.

> *'De impact van de vermaatschappelijking van de zorg wordt zwaar onderschat. Veel meer mantelzorgers, vrijwilligers, familie... staan er alleen voor. De druk op deze mensen wordt te groot waardoor het risico op ouderenmis(be)handeling vergroot.'*

> *'Etre à l'écoute des soignants s'occupant des personnes âgées et prévenir leur burn out, cause principale de maltraitance des soignants vis à vis des patients'*

3.10.2 Detection of elder abuse

The main theme related to the detection of elder abuse, was the implementation of a detection tool in clinical practice.

According to the respondents, **detection tools** should be incorporated in the care plans of several care settings, such as the hospital. However, adaptation of such a tool is needed for its use in different settings, such as primary care or emergency care. Therefore a more general detection tool was preferred which could be used in different clinical settings. A detection tool is only the step up to multidisciplinary consult with colleagues or with a specialised team and should ideally be incorporated in a procedure with a list of contact organisations. It was even suggested to make the detection procedure compulsory or as one of the conditions for accreditation of the residential care settings, and to be included in the electronic file of the elder.

> *'le même outil de détection généraliste destiné à tous les professionnels, ceux-ci seraient tous formés au même outil qui figurerait dans le dossier patient'*

> *'Mise en place d'une procédure, d'un canevas de détection et d'une liste des services à contacter'*

3.10.3 Management of elder abuse

The respondents had several ideas how to improve the management of elder abuse and more specifically related to the procedure of management itself, the role of the specialised organisations and/or a reference person, and implications for the juridical sector.

The **procedure** on itself should consist of an easy to use step-by-step plan (with a list of contact organisations or a unique contact point and even a mandatory reporting of every case of elder abuse) and should be made compulsory in every residential care setting. For the elaboration of such a procedure, a social worker could be involved or cases could be discussed on multidisciplinary meetings, even with the involvement of police or victim assistance. The implementation of such a procedure could be facilitated by the creation of an electronic shared platform. The need for more opportunities to share professional secrecy were also often mentioned by the respondents. The set-up of a specialised confidential centre for abuse was also suggested. This centre could give advice on the detection and management of a case and could even intervene himself via juridical way.

> *'bekendmaking tussen diensten van aanpak en detectie van mishandeling. Eventueel 1x per maand een overleg organiseren om casussen te brengen en expertise op te doen'*

> *'Sensibiliser les équipes de de police qui sont en premières lignes'*

'Duidelijk maken welke instanties te contacteren en duidelijk maken dat dit geen gevolgen heeft voor ons qua schending van beroepsgeheim.'

The respondents did not agree on the role of the **specialised organisations**. Where it was suggested to emphasize more the role of these organisations even in primary line, other suggest to regroup all these organisations to one unique centralised structure.

> *'Instanties voorzien die een dossier volledig overnemen van eerstelijnsdiensten zoals OCMW's om de werkdruk daar niet verder te laten toenemen.'*

> *'soutenir financièrement les organismes compétents et existants'*

> *'Une seule structure de centralisation de la problématique (et non pas un éparpillement des structures tel que conçu actuellement) qui soit connue, dont les missions sont claires et qui offre en son sein tous les services nécessaires, écoute, conseil juridique, orientation vers les personnes compétentes'*

> *'Uniformisation des plates-formes gestion de la maltraitance en un seul site - il y a trop d'interlocuteurs, pour quelqu'un qui n'est pas du métier, c'est complexe.'*

> *'financement d'organismes tels que "Respect Senior" à la fois pour la détection et la formation du personnel'*

Suggestions related to the role of a **reference person** were mainly oriented towards the implementation of such a role in every municipality or in every residential care setting. Such a reference person should have a coordinating role and should report to the competent authorities.

'Vertrouwenspersoon inschakelen in een woon zorg centrum'

'Je désignerais une personne de confiance (indépendante) dans toutes les communes'

The respondents suggested also specific ideas related to **home care**. More attention should be given to the detection and management of elder abuse in home care settings, including active inspection on the health professionals, regular visits to the elder at home by a supervising physician, a social worker or even multidisciplinary teams and further elaboration of home care services.

'Développer les services à domicile afin de multiplier les chances qu'un intervenant puisse constater une situation de maltraitance éventuelle, et ne pas laisser un intervenant unique prendre l'ascendant sur une personne âgée'

'une visite par an (ou 2 fois par an) d'un médecin contrôle'

'meer en betaalbare thuiszorgdiensten (voldoende groot urencontingent)'

'thuiszorgdiensten die meer tijd kunnen besteden aan zorgvrager en minstens even veel aan de mantelzorger'

In addition to home care, also some suggestions were made related to **institutional care**. More places should be foreseen for the urgent interventions for elder in home care settings. The well-being of the elder could be used as one of the conditions for the accreditation of a residential care setting, including regular inspections.

'Subsidier des solutions d'urgence (logements-places supplémentaires en home-...)'

'Subsidier les MR et MRS en fonction du bien-être des résidents (évalué par des organismes indépendants -type certifications) '

'Elaboration d'un label de qualité des institutions pour personnes âgées '

'des inspections régulières dans les maisons de repos sans prévenir (comme les inspections dans les cuisines des restaurants), visite aux patients mais aussi aux familles, les contacter pour voir le degré de satisfaction pas pour la nourriture, le bâtiment, les installations (visibles) mais bien au point de vue de suivi médical et surtout communication régulière avec médiateur entre le personnel, la famille et personnel médical et encore plus en fin de vie'

On **juridical level**, the respondents suggested to elaborate the legal framework for the protection of the elderly. Also more communication between health professionals and justice was suggested. And a more rapid response was also one of the requests.

'Des sanctions claires devraient être proposées pour les familles et les soignants maltraitants'

'mogelijk maken dat mensen veroordeeld worden voor mishandeling, ook al dient de oudere zelf geen klacht in'

'réponse rapide au niveau judiciaire'

3.10.4 Organisational aspects related to the EA step-by-step plan

The majority of suggestions on organisations aspects were related to the **quality of care** and which initiatives are needed to improve it. Main suggestions were to increase the human and financial resources in institutional care, in order to have more staff, more time to take care of the elder and more training. Also the set-up of multidisciplinary meetings requires adequate funding. A control on the quality of care could be done via a "star" ranking. More research should be done, to obtain solid evidence on best practices to tackle the problem of elder abuse.

'de meilleures conditions de travail et de staffing pour le personnel soignant'

'Donner du temps en finançant les prises en charge comme les réunions pluri, les rencontres... ces activités sont très gourmandes en temps si elles sont bien préparées et assurées'

'Donner du temps aux professionnels qui travaillent quotidiennement avec les personnes âgées (p.ex. supprimer les notions de temps définis par types de soins)'

On **community level** more resources should be provided to tackle the problem of elder abuse. Every municipality should have a service for senior citizens, which should have a coordinating role in the management of a case of abuse.

On **policy level**, the respondents suggested to modify the current financing system which is currently focused on fee-for-services rather than on quality of care. This altered financing system should also avoid medical shopping. The minister of Health should also consider elder abuse as priority theme in policy plans (similar to child abuse).

'Ik zou dus het gezondheidszorgsysteem veranderen zodat we niet, uit vrees prestaties te missen, moeten plooien voor de 'nukken' van de betrokkenen. Een ander financieringssysteem'

Key points

- Without a quantification of the results, it could be stated that the most cited ideas were about sensitization of the elderly, the (informal) caregivers and the general public; the need for training of the health professionals about the detection and management of elder abuse; and the need for detection tool.
- Ideas to improve the prevention of elder abuse were related to
  - The set-up of regularly repeated awareness campaigns oriented towards the elderly, the health professionals and the informal caregivers about general information, but also to make the information related to the detection and management of EA more publicly known (e.g. publicity about existing specialised organisations). Awareness campaigns for the general public could have an impact on the societal perception of the elder.
  - More training is needed, both in basic education of every type of health professional as in continuing training.
  - More support for the informal caregiver: e.g. more financial support for respite care and/or psychological support to prevent burn-out of the informal caregiver and/or automatic allocation of the right for special care services
- Ideas to improve the detection of elder abuse were related to the implementation of a detection tool in clinical practice, by incorporating a tool in the care procedure of a clinical setting. This procedure should also include multidisciplinary consultation and a step-by-step plan (with a list of contact organisations). This procedure could even be applied as one of the conditions for the accreditation of a residential care setting. The tool on itself should be applicable in different care settings.
- The management of elder abuse could be improved by
  - the elaboration of a procedure, including a step-by-step plan, multidisciplinary meetings and even collaboration across sectors (e.g. police, justice). A shared electronic platform could facilitate the shared professional secrecy.
  - The role of the reference person should be further elaborated, e.g. in every municipality or residential care setting.
  - More initiatives should be set up to improve the management of elder abuse in home and in institutional care, by increasing the home care services of linking the quality control in institutional care to accreditation for example.
  - The legal framework for the protection of the elderly should be more elaborated.
- Suggestions about organisational aspects were mainly related to the improvement of the quality of care by
  - increased human and financial resources and a more elaborated system of quality control. More resources are needed to improve clinical practice. The current (perceived) lack of staff and financial resources leads to a lack of time to take appropriately care of the

elder and to build a trust relationship with him/her in which (suspicion of) abusive situations can be discussed.

- Handling elder abuse should also be a priority for policy makers, on community level by the setup of a services for senior citizens and on authority level, by making this kind of abuse a priority in policy plans.

4 DISCUSSION

The online survey aimed to describe the current situation on how professionals and informal caregivers deal with (the suspicion of) elder abuse, e.g. how they would detect a case of abuse, to whom they would report and how they would react to stop the maltreatment of the elder person and what could be useful to help them in managing elder abuse cases by identifying the facilitators and barriers.

Following steps in the management of elder abuse were questioned: detection of abuse, interventions regarding the management of abuse (including a procedure, reference person, and role of contact organisations (e.g. Respect Senior, VLOCO)) and its organisational aspects to improve the current situation.

Within **detection**, the questions in the survey were focused on the potential added value of a detection tool, who should detect and which facilitators and barriers were the most often cited by the respondents. The majority of the respondents (professionals and informal caregivers) was convinced of the need for a detection tool, but the main objection against such a tool was the complexity of the problem, including burden of the caregiver, social situation of the elder, lack of family resources, etc., which could not be captured by a single detection tool. Nevertheless the cited complexity of the abusive situation, the respondents preferred a tool which should be easy in use, with clear instructions and which could be completed in a very short time of notice (less than 10 minutes). Also the applicability in different care settings was mentioned as an important characteristic of such a detection tool. Several respondents mentioned also the importance that this detection tool should be embedded in a step-by-step plan, which clearly states which steps should be taken after detection. The question in the online survey on who should detect for elder abuse, the respondents indicated clearly that everybody should be involved, and primarily the care professionals who are in close contact with the elder, such as the nurse, the physician, the nursing auxiliary, but also the persons around the elder. When suspicion is raised about potential abuse, the urgency to intervene should be evaluated. For this evaluation, a set of criteria could be helpful (cited by the majority of the respondents). In case of severe physical abuse, this kind of evaluation

seemed very logic, but in case of other types of abuse, the respondents were less clearly convinced of the added value of a set of criteria due to the complexity of the situation, which should be taken into account in the evaluation of the urgency to intervene. In these cases, the importance of clinical feeling and professional experience, including the need to be in contact with a specialised organisation, was often cited. The most often cited barrier for the detection of elder abuse, was the reluctance either by the elder or by the entourage of the elder, followed by lack of knowledge/skills and lack of detection tools. Interestingly the informal caregivers cited also the fear to cause harm to the relationship with the elder as a major barrier for the detection of abuse.

The **interventions** regarding the management of elder abuse should be described in a procedure (cited by the majority of the respondents). Main characteristic of such a procedure is the possibility to discuss with colleagues (in a team meeting or via a centralised contact point in every organisation), or even with the elder (and/or his relatives) before reporting the case. The reporting or notification to an external organisation and/or police and justice, should be the responsibility of everyone, moreover the GP was the most cited care professional. Some questions in the online survey were dedicated to the potential role of a reference person in the management of a case of elder abuse. Currently, only a third of the respondents confirmed the presence of a reference person in their clinical setting. This reference person main task is counselling and mediation. In settings with no particular reference person, this role has often been taken up by colleagues, a supervisor per department or coordinating physician. Main reason not to report a case of abuse to a contact organisation, is the lack of knowledge about this organisation. Barriers regarding to the management of elder abuse, were mostly related to work conditions (e.g. lack of time, inappropriate procedures, lack of staff, lack of training, etc.) or by perceptions, either by the professional (e.g. fear for false declaration, fear to cause harm to the elder, unclear definition on abuse, etc.) or by the elder or his relatives (e.g. fear for the consequences, barriers related to the social context of the elder (isolation, cultural or language barriers), poor health status of the elder, absence of family support, etc.).

The inappropriateness of the procedures refers to several aspects:

- In some care settings, no procedure is available for the health professional on how to detect, report and manage a case of elder abuse. Even if he/she is aware of the importance to detect and manage elder abuse, due to the lack of a clear guidance within his professional setting, he feels constrained and frustrated about this situation. This underlines that, even if we have noticed that a lot of health professionals are not aware of the problem 'elder abuse' and ignore it, that some other health professionals are blocked by contextual factors (such as lack of clear procedures).
- In other cases, the inappropriateness of procedures were mentioned. This means that a procedure was available but that either the document itself was outdated (e.g. contact details not correct anymore) or that the implementation of the procedure was hampered by different aspects, such as the so-called 'loi de la silence', or by lack of follow-up procedures (the health professional reported a case, but did not get any news about the follow-up and was still in doubt if he did the right thing to report the case and if the situation was improved for the elder). The 'loi de la silence', refers to the pressure either by colleagues not to report a case of abuse, committed by one of the colleagues, or pressure by the management not to report a case to the police (fear for reputational damage) or even ignorance by the management. The fear for reprisal and resignation was quite often mentioned by the health professionals, and in particular by the types who are more in a 'dependent' position, such as auxiliary nurses, but also by younger nurses, or students/trainees. Some mentioned also that the inappropriate procedures of attitudes by colleagues/management were one of the main reasons to quite their job, but I suppose that this is not specifically related to elder abuse but more about management aspects within a care setting. That is also why (I think) some respondents emphasised the need for anonymous reporting (as protection for their own position).
- Another aspect related to the procedures is more a general approach of (mis)management in the nursing homes, with a lack of time and staff for appropriate care for the elder (e.g. not enough time to assist the

elder to eat with malnutrition as a consequence), the so-called institutional-driven abuse.

Following **organisational aspects** which could improve the current situation, were mentioned by both the professionals and the informal caregivers:

- The set up of the most optimal step-by-step plan, including
  - an (or more) easily accessible detection tool(s)
  - effective interventions for the management and follow-up of abuse
  - contact details of the specialised organisations

  This plan should also be accompanied by awareness campaigns towards the elder persons themselves and their relatives.
- Multidisciplinary training of all involved professionals on how to tackle elder abuse
- Facilitation of the communication between professionals, by the set-up of multidisciplinary meetings, or by mutual access to the medical file of the elder
- More support for the informal caregiver, in order to decrease the risk for elder abuse due to overburden of the informal caregiver
- The need for a legal framework for the protection of the elder, with for example a modification of the juridical definition, and protection of the reporter
- More supervision in residential care settings, for example by independent organisations, or supervision by social assistant (or even by cameras)
- Improved work conditions for the care professionals, for example more staff, more care time, reimbursement of psychological support for the elder, support from management, multidisciplinary meetings in residential care settings, etc.

Overall could be stated that all respondents are aware of the severity of this topic and that action is needed to stop abuse and to protect the elder against future abusive behaviour. However, currently there is still a need for more sensitization by the set-up of awareness campaigns and training on how to tackle elder abuse. Detection on itself is not sufficient and this assessment should be incorporated in step-by-step plan which stipulates the fruther stepsfor the reporting and management of the case of abuse. Organisational aspects, such as the role of the reference person as counsellor and coordinator, the role of the specialised organisation as contact point for the health professionals and the informal caregivers, and the need for more financial and human resouorces in institutional care, should be further elaborated in order to facilitate the implemenation of a step- by-step plan to tackle elder abuse.

CHAPTER 7: POLICE AND JUSTICE

1 OPINIONS OF THE POLICE AND JUSTICE SECTORS IN PREVENTION, DETECTION AND MANAGEMENT OF ELDER ABUSE: AN EXPLORATORY QUALITATIVE STUDY BY INTERVIEWS

In this chapter professionals from the sectors police and justice in Flanders, Wallonia and Brussels were interviewed (see Appendix 63 for a description of the sectors police and justice in Belgium). The interviews are complementary to the lime survey (see Chapter 6) and intend to respond to objective 2 of the study i.e. what are the barriers and facilitators experienced by main actors involved in elder abuse tackling in Belgium? The interviews also aim to identify the gaps in the prevention, the detection and the management of elder abuse in Belgium.

2 METHODS

In contrast with the medical and social sector, it was decided not to include professionals of the justice and police sector in the Lime survey but to perform semi-directed exploratory interviews (see Box 12). The specificity of these sectors and the large variety of profiles and roles of professionals necessitated targeted questioning in a one-to-one setting. Furthermore, the interviews allowed us to have more detailed information on the current functioning and procedures in the respective sectors (see Appendix 63). We also interviewed representatives of the Family Justice Centers (FJC). Although currently only a minority of the cases treated by FJC are related to elder abuse, they are potential partners in the management of elder abuse. Furthermore they have a good helicopter view on the management of intra-family violence.

A generic interview guide, written for the semi-directed interviews was still used during the exploratory interviews and adapted according to the profile of each interviewee. The generic interview guide is available in Appendix 63.

Box 12 – Types of interviews

Semi-directed interview: it is a qualitative survey technique frequently used in humanities and social science research. It makes it possible to guide the discourse of the interviewee around different topics defined in advance by the interviewers and recorded in an interview guide. It can complement and deepen specific areas related to the non-directive interview, which on the basis of a question.

Exploratory interview: the interview takes place freely and is guided by one main first question.

Two researchers, one Dutch-speaking and one French-speaking made contact with stakeholders of the police and justice sectors. When the recruitment by phone call or email did not work, in particular in the French-speaking part, interviewees were recruited by the means of acquaintances in the family and working entourage of the researchers. A snowballing process allowed afterwards to make contact with not-linked stakeholders.

The interviews were conducted by one researcher (except in one case) in the place of working of the stakeholder. The interviews lasted for one to three hours. In a large majority, the interviewees accepted that the interview was recorded.

The analysis of the interviews content was done according to the different main topics broached in the interview guide: generalities on the working context; procedures; barriers, facilitators and solutions; collaboration with other sectors, professional secret and registration of data. The recordings were used as a support to clarify the notes taken during the interviews. The recordings are kept in a secure network internal to KCE and are only accessible to concerned researchers for the duration of the project.

3 RESULTS FROM THE INTERVIEWS

3.1 Police stakeholders' opinion

The interviewees are proximity agents, intervention team members, employees of the police assistance service to victims (PASV – Service d'Assistance policière aux victimes - Politionele slachtofferbejegening dienst), superintendents or chief superintendents, police officers in charge of senior-related matters, and a reference police officer for intra-family violence (charged with the implementation of all relevant guidelines and protocols within the police department).

All the information contained in the results' section is only based on the content of the interviews without interpretation or further analysis.

3.1.1 Generalities

The services of the police are free and **available 24/7**. The main role of first line policeman is judicial: he ascertains, tails, auditions and seizes. In police offices, PASV gives a short term support to victims, inform them about social and judicial procedures and orient them.

3.1.2 Types of abuse encountered by police

The typical type of maltreatment encountered by all interviewees is **intra-familial violence** (IFV) (violence intra-familiale – intrafamiliaal geweld). The frequency of cases concerning older people is estimated by one interviewee to around one by month and a PASV worker evokes a large black number of non-reported cases. Another interviewee explains that elder abuse can be committed by spouses, in particular in case of "grey wedding" (young person coming from abroad which target isolated older person to get marriage), by family helpers, housekeepers or health caregivers (nurse, auxiliary nurse,…).

The **underlying reason of the abuse** can be very different and goes from problems of poverty and social isolation, overburdened caregivers, drug and addiction problems. Some respondents also observe a rise in the number of cases where adult children financially and physically abuse their parents. Often, drug or other addictions are the underlying reason.

Respondents observe that individuals have different views on what is perceived as "maltreatment". Therefore it is important to have the older person's opinion/view. Maltreatment can also occur in **nursing homes** as evoked by several interviewees. The abuse can be perpetrated by staff members or by other residents.

The psychological, physical, financial and sexual abuse and neglect are well identified as elder abuse by the interviewed first line policeman but they have not always a personal experience of it. The managers are also aware about inappropriate use of drugs as an abuse (overuse, misuse or underuse). **Abandonment** is also mentioned. A PASV worker highlights that elder abuse is the most often sudden and violent gestures but without a will to harm. This type of abuse can be secondary to unpreparedness and lack of framing of families to take care of an older person.

3.1.3 Definition of an older person according to the interviewees

According to all interviewees, an older person is **defined by his vulnerability, his physical or cognitive frailty and his dependence, and not by his age** (but still rather a minimum of 60 years according to one interviewee). There is no legal limit that defines an old person. Moreover older people do not like to be categorized. An officer with specialisation in senior matters observes that there is a huge difference in persons under 80 and over 80. In her experience, the most isolated and lonely persons are in the category over 80 since they often do no longer connect with the environment (friends died, they do not fit in a digitalised world, etc.).

The **vulnerability is the common point of all cases of elder abuse**. According to a manager, vulnerability can be physical, psychological as well as social (isolation). A lack of autonomy in property management is also seen as a risk factor of elder abuse. Education as well has an impact on the vulnerability state because some older persons are very naïve and trust easily stranger, in particular from the administration. Some tricked theft offences are perpetrated by false policemen for example. When a person is weak, frail or dependent, he resists less and the risk of abuse increases.

3.1.4 Registration

In police database, **cases are classified according to the offences and not to the victims' profile**. Each offence corresponds to a code number. For example, 37 is the code for the intra-family violence. If the offence is perpetrated by a professional caregiver, it is an aggravating factor. When an offence is perpetrated on a vulnerable person, such as children, elderly, disabled persons, pregnant woman, LGBT, it is also an aggravating factor. In some police databases, each information file and police report is related to a place of living belonging to the police area, what allows to identify places where several events have occurred.

A large list of offences related to elder abuse exist (see Box 13) but **none specifically mentioned elder abuse.**

The more specific code related to the elderly is the code ASA/APA (Agressions sur Personne Agée) which mainly concerns tricky theft offence on elderly, usually done by strangers (so out of scope of this study). Often mentioned by interviewees, they are considered as **abuse of weakness**. Police managers highlight that tricked theft offence are largely underestimated because older persons are ashamed to have been stolen and afraid to be forced to enter a nursing home.

As there is a lack of definition of an older person in criminal offence, they are assimilated to vulnerable people. So sub-analysis focussing on offences related to older person are difficult to obtain. For example an interviewee explains that neglect is frequent but is difficult to match the complaint about neglect with any type of criminal offence.

However, even if no offence was identify (yet), one respondent mentioned that a **report 'social problem' also called police information fiche** can be drafted by police officers. In contrast with a police report, it is not obligatory to draft these kind of reports. Consequently, it is highly dependent on the sensibility of the respective police officer whether such a report will

be drafted or not. Moreover, these reports are administrative documents that are not transferred to justice. Ideally, the social assistants of the police get these documents and take action accordingly, but this is not systematically done.

Box 13 – List of offences related to elder abuse cited by first line policemen

Sexual assault
Assault and battery
Inhumane treatment
Torture
Lack of precaution
Sequestration
Breach of trust
Intra Family Violence (IFV)
Domestic theft
Extortion
Harassment
Injury
Lack of care
Grey marriage
Abuse of the state of weakness
Breach of trust
Reprehensible abstention
Non assistance to a person in danger

3.1.5 Procedures

Several types of guidelines are followed by local police like **protocols, circulars and procedures**.

Protocols are covenants concerning a specific domain between the local police and external partners. The protocols are for intern use inside the police area. They result from the work of the local police chief superintendent, the judicial police superintendent and the administrative police superintendent. One example is the protocol for disappeared persons with disorientation in time and space. A covenant is organised with nursing homes, managers and home nursing coordination services. All involved parties in the protocol know that, in case of disappearance of a disoriented person, a yellow lunch box is always present in the fridge of every older disoriented persons at risk of fugue and that the box contains precise information about this person, given by the family.

Circulars are edited by the college of general public prosecutors. One example is the circular for IFV[39] (see also Chapter 2 4.1.1). It stipulates that (i) IFV is high-priority, (ii) the prosecutor's contact is mandatory, (iii) the author has to be available to the justice and (iv) the author appears in court the day just after the facts. The main objectives are to keep away the author of the IFV and to write the report within 24h.

Procedures are edited by the prosecutor's office of the district court to which the police office is related to. One example is the specific procedure in case of tricked theft offence: (i) first line police ascertainment, (ii) in depth neighbourhood investigation, (iii) check of the shared photos panel, (iv) PASV short-term intervention, and (v) secondary prevention training delivered to older persons.

Internal guidelines: within the police departments, circulars are implemented and adapted to the local context via internal guidelines. In the police department of Antwerp for instance, a checklist for IFV will be digitalised and integrated in the police report (Appendix 65).

One French-speaking interviewee indicated that the politics in Flanders are more clear-cut.

3.1.6 Police elder abuse management

3.1.6.1 Differents points of entry

Policemen are **aware** of elder abuse cases **through different ways**: (i) a call to the 101, (ii) a complaint submitted by a third party (neighbours, peacekeepers, social workers, social service hospital, health care professionals, family, friends, nursing home directors, …) at the welcome desk of the police office or in the street (the more frequent situation according to interviewees), (iii) a concern of the proximity police agent during his patrol and (iv) a flagrant offense. The police can also be informed by the public prosecutor following a complaint by a healthcare professional, an association in charge of elder abuse care or of nursing homes' control. It is very rare that the older person himself comes to report his own abuse. **Usually the complaint comes from a witness** and not from the victim and even less from the author. The witness must prove his identity but the police must not disclose the witness' name to the victim or to the author. Another typical picture is when relatives or caregivers wonder if there is maltreatment and ask policemen' opinion on an unclear situation.

Interviewees stress that submitting a complaint to the police is often a '**final' step in a series of episodes of domestic disputes**. It was also mentioned that health care professionals rarely submit a complaint to the police. According to the interviewees, professional secrecy of the health care professional is one of the reasons why health care professionals refrain from reporting.

3.1.6.2 Specific procedure for elder abuse

There is **no specific procedure for the management of an elder abuse** complaint but there is for IFV (see the prosecutors' circular above).

The head of each police department is free to fine-tune the implementation of the IFV circular and to focus on more specific groups such as elderly. However, the policy of local police departments rarely focus on the elder population. Yet, **good examples** can be found, for instance in the police departments of Brussels (Bru-Nord) and in Leuven where 2 police officers for senior matters are assigned (see below).

In the same spirit, one French-speaking interviewee explains that policemen should better **go to the elderly home for audition** to make it more comfortable for the elderly.

3.1.6.3 Usual police procedure of case management

The usual global p**rocedure** depends on the **severity of the facts**. In the case of an offence, the procedure is not different for elder abuse than for other type of offences (assault and battery, robbery, sexual assault, harassment). The policeman aims to ascertain the facts and can report it to a superior officer if necessary. If it concerns **severe cases (offences),** the prosecutor's office will be directly contacted and the prosecutor can order the police to intervene immediately. If it concerns **less severe facts**, the case can be treated by the police officers themselves (Ambtshalve politioneel onderzoek/Enquête Policière d'Office[190]. An investigation for and against can be made by the police which includes auditions and check of databases. A police report is written and is passed on to the prosecutor. The decision of conducting an additional police investigation, of arresting the author, of involving a judicial expert or of summoning the author is taken by the prosecutor based on information given by the police, and notably the risk of recidivism. The victim can receive help from the PASV, social associations or health caregivers, accordingly. In some police departments this only takes place on the initiative of the victim, whereas in other departments, all case related to intra family violence are reviewed by social assistants who contact the victims. A follow-up of the victim or the author by a policeman can also occur.

In case of **unclear complaint of abuse**, some interviewees explain that proximity agents and PASV workers visit the victim at home. The support from relatives, caregivers and social workers is very important, notably to enter elders' houses. The policeman and the PASV worker evaluate the situation, the need of the victim and if the complaint is substantiated. They inform the older person about the social and judicial procedures and orientate them to mediation service or organisation specialized in elder abuse as "Ecoute Senior". When a complaint does not lead to the objectification of an offence, notably in case of psychological abuse, a report 'social problem' also called police information fiche is drafted and recorded

in the local police office database. Usually an action is taken against the author only if there is a repetition of unclear complaints. A trace of a complaint is always kept in police database.

According to the article 46 of the police code: a policemen can never skip a fact brought to his attention. So, it is **mandatory for a policeman to take into account any complaint**, even if the older person does not want to be helped. The police does not need the approval/complaint of the victim to act. An interviewee explains that it is sometimes beneficial for the senior that the police decides for him. If there is no offence, the administrative authority can take the lead and transfers the case to the public centre of social action (CPAS - OCMW).

Sometimes, the complaint about abuse is related to the **exhaustion of the informal caregiver or a social problem** (derailed informal care). These cases are often classified as matters that are not correctly addressed to the police. It depends on the perception of the intervening police officer, if the case needs to be registered in a police report.

Interviewees explain that, in family context, the feelings of the victims and authors are often variable and ambiguous. A protection measure of property and people (guardianship) can be decided as well as a measure of ban from the residence (i.e. the author is prohibited to come into contact with the abused elderly; see also Chapter 2). PASV workers can listen to caregivers to identify the cause of the abuse and to find solutions and relay. The cause of exhaustion can be diverse as the shame to ask help or the fear of financial consequences. As there is no help service for authors at the police, the informal caregiver responsible of abuse can be taken into charge by house of justice staff.

In case **of flagrance offence,** the procedure is faster and the local police chief inspector can decide (as a judicial police officer) to intervene and to arrest the author but must contact the prosecutor rapidly to take additional urgent decision. The older person can be secured in a hospital or in a nursing home.

When the older person does not confirm the abuse, even in the case of a flagrant offence, there is no impact on police interventions. In this case, the prosecutor has the power to ask a medical expertise to identify signs of the abuse but usually the case does not reach the state of a trial.

Regional differences in abuse procedures exist even if they should be similar (federal competence). Those differences are more related to (i) person sensitivity among policemen or prosecutors, (ii) difference in financial resources, (iii) different zonal wills of implementing procedures and (iv) varying offer of help services. Indeed, the organisation and offer of help services differs in Flanders and in Wallonia since this is the competence of the federated entities (Appendix 5).

Other interviewees highlighted a difference between the rural and the urban environment. In the first one, people know each other and it is easier to get information, while in the second one, people are more anonymous for each other.

3.1.6.4 Role of the PASV

According to some interviewees, the PASV follows several principles in the management of an elder abuse case. First, it establishes **a trust relationship** with the older person. The visit occurs at the elder's home, in the PASV office or in a public place. Second, the management is based on what the **older person wishes** through his speech but also through his non-verbal language. It is important to be aware to the environment of the elderly like the workload or fatigue of the informal caregiver, in keeping the older person in the centre of the management. Third, the PASV worker distinguishes if it is **a criminal situation or more a social one**. In case of urgent care situation, the discussion with the PASV is shortened and contact data are given. The recontact is sometimes done by the PASV. Fourth, the PASV **visits maximum twice or three times before referring the older person according to his/her needs**: social support (OCMW - CPAS, planning familial, specialized services); mental health support (community mental health centre (SSM - CGG)) or judicial support (assistance to judiciable-house of justice).

3.1.6.5 *Reference persons*

Interviewees explain that **reference policeman or prosecutors exist for IFV matter but not specifically for elder abuse matters.** In some public prosecutor's offices, the IFV reference prosecutor is the same than for youth cases. According to an interviewee, the public prosecutor's office is more sensitive to IFV on elderly when the prosecutor is a woman. Reference prosecutor could have few contact with the police as he is mainly involved in sensitization and administrative meetings. IFV reference policeman do not manage all the IFV and have more a role of trainer. The interviewed reference policeman explains that his role is to make the policemen of his corps familiar with the internal guidelines related to IFV. These guidelines are based on the circular related to IFV but are further translated into operational guidelines for the corps. For instance, at the moment of writing the digitalisation of a checklist IFV (Appendix 65) is worked on. Most policemen are general and are able to take care of the abuse cases. However, in Leuven, 2 police officers are appointed as **contact persons for all senior-related cases**. They are not part of the intervention team but they visit elder persons, go to rest homes and try to be involved in networks surrounding elderly (e.g. home care, etc.). This informal way of being in contact with the elder has a function of prevention or at least early detection of problem situations. In the Bru-Nord police zone, a police officer and a PASV worker are specifically assigned to cases involving older persons. Reference policemen also exist for tricked theft offences.

3.1.6.6 *Coordination*

At case level, the person which **coordinate** the case management is seen differently according to interviewees. On one hand, it is the prosecutor, on the other hand, it is a team of policemen including occasionally a police officer if high-responsibility decisions are required.

At service level, **coordination structure of different types of victims' help services** exist. It gathers PASV, victims help services of justice houses and victims help services of prosecutors' office. Those services meet once a year during the judicial district board. Investigation judges, IFV reference magistrate, judicial and administrative police directors and chief superintendent are also present. All decide the **main objectives for the district concerning victims' assistance**. According to one interviewee, this coordination structure is not always constructive.

At the sector level, **concertation meetings** between collaborators at the initiative of the police sector are rare and considered as insufficient by one interviewed manager. The past function of concertation agent involved in police office are now integrated in PASV. PASV may organise concertation meetings with the older person and the OCMW - CPAS to better appreciate if the case should open to a judicial procedure.

3.1.6.7 *Collaboration*

The global impression is that the **extent of collaboration with other partners in the process of management of elder abuse is variable** from one place to another and from one type of service to another. For interviewed professionals from the police sector, it is clear (i) that policemen cannot give information to other sector workers except the judicial workers because of the risk of disciplinary sanctions, (ii) that prosecutor does not give information to policeman or to any other professionals, and (iii) that medical secret is easily lifted by investigative judges. Interviewed managers perceive the professional secrecy and the duty of confidentiality of magistrate as very complicated and paralysing. According to an interviewee, each professional body has his own professional secret.

A **structural collaboration** of the police only exists with the **public prosecutor's office and with the victims' help service (PASV).** But some police officers regret the lack of feedback on what happened with a particular case by the prosecutor's office.

PASV is closely related to police office but not always inside the same building. The number of workers in a PASV depends of the number of policemen in the area. For example, a police office has one PASV staff member and another has ten. Only one amongst the interviewees explains that, in their office, they have a PASV worker specifically allocated to older people matters. PASV staff is composed of social workers, criminologists and/or psychologists. They can explain to policemen some suspicious behaviour but they are not obliged to report offences except if somebody is

in danger. PASV staff can also be consulted willingly by victims even if no complaint at the police office are filled. Proximity or intervention policemen can also warn the PASV about a case.

The **collaboration between the police and the local mediation service** can be very close and very good but lacks a legal frame to be structural. Local mediation service[a] is an autonomous service in every municipality born from a collaboration between the district prosecutors' office and the municipal authority and aiming to allow the police forces to devote themselves in priority to their missions of security, law and order. Local mediation helps in the management of relational conflicts of the inhabitants (misunderstandings, violence or separations in families, neighborhood disturbances ...) based on dialogue.

One of the interviewees is involved in a project of the Brussels Region about a **new inter-sectoral collaboration[b] to increase the links between all the workers involved in the security (police, firemen, ambulance men…).**

According to several interviewees, the **collaboration with the health sector** is **scarce**. GPs are seen as good help in acute and problematic situations (Diogen syndrome (extreme self-neglect), dementia) and caregivers, in general, are seen as potential complainer. For some interviewees, bilateral exchange of information does not exist between health and police sectors as the information only circulates in one direction, from the caregivers to the police.

Some police officers have the impression that healthcare professionals do not know when they can lift the professional secrecy or that some health professionals fear condemnation if they lift the professional secret. At the same time they mention that, when they have repetitive contacts with the same healthcare professionals or professionals from the assistance services, a relation of trust is created and there is more goodwill to apply professional secrecy in a pragmatic way. One explanation given by an interviewee is that, as the article 458 of the criminal code is very blurring, the concertation meetings between professionals are made informally.

Partnership can exist with all types of organisations or providers in charge of elders' care or assistance as nursing homes, **public centre for social action** (OCMW/CPAS), relatives, justice of the peace, elderly associations, organisations specialised in elder abuse, house of justice (for a description of the houses of justice see annex) …. **In one of the investigated police office, new comers start their job by meeting all partners to well know the network.**

Some interviewees complain that public centres for social action (OCMW/CPAS) and the judicial sector give no feedback. Public centres for social action (OCMW - CPAS) are even seen as not accessible at all to dialogue with the police or the PASV. One interviewee notices however that OCMW/CPAS sometimes communicates about the help around an older dependent person.

A French-speaking interviewee stipulates that the interactions between sectors are more frequent and transparent in Flanders. Indeed, several initiatives in the form of **collaboration between police, assistance and justice** are implemented. In a chain approach, information on complex cases is exchanged between police, care providers and judicial services. Often chain approach results in the elaboration of a family justice centre. The idea of a family justice centre is that all actors in the chain of assistance for victims of intra-family violence, i.e. police, assistance and judiciary services are integrated in one building (see also Chapter 2). Some French-speaking interviewees explain that the collaboration is much easier in Flanders like in the Netherlands where all the stakeholders meet to discuss a specific case and share data under professional secrecy in the interest of the victim. They have noticed that, in the French-speaking part of the country, professionals hide behind their professional secrecy according to

a https://www.mi-is.be/fr/themes/cohesion-urbaine-et-grandes-villes/sanctions-administrative-communales/mediation

b https://bps-bpv.brussels/fr/atteintes-lintegrite-de-la-personne

the French and Latina tradition. However it is possible that the mentalities are currently changing.

A last type of collaboration is between **PASV and judge of the peace**, notably when informal caregivers are lacking. The judge of the peace can give rights to families or to impose decision to the older adult.

Several interviewees from the French part of the country had never heard about the specialized organizations for elder abuse management (Respect Senior, Ecoute Seniors) nor concertation meetings or Family Justice Centre.

Other interviewees explained that **specialized organizations for elder abuse apply very strict conditions to accept the management of a case**. The explanation was that workers in specialized organization protect themselves from too complicated abuse situations. However, one point which is highly appreciated is the **visits at home by specialised organisations**.

3.1.7 Training

Police officers follow basic training. Those who want to go for criminal investigation, get a special training. **The topic of elder abuse, nor intra-family violence is integrated in the basic training or the training for the criminal investigation section**. During their professional career police officers can enrol on a voluntary basis to **baremic trainings** (= trainings that can be followed to achieve a higher wage scale). The topics of these trainings can vary. Intra-family violence is sometimes included in these training sessions. Specific training can also be foreseen on an ad hoc basis within the local police department.

3.1.8 Barriers, facilitators and solutions to the detection and management of elder abuse

In this section, all kinds of barriers, facilitators and solutions mentioned by different kinds of police officers are listed. Some of the mentioned issues directly relate to the profession of police officer, others relate to other institutions or partners involved in the trajectory of management of elder abuse.

Perceived barriers related to the profession of police officer

The first line policemen interviewees do **not** identify **institutional barriers** to the detection and management of elder abuse on the police level except the fact that proximity agent cannot enter people's house. First line policemen do not either identify a lack of training about elder abuse or about the way to interact with older people. They estimate that the manpower is sufficient for detection and management except for the long-term follow-up of elder abuse cases. In contrast, **police managers** stress **a lack of financial resources and training in the police and the justice sectors**. They explain that the behaviour of each policeman in face of elder abuse depends mainly on his personal sensitivity. PASV workers rather report that the first line policemen have **not a good knowledge of the potential partners** to collaborate with. Some managers highlight **a lack of reference policemen in senior matters**. Yet, each manager of a police department can freely choose to assign a police officer for seniors. The lack of reference policemen in senior matters may be due to the fact that decision makers in the justice and police sectors, notably the administrative police department**, never give high priority to elderly matters**. In addition, first line policemen are neither interested in senior matters and in the public, there is no awareness about elder abuse although some changes of mentalities are emerging recently. Some interviewees also stated that first a drama (shared in the press) is needed before a topic gets on the priority list. The efforts that were made in the organisation of the management of child abuse, were primarily due to a scandal (Case "Marc Dutroux").

In prosecutor's offices, the older persons' matters are not either a priority, except IFV and tricked theft offences.

Interviewees also mentioned that it is difficult to motivate police officers because the latter often have the feeling that after several police interventions, the case is still not taken into account for follow-up (by justice or other instances). This is perceived to be very demotivating.

Some interviewees underline the fact that police **lacks delicacy** when interacting with seniors. In this scope the police officer specialised in senior related matters also stressed the importance of having an **informal relationship with the elderly**. According to her, elderly will much easier

confine things that may go wrong when the elderly see the police officers as a person of trust and in 'non-police related' settings (e.g. the home setting of the elderly or events organised for elderly public).

The professional secret is not seen as a barrier or to have any impact on the procedure by first line policemen except one.

The investigation secret is preserved, even in regard of the family, except if the older person releases the police from the secret concerning a specific person.

Perceived barriers related to other institutions or partners involved in the trajectory of management of elder abuse

Interviewees highlight difficulties regarding the judicial sector about the **slowness of the judicial system and the complexity of the judicial language.** The prosecutor's office can be seen as taking inadequate decisions (e.g. dismissal) when there is no intention to harm even if there is non-assistance to somebody in danger. Prosecutors lack a practical internship on the field to better understand the needs of the victims instead of being feared to miss the democratic rights of authors. There is, currently, a loss of attention brought to victims in the judicial sector.

According to interviewees, people do **not know very well the existence of the PASV** maybe because **PASV workers can only give advice to caregivers but cannot contact older people in a proactive way**.

IFV matter is judged complicated by interviewees because proof is often missing, notably in case of psychological abuse or neglect. The absence of proof impairs the legal proceedings. Moreover, IFV matter are very close to underlying **social problems**.

Interviewees consider that **specialized organisation in elder abuse are not enough available, nor well-kno**wn. Each service narrows his frame and let problems go without taking care of it. The working frames are too rigid and people use time to justify why they do manage a case or not.

Some interviewees perceived a **too high workload or too little personnel** in the assistance services which may block a case.

In **nursing homes**, families identified abuse when the staff has not enough time and gives too much drugs. It is also recognized that maltreatment is often not intentional and can occur at home by relatives who lack time to care for the elder person. Managers also highlight that administrative procedure in the scope of agreement (agrément/erkenning) are burdensome and slow. Another barrier highlighted by interviewees is that the **collaboration with local mediation service lacks a legal frame to be structural**.

Families and relatives or the absence of them should be barriers or facilitators to the management of an EA case. The family is always heard in a prosecution and exculpatory way but in any case family members take part to the investigations. However, the PASV can discuss with relatives to clarify a situation.

Perceived barriers related to the characteristics of the abused individual or the author

According to interviewees, there are several barriers related to the characteristics of the abused individual. They are related (i) to the risk of misunderstanding of a complaint, for example in case of Diogene syndrome or paranoiac dementia, or a frustration of the older person to be dependent (ii) to the isolation of older persons, (iii) to the unawareness of the elderly concerning the abuse they undergo, (iv) the minimisation of the situation of abuse by the elderly or by his relatives, (v) the feeling of shame by the elderly or the relatives, (vi) the feeling of fear or (vii) to the obstinacy of older persons to decline any help, "forcing" their relatives to neglect them. It is not always possible for the police to protect this last category of older persons.

According to interviewees, older victims do not frequently **report** about abuse because of their **inability to walk, to phone or to be aware of what an abuse is; sometimes also they do not want to talk about it**. Moreover, older adults do not go with ease to the police office as they **do not know the 'help' function of the police**. In rural areas, older people do not

complaint because it was not done in the past to complain. Some are **afraid to disturb** uselessly the police.

Dementia is very difficult to manage. A policeman must report any complaint but in case of dementia, the policeman is often powerless. Sometimes Nixon procedure (forced admission to psychiatry) is needed. Other solutions available to police officers can be the 107 psychiatric mobile teams for adults (which sometimes accept to see older persons) and assistance and care coordination structures. However, the experience of interviewees is that waiting lists are huge, till one year for some 107 teams and that coordination structures just organise concertation meeting but do not act practically. In case of acute situation, only the municipal mediator and the police remain available 24/7.

The **trust relationship between the victim and the author** can also be a barrier to elder abuse detection and management. According to the interviewees, older persons decline to confirm a complaint of abuse in particular when their children are involved or in case of "grey weddings", even if their suffering is huge. The affective relationship/dependency and/or the long common history influence the older person's decision as well as the embarrassment of the situation and the fear to be mistreated even more or to enter a nursing home against his/her will. One possibility is also a win-win situation between the victim and the author.

Facilitators to the detection and management of elder abuse:

The first example, given by an interviewee, of facilitator to the detection and the report of elder abuse is the presence, among the population, of **perceptive and brave citizens** who take their responsibility in case of injustice situation.

The second facilitator evoked by the interviewees is the **collaboration with public centres of social action (CPAS/OCMW), with PASV and with general practitioners (GP),** particularly when the older person is not anymore able to take decision (dementia). A **partnership with specialized organisation** as "Ecoute Senior" is also seen as a facilitator. For **more severe cases, collaboration frameworks like chain approach or family justice centres** are perceived to have a huge added value on the Flemish side.

The third facilitator is the good **relationship of the police with the community** which allow a quick and effective exchange of information. **Everything is a question of trust and proximity**. One example is the feedback from the audience after information conferences given by the police on the request of seniors' associations. Moreover, information conferences participate to the continuation of a social link for isolated older persons. In the past, the local partnership for prevention in villages and neighbourhoods were organised by the police and allowed to sensitize the elderly to different type of abuses or offences. Interviewees explain that proximity agents are a presence in the environment of the older persons. They can sensitize them, help to detect abuse and be the recipient of elderly confidences. A **pro-active approach** is important with older people. When an older adult gives a hidden signal of suffering, the police must know how to tranlate it. Usually seniors have a deep trust in the police. A **good information of the population** is the fourth facilitator collected during the interviews but the opinion of interviewees differ totally from one to another concerning the knowledge of the public about the procedure to complaint to the police or declare an offence to the prosecutor. Some suggest that it is the role of policemen or of the PASV to explain judicial procedures to the population.

The training of policemen to victims' help during their initial and continue training is the fifth facilitator identified by first line policemen and police managers.

The visits **at home** done by some specialized organizations for elder abuse are highly appreciated and could be seen as a potential facilitator.

Solutions

Policemen suggested several types of solutions to improve the detection and management of elder abuse.

- Related to the profession of police officer

- To **improve the sensitization** and the training of policemen to elder abuse, to agreement and access conditions of nursing homes, to the frailty of the elderly, and to the pain and frail skin of the elderly.
- To develop **trust relationship between the police and the professional caregivers** to get around the professional secret. For example to suggest to professional caregivers to give policeman visit card to victims or to share secrets with the police through the victim or the witnesses.
- To improve the interaction and the **trust between older people and the police** by, for example, the intermediary of the social watchdog which favours the contact notably with children and older persons.
- To attribute a "**god-father" policeman** to each nursing home as it is for school.
- To better welcome older people in police office (and in justice office) with more **kindness and comfort.**
- To allow valid **police reports even without audition** of the older person because audition can impair the established trust with the policeman. Another way is to allow a trust person chosen by the elderly during the hearing/audition.
- To favour a specific training of policemen on how to help victims through practicum with actors.
- To make mandatory a **register of the local social services** in all the police offices.
- To improve the visibility and the interaction with specialized organisation of elder abuse, as **Respect Senior,** for example by sending a letter to all chief superintendents (chefs de corps) to inform them of their existence.
- To provide without exception a **psycho-social service** in every police office.
- To systematically **involve the PASV** and inform the public that the PASV is available even if no complaint are filled.
- To create police intervention cells specialized in seniors' matters.
- To establish a unified plan under a coherent strategy between police areas.
- To give a **better (non-repressive) image** to police and justice.

- Related to other institutions or partners involved in the trajectory of management of elder abuse:
  - To improve the **training of professional caregivers** about elder abuse, in the basic education and also in continued education.
  - To better respect the law about assistance to person in danger, in particular by **extending the lift of professional secret to case of IFV**.
  - To add a section about the elderly in the prosecutor' office IFV circular.
  - To improve the **collaboration between workers from different sectors**: (i) Project of family justice centre in Brussels (concertation centres, regional platforms) by a regionalization of the resources around IFV matter, (ii) to train police, mediator, peace keeper, ambulance man, firefighter and educator all together.
  - To organise more f**requent visits by different professionals in older person house** at different time to highlight dysfunctions.
  - To have a **contact person** different from the informal caregiver, to give the possibility to older person to confide.
  - To limit the isolation of older people and their caregiver by the **visit of volunteers which come to chat**. Volunteers can also identify relatives which go out the legal limits.
  - Better **train the hospital staff** to give advice to informal caregivers when older dependent people are discharged. The associations and volunteers offer good support.

- Related to policy
  - To establish structures aiming to **inform informal caregivers** whose the difficulties are often neglected.
  - To **inform older adults about elder abuse**, notably through local newspapers, TV spots and soaps. An interviewee even suggests to make the attendance to conference on elder abuse prevention mandatory for all older persons. The sensitization of older persons could also go through professional caregivers. Indeed, those are sometimes the only person still in contact with isolated older persons
  - To organise a **multidisciplinary network** around elder abuse cases with an integrated and global approach as the one of the SEL Waasland.
  - To establish a mediation chamber in the public prosecutor's office for the cases for which no trial is necessary. It should be more rapid and effective for elder abuse cases.
  - To systematically check the ability of older adults to decide and manage themselves.
  - To tell to decision makers that they should focus their attention on the elder part of the population and **invest on prevention, promotion and revaluation of the persons working with older people**.
  - To make victims and offenders aware on what elder abuse is and how to identify if they are confronted with.
  - To enable a **close monitoring** of elder abuse cases.
  - To attribute the **senior cases to the youth service** in the court because of its protective function
  - To stress older persons to think on **advance directives**.
  - To systematically organize a coordination of care for isolated people.
  - To **strive against the social isolation of older people** by, for example, the development of intergenerational housings.
  - To increase the means allowing older persons to stay independent at home.
  - To take into account the emotional burden of the professional in the system
  - To **revaluate** professional caregivers working with older persons in front of institutions' managers and older people families.
  - To approve a criminal code including a better definition of the vulnerable subpopulation as the elderly or the disabled persons.
  - To **change** the **mentalities** of the public about elder abuse

3.2 Justice stakeholders' opinion

Elder abuse can take many forms ranging from civil to criminal offences (see Chapter 2). Depending on the situation, elder abuse cases will most often come before the justice of the peace, before a correctional court or for the assize court. We interviewed a selection of magistrates in these matters: judges of peace, a substitute prosecutor in the lower court, substitute prosecutor-general in the court of appeal, a reference magistrate for intra-family violence, an investigation judge and a judge of the chamber of accusations. The entirety of the following information is only based on the content of the interviews.

As explained by one of the interviewees, justice gives the two possibilities: the **coercion and the restoration of a balance of power between individuals**. The criminal justice is the legal force but also an outstretched hand. In abuse situations, the objective is that the abuse stops by taking measures of (legal) authority over an abusive other authority (children, staff of nursing homes…). There is a whole range of repairing and restorative measures and sentences (cfr. Chapter 2) for example, repair the inflicted harm (often via financial compensation) and restore a balanced relationship in which the older person is respected. Justice is a necessary and interesting tool, complementary to non-profit organisations.

3.2.1 Judges of peace

The judge of the peace is a judge dealing with civil affairs, more particularly all the problems related to family life, residents and neighbours, home, etc.

There is 1 judge of the peace per canton (sub district grouping municipalities except for large cities).[a] For a more detailed description of the role of the judge of the peace see Appendix 63.

3.2.1.1 Types of abuse encoutered

Interviewees were confronted with different types of maltreatment. **Neglect** was illustrated by a nursing home resident whose clothes were not appropriate to his income, and by the abandonment of a dependent woman by her son**. Money** (sometimes combined with the use of drugs/alcohol by the offender) and a **problematic home situation** are named to be the trigger to have the judge of the peace involved. Judges of peace encounter also **psychological maltreatment** as when one family member prevents other family members to visit the older person, or when a member of family applies psychological pressure to remove an administration of properties which impaired a possible misappropriation. Judges of peace can also be the recipient of **physical maltreatment** complaints. Suspicion of sequestration by a family member or of financial abuse by close helpers (house keepers, family helpers) when each visit is systematically the occasion of receiving money from the elderly. Financial abuse can also be the act of professional administrators. According to the law, the judge of the peace has to visit the people under administration at least every two years in the follow-up of the decision of official receivership placement which is always considered as temporary.

Some stories of well-treatment are also noticed by the interviewees.

3.2.1.2 Definition of elder

To the opinion of interviewed judges of peace, an older person is not defined by his age but more **linked to a physical and/or cognitive impairment**. He is more a frail person in **loss of autonomy**.

3.2.1.3 Points of entry

It is often the **home care providers or other services like OCMW/CPAS** who bring on a case to the judge of the peace. General practitioners or other healthcare professionals are rarely declaring a case. According to the interviewee the underlying reasons are lack of knowledge but also the risk to breach the patient relationship. Since one cannot declare anonymously, health care providers fear that the elderly will see a declaration as a breach of confidence.

The interviewees highlight that older people with dependency are rarely able to tell about the abuse from which they suffer but a judge of the peace should be able to analyse the non-verbal language. Going to the police is even more difficult for dependant persons.

Moreover, it is not clear to which point the older person also sinks into a problematic and vicious circle. Usually, in intra-familial cases, people are not inclined to declare the abuse because they will lose too much.

One interviewee also stresses that people from underprivileged environments are often familiar with violence and are then resigned. Thus the cut-off of tolerance of the violence could depend on the socio-cultural environment.

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[a] https://www.om-mp.be/om_mp/files/en-savoir-plus/brochures/NL/10-0211_BROCHURE_VREDERECHTER.pdf

3.2.2 Collaborations, quality of contact and information exchange

Interviewees considered the relations with the medical and the social sector very good, in particular with hospitals' social services, nursing homes, home care coordination structures (coordination des soins à domicile, OCMW/CPAS, and seniors' associations. The professional secret is always shared through the medical certificate. The contacts with referent general practitioners, Psy 107 teams and judicial psychiatrist seem also good.

Judges of peace can have occasionally contact with prosecutors, for example when the judge is the recipient of a personal declaration of elder abuse (or another criminal offence), or if he needs a social investigation legally ordered by a prosecutor (when an administrator does not show up at a convocation or does not deliver an annual administration report). Prosecutors can also ask judge of the peace to establish a protection measure for people. Some specific communication ways are in use with prosecutors to declare elder abuse.

Managers of nursing homes are more willing to address abuse concerns to the judge of the peace than to the police. Police is mainly contacted in case of obvious offence.

Concertation meetings can occasionally be organized by professional administrators (lawyers), in particular by the ones specialized in the protection of property and people. It can also occur in the judge of the peace office but usually without the elder person (because, according to the interviewee, meeting could disturb the older person).

Contacts between judge of the peace and the police are scarce as are the contacts with the nursing home inspectors of the AVIQ.

3.2.2.1 Sensitization

It was stressed that sensitisation of the OCMW/CPAS and home care services of the possible measures that can be taken by the judge of the peace is of an utmost importance since these parties often see the people in their home situation or are familiar with their problems. An interviewee stated that in practice, judges can and should go and **inform the OCMW/CPAS themselves**, because it creates a partnership between justice and the sector of assistance. It is more difficult, however, to adress the home care services because of the privatisations of the sector.

According to interviewees, the sensitization of the elderly should be possible through **TV campaigns on which type of derailed care is not acceptable**. But this channel will only target older people able to watch TV. **The 80+ or the demented persons are probably not/less "touchable"/"sensitizable".** Are they even aware that they are maltreated?

According to the interviewed judges of peace, they are very sensitive to elder abuse. To the point of view of the interviewees, the judicial sector is probably sensitive to elder abuse but it has no enough means to take care of it. None or the interviewees in Wallonia know the family justice centres and all say that they are interested in the SEL Waasland booklet (see Chapter 2).

To the interviewed judges of peace point of view, the sensitization of the relatives of older persons seems to be difficult. One interviewee recommends a tool elaborated by the Baudouin King Fundation on how to talk to people with mental health problems.

- Data collection

According to interviewees, the data collection of elder abuse cases are not done by the judge of the peace. It is maybe done by police tribunal president, president of the judge of the peace, police manager of each area, FPS justice or Baudouin King Fundation.

Barriers, facilitators and solutions for the management of elder abuse

Barriers identified by the interviewees are:

- **Perceived barriers related to the profession of judge of the peace**
  - the lack of staff in justice of the peace to follow in a correct way each person under administration
  - the lack of means to identify money misappropriation by professional administrators
  - the lack of training to communicate with persons with mental health problems
  - the high cost of the mediation process
- **Perceived barriers related to other institutions or partners involved in the trajectory of management of elder abuse**
  - the unclear or **unappropriated writing of the medical** certificate required in the process of administration of goods and persons,
  - the lack of **staff in nursing homes**. To develop this last point, the following examples were given: supper is served at 3.30 pm, the lack of staff qualification (volunteers, staff based on people under art 60), only one staff member for 20 residents, no brain activity as promised in a cognitive unit (Cantou).
  - the **burn-out of administrators** with risk of neglect
  - the **lack of interventions needed by other assistance services** before a 'case' comes at the level of the judge of the peace
  - the **difficulties encountered with prosecutors' offices** :delay, no return of information, relational rigidity
  - the inappropriateness of the penal tribunals and courts concerning the intra-familial violence cases: explosion of families**, stigmatisation**
  - the **short work frame of Respect Senior**, limited to complaints directly coming from the elderly
  - the poor relationship with the police
  - the fact that the **AVIQ does not come to nursing homes** to see problematic situations
  - the lack of awareness of healthcare professionals about the role of judges of peace
  - the **lack of training and information** of the (home) care services
- **Perceived barriers related to policy**
  - Elder abuse is **not the priority** of the government.
  - According to the interviewee in Flanders, in Belgium, policy is too reactive (>< preventive). It remains too long in the sphere of voluntariness/field of action of the 'victim'. There is a **need for a more 'interventionist' policy in Flanders.** The interviewee referred to the 'bemoeizorg' in the Netherlands as a good example.[a] Bemoeizorg refers to the practice of care providers attempting to convince persons, unwilling to accept care or unable to find their way in the care options, to accept specialised care. Positive effects were demonstrated.[b]
  - New legislation will require that only recognised physicians or psychiatrists will be able to attest a medical certificate for the procedure of administration of goods and person. This will imply a high cost and administrative burden (for instance if there is a waiting list to be examined by a recognised physician or psychiatrists).

a https://kennisbank.patientenfederatie.nl/app/answers/detail/a_id/1892/~/bemoeizorg-of-openbare-geestelijke-gezondheidszorg-%28oggz%29; https://www.informatielangdurigezorg.nl/bemoeizorg

b https://www.movisie.nl/sites/movisie.nl/files/2018-03/De-effecten-van-bemoeizorg.pdf

- **Perceived barriers related to the characteristics of the abused individual or the author**
  - the people do not tell everything to the judge of the peace, in particular people from wealthy environment

Solutions:

- **Related to the profession of judge of the peace**
  - a **training** of all judges of peace by Respect Senior (ex: royal union of judges of peace)
  - a **training** of judge of the peace about the **communication with people with mental health problems** (Fondation Roi Baudouin: shame and contre shame).
  - a discussion about elder abuse at the combined commission of professional administrators and judges of peace, and with related institutions or partners involved in the trajectory of management of elder abuse
  - Draw attention to the good practice of going as much as possible at people's home. Judges of peace should be a visible and low threshold contact.
  - **Taking time to people's homes**
- **Related to other professions or institutions**
  - the attribution of **several administrated persons from the same nursing home** to the same professional administrator
  - a **reference person at the police office**
  - a **personalized contact with the prosecutors' office**
  - a **better communication with Respect Senior** through a widening of their availability (not only by phone)
- **Related to policy**
  - the possibility to ask **medical expert opinion** to neurologist and geriatrist in addition to psychiatrist;
  - the **computerization and centralization of the information about people under administration in a central data base** hosted by the federal public service of justice (project already in process)
  - the **creation of a tribunal specialized in older people matters**
  - the consideration of the **cultural aspect**
  - Implement 'bemoeizorg' teams, like in the model of the Netherlands

3.2.3 Magistrates involved in the criminal procedure

Several magistrates can be involved in a criminal procedure at the level of first instance or in appeal. **Prosecutors** represent the society and defend its interest. They therefore do not represent a suspect or a victim or either party, but ensure the enforcement of the laws. If there are indications of a crime, the investigating judge can (at the level of the court of first instance), at the request of the public prosecutor or of the victim, start a judicial investigation. When it is a full investigation, the **investigating judge** is in charge of the coordination while if it is a simple information, the prosecutor keeps the hand. A judicial investigation is the totality of acts of investigation aimed at identifying the perpetrators of crime, gathering evidence and taking measures to possibly bring the case to court. The investigating judge searches for the truth, analysing elements both to the advantage and to the disadvantage of the accused. An investigation judge does not decide on the outcome of a case. The investigating judge can, for example, interrogate witnesses and suspects and appoint experts. If the investigation requires this, the investigating judge can also order coercive measures such as for instance questioning the suspect, telecommunication detection, examination of the body, etc.

The chamber of indictment (kamer van in beschuldiging stelling/chamber de mises en accusation) is the investigating court at the level of the court of appeal (the council chamber (Raadkamer/Chambre du Conseil is the

investigating court at the level of the court of first instance), which supervises the course of the judicial investigation and does not, in principle, decides on the final outcome of a case.

If all information is gathered, the outcome of a case can be decided by judges of the respective competent courts in first instance or in appeal. For elder abuse, this will most often be the correctional court or for more severe cases (for instance murder) the assize court.

We interviewed an investigation judge (level of first instance) and a judge of the chamber of indictment (level court of appeal).

Perceptions of investigation judge and judge at the chamber of accusations

An investigation judge and a judge at the chamber of accusations in Wallonia were interviewed.

Types of abuse encountered

The main types of elder abuse are known by the interviewees. The **physical one** is considered as the most severe. All abuses can be attributed to a criminal offence as elder abuse is defined as any health damage to somebody. In the criminal Code, crimes against persons are from articles 392 to 460ter and are stipulated as confinement, failure to assist a person in danger, harassment, insults, denigration, poisoning, administration of toxic substances, illegal practice of medicine, torture, inhuman treatment, denigration, assault or murder. Aggravating circumstances are blood relationship and vulnerability (age, illness, disability) – see also chapter 2.

One interviewee suggests a **very large number of undeclared elder abuse cases**, much more important than for child abuse. This black number should be explained first by the less protective reaction of the population and relatives with regard to an older person than with regard to a child. Second, the feeling of potential shame of an older person, facing his/her own abuse, is more taken into account by professionals and relatives than for children. Third, older people lives in a more closed environment, inducing isolation. The monopoly of a unique social environment triggers the impossibility to recourse to another independent environment than the abusive one. Fourth, seniors don't want to disturb. So, elder abuse is seen as a very widespread violence but very difficult to detect by one interviewee. However, less reporting does not induce less situations. According to WHO, only 4% of elder abuse are reported for management but it is even that are declared in court.

Definition of elder

One interviewee explains that the limit of age of an older person is difficult to determine but is probably after 60 years old. **The state of vulnerability**, out of the working world, without enough physical and psychological strength to defend his/herself and to seek help. Another interviewee says that older people represents the part of the population undergoing the greatest change.

An interviewee explains that in youth courts, there are two angles of views of child abuse: the youth protection chambers and the criminal chambers. **For seniors, there is no such double vision, there is only the criminal view; there is no protection system.** Until recently there were not so many older people. Perhaps one day, a more specific legal framework will be needed for them. The state, through public prosecutors, can replace people considered as irresponsible. For minors, there is a presumption of irresponsibility. And there is an age limit. For older people, it is like for the driving licence, there is no age limit or presumption of irresponsibility. We have to be careful to avoid to infantilize the older persons. **So, currently it is considered that a legal protection system is not generally required to protect older adults in case of elder abuse.**

In the future new penal code, an interviewee explains that age is taken up as a discriminatory motive. This new code is therefore talking about vulnerable people rather than the elderly. And the vulnerable person is considered as minor for almost all offences. **The definition of vulnerability is related to physical, mental, age, pregnancy, illness... but not social vulnerability.** This will be the responsibility of forensic scientist/expert to establish vulnerability.

The registration of the file could include a vulnerability code but which will not allow to differentiate older people matters.

Examples of elder abuse cases

- Physical abuse in nursing homes
- Psychological abuse and malnutrition by relatives
- Theft, breach of trust and abuse of weakness by household helper, family helper or in public place as in a restaurant.

To an interviewee point of view, the most serious acts take place in institutions and not in the family context. The risk of recidivism is greater when it is not in the family context.

Management of elder abuse cases

Interviewees reflected on the different measures that can be imposed during a criminal procedure.

A **criminal mediation** aims to find a compromise between the victim and the perpetrator, to restore a balanced relationship where persons are respected. Criminal mediation is voluntary and need that the victim requests to put things in perspective. It is not coercive, but there is the threat of going further in the proceedings. Even if magistrates cannot oblige the author to it, there is still a stick because if the complaint goes before the judge, the possibility of imprisonment become a reality, and so it is more concrete. One interviewee explains that, in criminal cases, criminal mediation should be much more developed because what the victims usually ask for is that the abuse stops while they cannot always change institutions or cannot change families but they do not want that the author to go to prison.

If the victim does not want mediation, one can move on to **mediation and measures** which is a new way to envisage criminal mediation and which offers much more means than the classic mediation. It allows measures to be taken in relation to the perpetrator without confronting him/her with the victim. Mediation and penal measures are a way of controlling that the abuse stops. The perpetrator may have to undergo training in managing aggressiveness or stress, frustration. It's professionally managed. It allows the author to enter into a process of introspection, to learn to detect signals when the pressure rises and the risk to explode in violence increases and to learn to defuse. These training modules are imposed on the author by the public prosecutor's office. Everything is in the hands of the prosecutor. There is no trial. However, any intervention by the prosecutor's office is based on evidence.

According to one interviewee, when the author of an elder abuse has no criminal police record, at most he will have a **probationary stay** and therefore an opening towards **mediation and measures**. Probation sentences (conditional sentences), probationary stays (prison sentences which are not executed if the conditions are met) and conditional releases are all possibilities to ensure that abuses stops through the instauration of conditions which can protect the victims, on one part, and which can improve the future behaviour of the author, on the other part. Under these conditions, magistrates can put anything they want into it, including the obligation to participate in a multi-party concertation. A judge may require somebody to have psychological follow-up (1x/week) as the purpose of a trial in the form of a probation condition allowing a remission of sentence.

Under the conditions that are established, the bar should not be set too high. Because people are willing to say yes to anything so they don't go to jail. Above all, it is necessary to evaluate people's resources before setting the conditions. The lack of means and the lack of resources that authors have need to be taken into account. The aim is to valorise resources by studying feasibility and to avoid a new history of failure for the author and the justice system.

Authors cannot be forced to mediate or to accept conditions. He can choose the risk of prison. Some people hide in a rigid attitude of denial. There is the fear of losing your job, of being linked to serious criminals. And it is true that penal law can do damage. An interviewee confirms that, a part of the job of the magistrates is to try to get a confession and when there is a confession, there is no longer any need to see if there is enough evidence. However, a place is kept in the penal system for denials (code with lawyers:” my client says that”). Moreover, when authors says: “I didn't do anything, but I'd like a probation sentence", itis like an admission.

If the author continues to deny, then it is necessary to go to the confrontation i. e. to the **court.** And the range of sentences is shrinking. To summon before the court, it is necessary that prosecutors' office has evidence that the person can be convicted. However, the judge on the merits may still decide not to convict (acquit). The judge relies only on the case's file and on the people being heard. It may appoint an expert to assess the author's psychological state. A judge on the merits can impose that a person will be admitted to a psychiatric hospital if, during the facts and currently, that person is not aware of his or her acts as a result of a mental health problem.

Classification without further action can decided by the prosecutor, due to **opportunity or lack of evidence**. It does not mean that the facts do not occur but suspicion cannot be transformed into a charge, or there may be doubt about the person who committed the acts or about the circumstances. Some pretorian (based on jurisprudence) classification without further action can be conditional, like a kind of very light criminal mediation. The prosecutor could say: "I'll discontinue the proceeding if you follow a training or a therapy. But there is no legal framework and no coercive means for this type of condition. If the prosecutor had to choose a legal framework, he/she would take a mediation and actions. Nothing prevents the prosecutor from saying: "if you prove that you are in therapy, I will discontinue". And the person undergoes voluntarily therapy to have his or her classification without further action. For example, there is a great deal of classification without any further action after that the author gives a compensation for the victim. And this is often good for the victim, for the perpetrator and for the justice system.

After the investigation of the investigation judge or after the information done by the prosecutor, a dismissal can be decided because of a lack of charges. The case is closed and there is no follow-up from either the perpetrator or the victim.

Even at the end of a trial, the judge of merits can finally decide to acquit because there is not enough evidences. Again, the case is closed and there is no follow-up from either the perpetrator or the victim.

Some regional differences are evoked by an interviewee. Flemish population believe much more in the criminal justice than the French-speaking population. The cultures are different.

Other differences in procedure can also emerge from magistrates themselves according to their sensitivity, their availability and their personal investment.

Collaborations, concertation meeting and professional secret

In **Wallonia** there are **no structural collaboration models between police, justice and assistance services**. Concertation meetings exist for the IFV but not for elder abuse although one interviewee says that it should be planned. An interviewee says that he has never participated in a concertation meeting. He thinks that this probably depends on the Flemish region. Some judges have no contact with external people, including the judge of the peace, **although judges of peace are in good position to report financial abuse**. According to one interviewee, there is no information exchange with social worker, specialized organizations or caregivers. Social workers of the OCMW – CPAS and the caregivers are seen as potential whistleblowers by one interviewee and this collaboration is seen as good. An interviewee says that the judiciary is not in relation with specialised associations for elder abuse whereas in the case of IFV, the judiciary often refers to non-profit associations. Judges collaborate with justice assistants of the justice houses who are the ones that have contact with external people. **There is only structural collaboration with the police.** One interviewee says that it is **not the role of a judge in court or an investigating judge to make concertation meetings**. Yet a concertation can take place before the continuation. Magistrates try mediation and if it doesn't work, they go to criminal court. If there are prosecutions, it is the judicial actor who is predominant.

Criminal mediation is the responsibility of the criminal justice, while concertation is more a shared responsibility between participants. There is not one actor who is predominant. Although, the concertation work is not as intimate with the prosecutor as it is between the other actors. That is why some people do not like to collaborate with the police and criminal justice.

An interviewee describes criminal mediation as a measure between the perpetrator and the victim in the form of compensation, acknowledgement

of civil liability, explanation for apologies and the possibility of imposing a work sentence or medical or psychological follow-up, but he/she does not see any reason to go to mediation in a case of abuse because it is a serious and long-term event. Criminal mediation is difficult if the person is insane but could be considered if the older person is able to participate.

According to an interviewee **professional secrecy** has no impact on the conduct of an abuse case. The secrecy of the investigation is general to all files. This secrecy is absolute to keep the presumption of innocence. At certain times, the civil party has access to the file and third parties do not need to have access to it. External people have no secrets to share with the police and the judiciary, except information given to the judiciary being used in court.

One of the current goals of the College of Prosecutors General is to apply the 458ter to cases of domestic violence. The same attitude is also being considered for child abuse but not concerning elder abuse. There is a preliminary draft decree in the French community on the 458ter via the justice houses. No decree is planned in Flanders because Flemish prosecutors are much more inclined to use the 458ter than in the French community. An interviewee explains that he never used the article 458ter. With regard to the medical confidentiality of doctors, he/she asks to seize the medical files and so the forensic medical expert can consult it. One interviewee has never faced a problem of professional secrecy, neither medical nor with the PCSA. When necessary, the investigating judge can lift professional secrecy.

According to the interviewees, the principle of the **Family Justice Centre** is based on the fact that professional secrecy is counterproductive, even in the event of prosecution of an offence. One interviewee does not know the Family Justice Centre and another one talks about an interactionist approach and says that multiparty concertations exist in the Youth Protection Act.

One interviewee says that the article 458ter (i.e. an article in the penal code that allows concertation under certain conditions between different parties such as assistance services, police and justice) may be applied when a psychologist or a psychiatrist is appointed to assess the author. It is the investigating judge who decides what the expert has access to and then the expert reads the various files concerning the author.

Another interviewee is not a supporter of the 458ter because in case of abuse, it is always simple for the persons who takes care of another vulnerable one to refer to the "no assistance to a person in danger" article. The doctor can always be protected. Moreover, according to the deontological code this is a duty, for medical doctors, to act for the good of victims/patients. It is much more complicated for the one who follows the author. In this case, the secret cannot be broken unless in extreme cases with a risk of death. So, there is no need for the 458ter for people in the side of the victims.

To the opinion of this interviewee, the article 458ter was created to reassure social workers and carers that the prosecutor is informed of the problem. **The creation of this article was not a request from the prosecutors but from the participants.** The fact that the prosecutor is there prevents the participants from being blamed for acting behind the scenes when they had to file a complaint before things went wrong.

What must be very clear is that the 458ter concertations are a judicial tool. This is not an extra-judicial concertation. Indeed, when participants to the concertation commit themselves to it, they must be aware that the prosecutor can use what he or she hears for the prosecution of the offence. There is no guarantee of secrecy for the concerned offence. The prosecutor may prosecute and use anything said about the offence. **The misunderstanding inside the article 458ter is that it says it is a shared secret except for the offence in question, which is at the heart of the discussion**. When you want a non-criminal procedure, concertation 458ter is a little dangerous because the prosecutor can say at some point, I go to criminal court. A non-judicial concertation is without the prosecutor. Non-judicial concertations are what non-profit organisations do.

Art 458ter is full of unspoken words that refer to Flemish practices and that French-speaking people do not understand. The article was voted for because the practice had long been practised in Flanders. **French-speaking people are more reluctant to the principle of the 458ter concertation due to the opposition of French-speaking people who**

hold professional secrecy to help the criminal justice system. French-speaking people always wonders: "What will happen if the prosecutor suddenly decides to prosecute?" Indeed, there is, in the French-speaking part of the country, a little bit more mistrust of the criminal justice system but it is true that the prosecutor has this right and nothing can stop him/her. The prosecutor can decide against everyone's advice to act "in criminal matters". Some actors question this power granted to the prosecutor. One difference between Flanders and Wallonia is that Flemish people are more pragmatic. The same interviewee has the impression that provision 458ter Penal Code comes from the non-judicial concertation participants who wanted to be protected from any criticism for not having warned the courts. In Wallonia, everyone takes responsibility without being covered by the presence of the prosecutor.

A **positive vision of the article 458ter Penal Code** concertation meetings would be that participants need the prosecutor at certain times, for example, to **ban an abuser out of the house** of the abused older person. In that case, the justice is the only one which can impose it. Another positive vision of the concertation, according to the interviewee point of view, is that **participants in the 458ter concertations should be mobilized by the prosecutor when he/she decides not to prosecute a complaint**. As the prosecutor has the opportunity to prosecute, he may want not to penalize the case and to refer to a concertation. In this case, the prosecutor sends the hot potato back to the non-judicial sector. **If it is at the initiative of the prosecutor, he or she provides a guarantee that the secret will be shared because it is at his/her own request. And in this case, art 458ter works perfectly.** The prosecutor becomes an actor among others. Together, participants can find a non-criminal solution.

One interviewee says that it is better for the prosecutor rather than the police to be present at the concertation 458ter with regard to the PCSA's fear of disclosing secrets. Indeed, the police missions frame is much more squared/strict while the prosecutor has the power to dismiss and to commit himself. In addition, prosecutors have enough work to avoid prosecuting unrelated potential offences.

According to an interviewee, article 458ter is useless, although it formalizes what is happening in practice, because in reality many contacts are made outside the article 458ter. **Thanks to the legal framework of non-assistance to persons in danger, Article 458ter is not required to talk to the prosecutor about a professional secret**. For the PCSA, professional secrecy is currently not simple to manage because of the pressure exerted by the justice system about foreigners' office, terrorism, etc. This pressure is enormous.

The professional secrecy of justice assistants also exists in relation to justice, in relation to the social work with the client. Otherwise, there is no secret about the control work of the justice assistant. So no professional secrecy for the control aspect but there is one for the social aspect.

Barriers

- **related to the characteristics of the abused individual or the author**
  - Older people feel guilty about being dependent and therefore accept more easily to be abused.
- **related to policy**
  - Lack of respect and value granted to older people
  - The legal action window on the author is not very wide
  - The public opinion about criminal cases is based on fear.
- **related to other professions or institutions**
  - Caregivers are afraid of having misunderstood and of declaring something that is not true, that defames. People want certainty, they wait a certain amount of time before denouncing a problematic situation. They are just afraid to harm or of retaliation.
  - Lawyers are not sufficiently involved in mediation processes whereas they are for the sentences of probation, release on bail, etc
  - Major cultural problem among judges and lawyers in relation to the procedure for the recognition of guilt.



- Police is too intrusive so older people are not willing to go to the police.
- Linear economies where the entire budget is reduced by 20% everywhere.

- **related to the profession**
  - The lack of staff among sitting judiciary requiring that retired judge regularly come in support to sit.
  - The time factor: magistrates need at least two hours with the victim.
  - The valorisation of magistrates who only work 8 hours a day and who do not hear the victims. It is the same in the social field, in education...
  - When you have too much work, you end up doing your job badly even if you are good.
  - The worst is the "don't care" magistrates.
  - The work load of magistrate is not countable because the time that a victim needs is not countable.
  - Professionals who follow specific training are those who are already sensitized and aware.

Facilitators

- **related to policy**
  - To create intergenerational neighbourhoods
  - To set regular social contact to all older persons
  - To help each other
  - Population is well aware about judicial procedure
  - COL, extraordinary tools, allows you to address everyone
  - To be inspired by what is done in the IFV because the concepts are similar: intimacy of the circle, little transparency, closed environment...
- **related to the profession**
  - The judiciary is already aware of elder abuse. Indeed, in the criminal code, older people are considered as vulnerable persons (according to their age) and therefore the penalties will be heavier, as vulnerability is an aggravating condition
- **related to other professions or institutions**
  - Judges of the Peace are in close contact with older people. They are well placed and they have the authority to detect and manage elder abuses. Close contact of judge of the peace with older vulnerable people. Judge of the peace are in a good position to notice abuse, they have permission to enter people's private lives and they have authority. They are at the heart of the person's problems and projects (institution, family concertation, etc.).
  - The guilt recognition
  - Policeman with humanity
  - The specialized organisation: IFV campaigns first refer to non-profit organisations because they are very good mediators and they are not scary. The justice system works with them in IFV and recognizes that they are complementary.
  - It is already clear that justice is moving towards something else than prison.
  - To talk about a management problems instead of an abuse.
  - NPOs work with justice because they realize that it is an interesting tool. There is a complementarity between non-profit organisations and justice.

- **Promote criminal responses other than prison**. Make room for probation, mediation and confessions. The general public will be more receptive to mediations and measures in the context of elder abuse than in relation to sexual assaults, for example. We all know that one day or another, you may lose your ability to deal with a family member, especially if he's insane.
- All abuse facts should be **systematically written in a police record** even if it is not a criminal offence. For example, a suspicious act is registered under the code 45 (see for the codes https://www.om-mp.be/stat/corr/jstat2007/n/conversiepreventiecode.html) and is not a criminal offence
- To **highlight the qualities of the older people**. To enhance the value of seniors in the family circle and in society. Seniors will then feel more useful and less like a burden. In other cultures, ancestors are better respected. The value of elders in the eyes of society must be re-instilled to stem the abuse.
- To **train professionals** about elder abuse through case report.
- Training and therapy under constraint can help
- **Practical measures** as simple as putting a lock on a door should be in the criminal arsenal.
- **Listen to what the victim wants.** Give weight to the victims' expectations of the perpetrator.
- To see the administration of property as a way to ensure the well-being of the person. Once judge of the peace and professional administrator enter people's private lives, they are there to provide solutions. **Justice of the peace should systematically call on specialized associations or third parties in case of elder abuse**.
- The development of aid associations and a better knowledge by magistrates and lawyers of these associations.
- To create better defined intervention protocol for management of each type of problem in the justice system including the steps of police, mediation and measures, the conduct of social surveys ex officio...
- **To begin by providing relays by specialized associations** that develop a good expertise before planning permanent broad concertations. Concertations could be considered before entering into the criminal procedure. In the Netherlands, when there is a problem that falls squarely within the scope of criminal law, it first considers a path other than criminal law through concertation with a whole series of actors, including the PCSA. This vision is not so much about professional secrecy but rather about a desire to turn to alternatives to criminal law. And then, if it is decided to go to criminal court, alternatives to imprisonment can be considered with coercive conditions.
- Improving financial resources for sensitization campaigns
- Improving financial and human resources to justice houses
- Information on the **protocol of legal care** to combat the fear and disillusionment that people have a priori about the legal world.

Perception of prosecutors

A referent magistrate intrafamily violence and a substitute Prosecutor-general/reference magistrate ‘offences against persons’ in the court of appeal in Flanders were interviewed. The latter has also a broad experience as magistrate at the level of the Court of first instance.

Definition of elder abuse

The definition of an elder abuse was known by one of the interviewees. Another one lists the physical, psychological and financial type of elder abuse.

One interviewee expresses the difficulty to describe a typical situation of elder abuse because **“elder abuse” is not a legal term for an offence**.

But, according to interviewees, there has never been a lack of charges because of this absence of legal term. **For all types of elder abuse (physical, psychological, financial, sexual and neglect), a criminal offence can be identified**: assault, harassment, inhuman treatment, fraud, breach of trust, abuse of weakness, failure to assist a person in danger, theft, manslaughter due to lack of foresight or negligence. So in case of abuse, if the prosecutor wants to prosecute, he/she can always cling to an existing criminal offence.

An interviewee reports that a specific code exist for the recording of elder matter. This second code can be added to the first code used to identify the criminal offence. But there are problems with the use of a second code in databases.

Definition of older person

An older person is described by one respondent as a person older than 65 years with a certain vulnerability. Another one explains that an older person is better defined by his/her vulnerability than his/her age. Age is just an indication of vulnerability.

In front of the law, the **vulnerability criterion gives priority to the complaint file**. The vulnerability indication is evaluated based on the file but is not recorded. If the assault is done on an ascendant, it is also an aggravating circumstances. The severity of the impairment in everyday life functions secondary to the abuse is also of major importance in the criminal code. More than 4 months of "disability" versus less than 4 months of "disability" is a criterion which influence the penalty.

Types of abuse

According to the interviewees, there is a significant rise in the cases of elder abuse, in particular for the situations where the offender is a drug addict. Within this category a type of abuse that is upcoming is the abuse of elderly by their **addicted children that often live with the older person**.

Although the interviewed prosecutors are familiar with all types of abuse, **neglect** coming from derailed informal care is the most reported one. A particular type of neglect is when an older person lives with the family of his/her child. Most of the time, this type of informal caregiving starts with a lot of goodwill but over time, care for the elderly is often underestimated and then the risk for neglect arises.

Interviewees also point at an increasing risk for **financial abuse**. As the rules relates to heritage are rendered less restrictive and legal inheritants can be easily excluded, it is possible that more cases of financial abuse will arise. Moreover, payments are to an increasing extent digitalised, which makes elderly with poor knowledge of technology even dependent of third parties.

Point of entry

The point of entry depends on the type of abuse. In the case of neglect, the first persons noticing that things go wrong are the **employees of family help**, but they do not directly report to the prosecutor. Direct reporting to the prosecutor in Antwerp most often comes from the **OCMW/CPAS and the proximity agent**. According to the interviewees some assistance services are very reluctant to report to justice because they fear a breach of professional secrecy. This is probably due to a misconception of the notion professional secrecy or due to the very restrictive internal policy. **The interviewee also has the perception that the fear to breach professional secrecy is used as a shield, because care providers working in assistance services did not trust the collaboration model (chain approach and FJC).** If the abuse took place in a **rest/nursing home or a hospital** it is often a family member that reports the case to the police or justice.

General practitioners regularly report cases as well. According to the interviewee, this is because the professionals trust the approach of the FJC.

Management of elder abuse cases

The management of elder abuse cases **depends on the type of abuse and is often a case by case decision**. For the case of abuse **by addicted children,** the respective interviewee sees the option of 'banning from the residence" as good option but the problem is that once the actor is banned from the residence, there is no systematic follow-up by assistance services (in contrast to the Netherlands). Once the period of banning is expired, the actor often did not benefit any assistance/treatment for his/her abusive behaviour. Moreover, it is difficult to follow-up whether the ban from the residence is respected by the author. A positive thing is that the legislation now foresees the possibility of 1 year punishment in case the actor did not respect the banning from domicile. The practice in Antwerp is that in case of a non-respect of the ban from residence, systematically a mandate of detention is asked for.

In case of **informal caregiver burn-out** leading to the abuse, the judge takes into account the family situation but judges objectively and with his/her own sensitivity. In case of dementia with unmanageable behaviours, the judge of the peace can apply the law of mentally ill people. The complaint withdrawal by the victim has no effect on the legal procedure.

Interviewees state that the **management of intrafamily violence differs** amongst the prosecutors of the respective arrondissements. In Antwerp there is a specific subsection intrafamily violence.

The policy in Antwerp is that **each actor is called to account**. **Mediation, praetorian probation (no punishment as far as the actors fulfils certain conditions) and alternative measures (e.g. a severe written warning, imposing measures, calling the actor to account in the office of the prosecutor) are very often used, unless there is no proof.** In this scope the interviewees from Antwerp both stress that it is important to do something, to avoid that actors have the idea of being unpunished. According to the interviewees the choice for one or another measure sometimes depends on the **capacity of the respective services**. The interviewee gives the example of a period where many actors of violence were directed to mediation, till the mediation services got an overload of case. From that moment on, more cases where directed to the judge, till the judges were overloaded. Since it is important in the management of cases to react quickly, a good view on the feasibility (i.e. capacity of the respective services) of imposed measures is necessary.

One interviewee points the attention that the topic of 'intrafamily violence' is maybe less 'interesting' for justice, because compared to traffic cases, these cases cost a lot of effort and money.

The interviewee recogns that the **general population does not know the non-repressive measures that can be applied by justice**. It is not perceived as the task of the prosecutor to sensitize the general population.

Another striking observation, mentioned by the interviewee, is that **often repressive measures are requested for by assistance services because they are out of measures**.

Training

Interviewees states that the topic of intrafamily violence is included in the **basic training** of trainee magistrates and that the "Instituut voor Gerechterlijke Opleiding" **yearly** foresees training related to the topic of intrafamily violence. However, magistrates are free to choose to follow those sessions and not everyone has the same affinity with te subject.

Collaborations, quality of contact and information exchange

Interviewees stress that the management of abuse **stands or falls with the collaboration between police, justice and assistance services.**

The **police** is perceived to be an important actor in the chain since they are responsible to gather all the relevant information before a case is transferred to the prosecutor. Their **risk evaluation** is of an utmost importance. According to the interviewee police officers sometimes get the message from their chief not to spend to much time on cases of intrafamily violence. Moreover, the action modus of justice also depends on the **reaction time of police**. Unless, there is an urgency, police officers have 4 months to prepare the dossier and transfer the police report to the prosecutor. In practice this period is sometimes not respected. If a dossier only reaches the prosecutor a few months after the facts, many other facts or escalation may have taken

place. The interviewee also points at the good practice in Limburg and Antwerp of the **model police reports with a checklist for intra-family violence (see Appendix 65)**. In this model predefined questions and topics need to be filled out (e.g. what is the cause of the violence). This allows uniformisation and completeness of the police report.

Furthermore the interviewees point at the responsibility of the **assistance services** to report a case when they see that assistance does not work and that recurring events of violence take place. According to the interviewees assistance services need to be informed on the limits but also on the possibilities of lifting the professional secrecy. Both interviewees strongly believe in the **personal contact with assistance services and police** to get to know each other and to make clear that justice is not only repressive.

The interviewees from **Flanders** state to have an **excellent contact with police and assistance services**. This is partly due to the practice of **chain approach** and existence of the **Family Justice Center, facilitating the coordination and management of (complex) cases**. The interviewee experiences the existence of the Family Justice Centers and the collaboration between assistance services, police and justice in complex dossiers as a major added value. For the interviewees art. 458ter allows **partners that are not able to get to a solution on their own, to put the necessary information together to get a solution**. The interviewees stress also the added value of being physically in the same place in that sense that it enables efficient collaboration. The existing modalities in art. 458ter are operational and sufficient for the well functioning of the collaboration between the respective parties. Ad hoc consent of the prosecutor general is necessary to allow the collaboration between the respective parties but in the future there will be a protocol (at the time of writing the protocol is not signed yet) defining the modalities of collaboration between the respective parties so that consent for individual cases is no longer needed. Sometimes individual professionals (like general practitioners) are involved in the concertation. In that case the individual professional needs to sign a confidentiality document.

The interviewee explains that the **acceptance by the initial project of chain approach in Antwerp (CO3) was very difficult.** It took years to convince professionals to collaborate. Professionals from the assistance services in particular used the argument that this type of collaboration is a breach of professional secrecy. A change in attitude has come with some positive experiences of the consultants of the social service of the youth court who experienced that a close contact with the prosecutor could be very helpful in acute cases.

The interviewee admits that the collaboration is **often situated in the grey zone** of professional secrecy. Yet, she is convinced that professional secrecy needs to be fitted in a collaboration model. She feels frustrated that many manifest breaches of professional secrecy take place “at the coffee machine” and that a pragmatic approach towards professional secrecy in the scope of collaboration is critised. The interviewee also stresses that too many professionals fear the breach of professional secrecy. Yet, there are much more condemnations for non assistance of someone in danger than for breach of professional secrecy.The interviewee stresses another added value of the close collaboration with police, namely the **continuous optimisation of the process**. For instance, at the time of writing, **a digital model police report (for police in Antwerp) for intrafamily violence is under construction (see appendix 3).** The reference magistrate regularly gives **presentations on the functioning of her team at the police departments**. This personal contact enables a sound collaboration and makes mutual feedback possible, e.g. the reference magistrate and her team correct procedural mistakes in the police reports. **Although there is a general COL related to intrafamily justice including some guidelines, the respective referent magistrate has a lot a discretionary powers to decide on the policy related to intrafamily violence in his/her ressort.** The interviewee developed a guidance document intrafamily violence herself. Consequently it highly depends on the sensitivity of the respective magistrates for the topic, whether the policy is well elaborated or not.

Sensitisation

The referent magistrate for intra family violence stressed the importance of **regularly informing the assistance services herself on the functioning of her department**. A personal contact is a major time investment but it creates a relationship of confidence, which is necessary for reporting sensitive situations. As there is a huge turnover in assistance services, it is also primordial to contact and inform the assistance services regularly. **The abused individuals themselves are the most difficult to reach.** According to interviews, the specificity of the current generation of elderly plays a major role. They are part of a generation that does not come out with his/her problems or easily seeks help for personal problems. It is thus challenging to make clear that getting help is not a blame. Moreover, according to the interviewee, people should be aware of the fact that the **approach of justice is by preference not repressive.**

Barriers

- **related to the characteristics of the abused individual or the author**
  - Older people do not spontaneously report an abusive situation if they do not receive support.
  - Emotional abuse is very difficult to objectify.
- **related to policy**
  - The **lack of sensitization of victims and professionals**. People do not perceive what is abuse and so do not come to denounce.
  - There is a **perception in general public as well as in (healthcare) professionals that police and justice solely act in a repressive way**. The non- (or less) repressive measures are not know. The consequence is that people refrain from reporting to the police/justice because they fear that relatives-abusers will end up in jail.
  - The population have **not enough knowledge about judicial procedure** to report criminal offences.
  - There is a lack of active promotion of handling/reporting abuse toward all types of professionals, but in particular to general practitioners
  - The **absence of prosecutors' training** to the elder abuse problematic while it exists for the intra familial violence matters.
- **related to the profession**
  - The procedure of **"banning from residence**" is a good practice, but assistance should be provided to the actor during the period of banning. Currently this is not systematically done. Belgium should like at the system in the Netherlands.
  - The **lack of prosecutors** which induces that only severe violence or organized criminality is seen as priority and other cases are not prosecuted because of a lack of human and material resources. Some people, testimony of a criminal offence, judge useless to declare the facts at the police office because they are convinced that the prosecutors' office will not proceed. And they are right because of the lack of staff.
- **related to other professions or institutions**
  - There is a **lack of available places in nursing homes**. Consequently, families hesitated to complain about abuse
  - There is a lack in assistance services (help for addicts, psychiatric help) in general (long waiting lists)
  - There is a lack of training in intra family violence for police officers

Facilitators

- Older people will better report an abuse if they are sensitized and that they have a low threshold of abuse tolerance.
- For all types of abuse, a criminal offence can be identified.
- To have a global vision of the older person surroundings which facilitates the collection of hearings.

- To have a good **collaboration** with the regional inspection service of the nursing home
- To have a privileged contact with the police
- **To have a personal contact between the magistrates and police and assistance services to enable good collaboration.**
- To give the opportunity to the older person to confide in a **reference person** whose specific function is this, a trusted person under cover of anonymity, with a guarantee that there will be no repercussions or repression on the part of the nursing home, for example.

Solutions

- In the police zone of Antwerp a digital **checklist intrafamily violence** is included in the police report. This is a good practice that could be practised in other police zones.
- Every **death should be confirmed by an independent physician** with a good knowledge of injuries.
- The establishment of a **COL on elder abuse** which will sensitize the police and justice sector.
- **Emergency centres** should be created for older adults in danger
- **Sensitization of the older people and their relatives must be huge and by all possible means**. It must draw attention on clues or abnormal elements which could indicate a potential elder abuse. On top of sensitization campaigns focussing on the promotion of the existence of specialised services such as Ecoute Senior, 1712 etc. atttention should be given to the promotion of the non-repressive role of justice.

- Sensitization of police and magistrates will improve the proceeding of psychological abuse.
  - **Sensitisation and information on the approach/possible measures of justice should be provided to assistance services.** Preferably this should be done by the reference magistrate for intrafamily violence him/herself on a regular basis.
  - There should be **active promotion on how to recognise and handle/manage elder abuse** in the general population. However, this is not perceived to be the task of prosecutors.
  - According to interviewees in Flanders, **Family justice centers should be set up everywhere in Belgium.** On the Walloon side interviewees do not express the need for family justice Centers and/or structural collaboration between police, justice and assistance services.
  - To **create a trustful context** to help the older person to confide
  - **Increase the capacity of residential settings and assistance services**
  - Invest in **proximity officers/ police officers** for seniors
  - A multidisciplinary management of the elder abuse cases
  - To **increase the staff of prosecutors' offices in Belgium**
  - To invest in **specific training** about elder abuse in the '**justice training institute'** , open for all students, trainees or magistrates interested in this matter.

3.3 Chain approach and Family Justice Centers

The description of chain approach and Family Justice Centers can be found in Chapter 2. Given the specificity of the Family Justice Centers, the interviewee was in particular questioned on the mode of operation of the FJCs and the policy view of the management of elder abuse.

Types of abuse

According to the interviewee an upcoming type of abuse is the abuse by an **addicted child** (approx. 6% of the cases treated in the respective FJC). **Approximately 3% of the treated files at FJC concern elder abuse, in particular overburdened informal caregivers**. The interviewee states that

even more than for partner violence there is a huge dark number of cases of elder abuse. According to the interviewee, first a dramatic accident needs to take place before action is taken on a political level. The problem is also that more attention is given to elder abuse, the number of dossiers will increase extensively. So, in absolute numbers the number of elder abuse cases would significantly rise to diminish only 10 or 15 years later.

Rather reactive than preventive approach

Elder abuse is integrated in an overall approach of intrafamily violence. For instance, people can call 1712 which is a general number for intrafamily violence. According to the interviewee it is positive to bundle forces and to integrate all types of abuse but the problem is that there is **too little follow-up** for elder abuse. 1712 will only transfer people to other services. It is up to the people if they will contact the services they were referred to or not. The policy in Flanders is thus rather reactive then preventive. Often, escalation is needed before any action is undertaken, while a lot can be done in the preventive phase.

Too little capacity in the assistance services, too little support of the FJCs

The interviewee feels very frustrated about the fact that many activities and collaboration has been set up on a voluntary basis and that little support comes from the Flemish government. The chain collaboration and the Family Justice Centers are in fact initiatives based on goodwill of the participating partners. The operational costs are paid out of the means of each partner. Yet, the well-functioning of these initiatives can only be guaranteed if enough is invested in assistance services. Currently, there is lack of available services from the assistance services. Both in the Family Justice Centers and in the assistance services lack of manpower is a huge limitation.

Support professionals

According to the interviewee, professionals need to know where to go/what to do when they have a feeling that a situation goes wrong. They **need a contact point where they can report a case and be sure that it will be followed-up.** The FJC could take up this role but currently there is too little manpower. Currently, the FJC is not yet directly accessible to clients nor professionals. This is the target that is being worked towards.

A step plan (like the one of SEL Waasland) is a very good example and should be enrolled to Flanders. Also hospitals have a huge demand of training their professionals and anamnesis of a case on the spot, but the FJC has not enough manpower to respond to the demand.

Interesting measures in the management of elder abuse

The interviewee mentions the measure of **banning from residence** as an often used (100/year in the province of Limburg) and very interesting measure in cases of (elder) abuse by an actor living with the victim. Even if no offence has taken place, police can call the prosecutor, who can place the actor out of the domicile for 10 days (extendable by the judge of the peace). This offers a window of opportunities if assistance/therapy is available for the actor. However, this is currently not the case (mainly because of waiting lists). The FJC Limburg now adopts a methodology developed in the Netherlands (Intensive case management) where directly after the ban from domicile a case managers offers help to the actors and the victim(s) and the family is followed-up for at least one year. Directly after the measure of banning the actor, the case manager serves as an intermediary between the actor and the victim. In the Netherlands, the system has been evaluated. Whereas for intrafamily violence, there is 65% of recidivism, this numbers decreases to 15% with the system of intensive case management.

Collaboration

According to the interviewee it is a major added value to have a good relation with the prosecutor. The link between the FJC and the prosecutor makes that it is much easier to react fast and effective. Moreover, a prosecutor can use the FJC as a condition; e.g. 'if you do not collaborate with the FJC, more strict measures are going to be imposed'.

Resistance to FJC in Wallonia

According to the representative of the FJC Limburg, Wallonia is interested in and even enthusiastic about philosophy of the chain approach. The implementation seems to be more difficult, though. The assistance landscape is very scattered (CAW integrating several services). The interviewee's perception is that there is resistance to collaborate because they fear for savings by the government. In the government's perception collaboration implies more efficiency and thus less financing. This is one side of the story, since a better management will lead to more cases, for which more investments are needed. In a landscape where many VZWs, NGOs are offering assistance and receive public money, there is more resistance to collaboration because the public means will then be centralized and maybe the existing services will be merged. The interviewee also states that the issue of professional secrecy is an important barrier on the Walloon side.

Barriers

- **related to policy**
    - The policy of the Flemish government is **very reactif instead of proactive**. If cases are reported, they are handled (e.g. by CAW), but there is no proactive intervention.
- **related to the functioning of the FJC**
    - Too **limited human ressources in the FJC**. In FJC Limburg for instance 14 FTE are responsbile for 500 dossiers per year.
    - Since the entry point of the FCJ (Limburg) is a police report (and thus not directly accessible for professionals or individuals), many cases of elder abuse are probably not adressed by the FJC. There is a **wish from the FJCs to enlarge their role**, but manpower is lacking.
    - There is **no financing from the Flemish governement to support the FJC** (except for the coordinators). Money is not the core problem, priorities is. One first needs a media buzz to get something on the political agenda. The Flemish government likes to stress that the entire Flemish territory is covered by the chain approach, but as long as there is no financing this goes not far enough (and can not evolve towards a FJC)
    - There is a huge demand from the hospitals to the FJCs to train healthcare professionals to detect and to do anamnesis in the hospital, but **manpower is lacking in the FJC.**
- related to other institutions or partners involved in the trajectory of management of elder abuse
    - Many professionals, going from caregivers to general practitioners, **need a telephone number to which they can assign people and where action is taken.** However, the target population of the 1712 callers are not the professionals. Family justice centers could play this role but they currently do not have the capacity to do so.
    - There is **too little capacity in the assistance services** to respond to all the current dossiers. Improving detection and reporting of elder abuse, implies that more cases will have to be treated and more capacity will be needed.
    - Professionals have **no framework to manage elder abuse**. They do not know what to do and they have no guarantee that a case is taken up.
    - 1712 is only referral to services, but there is **no control and follow-up**. People are free to go to the services reffered to.

- Solutions
  - Make a **stepplan** for all professionals. This allows professionals to be more involved and aware of what they can do. A meldcode needs to indicate what the professionals can do in case of a problematic situation, what they can do on their own or within their team, when the need to refer to other services, etc…
  - Make FJC a **mandated service** (comparable to the mandated services for problematic situations for youngsters) to which professionals can refer a case to and mandate the FJC to explore the situation before police and justice are involved.There is a need for an **actor between the professionals and the police (like FJC)**, who is charged with taking over the 'there is something wrong' feeling and takes actions with the relevant assistance services.
  - Give **structural financing to the FJCs** and embed them in legislation.
  - **Increase the offer in the assistance services.**
  - Anamnesis (=evaluation of suspicion of EA) in the hospital by the FJC.

    The prosecutors are willing to give anonymous consults for professionals to discuss whether a case is serious enough to go for the judicial trajectory. This option should be more higlighted.

4 CONCLUSION

In this chapter we interviewed professionals from police and justice and a family justice center. Some of them have no particular affinity with the issue of elder abuse or interfamily violence in general while others are specialised in these matters. The aim of the interviews was to have these group of professionals' point of view on barriers, facilitators and solutions in the management of elder abuse. Moreover the interviews also allowed to have a better view on the working processes in these sectors.

Submitting a complaint to the police is often a 'final' step in a series of episodes of domestic disputes or problems. Reporting to police is done via different ways and by different persons. Most often it are persons that have witnessed or suspect abuse, such as neighbours, peacekeepers, social workers, social service hospital, health care professionals, family, friends, nursing home directors, proximity police office during his patrol or in the street. Sometimes police can also be informed by the public prosecutor following a complaint by a healthcare professional, an association in charge of elder abuse care or of inspection of nursing homes, etc.). Victims and authors rarely report.

The usual global p**rocedure** depends on the **severity of the facts**. In the case of an **offence**, the procedure is not different for older persons than for the same type of offences in other persons (assault and battery, robbery, sexual assault, harassment). The **police** is an important actor in the chain of management of elder abuse cases since they in first line responsible to judge whether a complaint is severe enough to make a police report. Their **risk evaluation** is thus of an utmost importance. Moreover police are responsible to gather all the relevant information before a case is transferred to the prosecutor. Hence, the action modus of justice also depends on the **reaction time and the accuracy of police**.

However, not all situations the police is called for related to an offence. Often police is called for recurrent disputes. If **no offence** was identify (yet), a **report 'social problem'** can be drafted by police officers. In contrast with a police report, it is not obligatory to draft these kind of reports. Ideally, the

social assistants of victim support service of the police get these documents and take action accordingly, but this is not systematically done.

Overall, there is **no systematic and uniform approach on situations of elder abuse amongst police zones**. Chief Intendents have a lot liberty to decide on priorities in the policy of their respective zone. That is why in some zones, there is particular attention to senior matters such as for instance police officers exclusively for senior matters and in other zones there is little affinity with the subject and no particular attention is paid to the group of older persons. In some zones specific aids and tools (such as a digitalised checklist in the police report) and personnel (for instance a referent police officer IFV) is foreseen for intra-family violence cases in general. Although elder abuse is often characterised by other dynamics than violence in a family with children, some of these good practices are (with some minor adaptations) also applicable for elder abuse.

In case of criminal offences, a **criminal procedure** is launched. Often this goes via the police but an offence can also be directly reported to justice. Similar to the police level, the procedure at justice level is not different for older persons than for the same type of offences in other persons (assault and battery, robbery, sexual assault, harassment). An upcoming type of elder abuse is where the older person is mistreated by an addicted child that lives in the same house. There are measures that are regularly applied for cases of elder abuse: criminal mediation (with conditions), probation ban from the domicile of the author,… Yet, the popularity of some of these measures (particularly for mediation) also makes that the demand sometimes overrides the offer. Interviewees state that it is of an utmost importance that victims and the population at large are aware that actors not necessarily go to prison and that rather non repressive measures exist.

Although a circular for intrafamily violence is available (and a COL elder abuse is under construction at the time of writing the report), there **is no uniform approach related to intrafamily violence/elder abuse amongst the judicial arrondissements**. In some arrondissements a referent magistrate for intrafamily violence is assigned and a more elaborated policy is available whereas in other arrondissements there is no referent magistrate and intrafamily violence is not a high priority. Interviewees also stress that the lack of personnel is sometimes the reason why priority goes to the most severe cases. In Flanders, collaboration models (chain approach and family justice centers) between assistance services, police and justice exist. Most often these collaboration starts up for the most complex, multiproblem cases where it is hard for 1 sole party to solve the case and where collaboration between the cited parties allows a more close follow-up and hands-on approach. The necessary information is shared between the cited parties within the legal boundaries of shared professional secrecy specified in art. 458ter. Interviewees in Flanders were all very familiar with the practice and stress the added value of this collaboration although it took time to gain trust in this model. On the Walloon side, interviewees do not see the necessity of such a collaboration. Some see the construction as a shield to protect police or employees of assistance services**:** the fact that the prosecutor is present during the concertation protects the participants from being blamed for acting behind the scenes when they had to file a complaint before things went wrong. Moreover, interviewees point at the fact that when participants must be aware that the prosecutor can use what he or she hears for the prosecution of the offence and take initiative to do so. For them it is the prosecutor who keeps the monopoly on the decision to prosecute or not. It is also obvious that not all interviewees from the Walloon side interpret the concept of the collaboration model in the same way.

Whereas there is no shared vision on structural collaboration between assistance services, police and justice, almost all interviewees of the sectors police and justice stress the importance of having a good personal contact with the local players. Some interviewees have the good practice to present themselves and their services in person to the relevant local players.

Elder abuse can result in criminal offences but a lot of cases are problematic without being criminal (or where a criminal offence cannot be proven). This might the case when for instance informal caregivers (that are sometimes cohabitating spouses) get overburdened, regular disputes make a situation difficult to live in, the elder gets demented and is easily susceptible for financial abuse, etc. Moreover, as many victims are abused by family members, loyalty plays and the victims often do not want the offender to be punished. In all these cases where family relations and related problems are at stake, **the judge of the peace** can intervene to protect people (and their

property). Judges of peace have different techniques or measures at their disposal that can be very effective in situations of elder abuse. They can call the parties concerned for mediation (where possibly conditions for the future such as can be agreed on) or take protective measures such as assigning an administrator for goods and/or a person lacking mental capacity, collocation in a psychiatric ward…).

Overall, interviewees from police and justice agree that more training and sensitisation of the respective employees is needed. Moreover good collaboration and a personal approach towards the local services is primordial. Measures to tackle elder abuse seem to be perceived as sufficient, although the implementation of the measures is sometimes difficult due to lack of capacity of respective services (for instance the mediation services, lack of places in nursing homes) or lack of good follow-up (for instance ban from the residence). In Flanders some interviewees plead for a more interventionist approach, with models such as "Bemoeizorg" or the intervention of mandated services that are able to supervise where more intrusive action of the government/society is needed.

4.1 Key messages

As the perceptions of the interviewees in Flanders and Wallonie differ (due to differences in organisation but also cultural differences), we opted to split the key messages.

Key messages from the interviewees in Flanders

- **Abuse of older people is defined by their vulnerability (due to loss of autonomy), not by their age.**
- **Abuse by addicted adult children is an upcoming type of elder abuse. Furthermore neglect, often caused by an overburdened caregiver, is a frequent type of abuse.**
- **Interviewees point at an increasing risk for financial abuse because of an increased digitalisation of financial transactions and the less strict rules on heritage.**
- **Some interviewees in Flanders plead for a more 'interventionist' approach ("aanklampende aanpak") in the phase of 'voluntary assistance' (when no criminal act has been committed (yet). The policy in Flanders is perceived as reactive, rather then preventive. Several solutions can come forward to this: "Bemoeizorg" (stemming from the Netherlands), direct access of individuals and healthcare professionals to the FJC as an actor between the individual/HCP and police/justice.**
- **The follow-up for elder abuse is rather poor. 1712 will only transfer people to other services. It is up to the people if they will contact the services they were referred to or not.**
- **Professionals need an actor between police and justice to share their concerns related to EA. 1712 does not target professionals and VLOCO is poorly known.**
- **Banning an actor from the residence is a measure with a major added value in the dossiers where an addicted child abuses his/her parents. Yet, this measure should be linked to intensive**



case management with the actor and the victim starting from the moment of the ban from domicile.

- In Flanders, the ideology of a Family Justice Center is much appreciated by police, justice and assistance services, although the process to accept such as collaboration model has taken many effort, in particular in the assistance services. Interviewees point out that professionals from assistance services often fear a breach of professional secrecy because of a lack of knowledge or because there is in internal policy of 'very strict interpretation of the professional secrecy' in the respective service.
- Currently, Family Justice Centers have a limited role in the management of elder abuse. In theory, Family Justice Centers could take up many additional roles: they could serve as a contact point for professionals, train professionals, be involved in prevention of abuse, do anamnesis in hospitals…
- Even if there is no criminal offence, police officers can draft a document 'social problem'. A good practice is that these documents should be systematically screened by the social assistants for the PSAV and that the persons involved are contacted and offered help.
- A good practice in the police department of Antwerp is a digitalised checklist for IFV integrated in the police report.
- Although there is a national COL related to intrafamily justice including some guidelines, the (respective referent) magistrate has a lot a discretionary powers to decide on the policy related to intrafamily violence in his/her ressort. In practice, differences in the implementation exist, between ressorts but also between Flanders and Wallonia
- Elderly rarely report abuse themselves. A good practice is to have a police officer specialised in senior matters, who is present in the 'daily life' setting of the elderly. Once a trust relation is established people more easily confine what goes wrong.
- Interviewees perceive the current offer of residential and ambulatory assistance services as insufficient.
- Prosecutors and judges of peace feel that the arsenal of existing measures at their level to handle cases of EA are sufficient but that management of elder abuse cases is often an exercise in finding case-by-case solutions. According to the interviewees the choice for one or another measure sometimes depends on the capacity 'of that particular moment' of the respective services (e.g services for mediation).
- Interviewees indicate that professionals fear to breach the relation with their patient and that there is no intermediary actor taking care of EA cases between HCPs and police and justice. The FJC could play this role, but currently they are not directly accessible for HCPs because of a lack of manpower and means.
- Interviewees consider the abused persons and their relatives as the most difficult group to sensitize. They highlight the specificity of the current population of elderly: they never learned to come out with their personal problems or to search external help. On top of the promotion and the visibility of specialised services, interviewees also plead for the information of the general public of the (possible) non-repressive approach of justice. It should be clear that reporting to the police/justice does not automatically imply that the offender will go to jail.
- There is no specific 'code' to register Elder abuse. Yet, within the codes for crimes (for instance battery and assault code 43), there is a subdivision for intra-family violence. Yet, it depends on the sensitivity of the respective professional whether it will be 'correctly' labelled or not. Today, it is impossible to have a correct overview of the number of elder abuse cases at the level of police or justice.

- Even if there are guidelines for the management of intrafamily violence (at the level of justice-police COL 2006), differences in policy exist within the ressorts and the police departments.

Key messages from the French speaking interviewees

- Older people are defined by all interviewees (police sector, judges of peace…) by their vulnerability rather than by their age. This is of importance as vulnerability is an aggravating circumstance while ageing is not.
- Elder abuse (EA) is not a legal term of an offence but many different types of offences can be EA. Policemen and magistrates are confident that they can find an offence for all EA situations.
- According to interviewees, Intra Family Violence (IFV) is the main type of maltreatment encountered in the police and justice sectors
- According to interviewees, EA is often perpetrated by a family member or a professional caregiver although a blood-relationship with the victims or the status of professional caregivers are both aggravating circumstances.
- Interviewed policemen and prosecutors have rarely encountered each type of EA in their practices. In contrary, interviewed judge of the peace are often witness of EA and in a good position to report it.
- There is no specific written police procedure for EA cases. The management of EA cases is the same than for the identical type of offence and are managed by general policemen. The number and the order of the steps of an offence procedure vary among interviewees.
- When the complaint is not an offence, the EA case can be transferred to the administrative authority (mayor (bourgmestre) and CPAS.
- Currently, police or magistrate referent in EA matters are very rare. It may exist in PASV a worker specifically dedicated to elder matters
- OP are not considered as irresponsible like it is for children. So EA are only seen under a criminal vision by the justice and not under a protective vision.
- There is a large black number in EA and the way that data are collected in the police and justice sector does not help to know the epidemiology as cases are classified by offence types and not by victim profile.

Practical issue in procedure

- All interviewees agree that the report of an EA at the police or the penal justice is much more often the fact of a caregiver or a relatives than of an older person.
- The opinion of the older person regarding their EA seems not to weight a lot for policemen and prosecutors (article 46 of the police, opportunity of the proceeding by the prosecutor, few importance given to the empowerment of older persons). However, the no confirmation of a complaint by the OP has still consequences on the justice procedure (more proof needed, less chance to go to the trial…)
- Alternative solution to prison as mediation and measure are seen as to offer more opportunity to stop EA as wished by older person (ex : perpetrator must follow agressivity control training, measure of protection of propert and the person, and measure of remoteness). Criminal mediation can lead to financial compensations, acknowledgement of civil liability, explanation for apologies, to a more balanced and respectful relationship

and the possibility to impose a work sentence or a medical/psychological follow-up.

- During the justice process, the steps of discontinuation (classement sans suite), dismissal (non lieu) and acquittal (acquittement) do not allow to stop EA as wished by older person except in case of pretorian discontinuation with warning (classement sans suite avec avertissement). Probation suspension (sursis probatoire), probation sentences (peine de probation) and conditional release (libération conditionnelle) allow possibility to introduce conditions which can protect the victims and/or can improve the behavior of the author.
- Usual probation conditions are usually a ban on contact with the victims and a training in agressivity management. Other conditions can be the obligation to participate to multi-party concertation as well as a psychological follow up but they seem much less used.
- Some interviewees explained that EA is seen differently from one person to another and can be seen as violent gesture with no will to harm or as the consequence of variable and ambiguous feelings in family context. Judge can take into account the family situation in case of EA secondary to familial burn out of the informal caregiver.
- Policeman and PASV better go at home in case of unclear complaint. The fact that some specialized organization go at home is highly appreciated.

Communication, collaboration and concertation

- Several police and justice stakeholders expressed that there is no need of info exchange between the police and justice sectors and the other sectors. Caregivers are seen as potential complainer and GPs as a good resource in case of dementia or Diogen syndrome. However, according to SAPV workers, the support of relatives, caregivers and social workers is very important.
- According to some interviewees, there is a lack of good communication between judge of the peace, police, justice, social, medical and mental health workers. Prosecutors' office and PCSA (CPAS) are seen as the less transparent partners. It happens that no contact exist between police and judge of the peace; or IVF reference prosecutor. Some court judges have no contact and so no collaboration with people outside the justice sector.
- Collaboration inside the justice sector is variable:
  - Judges of peace can contact prosecutors if they are the recipient of a criminal offence complaint or if they need a social investigation legally ordered but those contacts seem rare.
  - Prosecutors contact judge of the peace to establish a protection measure
  - A collaboration between prosecutors or judge, and judge of the peace, can take place in case of dementia
- Judge of the peace can have very good collaboration with medical and social sectors. Judge of the peace are willingly contacted by nursing home manager in case of unclear EA offence. Medical secret is shared through the medical certificate with the judge of the peace
- According to the French-speaking interviewees, in Flanders, interactions between sectors are seen as more frequent and transparent. Collaboration between sectors is easier in Flanders because stakeholders meet to discuss cases and share professional secret. In the French-speaking side, professionals hide behind their professional secret.

- Most of the interviewees expressed that EA can be reported by caregiver without violation of professional secret and the medical secret can be lift easily by instruction judge. In contrary, the instruction secret seems absolute to keep the presumption of innocence.
- Concertation meetings exists for IFV matters but not for EA. They seem to be considered as a judicial tool and not an extra judicial process. Concertation meetings are seen as inducing a shared responsibility between participants while criminal mediation is only the responsibility of the justice sector. A draft of decree about the 458 ter application by house of justice is planned in Wallonia.
- Although this opinion was not shared by all interviewees, some interviewees expressed that concertation meetings should take place before prosecution by the justice sector. In the reality, a lot of unformal concertations seem already occur between stakeholders from different sectors.
- Other types of concertation meetings can be organized by PASV (SAPV), judge of the peace and professional administrators.
- Population and association and coordination
- Opinion of interviewees differ totally concerning the knowledge of the population about the procedure to complain.
- Specialized organisations, family justice centre and concertation meeting are only known by very few interviewees. The specialized organizations on EA are judged as not enough visible and available.
- Houses of justice staff helps victims and perpetrators/litigants/authors. There is no help service for litigants in police office. PASV can orient litigants to the house of justice litigants help service
- Victim support service of prosecutors' office (related to house of justice) gives information and refer to other services. It does not provide psycho-social support to victims while SAPV gives short psycho-social support before orientation to other services.
- Justice assistants of house of justice help to set up and control conditions in case of release or sentence on probation. They study the feasibility of conditions. A justice assistant can manage around 70 cases for the same cost than for one imprisonment
- It exists a district coordination structure involving the chief of local and federal police, IFV referent magistrates and victims help services (PASV (SAPV) and house of justice)
- The College of Prosecutors General is currently writing a circular about EA matter including the designation of a referent in elder matter at the police and the justice level and magistrate training. The COL should also stipulate that EA cases cannot be neglected.

Barriers and Facilitators

- Complaint for psychological abuse often does not lead to the objectivization of a criminal offence (said by policemen and prosecutors)
- Lack of legal frame to make structural collaboration between police and municipal mediation services.
- Barriers to concertation meetings are dementia and lack of willingness of the participants.
- EA is a widespread violence but very difficult to detect
- According to the article about « non-assistance to people in danger », there is no problem with the professional secret to talk about an EA. The problem is when the caregiver takes care of the author but not of the victim

- **Judge of the peace are often in contact with very dependent old persons, at high risk of abuse. They have the obligation to visit OP under protection at least one time per two years. In addition, judge of the peace can also pay attention to the well-being of the administrator.**
- **A judge can ask during a trial to assess the psychological state of the author**
- **According to the interviewee profile, the list of potential offences which could be related to an elder abuse situation vary.**

CHAPTER 8: STAKEHOLDERS AND EXPERTS CONSULTATION ON SPECIFIC ISSUES

1 INTRODUCTION

From the results identified in each previous chapters (Chapter 1 to 7) have emerged several clear conclusions but also some controversial or unclear issues. Internal meetings with all KCE experts involved in the study allow to identify the problematic points still unsolved at this advanced stage of the study. It was then decided to gather, on this problematic points, the opinion of Belgian specialised stakeholders (SH) and experts involved in elder abuse management, with a particular expertise on the discussed issues and originated from different sectors. This chapter presents their opinion collected through a two-steps consultation. The first step consisted in discussion groups around controversial statements and the second step in a Lime Survey about the acceptability and the feasibility of solutions.

2 METHOD

2.1 Experts and specialised stakeholders consultation in discussion groups

To find solutions to the problematic points and the advantages and disadvantages of them, experts and specialised SH in elder abuse issues were consulted during open discussion in four small groups (from 7 to 13 persons). For a good distribution of the participants among the groups, each participant filled in, before the meeting, a small form about his/her three favourite subjects (problematic point) they would like to discuss about and the sector they are originated from. Each discussion group was framed by two KCE members. A support was given by the KCE cell in qualitative research. Notes and recordings were taken during the discussion with the agreement of the participants.

A statement about a problematic point was discussed during around 15 minutes. Two sessions of around 1.5 hour were held. During the first session, the same set of statements was discussed in every groups while, during the second session, two different sets of statements were discussed according to the interest and expertise of each group.

The statements were elaborated in the aim to induce reaction from the participants and did not necessarily reflect the KCE opinion. Additional questions were available to reopen the discussion if necessary. Documents and short oral presentations were given before the start of the discussion groups to facilitate the discussion.

2.2 Acceptability on and feasibility of solutions according to experts and specialised stakeholders

An online survey (Lime Survey) was built with the suggested solutions identified and discussed during the discussion groups. The respondents had to express their opinion, first on the acceptability of the suggested solutions by practitioners of the sector they belong to, and second on the feasibility to implement those suggested solutions in their sector. They had the

opportunity to give additional explanations or to give a 'white' answer. This survey was sent to the participants of the discussion groups and to some additional ones which do not attend the discussion groups but were invited to or lately referred. The language used in the survey (NL and FR) was reviewed by the communication cell of the KCE to avoid misunderstanding in the formulation of the propositions. The conditional language was used in the FR version while a more direct language was used in the NL version to be appropriate to each usual language style. The analysis of the results was done separately for the quantitative and the qualitative results and was merged in a second time.

3 PROBLEMATIC POINTS FROM PREVIOUS CHAPTERS

KCE internal discussions about the key messages from all previous chapters lead to a list of problematic points, either controversial or simply unclear or needing more input. Those mainly concern grey zone around barriers and emerging potential solutions that the KCE team wanted to confront with the opinion of experts and specialised SH.

Unclearness around barriers: more input required

- Professional secrecy (articles 458 et seq. of the Criminal Code) and exceptions to this secrecy
- Respect for the (decision-making) autonomy of abused older people
- Dementia, mental health problems and informed consent in abused older adults
- Lack and possibility of emergency accommodation to host abused older people
- Media campaign funding
- Consequences of a broader detection of elder abuse – shortage of specialised assistance services
- Controversy about the detection tool: should it be both short and/or holistic?

Emerging potential solutions: opinion required

- **Entry door**(s) the most likely to receive reports of abuse (police, justice, single national call number, specialised organisations, general practitioners, CPAS, CAW, etc.)
- Administrative **centralisation of data** on abuse cases
- **Complying with a "meldcode"** including the obligation to follow a procedure in case of suspected abuse

- Establishment of political and operational **agreement protocols** between the involved sectors
- Identification of risk factors and cases of abuse through **medical and social records**, shared or not, in light of the legal consequences
- Reporting of abuse cases in the light of alternative (**less repressive) resolution methods** (mediation, transaction...)
- **Mandatory** elder abuse **sensitization and training** of professionals outside the sector of health and assistance to older people.
- Designation of an **"older people issues" referent** amongst professionals outside the sector of health and assistance to older people.
- **Monitoring of health and assistance services** regarding the respect for the life projects of dependent older people and the quality of provided care.
- Implementation of **well-treatment charter**.
- Usefulness of **co-existence**, in the three regions, of organisation specialised in the care of abused older people AND multi-sectoral consultation structures such as the FJC.

4 EXPERTS AND SPECIALISED STAKEHOLDERS CONSULTATION IN DISCUSSION GROUPS

4.1 Groups description

The specialised stakeholders and experts were distributed in 4 groups. Groups were determined by the language (Dutch or French), a multisector aspect (mix of justice, police, social assistance, health and patients sectors) and the interest of each participant, known thanks to the form the participants filled in before the meeting (see Methods - section 2)

Group 1

Discussion group 1 was composed of 8 Dutch-speaking participants which were either experts in legal issues (in particular professional secrecy) or representatives of the sector of Justice (FPS Justice, FJC, Houses of Justice), of specialised organisations (VLOCO, FJC), of assistance services (CAW), of the patient sector (Vlaamse Ouderenraad) and of the sector of general practice.

Group 2

Discussion group 2 was composed of 13 French-speaking participants. Three were from the health sector (GP, nurse, psychologist), three from specialized organisations (Age platform, Infor-home, Respect Senior), two from the justice sectors (lawyer, magistrate), two from the patients sector (LUSS), one from the police sector (proximity superintendent), one from the academic sector (clinical research in geriatrics) and one from the nursing home sector (manager). The settings of hospital, at home and nursing home were therefore represented. The discussions were structured and rich of diverse opinions. Only one statement about political protocol did not find any echo amongst participants. Indeed, none political representative was present.

Group 3

Discussion group 3 was composed of 11 French-speaking participants: four clinicians (old age psychiatrist, geriatrician) or researchers (in mental health); two representatives of home care organisation; 3 representatives of specialised organisations (Ecoute Senior, Respect Senior, Age Platform); one representative of the patients; and one representative of the civil justice. The professionals in this group were all field professionals in regular contact with the elderly. It was a very dynamic and contributing group whose field experience has provided additional insights compared to the literature and previous collected data.

Group 4

Discussion group 4 was composed of 7 Dutch-speaking participants: researchers involved in the development of the RITI scale and in ethical considerations and representatives of home care organisation, GP, family justice centre and dementia organisation.

4.2 Statements

The statements submitted to the discussion to gather the opinion of the participants in the groups are presented in the Appendix 66. The first set of statements (statements 1 to 5) are more generic and were discussed in all groups (1 to 4). The second set of statements (statements 6 to 11) were discussed in group 1 and 2, and concern more legal issues as well as quality of care. The third set of statements (statements 12 to 17) were discussed in group 3 and 4, and concern more the detection and the interventions in the assistance and care sector.

4.3 Conclusion about the opinion of experts and specialised stakeholders

For the reader interested in the content of the discussion within each group, a summary is given in Appendix 1.

- Generic statements (statements 1 to 5)

Concerning **the existence and the setting of a step-by-step protocol** in case of suspicion of elder abuse (statement 1), all the groups agree that following predefined steps is important but one group enunciates concerns and shortcomings about a step-by-step plan: (i) its use should be limited to unambiguous elder abuse situations; (ii) networking and collaborations are more important than the use of a step-by-step plan; and (iii) a case by case assessment should be favoured over a standardised procedure. However, the three other groups state that the availability of a step-by-step plan is important and expressed several conditions for an optimal use. First, the step-by-step plan must be included in a global policy notably on prevention. Second, the step-by-step plan should not imply the creation of new structures. Third, the step-by-step plan should respect the adult status of older people. Fourth, the professional using the step-by-step plan should be assured that a quality management by specialised organisations is available downstream. And fifth, the step-by-step plan should include concrete steps for the detection and the early management of elder abuse.

Several steps were suggested by the participants including a step where the consent of the senior is asked, a step where the danger is analysed, a step of discussion with a referent person, a step where the frailty status of the senior is assessed, a step where professionals are allowed to talk despite the professional secret and a step where it is possible to contact a FJC.

The development of the step-by-step plan should involve all types of concerned stakeholders from different disciplines and different sectors. It was suggested in one group that a generic framework was done by the authorities, then an more adapted version was elaborated by zonal structure (like the eerste lijnszone) and finally a detailed adaptation to practice was done by each structure or solo-professional.

Practically, the participants insist on the creation and financing of inter-professional consultation, in particular for solo-professional; on the reinforcement of existing structures and organisations; and on the sensitization and training of professionals on elder abuse before the introduction of a step-by-step plan. They also highlighted the risk of administrative burden due to the assessment via tools, reporting procedure, holding of multidisciplinary meetings…

However, a tricky point remains at the end of the discussion about the 'mandatory' approach of a step-by-step plan. While some SH insist on the importance of the compulsory aspect, others are against.

And finally, on the national level, it was suggested to include EA in the national step-by-step plan against gender-related violence and in the national safety plan.

Concerning the **unique entrance point** to which all elder abuse situations are reported and assuming the management of them (statement 2), the opinions between groups were divided. While, in one group, participants expressed their interest in a unique contact point like 1712 but preferably not like a Family Justice Centre, in other groups, several shortcomings were highlighted concerning a unique entrance point. They evoke the impossibility for a quick evaluation of complex situations as are EAs, and the risk of repeated referrals and its related difficulty to preserve anonymity. Furthermore according to some participants, the best approach for early management, is first trying to manage cases within the health and assistance sectors: the first reflex of a professional is to question him/herself on how can I organise help. And reporting should come in a second time. In addition, some stakeholders like GPs would like to remain the coordinator of the management and get feedback and support from specialised organisations.

If a unique entrance point is unavoidable, conditions to its implementation, were suggested by participants:

- to avoid common hotline with all types of violence,
- to avoid the creation of new structure,
- to hire sufficient staff with expertise able to take the pace of the older person,
- to provide enough logistic and financial support,
- to have very large openings hours,
- and to collaborate with proximity caregivers in charge of the management coordination.

Concerning the **decisional autonomy of older person and the legal protection of them (statement 3)**, all groups agree that decisional autonomy is very important and that no legal framework allows to break a person's autonomy except in case of mental incapacity. So, according to participants, interventions to manage EA have to be decided in agreement with the older person, in the respect of his/her values and after a clear explanation about the consequences (positive and negative) of each type of intervention. But reaching a real informed consent requires to take the pace of older people and to build trust, what needs time. Care consultations between the elder, his relatives and the professional caregivers should be a solution if the opinion of the elder is taken into account and his/her decision is respected. Regional structure like 'eerste lijn zone' could have a role in the organisation of those care consultations. However, participants from the justice sector explain that the justice does not reflect in a same way: the justice acts for the good of people but not always with their consent. Similarly, participants from the patient sector highlight that some medical doctors are still acting in a too paternalistic way. Financing of concertation and sensitization of professionals should be planned to succeed.

In case of mental incapacity related to a psychiatric disease or a cognitive disorder, an ethical reflexion is suggested by participants to determine if it is the will or the interest of the senior which is predominant. A legal representative could decide instead of the older person but a clarification of the legal definition of a person representative has to be done in the Belgian legislation. However, participants highlight that it is difficult and stigmatizing to establish the decisional capacity of someone.

Concerning the **training of professionals (statement 4)**, all groups agree that it should be a priority for managers to organise and support their staff training on a regular basis. Basic training about EA issues should be delivered to homogenous audience while continuing training should be given to heterogeneous audience in a more local context. However, multidisciplinary and multisector trainings are difficult to organise, notably because of time constraint, and only motivated professionals attend to trainings organised outside their place of working. For the moment, regional authorities support some hours of training for nursing homes staff. Participants highlight that the content of the existing training lacks on how to start a conversation with an elder suspected to be abused and how to manage ethical reflexion. Suggested solutions by participants are training in small workshops with trainers coming on site, even better during the delivering of care in the aim to observe and correct the mistakes. Training should be free for the participants, mandatory and also planned for solo-professionals. Specialized organizations like VLOCO could teach the generic knowledge about EA while zonal structures like 'eerste lijn zone' could teach the local operational issues (who is who, who can I contact etc.). Finally, participants insist on a shared outcome of the training between staff and management as logistic and financial means are required to implement the knowledge in practice.

Concerning the **sensitization (statement 5)**, participants give their opinion on who has to be sensitized, on what and how. The general public, the media, the health care professionals, the justice sector, the local authorities, children and elderly were cited as potential targets of sensitization campaigns. The content of the campaigns should aware on what elder abuse is, on what good care is; on anti-ageism approach (elderly are valuable citizens who merit to be treated with respect); on geriatrics issues, on what to do when an EA is suspected; on the fact that elders' worries about their autonomy are taken into account, on the importance of informal caregivers and the existence of derailed informal care; on law enforcement aspects and on the non-repressive options of the justice. Finally, sensitization campaigns should be done through the media by sensitised specialist of communication (very powerful), by meeting older people at their home and by going in school with clear and practical messages for children. At the justice level, the best way to sensitize the magistrates and the police is that EA becomes a priority.

- Statements related to organisational aspects

The statements related to **the (role of) the Family Justice Centres (statement 6)** were different in the Dutch speaking and in the French speaking groups since these centres are solely operational in Flanders. In Flanders, participants were pleading for a further rollout of the FJC. To them, this seems an obvious evolution since in all provinces chain approach (cfr. Chapter 2), which is usually the step before the creation of a FJC, is already existing in all Flemish provinces. A structural financing by the competent authorities of the FJC is perceived as a primordial step in the further rollout of the FJC. There was unanimity about the fact that FJC should not be the unique entrance and dispatch point for elder abuse situations. It was stressed that, where possible, situations of elder abuse should stay in the voluntary help and the first reflex of a professional should be "how to organise assistance in concertation with the elder and his/her relatives". According to the participants, FJC should primarily deal with the most complex cases. Ideally, FJC should also be involved in the prevention of cases, but this necessitates a major extension of manpower. It was also stressed that, till today, elder abuse cases rarely get to the FJC.

In Wallonia, concerning the Family Justice Centre (FJC), the point of view differs between the care/help sectors and the police/justice sectors. Indeed, care/help sectors should prefer that FJC focus their activities only on severe cases which require a collaboration between police, justice and assistance. The care/help sectors would like to put their focus on the prevention and on concertation between care/help professionals, families and elders. On the other side, the police/justice sectors asked for discussion with care/help sectors when they are confronted with unclear situation regarding the law. However, taking common decision is very complex as functioning differs a lot from one sector to another. Despite the silo partitioning between justice/police and help/care sectors, recent initiatives should lead to the elaboration of a circulaire (COL) from the "Collège des Procureurs Généraux" which should include forum of discussion between magistrates and specialized organisations in EA, and the designation of referent

professionals in EA in the police and justice sectors. Moreover, inter sector consultations are seen as highly promising even if an attempt to create a FJC failed in Brussels and that systematic consultation will be too hard to organise.

It is clear for the participants that the issues with the **professional secrecy** (statement 7) are the lack of knowledge about it, the high complexity of it, the fear of professionals of being responsible for its breach, the interpersonal variation in its interpretation, and the possibility that some professionals hide behind it to cover lazy or inappropriate behaviours. Some participants state that the rules related to professional secrecy are so complex that it is too ambitious to expect that professionals would understand and correctly apply the rules. Instead, professionals should have the opportunity to contact lawyers in-or outside the setting they work in (e.g. for GPs the order of general practitioners). To share professionals secrecies between involved professionals could be a solution but the experts highlight several condition to succeed: the need of a good intra-team functioning, the share of only required data to solve the case and the involvement of the older people in multidisciplinary and inter sector consultations. But the privileged solutions to the professional secrecy issues are the involvement of lawyers more often and the adaption of the law about the lift of the professional secrecy to less severe situations.

A specific aspect related to **professional secrecy in the context of case concertation** (statement 8) between assistance, policy and justice (art. 458ter Penal Code) was discussed with the participants. Today art. 458ter foresees the possibility for case concertation but does not specify the modalities (who can share data? common file? etc). In Flanders, participants explained that there is no need to specify the modalities of professional secrecy during case concertation in the law. Indeed, in Flanders, the modalities of case concertation are included in a protocol agreement (Protocolakkoord) to create a uniform mode of operation amongst all actors involved in case concertation. At the moment of the writing of this report, the protocolakkoord is not public. With regard to the sharing of information the idea is that involved actors can share the necessary information about the abused elder and the author but that none of the actors is obliged to do so. In principle the respective elder should consent to this sharing of information, but if the sharing of information is judged as absolutely necessary by the actors involved, he/she should at least be informed that data are shared amongst different actors of the concertation.

The purpose of statement 9 was to find out how participants think about the existence of a **protocol-agreement regarding a common approach on EA between the sectors of assistance, justice and police**. In one group, participants highlighted that formal agreements solely work if they are initiated by the respective parties themselves (as was the case for the topic of child abuse) and not if it was imposed from higher up. According to participants, more power should be given to local or zonal structures which are the best positioned to align approaches about EA between the sectors of health, well-being and welfare assistance and police and justice. They did not express themselves if this has to be officialised in a protocol but they just pointed the first line zones (eerste lijn zone) as responsible to take up the role to put all actors around the table to reflect on a common local policy related to EA.

In the other group, no comment was made about a protocol-agreement. The participants only highlighted that the population in general and the health care professionals in particular are afraid by the justice sector.

Concerning the **quality of care (statement 10)**, participants mainly discussed about residential quality of care as suggested by the statement. Anyway, they still says that, at home, quality of care should not be forgotten, that lack of support to informal caregivers leads to overburden and derailed informal care and that decrease in at home care financing will have an impact on the large majority of older people which lives at home.

First, participants highlighted that quality of care in residential settings does not necessarily leads to quality of life for older people. Indeed, the caregiver can deliver a high quality procedure without a word or a look to the older person. Second, they explained that quality of life of residents tightly depends on the quality of work and motivation of caregivers. For that, they suggest to improve the attractiveness and the working conditions of caregivers (training, time, valuation of travel time, etc.). They precise that, in the large majority, staff knows what good care is. Their opinion is to better finance and staff nursing homes instead of increasing the controls.

For the moment, the financing of nursing homes is considered as perverse as it stimulates managers of for-profit organisations to keep resident in a dependant state. In addition, a decrease of nursing homes subvention impaired the care to the most dependant persons. Accordingly, participants talked about EA induced by healthcare system. They rather suggest either a financing based on older people satisfaction or a system in which nursing homes are ranked by the elders themselves.

Controls specifically around EA in nursing homes does not exist as is. And general controls by regional inspectors are rare, do not include contact with residents and are most of the time known and prepared by managers. Indicators of quality used for the controls vary from one region to another but usually are more quantitative and administrative than qualitative. The participants suggest to avoid administrative indicators which could easily be fake. They insist to keep architectural indicators and to control the 'care' aspect rather than the 'cure' aspect. They suggest to involve the residents in the evaluation and to render the control report public.

To improve the quality of care, participants explains that more transparency is needed. They suggested to rise taboo around EA and to breach the law of silence inside institution. One solution should be to organise open discussion between nursing home staff, management, residents and families. The empowerment of staff and of older people should also improve the quality of care. For example staff could develop auto-control tools of well-treatment behaviour and give the opportunity to older people to organise freelance resident comity. Moreover, the society in general should allow older people to take risks as a guarantor of individual liberty and as such, to improve their quality of life.

In hospitals, participants explained that accreditation processes allow to come back to good care procedure and to long-term follow-up of it. They also highlighted that hospitals' organisation and financing present a lack of updating as the profile of the patients change a lot since the set-up of it.

Charter in residential settings (statement 11) were seen as positive trigger to well-treatment if staff and residents were involved in its development and implementation. All people concerned by the residents' life should be sensitize to the charter. However two shortcomings were cited: the lack of means to force the respect of the charter and the risk to create a gap between the staff and the management if a mandatory application of a charter is decided.

- Statements related to practical issues

Two examples of **detection tools (statement 12, 13 and 14)** were given by participants: the RITI scale by the Dutch-speaking participants and the EASI scale by the French-speaking participants. According to one group, detection tools should not be necessary as having common sense and discussing in multidisciplinary meetings should be sufficient to detect elder abuse. This group highlighted the following shortcomings to the use of detection tools: they do not fit within a normal conversation with the older patient and they do not capture the whole situation. If detection tools have to be developed, they should have good sensitivity and specificity, be specific for each type of abuse, assess the risk of potential abuse by caregivers, and be short, comprehensive and based on scientific evidences. Participants should rather favour longitudinal follow-up to systematic screening for which they highlight the difficulty to reach the very frail and isolated persons.

No participants were convinced by **merging/sharing the older person files (statement 15)** between different sectors because it require the patient agreement and it triggers a legal problem with people not subject to a medical secret.

Only one group stakeholders discussed about **emergency situation (statement 16)**. They explains that the possibility to ban the authors should be envisaged in case of emergency and not only the placement of the abused older person. Quick solutions for abused older persons in danger are to be hospitalized (but with his/her consent) or to be hosted by trusted family members from where network of caregivers can be organised.

The designation of **reference persons (statement 17)** in elder abuse does not receive the approbation of the participants. But if this position is necessary, it should be come from already existing structures like specialised organisation in elder abuse. Participants thought that it will be more efficient to have regional referents who links professionals with each

other's. One shortcoming should be the need of a team of referents to provide a continuity.

The majority of tricky points were discussed during the SH/experts meeting. However, due to the lack of participants from the administrations or the authorities, some points remains unclear as the position of authorities and administration to support media campaign funding, to centralise data about EA and to support the consequences of an increased detection rate of EA. Questions about attractiveness of older people matters within professionals not specialized in care and help to older people was neither solve as all experts present at the meeting were specialized in older people matters.

For some of the statements, Dutch-speaking and French-speaking experts' opinions were different. An explanation given by the participants from one group could partly highlight this difference. In Flanders, financial restrictions led to a minimal specialised service provided by VLOCO and were followed by a political decision to gather all types of violence in a centralised contact point (1712), while in the French-speaking community, specialised organisations, such as "écoute seniors" and "respect seniors" were further elaborated.

5 ACCEPTABILITY ON AND FEASIBILITY OF SOLUTIONS ACCORDING TO EXPERTS AND MAJOR STAKEHOLDERS

5.1 Survey responses

After the stakeholders meeting, the statements submitted to the expert stakeholders were adapted by the KCE researchers according to their comments and combined with new information retrieved in the other chapters from this report (e.g. step-by-step plans from abroad).

The online survey was send to 146 experts and stakeholders (73 Dutch-speaking and 73 French-speaking) and during two weeks they had the time to complete the questionnaire. In total 51 responses were recorded, of which 34 complete responses (i.e. submitted the survey at the last page, but this does not mean that all questions were filled in) and 17 incomplete responses. From the incomplete responses 13 responses were excluded from the analysis (only page 1 about the personal characteristics completed), resulting in 38 responses that were further analysed.

In Figure 36, an example is given from the questionnaire with the response options on acceptability (acceptable/not acceptable) and feasibility (feasible/not feasible). If the respondent didn't want to answer and felt not competent enough to assess the statement, he could also indicate the option 'no answer'. After every block of statement an open question was added in which the stakeholder could add some comments, propositions or conditions to success or explain his disagreement with the statement. These open questions were not compulsory. The full version of the questionnaire can be received on request (via mail: info@kce.fgov.be).

Figure 36 – An example of a statement with the answer options



Procedure of analysis

The analysis of the responses is a combination of a quantification of the number of respondents who indicated that a statement was acceptable and/or feasible and a qualitative approach in which additional comments were linked to the quantitative data.

In the following tables the statements with a percentage >75 for acceptability are indicated in green. The responses with a blank on acceptability were not taken into account in the overall percentages but were analysed separately (where needed). The results on feasibility are not presented in the tables in the scientific report but can be found in Appendix 68.

In the statements with a regional aspect, for example the role of the 'eerstelijnszones' in Flanders or the 'SISDs' in Wallonia, a sub-analysis was made between the Dutch-speaking or French-speaking respondents, in order to see if the perception on the acceptability of the statement differed due to the different organisation of such primary care structures. More background information about the federated organisation of primary care can be found in the most recent Health in Transition report (in preparation) or in preceding chapter (see Chapter 2).

The qualitative analysis of the responses on the open questions helped to understand and explain the choices of the respondents and their motivations. For example:

- For acceptability: In some cases some respondents disagree with the statement whereas more than 75% agreed on the acceptability of that statement. The analysis of the open questions helped the researchers to understand what the arguments were for the non-acceptability of those respondents.
- For feasibility: Those who said "acceptable" but "not feasible", their comments could help to improve the statements. If a statement was indicated as "non-acceptable" but still "feasible", this could mean it is not appropriate but still done in practice.

The details of the thematic analysis of the open questions is presented in appendix 5.

Limitations of the applied methodology

- The purpose of the set-up of the online questionnaire was to assess the acceptability and feasibility of each of the statements. If the respondents did not want to answer of did not feel comfortable to answer, a 'no answer' button could be clicked at. A major restriction of the use of the Lime software is that this 'no answer' button was automatically filled in. Unless the respondent clicked on feasibility or acceptability, this answer option remained active. It is difficult to retrieve the reason for the 'no answer', for example disagreement on the statement, not feeling comfortable to answer, forgotten to answer, etc, except if a comment is given in the related open question.
- The statements were grouped per theme in which often the statements suggested different solutions for the same problem. Most respondents answered positively on these different options, which could be seen as contradictory but these answers should be interpreted as "or" options without a specific preference for one or the other. This can be seen as a limitation of the online questionnaire, i.e. the respondents were not forced to choose for one option, however the absence of a single choice gave the opportunity to identify a range of possibilities for future policy recommendations.
- At the end of the survey, the respondents could give their name and their affiliation. Nevertheless all respondents gave their contact details, we choose not to link the responses to their organisation. First, the answer options were too dichotomous to capture every nuance in their opinion about the statements. In the open questions the stakeholders could describe their opinion, but since these questions were not obligatory, most of the stakeholders focused on the acceptability and feasibility of the statements. Second, respondent do rather answer in their own name and not exclusively as representative of a sector or an organisation. So, mentioning in the results that for example a certain organisation was against a statement, would be a tooshort..
- Across the survey, the number of non-responders increased, probably due to the length of the online survey. The percentage on acceptability and feasibility were calculated based on the number of responders per statement.

5.2 Characteristics of the respondents

The questionnaire was sent to a variety of stakeholders, including different care profiles, juridical sector and governmental sector (decision makers). Within the 38 respondents, following professions were found:

- Care profile: physicians, psychologists, nurses, occupational therapists, social worker
- Coordinator profile: managers of care settings (e.g. home for the elderly), coordinators
- Patient profile: patient representatives
- Policy profile: member of a governmental setting
- Juridical profile: magistrate, lawyer, police officer
- Researcher profile: researchers in the domain of care for the elder (including elder abuse)

Due to the limited number of respondents, not all care professions were represented (such as physiotherapists, nursing auxiliary). Most of the respondents represented also different roles, for example somebody could have a care profile as basic education, but is working as coordinator in a care setting or in an organisation specialised in elder abuse. Importantly representatives from the main specialised organisations (Ecoute Senior, Respect Senior, VLOCO, Brussels Meldpunt OMB) filled in the questionnaire as well as 5 representatives of authorities (this sector was not represented during the discussion group).

There was an equal distribution between languages with 20 Dutch-speaking respondents and 18 French-speaking respondents. Geographical distribution of the work setting showed a small number of respondents working in Wallonia (n=8), with the majority working in Flanders (n=16) or in Brussels (n=14).

5.3 Step-by-step plan in case of suspicion of elder abuse

5.3.1 Step-by-step plan in case of suspicion of elder abuse

In Table 31 the percentages on acceptability and feasibility of a step-by-step plan in case of suspicion of elder abuse are presented. These first block of statements contains more general statements about the use of a step-by-step plan in all organisations or by every individual professional (stat 1), if such a step-by-step plan should be legally obliged (stat 2) or should be part of the procedure of recognition and quality control (stat 3), or about the role of the authorities in the development of a general framework (stat 4) or the role of the primary care structures in the adaptation to the local context (stat 5).

In the accompanying text of this block of statements, it was explained that if the respondent did not agree on the acceptability of the first statement, the further four statements did not have to be answered. Only one respondents did so and indicated in the first statement that these statements were not acceptable nor feasible (and he stopped definitely to answer to the rest of the questionnaire).

For each of the 5 statements in this block, more than 75% of the respondents agreed on the acceptability of these statements. Among those respondents there was also an overall agreement on the feasibility of the statements.

For the second statement, the overall agreement was just 75%, indicating that 27 respondents agreed that the use of a step-by-step plan should be legally obligatory, in contrast to 9 respondents who did not agree on the acceptability and 1 blank response. One of the 'not acceptable' respondents clarified, in an open comment, that the professional should estimate himself if further action is needed, based on his own experiences rather than the obligation of a step-by-step plan.

Across the other open comments, the need for such a step-by-step plan was emphasised by the stakeholders, but some remarks were formulated regarding the feasibility of such a plan in clinical practice, by mentioning the risk for administrative burden and the lack of time by the care professionals. Also a more fundamental issue related to the obligatory use of a step-by-step plan was raised, namely the right of the elder to refuse help which implies that a care professional should have to ignore this decision in case of an obligatory step-by-step plan.

Other comments were more related to the development of the step-by-step plan, like the need for the prioritization of EA by the government and for the involvement of a variety of actors like Ecoute Senior, Respect Senior, VLOCO, SISDs, regional inspectorates and the College of General Prosecutors, and the existence of Belgian initiatives, such as the plan of SEL Waasland, which could be taken into account.

Regarding potential regional differences, a sub-analysis was made for the fifth statement (on the role of the primary care structures for the adaptation of the generic plan for each of their geographical zones). Within the 23 respondents (88.46%) who agreed on the acceptability of this statement, a fairly equal distribution was found between Dutch-speaking and French-speaking stakeholders (n=10 versus n=13). The three stakeholders who did not accept this statement were all Dutch-speaking. No major difference was found between the number of Dutch- or French-speaking non-responders (n=6 versus n=4). Based on this rough analysis, the perception of the stakeholders did not differ according their language (and probably the region linked to).

A high number of no responses were found for the fifth statement, probably the respondents felt less comfortable with the content of this statement. In the open comments no further explanation could be retrieved to explain this increased number of no responses.

Table 31 – Step-by-step plan in case of suspicion of elder abuse

Statements	Acceptable	Not acceptable	No response
1. Every organisation or individual professional involved in the care or assistance of older people should use a step-by-step plan (a guide with the different steps to be taken + practical and legal information) in case of (suspected) elder abuse	91.89% (n=34)	8.11% (n=3)	n=0
2. The use of this plan of action should be mandatory by law	75% (n=27)	25% (n= 9)	n=1
3. This obligation must be part of the recognition and control process of the quality of care.	91.67% (n= 33)	8.33% (n=3)	n=1
4. The general principles and generic framework of this step-by-step plan should be defined by the competent authorities.	88.57% (n= 31)	11.43% (n=4)	n= 3
5. The care councils (zorgraden) of the primary care zones (eerste lijn zones) in Flanders and the SISD (Service Intégré d'Aide à Domicile) in Wallonia and Brussels should adapt the generic framework to their geographical zone before each organisations or professionals can adapt it to their context.	88.46% (n= 23)	11.54% (n= 3)	n= 12

5.3.2 General principles of a step-by-step plan

Five principles of a step-by-step plan were proposed to the stakeholders: containing concrete actions (stat 6a), inter-sectoral working (stat 6b), informing the elder and asking for his consent (stat 6c), taking into account the whole situation (stat 6d) and offering the possibility to guarantee anonymity (stat 6e).The majority of the respondents agreed on the acceptability and the feasibility of the five statements (see Table 32). Only 2 to 4 respondents indicated that these statements were not acceptable, invoking, inter alia, the fundamental right to protect people in danger (even without their consent).

Comments highlighted that the implementation of inter-sectoral collaboration (stat 6b) requires an expanding or adaptation of the Royal Decree art 458ter so that collaboration and data sharing between care providers and police/justice is possible but with a certain guarantee for the author that this data sharing will not immediately lead to prosecution by judicial authorities. Another stakeholder emphasised the importance of the involvement of the family or nearby of the victim.

- The majority of the comments were related to the consent of the elder (stat 6c) and the guarantee of anonymity (stat 6e): Some comments highlighted the importance of obtaining patient consent and informing patients. However, the experts recognized the difficulty to get agreement from seniors who have mental health problems (e.g. cognitive impairment or dementia) or other health problems such as an infectious episode or dehydration. Another stakeholder questioned why an elder should need to give his consent in case of abuse. In his opinion, the right for safety is a fundamental right and elder who refuse help are often in the most troubled situations. Such comments could be related to a misunderstanding that in every case a consent is required. However, the regulation foresees that a consent is only required in capable patients and that even in these cases informing the patient is sufficient in case of severe or urgent danger. More information about this topic can be found in Chapter 2.

- The possibility to guarantee the anonimity was also questioned. If physical or psychological integrity is compromised, the care provider must be able to appeal to the right to speak to the public prosecutor.

Table 32 – General principles of a step-by-step plan in case of suspicion of elder abuse

Statements	Acceptable	Not acceptable	No response
6. In general, this plan should:			
a) propose concrete actions	90.91% (n= 30)	9.09% (n= 3)	n= 5
b) be inter-sectoral (including the police and justice sector) and not only intra-sectoral (limited to the care and assistance sector)	94.12% (n= 32)	5.88% (n= 2)	n= 4
c) keep the older person informed and ask for his consent	88.57% (n= 31)	11.43% (n= 4)	n= 3
d) take into account the whole situation	93.75% (n= 30)	6.25% (n= 2)	n= 6
e) offer the possibility to guarantee anonymity	91.18% (n= 31)	8.82% (n= 3)	n= 4

5.3.3 The generic framework of a step-by-step plan

For the implementation of a step-by-step plan in clinical practice, an adaptation of a more generic framework to the local context is required. This generic framework should contain the following 7 elements (as suggested by the KCE researchers): the steps to follow (stat 7a), a toolbox (stat 7b), an annex with local information (stat 7c), legal information (stat 7d), a multidisciplinary discussion (stat 7e), a specific reference person (stat 7f), and specialised organisations as intermediary (stat 7g).

A high number of respondents indicated that these 7 elements were acceptable and feasible (see Table 33). The number of respondents who were not convinced about the acceptability varied from 1 to 4.

A respondent mentioned the difficulty in clinical practice to organise and to attend to multidisciplinary meetings (stat 7e) due to lack of time, resources, etc., and collaboration with other sectors, such as police or justice seemed to be even more difficult.

Most comments were regarding the role of a reference person (stat 7f). In these times of budgetary constraints, the comments went in the direction of appointing an additional role to a person who is already a referent in another field (dementia, restraint, palliative care, wounds, etc.) or enhancing the value of the specialised organisations already in place by giving them the necessary material and human resources (Ecoute Seniors, , Respect Seniors or VLOCO). These organisations could also be used as relays for evaluation and coordination of follow-up or play the role of advising and coaching reference persons.

The proposal concerning the local contact information with a regular update (stat 7c) also provoked some scepticism: the comments reflect that it would be an ideal situation to have "an annex containing all practical information on contact persons in the geographical area to be regularly updated", however, this task was considered by some comments as not feasible due to the small amount of funding allocated and the amount of time that would have to be spent on this task.

Some stakeholders added the need for (financial) revalorisation of the already existing specialised organisations for the support to the care professional as one of the elements of such a generic framework.

Table 33 – The generic framework of a step-by-step plan in case of a suspicion of elder abuse

Statements	Acceptable	Not acceptable	No response
7. The generic framework of this step-by-step plan should include ...			
a) the (mandatory) steps to follow	90.36% (n= 29)	9.38% (n= 3)	n= 6
b) a 'toolbox' with detection tools and risk factors evaluation scales - to be used as a decision aid in case of suspicion of EA - and a guide for conducting the conversation with the victims and their entourage.	96.88% (n= 31)	3.13% (n= 1)	n= 6
c) an annex containing all practical information concerning the contact persons of the geographical area	97.06% (n= 33)	2.94% (n= 1)	n= 4
d) legal information on the possibilities of lifting professional secrecy and a reference to an external body/person able to provide legal advice	93.94% (n= 31)	6.06% (n= 2)	n= 5
e) a discussion phase within a multidisciplinary team	96.97% (n= 32)	3.03% (n= 1)	n= 5
f) the designation of a reference person for elder abuse - trained in the fight against abuse - and to whom care and assistance providers can turn in the event of (suspected) abuse	93.94% (n= 31)	6.06% (n= 2)	n= 5
g) the designation of (a) specialised organisation(s) as an intermediary for the evaluation of the situation, the approach and the follow-up	87.50% (n= 28)	12.50% (n= 4)	n= 6

5.3.4 *Different steps of a step-by-step plan in case of suspicion of elder abuse*

The following steps of a step-by-step plan were proposed to the stakeholders: a detection phase (stat 8a), a risk assessment (stat 8b), a consultation phase with the elder (stat 8c), with the entourage of the elder (stat 8d) and with the other involved professionals (stat 8e), and a decision tree (stat 8f). Almost all respondents agreed on the acceptability and feasibility of these different steps (see Table 34). Only 1 to 4 respondents did not agree on the acceptability.

One of the statements with the lowest% on acceptability is the statement related to communication with the family of the victim (stat 8d). Some comments indicated the fact that abuse can come from within the family, therefore such a consultation with the family/potential abusers would not be appropriate in this case or the elder would not give his consent out of shame or fear for retaliations. Also one of the stakeholders mentioned that specific competences are needed to guide a constructive conversation with the elder and his family. The specialised organisations could have an important role as mediator, and sufficient resources for the functioning of these organisations should be provided. In line with this comment on the need for sufficient resources for the specialised organisations, another respondents mentioned a similar need for sufficient resources to setup the multidisciplinary discussions (stat 8e) and for the role of the reference person. The issue about the need for more clarification about the shared professional secrecy was also raised by somebody. One respondent raised the point that discussion with the author of abuse was not included in any of the steps of the step-by-step plan and considered this as an important lack. Often the authors is not aware of his abusive behaviour, for example derailed care and a constructive dialogue with the author could be an important step to stop or prevent abuse.

Nevertheless the preference was set for an easy-to-use guidance without a waste of time to find the information (mentioned by one of the respondents) while the use of a decision tree (stat 8f) was questioned by others, referring to the often complex situations of abuse.

Table 34 – Different steps of a step-by-step plan for the detection and management of elder abuse

Statements	Acceptable	Not acceptable	No response
8. This plan should include the following steps...			
a) a detection phase, based on a number of alarm signals	96.88% (n= 31)	3.13% (n= 1)	n= 6
b) a phase in which the (actual, certain and serious) danger is assessed	90.93% (n= 29)	9.38% (n= 3)	n= 6
c) a consultation phase with the older	93.75% (n= 30)	6.25% (n= 2)	n= 6
d) a consultation phase with the environment of the elder	86.67% (n= 26)	13.33% (n= 4)	n= 8
e) a consultation phase within a multidisciplinary team or the possibility for individual healthcare providers to contact a specialised organisation for advice or consultation	96.88% (n= 31)	3.13% (n= 1)	n= 6
f) a decision tree with all the actions to be taken	93.55% (n= 29)	6.45% (n= 2)	n= 7

Key points regarding step-by-step plan for the detection and management of elder abuse

- **An overall agreement was found on the acceptability of a step-by-step plan to encounter elder abuse.**
- **Potential bottlenecks of a step-by-step plan were**
  - **Risk for administrative burden and time-consuming procedure for the professional**
  - **The obligatory aspect of a step-by-step plan: the obligation to use a step-by-step plan in practice could facilitate the detection and management of elder abuse, however this obligatory aspect could also negatively affect the collaboration between the professional and the victim, for example when the elder refuses to accept help**
  - **The need for consent of the victim: All stakeholders were convinced about the need to inform the elder about the management of his case, but getting the consent of the elder before acting was perceived as a major barrier by the professionals. Due to health problems (e.g. dementia) or social context (e.g. fear for retaliation by the author) the elder is often not capable to give his consent.**
  - **Specific competences are needed to guide a constructive conversation with the victim, the family or the author. Specialised organisations could play a role as mediator in this process.**
  - **Sufficient resources for the organisation of multidisciplinary meetings**
- **The agreement on the feasibility was somewhat lower, and most of the comments were related to the implementation of such a plan in (clinical) practice and what additional resources (financial and human) are needed.**
- **(Additional) Conditions for implementation were:**
  - **The prioritization of elder abuse by the government, by incorporating the development of a generic framework in a national policy on elder abuse and the reinforcement of existing structures and organisations**
  - **Adaptation of the current legislation (RD art 458ter) is needed to facilitate the collaboration and data sharing between care providers and police/justice**

5.4 Centralised contact point

5.4.1 Principle of a centralised contact point

In the accompanying text of this block of statements, it was explained that if the respondent did not agree on the acceptability of the first statement, the further blocks of statement did not had to be answered. None of the respondents used this option and continued answering to the following blocks of statements on the centralised contact point.

Within the 34 responses (4 non-responders) the majority (30 stakeholders) agreed on the acceptability and feasibility of a centralised contact point, accessible for the elder and/or his family (stat 9) (see Table 35). Some respondents emphasised the need for such a centralised contact point by stating that a centralised contact point will increase the visibility and the awareness for the patient and/or relatives and the professional. The four respondents who did not accept this statement, also found this kind of centralised contact not feasible.

Main objections mentioned in the open comments (even by respondents who accepted the statement) were related to the set-up of a new contact point. The respondents preferred to further elaborate the current existing contact points (such as 1712, Woonzorglijn, etc.) rather than a separate contact point for elder abuse. Also more sensitization and training is needed of the professionals (including police and justice) so that the elder can directly contact a professional rather than via a centralised contact point.

Other comments suggested to mandate existing specialized organizations to refer at the national level. And another one referred to the current regional differences in contact points, risk for a long procedure for the caller before obtaining the information, and the risk for fragmentation of information from one service to another.

One respondent mentioned also the set-up in Quebec, where a centralised contact point is dedicated to elder abuse.

Table 35 – Centralised contact point

Statements	Acceptable	Not acceptable	No response
9. There should be a centralised contact point, where the elderly person or his family can call for help in case of (suspected) elder abuse(s), except if a call to 112/101 (persons in danger) is necessary.	88.24% (n= 30)	11.76% (n= 4)	n= 4

5.4.2 Type of centralised contact point

In this block of statements, three options of centralised contact points were suggested (a new unique national number (stat 10a), one of the currently existing contact points such as 1712, 106, 107 (stat 10b) or the specialised organisations, such as Ecoute Senior, CAW, etc. (stat 10c)).

The percentages on acceptability were much lower for this block of statements compared to the other statements related to a centralised contact point (see Table 36). No conclusion could be made on which option would be the most suitable as contact point for the elder and the professional, but the option of centralisation by the specialized organisations is the less controversial with 70% of agreement.

Across the different comments, a common preference was noticed for a centralised contact point (some prefer a new unique number whereas others prefer the current existing contact points such as 1712) which should be coordinated by a national number (i.e. no different regional numbers) but which should transfer the call to the regional, specialised organisations or services. One of the respondents preferred even that the specialised organisations, which are currently organised on regional level, should be organised on national level to avoid regional differences. The staff at the centralised contact point should be trained in the specificities of elder abuse and should have a good knowledge of the network and the different actors in the field. This kind of set-up of a centralised contact point requires sufficient human and financial resources, even so for the specialised organisations.

One respondent, who rejected the three proposals, pointed out that there is a difference between a hotline, which should be called in crisis situations (e.g. police, crisis centres) and requires permanent staffing and a helpline, such as 1712 or VLOCO.

Table 36 – Types of centralised contact point

Statements	Acceptable	Not acceptable	No response
10. This central point of contact should be...			
a) a new unique national number that is accessible 24/7 and is intended for elder abuse only	51.61% (n= 16)	48.39% (n= 15)	n= 7
b) national or regional helplines (1712, 106, 107)	57.14% (n= 16)	42.86% (n= 12)	n= 10
c) Organisations specialised in the psychosocial approach to elder abuse (CAW, Brussels Meldpunt OMB, Ecoute Seniors, Respect Seniors)	70.37% (n= 19)	29.63.% (n= 8)	n= 11

5.4.3 New centralised contact point

In this block of statements related to a new unique national number, four working conditions were suggested: sufficient time (stat 11a), guarantee of the anonymity of the caller (stat 11b), sufficient staffing (stat 11c) and direct transfer of calls towards specialised organisations (stat 11d).

Similar to the previous statements on a centralised contact point, the percentages are lower compared to the previous sections, but still some agreement on the acceptability could be found (see Table 37). However, the organisational feasibility is more questioned by the respondents, for example:

- Financial impact of the set-up of a new number within the current cost-cutting policies
- As mentioned in the previous section, this centralised contact point should be embedded in the network of the different organisations and services. –

More ethical issues were also raised:

- Is a phone service the most suitable solution to build a trust relationship with the caller? Will the staff have enough time for this? And in case this contact point functions as dispatching centre towards the regional services, will there be suffieicient time for the empathic aspect during the contact with the caller?
- The guarantee of the anonimity of the caller and the triage of cases demands a bio-ethical reflexion before implementation.

Table 37 – New centralised contact point

Statements	Acceptable	Not acceptable	No response
11. If a new unique national number were to be the central contact point, the organization behind this number should ...			
a) be able to take the time to build a relationship of trust with the reporter	80.77% (n= 21)	19.23% (n=5)	n= 12
b) be able to guarantee the anonymity of the reporter in order to reassure those who fear retaliation	86.21% (n= 25)	13.79% (n=4)	n= 9
c) have competent staff to carry out triage between cases requiring immediate notification to the Public Prosecutor or requiring only intervention by a specialised organisation (CAW, Brussels Meldpunt OMB, Ecoute Seniors, Respect Seniors).	85.19% (n=23)	14.81% (n=4)	n= 11
d) forward the call immediately to the specialised organisations	70.83% (n= 17)	29.17% (n=7)	n= 12

5.4.4 Current contact points

The similar four working conditions were suggested for the designation of currently existing contact points as the centralised contact point for elder abuse, with the addition of two conditions: the expansion of the contact days and hours (stat 12e), and the disposition of staff specialised in elder abuse (stat 12d). The majority of these six working conditions were accepted by the majority of the respondents, except for the transfer of calls towards specialised organisations (stat 12f) as it was in the previous section (see Table 37 and Table 38).

The percentages for the feasibility of the working conditions was less clear, with either the choice for feasible or for a blank response. Comments related to the feasibility might explain this uncertainty by the respondents. They concern the lack of trained staff in the regional contact points and the unfeasibility to expand the opening hours during the evening and the weekends in the regional contact points. In addition, the current restricted contact hours of the specialised organisations, hamper the direct transfer of calls to these organisations. A kind of guided/indirect transfer of the call, in which the centralised contact point can make an appointment with the specialised organisation or service in name of the caller, could be a solution.

Table 38 – Current contact points as centralised contact point for elder abuse

Statements		Acceptable	Not acceptable	No response
12. If the current national or regional helplines (1712, 106, 107) were the central contact point, they should...				
a)	be able to take the time to build a relationship of trust with the reporter	92.59% (n= 25)	7.41% (n=2)	n= 11
b)	guarantee the anonymity of the reporter in order to reassure those who fear retaliation	86.67% (n= 26)	13.33% (n=4)	n= 8
c)	have persons specialised in elder abuse(s)	93.10% (n=27)	6.9% (n= 2)	n= 9
d)	have competent staff to carry out triage between cases requiring immediate notification to the Public Prosecutor or requiring only intervention by a specialised organisation (CAW, Brussels Meldpunt OMB, Ecoute Seniors, Respect Seniors).	89.66% (n=26)	10.34% (n=3)	n= 9
e)	expand their opening hours and days (1712)	88.89% (n= 24)	11.11% (n= 3)	n= 11
f)	forward the call immediately to the specialised organisations	72.73% (n= 16)	27.27% (n= 6)	n= 15

5.4.5 *Specialised organisations as contact point*

When specialised organisations, such as CAW, Brussels Meldpunt OMB, Ecoute Seniors, and Respect Seniors, were considered as the centralised contact point for elder abuse, the following three working conditions were questioned for their acceptability and feasibility: expansion of their contact days and hours (stat 13a); systematic management of every case of elder abuse, including the cases for which a transfer to 112/101 (urgent calls) or reporting to the Prosecutors have been required (severe case) (stat 13b); and the transfer to 112/101 or to the Prosecutor of very urgent or very severe cases (stat 13c) . Those three statements were accepted by the majority of the respondents, however a slightly lower percentage was found for the second working condition, in which all cases should be handled by the specialised organisations (see Table 39). The percentages for feasibility within the group of respondents who accept the statements was quite low (ranging from 47 to 65%).

Main comments related to (non-)feasibility of the statements were:

- The risk for fragmentation of contact points, which will lead to confusion for the general public
- The need of sufficient (financial and human) resources for the specialised organisations in order to function as a contact point for the elder, the general public and the professionals

Table 39 – Specialised organisations as contact point

Statements	Acceptable	Not acceptable	No response
13. If the organisations specialised in the psycho-social approach to abuse (CAW, Brussels Meldpunt OMB, Ecoute Seniors, Respect Seniors) were to be the central contact point, they would...			
a) expand their opening hours and days	88.46% (n= 23)	11.54% (n= 3)	n= 12
b) deal with any case of elder abuse, including those having required a call to 112/101 or a report to the Public Prosecutor's Office	76% (n= 19)	24% (n= 6)	n= 12
c) forward very urgent or very serious cases to 112/101 or to the Public Prosecutor's Office.	88.46% (n= 23)	11.54% (n= 3)	n= 12

Key points regarding a centralised contact point

- **An agreement emerges on the principles of a centralised contact point but not on which type of structure should take this role. However, a preference seems go to specialised organisations rather than to a unique national or existing regional helplines.**
- **An agreement on the feasibility is not present as respondents questions the training of centres' staff, the lack of financial and human resources, and the difficulty to expand the opening hours.**
- **No (additional) conditions for implementation were formulated by the stakeholders.**

5.5 Professional secrecy and inter-sectoral consultation

5.5.1 Legal basis behind the professional secrecy

Confusion about professional secrecy was several times mentioned by the professionals during the first lime survey, the interviews and the stakeholders meeting. The following two statements aim to clarify the legal aspects of professional secrecy. For both statements a high percentage for acceptability and feasibility was found, indicating the need for a contact point to receive more information about professional secrecy (stat 14) and about the cases/situations for which this secrecy can be suspended (stat 15) (see Table 40).

About the role of specialised organisations in professional secrecy, some stakeholders commented on the currently restricted contact hours of these organisations. One stakeholder preferred that professionals should go for advice within their own organisations or anonymously with the Prosecutor whereas another stakeholder mentioned that VLOCO has already this role (and that this role has been legally regulated) but not the CAW. In the comments it was also pointed out that there is currently already a legal regulation about professional secrecy (art 485bis on the right to speak in case of abuse in vulnerable people and art 485ter on multidisciplinary meetings). More information about these regulations can be found in Chapter 2.

The second statement (about the professional secrecy in vulnerable people) induced some comments about the definition of vulnerability (linked to a certain age or not). Also one stakeholder indicated that this statement could be interpreted as that consent of the elder seems not be needed anymore when the person is considered as vulnerable.

Table 40 – Legal basis behind the professional secrecy

Statements	Acceptable	Not acceptable	No response
14. In order to know whether their professional secrecy can be lifted, professionals should be able to turn to a specialised organisation (e.g. CAW, Brussels Meldpunt OMB, VLOCO, FJC, Respect Senior, Ecoute Senior, etc.).	93.55% (n=29)	6.45% (n= 2)	n= 7
15. The legal rules on professional secrecy must clearly express that they do not apply when a case of (suspected) neglect, mistreatment or abuse is reported about a person considered vulnerable in view of his age to governmental, medico-social or judicial authorities (and not only to the Public Prosecutor, as is currently the case).	89.29% (n= 25)	10.71% (n= 3)	n= 10

5.5.2 Types of inter-sector consultation

The majority of the respondents agreed that, for the facilitation of the consultation between the sector of police, justice and the psycho-medico-social services, structures are needed, such as discussion platforms (stat 16a) or a permanent structure in each juridical region for more complex cases (stat 16b) (see Table 41).

Some comments were mentioned regarding the implementation of such structures for inter-sector consultation:

- An identical operation of this structure should be obtained in every district
- Sufficient resources (working time) should be foreseen for the professionals
- Consultation between professionals and magistrates has already been made possible via the chain approach and the stakeholders preferred to elaborate this kind of structure rather than the set-up of a new structure
- Other actors, like patient organisations with experience in the management of certain pathologies, could also be involved in the consultation platforms.

Table 41 – Types of intersectoral consultation

Statements	Acceptable	Not acceptable	No response
16. In order to enable the police, prosecutors, judges and psycho-medico-social services to deal with complex individual cases, it is important to have at their disposal...			
a) Consultation platforms between the specialised organisations (CAW, Brussels Meldpunt OMB, VLOCO, Respect Seniors, Ecoute Senior, …) and the magistrates, with the possibility of also discussing anonymous cases.	93.75% (n= 30)	6.25% (n= 2)	n= 6
b) A permanent structure in each judicial district for inter-sectoral consultation on complex cases, such as the 'chain approach' model of Family Justice Centers.	100% (n= 32)	0% (n= 0)	n= 6

5.5.3 *Inter-sector consultation like in Family Justice Centres*

Currently inter-sector consultation like Family Justice Centres, are in most cases only accessible via police, justice or assistance services and are not directly accessible for (healthcare) professionals, the general public or the victim/author. Moreover they are oriented towards the more complex cases of intra-familial violence. In the following statements, some adjustments to the functioning of these centres have been proposed to the stakeholders.

Overall could be stated that the majority of the respondents accepted these statements (see Table 42), in particular the statement about the follow-up and the impact evaluation of the care and management plan (case management). So stakeholders globally agree on the fact that:

- The FJC also accept requests from care professionals (stat 17a)
- These centres function as a secondary care centre, this means that less complex cases are referred back to the appropriate services (stat 17b)
- These centres are also responsible for the case management, i.e. follow-up of the interventions (stat 17c)
- Training for care professionals could be organised by the FJC in their geographical region (juridical district) (stat 17d)

Nevertheless the agreement on acceptability of these statements, the percentages for feasibility were a bit lower. Objections, mentioned by the stakeholders in the open comments, were mainly related to the difficulty related to the definition of complex cases (and the risk of excluding certain cases in which an inter-sectoral consultation should be appropriate) and the need for more training on elder abuse for the staff of a FJC.

Table 42 – Inter-sectoral consultation like in Family Justice Centers

Statements	Acceptable	Not acceptable	No response
17. After they have been set up, the structures for intersectoral case consultations (such as Family Justice Center) should...			
a) also accept requests for help from professionals in the care and assistance sector	83.87% (n= 26)	16.13% (n= 5)	n= 7
b) be reserved for complex cases (multiple problems) of abuse. They should forward the less complex cases to the competent services.	82.76% (n= 24)	17.24% (n= 5)	n= 9
c) ensuring that the agreed aid measures for the older person have been implemented and checking that they are having an impact (case management)	96.55% (n= 28)	3.45% (n= 1)	n= 9
d) organising the training of care and assistance workers within their geographical area (judicial district)	79.31% (n= 23)	20.69% (n= 6)	n= 9

Key points regarding the inter-sectoral consultation

- **An overall agreement was found on the need of more availability of legal information and on a clearer and more expanded legal frame for which professional secret could be lift, on the presence of inter-sectoral structures or pathways (0% of non-acceptability) and on a more specific role for FJC through supervision of complex cases.**
- **Potential bottlenecks were the shortness of the opening hours of the organisations which hold the legal information and the risk to skip elder consent with an expanded legal frame, and the lack of a clear definition of a complex case.**
- **Remaining question: who will do the control of the effectiveness of the follow-up in a inter-sectoral pathway approach?**
- **The agreement on the feasibility was bit lower**
- **Additional condition for implementation were the need for more training on elder abuse for the staff of a FJC**

5.6 Decisional autonomy

5.6.1 Decisional autonomy of the elder

In the following three statements it was suggested that in all cases of abuse the different possible interventions should be discussed with the elder (stat 18a), with the family or representatives (stat 18b) and that the professional should wonder whether the will or the interest of the elder prevails (stat 18c).

The high percentages on acceptability underline the importance that the stakeholders gave to the decisional autonomy and the involvement of the elder (see Table 43). The feasibility of these statements was questioned by some stakeholders in the open comments, mostly related to lack of time by the professional for the discussion with the elder and the family, or lack of training of primary care professionals. Also the principle of open discussion with the elder is questioned in cases in which the elder is disoriented for example. Systematically consulting the family can also be hampered by the suspicion that the author of the abuse is one of the family members.

Table 43 – Decisional autonomy of the elder

Statements		Acceptable	Not acceptable	No response
18. In all cases of abuse, one must...				
a)	discuss the different possible interventions with the older person	100% (n=35)	0% (n= 0)	n= 3
b)	consult with the family, trusted representative/legal representative/administrator of the older person	93.75% (n=30)	6.25% (n= 2)	n= 6
c)	wonder whether the will of the older person or his interest prevails	97.06% (n= 33)	2.94% (n= 1)	n= 4

5.6.2 Conditions for non-respect to the will of the elder

In the following statements four conditions related to the assessment of the decisional autonomy and the non-respect to the will of the elder, were suggested:

- A systematic assessment of the conditions as determined in art 422bis (person in acute and real danger) (stat 19a)
- Assessment of the vulnerability, the decisional autonomy and the functional independence of the elder (stat 19b)
- An ethical reflexion on the remaining capabilities of the elder between professionals from primary and secondary care (stat 19c)
- Multidisciplinary ethical discussions organised by integrated primary care structures (Zorgraden van eerste lijn zones and SISDs) (stat 19d)

Stakeholders mainly accepted the first three conditions, whereas for the last condition less consensus could be found on the acceptability that integrated primary care structures organised these multidisciplinary ethical discussions (see Table 44). The comments could clarify the reluctance to the set-up of such multidisciplinary ethical discussions: the practical set-up of these multidisciplinary discussions was criticised referring to time restraints, need for additional funding and a suggestion was made not to restrict the role of organiser of such meetings to the primary care structures and that additional training should be provided to guide such ethical discussions. Within the comments formulated by the stakeholders who did not accept this statement on multidisciplinary discussions, it was mentioned that there is more need for an individualised, person-centred approach rather than large group discussions.

The assessment of the vulnerability of an elder person could also depend on the profile of the assessor (which professional profile, informal caregiver or more neutral) and requires insights in the lifecycle of the elder.

A subanalysis was made on the potential difference between Dutch- or French-speaking stakeholders on the statement about the role of the primary care structures (GDT or eerstelijnszones in Flanders and the SISDs in Wallonia) for the organisation of multidisciplinary ethical discussions. Within the 17 stakeholders who accepted this statement, the majority were Dutch-speaking (n=12 versus n=5), whereas in the group who did not accept this statement, most of them were French-speaking (n=6 versus n=2). In the group of non-responders a fairly equal distribution was found (n=5 Dutch-speaking versus n=7 French-speaking). Based on this rough analysis and without further information about the reasons for non-response, a preference could be identified for this statement by the Dutch-speaking stakeholders compared to the French-speaking stakeholders.

Table 44 – Conditions for non-respect to the will of the elder

Statements	Acceptable	Not acceptable	No response
19. Several steps will be necessary to decide whether an older person should be protected anyway, even against his will...			
a) systematically questioning whether the conditions laid down in Article 422a (obligation to provide assistance in the event of serious and real danger) or the state of emergency (possibility of disregarding professional secrecy in the event of serious, actual and certain danger) are met so that the necessary assistance can be organised	93.94% (n=31)	6.06% (n= 2)	n= 5
b) assess the vulnerability, decision-making autonomy and functional independence of the older person.	97.06% (n=33)	2.94% (n= 1)	n= 4
c) holding an ethical reflection with the professionals from the first and second line on the older person's residual capacities: what to do in his place, what to support him in and what he can still assess for himself.	96.77% (n=30)	3.23% (n= 1)	n= 7
d) The SISD (Integrated Home Care Services - service intégré de soins à domicile) or the Health Care Councils of the first-line zones (eerste lijn zones) should organise meetings around such multidisciplinary ethical discussions.	68% (n=17)	32% (n= 8)	n= 3

Key points regarding decisional autonomy

- **The stakeholders gave high importance to the decisional autonomy and the involvement of the elder (if he is able) and an individualized, elder-centred approach.**
- **An overall agreement was found on the acceptability of ethical reflexion, assessment of danger and of elder capability, preferably by more than one carer.**
- **Potential bottlenecks of an evaluation of the decisional autonomy were the lack of time and training of primary care professionals to discuss.**
- **Remaining question: who will organise ethical reflexion? (depends probably of the settings….)**

5.7 Training

5.7.1 Training for police and justice

All respondents agreed on the need for specific trainings for police and justice regarding elder abuse and the management of it (see Table 45). Within the few comments formulated by the stakeholders, following additions were found: the specialised organisations could guide these trainings and such trainings should also be accessible for other publics, such as psychosocial workers, administrators of property and person, organisations for the elder, etc.

One of the stakeholders preferred to integrate the specific training on elder abuse in the training package on intrafamiliar violence.

Table 45 – Training for police and justice

Statements	Acceptable	Not acceptable	No response
20. The training centres for police and justice (prosecutors, justice of the peace, ...) must organise specific training ...			
a) about notions of elder abuse(s)	100% (n=31)	0% (n= 0)	n= 7
b) on repressive and non-repressive measures in case of abuse	100% (n=31)	0% (n= 0)	n= 7
c) on notions of a vulnerable person, abuse of the weak condition of persons and incapacitated persons	100% (n=30)	0% (n= 0)	n= 8
d) on the obligation to provide assistance (Article 422a of the Penal Code)	100% (n=30)	0% (n= 0)	n= 8
e) on the existence of a plan of approach to (suspected) elder abuse(s)	100% (n= 32)	0% (n= 0)	n= 6

5.7.2 Training for assistance and care professionals

The need for training on elder abuse was already mentioned in the interviews (see Chapter 7, the first lime survey (see Chapter 6) and during the stakeholders meeting (see section 4.2) and was confirmed in this online survey, with the vast majority of the respondents accepting the suggested statements related to a specific training for assistance and care professionals (see Table 46).

Not every respondents who indicated that a statement was not feasible or left the answer open, clarified his choice in the open question, therefore the interpretation of the data is restricted to the given comments. A respondent insist on the importance of training saying it is “necessary and useful”.

The stakeholders suggested to integrate the training on elder abuse in the basic training or in the continuing education for reference persons, to add also art 458bis to the content (because a lot of professionals lack of knowledge about this regulation) and to give a leading role to the specialised organisations for the guidance of these trainings.

Table 46 – Training for care professionals

Statements	Acceptable	Not acceptable	No response
21. Any professional involved in the care of the elderly should...			
a. receive training on the characteristics of older people (geriatrics and gerontology course)	96.88% (n=31)	3.13% (n= 1)	n= 6
b. receive training on notions of abuse	100% (n=32)	0% (n= 0)	n= 6
c. know that there is a plan of action in case of (suspected) elder abuse(s)	100% (n=31)	0% (n= 0)	n= 7
d. be aware of the obligation to provide assistance (Article 422bis of the Penal Code)	100% (n=30)	0% (n= 0)	n= 8
e. have notions about the legal concepts of a vulnerable person, abuse of the weak condition of persons and incapacitated persons	100% (n=32)	0% (n= 0)	n= 6

5.7.3 Practical aspects related to the training for care professionals

The following statements are focused on the practical aspects of the training for assistance and care professionals: integrated in basic training (stat 22a), regularly refreshed in further trainings (stat 22b), accompanied by an increased number of subsidised training (stat 22c) and the training itself should include detection and management of elder abuse (stat 22d). Data show that there is not much discussion about the acceptability and feasibility of the statements (see Table 47). Stakeholders confirmed in their comments that the training on elder abuse should be included in the continuing training and that more hours of subsidised training are needed. A suggestion was made to include also a permanent consultation between the different policy levels in accordance to their respective competences. A respondent suggested increasing the hours of training (subject to acceptability by physicians) since the physician accreditation system does not define the content of the training taken, which may therefore be totally undiversified.

Table 47 – Practical aspects related to the training for care professionals

Statements	Acceptable	Not acceptable	No response
22. The training of assistance and care providers on elder abuse(s) must...			
f. be included in basic training	94.12% (n=32)	5.88% (n= 2)	n= 4
g. be regularly refreshed in further training	100% (n=31)	0% (n= 0)	n= 7
h. made possible by an increase in the number of hours of subsidised training	96.43% (n=27)	3.57% (n= 1)	n= 10
i. include the identification of a case of abuse and the plan of action	100% (n=31)	0% (n= 0)	n= 7

5.7.4 *Principles of continuing education on elder abuse*

Very high percentages for acceptability were found for all six suggested statements related to the principles of continuing education (see Table 48). The percentages for feasibility were lower, probably due to respondents who did not assessed the feasibility. Not every respondent who did not agree on the acceptability or on the feasibility clarified his choice.

A suggestion was made to expand the role of the reference person (stat 23e) as a teacher to the specialised organisations, such as VLOCO with the argument that reference persons are more linked to care settings whereas the specialised organisations can cover geographical areas. Also more funding for the role of the reference person seemed necessary.

One of the stakeholders suggested to change the supervision on the field (stat 23d) to a support by distance (by phone for example) in order not to be perceived as intrusive in the trust relationship between the professional and the elder.

Table 48 – Principles of continuing education on elder abuse

Statements	Acceptable	Not acceptable	No response
23. Continuing education on elder abuse(s) must follow the following principles...			
a) fit within a common project between care providers and their management	86.67% (n=26)	13.33% (n= 4)	n= 8
b) be supported with logistical resources to put what has been learned into practice	100% (n=29)	0% (n= 0)	n= 9
c) bring together a multidisciplinary (doctors, nurses, social workers, managers, etc.) and multi-sectoral (police officer, justice of the peace, ambulance operator, health care professional, etc.) audience.	100% (n=31)	0% (n= 0)	n= 7
d) combining online tools, workshops and practical support (supervision in the field)	100% (n=29)	0% (n= 0)	n= 9
e) given by an external teacher (the reference person for the geographical area) at the workplace	90.63% (n=29)	9.38% (n= 3)	n= 6
f) be free of charge through financing by the competent authorities	93.33% (n=28)	6.67% (n=2)	n= 8

Key points regarding the training of professionals

- **A full agreement was found on the need of the training of the police and justice SH, preferably in line with intra-familial violence training. A same degree of acceptability was found for the training of care and assistance professionals in basic and continuing cursus, as well as on the role of the specialized organisations in the delivery of those training. The importance of legal notion and of practical skills are highlighted.**
- **Potential bottlenecks of onsite continuing training were the width of the zone to cover by specialised organisations, the risk of an intrusiveness feeling and the lack of funding of reference person within care and assistance structures.**
- **Additional conditions for implementation were for continuing training that specialised organisations train reference persons for which the position should be first funded**

5.8 Awareness

5.8.1 Aims of awareness

A similar tendency is observed between the discussions during the stakeholders meeting and the responses to this online survey: all stakeholders agreed on the need for more awareness about elder abuse, but less agreement was found on the content or the target group of such awareness campaigns (for example targeting a general public or rather oriented towards a specific group) (see next sections and Table 49).

In the open comments the stakeholders nuanced their responses: one stakeholder did not answer on the acceptability and feasibility because he/she was not convinced that awareness campaigns as stand-alone are effective and often not reach the target public. This is in contrast with other stakeholders who mentioned that sensitization is highly necessary, but should be oriented towards specific target publics. Another stakeholder warned for the risk for overload for information and recommended that the awareness campaign should lead the person to a centralised point of information (a unique phone number, website, etc.) where all additional information could be retrieved. A distinction should also be made between awareness campaigns (with a simple message) and training (with more information and nuance). A suggestion was made to incorporate the awareness about elder abuse in the handbooks of currently existing trainings (e.g. reference person in palliative care/dementia/ethics/…).

Table 49 – Aims of awareness

Statements	Acceptable	Not acceptable	No response
24. Awareness-raising campaigns should...			
a) address the phenomenon of abuse and age discrimination	100% (n=29)	0% (n=0)	n= 9
b) allowing a better assessment of abuse and its approach	100% (n=31)	0% (n=0)	n= 7
c) explaining the differences in approach between specialised organisations and the judiciary (aimed at mediation and/or punishment)	87.88% (n=29)	12.12% (n=4)	n= 5
d) provide information about the central contact point	93.75% (n=30)	6.25% (n=2)	n= 6
e) informing on the need for multidisciplinary and inter-sectoral consultation in the majority of cases of (suspected) abuse	86.67% (n=26)	13.33% (n=4)	n= 8

5.8.2 Target public for awareness campaigns

In this block of statement the acceptability of different target publics, such as the policymakers (stat 25a), the professionals (stat 25b), the general public (stat 25c) and the young public (stat 25d), was examined. The results show a high degree of acceptability for all of the four target publics, with a slight higher preference for the professionals and the general public (this interpretation was made on the higher percentages on acceptability) (see Table 50).

A similar comment as in the previous section was given on the ineffectiveness of awareness campaigns as stand-alone initiative. Other comments emphasised the need to repeat regularly the awareness campaigns (e.g. minimal once per year), to use also social media, and to orient mainly towards the general public and the young public in schools. A suggestion was made that the campaigns should also focus on future care/social/educational professionals.

Table 50 – Target public for awareness campaigns

Statements	Acceptable	Not acceptable	No response
25. Awareness-raising campaigns should focus on...			
a) policymakers, who should make it a priority	83.33% (n=25)	16.67% (n=5)	n= 8
b) the professionals in the field so that they are constantly reminded of what they have seen in continuing training	100% (n=31)	0% (n=0)	n= 7
c) the general public, in order to be able to better assess situations of abuse and to be better aware of the differences in approach	96.77% (n=30)	3.23% (n=1)	n= 7
d) the young public in schools, to improve the social view of older people	83.87% (n=26)	16.13% (n=5)	n= 7

5.8.3 Types of awareness

Compared to the previous blocks of statements related to awareness, lower percentages were found for acceptability of the types of support to awareness actions, such as the national plan against violence (stat 26a), the national security plan (stat 26b), television campaigns (stat 26c), prevention plan (stat 26d) (see Table 51).

The few comments that were mentioned by the stakeholders were related to the inclusion of elder abuse in the current existing plans. Elder abuse occurs not only in the family situation, therefore only including it as part of the plan on intra-family violence seemed a shortage. Another stakeholder mentioned the overshooting by including elder abuse in the national security plan, because elder abuse is often not-intentional violence and more psychological abuse due to derailed care, related to an overburden of the caregiver and to intergenerational conflicts. Prevention is currently already a regional competence, therefore a stakeholder mentioned that a prevention

campaign should be initiated on regional level (Flanders, Wallonia) and further elaborated per area.

Table 51 – Types of awareness

Statements	Acceptable	Not acceptable	No response
26. Raising awareness about abuse and the fight against them must be supported by...			
a) to include the issue in the next version of the national plan against all forms of gender-based violence	77.78% (n=21)	22.22% (n=6)	n= 11
b) explicitly mention it as part of the National Security Plan (and not indirectly as part of intra-family violence)	88.89% (n=24)	11.11% (n=3)	n= 11
c) the financing of television campaigns at regular intervals by the competent authorities	88.89% (n=24)	11.11% (n=3)	n= 11
d) the drawing up of a prevention plan for each zone, by local (governmental and judicial) institutions, specialised organisations and first-line zones/SISD	92.59% (n=25)	7.41% (n=2)	n= 11

Key points regarding the awareness about EA

- **All stakeholders agreed on the need for more awareness about elder abuse, but less agreement was found on the content or the target group of such awareness campaigns. Larger support of awareness campaigns could be done through prevention plans.**
- **An overall agreement was found on the acceptability**

5.9 Quality of care

5.9.1 Actions for the quality of care

Thirteen actions to improve the quality of care for the elder were proposed to the stakeholders (see Table 52 stat 27a-m). High percentages for acceptability were found for most of the statements, except for two: making the results of the control visits publicly available (stat 27c); and the set-up of a backpack financing in which the elder chooses himself how to manage his care budget (stat 27f) (see Table 52). The percentages for feasibility were much lower, potentially indicating that the respondents agreed on the acceptability of the statement but found it more difficult to estimate the feasibility of these statements in their work setting (see the relative high scores of the blank responses in Table 52).

Some general comments, mostly reflecting scepticism of the respondents, mentioned that if these actions should be executed on a voluntary basis, it would be less effective. Another stakeholder expressed his frustration that anonymous complaints, given by disappointed professionals, are submitted to the control agencies and this hamper the set-up of good practices and the sharing of common values. Another comment indicated that currently several quality charters exist already but often not applied in practice, therefore the stakeholder suggest that several actors of the field and elder persons should be involved in the development of such a quality charter. In line, it was mentioned that charters or meetings should be linked to concrete actions and the care settings should be evaluated on the basis of these actions (stat 27l) Next to the training of the care professionals, the managers and direction should also (obligatory) gain knowledge about elder abuse (stat 27j).

Next to openly discussing cases of elder abuse (stat 27m), one of the stakeholders indicated that elder persons and/or their representatives should be integrated in the discussions or decisions.

One of the stakeholders mentioned also that a coordination of the different actions is needed and that it is necessary to highlight good practices.

As highlighted by one respondent, currently, the evaluation of the quality of care differs between the regions due to the federated organisation of elder care in Belgium. For example, a Dutch-speaking respondent explained that measurement of "quality of life" indicators (stat 27a) is already carried out in Flemish nursing homes. It is also the case for the public accessibility of the control visit's results, already in place in Flanders.

We looked at potentially regional differences for one of the statements in which no overall agreement could be found on the acceptability of the latter (the statement on making the results of control visits publicly accessible). Within the 16 stakeholders who accepted the statement, a relatively equal distribution was fond between the Dutch- or French-speaking respondents (n=7 versus n=9). Within the 8 stakeholders who did not accept this statement, even a more equal distribution was found with 4 Dutch-speaking and 4 French-speaking respondents. More Dutch-speaking stakeholders did not answer on this statement (n=9 versus n=4). Nevertheless this kind of publicly accessible data is already implemented in Flanders and not (yet) in Wallonia, no major differences in perception between Dutch- or French-speaking persons could be found. The higher number of Dutch-speaking non-responders cannot be explained without further details on the reason why no answer was provided on the question.

A suggestion to improve the quality of care, i.e. improvement of the work conditions for the care professionals, was already mentioned in the stakeholders meeting and was repeated in the open comments.

Table 52 – Actions for the quality of care

Statements	Acceptable	Not acceptable	No response
27. A large number of actions would improve the quality of care and assistance for the elderly, namely...			
a) add quality of life criteria to the accreditation standards	100% (n=26)	0% (n=0)	n= 12
b) verification of compliance with standards during unannounced visits	80.77% (n=21)	19.23% (n=5)	n= 11
c) the publication of the results of the monitoring visits	66.67% (n=16)	33.33% (n=8)	n= 14
d) requiring the reporting of indicators relating to the risk of abuse (staff turnover, staff incapacity for work, adverse events affecting older people or their families, suicide attempts, etc.).	83.33% (n=20)	16.67% (n=4)	n= 14
e) measuring the satisfaction of the elderly	92.86% (n=26)	7.14% (n=2)	n= 10
f) setting up a "backpack" financing system whereby each elderly person manages his or her own budget for care and assistance	70.59% (n=12)	29.41% (n=5)	n= 21
g) the inclusion of improvements to the independence and autonomy of the older person in the criteria for funding	86.96% (n=20)	13.04% (n=3)	n= 13

h)	introducing a learning culture, such as in hospitals, where an internal system of consultation is set up to discuss mistakes	95.55% (n=28)	3.45% (n=1)	n= 9
i)	the development and follow-up of practical guidelines concerning (pharmacological and physical) fixation measures	100% (n=29)	0% (n=0)	n= 9
j)	linking any training of staff on mis(er) conduct to organisational measures, supported by management	100% (n=28)	0% (n= 0)	n= 10
k)	drawing up a charter of good practice, bringing a positive message and involving staff, in order to improve compliance with this charter	92.86% (n=26)	7.14% (n=2)	n= 10
l)	linking the drawing up of a quality manual to organisational measures, which are supported by the management for their elaboration	96.67% (n=29)	3.33% (n=1)	n= 8
m)	openly discussing cases of abuse within the team and with the older person and his entourage.	100% (n=28)	0% (n=0)	n= 10

5.9.2 Support for professional and informal caregivers

An aspect within the detection and management of elder abuse that was often repeated by the stakeholders during previous questionnaires, interviews and meetings, was the need for support for the professional caregiver and for the informal caregiver. And more specifically the lack of staff and the lack of training for the professional caregivers, lead to the formulation of the second statement (next to the specific statements on training (see previous section on training)) in which is stated that the profession of the healthcare assistant and the nurse should be strongly revalued and initiatives should be set-up to make these professions more attractive for current and future professionals (stat 29). There was no discussion about this statement, all respondents agreed on the acceptability of this statement (see Table 53). All the comments were in favour of this statement, nevertheless a respondent highlighted that, despite budget restraints, all care professions should be revalorised. Older people have to suffer the negative consequences of the undervaluing of care staff and they cannot defend themselves. Another stakeholder suggested to add to the statement: … and made much more attractive 'to take care of elder persons'.

An overall agreement on the acceptability was also found for the statement on the need for support for the informal caregivers (stat 28) (see Table 53). The Scandinavian model was suggested in the statement.

Table 53 – Support for informal caregivers

Statements	Acceptable	Not acceptable	No response
28. Governments need to invest in supporting informal carers. The Scandinavian models can serve as a model for this.	100% (n=28)	0% (n=0)	n= 10
29. The profession of health assistant and nurse needs to be strongly revalued and made much more attractive.	100% (n=32)	0% (n=0)	n= 6

Key points regarding the quality of care

- **An overall agreement was found on the acceptability on a higher support to and revaluation of formal and informal caregivers. Other suggestions to improve the quality of care were also well supported by respondents with few concerns like adding quality of life criteria in accreditation process, using guidelines on fixation measures, associating any training with practical changes supported by management and setting-up open discussion about EA situation with all concerned protagonists.**
- **Potential limitation of the analysis could exist in the misunderstanding of examples given in two statements.**
- **Controversial comments are expressed on the effectiveness of charter and its voluntary application.**
- **Conditions for improvement were a better highlighting of the good practices in the same mind about the revaluation of elders caregivers work.**

5.10 Detection tools

Four statements were formulated based on the findings of the overview of detection tools (see Chapter 5). Also the potential need for detection tools was emphasized by the majority of stakeholders in previous questionnaires, interviews and meetings. A gradual approach can be seen in the statements (the results on acceptability can be found in Table 54):

- A more general statement emphasising the need for detection tools for clinical practice (stat 30): a 100% agreement on the acceptability and almost everyone agreed on the feasibility;
- A first step in the detection of elder abuse is the risk assessment of urgent danger for the elder (stat 31). In case of no imminent danger, the assessment of the elder can be multidisciplinary discussed and a team decision can be taken on the further management: a 100% agreement on the acceptability and almost everyone agreed on the feasibility;
- A single detection tool is not sufficient for the comprehensive assessment of the situation of the elder, therefore a set of tools is needed with more general, quick tools and more detailed, specific tools (stat 32). The professional can then choose which tool is the most suitable for the situation. A high percentage of agreement was found on acceptability. Some remarks were formulated regarding the (non) added value of a toolbox: the stakeholder preferred the selection of one or two detection tools and make it obligatory to use them (eventually to include them in the BelRAI) Another stakeholder mentioned the existing meldcode for physicians, developed by the Instituut voor Gelijkheid van Vrouwen en Mannen and to adapt this for the detecftion of elder abuse, rather than to develop a new meldcode or detection system.
- A more systematic evaluation of elder persons with several risk factors (e.g. cognitive impairments, emotional instability of the caregiver, etc) was suggested (stat 33) and the majority of the stakeholders agreed on this statement. However, some objections were mentioned such as lack of (human and financial) resources, time , function valuation, overload of administrative work, which could hamper the systematic approach in the detection of elder abuse

A suggestion was made to integrate the information about the detection tools on different websites, e.g. Vlaamse Ouderenraad, WSG, Zorgnet Icuro, centres of expertise for dementia, etc. to increase the accessibility of these tools.

A more general comment was given regarding the efficacy of detection of elder abuse (by care professionals), by suggesting that specialised organisations could also have a supervisory role towards the care professionals.

Table 54 – Detection tools

Statements	Acceptable	Not acceptable	No response
30. Assistance and care professionals should have detection tools at their disposal to help them make a decision in the event of a suspicion of elder abuse(s)	100% (n=32)	0% (n=0)	n= 6
31. The detection of elder abuse(s) can be done in two steps: 1/ assess whether there is an imminent danger and, 2/ if there is no imminent danger, complete the evaluation so that the professional has sufficient elements for a team discussion and multidisciplinary decision making.	100% (n=32)	0% (n=0)	n= 6
32. A "toolbox" with the different detection tools described in the literature, covering all types of elder abuse(s), should be available to all care and assistance professionals.	96.77% (n=30)	3.23% (n=1)	n= 7
33. Each elderly person with multiple risk factors for abuse (cognitive decline of the elderly, emotional instability of the main carer, etc.) should be systematically and comprehensively evaluated.	86.67% (n=26)	13.33% (n=4)	n= 8

Key points regarding detection tools

- **An overall agreement was found on the acceptability on and of the need for detection tools in clinical practice including assessment of the danger and if appropriate, a comprehensive assessment of the situation.**
- **Potential bottlenecks of an systematic detection of abuse in high risk elders were the lack of financial, logistic and human resources**
- **Solution for implementation were: the spreading of detection tools in already existing websites and programmes (Bel RAI, dementia expertise centers…**

5.11 Reference person

5.11.1 Reference person

In elderly care, the role of a reference person has already been determined for dementia. The researchers suggested to set up a similar role for a specific reference person in elder abuse. Such a reference person has already been discussed in the stakeholders meeting with several pros and cons regarding this topic. The statements were reformulated according to these arguments. The respondents found it acceptable that such a reference person should be present in every residential care setting and should be a member of the staff (stat 34a) (see Table 55). A preference was expressed to add this function to the existing reference persons rather than to create new functions. Some objections were formulated, explaining the disagreement on the acceptability of this statement: an overload of different tasks for the same reference person by adding multiple roles (e.g. reference person for prevention, hydration, elder abuse, etc.) could induce less performance and to whom a professional or elder should go in case the reference person himself is the author of abuse. Not every organisation or care setting should dispose a reference person, a stakeholder suggested

that it would be desirable to have a reference person on site in the bigger organisations, but for the smaller organisations the reference person could be linked to the local primary care structures (eerstelijnszones).The two subsequent statements tried to determine the background of the reference person: either from the primary care zones (stat 34b) or either from specialised organisations (such as CAW, Brussels Meldpunt OMB, VLOCO, Respect Senior, Ecoute Senior, FJC, etc.) (stat 43c) (or both). The data show that the respondents preferred that a reference person should come from specialised organisations (see Table 55). One of the comments highlighted the preference to support and to promote the existing structures rather than creating new ones.

A subanalysis was made on the potential regional differences between the Dutch- or French-speaking stakeholders for the second statement (role of the primary care structures in the provision of the reference person). Due to the current differences in the organisation of these primary care structures between regions, the perception of the stakeholders could differ according to the region in which they are working. Data on this statement showed a fairly similar distribution between both languages in the group who accepted the statement (n=8 Dutch-speaking versus n=6 French-speaking), whereas in the group who did not accept the statement more French-speaking stakeholders could be retrieved (n=5 versus 3). More Dutch-speaking stakeholders did not answer to this statement (n=8 versus n=5).

Table 55 – Reference person

Statements	Acceptable	Not acceptable	No response
34. The reference person for the fight against elder abuse and to whom caregivers and carers can turn in case of (suspected) elder abuse(s), should....			
a) be present in each institution and be staff members of the institution	76.67% (n=23)	23.33% (n=7)	n= 8
b) come from the first-line zones or from the GDT/SISD	63.64% (n=14)	36.36% (n=8)	n= 16
c) come from specialised organisations (CAW, Brussels Meldpunt OMB, VLOCO, Respect Senior, Ecoute Senior, FJC, ...).	92.31% (n=24)	7.69% (n=2)	n= 12

5.11.2 Missions of a reference person

The different tasks that a reference person for elder abuse could take up, were listed up in 7 statements: the provision of permanent training (stat 35a), the establishment of a personal relationship (stat 35b), organisation of intervision meetings (stat 35c), supervision of healthcare providers (stat 35d), organisation of workshops (stat 35e), liaison with the relevant actors (stat 35f), familiarity with the legislation (stat 35g). A high percentage on the acceptability was found for all of these 7 statements (see Table 56). Some additional comments were mentioned about the conditions for implementation, such as:

- A need to guarantee the independence of the reference person by giving him sufficient resources (logistical and human resources and funding) and by the supervison of this person by external organisations.
- The fulfillment of all tasks seemed to the stakeholders, very time-consuming for one person. And in an ideal world, this person should also know the particularities of the clinical practice.
- The reference person should be in direct contact with the specialised organisations.
- The reference person should have a basic knowledge of the legislation, but should also be able to assess when to refer to a lawyer or for anonymous advice with the Prosecutor.
- One of the stakeholders disagreed on the role of supervision of healthcare providers and in his opinion this is the role of the manager, not of the reference person.

Table 56 – Missions of a reference person

Statements		Acceptable	Not acceptable	No response
35. In a defined geographical area, the reference person should...				
a)	providing permanent training on elder abuse(s)	93.10% (n=27)	6.90% (n=2)	n= 9
b)	establish a personal relationship with the caregivers during these training sessions	96.43% (n=27)	3.57% (n=1)	n= 10
c)	organise and participate in intervision meetings (= meetings between assistance and care professionals (and other relevant sectors)) in order to exchange experiences and reflect together on their professional attitude on the basis of a case study.	100% (n=30)	0% (n=0)	n= 8
d)	supervision of healthcare providers in the field	82.14% (n=23)	17.86% (n=5)	n= 10
e)	organise simulation workshops	96.30% (n=26)	3.70% (n=1)	n= 11
f)	liaising at least once a year with the relevant actors in the other sectors concerned (police, judiciary, administrators, etc.).	100% (n=30)	0% (n=0)	n= 8
g)	be familiar with the legislation on elder abuse (rules on guilty negligence, professional secrecy, etc.).	100% (n=31)	0% (n=0)	n= 7

Key points regarding reference person

- **An overall agreement was found on the acceptability of the designation of a reference person but preferably in large structure rather than all structures and from specialised organisation rather than from eerste lijn zone/SISD.**
- **Potential bottlenecks of a step-by-step plan were about the supervision role of the reference person on the providers.**
- **Conditions for implementation were: the supervision/thigh relationship of the reference person by/with specialised organisation, its financial and logistic independence, high-level knowledge of the legislation.**

5.12 Coordination and interaction during the long-term management of elder abuse

In previous questionnaires and interviews, the stakeholders mentioned the need for involvement of all concerned professionals for the management of a case of elder abuse. A collaboration between different professionals and across different sectors requires a mutual agreement on who will coordinate this multidisciplinary approach. In the three following statements, some suggestions were made towards the stakeholders (the results on acceptability and feasibility are presented in Table 57):

- The planification of the interventions should be made by both the professionals from primary and secondary line (including the care sector, police, justice and specialised organisations) and by the elder (and his entourage) (stat 36a): the majority of the stakeholders agreed on the acceptability and feasibility of this statement;
- All professionals from primary line should be involved in the set-up of the interventions and/or coordination should be foreseen (stat 36b): full agreement on the acceptability was found for this statement;

- In case of more complex situations or ongoing problems despite adequate psychosocial care, the professionals should have the possibility to contact a Family Justice Center or a similar structure for a new risk assessment and a new inter-sector approach (stat 36c): full agreement on the acceptability and feasibility was found for this statement.

One of the stakeholders emphasised the coordinating role of primary care and secondary line should have an advisory/supportive role for primary care. However, somebody else mentioned that the professionals from primary care are not always sufficiently available and that in practice often the severity of the case will determine which actors are involved. Whereas another stakeholder was more convinced of the decisional autonomy of the elder, in which the elder himself chooses which professional is the most suitable for the coordination of the management of his abuse.

A suggestion was made by one of the stakeholders to add the specialised organisations in these statements, as they play an important role in the detection and management of elder abuse.

Table 57 – Coordination and interaction during the management of elder abuse

Statements	Acceptable	Not acceptable	No response
36. The measures to be taken must involve first-line workers (assistance and care professionals and/or police officers), second-line workers (specialised organisations and/or the Public Prosecutor's Office) and the older person and his entourage.	80% (n=20)	20% (n=5)	n= 13
37. The first-line professional(s), who are close to the older state, should be involved in the implementation of interventions and/or coordinate the care and assistance.	100% (n=27)	0% (n=0)	n= 11
38. If, despite adequate psychosocial care (=complex case), there are still problems, professionals should be able to contact a Family Justice Center (FJC) or similar structure, for a new risk assessment and a new intersectoral approach.	100% (n=28)	0% (n=0)	n= 10

Key points regarding coordination and interaction during the long-term management

- **An overall agreement was found on the acceptability of the involvement of first line caregivers in the intervention plan in addition to specilaised organisation, and of the necessity to have inter-sector structures (FJC) for complex cases.**
- **Conditions for implementation were: the elderly could choose who is the most appropriate to coordinate the intervention plan.**

6 CONCLUSION

6.1 Complying with the obligation to follow a step-by-step plan in case of suspected abuse

The results of the experts and specialised SH consultation allow to conclude that field stakeholders could agree with the obligation to follow a step-by-step plan in response to a suspicion of EA but under several condition: first, a prioritization of the elder abuse issue by the competent authorities through the reinforcement of the existing specialised structures and the development of a global national policy of prevention; second, an adaptation of the legislation about the professional secrecy in the aim to facilitate the collaboration and the exchange of data between the health, assistance, justice and police sectors; third, the respect of the adulthood status of older person; and fourth, the necessity to have specific competency to engage in constructive discussions with victims, authors and families. This point requires an increased availability of the specialised organisations providing quality management of EA. Stakeholders highlight the risk of administrative burden and of breaking the relationship of trust with the older person when complying with the obligation to follow a step-by-step plan. The stakeholders could also agree with a reporting of the abuse without the older people consent in case of a definite and severe criminal offense or a definite and severe danger for the older person. Some concerns of feasibility were expressed by stakeholders regarding the need of more funding, of more human resources, of more time for professionals to handle a step-by-step plan and for an adaptation of the tool to the clinical practice. Even if a large majority of the questioned stakeholders (>90%) agree with a procedure to response to a suspicion of EA, few of the questioned stakeholders call for only a case by case assessment.

6.2 Centralised contact point in case of elder abuse

An agreement emerges on the principles of a centralised contact point. The type of structure which should take this role, between a new unique EA hotline, the current lines 106, 107 or 1712, the lines of specialised organisations (VLOCO, RS, ES) or a new type of structure like the Family Justice Centre, is less clear. According to some stakeholders, an explanation was given to differences in opinion. Indeed, in Flanders, financial restrictions led to a minimal specialised service provided by VLOCO and were followed by a political decision to gather all types of violence in a centralised contact point (1712), while in the French-speaking community, specialised organisations, such as “écoute seniors” and “respect seniors” were further elaborated. However, FJC seem less favoured to take the role of contact point and a preference seems go to lines of specialised organisations. Some argument to support these opinions are the importance given by some participants to the anonymity, the wish to avoid a common contact point with all types of violence and to avoid the creation of a new structure were several times expressed.

On the feasibility, stakeholders state the following shortcomings: (i) the impossibility to quickly evaluate a complex situations such as every EA case, (ii) the risk to repeat referrals and the related difficulty to preserve anonymity; and (iii) the risk to miss a rich discussion with the caregivers of the older person. Then, several conditions to a successful implementation of a unique entrance point were suggested by participants to the consultation: (i) the possibility to take the pace of the older person, (ii) the necessity to hire sufficient staff with expertise, (iii) the necessity to provide enough logistic and financial support, (iv) the enlargement of openings hours, and (v) the further collaboration with proximity caregivers in charge of the coordination of the long-term EA case management.

6.3 Professional secrecy and inter-sectoral concertation

An overall agreement was found among participants on the need of a clearer and more expanded legal frame around professional secrecy, and in particular when it could be lift. Participants highlight the following issues with the professional secrecy: (i) the lack of knowledge about it, (ii) the high complexity of it, (iii) the fear of professionals to be liable in case of a breach, (iv) the interpersonal variation in its interpretation, and (v) the possibility that some professionals hide behind it (to cover lazy or inappropriate behaviours).

Participants suggested and globally approved several solutions: First, a greater availability, for health and assistance professionals, of legal information by asking more often advices to lawyers and by wider opening hours of the organisations which hold the legal information. Second, the maintain/creation of inter-sectoral structures or pathways including health, assistance, justice and police sectors in which only required data to solve the case are shared and in which older people could be involved (in principle the respective elder should give consent on his/her data sharing but if it is not possible, he/she should at least be informed that data are shared amongst different actors of the concertation). Third, an adaptation of the law about the lift of the professional secrecy for less severe situations. However, some participants explained that the law about professional secrecy could not be modified. Indeed, in Flanders, the modalities of case concertation are included in a protocol agreement (Protocolakkoord) to create a uniform mode of operation amongst all actors involved in case concertation. The idea is that involved actors can share info about the abused elder but that no one is obliged to do so.

Other stakeholders highlighted the necessity to have inter-sector structures (FJC) for complex cases. Indeed, the point of view differs between the health and assistance sectors and the police and justice sectors. Health and assistance sectors should prefer that FJC focus their activities only on severe cases which require a collaboration between police, justice and assistance while the professionals of the health and care sectors would put their focus on the prevention and concertation between caregivers, families and elders. On the other side, the police and justice sectors asked for discussion with care/help sectors when they are confronted with unclear situations regarding the law or situations which are not related to an offence.

Shortcomings identified by participants about inter-sectoral concertations are: (i) taking a common decision is very complex as functioning differs a lot from one sector to another; (ii) an attempt to create a FJC failed in Brussels; and (iii) systematic inter-sector consultations will be too hard to organise. One solution could be the recent initiative from the justice sector consisting in the elaboration of a circulaire (COL) from the “Collège des Procureurs Généraux” which should include a discussion forum between magistrates and specialized organisations in EA, and the designation of referent professionals in EA in the police and justice sectors.

No participants were convinced by merging the health, assistance and judicial folders concerning older people because it will requires the patient’s agreement and it triggers a legal problem with professionals which are not submitted to professional secrecy.

6.4 Decisional autonomy and involvement of the older adult

The stakeholders give high importance to the decisional autonomy and the involvement of the elder. They insist on an individualized, elder-centred approach. Interventions to manage EA have to be decided in agreement with the older person, with respect to his/her values and after a clear explanation about the consequences (positive and negative) of each type of intervention. Care consultations between the elder, his relatives and involved professional caregiver(s) could lead to informed consent if the pace of older people is taken, a trust relationship is built, the opinion of the elder is taken into account and his/her decision is respected. The financing of those care consultations is a condition to its implementation and regional structure like ‘eerste lijn zone’ could have a role in the organisation of those care consultations. However, a major potential bottlenecks of care consultations is the lack of time, sensitization (some HCP are still too paternalistic) and training of primary care professionals to lead those discussions. Another difficulty is to obtain older people real consent because of internal barrier related to the person (cognition, mental health) and of external barrier related to the environment like the fear of retaliation.

Concerning the decisional autonomy of older person and the legal protection of them, all agree that no legal framework allow to break a person's autonomy of decision except in case of mental incapacity. So, any step-by-step plan about EA should respect the adult status of older people, even vulnerable ones. In case of mental incapacity related to a psychiatric disease, a mental disability or a cognitive disorder, an ethical reflexion is suggested by participants to determine if it is the will or the interest of the senior which is predominant. In the lime survey, an overall agreement was found on the acceptability of ethical reflexion, assessment of danger and of elder capability, preferably by more than one carer. However, participants highlighted that it is difficult and stigmatizing to establish the decisional capacity of someone. A legal representative should decide in the older person's name but before this can be done, a clarification of the legal definition of a person's representative is needed within the Belgian legislation.

The justice sector does not seem to reflect in the same way. According to magistrates involved in the SH consultation, the justice acts for the good of people but not always with their consent.

6.5 Training

A full agreement was found on the need of the training of the police and justice SH, preferably in line with intra-familial violence training.

A same degree of acceptability was found for the training of health and assistance professionals in basic and continuing cursus, as well as on the role of the specialized organisations in the delivery of those training. The importance of legal notion and of practical skills are highlighted. All agree that the training of health and assistance professionals should be a priority for managers and that it should be done on a regular basis. For the moment, regional authorities support some hours of training for nursing homes staff. According to a participant, basic training about EA issues should be delivered to a homogenous audience, while continuous training should be given to a heterogeneous audience in a more local context. Multidisciplinary and multisector training receive a good echo amongst participants but a lot of feasibility concerns were evoked as the difficulty to organise such training notably because of time constraints, and as only motivated professionals attend to training outside their place of working.

Suggested solutions by participants are training in small workshop with trainers coming on the working place, even better in the services during the care to observe and correct the mistakes. Training should be free, mandatory including for solo-professionals. Specialized organizations like VLOCO could teach the generic knowledge about EA while zonal structures like 'eerste lijn zone' could teach the local operational issues. However, potential bottlenecks about continuing training on the working place were the width of the zone to cover by specialised organisations and the risk of an intrusiveness feeling. One additional solution suggested by participants is that specialised organisations train a reference persons within large institutions. This could be only possible if the position of reference person is first created and funded.

Participants highlighted that the content of the existing training lacks information on how to start a conversation with an elder suspected to be abused and how to manage ethical reflexion and insist on a shared outcome of the training between staff and management as logistic and financial means are required to implement the knowledge into practice. A full agreement was found in the Lime Survey amongst participants about this last suggestion.

6.6 Awareness and prevention

All stakeholders agreed on the need for more awareness about elder abuse, but less agreement was found on the content or the target group of such awareness campaigns. The general public, the media, the health care professionals, the justice sector, the local authorities, children and elderly were cited as potential targets of sensitization campaigns. The content of the campaigns should be on what elder abuse is, on what good care is; on anti-ageism (elderly are valuable citizen who merit to be treated with respect); on geriatrics issues, on what to do in case of suspicion of EA; on the fact that elders autonomy is taken into account, on the importance of informal caregivers and the existence of degenerated informal care; and on law enforcement aspects.

Sensitization campaigns should be done through the media by communication specialists and after sensitization of the media professionals first (very powerful); and also by meeting older people at their home and by going in schools with clear and practical messages. The financing of television campaigns at regular intervals by the competent authorities receive a large agreement.

At the justice level, the best way to sensitize the magistrates and the police is that EA becomes a priority. This step could be reach at the national level by including EA issues in the national step-by-step plan against gender-related violence and in the national safety plan. Those suggestions received a quite good approval from respondent to the Lime Survey (more than 75%).

Larger support of awareness campaigns could be done through prevention plans which are seen by participants as a condition to any step-by-step plan. Zonal/local prevention plans receive a good agreement by participants (>90%) It was suggested in the Lime Survey that this kind of prevention plan groups the local authorities (administrative and judicial), the specialised organisations and the zonal primary care multidisciplinary structures (SISD/eerstelijnzones).

6.7 Quality of care

Participants highlighted that quality of care in residential settings does not necessarily lead to quality of life for older people. Even if all participants agree on the interest of quality of live criteria, few concerns were expressed about adding quality of life criteria in accreditation process of residential care structures. Participants explained that quality of life of residents highly depends on the quality of work and motivation of caregivers. So, they suggest to improve the attractiveness and the working conditions of professional caregivers (training, time, valuation of travel time, etc.). They precise that, in the large majority, staff knows what good care is. The opinion of some stakeholders is to better finance and staff nursing homes instead of increasing control. An overall agreement was found on a higher support to and revaluation of formal and informal caregivers. A suggested solution for revaluation is a better highlighting of the good practices of elders caregivers work.

The financing of nursing homes is considered as perverse as it stimulates managers of for-profit organisations to keep residents in a dependant state. In addition, a decrease of nursing homes subventions impaired the care to the most dependant persons. Accordingly, participants talked about EA induced by the healthcare system. They rather suggest a financing based on older people satisfaction and a system of ranking of nursing homes by the elders themselves. However, the set-up of a backpack financing in which the elder chooses himself how to manage his care budget encountered some concerns from respondents to the Lime Survey.

Controls specifically on EA does not exist. Control of residential structure done by regional inspectors is rare, does not include contact with residents and is most of the time known beforehand and prepared by managers. A quite good agreement was found between participants on verification of compliance with standards during unannounced visits (80%). Indicators of quality vary from one region to another but usually are more quantitative and administrative than qualitative. The participants suggest to avoid administrative indicators which could easily be fake, to keep architectural indicators, to control the ‘care’ aspect rather than the ‘cure’ aspect, to involve elders in the evaluation and to render the control report public. However, a part of the participants found this last proposition not acceptable (33%).

The transparency was also highlighted by the participants which suggested to lower taboo and the silence law from institutions, and to better organise open discussions between nursing home staff and management, residents and families. This proposition was fully agreed by the participants. The empowerment of staff and of older people should also be improved by developing auto-control tools of well-treatment behaviour for staff and to give the opportunity to older people to organise freelance resident committees and to allow them to take risks as a guarantee for individual freedom.

Charters in residential settings were seen as a positive trigger to well-treatment if staff and residents were involved in its development and implementation, and all people concerned by the residents’ life are sensitized to the charter. Charter, which are seen as an empowerment tool, leads however to controversial comments on the effectiveness of it and on its voluntary application. Another shortcomings is the risk of a mandatory

application of a charter decided by the management which will create a gap between the staff and the management and make disappearing the empowerment aspect.

The use of guidelines by the professionals when the question of fixation measures emerges was fully accepted by the participants.

At home, in any case, participants say that at home quality of care should not be forgotten, that lack of support to informal caregivers leads to overburden and degenerated informal care and that decrease in at home care financing will have an impact on the large majority of older people who are currently living at home.

6.8 Detection tools

An overall agreement was found on the acceptability on and of the need for detection tools in clinical practice including assessment of the danger and if appropriate, a comprehensive assessment of the situation. A solution for implementation of detection tools suggested by participants is the spreading of detection tools in already existing websites and programmes (Bel RAI, dementia expertise centres …Two examples of detection tools were given by participants: the RITI scale by the Dutch-speaking and the EASI scale by the French-speaking. However, some participants expressed that detection tools should not be necessary because having common sense and discussing in multidisciplinary meetings should be sufficient to detect elder abuse. In addition, they expressed that detection tools do not fit within a normal conversation with the older patient and they cannot capture the whole situation of abuse.

If detection tools have to be developed, they should have good sensitivity and specificity, be specific for each type of abuse, assess the risk of potential abuse by caregivers, and be short, comprehensive and based on scientific evidences.

About systematic detection of abuse in high risk elders, participants should rather favour longitudinal follow-up to systematic screening for which they highlight the difficulty to reach the very frail and isolated persons. A potential bottlenecks of a systematic detection is also the lack of financial, logistic and human resources.

6.9 Reference person

A controversy was identified between the results of the SH meeting and the Lime Survey about the presence of a referent person in residential settings. Indeed, the designation of a reference person in elder abuse does not receive the approval of participants to the SH meeting while an overall agreement was found on the acceptability of the designation of a reference person in the Lime survey. One explanation could be that in the Lime Survey some preferences were expressed as condition to the creation of this position: the reference person should preferably be present in large structure rather than in all structures and could rather come from specialised organisation rather than from eerste lijn zone/SISD. Conditions for a successful implementation of a reference person in a structure are that the financial and logistic independence of this position is guaranteed, that he/she has a high-level knowledge of the legislation, and that his/her work is done in tight relationship with a specialised organisation. A potential bottlenecks could be the acceptability of the supervision role of the reference person by the professionals caregivers and the need to have a team (of three) referent persons to provide a continuity.

An alternative to local referent person is the existence of regional referent persons which links professional caregivers with each other's.

6.10 Coordination and interaction during the management of elder abuse

An overall agreement was found on the acceptability of the involvement of first line caregivers in the intervention plan in addition to specialised organisation but a conditions for the implementation of the management is that the elderly could choose who is the most appropriate to coordinate the intervention plan. For some participants, networking and collaborations are more important than an intervention plan.

Other stakeholders highlighted the necessity to have inter-sector structures (FJC) for complex cases and there is an agreement on the need to clarify the role of FJC notably about the long-term supervision of complex cases and the definition of a complex case.

6.11 Role of eerste lijn zone and SISD

Amongst the different topics studied during the SH consultation, the role of zonal intersectoral structures like the 'eerste lijn zone' in Flanders, the 'SISD' in Wallonia and BRUSANO in Brussels –Capital region was several times questioned and a link with the regional competence on primary care organisation was deeper analysed where appropriated.

First, for the development of the step-by-step plan, it was suggested that the generic framework of this plan was then adapted by zonal structure. Although some respondent seems to be less comfortable with answering the question about the topic of zonal structures (more 'no answer' maybe related to a lack of knowledge), a large majority agrees with the proposition. A fairly equal distribution was found between Dutch-speaking and French-speaking stakeholders. So, the perception of the stakeholders seems not to differ according to the language (and probably to the structure differing from the region linked to).

Second, zonal structure could have a role in the organisation of the care consultations seeking to reach an informed consent or to lead an ethical reflexion in EA situations. Again, less participants answer the question with a mitigated opinion on this role. A subanalysis was made on the potential difference between Dutch- or French-speaking stakeholders. Based on a rough analysis and without further information about the reasons for non-response, a preference could be identified for this statement by the Dutch-speaking stakeholders compared to the French-speaking stakeholders.

Third, for the implementation of training, zonal structures could be involved in teaching the local operational issues (who is who, who can I contact etc.) to professional caregivers. Participants also thought that it will be more efficient to have zonal referents who can link professionals with each other. Indeed, zonal structures are best positioned to tune the approaches about EA between the sectors of health, well-being and welfare assistance. Moreover, participants explain that the wish for collaboration needs to come from the local actors as it is necessary to can count on the spontaneous goodwill of all partners, what is more random in official collaboration protocols. In Flanders, they pointed the first line zones (eerste lijn zone) as well positioned to take up the role to put all actors around the table to reflect on a common local policy related to EA. This role would be directly related to the suggested proposition to involve zonal structures in the development of prevention plan at the local level.

Globally, the roles suggested for the zonal structure are similar to the roles already provided by specialised organisations in Wallonia and Brussels capital region but in 'on demand' approach.

6.12 Emergency accommodation

Only few participants discussed emergency situations during the SH meeting. They explain that the possibility to ban the author should be envisaged in case of emergency and not only the ban of the abused older person. They also suggested that quick solutions for abused older persons in danger include to be hospitalized (but with his/her consent) or to be hosted by trusted family members from where a network of caregivers can be organised.

APPENDICES

CHAPTER 1: INTRODUCTION

APPENDIX 1. DEFINITION OF ELDER ABUSE IN THE LITERATURE

References	Definition of EA
Gallione, 2017[3]	The globally recognised definition of 'elder abuse' is the one adopted by WHO: a single or repeated act or lack of appropriate action, occurring within any relationship in which there is an expectation of trust, that causes harm or distress to older people
Hullick, 2017[191]	The Australian Network for the Prevention of Elder Abuse specifies that elder abuse is "any act occurring within a relationship where there is an implication of trust, which results in harm to an older person. Abuse may be physical, sexual, financial, psychological, social and/or neglect."
Namboodri, 2018[179]	Elder abuse is defined by the Centers for Disease Control and Prevention as "an intentional act, or failure to act, by a caregiver or another person in a relationship involving an expectation of trust that causes or creates a risk of harm to an older adult.
Platts-Mills, 2018[178]	Elder abuse (EA) is "an intentional act, or failure to act, by a caregiver or a person with whom there is an expectation of trust that causes or creates a risk of harm to an older adult" (Prevention, 2017)
Rosen, 2018[7]	EA encompasses behaviors or negligence againts an older adult that result in harm or the risk of harm committed by someone in relationship with an expectation of trust or when rthe victim is targeted because of age or disability
Duru, 2017[153]	Elder abuse has been 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" by the International Network for the Prevention of Elder Abuse and the World Health Organization (2
De Donder, 2018[145]	Differences of opinion on the definition of elder abuse still exist
Yi, 2019[146]	TheWHO (2002a) has defined elder abuse 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 the elderly''
Melchiorre, 2017[171]	Elder abuse has been 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"
Perez-Rojo, 2015[169]	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. It can be of various forms: physical, psychological/ emotional, sexual, or financial/material abuse, and/or intentional or unintentional neglect

Rivera-Navarro, 2018[170]	Family maltreatment in older adults is understood as any act committed by a family member that by action or omission causes physical or psychological harm to an older adult
Ruelas-Gonzales, 2018[192]	adult mistreatment 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”
Jin, 2018[193]	CDC defines elder abuse as “an intentional act or failure to act by a caregiver or another person in a relationship involving an expectation of trust that causes or creates a serious risk of harm to an older adult.
Teresi, 2019[194]	Abuse is defined as an act (or actions) and/or inaction(s) by a caretaker or a person who is in a trusted relationship with the elder, which causes intentional or unintentional harm or distress to the elder
Touza, 2018[158]	“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” AND (a) Intentional actions that cause harm or create serious risk of harm (whether or not harm is intended) to a vulnerable elder by a caregiver or other person who stands in a trust relationship to the elder or (b) failure by a caregiver to satisfy the elder’s basic needs or to protect the elder from harm
Garma, 2017[187]	Elder Abuse is a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust
Silva, 2017[188]	EA is defined as an aggression or lack of care, caused voluntarily or not.
Kamavarapu, 2017[195]	Elder Abuse is a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust
Baker, 2016[8]	According to the World Health Organization (WHO), elder abuse is defined as “a single, or repeated act, or lack of appropriate action, occurring within any relationship where thereis an expectation of trust, which causes harm or distress to an older person”
Ayalon, 2016[196]	Elder maltreatment or elder abuse is broadly defined as ‘a single or repeated act or lackof appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person’
Cadwell, 2013[197]	In this article, we use the World Health Organization’s definition: “A single, or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust that causes harm or distress to an older person.”
Cohen, 2011[198]	elder abuse is defined as “a single, or repeated act, or lack of appropriate action, occurring within any relationship where thereis an expectation of trust, which causes harm or distress to an older person”
Daly, 2011[199]	abuse 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”
Rideout, 2017[17]	“Elder abuse is a multidimensional phenomenon that encompasses a broad range of behaviours, events, and circumstances. Unlike random acts of violence or exploitation, elder abuse usually consists of repetitive instances of misconduct”

APPENDIX 2. STRENGTH OF EVIDENCE FOR THE RISK FACTORS

Table 3.1. Risk factors for elder abuse and strength of evidence for the risk factor

Level	Risk factors	Strength of evidence
Individual (victim)	Gender: female	Low–moderate
	Age: older than 74 years	Low–moderate
	Dependence: significant disability	Strong
	Poor physical health	Strong
	Mental disorders: depression	Strong
	Low income or socioeconomic status	Strong
	Financial dependence	Low–moderate
	Race	Low–moderate
	Cognitive impairment	Strong
	Social isolation	Strong
Individual (perpetrator)	Mental disorders: depression	Strong
	Substance abuse: alcohol and drug misuse	Strong
	Dependence on the abused: financial, emotional, relational	Strong
Relationship	Victim–perpetrator relationship	Low–moderate
	Living arrangement: victim lives alone with perpetrator	Strong
	Marital status	Low–moderate
Community	Geographical location: socially isolated	Low–moderate
Societal	Negative stereotypes about ageing	Insufficient data
	Cultural norms	Insufficient data

World Health Organization-WHO. World Report on Ageing and Health. 2015. Available from: https://apps.who.int/iris/bitstream/handle/10665/186463/9789240694811_eng.pdf;jsessionid=8271CB1A412F1F73DA1EAA54A2673AF2?sequence=1)

APPENDIX 3. DETAILS ON THE BELRAI

BelRAI[a] is indeed an online platform proposing scientifically validated instruments enabling an assessment of **the degree of dependency** and the care needs of individuals (not only elders). The system is currently restricted to usage by healthcare professionals and healthcare organisations, but allows the exchange of the assessments between the different providers who have the right to see information about a given patient or client because they have a care relationship with the vulnerable person.

The basis of BelRAI is a structured set of observations (by means of questionnaires) made by nurses and nursing staff (or other HCP). It covers medical, physical and social functioning, as well as individual preferences, strengths and weaknesses. All this information is stored in the personal BelRAI file, which can be shared with all the care professionals and organisations involved in the individual care plan throughout life. In this way, everyone (general practitioner, home care worker, care assistant in a service, care and housing centre, emergency doctor, etc.) is aware of the personal situation and its evolution, and each care professional can administer the care and treatment best suited to the individual needs and circumstances. This tool is freely available and its use in not mandatory.

[a] https://www.belrai.org/fr.

APPENDIX 4. EVIDENCE-BASED DATA ON ELDER ABUSE UP-DATED TILL APRIL 2020 BY THE RESEARCH CHAIR ON ELDER ABUSE, UNIVERSITY OF SHERBROOKE, QUÉBEC.

Table 58 – Maltraitance envers les aînés et problématiques connexes:Recension des articles à haut niveau de scientificité (Recension mise à jour le 22 avril 2020)

2020	
Critical review	Blundell, B., Warren, A., & Moir, E. (2020). Elder abuse protocols: identifying key features and establishing evidence for their use and effectiveness. Journal of Elder Abuse & Neglect, 32(2), 134–151.
Critical review	Burholt, V., Winter, B., Aartsen, M., Constantinou, C., Dahlberg, L., Feliciano, V., De Jong Gierveld, J., Van Regenmortel, S., & Waldegrave, C. (2020). A critical review and development of a conceptual model of exclusion from social relations for older people. European Journal of Ageing, 17(1), 3–19.
FSystematic	Chang, E.-S., Kannoth, S., Levy, S., Wang, S.-Y., Lee, J. E., & Levy, B. R. (2020). Global reach of ageism on older persons' health: A systematic review. Plos One, 15(1), e0220857.
Systematic	Marques, S., Mariano, J., Mendonça, J., De Tavernier, W., Hess, M., Naegele, L., Peixeiro, F., & Martins, D. (2020). Determinants of Ageism against Older Adults: A Systematic Review. International Journal of Environmental Research and Public Health, 17(7).
Scoping	Mercier, É., Nadeau, A., Brousseau, A.-A., Émond, M., Lowthian, J., Berthelot, S., Costa, A. P., Mowbray, F., Melady, D., Yadav, K., Nickel, C., & Cameron, P. A. (2020). Elder Abuse in the Out-of-Hospital and Emergency Department Settings: A Scoping Review. Annals Of Emergency Medicine, 75(2), 181–191.
Lit. review	Rohringer, T. J., Rosen, T. E., Lee, M. R., Sagar, P., & Murphy, K. J. (2020). Can diagnostic imaging help improve elder abuse detection? The British Journal of Radiology, 20190632
Lit. review	Storey, J. E. (2020). Risk factors for elder abuse and neglect: A review of the literature. Aggression & Violent Behavior, 50, N.PAG
Systematic	Välimäki, T., Mäki-Petäjä-Leinonen, A., & Vaismoradi, M. (2020). Abuse in the caregiving relationship between older people with memory disorders and family caregivers: A systematic review. Journal of Advanced Nursing.
2019	
Meta-analysis	Abdi, A., Tarjoman, A. & Borji, M. (2019). Prevalence of Elder Abuse in Iran: A Systematic review and meta-analysis. Asian Journal of Psychiatry, 39, 120-127.
Meta-analysis	Ayalon, L., Dolberg, P., Mikulionienė, S., Perek-Bialas, J., Rapolienė, G., Stypinska, J., Willinska, M., & de la Fuente-Nunez, V. (2019). A systematic review of existing ageism scales, Ageing Research reviews, 1-65
Meta-analysis	Burnes, D., Sheppard, Charles, C., Henderson H., Cope, R., Barber, C. & Pillemer, K. (2019). Interventions to Reduce Ageism Against Older Adults: A Systematic Review and Meta-Analysis. American Journal of Public Health, 109, e1-e9,

Systematic	Dominguez, S.F., Storey, J.E., Glorney, E. (2019). Help-seeking behavior in victims of elder abuse: A systematic review. Trauma, Violence & Abuse, 1-15
Systematic	Mileski, M., Lee, K., Bourquard, C., Cavazos, B., Dusek, K., Kimbrough, K., … McClay, R. (2019). Preventing The Abuse Of Residents With Dementia Or Alzheimer's Disease In The Long-Term Care Setting: A Systematic Review. Clinical Interventions in Aging, 14, 1797–1815.
Systematic	Mohd Mydin, F. H., Yuen, C. W., & Othman, S. (2019). The Effectiveness of Educational Intervention in Improving Primary Health-Care Service Providers' Knowledge, Identification, and Management of Elder Abuse and Neglect: A Systematic Review. Trauma, Violence & Abuse, 1524838019889359.
Systematic	Rosen, T., Elman, A., Dion, S., Delgado, D., Demetres, M., Breckman, R., … Lachs, M. S. (2019). Review of Programs to Combat Elder Mistreatment: Focus on Hospitals and Level of Resources Needed. Journal Of The American Geriatrics Society, 1-9.
Lit. review	Ryan, J., & Roman, N. V. (2019). Family-Centered Interventions for Elder Abuse: a Narrative Review. Journal of Cross-Cultural Gerontology, 34, 325-336.
Systematic	Saghafi, A. Bahramnezhad, F., Poormollamirza, A., Dagdari, A., & Navab, E. (2019). Examining the ethical challenges in managing elder abuse: a systematic review. Journal of Medical Ethics and History of Medecine, 12(7), 1-18.
Systematic	Sao José, J.M.S., Filipe Amado, C.A., Ilinca, S., Buttigieg, S.C., & Taghizadeh Larsson, A. (2019). Ageism in health care: A systematic review of operational definitions and inductive conceptualizations. The Gerontologist, 59(2), e98-e108.
Systematic	Stall, N.M., Kim, S.J., Hardcra, K.A., Shah, P.S., Straus, S.E., Bronskill, S.E., Lix, L.M., Bell, C.M. & Rochon, P.A. (2019). Association of informal caregiver distress with health outcomes of community-dwelling dementia care recipients: A systematic review. Journal of the American Geriatrics Society, 67(3), 609-617
Lit. review	Van Den Bruele, A. B., Dimachk, M., & Crandall, M. (2019). Elder Abuse. Clinics In Geriatric Medicine, 35(1), 103–113.
Scoping	Warren, A., & Blundell, B. (2019). Addressing elder abuse in rural and remote communities: social policy, prevention and responses. Journal of Elder abuse & Neglect,31(4-5), 424-436.
Meta-analysis	Yon, Y., Mikton, C., Gassoumis, Z. D., & Wilber, K. H. (2019). The Prevalence of Self-Reported Elder Abuse Among Older Women in Community Settings: A Systematic Review and Meta-Analysis. Trauma, Violence & Abuse, 20(2), 245–259.
Systematic	Yunus, R. M., Hairi, N. N. & Choo, W. Y. (2019). Consequences of Elder Abuse and Neglect: A Systematic Review of Observational Studies. Trauma, Violence & Abuse, 20(2), 197-213.
	2018
Systematic	Arab-zozani, M., Mostafazadeh, N., Arab-zozani, Z., Ghoddoosi-Nejad, D., Hassanipour, S. & Soares, J. (2018). The Prevalence of Elder Abuse and Neglect in Iran: A Systematic Review and Meta-analysis. Journal of Elder Abuse & Neglect, 30(5), 408-423.
Lit. review	Fang, B. & Yan, E. (2018). Abuse of Older Persons with Dementia: A Review of the Literature. Trauma, Violence & Abuse, 19(2), 127-147.
Systematic	Smith, D., Bugeja, L., Cunningham, N. & Ibrahim, J. E. (2018). A Systematic Review of Sexual Assaults in Nursing Homes. Gerontologist, 58(6), e369–e383.

Scoping	Warren, A., & Blundell, B. (2018). Elder abuse in rural & remote communities: Social policy, prevention and responses. Perth, WA: Curtin University and the Older Person's Advocacy Network
Meta-analysis	Yon, Y., Ramiro-Gonzalez, M., Mikton, C. R., Huber, M. & Sethi, D. (2018). The Prevalence of Elder Abuse in Institutional Settings: A Systematic Review and Meta-analysis. European Journal Of Public Health, 1-10.
	2017
Systematic	Burnes, D., Henderson, C.R., Sheppard, C., Zhao, R., Pillemer, K., & Lachs, M.S. (2017). Prevalence of financial fraud and scams among older adults in the united states: A systematic review and meta-analysis. AJPH Research, 107(8), e13-e21.
Systematic	Day, A., Boni, N., Evert, H. & Knight, T. (2017). An Assessment of Interventions that Target Risk Factors for Elder Abuse. Health & Social Care in the Community, 25(5), 1532–1541.
Systematic	Fearing, G., Sheppard, C. L., McDonald, L., Beaulieu, M. & Hitzig, S. L. (2017). A Systematic Review on Community-based Interventions for Elder Abuse and Neglect. Journal of Elder Abuse and Neglect, 29(2-3). 102-133.
Systematic	Gallione, C., Dal Molin, A., Cristina, F. B., Ferns, H., Mattioli, M. & Suardi, B. (2017). Screening Tools for Identification of Elder Abuse: A Systematic Review. Journal Of Clinical Nursing, 26(15-16), 2154-2176.
Exploratory	Garma, C. T. (2017). Influence of Health Personnel's Attitudes and Knowledge in the Detection and Reporting of Elder Abuse: An Exploratory Systematic Review. Psychosocial Intervention, 26(2), 73–91
Meta-analysis	Ho, C., Wong, H., Chiu, M. & Ho, R. (2017). Global Prevalence of Elder Abuse: A Meta-analysis and Meta-regression. East Asian Arch Psychiatry, 27, 43-55.
Systematic	Kamavarapu, Y. S., Ferriter, M., Morton, S. & Völlm, B. (2017). Institutional abuse - Characteristics of Victims, Perpetrators and Organisations: A Systematic Review. European Psychiatry, 40, 45-54.
Systematic	McCarthy, L., Campbell, S. & Penhale, B. (2017). Elder Abuse Screening Tools: A systematic review. Journal Of Adult Protection, 19(6), 368-379.
Meta-analysis	Molaei, M., Etemad, K., & Taheri Tanjani, P. (2017). Prevalence of elder abuse in Iran: A systematic review and meta analysis. Iranian Journal of Ageing, 12(2), 242–252.
Systematic	Moore, C. & Browne, C. (2017). Emerging Innovations, Best Practices, and Evidence-Based Practices in Elder Abuse and Neglect: A Review of Recent Developments in the Field. Journal Of Family Violence, 32(4), 383-397.
Meta-analysis	São José, J. M. S. de, Amado, C. A. F. & São José, J. M. S. de. (2017). On Studying Ageism in Long-Term Care: A Systematic Review of the Literature. International Psychogeriatrics, 29(3), 373–387.
Systematic	Silva, Luanderson., Souza-Silva, B., De Alcântara Rodrigues, J., Rigo, L., Cericato, G., Franco, A. & Paranhos, L. R. (2017). Identification and Management of Elder Physical Abuse in the Routine of Dentistry: A Systematic Review. Gerodontology, 34, 3-12.
Meta-analysis	Yon, Y., Mikton, C., Gassoumis, Z. & Wilber, K. (2017a). Elder abuse Prevalence in Community Settings: A Systematic Review and Meta-analysis. The Lancet, 5, e147-e156.

Meta-analysis	Yon, Y., Mikton, C., Gassoumis, Z. D. & Wilber, K. H. (2017c). The Prevalence of Self-Reported Elder Abuse Among Older Women in Community Settings: A Systematic Review and Meta-Analysis. Trauma, Violence & Abuse, 1-15.
Systematic	Yunus, R. M., Hairi, N. N. & Choo, W. Y. (2017). Consequences of Elder Abuse and Neglect: A Systematic Review of Observational Studies. Trauma, Violence & Abuse, 1-17.
	2016
Meta-analysis	Ayalon, L., Lev, S., Green, O. & Nevo, U. (2016). A Systematic Review and Meta-analysis of Interventions Designed to Prevent or Stop Elder Maltreatment. Age and Ageing, 0, 1–12.
Systematic	Baker, P. R. A., Francis, D. P., Hairi, N. N., Othman, S. & Choo, W. (2016). Interventions for Preventing Abuse in the Elderly. The Cochrane Database of Systematic Review, 8, 1-125.
Systematic	Hirst, S. P., Penney, T., McNeill, S., Boscart, V. M., Podnieks, E. & Sinha, S. K. (2016). Best-Practice Guideline on the Prevention of Abuse and Neglect of Older Adults. La Revue Canadienne Du Vieillissement, 35(2), 242-260.
Systematic	Jackson, S. L. (2016). A Systematic Review of Financial Exploitation Measures in Prevalence Studies. Journal of Applied Gerontology, 1-39.
	2015
Systematic	Dong, X. (2015). Elder abuse: Systematic Review and Implications for Practice. Journal of the American Geriatrics Society, 63(6), 1214-1238.
Systematic	Ferrah, N., Murphy, B., Ibrahim, J. E., Bugeja, L. C., Winbolt, M., Logiudice, D., & ... Ranson, D. L. (2015). Resident-to-Resident Physical Aggression leading to Injury in Nursing Homes: A Systematic Review. Age & Ageing, 44(3), 356-364.
Systematic	Hutchison, A. & Stenfert Kroese, B. (2015). A Review of Literature Exploring the Possible Causes of Abuse and Neglect in Adult Residential Care. Journal of Adult Protection, 17(4), 216–233.
Systematic	Killick, C., Taylor, B. J., Begley, E., Carter Anand, J. & O'Brien, M. (2015). Older People's Conceptualization of Abuse: A Systematic Review. Journal of Elder Abuse and Neglect, 27(2), 100-120.
Scoping	Malmedal, W., Iversen, M. H. & Kilvik, A. (2015). Sexual Abuse of Older Nursing Home Residents: A literature Review. Nursing Research and Practice, 1-7.
Scoping	McDonald, L., Sheppard, C., Hitzig, S.L., Spalter, T., Mathur, A., * Singh Mukhi, J. (2015). Resident-to-resident abuse: A scoping review. Canadian Journal on Aging, 34(2), 215-236.
Systematic	Wang, M. S., Kang, S.-W. & Schiamberg, L. B. (2015). Ecological Factors Associated with Elder Abuse in Taiwan: A Systematic Review. Asia Pacific Journal of Social Work and Development, 25(1), 13-28.

Systematic	Yan, E., Chan, K.-L. & Tiwari, A. (2015). A Systematic Review of Prevalence and Risk Factors for Elder Abuse in Asia. Trauma, Violence and Abuse, 16(2), 199-219.
	2014
Lit. review	Ernst, J. S., Ramsey-Klawsnik, H., Schillerstrom, J. E., Dayton, C., Mixson, P & Counihan, M. (2014). Informing Evidence-Based Practice: A Review of Research Analyzing Adult Protective Services Data. Journal of Elder Abuse & Neglect, 26(5), 458–494.
Systematic	Finfgeld-Connett, D. (2014). Intimate Partner Abuse Among Older Women: Qualitative Systematic Review. Clinical Nursing Research, 23(6), 664-683.
	2013
Systematic	Dong, X., Chen, R., Chang, E.-S. & Simon, M. (2013). Elder Abuse and Psychological Well-being: A Systematic Review and Implications for Research and Policy - A mini Review. Gerontology, 59(2), 132–142
Systematic	Johannesen, M. & LoGiudice, D. (2013). Elder Abuse: A Systematic Review of Risk Factors in Community-dwelling Elders. Age & Ageing, 42(3), 292-298.
Systematic	Reader, T. W., & Gillespie, A., (2013). Patient neglect in healthcare institutions: a systematic review and conceptual model. BMC Health Services Research, 13(156),1-15.
Systematic	Sooryanarayana, R., Choo, W.-Y. & Hairi, N. N. (2013). A Review on the Prevalence and Measurement of Elder Abuse in the Community. Trauma, Violence & Abuse, 14(4), 316-325.
	2012
	Anna Gunde, A. G., Liepe, K., Blättner, B. & Grewe, H. A. (2012). Violence Against Elderly Care-dependents Through Family Caregivers - A Systematic Overview about Screening and Assessment-instruments. Pflegewissenschaft, 14(7–8), 399–407.
	2011
Systematic	Alt, K. L., Nguyen, A. L. & Meurer, L. N. (2011). The Effectiveness of Educational Programs to Improve Recognition and Reporting of Elder Abuse and Neglect: A Systematic Review of the Literature. Journal of Elder Abuse & Neglect, 23(3), 213-233.
Systematic	Cook, J.M., Dinnen, S., & O'Donnell, C. (2011). Older women survivors of physical and sexual violence : A systematic review of the quantititive literature. Journal of Women's Health, 20(7), 1075-1081.
Systematic	Daly, J. M., Merchant, M. L. & Jogerst, G. J. (2011). Elder Abuse Research: A Systematic Review. Journal of Elder Abuse & Neglect, 23(4), 348-365.
Systematic	McGarry, J., Simpson, C., &Hinchliff-Smith, K. (2011). The impact of domestic abuse for older women: a review of the literature. Health and Social Care in the Community, 19(1), 3-14.
	2009
Systematic	Cooper, C., Selwood, A. & Livingston, G. (2009). Knowledge, Detection, and Reporting of Abuse by Health and Social Care Professionals: A Systematic Review. American Journal of Geriatric Psychiatry, 17(10), 826-838.

Systematic	Killick, C. & Taylor, B.J. (2009). Professional Decision Making on Elder Abuse: Systematic Narrative Review. Journal of Elder Abuse and Neglect, 21(3), 211-238.
Systematic	Ploeg, J., Hutchison, B., MacMillan, H. & Bolan, G. (2009). A Systematic Review of Interventions for Elder Abuse. Journal of Elder Abuse and Neglect, 21(3), 187-210.
	2008
Systematic	Cooper, C., Selwood, A. & Livingston, G. (2008). The Prevalence of Elder Abuse and Neglect: A Systematic Review. Age and Ageing, 37(2), 151-160.
	2007
Systematic	Erlingsson, C. L. (2007). Searching for Elder Abuse: A Systematic Review of Database Citations. Journal of Elder Abuse & Neglect, 19, 59-78.
Systematic	Lindbloom, E. J., Brandt, J., Hough, L. D. & Meadows, S. E. (2007). Elder Mistreatment in the Nursing Home: A Systematic Review. Journal of the American Medical Directors Association, 8(9), 610-616.

CHAPTER 2: BELGIAN CONTEXT

APPENDIX 5. HIGHLIGHTS ON THE COMPETENCES EXERCIZED BY THE FEDERATED ENTITIES IN BELGIUM

When we use the term Federated entities in this section, it is important to note that the above-mentioned matters are matters that affect persons and as such they are constitutionally transferred to the communities. It should however be noted that in the **North of the country**, the government and parliament of the Dutch speaking Community exercise, in addition, all the competences of the Flemish Region: there is a single legislative and political power, a single administration and a single budget. The Dutch speaking Community is competent in the Dutch speaking territories of Belgium and for some specific services organised exclusively in Dutch in the bilingual territory of Brussels (see infra).

The situation is reversed in the **South** where, since 1994, the competences of the French speaking Community is exercised, partly, by the **Walloon Region** in the French-speaking region, and by the COCOF[a] in the bilingual region of Brussels-Capital (the COCOF thus received a legislative power for the competences whose exercise is transferred to it). The matters transferred to the Walloon Region mainly concern welfare[b] and health policy. The remaining competences of the French speaking Community essentially concern culture, education, youth help, sports and justice houses.

In the bilingual **Region of Brussels-capital**, three specific Commissions are involved:

- The French speaking Community Commission (Commission communautaire française or COCOF) has legislative power in matters transferred by the French Community (mainly related to social aid and health). It is therefore responsible for the supervision and funding of Ecoute Senior and Infor-Homes. The COCOF is competent for the service flats, day centers and home care services organized in French, but the competence for the French speaking rest-and nursing homes in Brussels was transferred to the COCOM. In persons related matters not transferred by the French Community, as well as in cultural and educational issues, the COCOF acts under the supervision of the French speaking Community. Its executing decrees must respect and apply, taking into account the specificities of Brussels, the decrees of the French speaking Community.
- The Flemish Community Commission (Vlaamse Gemeenschapscommissie, or VGC) has no legislative power: it cannot therefore adopt legislative texts, but only executing decrees, under the supervision of the Dutch speaking Community. The VGC executing decrees must respect and apply the decrees of the Dutch speaking Community taking into account the specificities of Brussels. Within those limits, the VGC is competent for all services to elders organised exclusively in Dutch. It is therefore responsible for the supervision and funding of the Brussels Meldpunt Ouderen(mis)behandeling and Home-Info.
- The Joint Community Commission (commission communautaire commune or COCOM) is responsible, in the bilingual region of Brussels-Capital, for institutions (public services, non-profit

[a] The Joint Community Commission has responsibility for matters considered as “bi-personal”, the personal matters for which the Communities do not have competence on the bilingual territory of the Brussels-Capital Region. These matters concern, on the one hand, measures applying directly to individuals and, on the other hand, institutions which, because of their organisation, are not attached exclusively to one of the Communities. These bilingual institutions are either public institutions which are bilingual by definition, such as public hospitals, or private institutions which have not opted for either, such as bilingual services.

[b] Article 3, 7°, of Decree II of 22 July 1993.

associations) active in the field of competence of the communities and which do not fall solely within the competence of the French Community or the Flemish Community. It is for instance responsible for a joint platform between Infor-homes (FR) and Home-Info (NL). With regard to all these institutions organised in a bilingual manner, the Joint Community Commission acts as a legislative power: it autonomously adopts legislative texts. The COCOM is also competent for the French speaking rest-and nursing homes in Brussels.

APPENDIX 6. OVERVIEW OF THE STEPS OF CRIMINAL PROCEDURE

In this section the steps of a criminal procedure will be summarised. In appendix 1 of chapter 7 some of these steps and roles of the actors involved in these steps will be further explained based on information obtained by the interviewed stakeholders.

Reporting

Victims can always report the offense committed against them either to the police, to the prosecutor or directly to the investigation judge (only possible if they are victims of the offense). A prosecutor may also have heard something and decide to prosecute.

Relatives of the victim, fields actors (HCP's, administrator of the elder's personal property or personal decisions of an elder, judges of peace, civil servant, HCP's) or anyone witnessing an abuse can report a (presumed) offense.

According to Article 30 of the Code of Criminal Procedure, and unless professional secrecy applies, any person **who has directly witnessed** an **attack on public security, on a person's life or property** must report this to the public prosecutor's office. The private reporting obligation rests on every citizen, regardless of his or her position. The term 'attack' must be interpreted broadly. Any violent act or ettempt to integrity and property are included. The person making the report must have witnessed the crime directly.

Moreover, unless professional secrecy applies[a], any **public authority, public officer or civil servant** who becomes aware of a **crime or a misdemeanour**[b] in the performance of his duties is obliged to report it to the public prosecutor's office (Article 29 of the Code of Criminal Prosecution).

[a] Cass., 29 May 1986, Pas., 1986, I, n°609).

[b] This applies to "crimes" and "délits" not to "contraventions".

Even in cases were professional secrecy applies, everyone is, in some cases, obliged or allowed to report certain behaviours (see infra section 5).

Police management

A police officer will always record the complaint in a police report. If necessary, they will interrogate the victim, check possible precedents in their database etc. Police services have an obligation to transfer any case that could be prosecuted even without the consent of the victim (article 5 of the law on the police function). Moreover, they are obliged to assist victims by providing them with the necessary informations. Additionally, they can refer the cases to specialised services (article 46 of the law on the police function).

The police will evaluate if the reported facts constitute or not an offense. They can first investigate a case themselves via an EPO (Enquête Policière d'Office[a]) or forwards this document to the prosecutor's office for investigation.

Normally, polices services and specific victim support services linked to the police stations (PASV Service d'Assistance Policière aux Victimes) should receive a specific training to deal with vulnerable victims and are legally required to treat them accordingly[b] during the first steps of the procedure (claim, referral to support or specialized services, etc.). Unlike what exists for the fight against domestic violence[c] or child abuse and interfamilial violence[d], polices services and prosecutor's offices do not have any specific guidelines or instructions in these specific cases. [e]Moreover, in practice, not all police stations can effectively rely on PASV services. The function of the SAPV is mainly to orient the victims to the house of justice victims help service.

Transfer to the prosecutor's office

After the complaint has been filed (or on his own initiative), the public prosecutor's office initiates a criminal investigation.

If there is not enough evidence, the prosecutor will drop the case or transfer it to the competent authority.

It should also be noted that prosecution priorities are applicable at this stage. The Justice Minister, after the advice of the college of Public prosecutors, can issue binding guidelines to define priorities in the prosecution of certain offenses[f]. When their competences are involved, Communities and regions participate in the development of those guidelines[g].

For instance there is a joint circular of the minister of justice and the college of public prosecutors for criminal policy regarding violence between partners[h] or another for the identification and data collection on intra-family

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a https://www.om-mp.be/sites/default/files/u1/col_8_2005_tekst_gewijzigd_door_col_5_2009_met_bijlagen_def.pdf.

b Article 3bis of the Code of Criminal Investigation.

c https://igvm-iefh.belgium.be/sites/default/files/downloads/col42006_fr.doc.pdf.

d http://www.egalite.cfwb.be/index.php?eID=tx_nawsecuredl&u=0&g=0&hash=b7615c08c93be8ba5555b73144d54481b94730ea&file=fileadmin/sites/sdec_III/upload/sdec_III_super_editor/sdec_III_editor/documents/Violence/Circulaire_COL_3-2006.pdf.

e https://www.departementwvg.be/justitiehuizen/slachtoffer

f Article 151 of the Belgian Constitution and article 143quater of the Judiciary Code,

g Tant l'article 11bis de la LSRI que l'article 2, § 1er de l'accord de coopération du 7 janvier 2014 conclu entre l'État fédéral, les Communautés et les Régions relatif à la politique criminelle et à la politique de sécurité.

h COL 4/2006: https://igvm-iefh.belgium.be/sites/default/files/downloads/col42006_fr.doc.pdf.

violence[a]. The content of this circular can be further elaborated by the reference prosecutor for intra-family violence for a respective arrondissement. At the time of writing, a circular was being prepared on elder abuse but the KCE research team could not have access to its content.

If the investigation confirms there is a criminal offence, the public prosecutor can take different **decisions**:

- He may propose a settlement (transaction). This is only possible if the author admits his/her responsibility and at least part of the damage has been repaired.
- He may propose criminal mediation (216ter of the Code of criminal investigation). The public prosecutor may ask the author to compensate the victim for the damage caused to her/him. The author must also be able to show that he or she has actually compensated the damage.
- He may transfer the case to an **investigating judge:** in this case, we are talking about a judicial investigation. Once the investigation is completed, the Chamber of Counsel decides on the outcome of the case.
- He may reprimand (recall the law)
- When the prosecutor is of the opinion that there are enough charges to prosecute someone, he or she may bring the suspect before the trial court. (direct citation)

Investigating judge

The investigating judge must examine both the elements favourable to the suspect and the elements unfavourable to him. He may, for example, hear witnesses and suspects and appoint experts. If necessary for the investigation, the investigating judge may also order binding measures such as: search and seizure; the arrest and prosecution of a suspect; the interrogation of the accused; the search for telecommunications; the body search; listening to telecommunications (telephone tapping); the DNA analysis.

When the investigating judge has completed his investigation, he transmits the file to the General Prosecutor who may decide to ask the chambers to refer the suspect to the criminal court if there is sufficient evidence of guilt or to request that the case be dismissed.

Options before reference to the criminal court

There are two types of recognized mediation procedures in case of offenses. The first one has a more restrictive scope of application and can prevent a case to be tried before a criminal court. The other one is complementary to a possible trial in court.

A. Criminal mediation (settlement)

Criminal mediation (article 216ter of the Code of criminal investigation) is a form of alternative intervention by the judicial authority to provide a response to a conflict situation caused by a proven offence. It is only possible before the investigation phase. Criminal mediation can only be used if the offence does not appear to be punishable by more than two years correctional imprisonment or a heavier sentence.

During this criminal mediation, the parties (victims and authors) cooperate in order to get closer of the causes of the offence and to take into account the interests of victims.

In fact, article 216ter of the Code of Instruction provides for four different measures that may be proposed, if necessary, in combination:

- Mediation "in the strict sense" between the author and the victim.

[a] COL 3/2006 : http://www.egalite.cfwb.be/index.php?eID=tx_nawsecuredl&u=0&g=0&hash=b7615c08c93be8ba5555b73144d54481b94730ea&file=fileadmin/sites/sdec_III/upload/sdec_III_super_editor/sdec_III_editor/documents/Violence/Circulaire_COL_3-2006.pdf.

- The follow-up of a therapy.
- The follow-up of a training.
- The performance of community service.

The criminal mediation is a “settlement”: if the author complies with all the conditions, the public prosecution is terminated.

This mediation is organised by the justice houses services.

B Mediation under the law of 2005

With regard to so called mediation under the "law of 2005 ", the exercise of public prosecution is independent of the initiation, the progress and the outcome of the mediation process. Unlike the mediation imposed in the context of a settlement (criminal mediation), mediation under the law of 2005 is not a settlement and is not a judicial measure imposed by a judge. The parties themselves, the authors, the victims, their families and close relatives, can request the mediation. Its scope is much wider than the settlement since it is not limited by the nature of the offence, nor by its seriousness.

Mediation under the law of 2005 is a process that allows people in conflict to participate actively, if they freely consent, and in complete confidentiality, to the resolution of difficulties resulting from an infringement, with the help of a neutral third party relying on a specific methodology. Its purpose is to facilitate communication and to help the parties to reach on an agreement on how to appease and repair the consequences of the offense.

According to article 553 § 2 of the Code of Criminal Investigation, the public prosecutor, the investigating judge, the investigating courts and the judge shall ensure that the parties involved in a judicial procedure are informed about the possibility of requesting a mediation. As far as they consider it in concrete cases, they can themselves propose a mediation to the parties. This mediation may take place at any stage of the procedure and even after the author was convicted.

Normally, the parties shall be informed of this possibility at a very early stage of the procedure because this must be explained on the complaint receipt sheet when a complaint is filled to the police services (COL 5/2009). According to COL 5/2014, police services have an obligation to inform the victims of this possibility through the minutes of the claim”.

The mediation "law of 2005"[a] is not organised by the justices houses but by specific services that are external to both the FPS Justice and the judicial authorities; those services are licensed by the Minister of Justice to fulfil this mission. Currently, only two non-profit organisations are approved by the Minister of Justice to operate mediation on the basis of articles 553, 554 and 555 of the Code of Criminal Investigation: MEDIANTE[b] for the French speaking part and MODERATOR[c] for the Dutch speaking part. This procedure is free for the parties.

A specific COL (5/2014) tries to promote the use of this type of mechanism by imposing the steps of the procedure and the actors who must inform the victims about this type of mediation.[d]

C Obstacles to mediation

Due to the justice overload and priorities, insults, threats, assault, breach of trust, abuse of weakness seem to be often considered as “minor offenses”. Moreover, due to the close relationship between the elder and the author, the victim is often reluctant or unable to cooperate fully with the judicial authorities. On the field, it was reported that those services refuse to intervene when there is an unbalanced relationship which is almost the

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[a] Law of 22 June 2005, modifying art. 216ter of the Code of Criminal investigation, aiming at the organization of mediation in criminal offences, O.J. 27 July 2005.

[b] http://mediante.be/mediante.php.

[c] https://moderator.be/suggnome-wordt-moderator/

[d] https://www.om-mp.be/nl/meer-weten/omzendbrieven

cases in all elder abuse (and intra familial violence) cases. This criterion is however not included in the law of 2005.

Figure 37 – Overview of the step in a criminal procedure



CHAPTER 3: ELDER ABUSE PREVENTION

APPENDIX 7. DEFINING EA PREVENTION

In 2010, the Canadian Ministry for families and seniors published this explanation about elder abuse prevention : « La prévention [de la maltraitance] vise à réduire, voire à éliminer l'incidence de ce phénomène dans tous les milieux de vie des personnes aînées. Elle repose sur la promotion de valeurs telles que le respect de la dignité humaine, sur une connaissance des causes et des facteurs associés à la maltraitance et sur la responsabilisation de tous les acteurs sociaux dans la lutte pour réduire cette problématique sociale. Elle a pour effet d'augmenter le degré de sensibilité collective et de contribuer à l'acquisition d'attitudes et de comportements respectueux envers les aînés. Elle crée un climat où les personnes concernées se sentiront plus à l'aise pour briser le silence et faire les gestes nécessaires afin que cesse la maltraitance ».[100]

The new official Quebec reference guide to fight elder abuse told us that prevention is the best way to fight abuse. It widely illustrates the integration of the concepts of welltreatment, anti-ageism and active ageing that allows to act before the occurrence of elder maltreatment.[12]

Welltreatment is a way to care where the caregiver always search to individualise and to personalise the care. According to the "Agence nationale de l'évaluation et de la qualité des établissements et services sociaux et medico-sociaux canadiens-ANESM", 4 actions improve welltreatment :[200]

- The elderly is co-author to his intervention plan
- The quality of the relation link between the user and the professional is high
- Relatives and families enrich and support the intervention plan
- The professionals are helped by the management and the authorities in their welltreatment procedures

Abuse affects a number of people, but well-being affects everyone. Well-being is much broader. It is based on the respect of the person, its dignity and its peculiarity. Establishing well-treatment helps prevent unintentional abuse or neglect.[12]

Active ageing is the process of optimizing opportunities in order to enhance quality of life as people age.[201] It allows people to realize their potential for physical, social, and mental wellbeing throughout the life course and to participate in society according to their needs, desires and capacities, while providing them with adequate protection, security and care when they require assistance. The three main principles of active ageing are health, social participation and security.[12]

The *ageism* is the process by which people are stereotyped and discriminated because of their age. It results from the false vision of the population about *ageing*. Often irrational, *ageism* can lead to marginalization and loss of power in the elderly. A solution to fight ageism is to sensitise health care professionals in charge of seniors but also the elderly themselves, the young people and all the workers about active ageing and welltreatment.[12]

The society need to value the multiple contribution of the elderly on the social and economic point of view. The intergenerational link needs to be reinforced and the normalisation of the ageing life step will help to decrease ageing deny among younger people. Influent older persons can help to it as well as association against other types of discrimination. To favour the inclusion and participation of seniors into the society gives to the elderly the feeling that they have a role in their family and community. Social participation is about taking part in activities of all kinds in society. It would improve health and increase the feeling of well-being.[101]

A Cochrane review published in 2016[8] listed 3 types of primary prevention of elder abuse:

- Changes in policies
- Community-based interventions as awareness campaigns and societal health education using mass media

- Individually-focused activities as intergenerational programmes, health educational programmes, skills-based programmes.

Since abuse occurs in a variety of contexts and takes a variety of forms, prevention needs to be comprehensive and general in order to deal with this complex subject by targeting several audiences: the elderly person, the family and relatives, institutions and their staff, professional stakeholders, society as a whole and the media. Each of these actors can help and get involved in this issue of the society.[202]

Preventive measures pursue the following objectives:[202]

- To make known the rights of seniors;
- To develop the autonomy and the empowerment of the elderly;
- To maintain social contacts and reducing isolation;
- To inform on the aging process, the types of abuse, the risk factors, the existence of support services for all audiences (professionals, family, friends, seniors, schools, pensioners, volunteers, ...)
- To assess the risks of abuse;
- To train and supervise professionals;
- To coach caregivers (helping the family recognize its limits and accepting help) and;
- To set up speaking spaces where professionals as well as family or exchange, listen and share experiences. It aims to provide the necessary support to both relatives and professionals and to prevent overworking or burnout, which can lead to abuse.

Multiple preventive measures and actions can be put in place as, for example, networking, adequate behaviour which favour the remaining capacities of the older person, personalized care plan and allowing caregivers to have time to listen.[202]

APPENDIX 8. SCIENTIFIC REVIEWS ILLUSTRATING THE LACK OF EVIDENCE IN THE PREVENTION OF EA

Dong 2015[77]

"This review identifies important knowledge gaps, such as a lack of consistency in definitions of elder abuse; insufficient research with regard to screening; and etiological, intervention, and prevention research. **Concerted efforts** from researchers, community organizations, healthcare and legal professionals, social service providers, and policy-makers should be promoted **to address the global problem of elder abuse**."

Baker 2016[8]

According to the Cochrane review of Baker in 2016, the **scarce current scientific data** show that **some EA interventions may change the combined measure of anxiety and depression of caregivers**. However, data cannot show whether targeted educational interventions improve the knowledge of professionals and caregivers about EA, whether any improved knowledge actually leads to changes in the way they behave, and whether this leads to the elderly being abused less. The review acknowledges that many of the existing studies were unclear in the design, too small in size or not similar enough in their findings to have full confidence in the findings.

Ayalon 2016[196]

"The **most effective** place to intervene at the present time is by directly **targeting physical restraint by long-term care paid carers**. Specific areas that are still lacking evidence at the present time are interventions that target (i) elder neglect, (ii) public awareness, (iii) older adults who experience maltreatment, (iv) professionals responsible for preventing maltreatment, (v) family caregivers who abuse and (vi) carers who abuse"

Pillmer 2016[203]

Pillemer et al in 2016 highlights the urgent need to make elder mistreatment prevention programs more effective and evidence based.

Hirst 2016[204]

"The review resulted in 62 studies that focused on identifying, assessing, and responding to abuse and neglect of older adults; education, prevention, and health promotion strategies; and organizational and system-level supports to prevent and respond to abuse and neglect. **Abuse and neglect of older adults remains under-explored in terms of evidence-based studies**; consequently, further research in all of the areas described in the results is needed."

Day 2017[205]

"Although there is increasing concern about both the prevalence of, and harms associated with the abuse of older adults, **progress in the development of interventions to prevent its occurrence has been slow**. This paper reports the findings of a systematic review of the published literature that identified studies in which the outcomes of preventative interventions are described. A total of eight different intervention trials, published since 2004, are described across the primary, secondary and tertiary levels of prevention and in terms of the types of risk factor that they target. The current evidence to support the effectiveness of these interventions is not only limited by the small number of outcome studies but also the poor quality of evaluation designs and the focus of many interventions on single risk factors. It is concluded that **work is needed to strengthen the evidence base that supports the delivery of interventions to prevent elder abuse**."

APPENDIX 9. EXAMPLES OF EA PREVENTIVE STRATEGIES

Some examples illustrating the preventive actions for each category extracted from the different plans, reports and publications at the international level are given below:

Defining international, national or subnational policies and/or action plans and/or laws

- Developing national action plan to handle elder abuse
- Voting a law which prevent retaliation against a professional reporting an elder abuse

Improving policies and practices in residential care facilities:

- Defining and improving standards of care: the senior is co-author of his intervention plan; the quality of the relationship between the user and the professional is high; the relatives and families enrich and support the intervention plan; caregivers have time to listen
- Training caregivers on dementia;
- Supervising professionals;
- Implementing well-treatment procedures with the support of the management and the authorities.

Professional awareness and training:

- Setting up campaigns to inform the professionals on the aging process, the types of abuse, the risk factors, the existence of support services for all audiences
- Informing professional that they should questions himself on what maltreatment is
- Organizing individualized skills-based training programmes for professionals (i) on how to assess the risks of abuse (detection of potential victims and abusers); (ii) on dementia; and (iii) on the

adequate behaviour which favour the remaining capacities of older persons

- Favouring the networking

Support to informal caregivers to avoid burden:

- Providing respite care and services to relieve their burden and to manage their stress
- Setting up speaking spaces inside institutions where professionals as well as families can exchange, listen to each other's and share experiences
- Training caregivers on dementia; and on how recognize their limits and accepting help

Awareness campaigns for the public:

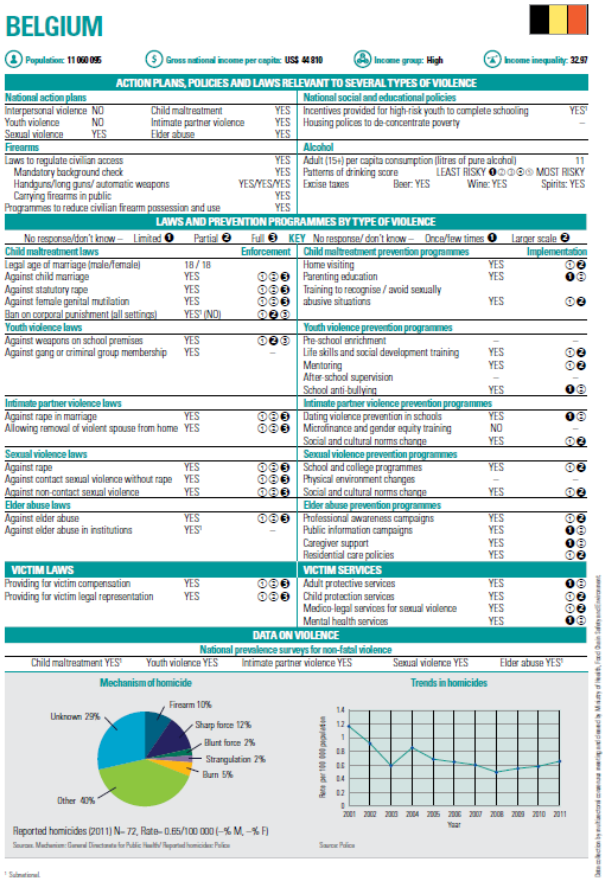
- Informing the public (i) on how to identify the signs of EA and where help can be obtained; and (ii) on the aging process, the types of abuse, the risk factors, the existence of support services for all audiences (professionals, family, friends, seniors, schools, pensioners, volunteers, ...);
- Organizing societal health education using mass media and individual health educational programmes (in the aim that everyone questions himself on what maltreatment is);

Programmes to decrease societal attitudes and stereotypes towards older people and empowerment of seniors:

- Organizing intergenerational programmes,
- Making known the rights of seniors;
- Developing the autonomy and the empowerment of the elderly;
- Maintaining social contacts and reduce isolation.

APPENDIX 10. BELGIUM REPORT ON VIOLENCE PREVENTION

Figure 38 – Global status report on violence prevention in Belgium in 2014



BELGIUM

Population: 11 060 095 | Gross national income per capita: US$ 44 810 | Income group: High | Income inequality: 32.97

ACTION PLANS, POLICIES AND LAWS RELEVANT TO SEVERAL TYPES OF VIOLENCE

National action plans

Interpersonal violence	NO	Child maltreatment	YES
Youth violence	NO	Intimate partner violence	YES
Sexual violence	YES	Elder abuse	YES

Firearms

Laws to regulate civilian access	YES
Mandatory background check	YES
Handguns/long guns/ automatic weapons	YES/YES/YES
Carrying firearms in public	YES
Programmes to reduce civilian firearm possession and use	YES

National social and educational policies

Incentives provided for high-risk youth to complete schooling	YES[1]
Housing polices to de-concentrate poverty	–

Alcohol

Adult (15+) per capita consumption (litres of pure alcohol)			11
Patterns of drinking score	LEAST RISKY ❶ ❷ ❸ ❹ ❺ MOST RISKY		
Excise taxes	Beer: YES	Wine: YES	Spirits: YES

LAWS AND PREVENTION PROGRAMMES BY TYPE OF VIOLENCE

No response/don't know – Limited ❶ Partial ❷ Full ❸ KEY No response/ don't know – Once/few times ❶ Larger scale ❷

Child maltreatment laws

		Enforcement
Legal age of marriage (male/female)	18 / 18	
Against child marriage	YES	①②③
Against statutory rape	YES	①②③
Against female genital mutilation	YES	①②③
Ban on corporal punishment (all settings)	YES[1] (NO)	①❷③

Youth violence laws

Against weapons on school premises	YES	①❷③
Against gang or criminal group membership	YES	–

Intimate partner violence laws

Against rape in marriage	YES	①②③
Allowing removal of violent spouse from home	YES	①②③

Sexual violence laws

Against rape	YES	①②③
Against contact sexual violence without rape	YES	①②③
Against non-contact sexual violence	YES	①②③

Elder abuse laws

Against elder abuse	YES	①②③
Against elder abuse in institutions	YES[1]	–

Child maltreatment prevention programmes

		Implementation
Home visiting	YES	①❷
Parenting education	YES	❶②③
Training to recognise / avoid sexually abusive situations	YES	①❷

Youth violence prevention programmes

Pre-school enrichment	–	–
Life skills and social development training	YES	①❷
Mentoring	YES	①❷
After-school supervision	–	–
School anti-bullying	YES	❶②

Intimate partner violence prevention programmes

Dating violence prevention in schools	YES	❶②
Microfinance and gender equity training	NO	–
Social and cultural norms change	YES	①❷

Sexual violence prevention programmes

School and college programmes	YES	①❷
Physical environment changes	–	–
Social and cultural norms change	YES	①❷

Elder abuse prevention programmes

Professional awareness campaigns	YES	①❷
Public information campaigns	YES	❶②③
Caregiver support	YES	❶②③
Residential care policies	YES	①❷

VICTIM LAWS

Providing for victim compensation	YES	①②③
Providing for victim legal representation	YES	①②③

VICTIM SERVICES

Adult protective services	YES	❶②
Child protection services	YES	①❷
Medico-legal services for sexual violence	YES	①❷
Mental health services	YES	❶②

DATA ON VIOLENCE

National prevalence surveys for non-fatal violence

Child maltreatment YES[1] Youth violence YES Intimate partner violence YES Sexual violence YES Elder abuse YES[1]

Mechanism of homicide

Reported homicides (2011) N= 72, Rate= 0.65/100 000 (–% M, –% F)

Sources: Mechanism: General Directorate for Public Health/ Reported homicides: Police

Trends in homicides

Source: Police

[1] Subnational.

World Health Organization (2014). Global Status report on violence prevention. Geneva. Belgium report available at https://www.who.int/violence_injury_prevention/violence/status_report/2014/coutry_profiles/BELGIUM.pdf?ua=1

APPENDIX 11. REVIEW OF VARIOUS CASES IN THE EUROPEAN COURT OF HUMAN RIGHTS

Review of various cases in which the European Court of Human rights condemned Member States for having failed to take the elder's particular vulnerability into account in the protection of the human rights enshrined by the European Convention on Human Rights:

- Heinisch v. Germany 21 July 2011

  This case concerned the dismissal of a geriatric nurse after having brought a criminal complaint against her employer alleging deficiencies in the care provided. The applicant complained that her dismissal and the courts' refusal to order her reinstatement had violated Article 10 (freedom of expression) of the Convention. The Court held that there had been a violation of Article 10 (freedom of expression) of the Convention, finding that the applicant's dismissal without notice had been disproportionate **and the domestic courts had failed to strike a fair balance between the need to protect the employer's reputation and the need to protect the applicant's right to freedom of expression**. The Court observed in particular that, **given the particular vulnerability of elderly patients and the need to prevent abuse**, **the information disclosed had undeniably been of public interest**. Further, the public interest in being informed about shortcomings in the provision of institutional care for the elderly by a State-owned company was so important that it outweighed the interest in protecting a company's business reputation and interests. Finally, not only had this sanction had negative repercussions on the applicant's career, it was also liable to have a serious **chilling effect both on other company employees** and on nursing-service employees generally, so **discouraging reporting in a sphere in which patients were frequently not capable of defending their own rights and where members of the nursing staff would be the first to become aware of shortcomings in the provision of care.**

- Farbtuhs v. Latvia 2 December 2004

  The applicant, who in September 2009 was found guilty of crimes against humanity and genocide for his role in the deportation and deaths of tens of Latvian citizens during the period of Stalinist repression in 1940 and 1941, complained that, in view of his age and infirmity, and the Latvian prisons' incapacity to meet his specific needs, his prolonged imprisonment had constituted treatment contrary to Article 3 (prohibition of inhuman or degrading treatment) of the Convention. In 2002 the domestic courts finally excused the applicant from serving the remainder of his sentence after finding inter alia that he had contracted two further illnesses while in prison and that his condition generally had deteriorated. The applicant was released the next day. **The Court held that there had been a violation of Article 3 (prohibition of degrading treatments)** of the Convention. It observed that the applicant was 84 years old when he was sent to prison, paraplegic and disabled to the point of being unable to attend to most daily tasks unaided. Moreover, when taken into custody he was already suffering from a number of serious illnesses, the majority of which were chronic and incurable. **The Court considered that when national authorities decided to imprison such a person, they had to be particularly careful to ensure that the conditions of detention** were consistent with the specific needs arising out of the prisoner's infirmity. Having regard to the circumstances of the case, the Court found that, in view of his age, infirmity and condition, the applicant's continued detention had not been appropriate. **The situation in which he had been put was bound to cause him permanent anxiety and a sense of inferiority and humiliation so acute as to amount to degrading treatment**. By delaying his release from prison for more than a year in spite of the fact that the prison governor had made a formal application for his release supported by medical evidence, the Latvian authorities had therefore failed to treat the applicant in a manner that was consistent with the provisions of Article 3 of the Convention

  Budina v. Russia 18 June 2009 (decision on the admissibility). The applicant was in receipt of a disability allowance. On reaching retirement age and at her request the allowance was replaced by an

old-age pension. Considering the pension inadequate for her needs, she unsuccessfully sought to have it upgraded by the courts. Subsequently, she complained to the Russian Constitutional Court that the Law on Pensions allowed pensions below the established subsistence level, but to no avail. The Court declared the application inadmissible (manifestly ill-founded), pursuant to Article 35 (admissibility criteria) of the Convention. It **observed that it could not exclude that State responsibility could arise for "treatment" where an applicant wholly dependent on State support found herself faced with official indifference when in a situation of serious deprivation or want incompatible with human dignity**. However, even though the applicant's income was not high in absolute terms, she had failed to substantiate her allegation that the lack of funds translated itself into concrete suffering. Indeed there was no indication in the materials before the Court that the level of pension and social benefits available to the applicant were insufficient to protect her from damage to her physical or mental health or from a situation of degradation incompatible with human dignity. Therefore, even though her situation was difficult, the Court was not persuaded that in the circumstances of the present case the high threshold of Article 3 (prohibition of inhuman or degrading treatment) of the Convention had been met.

APPENDIX 12. EXTRACTS FROM THE EUROPEAN CHARTER OF THE RIGHTS AND RESPONSIBILITIES OF OLDER PEOPLE IN NEED OF LONG-TERM CARE AND ASSISTANCE

Table 59 – Articles, quotes, recommendations and examples of good practices from the European Charter of the rights and responsibilities of older people in need of long term care and assistance

Articles of the Charter	Quotes extracted from the European Charter Guide	Recommendations for implementation of the articles	Example of good practices in Europe extracted from the European Charter Guide
Right to dignity, physical and mental well-being, freedom and security	*"I am not hungry, the only thing I would eat is the yoghurt but I can't open it, so I leave it."* *"I know that I shouldn't give him money each time he comes, but I feel so lonely…"* *"Don't worry about those bruises, it must be because she doesn't have a good balance and bumps into furniture."*	Caregivers should be aware that they have a key role in protecting older dependent persons from abuse Check if your practices are the right ones Develop a systematic process to prevent abuse and take complaints into account Raise awareness on elder abuse Provide information on where to call for support Cooperate with a wide range of stakeholders Create a public body responsible for anti-discrimination and the fi ght against elder abuse	United Kingdom: Guide on Dignity in care (www.scie.org.uk/publications/guides/guide15/fi les/guide15.pdf) Czech Republic: Stop violence against older people campaign by Zivot90 (www.zivot90.cz) The Netherlands: the Amstelland police provide information on elder abuse to their staff (politie-amsterdam-amstelland.nl)
Right to self-determination	*"What I miss is the freedom to choose, to choose when I get up, what to have for lunch, what to wear today."* *"I don't understand why I have to take all these*	Involve people in their care Respect the needs and wishes of the person Take steps to ensure mobility and autonomy are maintained	Alzheimer Europe advice on advance directives (summary) (www.alzheimer-europe.org) Involvement of older people in their care – some examples in Europe Spain: Transport on demand in Castilla y Leon (www.jcyl.es) Support to independent living in Slovenia (www.enil.eu)

	medications, they make me feel dizzy."	Provide adequate support for decision-making Rely on a third party if needed and limit restrictions to the person's autonomy Give information on the rights and limits of representation by a third party	
Right to privacy	*"I don't like being treated like a piece of furniture. Can't they talk to me when they wash me instead of discussing between them what they did last weekend? I am not dead yet. I have feelings too!"* *"It took me three years as a child to learn not to wet my bed at night and now they want me to do it again because they don't have time to come and help me to the toilet at night!"*	Integrate the respect for privacy in the service management and in the care contract Allow places and moments for intimacy Have clear rules on respect for confidentiality and data protection Prevent intrusion into the private sphere and respect the person's modesty feelings Develop clear data protection rules protecting the users	European Union: European Directive on data protection (europa.eu/legislation_summaries/information_society/l14012_en.htm) United Kingdom: Dignity behind Closed Doors Campaign (www.bgs.org.uk/campaigns/dignity.htm#aims) United Kingdom: Red Means Stop! (www.uhl-tr.nhs.uk/patients/patient-information/caring-at-its-best/red-means-stop) France: Charter of the rights and liberties of the cared person includes protection of privacy United Kingdom: British Medical association – Confidentiality and disclosure of health information toolkit (www.bma.org.uk)
Right to high quality and tailored care	*"She doesn't understand why I cry when I have to wait so long on the toilet seat before she comes to help me. I know she is very busy, but if she could only understand how painful it is for me."* *"Can't they put some nice music when we have lunch? That would boost everyone's appetite!"*	Improve the living conditions of the person especially through timely support Respect the person's background and personal needs Ensure that staff are adequately trained and qualified Ensure services are adapted to the person's needs	Ireland: « Your right to know » (www.hiqa.ie and www.hse.ie.) European organisation EDE: development of a quality management system E-Qalin® (www.e-qalin.net/index.php?id=2&L=1) France: "France Alzheimer" association help carers to rest (www.francealzheimer.org/ and www.unaf.fr) Sweden: Respite care solutions for carers Slovenia: the role of the older people organisations Canada: The Patient Dignity Question (PDQ) (dignityincare.ca/en/toolkit.html#The_Patient_Dignity_Question)

		Ensure continuity of care and staff coordination The care plan should include the provision of good, tasty and varied food Support informal carers in improving the living conditions of the care recipient Regularly re-assess the needs of the care recipients Develop mandatory standards for quality long-term care Enable respite care solutions for informal carers Protect vulnerable care workers Make quality of long-term care services a priority, especially in public expenditures	
Right to personalised information, advice and informed consent	*"I wish I had known before. Now it's too late. I don't have the energy anymore to look for alternative and I have no one to help me."* *"I can't cope anymore and need to find a solution for my father (with severe Alzheimer) but I can't find the information I need about what is available. I spent hours on the phone and I still don't know what to do."*	Develop a legal framework protecting the rights and duties of users in all care settings Provide clear explanations to carers and users Promote and facilitate access to one's own personal medical data Promote and regulate the participation of older people in research projects Provide user-friendly information on the full range of available services	Finland: Helsinki City has developed clear easy-to- understand information on available health and social care services for older people (www.hel.fi /hki/helsinki/en/Services/Families+and+social+services/The+elderly) Italy: Legal Assistance for Elderly off ered by Anziano e Non Solo (www.anzianienonsolo.it)

Right to continued communication, participation in society and cultural activity	*"When my wife died, I felt really hopeless and isolated. I didn't know how to cook a proper meal, yet I didn't want to call for the meals-on-wheels. The lady from the community service encouraged me to join their cooking class for seniors and here I am. At 93, I am enjoying every moment of it! I have made new friends and we have fun together."*	Join WHO Age Friendly Cities Programme Inform and support care recipients on access to their civic rights Encourage social participation of older people in long-term care Provide support to people to respond to their social participation and communication needs and wishes Promote and encourage access to new information and communications technologies (ICTs)	Sweden: Culture for Seniors - Culture and health: the Umeå-model (: www.umea.se/senior) France: Association 'Petits frères des Pauvres' organizes range of activities for socially excluded older people (www.petitsfreres.asso.fr) Ireland: Third Age Foundation (TAF) provides activities for St Joseph long-term residents (www.thirdage-ireland.com) Finland: Psychosocial group rehabilitation for older people suff ering from loneliness (www.vanhustyonkeskusliitto.fi)
Right to freedom of expression and freedom of thought/conscience: convictions, beliefs and values	*"I never asked for that priest to visit me. Who let him in and why is he calling me my son? I don't believe in God and I don't want to listen to him!"*	Promote tolerance and create opportunities to exchange views on diff erences Allow private places for practising one's beliefs Prevent proselytism Support people in their wish to associate and participate to groups Provide a wide access to diversified information	Slovenia: Informal round tables on usages and religious practices at Easter Germany: Special units for migrants in nursing homes France: special training on religion for carers
Right to palliative care and support, and respect and dignity in dying and in death	*"I don't understand how it is still possible today to let people develop such bedsores!"* *"I love him but I couldn't stand his screams anymore and I slapped*	Regulate by law the principles and requirements of palliative care Develop quality palliative care in an interdisciplinary approach	United Kingdom: Charter for Dignity at the End of Life (www.dignityindying.org.uk) Sweden: The Palliative care project in SABO (www.pvis.se) Canada: The Dignity Model (dignityincare.ca) Austria: Mobile palliative care units (www.hospiz-stmk and johann.baumgartner@kages.at)

	him. Now I feel miserable." *"I felt her life wasn't worth living anymore..."*	Involve the care recipient in the palliative care and support his/ her autonomy Involve the families in the palliative care Respect national regulations on the end-of–life Respect and support the spiritual needs and wishes of the dying person Support and respect advance directives	
Right to redress	*"When I tried to report elder abuse to my line manager, the next day I received a letter from the Director telling me that I was sacked for moral harassment of other staff."* *"She will never complain. She is too afraid and I don't know how help her?"*	Develop dedicated bodies and public information to tackle elder abuse Develop individualised responses to victims of abuse Check the criminal record of professional caregivers Develop training to caregivers on how to detect abuse Provide support and protection to victims and those reporting elder abuse	Belgium: East Flanders and the reporting of elder abuse (http://www.meldpuntouderenmishandeling.be) France: "Call 3977" helpline for older people victims of elder abuse (www.travail-solidarite.gouv.fr) Netherlands: Protocol to report elder abuse for external visitors

APPENDIX 13. DESCRIPTION OF THE 'BREAK THE TABOO' PROJECTS

"Breaking the Taboo 1 (BtT1) about violence against older women within the family: recognizing and acting" is a European project aiming to empower health and social service professionals to combat violence against older women within families.[206] This project was funded within the DAPHNE II and III programme led by the EU-DG Justice, Freedom and Security. The BtT1 main activities were carried out in Austria, Finland, Italy and Poland in collaboration with partners from Belgium, France and Portugal. The evaluation was carried out by a German partner[a]. The BtT2-project was coordinated by the Austrian Red Cross and gathered organisations from Austria, Belgium, Bulgaria, Germany, Portugal and Slovenia. Belgium was one of the main partner of the project through the office LACHESIS of Expertise on Ageing and Gender in corporation with the Flemish Reporting Point for Elderly abuse[b].

The project "Breaking the Taboo 1" aimed:

- To raise awareness concerning violence against older women in families,
- To empower health and social service professionals to recognize abusive situations and to help combat them.
- To develop awareness raising activities and materials
- To develop tools and strategies to improve early recognition of violence against older women in the family and to support professionals to react accordingly

The final report of the BtT1 shows that many health and social service providers do not have clear organisational procedures dealing with abuse against older women. Hence, organisations working with older people need to develop standards, procedures and trained staff members as peer advisors. It was also recommended to strengthen cooperation and networks between victim protection organisations and community health and care organisations. On an organisational level, it is recommended to develop clear organisational policies; to offer training and education of staff; to secure appropriate working conditions; and to enable multi-disciplinary cooperation and communication. On a policy level, the BtT1 recommend to raise awareness; to enforce prevention and early detection; to support networking initiatives; to create adequate structures; to improve the legal framework; to encourage further research; and to secure sustainable funding.

The project "Breaking the Taboo Two" was built on the previous project "Breaking the Taboo". It runs from December 2009 until December 2011 and aimed:

- To continue awareness raising at European and National level through promoting training in this field.
- To develop a curriculum to train professionals working in the field of community health and social services
- To train peer advisers and workshop facilitators (=trainers) to sensitise professionals working in community health and social services.

Five tools for raising awareness were finally developed by the "Breaking taboo II" project:

- A brochure of 17 pages for health care professionals available in Dutch, German or French,

a http://www.btt-project.eu/

b http://www.btt-project.eu/fileadmin/btt/redaktion/Project_leaflet-BtT2_English.pdf

- A training handbook which can be ordered in English on the website[a]. The handbook provides a two-day training course for health and social service staff members who work in older people's own homes, and is designed to help them to recognize violence against older women within families and to take action.
- A recommendations' book in German, Dutch and French[b] which provides an overview on strategies at organisational as well as policy level in order to combat violence against older women within the family.(more details up there)
- Reports about awareness[c]: a European one which summarises the most important results of the national reports and points out the differences and similarities between European countries and individualised report for Belgium, Austria, Finland, France, Italy, Poland and Portugal.
- Reports about training whose the Belgian one overviews existing train-the-trainer-courses dealing with violence and abuse against older women in the field of community-based health and social services in Flanders.[91]

The training manual is available online.[207] It aims (i) to introduce to challenges of prevention of violence against older women in Europe; (ii) to explain key terms, concepts and approaches; (iii) to introduce health care and medical aspects of the identification and examination of violence against older persons; (iv) to build the capacity of professionals to work with older persons and female victims or at risk of violence; and (v) to promote the development of quality services from the point of view of older victims and survivors.[207] In addition, workshops and conferences were organised in Austria, Poland, Finland, Portugal and Italy.

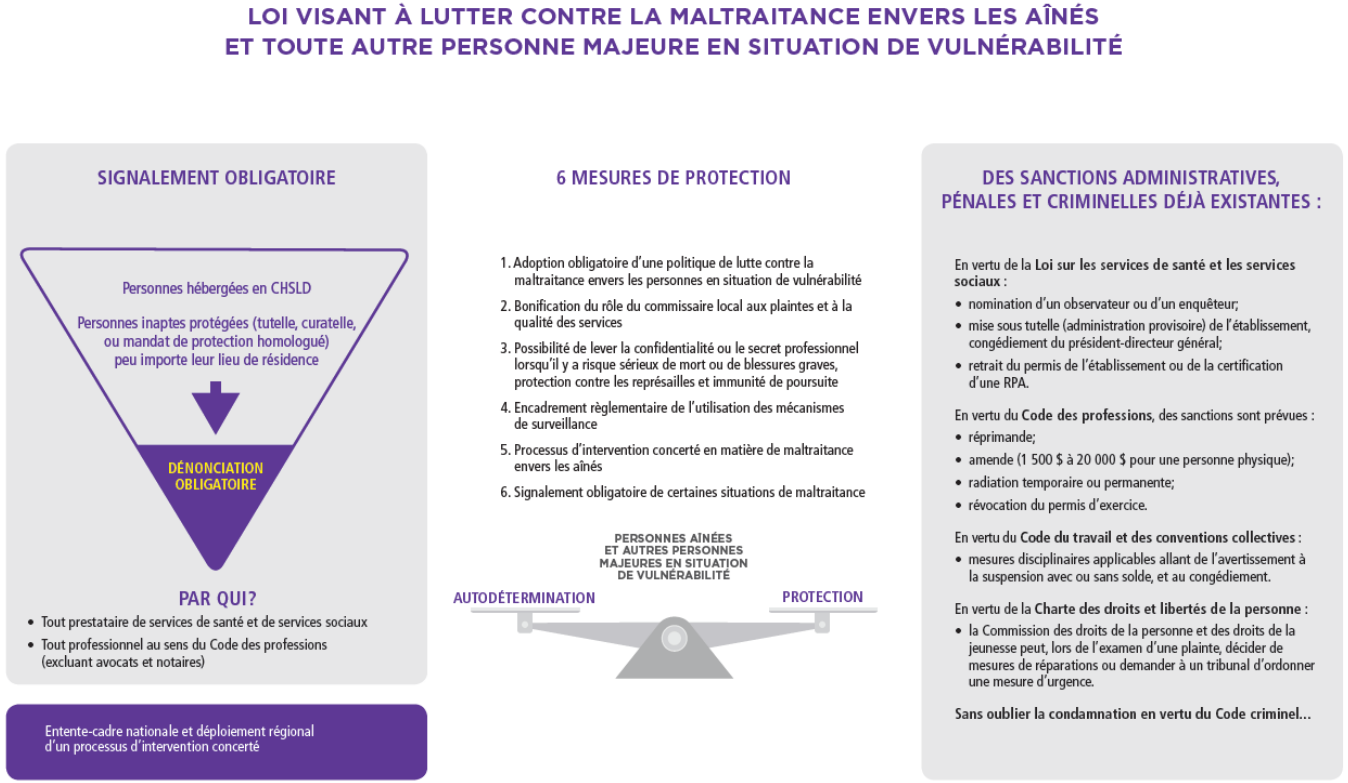
a http://www.btt-project.eu/index.php?id=29

b http://www.btt-project.eu/index190a.html?id=17

c http://www.btt-project.eu/indexa9bc.html?id=19

APPENDIX 14. LAW OF QUÉBEC COMBATTING ABUSE AGAINST SENIORS AND VULNERABLE ADULTS

Figure 39 – Law of Québec combatting abuse against seniors and vulnerable adults



PORTRAIT DES SANCTIONS POSSIBLES POUR LA PERSONNE QUI AURAIT COMMIS DE LA MALTRAITANCE OU OMIS D'AGIR POUR FAIRE CESSER LA SITUATION

ÉTABLISSEMENT	PROFESSIONNEL	PRESTATAIRE DE SOINS	TOUTE PERSONNE
En vertu de la Loi sur les services de santé et les services sociaux : • Nomination d'un observateur ou d'un enquêteur • Mise sous tutelle (administration provisoire) de l'établissement • Retrait du permis de l'établissement ou révocation de la certification d'une RPA En vertu de la Loi modifiant l'organisation et la gouvernance du réseau de la santé et des services sociaux, notamment par l'abolition des agences régionales et de la Loi d'interprétation : • Mise à pied du président-directeur général, de hors-cadres ou de cadres	En vertu du Code des professions : • Réprimande • Amende (au moins 1 500 $ et au plus 20 000 $ ou, dans le cas d'une personne morale, au moins 3 000 $ et au plus 40 000 $. En cas de récidives, ces amendes sont doublées) • Radiation temporaire ou permanente • Révocation du permis En vertu du Code du travail et des conventions collectives : • Mesures disciplinaires applicables, allant de l'avertissement ou de la lettre au dossier de l'employé jusqu'à la suspension avec ou sans solde et même jusqu'au congédiement En vertu de la Charte des droits et libertés de la personne, la Commission des droits de la personne et des droits de la jeunesse (CDPDJ) peut, lors de l'examen d'une plainte, décider de mesures de réparation comme celles-ci : • Cessation de l'acte reproché • Paiement d'une indemnité La CDPDJ peut également : • prendre toutes les mesures appropriées pour faire cesser l'exploitation, assurer la sécurité de la personne âgée ou handicapée et obtenir réparation pour le tort subi; • demander à un tribunal d'ordonner une mesure d'urgence. En vertu du Code criminel : • Ordonnance de remboursement • Ordonnance de protection (ex. : impossibilité pour l'abuseur d'entrer en contact avec sa victime) • Peine d'emprisonnement	En vertu du Code du travail et des conventions collectives : • Mesures disciplinaires applicables, allant de l'avertissement ou de la lettre au dossier de l'employé jusqu'à la suspension avec ou sans solde et même jusqu'au congédiement En vertu de la Charte des droits et libertés de la personne, la CDPDJ peut, lors de l'examen d'une plainte, décider de mesures de réparation comme celles-ci : • Cessation de l'acte reproché • Paiement d'une indemnité La CDPDJ peut également : • prendre toutes les mesures appropriées pour faire cesser l'exploitation, assurer la sécurité de la personne âgée ou handicapée et obtenir réparation pour le tort subi; • demander à un tribunal d'ordonner une mesure d'urgence. En vertu du Code criminel : • Ordonnance de remboursement • Ordonnance de protection (ex. : impossibilité pour l'abuseur d'entrer en contact avec sa victime) • Peine d'emprisonnement	En vertu de la Charte des droits et libertés de la personne, la CDPDJ peut, lors de l'examen d'une plainte, décider de mesures de réparation comme celles-ci : • Cessation de l'acte reproché • Paiement d'une indemnité La CDPDJ peut également : • prendre toutes les mesures appropriées pour faire cesser l'exploitation, assurer la sécurité de la personne âgée ou handicapée et obtenir réparation pour le tort subi; • demander à un tribunal d'ordonner une mesure d'urgence. En vertu du Code criminel : • Ordonnance de remboursement • Ordonnance de protection (ex. : impossibilité pour l'abuseur d'entrer en contact avec sa victime) • Peine d'emprisonnement

https://publications.msss.gouv.qc.ca/msss/fichiers/ainee/Affichette-Projet-loi115.pdf

https://cdn-contenu.quebec.ca/cdn-contenu/sante/images/Autres_themes/tableau_sanctions-possibles.pdf?1542053069

APPENDIX 15. LAWS IN CANADA AND QUÉBEC CONCERNING ELDER ABUSE

Figure 40 – General and sectorial laws concerning elder abuse

LOIS GÉNÉRALES

LOIS	RÉSUMÉ	ORGANISMES RESPONSABLES DE SON APPLICATION OU POUVANT PARTICIPER AU PROCESSUS
Charte canadienne des droits et libertés	La Charte canadienne des droits et libertés encadre les rapports entre l'État et les individus. Elle garantit les droits et libertés qui y sont énoncés, notamment la liberté de conscience et de religion. Elle garantit aussi le droit à la vie, à la liberté et à la sécurité de sa personne et à la protection contre tous traitements ou peines cruels et inusités.	**Tribunal compétent**
Charte des droits et libertés de la personne	La Charte québécoise des droits et libertés de la personne encadre les rapports des citoyens entre eux et avec leurs institutions. Les droits à la vie, à la sûreté, à l'intégrité et à la liberté de sa personne sont affirmés par cette charte. Celle-ci décrète également que toute personne a droit à la reconnaissance et à l'exercice, en pleine égalité, de ses droits et de ses libertés, sans distinction, exclusion ou préférence fondée notamment sur l'âge, le handicap ou l'utilisation d'un moyen pour pallier ce handicap. Au sens de la Charte des droits et libertés de la personne, exploiter une personne aînée ou handicapée consiste à profiter de sa vulnérabilité ou de son état de dépendance en la privant de ses droits, en lui soutirant notamment de l'argent ou des biens, en lui infligeant de la maltraitance, en la privant de soins nécessaires à sa santé, à sa sécurité ou à son bien-être ou encore en portant atteinte à sa dignité.	**Tribunal des droits de la personne** **Commission des droits de la personne et des droits de la jeunesse**
Code criminel	À titre indicatif, certaines infractions criminelles peuvent constituer différents types de maltraitance : ▪ La maltraitance physique (ex. : voies de fait, infliction de lésions corporelles, voies de fait graves, séquestration, etc.); ▪ La négligence (ex. : négligence criminelle, omission de fournir les choses nécessaires à l'existence, etc.); ▪ La maltraitance sexuelle (ex. : agression sexuelle, etc.); ▪ La maltraitance psychologique et émotionnelle (ex. : harcèlement, menaces de mort ou de lésions corporelles, communications harcelantes, intimidation, etc.); ▪ La maltraitance financière et matérielle (vol, extorsion, fraude, vol d'identité, etc.).	**Cour du Québec** **Cour supérieure du Québec** **Cour d'appel du Québec** **Directeur des poursuites criminelles et pénales**
Code civil du Québec	Le Code civil du Québec prévoit des dispositions générales qui s'appliquent à certaines situations de maltraitance, notamment : ▪ La maltraitance physique, sexuelle et psychologique (ex. : toute personne est inviolable et a droit à son intégrité; toute personne a le devoir de respecter les règles de conduite qui, suivant les circonstances, les usages ou la loi, s'imposent à elle, de manière à ne pas causer de préjudice à autrui, etc.); ▪ La maltraitance financière (consentement libre et éclairé, clause abusive dans un contrat, donation, etc.). Les conditions d'hébergement sont également couvertes par le Code civil, du moins lorsqu'il est question de location de logements (ex. : jouissance paisible des lieux, mauvais état du logement, etc.). Toutefois, ces règles ne s'appliquent pas, notamment, aux chambres en établissement de santé.	**Cour du Québec** **Cour supérieure du Québec** **Cour d'appel du Québec**

LOIS SECTORIELLES

LOIS	RÉSUMÉ	ORGANISMES RESPONSABLES DE SON APPLICATION OU POUVANT PARTICIPER AU PROCESSUS
Loi visant à lutter contre la maltraitance envers les aînés et toute autre personne majeure en situation de vulnérabilité	La Loi visant à lutter contre la maltraitance envers les aînés et toute autre personne majeure en situation de vulnérabilité vise à prévenir les situations de maltraitance, à en faciliter la dénonciation et à favoriser la mise en œuvre d'un processus d'intervention efficace à cet égard. Cette loi met en place ou renforce les mesures de protection suivantes : 1. Adoption obligatoire, par les établissements du réseau de la santé et des services sociaux, d'une politique de lutte contre la maltraitance envers les personnes en situation de vulnérabilité qui reçoivent des services de santé et des services sociaux; 2. Traitement des plaintes et des signalements relatifs à de la maltraitance par le commissaire local aux plaintes et à la qualité des services; 3. Conclusion d'une entente-cadre nationale concernant la maltraitance envers les aînés, dont le déploiement s'effectue par région et qui pourra s'appliquer, dans un second temps, à toute personne majeure en situation de vulnérabilité; 4. Levée de la confidentialité ou du secret professionnel possible lorsqu'il y a risque sérieux de mort ou de blessures graves; 5. Encadrement réglementaire de l'utilisation, par les usagers ou par leurs représentants, des mécanismes de surveillance, tels que les caméras. La loi prévoit également rendre obligatoire, pour tout prestataire de services de santé et de services sociaux et tout professionnel (sauf les avocats et les notaires), le signalement des situations de maltraitance qui portent atteinte de façon sérieuse à l'intégrité physique ou psychologique des personnes suivantes : • Les personnes résidant dans un centre d'hébergement et de soins de longue durée; • Les personnes inaptes (sous tutelle, curatelle ou dont le mandat de protection a été homologué). Le signalement est effectué auprès du commissaire local aux plaintes et à la qualité des services d'un établissement si cette personne y reçoit des services ou, dans les autres cas, au corps de police concerné.	**Ministère de la Famille, Secrétariat aux aînés** **Ministère de la Santé et des Services sociaux** **Ministère de la Sécurité publique** **Ministère de la Justice du Québec** **Directeur des poursuites criminelles et pénales** **Autorité des marchés financiers** **Commission des droits de la personne et des droits de la jeunesse** **Curateur public du Québec** **Commissaire local aux plaintes et à la qualité des services** **Corps de police**
Loi sur les services de santé et les services sociaux	La Loi sur les services de santé et les services sociaux instaure un régime de services ayant pour but, entre autres choses, de maintenir et d'améliorer la capacité physique, psychique et sociale des personnes. En ce qui a trait à la lutte contre la maltraitance, cette loi a pour objectifs connexes : • d'agir sur les facteurs déterminants pour la santé et le bien-être et de rendre les personnes, les familles et les communautés plus responsables à cet égard par des actions de prévention et de promotion; • de favoriser le recouvrement de la santé et du bien-être des personnes; • de favoriser l'adaptation ou la réadaptation des personnes, leur intégration ou leur réintégration sociale; • de diminuer l'impact des problèmes qui compromettent l'équilibre, l'épanouissement et l'autonomie des personnes.	**Ministère de la Santé et des Services sociaux** **Comité des usagers** **Commissaire local aux plaintes et à la qualité des services**

LOIS SECTORIELLES

LOIS	RÉSUMÉ	ORGANISMES RESPONSABLES DE SON APPLICATION OU POUVANT PARTICIPER AU PROCESSUS
Loi sur le Curateur public	La Loi sur le Curateur public prévoit notamment l'organisation administrative et certaines des attributions du Curateur public du Québec. En vertu de cette loi, le Curateur public peut notamment intervenir dans toute instance relative à l'homologation ou à la révocation d'un mandat donné en prévision de l'inaptitude (ou mandat de protection), ou à l'ouverture d'un régime de protection (tutelle ou curatelle).	**Curateur public du Québec**
Loi sur le Protecteur des usagers en matière de santé et de services sociaux	La loi sur le Protecteur des usagers en matière de santé et de services sociaux prévoit que le Protecteur du citoyen exerce les fonctions de Protecteur des usagers en matière de santé et de services sociaux. Il a pour principale fonction d'examiner la plainte formulée par un usager. Il veille au respect des usagers ainsi qu'aux droits qui leur sont reconnus, notamment par la Loi sur les services de santé et les services sociaux.	**Protecteur du citoyen**
Loi sur la protection des personnes dont l'état mental présente un danger pour elles-mêmes ou pour autrui	La Loi sur la protection des personnes dont l'état mental présente un danger pour elles-mêmes ou pour autrui complète le Code civil du Québec relativement à la garde, par un établissement de santé et de services sociaux, des personnes dont l'état mental présente un danger pour elles-mêmes ou pour autrui et sur l'évaluation psychiatrique visant à déterminer la nécessité d'une telle garde.	**Ministère de la Santé et des Services sociaux**
Loi sur l'aide aux victimes d'actes criminels	La Loi sur l'aide aux victimes d'actes criminels prévoit plusieurs dispositions visant à répondre aux besoins et aux préoccupations des personnes victimes d'actes criminels. Cette loi édicte notamment qu'une personne victime d'un acte criminel a le droit : • D'être traitée avec courtoisie, équité, compréhension et dans le respect de sa vie privée; • De recevoir, de façon prompte et équitable, réparation ou indemnisation pour le préjudice subi; • De recevoir l'assistance médicale, psychologique et sociale que requiert son état ainsi que les autres services d'aide appropriés à ses besoins en matière d'accueil, d'assistance et de référence aux autres services les plus aptes à lui venir en aide.	**Ministère de la Justice du Québec** **Bureau d'aide aux victimes d'actes criminels** **Centres d'aide aux victimes d'actes criminels**
Loi sur l'indemnisation des victimes d'actes criminels	La Loi sur l'indemnisation des victimes d'actes criminels permet aux victimes d'actes criminels d'obtenir du soutien et un dédommagement financier destiné à compenser les blessures physiques et psychologiques qu'elles ont subies.	**Ministère de la Justice du Québec** **Direction de l'indemnisation des victimes d'actes criminels** **Centres d'aide aux victimes d'actes criminels**

LOIS SECTORIELLES

LOIS	RÉSUMÉ	ORGANISMES RESPONSABLES DE SON APPLICATION OU POUVANT PARTICIPER AU PROCESSUS
Loi sur l'Autorité des marchés financiers	La Loi sur l'Autorité des marchés financiers établit la mission de l'Autorité des marchés financiers soit, entre autres, de prêter assistance aux consommateurs de produits et services financiers, notamment en établissant des programmes éducationnels en matière de consommation de produits et services financiers, en assurant le traitement des plaintes reçues des consommateurs, en leur donnant accès à des services de règlement de différends et en mettant en place des programmes de protection et d'indemnisation des consommateurs. L'Autorité veille également à l'application des lois propres à chacun des domaines qu'elle encadre, dont la Loi sur les assurances, la Loi sur les coopératives de services financiers, la Loi sur la distribution de produits et services financiers, la Loi sur les valeurs mobilières et la Loi sur les instruments dérivés. Ces lois comportent de nombreuses dispositions qui visent la protection des consommateurs de produits et services financiers. L'Autorité peut aussi faire appel à des organismes d'autoréglementation, tels la Chambre de la sécurité financière, la Chambre de l'assurance de dommages et l'Organisme canadien de réglementation du commerce des valeurs mobilières, auxquels sont délégués certains pouvoirs d'encadrement.	**Autorité des marchés financiers** **Tribunal administratif des marchés financiers** **Cour supérieure du Québec** **Chambre de la sécurité financière** **Chambre de l'assurance de dommages** **Organisme canadien de réglementation du commerce des valeurs mobilières**
Loi sur la protection du consommateur	La Loi sur la protection du consommateur s'applique à tout contrat conclu entre un consommateur et un commerçant dans le cours des activités de son commerce et ayant pour objet un bien ou un service (ex. : vente itinérante, achat d'un voyage, etc.).	**Office de la protection du consommateur du Québec**

APPENDIX 16. BRIEF DESCRIPTION OF THE TOOLS DEVELOPED BY THE STRUCTURES RÉGIONALES D'APPUI À LA QUALITÉ DES SOINS ET À LA SÉCURITÉ DES PATIENTS

The tools developed by the SRE's[a] involve tools of auto-evaluation which allow to evaluate in one hand the structure (organisation, support, methods) and in the other hand the professionals (to question its own practices, to give its opinion on the organisation, methods and support). The auto-evaluation tool from the Rhône-Alpes region uses current situation of care in which everybody can identify the risk of EA and questions his practices and the structure's organisation. Another type of tool consists of a list of items (related to the structure or the care) which have to be debated inside institutions with a score of risk of maltreatment for each item. It allows to prioritize the actions of the well treatment plan. Open discussions based on real life situation in nursing homes with collective and global questioning about practices are also suggested by SRE. A well treatment charter is available in two regions (Basse-Normandie and Franche-Comté) where institutions develop actions around 10 key points extracted from the charter[110].

[a] http://www.ccecqa.asso.fr/outil/changement-des-pratiques-professionnelles/bientraitance

Table 60 – Characteristics of the tools developed by the SRE's

Name	Type	Objective	Target setting/population
Improvement of well-treatment practices: tool of evaluation of the SRE-REQUA	Auto-evaluation	Evaluation of the professionals practices including an individual part and an institutional section	Long-term hospitalisation units and nursing homes
Crossed regards on the well-treatment: tool of evaluation of the SRE-RQS	Auto-evaluation	Evaluation of the professionals practices including an individual section and an institutional section	Health institutions
The well-treatment in question: individual evaluation of practices of the SRE-CEPPRAL	Auto-evaluation	Prevention of maltreatment risk in the professionals practice	Caregivers
Dashboard of well-treatment: mapping of risks of the SRE-RSQ	/	Identification and prevention of maltreatment risks	Health institutions and nursing homes
Well-treatment in life situations: tool for team animation of the SRE-CCECQA	Animation tool	Sensitization and animation of team around well-treatment	Teams in health institutions
Specifications of training: tool to help at the decision of the SRE-RSQ	Decision support tool	Building of training specifications in the scope of the institution's well-treatment project	Manager of institutions
Well-treatment principles: declension of a charter of the SRE-RBNSQ	/	Sensitizing professionals to the well-treatment theme	Health institutions and nursing homes

APPENDIX 17. COMPARATIVE TABLE OF PREVENTIVE ACTIONS IN 3 COUNTRIES

Table 61 – Data on preventive actions in the Netherlands, France and Québec

Preventive actions category	The Netherlands	France	Québec
Existence of laws and policies specifically on elder abuse handling	2011-2018: National Action Plan "Ouderen in veilig handen"	2007 : Plan de développement de la bientraitance et de renforcement de la lutte contre la maltraitance 2007: Decree creating "Comité national de vigilance et de lutte contre la maltraitance des personnes âgées et des adultes handicapés » 2013 : Decrees creating « Comité national pour la bientraitance et les droits des personnes âgées et des personnes handicapées"	2010-2015: Plan d'action gouvernemental pour contrer la maltraitance envers les personnes aînées 2017-2022 : Plan d'action gouvernemental pour contrer la maltraitance envers les personnes aînées 2017 : Loi visant à lutter contre la maltraitance envers les aînés et toute autre personne majeure en situation de vulnérabilité
Policy and practice improvement in nursing homes	Wkkgz Act: mandatory report of care incident in RCF to the management or the Health Care Inspectorate In the NAP 2011-2018: compulsory certificate of good behaviour (verklaring omtrent gedrag) for professional in RCF + manual for screening new staff; Safe Care Relationship Guide addressed to RCF managers (Leidraad Veilig Zorgrelatie)	2002-2003: charter of rights and freedoms in RCF Code of Social Action and Families: Obligation to report to authorities any organisational dysfunction impacting RCF residents well-being National policy main actions includes for RCF: the implementation of policy of good treatment; the culture of analysis and risk management; diffusing good practices and guidelines with the support of the ANESM and the HAS; strengthening controls (verify hosting and care conditions, identify abuse and risk factors, propose solutions and give sanctions).	Québec Act to combat abuse: RCF are obliged to adopt and implement policy to combat abuse and to diffuse it (poster, webstite); mandatory reporting of any abuse in RCF by any professional of the health or social sector; mandatory procedure to intervene in case of abuse Possible administrative, legal and criminal sanctions according to the Act on health services and social services; the professional code; the work and collectives agreements code; the charter for right and freedom of people in Canada and Québec; and the criminal code. Practical guide to combat EA suggests the adoption in every RCF of a charter including prevention, sensitisation and intervention Qc AP 2017-2022 suggests the revision of certain programs depending on the practice evolution, the release of staff to take part in professional development activities, and the creation of specialized teams to

			promote the transfer of knowledges to the peer.
Training of professionals	NAP 2011-2018: e-learning module for actual and future physician, nurse and nurse assistant on detection and early management; Movisie training for professionals and volunteers to discuss out of the taboo; practical guidelines for volunteers; guide on EA prevention for municipality officers; e-learning tool for bank employees	CNSA MobiQual programme: training kits for professional in RCF, hospitals and at home services on notably well-treatment + support to basic training of nurse, educators, nurse assistant, medico-psycho-assistant,… CNCPH 2019: call the French government to develop practical training (role-playing games) in RCF involving vulnerable people and their caregivers	AP 2010-2015: creation and support of a research and teaching academic chair in EA whose missions are to develop and disseminate awareness and training tools, to organise networking and to host a website including all materials about EA + helpline Info-Aidant: free and confidential helpline for professionals AP 2017-20122: one objective is to inform, train and tool field actors concerning EA in different sectors: Financial sector: checklist, info sessions, guidelines, forum and website Police sector: newsletter with statistics on EA, info sessions, Police Practice Manual on EA Justice sector: directives for prosecutors about victims handling, training of prosecutors about financial crimes against older persons, training on mediation in the context of protection regime and mandates and training on law about disclosure of confidential info Health and assistance: deployment of the existing tools (in particular the reference guide) with update, feedback meeting with professionals about tools use, community agencies education on EA prevention and development of specific tool on EA of LGBT seniors Education and housing: awareness-raising activities in the public housing sector and dissemination of awareness tools in the education sector

Informal caregivers' support	Official Dutch website: highlight the need to bring derailed IC out the taboo sphere Website "aanpak-OMB": stepplan in case of risk of EA related to derailed IC + 'mantelscan' which maps the network around the OP and alerts possible gap and risk of overburden Markant organisation: self-assessment '3-minutes check for caregivers' Guide to support HCP in preventing and supporting overburdened and derailed IC	HAS: guide about care path of people with chronic disease highlights the need to support ICG by annual medical check, helpline, respite care… ANESM (now HAS): recommendations to HCP to support ICG. Tool available on how to help ICG. Law 2015-1776 on the adaptation of the French society to ageing asks to support and value ICG. APA can finance respite for ICG and care relay if ICG is hospitalised 2019: CNBD ask a better centralisation of the support to ICG	Since 2018, Qc ministry of health and social help develops a plan to consolidate the recognition of ICG, promote their role and provide them with the necessary support, i.e. to care to ICG before they become exhausted "L'appui" offers info, helpline, training, psychological support and respite to ICG RANQ: federation of ICG associations: raise awareness about ICG and promote their interest Few leaves and taxes adaptations exist but not specifically for ICG
Public awareness	2012: national public campaign on the radio and TV "een veilig thuis" with a free call number 24/7 if any concern about EA 2013: DVD with 5 types of EA 2016: tool to sensitize OP to financial abuse Official state website includes an interactive webpage to learn to identify sign of EA Several awareness campaigns done by seniors associations and municipalities Joint action of health and justice ministries "huiselijk geweld" has focussed in 2019 on EA through poster, videos, texts on social media, fact sheets and audio materials	2007: FIAPA call to the French government to disseminate info about financial abuse via media alerts 2008: national campaign on EA and the helpline 3977 2018: FIAPA organises a campaign with ads on TV, posters and folders to sensitise on EA signs and at risk situations + helpline 3977 2019: CNBD commission call to the French government for recurrent communication about EA on a large public	Since the AP 2010-2015: at least 5 sensitisation programs on signs of abuse, sexual EA, financial fraud, civil rights of victims Other sensitisation process (than campaign): updating of Qc resource directory for EA In the plan 2017-2022: sensitisation campaigns on society behaviour, on well-treatment, on financial abuse, on rights and remedies, on help trajectories of services; addressed to large public or older victims or informal caregivers In the Reference guide: highlighting of the 15th of June and the importance of the local media In 2016 in Québec, it can be set that Qc population has increased its level of vigilance about EA. Campaigns have targeted large public, seniors, informal caregivers and volunteers. The means of sensitisation are very diverse: folder, games, theatre play, movies, ads, … The content are about types of EA, good

			practices of self-protection or resources services. To reach isolated seniors, spot on TV and radio, and meeting in nursing homes or day care are recommended. The best sensitisation tool is dynamic, close to hand, elaborated with seniors and avoid waste of time and materials. The best sensitisation meeting include several specialists with seniors and stakeholders, the audience is multi sectorial and a large time after the meeting is planned.
Programme decreasing ageist attitude and stereotypes toward older people + empowerment of OP	EA prevention done by municipalities to be integrated in the local policy of societal support and safety. Op should stay at home and includes in the society.	2019: CNDB: to support autonomy and prevent EA, a profound transformation of the care approach is needed 2018: CCNE-advice 128: deconcentrating OP out of RCF with a more inclusive society for OP Fight against ageism highlighted in a book of the 3977 administrator Empowerment of OP highlighted on website for the elderly: Alma, France-victims, Age-Village 2015: HAS-FORAP highlights well-treatment and a shift of paradigm in the caregiver-care receiver relationship with a shared medical decision-making process 2015-1776 law on the adaptation of the French society to ageing: financing prevention of autonomy loss, financing means against isolation, establishment of senior civic volunteering, establishment of collective housing and transport, strengthening the procedure for obtaining consent to enter RCF, enable OP to designate a trusted person	Reference guide: promotion of acting ageing and combating ageism Website 'vieillir en liberté' supports the empowerment of OP Guide 2011 of the Department of Justice in Canada gives advices which empower OP to fight EA Website 'educaloi' explaining Canadian laws to the public empowers OP in the procedure to complain

APPENDIX 18. COMPARATIVE TABLE OF PREVENTIVE ACTIONS IN BELGIUM

Table 62 – Data about preventive actions in Belgium at the federal and federated levels

Preventive actions category	Belgium	Flanders	Wallonia	Brussels
Existence of laws and policies specifically on elder abuse handling	2006: global policy against IFV includes a step plan to guide HCP to handle EA situations National Plan against gender-related violence 2010-2015 includes the training of GPs about EA National Plan against gender-related violence 2015-2019 includes specific campaigns for fragile people including older people COL on violence against older people (in progress)	2012: Decree creating the specialised organisation VLOCO	2008: Decree creating the specialised organisation Respect Senior (Articles 378 to 388 of the Code Wallon de la santé et de l'action sociale)	Decree creating the specialised organisation Ecoute Senior 2009: Decree creating the Brussels Meldpunt OMB
Policy and practice improvement in residential care facilities (RCF)	2003: law prevent that RCF staff and manager to inherit	2001: Decree on quality requirement for RCF: falls prevention, restraint use, complaint procedure 2003: Quality decree 5: obligation in Flemish nursing homes to have a quality charter (kwaliteitshandboek); self-evaluation; annual quality plan 2009: Decree on RCF accreditation standard 2012: EU charter 2010 on LT-care is translated in Dutch 2013: Flemish quality indicator project aims to include objective and subjective indicators in quality evaluation	2010: Tools from the AWHIP in case of abuse against disabled people Art 337 of the Walloon code is about the well-being of resident in nursing homes Art 338 of the Walloon code is about the free ratification by walloon RCF of a quality charter about the needs, the expectations and the respect of the residents Coordinator GP and head nurse of RCF must elaborate a program of quality: minimal procedure of registering falls and restraint use. Audit and Control department of the AViQ: conciliation to sanction	Infor-Home – Home-Info: visit, mediation and advices COCOM legal rules: obligation for all RCF to display information about Ecoute Senior and to train their staff and manager about EA

		2019: Decree "Woonzorg": well-treatment; right to complaint; satisfaction monitoring Control by "Vlaams Zorginspectie": results on the website; quality norms and indicators; compliance with accreditation standards Woonzorglijn: advises en complaint handling	Senoah: conciliation between RCF and AViQ	
Training of professionals	2012: Pilot project for professionals in 9 hospitals Non-obligatory training for policemen and magistrate RIZIV-INAMI: training of referent people for dementia includes well-being approach	E-learning tools of Domus Medica for GPs Guidelines from Domus Medica Kennisplein.be website groups training tools and EA infos Tool SEL Waasland eerste lijnszone Training given by VLOCO to professionals through the 'train the trainer' approach Diverse trainings given by private parties in hospitals and other settings.	Guidelines SSMG (2013) Isolated initiaves (ULg-Psychology Department) Training to professionals and future professionals given by Respect Senior on demand	Training to professionals (particularly of nursing homes) and to future professionals given by Ecoute Senior Training to professionals given by Brussels Meldpunt
Informal caregivers' support	Law recognising the informal caregiver (ICG) status (2014) + amendment 2019 on specific leave (but Royal Decree is lacking) Law allowing ICG to keep their unemployment allocation without being on the work market Diverse initiatives by sickness funds, like premiums for people with high care needs (but this is not directly paid to the informal caregiver) or respite care	Mantelzorg Plan 2016-2020 Flemish region policy supporting financially ICG : Flemish care allowance of 130 euros/month to the dependent OP and only for non-medical purpose Decree 2019 "woonzorg" also concerns ICG associations and includes a budget for OP with care need.	Walloon specialised organisation dedicated to ICG supported by the authorities (Aidants proches) since 2015: train HCP to the needs of ICG and develop political action plan in 2019 AViQ 'Bien vivre chez soi' : improving QoL at home + involvment in Interreg V about training of HCP to care ICG Respite care available in residential care facilities and by other initiatives from different	Brussels specialised organisation dedicated to ICG supported by the authorities (Aidants proches-Brussels) Respite care is available in residential care facilities and by other initiatives from different actors, such as sitting home-respite care provided by the sickness funds Different regional and local organisations and institutions (social services of the sickness

	Paid leaves for the informal caregiver to give a medical assistance to smn Time credit or career break to care smn sick	Flemish government foresee respite care 'oppashulp/gastopvang' Flemish organisation specialised in informal care (Vlaams expertisepunt mantelzorg) Respite care is available in residential care facilities and by other initiatives from different actors, such as sitting home-respite care provided by the sickness funds Flemish dementia plan including psycho-education of ICG Mantelzorgpremie in several Flemish municipalities Different regional and local organisations and institutions (social services of the sickness funds, informal caregiver associations, social services of the hospitals, public municipal welfare centres, etc) provide information to informal caregivers Six non-profit associations (Steunpunt Mantelzorg Liever Thuis LM Ziekenzorg van de Christelijke Mutualiteiten Ons Zorgnetwerk OKRA-ZORGRECHT van OKRA, trefpunt 55+ and S- Plus Mantelzorg)	actors, such as sitting home-respite care provided by the sickness funds Different regional and local organisations and institutions (social services of the sickness funds, informal caregiver associations, social services of the hospitals, public municipal welfare centres, etc) provide information to informal caregivers APA paid to the dependent older person	funds, informal caregiver associations, social services of the hospitals, public municipal welfare centres, etc) provide information to informal caregivers. APA paid to the dependent older person Six non-profit Dutch-speaking associations (Steunpunt Mantelzorg Liever Thuis LM Ziekenzorg van de Christelijke Mutualiteiten Ons Zorgnetwerk OKRA-ZORGRECHT van OKRA, trefpunt 55+ and S- Plus Mantelzorg)
Public awareness		By 1712 about their existence	By Respect Senior about their existence	By Infor-Home on early detection of EA

		By 1712 every year in June – International day against elder abuse Numerous sensitisation activities by 1712 (publicity on busses De Lijn, posters, short movies on the website, TV spots, …) targeting older people and public at large By VLOCO about their existence By VLOCO every year in June – International day against elder abuse Numerous sensitisation activities by VLOCO (press articles and interviews, a cartoon referring to VLOCO was printed and distributed via 50.000 bread bags, …)	By respect Senior every year in June about elder abuse Numerous sensitisation activities by Respect Senior (cinema, théâtre, conférences, expo, quizz, games) targeting older people, all public and young people	By BMO (giving lectures, organising an annual colloquium and workshops, developing projects, participating in events with an info stand, an extensive website and distributing promotional material,…) on elder abuse targeting all public and the authorities in particular. By BMO every year in June – International day against elder abuse By Ecoute Séniors ('matinée de réflexion' at VUB, several sensibilisation and training activities for students, professionals in contact with older persons, informal caregivers,folders and posters are regularly sent to interested parties. . By Ecoute Senior on elder abuse in particular to ICG and authorities
Programme decreasing ageist attitude and stereotypes toward older people + empowerment of OP	Extra-judiciary mandate in the civil code (advanced directives by people growing old) National private initiatives (be.source; fellow servicemen (compagnons dépanneurs), Angry Old People Gang) King Baudouin Foundation: financing of project with empowerment of nursing home's residents	Flemish initiatives supported by the authorities (Road 67, Forget dementia project, digitalisation and senior citizen) 'Vlaams ouderenbeleidsplannen' include OP needs and OP involvment Flemish Elderly Council OKRA highlights OP empowerment	'Conseil consultative des Aînés' in each Walloon municipality AViQ : coaching in nursing homes to support the co-management with the residents Intergenerational project (Atoutage, Social cohesion plan) 'Code wallon santé et social' art. 341: residents council in every RCF	Brussels initiatives supported by authorities (Pens(i)on Quartier; Maison-Biloba-Huis, Labolobo project, Entr'age) Brussels = U.N. global aged-friendly city

	Age Platform: sensitisation campaign in Brussels (2018) on the human rights of older people	Woonzorglijn poster addressed to older persons
	Sickness fund initiatives: ENEO	

CHAPTER 4: INTERNATIONAL OVERVIEW OF STEP-BY-STEP PLANS IN CASE OF SUSPICION OF ELDER ABUSE

APPENDIX 19. ELDER ABUSE POLICIES AND GUIDELINES IN AUSTRALIA

Figure 41 – Overview of elder abuse policies and guidelines in Australia

Table 1: State/territory elder abuse policy frameworks and practice guidelines

State/territory	Organisation/department	Policies and guidelines
Victoria	Department of Health and Human Services	Elder Abuse Prevention and Response Guidelines for Action 2012-14 (2012); and With Respect to Age Practice Guidelines (2009)
South Australia	SA Health	Strategy for the Safeguarding of Older South Australians Action Plan 2014-21 (2015)
New South Wales	Department of Ageing, Disability and Home Care	Interagency Protocol for Responding to the Abuse of Older People (2007)
Tasmanian	Department of Health and Human Services	Responding to Elder Abuse: Tasmanian Government Practice Guidelines for Government and Non-Government Employees (2012)
ACT	ACT Government	ACT Elder Abuse Prevention Program Policy (2012)
Western Australia	Alliance for the Prevention of Elder Abuse	Elder Abuse Protocol: Guidelines for Action (2013)
Queensland	-	Strategy not publicly available, but note Elder Abuse website and Elder Abuse Prevention Unit (UnitingCare)
NT	-	-

Source: Chesterman, (2015a), p. 2

Source: Kaspiew, 2016[116]

APPENDIX 20. AUSTRALIAN NATIONAL PLAN

Figure 42 – Priority areas, initiatives and time frame of the Australian National Plan to respond to the abuse of older Australians 2019-2023

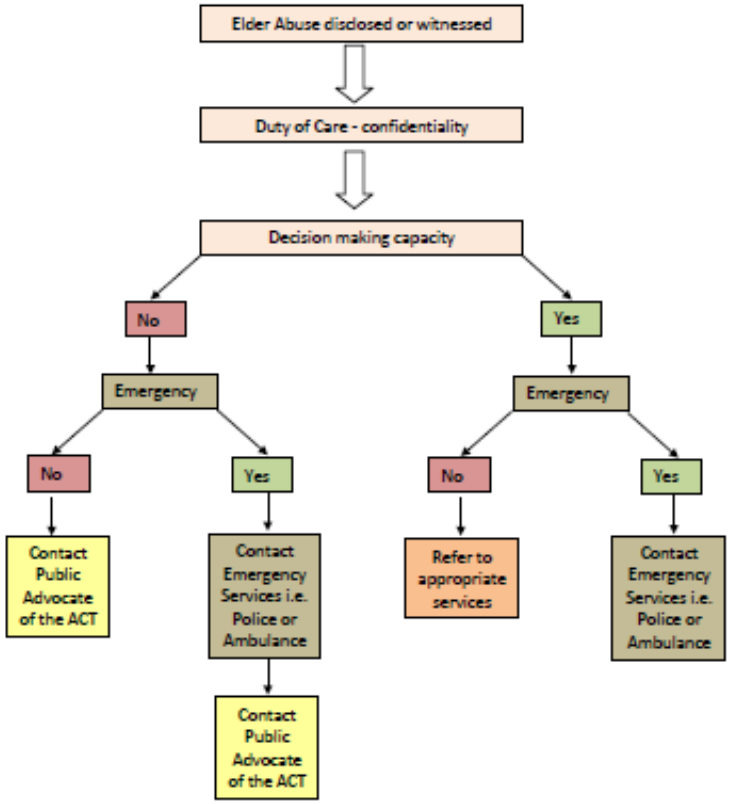
INITIATIVES	TIMEFRAMES
PRIORITY AREA 1—ENHANCING OUR UNDERSTANDING	
1.1 Conduct a national prevalence study on abuse of older people	Short term
1.2 Develop an agreed set of national research priorities	Medium term
1.3 Improve our ability to share learnings from existing programs, in order to better target future programs	Ongoing
1.4 Evaluate and report on the effectiveness of the National Plan through monitoring and review	Ongoing
PRIORITY AREA 2—IMPROVING COMMUNITY AWARENESS AND ACCESS TO INFORMATION	
2.1 Develop a communication strategy that integrates the views of older people, including diverse groups of older people, to increase understanding and awareness of abuse of older people in the community	Short term
2.2 Start building a National Knowledge Hub to consolidate information and resources about abuse of older people in one online location, including information and resources for diverse groups of older people	Short term
PRIORITY AREA 3—STRENGTHENING SERVICE RESPONSES	
3.1 Establish and evaluate front-line support services for older people experiencing abuse in a range of locations across the country	Short term
3.2 States and territories continue to provide and strengthen front-line responses to emerging needs	Ongoing
PRIORITY AREA 4—PLANNING FOR FUTURE DECISION-MAKING	
4.1 States and territories consider developing options for harmonising enduring powers of attorney, particularly in relation to financial powers of attorney, to achieve greater national consistency	Medium term
4.2 Investigate the feasibility of developing a national online register of enduring powers of attorney	Short to medium term
4.3 Better inform people of rights and obligations when entering into arrangements that enable others to make decisions on their behalf	Ongoing
PRIORITY AREA 5—STRENGTHENING SAFEGUARDS FOR VULNERABLE OLDER ADULTS	
5.1 Review state and territory legislation to identify gaps in safeguarding provisions	Medium to long term
5.2 Continue to reform the Commonwealth's regulatory framework for aged care to protect and enhance the safety, health, well-being and quality of life of aged care consumers	Short term

Source: Council of Attorneys-General, 2019[117]

APPENDIX 21. ACT STEP PLAN

Figure 43 – Step plan for early management by ACT Government agencies and funded community partners

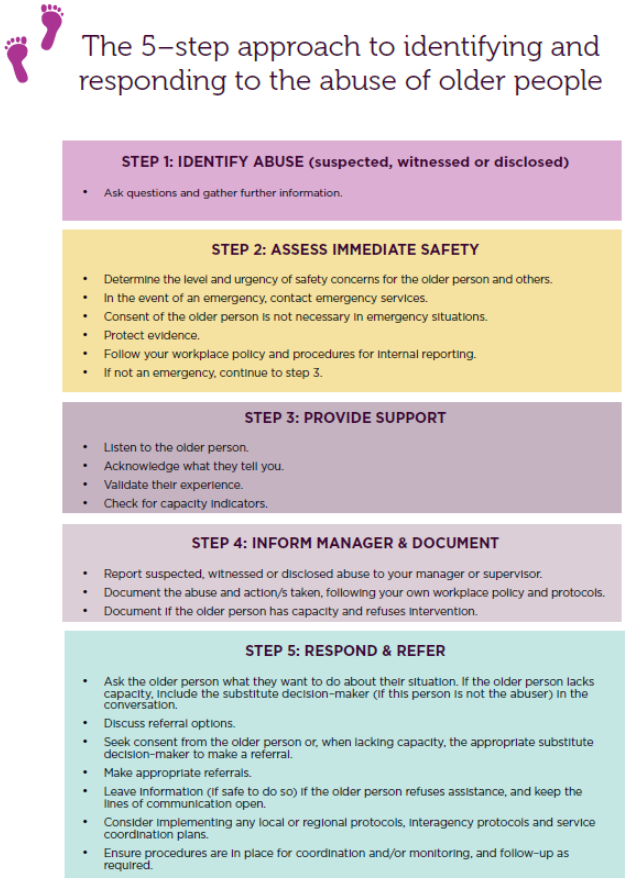
Attachment 1: Service Response to Abuse of Older People



Source: ACT Government, 2012[118]

APPENDIX 22. NSW STEP PLAN

Figure 44 – The 5-steps approach to identifying and responding to the abuse of older people



Source: NSW Elder Abuse Helpline & Resource Unit (EAHRU), 2016[119]

APPENDIX 23. QUEENSLAND'S STEP PLAN FOR HEALTH PROFESSIONALS

Identify the abuse[a]

- Include general questions during an assessment to help identify elder abuse.
- Use direct questions for older adults who present with signs or symptoms of elder abuse.
- Consider using direct questions where there is an increased risk of elder abuse.

Provide emotional support

- Listen to the person's story.
- Acknowledge what they tell you.
- Validate their experience.

Assess risk

- Determine the level and urgency of safety concerns.
- Identify if the risk is life threatening (including risk of homicide).
- Identify the risk of suicide or self-harm.

Safety planning

- If the older person is at risk of serious harm or death, advise them of your concerns and contact the police. Contact the Elder Abuse Helpline and relevant agencies such as social workers and mental health services.
- For all other safety concerns, ask for the person's consent to refer them for support and discuss a safety plan and referral options.
- Educate and support the person whatever their choices, and provide contact information for services.

Document

- Record the action you have taken and document any current or past injuries.

Refer

- Refer the person experiencing abuse to the Elder Abuse Helpline, a Seniors Legal and Support Service, other social and/or legal services and health services.
- If the person refuses intervention, let them know they may talk to you or other support agencies in the future and give them contact details for support.
- Where the older person has impaired capacity, talk with the formally appointed decision maker if appropriate or refer the matter to the Office of the Public Guardian for investigation.
- Ensure procedures are in place for intervention, and follow up as required.

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[a] https://www.qld.gov.au/seniors/safety-protection/discrimination-abuse/elder-abuse/info-health-professionals

APPENDIX 24. QUEENSLAND'S INFO FOR NON HEALTH PROFESSIONALS

How to get help[a]

If you or someone you know is experiencing elder abuse, it is important to know that help is available.

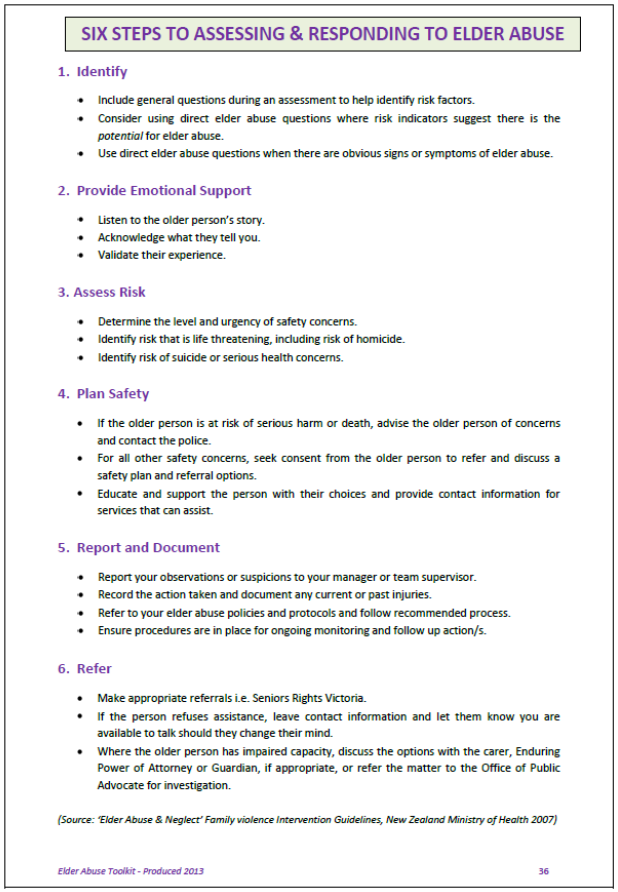
If you know or suspect someone is being abused, you can...
•Let them know that help is available.
•Invite them to talk in a place where they are alone and safe, and listen to them.
•Let them know it is not their fault.
•Respect their right to make their own decisions.
•Avoid being critical of the abusive person.
•Keep providing support, even if they refuse help.

How to get help
•In an emergency phone the police on Triple Zero (000)
•Call the Elder Abuse Helpline (9am–5pm, Monday to Friday) for free and confidential advice for anyone experiencing elder abuse or who suspects someone they know may be experiencing elder abuse.
Phone: 1300 651 192 (Queensland only) or (07) 3867 2525 (rest of Australia).
•Legal support for seniors
•Office of the Public Guardian looks after the interests of adults with impaired capacity
•Other support services for seniors.

[a] https://www.qld.gov.au/seniors/safety-protection/discrimination-abuse/elder-abuse/how-to-get-help

APPENDIX 25. EXAMPLE OF STEP-BY-STEP PLAN IN VICTORIA STATE

Figure 45 – Step-by-step plan developed by Eastern Community legal centre of Victoria State



SIX STEPS TO ASSESSING & RESPONDING TO ELDER ABUSE

1. Identify

- Include general questions during an assessment to help identify risk factors.
- Consider using direct elder abuse questions where risk indicators suggest there is the *potential* for elder abuse.
- Use direct elder abuse questions when there are obvious signs or symptoms of elder abuse.

2. Provide Emotional Support

- Listen to the older person's story.
- Acknowledge what they tell you.
- Validate their experience.

3. Assess Risk

- Determine the level and urgency of safety concerns.
- Identify risk that is life threatening, including risk of homicide.
- Identify risk of suicide or serious health concerns.

4. Plan Safety

- If the older person is at risk of serious harm or death, advise the older person of concerns and contact the police.
- For all other safety concerns, seek consent from the older person to refer and discuss a safety plan and referral options.
- Educate and support the person with their choices and provide contact information for services that can assist.

5. Report and Document

- Report your observations or suspicions to your manager or team supervisor.
- Record the action taken and document any current or past injuries.
- Refer to your elder abuse policies and protocols and follow recommended process.
- Ensure procedures are in place for ongoing monitoring and follow up action/s.

6. Refer

- Make appropriate referrals i.e. Seniors Rights Victoria.
- If the person refuses assistance, leave contact information and let them know you are available to talk should they change their mind.
- Where the older person has impaired capacity, discuss the options with the carer, Enduring Power of Attorney or Guardian, if appropriate, or refer the matter to the Office of Public Advocate for investigation.

(Source: 'Elder Abuse & Neglect' Family violence Intervention Guidelines, New Zealand Ministry of Health 2007)

Elder Abuse Toolkit - Produced 2013 36

Source: Eastern Community Legal Centre, 2013[208]

APPENDIX 26. VICTORIAN INTERAGENCY RESPONSE FRAMEWORK

Figure 46 – Victorian interagency response framework

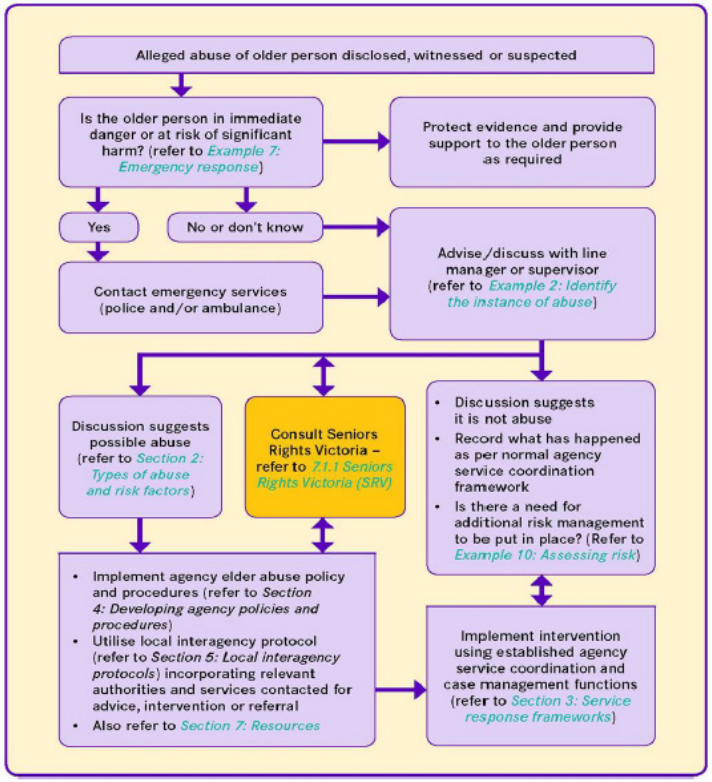
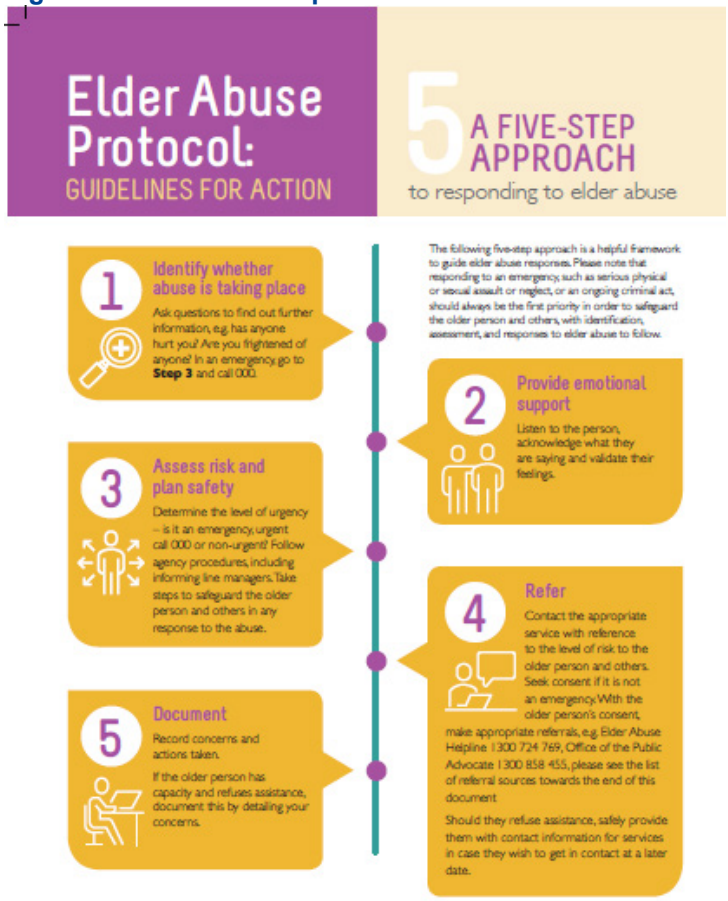


Figure 1: Victorian Interagency Response Framework.
Adapted from the NSW Department of Ageing, Disability and Home Care, 2007, Interagency protocol for responding to abuse of older people

Source: Goulburn Valley Primary Care Partnership, 2015[209]

APPENDIX 27. ELDER ABUSE PROTOCOL OF WESTERN AUSTRALIA

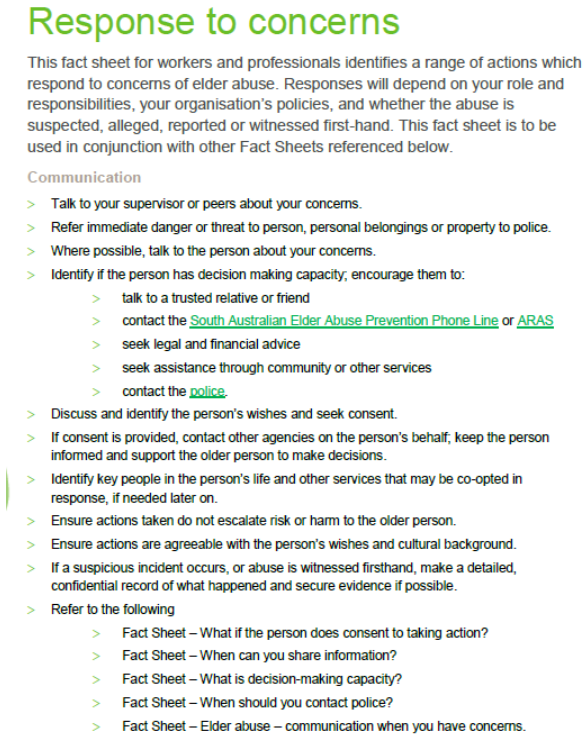
Figure 47 – Elder abuse protocol of Western Australia



Source: Alliance for the prevention of elder abuse, 2018[210]

APPENDIX 28. FACT SHEET TO RESPOND TO ELDER ABUSE CONCERNS IN SOUTH AUSTRALIA

Figure 48 – Fact sheet to respond to elder abuse concerns



Response to concerns

This fact sheet for workers and professionals identifies a range of actions which respond to concerns of elder abuse. Responses will depend on your role and responsibilities, your organisation's policies, and whether the abuse is suspected, alleged, reported or witnessed first-hand. This fact sheet is to be used in conjunction with other Fact Sheets referenced below.

Communication

- Talk to your supervisor or peers about your concerns.
- Refer immediate danger or threat to person, personal belongings or property to police.
- Where possible, talk to the person about your concerns.
- Identify if the person has decision making capacity; encourage them to:
  - talk to a trusted relative or friend
  - contact the South Australian Elder Abuse Prevention Phone Line or ARAS
  - seek legal and financial advice
  - seek assistance through community or other services
  - contact the police.
- Discuss and identify the person's wishes and seek consent.
- If consent is provided, contact other agencies on the person's behalf; keep the person informed and support the older person to make decisions.
- Identify key people in the person's life and other services that may be co-opted in response, if needed later on.
- Ensure actions taken do not escalate risk or harm to the older person.
- Ensure actions are agreeable with the person's wishes and cultural background.
- If a suspicious incident occurs, or abuse is witnessed firsthand, make a detailed, confidential record of what happened and secure evidence if possible.
- Refer to the following
  - Fact Sheet – What if the person does consent to taking action?
  - Fact Sheet – When can you share information?
  - Fact Sheet – What is decision-making capacity?
  - Fact Sheet – When should you contact police?
  - Fact Sheet – Elder abuse – communication when you have concerns.

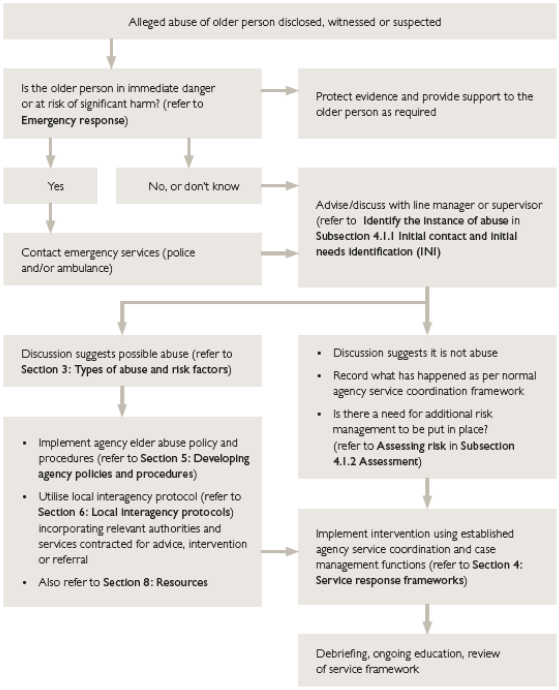
Source: https://www.sahealth.sa.gov.au/wps/wcm/connect/4e48e3004a1e18088993e990d529bdaa/Workers+-+Response+to+concerns.pdf?MOD=AJPERES&CACHEID=ROOTWORKSPACE-4e48e3004a1e18088993e990d529bdaa-mN5HcN1

APPENDIX 29. TASMANIA INTERAGENCY RESPONSE FRAMEWORK

Figure 49 – Tasmania interagency response framework to elder abuse

Figure 1: Tasmanian interagency response framework

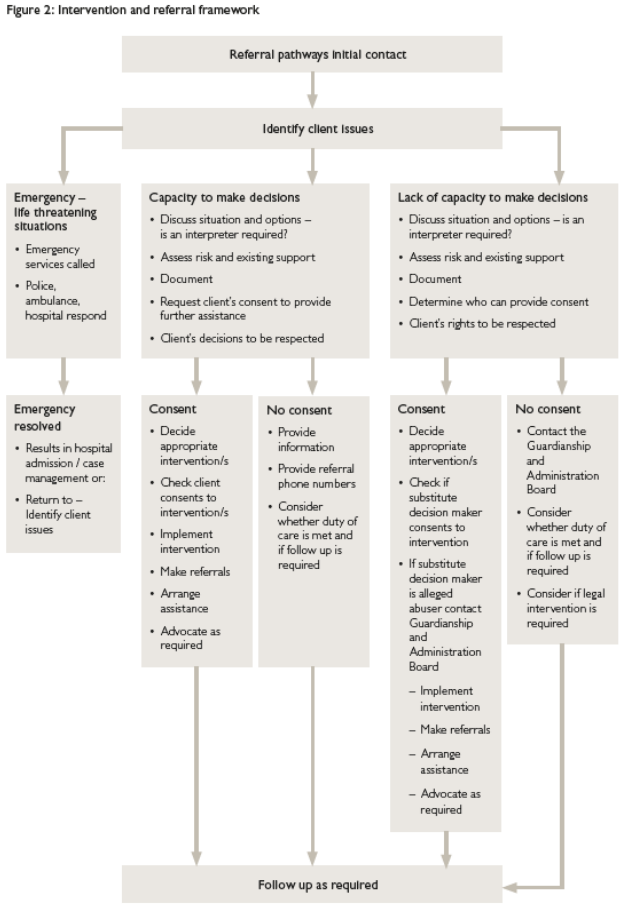
Adapted from the New South Wales Government, Interagency Protocol for Responding to Abuse of Older People, 2007.



Source: Tasmanian Government, 2012[120]

APPENDIX 30. INTERVENTION AND REFERRAL FRAMEWORK IN TASMANIA

Figure 50 – Intervention and referral framework in case of elder abuse in the Tasmania state



Source: Tasmanian Government, 2012[120]

APPENDIX 31. ADVICES GIVEN TO ELDERS BY THE DEPARTMENT OF JUSTICE OF CANADA IN CASE OF ABUSE

In case of physical violence, the advice is first to leave the place of living and to find a secure place and next to call the police or the 911. Others given possibilities are: talking to someone you trust, consulting a social worker, having a medical appointment, calling the local hotline, talking to the GP or the pharmacist in case of doubt on the received quantity of medicine, calling the police to get a court order to keep the perpetrator away, consulting a lawyer or a victims service provider to obtain a civil protection keeping the perpetrator away from home.[105]

In case of sexual violence, the advices of the guide are: talking to someone you trust, calling the hotline for sexual violence, having an appointment with a doctor, a nurse or a social worker; Calling the police; calling the 911; calling the police to get a court order to keep the perpetrator away. They insist on the contact with the police and the 911.[105]

In case of psychological violence, the advices of the guide are: talking to someone you trust, consulting a social worker; trying not let the violence to silent you, writing down what is happening to you and keeping the note in a safe place; leaving the place of leaving if possible; calling the police if you are afraid.[105]

In case of financial abuse, the advices of the guide are: talking to someone you trust and asking him to review contracts and other documents before signing them, consult a lawyer about the possibilities that are legally available to you to manage and protect your assets, properties and money; changing your power of attorney (procuration) and designate someone you can trust; and calling the police if you think that a crime has been committed.[105]

In case of neglect at home, the advices of the guide are: talking to someone you trust; consulting a nurse, a doctor or a social worker; calling the hotline; and calling the 911 if emergency.[105]

In case of neglect in residential settings, the advices of the guide are: talking to someone you trust, your pharmacist, your GP, a community legal clinic or a health and social help service; calling a hotline for elder people; talking with a staff member of the institution; calling the province administration services; calling the police or 911.[105]

APPENDIX 32. THE ACT AGAINST ELDER ABUSE IN QUÉBEC

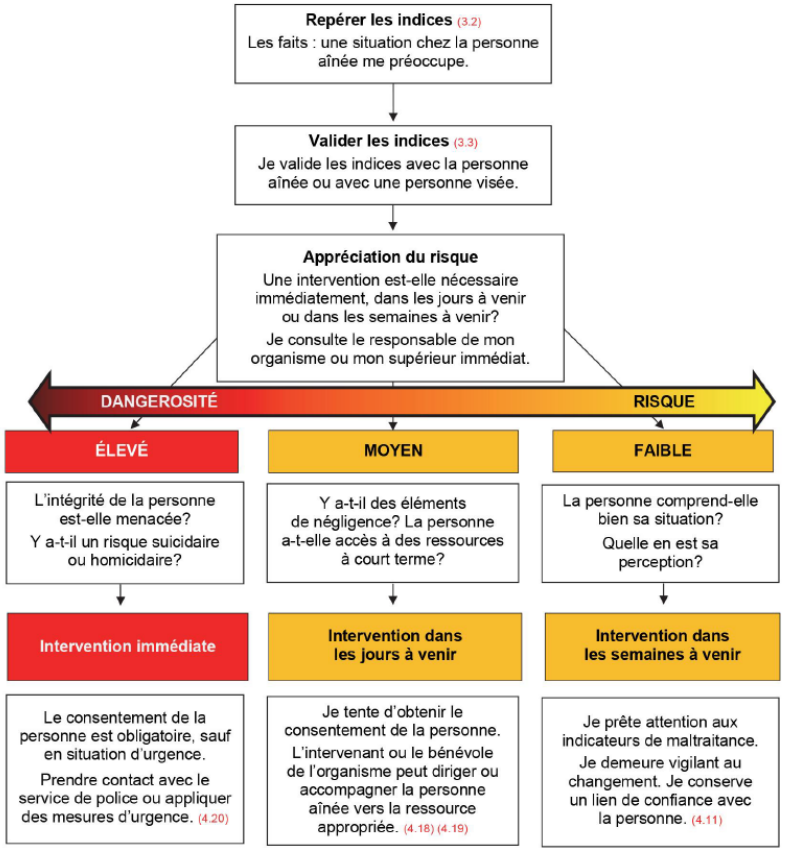
The Act provides 6 measures to combat elder abuse and any other adult in a vulnerable situation[a]:

- Mandatory adoption and implementation, in all institutions in the health and social help sectors, of a policy to combat abuse of persons in vulnerable situations. The policy must be posted in public view and published on the institution's website.
- Enhanced role of the 'local commissioner for complaints on services' quality' (CLPQS), responsible for ensuring that the rights of users are respected and for dealing diligently with the complaints in health and social services institutions. The CLPQS must also deal with all reports concerning a situation of potential abuse, including reports made by persons other than the user, such as a family member or an employee.
- Ability (i) to waive confidentiality or professional secrecy where there is a serious risk of death or serious injury, (ii) to be protected from reprisals and (iii) to be immunized from prosecution.
- Authorisation and regulation of the use of cameras or other surveillance mechanisms concerning users, their relatives, the residential establishments and any person working within the establishment.
- Establishment of a national framework agreement and collaborative intervention processes to combat elder abuse between the concerned actors in the fight against abuse: police, social services, prosecutors, etc. The deployment of the concerted intervention processes across Quebec began in March 2018 and is expected to be completed in December 2020.
- Mandatory reporting of certain situations of maltreatment: any health and social services provider and any professional recognized under the Professional Code (except for lawyers and notaries) are required, if they have reasonable grounds to believe that a person is being abused, to report the case without delay. Reporting is mandatory when it concerns users of residential and long-term care centres (CHSLDs) and protected unfit persons, regardless of their place of residence. Mandatory reporting must be made to the CLPQS of an institution if the abused person is receiving services there or, in other cases, to the police force.
- Voluntary reporting: the Act encourages voluntary reporting of abuse at all times. The report may be made, among other things, to the police; to the integrated health and social services centre in their region; to the local 'Centre intégré universitaire de santé et de services sociaux'; to the CLPQS of an institution if the victim of abuse is receiving services there.

[a] https://www.quebec.ca/famille-et-soutien-aux-personnes/aide-et-soutien/maltraitance-aines/loi/ http://legisquebec.gouv.qc.ca/fr/showdoc/cs/L-6.3

APPENDIX 33. STEP PLAN IN CASE OF CONCERN ABOUT ELDER ABUSE IN QUÉBEC

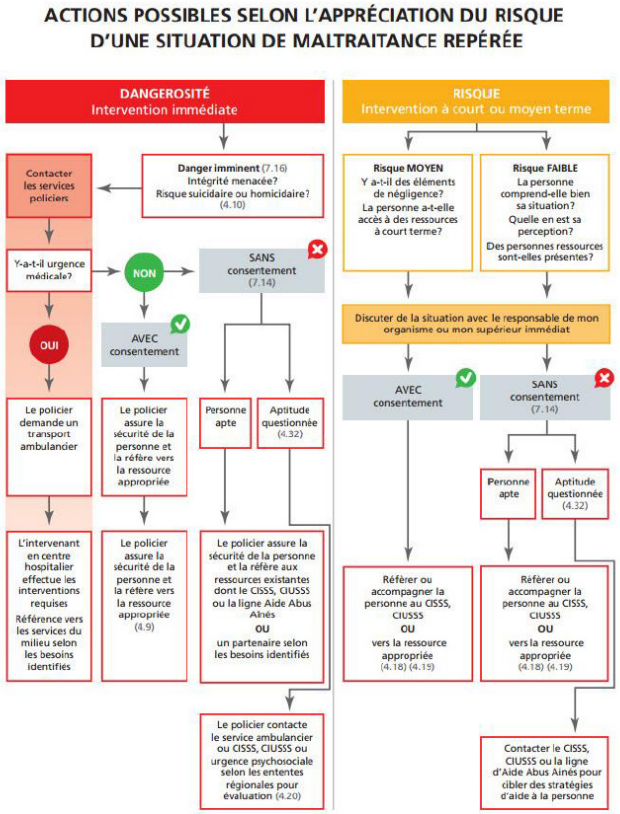
Figure 51 – Step plan addressed to any person which question himself about the need to intervene where a concern about an elder abuse occurs



Source: Partenaires multisectoriels, 2016[12]

APPENDIX 34. STEP PLAN FOR POLICE AGENT IN CASE OF ELDER ABUSE IN QUÉBEC

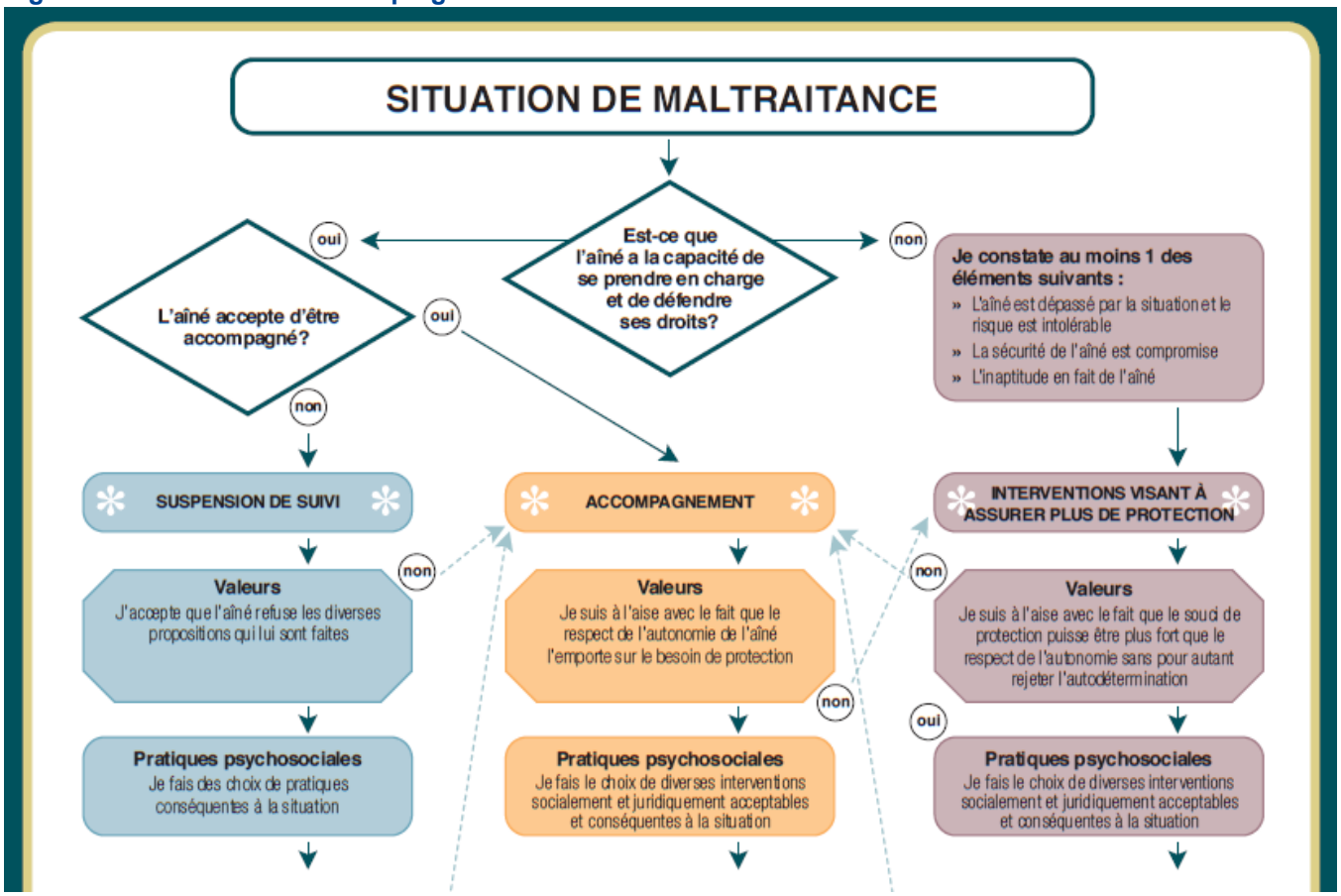
Figure 52 – Step plan addressed to police agent confronted to a clear situation of elder abuse

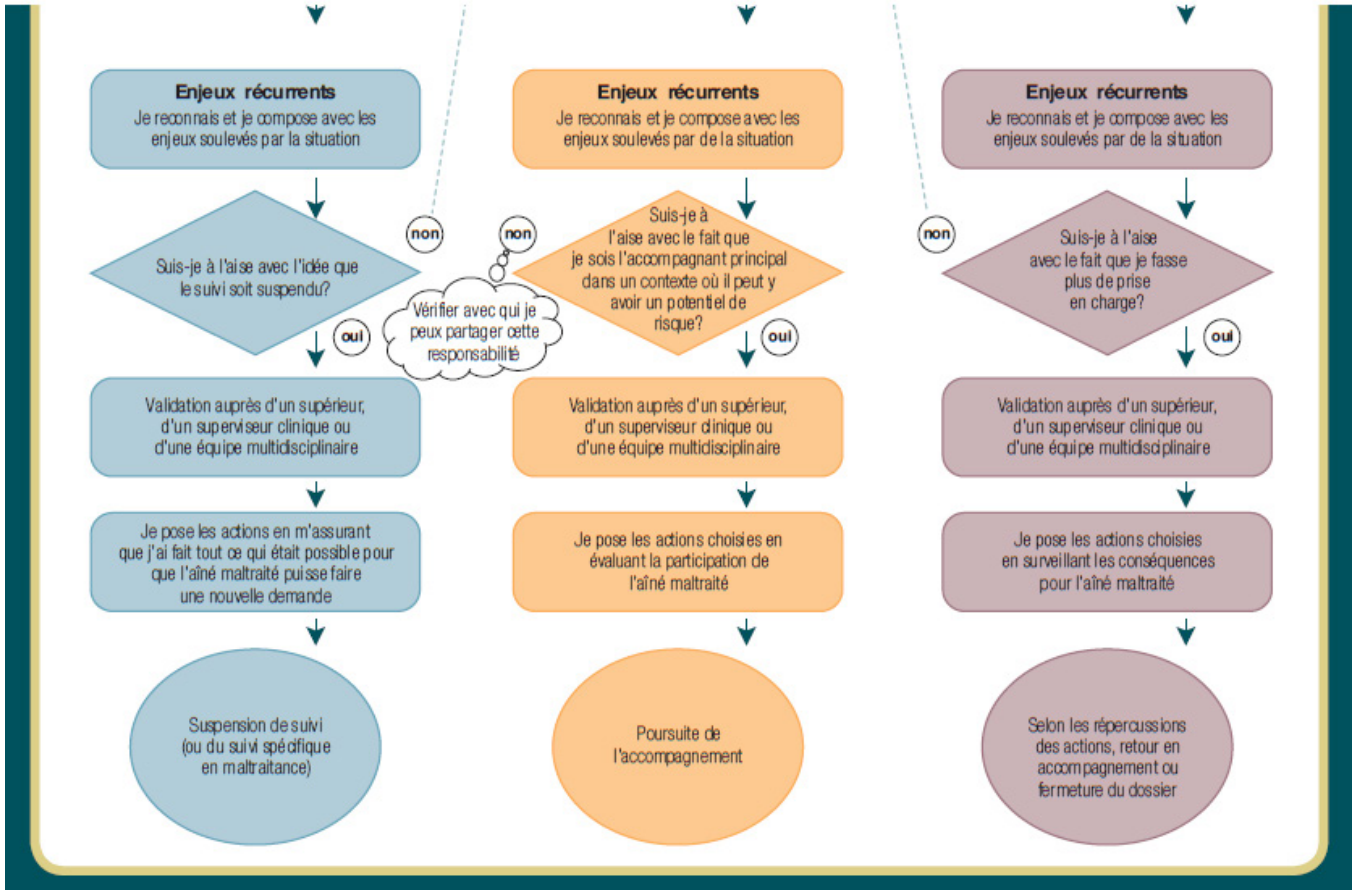


Source: Partenaires multisectoriels, 2016[12]

APPENDIX 35. TOOL 'EN MAINS' HELPING THE ETHICAL DISCUSSION AROUND ELDER ABUSE SITUATIONS

Figure 53 – Tool 'En Mains' helping the ethical discussion around elder abuse situations

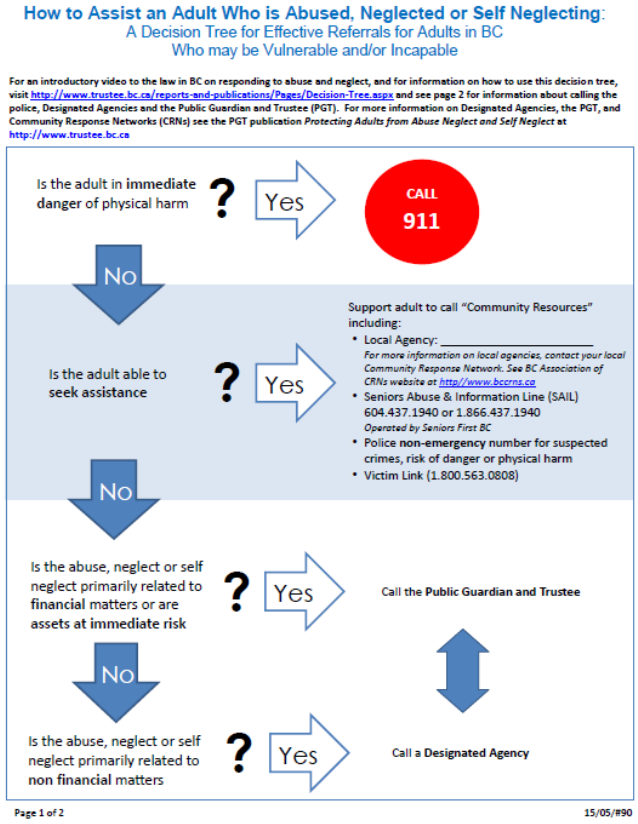




Source: NICE, 2010[211]

APPENDIX 36. BRISTISH COLUMBIA'S EASY-TOT-USE DECISION TREE

Figure 54 – CREA easy-to-use decision tree



From: http://reduceelderabusebc.ca/report-elder-abuse/

Decision Point 1: Is this an emergency where the person is in immediate physical danger? Report elder abuse by calling 911. The police have information about getting connected to Elder Abuse supports.

Decision Point 2: Is the person able ***and likely*** to seek assistance? If so, choose from one of these actions for finding help:

Support the adult to connect with the **BC Association of Community Response Networks**. These networks exist in >160 communities in BC. Find listings for your community and connect with your local CRN: http://www.bccrns.ca.

Call the Seniors' Abuse and Information Line between 8 am and 8 pm. (1-604-437-1940 or 1-866-437-1940) Operated by Seniors First BC.

Call the Police non-emergency number for suspected crimes, risk of danger or physical harm. This information can be found via the BC Association of Community Response Networks (see above)

Contact Victim Link 24 hours a day, 7 days a week. (1.800.563.0808)

Decision Point 3: Is the abuse, neglect or self-neglect related to financial matters or are assets at immediate risk? If so, contact the Public Guardian and Trustee. Phone: (Vancouver) 604.660.4444 (Victoria) 250.356.8160 (Interior/North) 250.712.7576 Website: http://www.trustee.bc.ca

Decision Point 4: Is the abuse, neglect or self-neglect primarily related to non-financial matters? Call a Designated Agency.

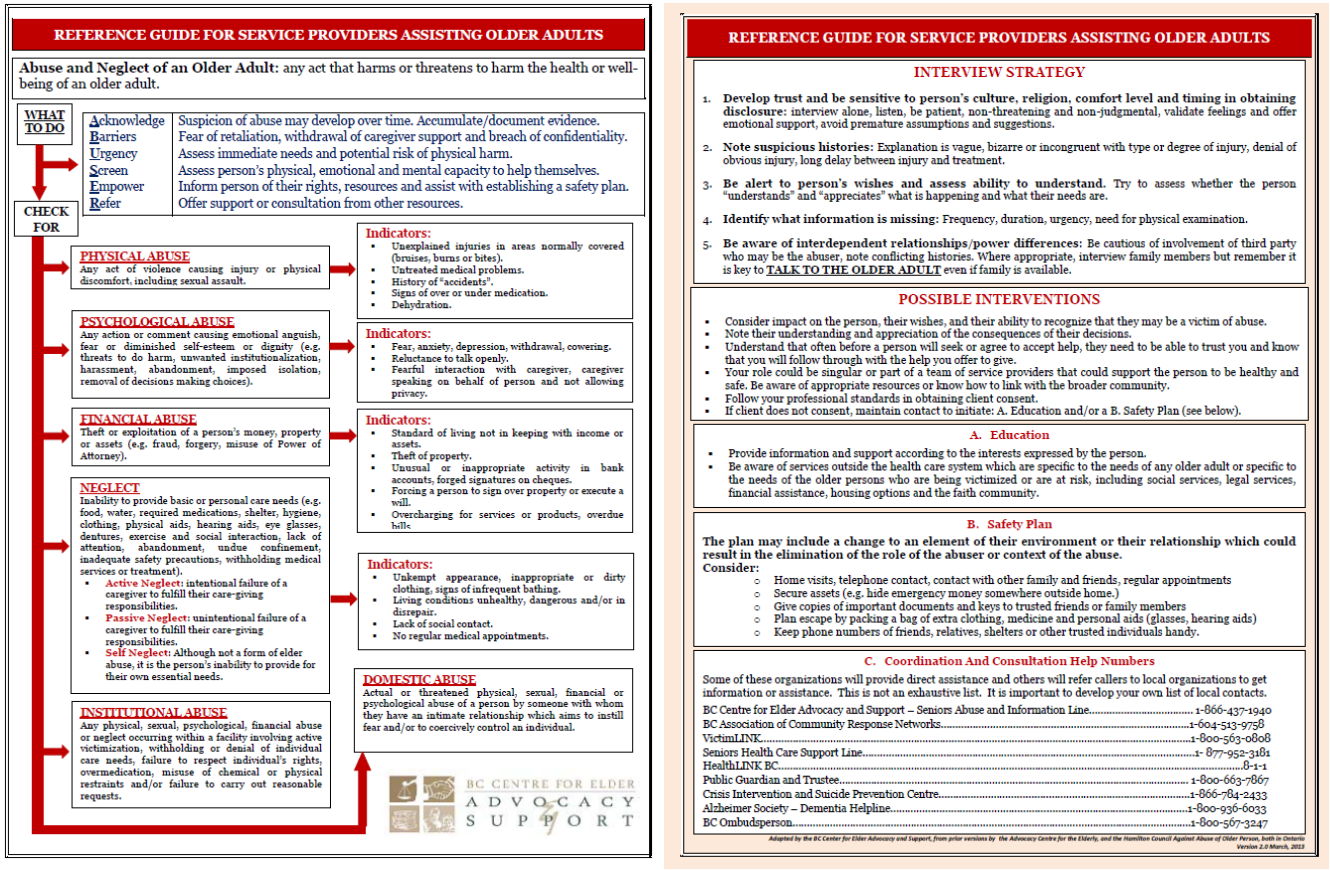
Community Living BC: Community Living BC (CLBC) is a provincial crown agency, mandated under the Community Living Authority Act that funds supports and services through service agencies for adults with developmental disabilities and their families in British Columbia. You can find Community Living online: http://www.communitylivingbc.ca/ or call them at 604.664.0101 or 1.877.660.2522.

Your Regional Health Authority: Find links for all BC Health Authorities here: https://www2.gov.bc.ca/gov/content/health/about-bc-s-health-care-system/partners/health-authorities/regional-health-authorities.

From: http://reduceelderabusebc.ca/report-elder-abuse/

APPENDIX 37. GUIDE FOR SERVICE PROVIDERS ASSISTING OLDER ADULTS IN BRITISH COLUMBIA

Figure 55 – Reference guide for service providers assisting older adults in BC



REFERENCE GUIDE FOR SERVICE PROVIDERS ASSISTING OLDER ADULTS

Abuse and Neglect of an Older Adult: any act that harms or threatens to harm the health or well-being of an older adult.

WHAT TO DO

Acknowledge	Suspicion of abuse may develop over time. Accumulate/document evidence.
Barriers	Fear of retaliation, withdrawal of caregiver support and breach of confidentiality.
Urgency	Assess immediate needs and potential risk of physical harm.
Screen	Assess person's physical, emotional and mental capacity to help themselves.
Empower	Inform person of their rights, resources and assist with establishing a safety plan.
Refer	Offer support or consultation from other resources.

CHECK FOR

PHYSICAL ABUSE
Any act of violence causing injury or physical discomfort, including sexual assault.

Indicators:
- Unexplained injuries in areas normally covered (bruises, burns or bites).
- Untreated medical problems.
- History of "accidents".
- Signs of over or under medication.
- Dehydration.

PSYCHOLOGICAL ABUSE
Any action or comment causing emotional anguish, fear or diminished self-esteem or dignity (e.g. threats to do harm, unwanted institutionalization, harassment, abandonment, imposed isolation, removal of decisions making choices).

Indicators:
- Fear, anxiety, depression, withdrawal, cowering.
- Reluctance to talk openly.
- Fearful interaction with caregiver, caregiver speaking on behalf of person and not allowing privacy.

FINANCIAL ABUSE
Theft or exploitation of a person's money, property or assets (e.g. fraud, forgery, misuse of Power of Attorney).

Indicators:
- Standard of living not in keeping with income or assets.
- Theft of property.
- Unusual or inappropriate activity in bank accounts, forged signatures on cheques.
- Forcing a person to sign over property or execute a will.
- Overcharging for services or products, overdue bills

NEGLECT
Inability to provide basic or personal care needs (e.g. food, water, required medications, shelter, hygiene, clothing, physical aids, hearing aids, eye glasses, dentures, exercise and social interaction, lack of attention, abandonment, undue confinement, inadequate safety precautions, withholding medical services or treatment).
- **Active Neglect:** intentional failure of a caregiver to fulfill their care-giving responsibilities.
- **Passive Neglect:** unintentional failure of a caregiver to fulfill their care-giving responsibilities.
- **Self Neglect:** Although not a form of elder abuse, it is the person's inability to provide for their own essential needs.

Indicators:
- Unkempt appearance, inappropriate or dirty clothing, signs of infrequent bathing.
- Living conditions unhealthy, dangerous and/or in disrepair.
- Lack of social contact.
- No regular medical appointments.

DOMESTIC ABUSE
Actual or threatened physical, sexual, financial or psychological abuse of a person by someone with whom they have an intimate relationship which aims to instill fear and/or to coercively control an individual.

INSTITUTIONAL ABUSE
Any physical, sexual, psychological, financial abuse or neglect occurring within a facility involving active victimization, withholding or denial of individual care needs, failure to respect individual's rights, overmedication, misuse of chemical or physical restraints and/or failure to carry out reasonable requests.

BC CENTRE FOR ELDER ADVOCACY SUPPORT

REFERENCE GUIDE FOR SERVICE PROVIDERS ASSISTING OLDER ADULTS

INTERVIEW STRATEGY

1. **Develop trust and be sensitive to person's culture, religion, comfort level and timing in obtaining disclosure:** interview alone, listen, be patient, non-threatening and non-judgmental, validate feelings and offer emotional support, avoid premature assumptions and suggestions.
2. **Note suspicious histories:** Explanation is vague, bizarre or incongruent with type or degree of injury, denial of obvious injury, long delay between injury and treatment.
3. **Be alert to person's wishes and assess ability to understand.** Try to assess whether the person "understands" and "appreciates" what is happening and what their needs are.
4. **Identify what information is missing:** Frequency, duration, urgency, need for physical examination.
5. **Be aware of interdependent relationships/power differences:** Be cautious of involvement of third party who may be the abuser, note conflicting histories. Where appropriate, interview family members but remember it is key to TALK TO THE OLDER ADULT even if family is available.

POSSIBLE INTERVENTIONS

- Consider impact on the person, their wishes, and their ability to recognize that they may be a victim of abuse.
- Note their understanding and appreciation of the consequences of their decisions.
- Understand that often before a person will seek or agree to accept help, they need to be able to trust you and know that you will follow through with the help you offer to give.
- Your role could be singular or part of a team of service providers that could support the person to be healthy and safe. Be aware of appropriate resources or know how to link with the broader community.
- Follow your professional standards in obtaining client consent.
- If client does not consent, maintain contact to initiate: A. Education and/or a B. Safety Plan (see below).

A. Education

- Provide information and support according to the interests expressed by the person.
- Be aware of services outside the health care system which are specific to the needs of any older adult or specific to the needs of the older persons who are being victimized or are at risk, including social services, legal services, financial assistance, housing options and the faith community.

B. Safety Plan

The plan may include a change to an element of their environment or their relationship which could result in the elimination of the role of the abuser or context of the abuse.
Consider:
- Home visits, telephone contact, contact with other family and friends, regular appointments
- Secure assets (e.g. hide emergency money somewhere outside home.)
- Give copies of important documents and keys to trusted friends or family members
- Plan escape by packing a bag of extra clothing, medicine and personal aids (glasses, hearing aids)
- Keep phone numbers of friends, relatives, shelters or other trusted individuals handy.

C. Coordination And Consultation Help Numbers

Some of these organizations will provide direct assistance and others will refer callers to local organizations to get information or assistance. This is not an exhaustive list. It is important to develop your own list of local contacts.

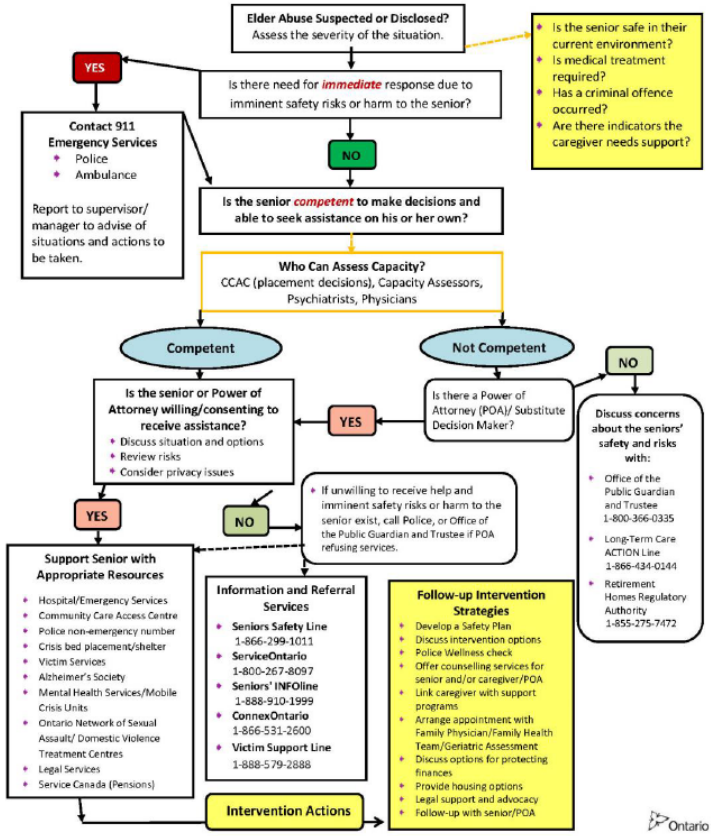
BC Centre for Elder Advocacy and Support – Seniors Abuse and Information Line	1-866-437-1940
BC Association of Community Response Networks	1-604-513-9758
VictimLINK	1-800-563-0808
Seniors Health Care Support Line	1- 877-952-3181
HealthLINK BC	8-1-1
Public Guardian and Trustee	1-800-663-7867
Crisis Intervention and Suicide Prevention Centre	1-866-784-2433
Alzheimer Society – Dementia Helpline	1-800-936-6033
BC Ombudsperson	1-800-567-3247

Adopted by the BC Center for Elder Advocacy and Support, from prior versions by the Advocacy Centre for the Elderly, and the Hamilton Council Against Abuse of Older Person, both in Ontario
Version 2.0 March, 2013

Source: BC centre for elders advocacy support, 2013[212]

APPENDIX 38. GENERAL STEP PLAN IN ONTARIO

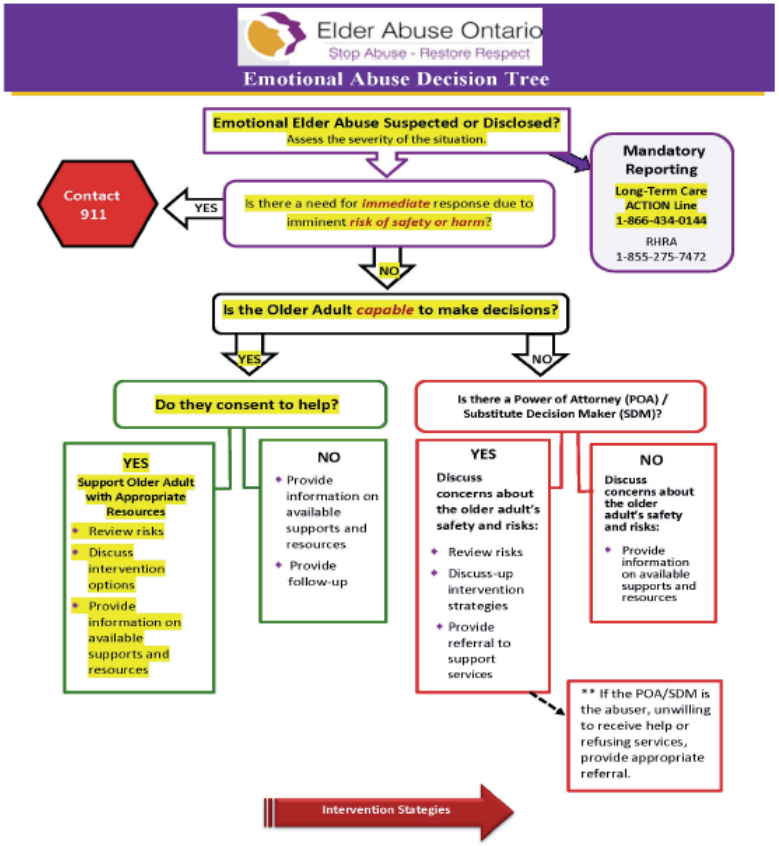
Figure 56 – General step plan from 'Elder Abuse Ontario'



From: https://socialhealthpracticeottawa.files.wordpress.com/2018/12/EATraining_SWAG_Nov222018-1.pdf

APPENDIX 39. STEP PLAN FOR EMOTIONAL ABUSE IN ONTARIO

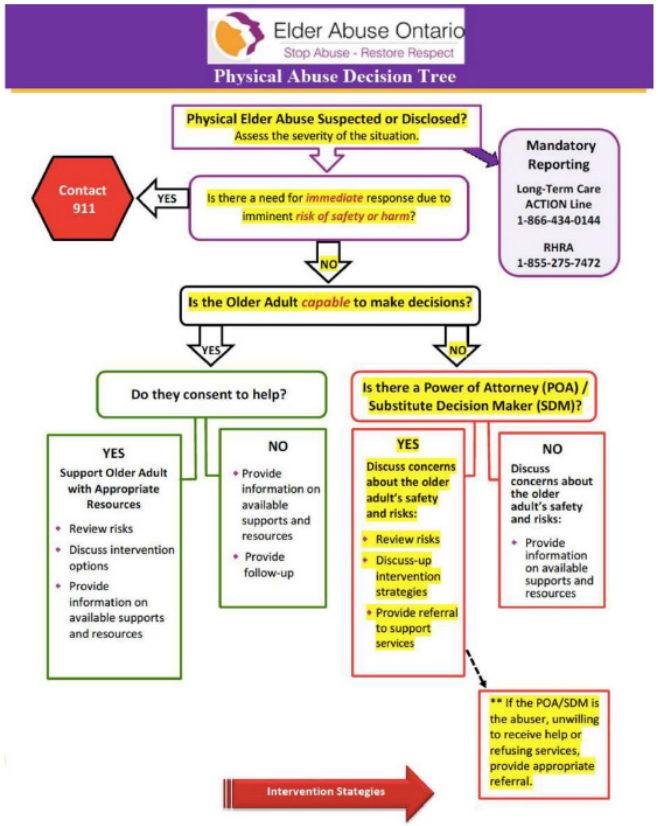
Figure 57 – Step plan for emotional abuse from 'Elder Abuse Ontario'



From: *https://socialhealthpracticeottawa.files.wordpress.com/2018/12/EATraining_SWAG_Nov222018-1.pdf*

APPENDIX 40. STEP PLAN FOR PHYSICAL ABUSE IN ONTARIO

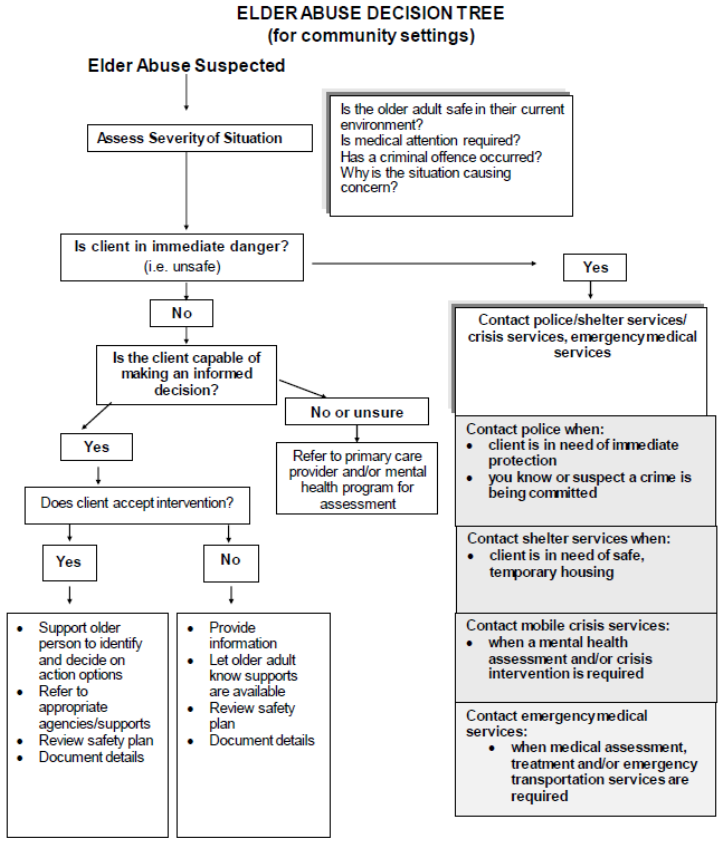
Figure 58 – Step plan for physical abuse from 'Elder Abuse Ontario'



From: https://socialhealthpracticeottawa.files.wordpress.com/2018/12/EATraining_SWAG_Nov222018-1.pdf

APPENDIX 41. ELDER ABUSE DECISION TREE IN MANITOBA

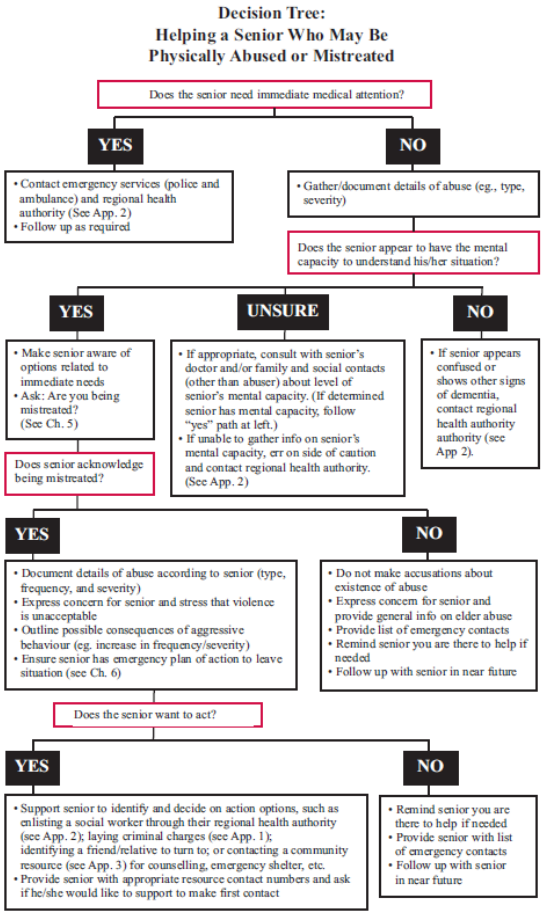
Figure 59 – Elder Abuse decision tree of the Winnipeg regional health authority



From: https://wrha.mb.ca/wp-content/site-documents/community/seniors/files/ElderAbuseDecisionTree.pdf

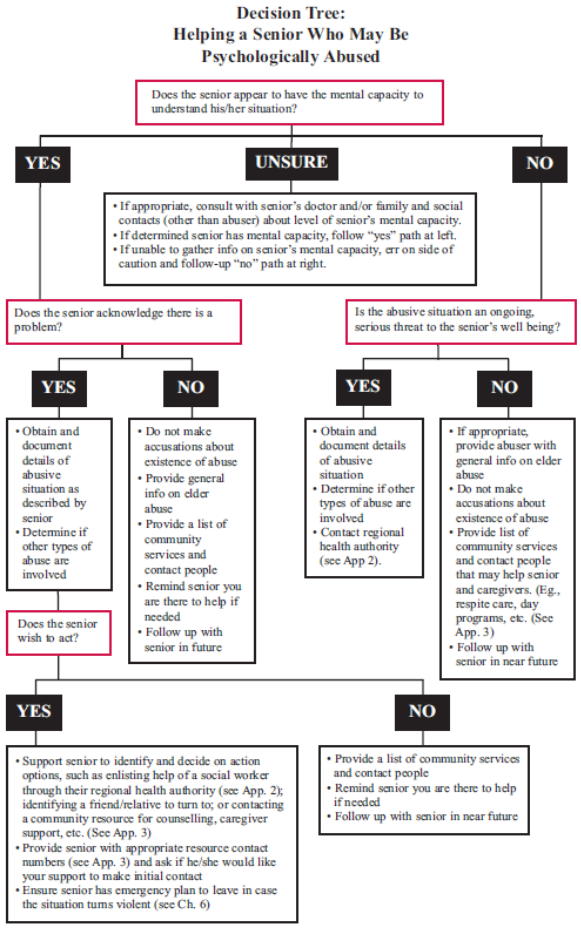
APPENDIX 42. ELDER ABUSE DECISION TREES IN NEW FOUNDLAND AND LABRADOR

Figure 60 – Decision tree to guide service providers helping a senior who may be physically abused or maltreated in NL



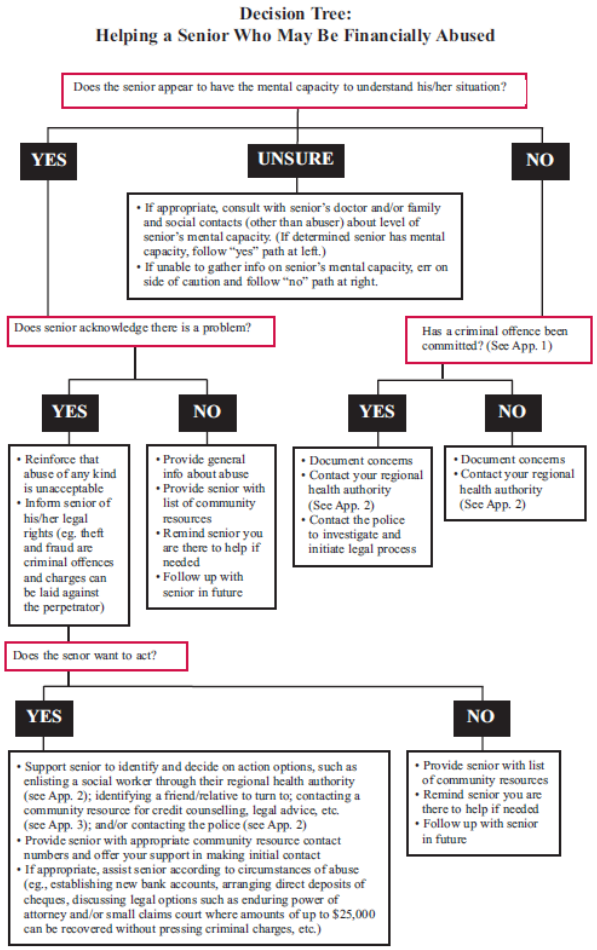
From: http://nlnpea.ca/sites/default/files/documents/Chapter6_v3_2.pdf

Figure 61 – Decision tree to guide service providers helping a senior who may be psychologically abused or maltreated in NL



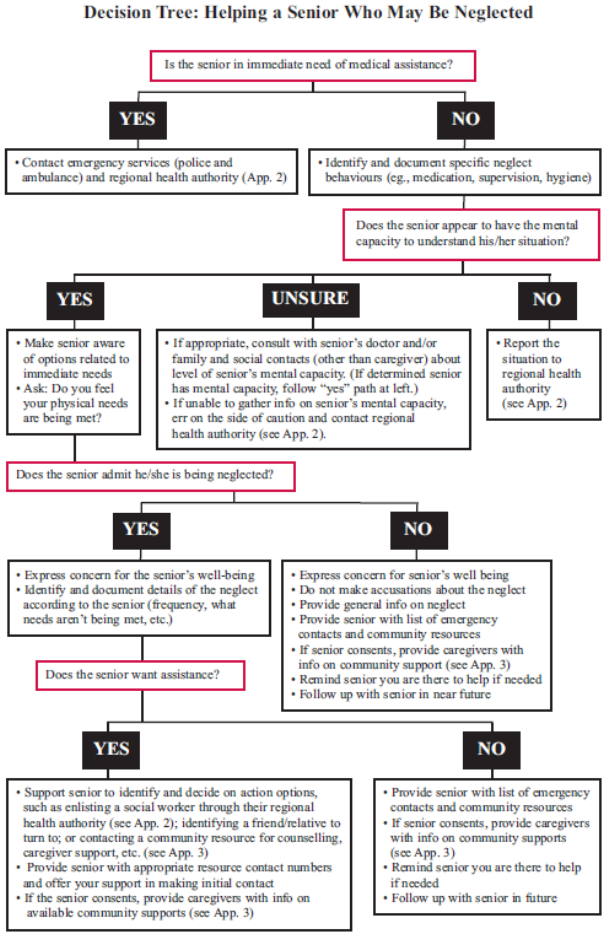
From: http://nlnpea.ca/sites/default/files/documents/Chapter6_v3_2.pdf

Figure 62 – Decision tree to guide service providers helping a senior who may be financially abused or maltreated in NL



From: http://nlnpea.ca/sites/default/files/documents/Chapter6_v3_2.pdf

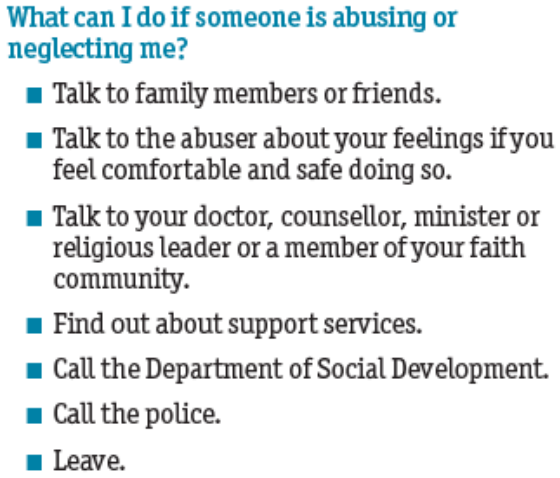
Figure 63 – Decision tree to guide service providers helping a senior who may be neglected in NL



From: http://nlnpea.ca/sites/default/files/documents/Chapter6_v3_2.pdf

APPENDIX 43. CONCRETE ACTIONS TO DO IN NEW BRUNSWICK

Figure 64 – Concrete actions to do in case of abuse addressed to seniors in New Brunswick

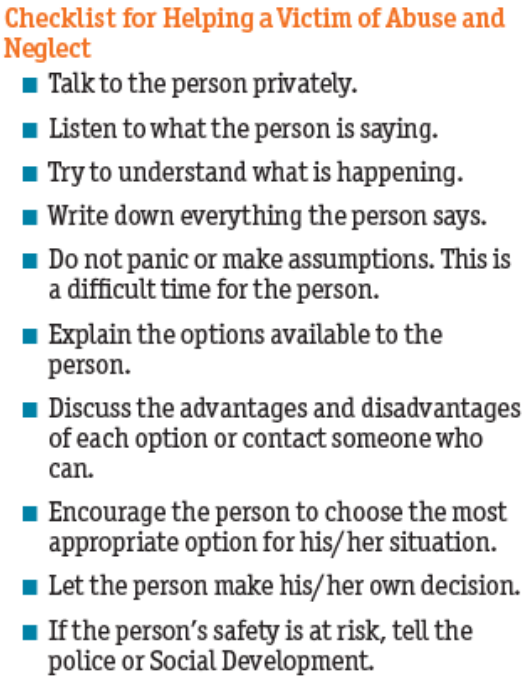


What can I do if someone is abusing or neglecting me?

- Talk to family members or friends.
- Talk to the abuser about your feelings if you feel comfortable and safe doing so.
- Talk to your doctor, counsellor, minister or religious leader or a member of your faith community.
- Find out about support services.
- Call the Department of Social Development.
- Call the police.
- Leave.

Source: Public legal education and information service of New Brunswick, 2018[125]

Figure 65 – Concrete actions to do in case of abuse addressed to concerned friends or neighbours



Checklist for Helping a Victim of Abuse and Neglect

- Talk to the person privately.
- Listen to what the person is saying.
- Try to understand what is happening.
- Write down everything the person says.
- Do not panic or make assumptions. This is a difficult time for the person.
- Explain the options available to the person.
- Discuss the advantages and disadvantages of each option or contact someone who can.
- Encourage the person to choose the most appropriate option for his/her situation.
- Let the person make his/her own decision.
- If the person's safety is at risk, tell the police or Social Development.

Source: Public legal education and information service of New Brunswick, 2018 [125]

APPENDIX 44. TIPS TO RESPOND TO ELDER ABUSE IN YUKON

Figure 66 – Tips to respond to abuse neglect and self-neglect of older adults

Tips for helping:

- Always take disclosure of abuse seriously.
- Document details of the disclosure and what actions you have taken.
- Staff/volunteers should always advise their supervisor about abusive situations in a timely manner.
- The most effective response is achieved when all supports work collaboratively.
- Be aware that an older adult may experience extreme guilt/remorse and the stress could trigger a medical crisis or delirium.
- When compromised or fluctuating capacity is observed, further assessment from a health professional should be sought.
- After a disclosure of abuse, the risk to the older person may increase and therefore thorough safety planning is required (see sheet #3 – *Safety planning and the older adult*).
- Strive to provide support in the least intrusive and most effective manner.

From: http://www.hss.gov.yk.ca/pdf/2_Responding_to_abuse_neglect_and_self_neglect_of_older_adults.pdf

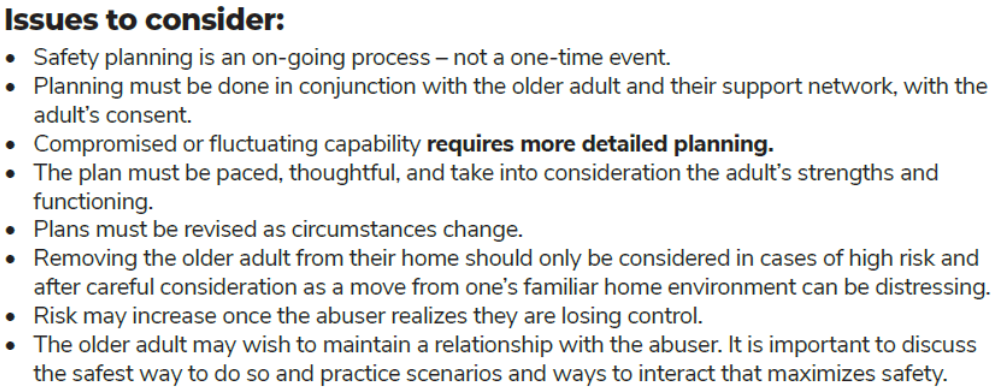
Figure 67 – Tips to help in case of elder abuse

How can you help?

- Talk to the adult alone where they feel safe (i.e. away from the abuser).
- Tell them in a caring way what your concerns are and that you are there to help.
- Believe what they say and ask if they would like assistance.
- Listen, support and assure them that there is help and that they are not alone.
- Educate yourself about abuse and available resources and offer to be part of the adult's safety planning.
- Do not judge the adult or deny that the abuse is occurring.
- Be patient and seek support for yourself too.

From: http://www.hss.gov.yk.ca/pdf/elderabuseb.pdf

Figure 68 – Issues to consider when elaborating a safety planning with an older adult



Issues to consider:

- Safety planning is an on-going process – not a one-time event.
- Planning must be done in conjunction with the older adult and their support network, with the adult's consent.
- Compromised or fluctuating capability **requires more detailed planning.**
- The plan must be paced, thoughtful, and take into consideration the adult's strengths and functioning.
- Plans must be revised as circumstances change.
- Removing the older adult from their home should only be considered in cases of high risk and after careful consideration as a move from one's familiar home environment can be distressing.
- Risk may increase once the abuser realizes they are losing control.
- The older adult may wish to maintain a relationship with the abuser. It is important to discuss the safest way to do so and practice scenarios and ways to interact that maximizes safety.

From: http://www.hss.gov.yk.ca/pdf/3_Safety_planning_and_the_older_adult.pdf

APPENDIX 45. PROCEDURE TO RESPOND TO ELDER ABUSE IN FRANCE

« Vous êtes concerné par une situation de maltraitance[a]

Vous soupçonnez une situation de maltraitance, vous en êtes la victime ou le témoin : il est essentiel de ne pas rester seul face à cette situation. Il est inscrit dans le Code pénal que tous les actes de maltraitance prouvés ou présumés doivent faire l'objet d'un signalement au Procureur de la République.

En fonction de l'urgence et de la gravité de la situation, il existe plusieurs solutions pour signaler un fait de maltraitance.

Lorsque la maltraitance est le fait d'un professionnel travaillant dans un établissement ou un service : contacter son supérieur hiérarchique.

Appeler le 39 77, la plate-forme nationale d'écoute contre la maltraitance gérée par ALMA, l'association Allo maltraitance des personnes âgées et/ou des personnes handicapées, qui dispose de centres d'écoute.
Une personne écoutera votre présentation de la situation et vous conseillera sur les démarches à entreprendre. Elle transmettra votre dossier à la structure départementale avec laquelle elle a passé convention pour le traitement de ces situations.

Faire un signalement au Procureur et aux services de Police ou Gendarmerie.
En cas d'urgence, la situation de maltraitance (de maltraitance grave ou/et de danger imminent et manifeste) doit être signalée au Procureur et aux services de Police ou Gendarmerie.
Certains départements ont mis en place des dispositifs de traitement des signalements des situations préoccupantes avec parfois un numéro vert.

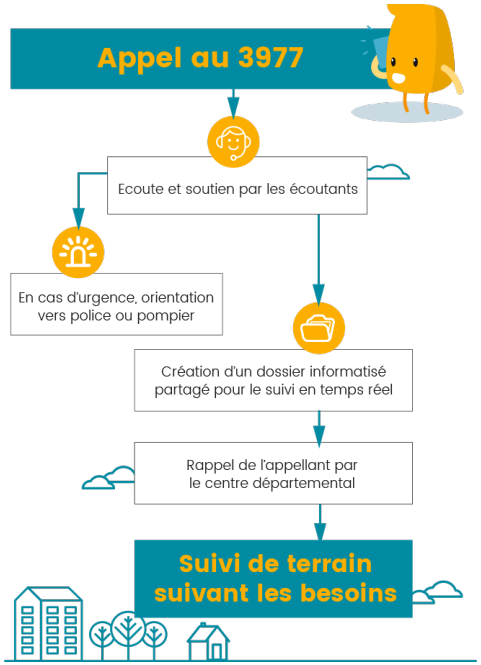
Lorsque la personne est sous tutelle ou curatelle, la maltraitance peut être signalée à son tuteur ou son curateur qui pourra accompagner la personne dans ses démarches ou la représenter. Si la maltraitance est le fait du tuteur ou du curateur, le signalement doit se faire auprès des juges des tutelles ou au procureur de la République.

En maison de retraite : contacter l'ARS (agence régionale de santé) et le conseil départemental.
En établissement, le signalement peut être transmis à l'ARS et au conseil départemental qui ont une mission de contrôle. Ils pourront réaliser des inspections et enquêtes au sein de la structure concernée. Ces inspections peuvent donner lieu à des injonctions administratives qui visent à corriger les dysfonctionnements constatés. Dans les situations les plus graves, elles peuvent conduire à des fermetures provisoires ou définitives des structures. »

[a] https://www.pour-les-personnes-agees.gouv.fr/exercer-ses-droits/en-cas-de-maltraitance

APPENDIX 46. FOLLOW-UP OF ELDER ABUSE BY 3977 SERVICE IN FRANCE

Figure 69 – Step plan for the follow-up of the caller by the 3977 in France



From: https://3977.fr/je-contacte-le-3977-et-apres/

APPENDIX 47. MAIN ACTION POINTS OF THE DUTCH NAP 'OUDEREN IN VEILIGE HANDEN'

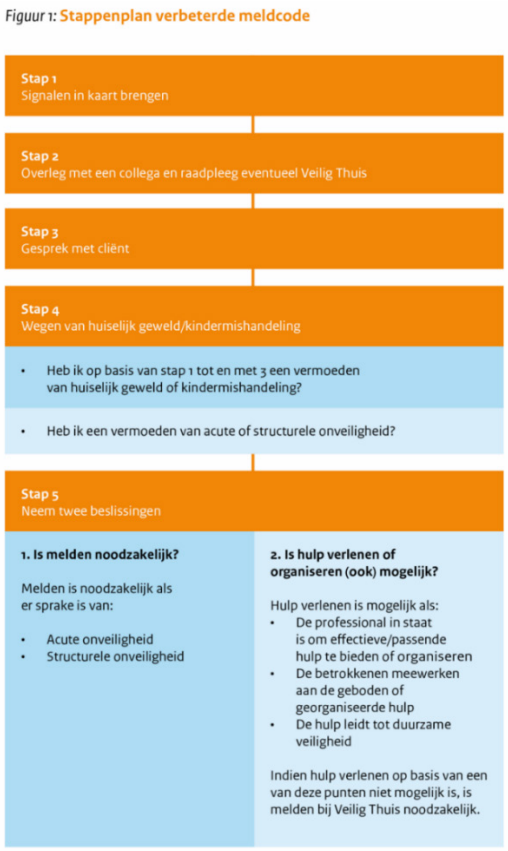
The national action plan 'Ouderen in veilige handen'[a] (2011-2018) included 10 action points:[94]

- A guide on preventing EA for municipalities and a tool to prevent financial exploitation
- A targeted information campaign among older people about elder abuse
- A compulsory Certificate of Good Behaviour (Verklaring Omtrent Gedrag, VOG) for professionals in long-term care services and a manual for screening new staff members.
- A toolkit for (volunteer) organizations with tools for agenda-setting, prevention, repression and communication about elder abuse.
- A duty to report abuse committed by professionals, a mandatory reporting protocol for domestic abuse, and a guideline on elder abuse.
- A training course on identifying and reporting elder abuse for professionals and a training course 'prevention of elder abuse' for the local infrastructure
- A formal hotline related to contact points on domestic violence, a separate reporting point for elder abuse in the care inspection service, a research into possibilities for mandatory cooperation between contact points and inspection services, and an inclusion of elder abuse in the "Wet Maatschappelijke ondersteuning" registration scheme.
- A reference person for the elderly for reporting elder abuse and a setup of crisis shelter for victims of elder abuse.
- An emergency sign to use in case of derailed informal care, and a cooperation between contact points for domestic violence and contact points for informal care in case of elder abuse.
- A judicial approach to offenders and a close monitoring of elder abuse.

a https://www.rijksoverheid.nl/documenten/kamerstukken/2011/03/30/actieplan-ouderen-in-veilige-handen

APPENDIX 48. IMPROVED 'MELDCODE' IN THE NETHERLANDS

Figure 70 – Meldcode of the Netherlands



From: https://www.rijksoverheid.nl/onderwerpen/huiselijk-geweld/meldcode

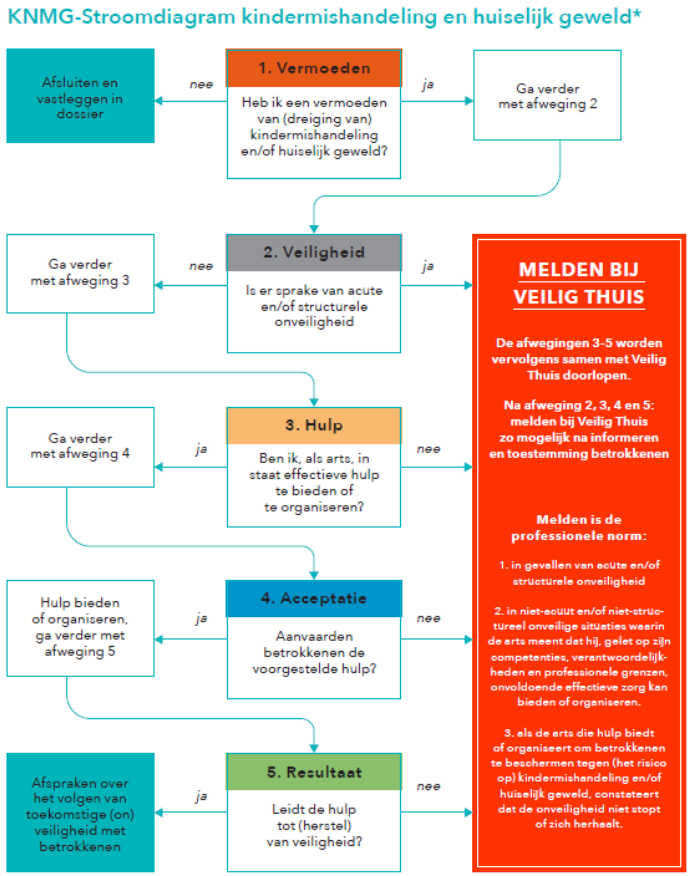
APPENDIX 49. ADAPTED 'MELDCODE' FOR THE USE OF DUTCH GP'S

Figure 71 – Meldcode applied to general practitioners



From: https://www.knmg.nl/advies-richtlijnen/knmg-publicaties/meldcode-kindermishandeling-en-huiselijk-geweld-1.htm

Figure 72 – Decision tree related to the Meldcode adapted for general practitioners



From: *https://www.knmg.nl/advies-richtlijnen/knmg-publicaties/meldcode-kindermishandeling-en-huiselijk-geweld-1.htm*

APPENDIX 50. CONTENT OF THE NHS-UK WEBSITE ON ABUSE AND NEGLECT OF VULNERABLE ADULTS

I think I am being abused or neglected – what can I do?[a]

There are many people you can talk to. If you feel you are being abused or neglected:

Don't worry about making a fuss – tell someone you trust as soon as possible

Speak to friends or careworkers who may have an understanding of the situation and be able to take steps quickly to improve the situation

Talk to professionals such as your GP or social worker about your concerns, or ask to speak to your local council's adult safeguarding team or co-ordinator

Call Action on Elder Abuse on 0808 808 8141 for advice

If you believe a crime is being, or has been, committed – whether it's physical abuse or financial – talk to the police or ask someone you trust to do so on your behalf

I'm worried about someone who may be experiencing abuse or neglect – what should I do?[b]

Start by talking to the person in private, if you feel able to do so. Mention some of the things that concern you – for instance, that they've become depressed and withdrawn, have been losing weight or seem to be short of money.

Let them talk as much as they want to. However, be mindful that if they've been abused, they may be reluctant to talk about it because they are afraid of making the situation worse, don't want to cause trouble, or may be experiencing coercion or threats.

It's best not to promise the person that you won't tell anyone what's been said. If an adult is being abused or neglected, it's important to find help for them and stop the harm. Stay calm while the person is talking, even if you're upset by what you hear, otherwise they may become more upset themselves and stop telling you what's been going on.

It can be very difficult for an abused or neglected person to talk about what's been happening to them. Unless you're concerned for their immediate health and safety and feel it's vital to act straight away, give them time to think about what they'd like to do.

If you're right and the person has been abused or neglected, ask them what they would like you to do. Let them know who can help them and tell them you can seek help on their behalf if they want or if it's difficult for them to do so themselves.

It's important to listen to what they say and not charge into action if this isn't what they want.

a https://www.nhs.uk/conditions/social-care-and-support-guide/help-from-social-services-and-charities/abuse-and-neglect-vulnerable-adults/

b https://www.nhs.uk/conditions/social-care-and-support-guide/help-from-social-services-and-charities/abuse-and-neglect-vulnerable-adults/

Who to contact if an older person is being abused?[a]

If an adult has told you about their situation, you might want to talk to other people who know them to find out if they have similar concerns.

There are also professionals you can contact. You can pass on your concerns to the person's GP and social worker. Local authorities have social workers who deal specifically with cases of abuse and neglect. Call the person's local council and ask for the adult safeguarding co-ordinator.

You can also speak to the police about the situation. Some forms of abuse are crimes, so the police will be interested. If the person is in danger or needs medical attention, call their GP (if known) or emergency services if immediate assistance is required.

You can also call the free, confidential Action on Elder Abuse helpline on 0808 808 8141.

[a] https://www.nhs.uk/conditions/social-care-and-support-guide/help-from-social-services-and-charities/abuse-and-neglect-vulnerable-adults/

APPENDIX 51. STEP PLAN TO REPORT ABUSE TO APS IN CALIFORNIA

Figure 73 – Step plan to report abuse to APS in California

Steps to report Dependent Adult or Elder Abuse to Adult Protective Services:
(Call 911 for Life-Threatening Emergencies)

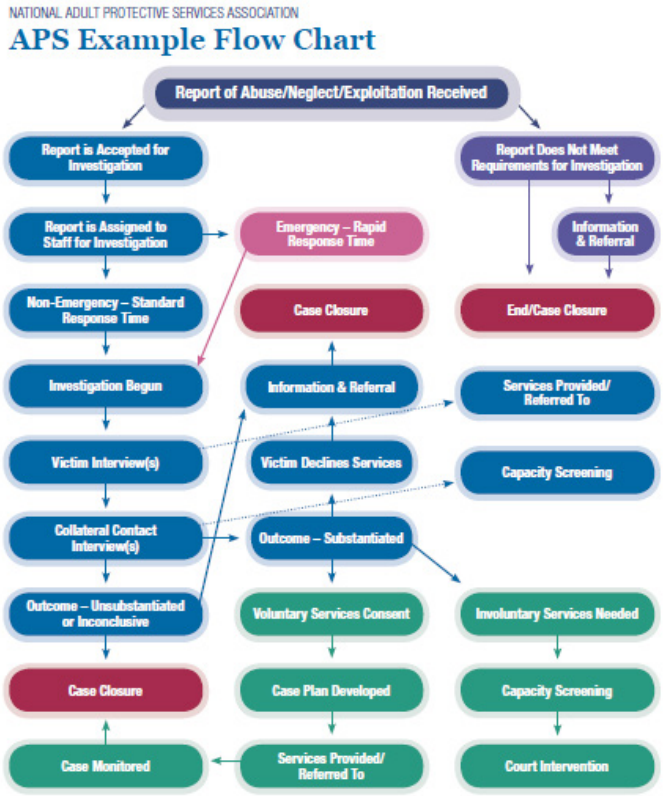
1. Call APS to report dependent adult or elder abuse:
   - **408-975-4900 or 1-800-414-2002**
2. Complete State of California Abuse report forms:
   - Mandated Reporters and all other reporters use this form: Report of Suspected Dependent Adult/Elder Abuse: SOC 341 (PDF)
   - Translation: Spanish (PDF)
   - Statement Acknowledging Requirement To Report Suspected Abuse Of Dependent Adults And Elders (SOC 341A)
   - Financial Institutions ONLY use this form: Report of Suspected Dependent Adult/Elder Financial Abuse: SOC 342
3. Mail the written report within 2 working days to:
   - **Santa Clara County Adult Protective Services**
     333 West Julian St. – Fourth Floor
     San Jose CA 95110

To report dependent adult/elder abuse in a long term care facility such as a skilled nursing facility or residential care facility, call the Long Term Care Ombudsman:
408-944-0567

From: https://www.sccgov.org/sites/ssa/daas/aps/Pages/info.aspx

APPENDIX 52. GENERIC FLOW CHART FOR APS WORKER

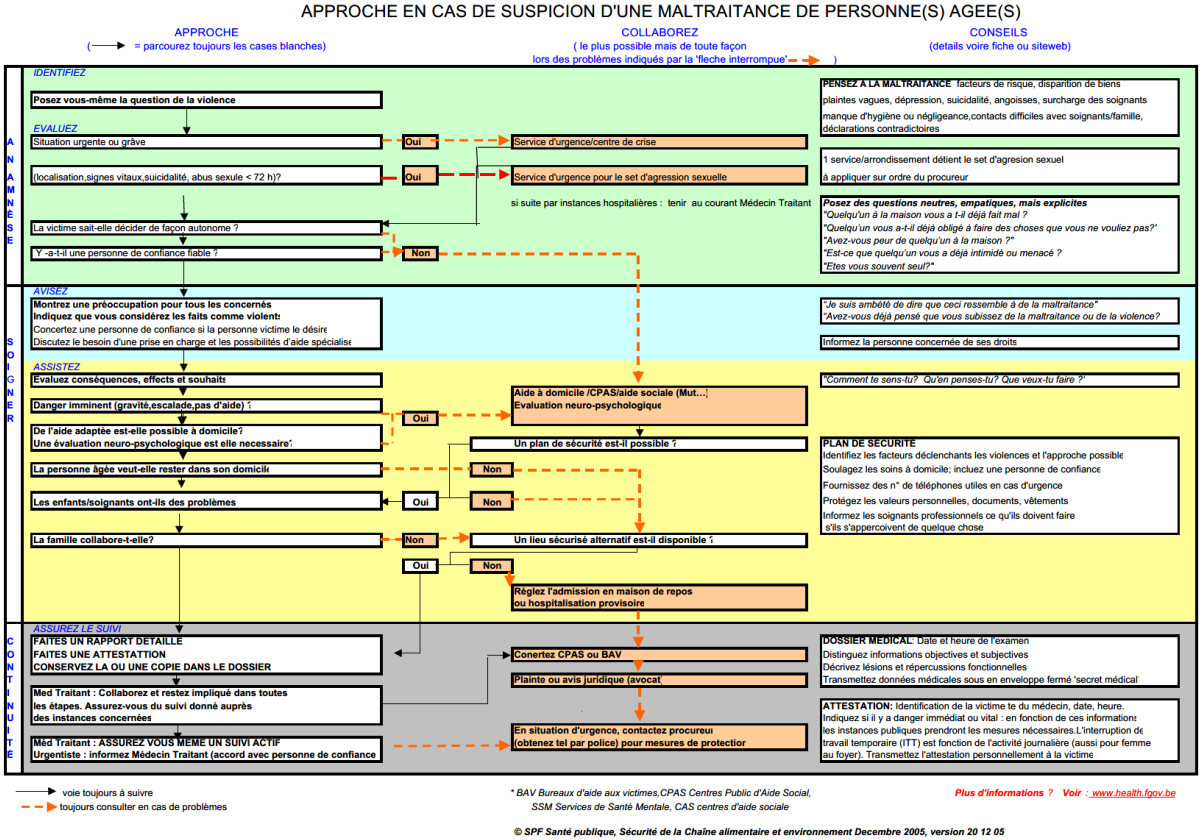
Figure 74 – Generic flow chart for APS workers made by NAPSA



From: http://www.napsa-now.org/

APPENDIX 53. STEP-BY-STEP PLAN FROM BELGIAN GUIDE ABOUT VIOLENCE AGAINST OLDER PEOPLE

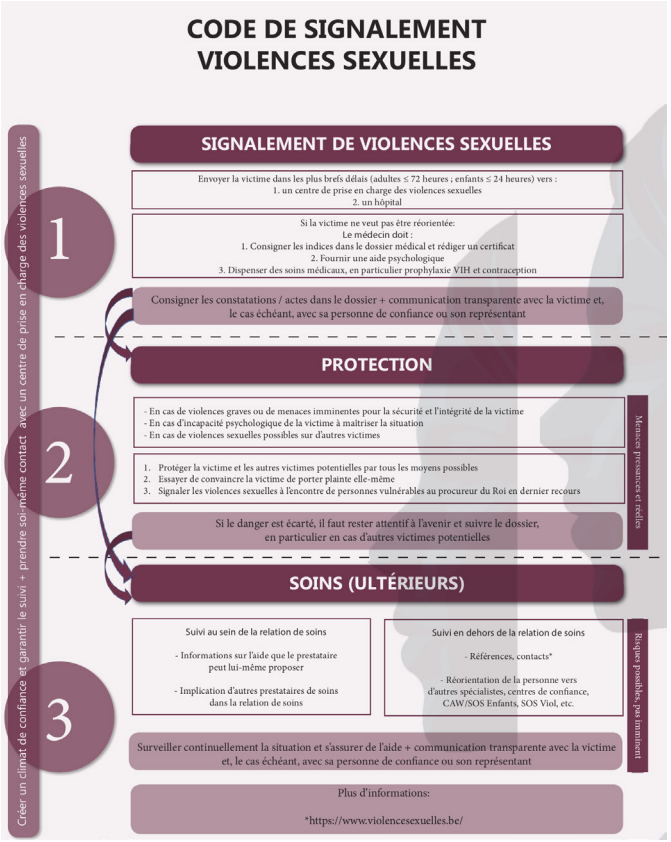
Figure 75 – Generic step-by-step plan in case of elder abuse presumption addressed to Belgian HCP



From: https://www.health.belgium.be/sites/default/files/uploads/fields/fpshealth_theme_file/arbre_maltraitance_de_personnes_agees_0_8312428_fr.pdf

APPENDIX 54. CODE FOR REPORTING SEXUAL VIOLENCE IN BELGIUM

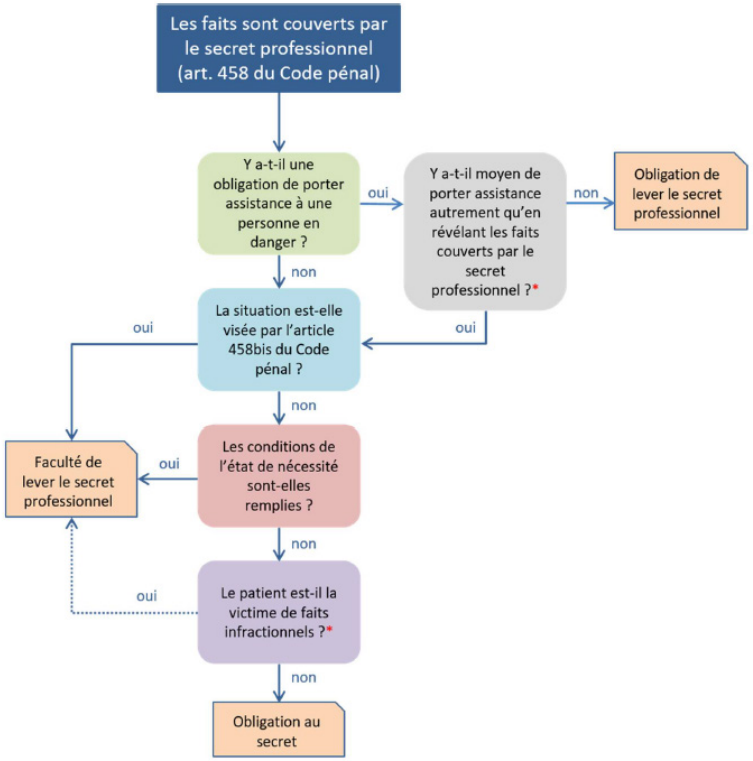
Figure 76 – Code for Reporting Sexual Violence in Belgium



From: https://www.ordomedic.be/fr/actualites/code-de-signalement-violences-sexuelles

APPENDIX 55. DECISIONAL TREE ON PROFESSIONAL SECRECY ADDRESSED TO BELGIAN PSYCHOLOGISTS

Figure 77 – Decisional tree on professional secrecy addressed to Belgian psychologists



*Les incidences liées à ces questions sont particulièrement sensibles. Celles-ci appellent à la plus grande réserve, comme y invitent d'ailleurs les textes rédigés par les soins de la Commission des psychologues.

From: https://www.compsy.be/assets/images/uploads/Arbre_Schema_ClientVictime.pdf

CHAPTER 5: CLINICAL TOOLS FOR THE DETECTION OF ELDER ABUSE

APPENDIX 56. SEARCH STRATEGIES PER DATABASE

Search in Cochrane

Date	06/05/2019 22:56:40	
Database	Cochrane@Wiley.com	
Search strategy		
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#2	((aged or ageing or elder* or senior# or pensioner#) NEAR/5 abus*):ab,ti,kw	136
#3	((aged or ageing or elder* or senior# or pensioner#) NEAR/5 neglect*):ab,ti,kw	27
#4	((aged or ageing or elder* or senior# or pensioner#) NEAR/5 maltreat*):ab,ti,kw	5
#5	((aged or ageing or elder* or senior# or pensioner#) NEAR/5 mistreat*):ab,ti,kw	9
#6	((aged or ageing or elder* or senior# or pensioner#) NEAR/5 violence):ab,ti,kw	17
#7	((aged or ageing or elder* or senior# or pensioner#) NEAR/5 ostrac*):ab,ti,kw	0
#8	((aged or ageing or elder* or senior# or pensioner#) NEAR/5 bully*):ab,ti,kw	4
#9	((aged or ageing or elder* or senior# or pensioner#) NEAR/5 assault*):ab,ti,kw	19
#10	((aged or ageing or elder* or senior# or pensioner#) NEAR/5 exploit*):ab,ti,kw	3
#11	((aged or ageing or elder* or senior# or pensioner#) NEAR/5 fraud*):ab,ti,kw	2
#12	((aged or ageing or elder* or senior# or pensioner#) NEAR/5 aggress*):ab,ti,kw	266
#13	((aged or ageing or elder* or senior# or pensioner#) NEAR/5 coerc*):ab,ti,kw	0
#14	((aged or ageing or elder* or senior# or pensioner#) NEAR/5 extort*):ab,ti,kw	0
#15	((aged or ageing or elder* or senior# or pensioner#) NEAR/5 intimidat*):ab,ti,kw	0
#16	#2 OR #3 OR #4 OR #5 OR #6 OR #7 OR #8 OR #9 OR #10 OR #11 OR #12 OR #13 OR #14 OR #15	470
#17	#1 OR #16	470
#18	[mh "Aged"[mj]]	95

#19	[mh "geriatrics"[mj]]	62
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#21	(geriatric* or elder* or old-age* or pensioner*):ti,kw	27374
#22	#18 or #19 or #20 or #21	94206
#23	(neglect* or ill-treat* or maltreat* or mistreat* or exploit* or fraud* or assault* or crime* or violen* or bully* or intimidat* or aggressi* or coerc* or extort* or stigmati* or ostrac* or abus*):ti,kw	13542
#24	[mh ^"fraud"[mj]] or [mh ^"homicide"[mj]] or [mh ^"sex offenses"[mj]] or [mh ^"rape"[mj]] or [mh ^"theft"[mj]] or [mh ^"violence"[mj]] or [mh "domestic violence"[mj]]	625
#25	#23 or #24	13546
#26	#22 and #25	627
#27	#17 or #26	828
#28	[mh "diagnosis"]	314119
#29	[mh "mass screening"]	3590
#30	[mh "geriatric assessment"]	1395
#31	[mh "questionnaire"]	51127
#32	[mh "interview"]	7
#33	#28 OR #29 OR #30 OR #31 OR #32	333964
#34	screening:ab,ti,kw	46868
#35	detect*:ab,ti,kw	79250
#36	suspect*:ab,ti,kw	10880
#37	suspicion:ab,ti,kw	1536
#38	identif*:ab,ti,kw	115893
#39	diagnos*:ab,ti,kw	211633
#40	assessment:ab,ti,kw	193934
#41	tool:ab,ti,kw OR tools:ab,ti,kw	28458



#42	report*:ab,ti,kw	211841
#43	'self report*':ab,ti,kw	41309
#44	recogni*:ab,ti,kw	18904
#45	evaluat*:ab,ti,kw	430272
#46	survey:ab,ti,kw OR surveys:ab,ti,kw	52048
#47	questionnaire:ab,ti,kw OR questionnaires:ab,ti,kw	105497
#48	interview:ab,ti,kw OR interviews:ab,ti,kw	24708
#49	#34 OR #35 OR #36 OR #37 OR #38 OR #39 OR #40 OR #41 OR #42 OR #43 OR #44 OR #45 OR #46 OR #47 OR #48	845888
#50	#33 OR #49	951599
#51	#27 AND #50	664
#52	#51 with Cochrane Library publication date Between Jan 2015 and Dec 2019	385
Comments		

Search in Cinahl

Date	**Thursday, May 09, 2019 9:07:25 AM**	
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Search strategy		
S1	(MJ "Elder Abuse+")	3,937
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S3	TI (((aged or ageing or elder* or senior# or pensioner#) N5 neglect*)) OR AB (((aged or ageing or elder* or senior# or pensioner#) N5 neglect*))	553
S4	TI (((aged or ageing or elder* or senior# or pensioner#) N5 maltreat*)) OR AB (((aged or ageing or elder* or senior# or pensioner#) N5 maltreat*))	70
S5	TI (((aged or ageing or elder* or senior# or pensioner#) N5 violence)) OR AB (((aged or ageing or elder* or senior# or pensioner#) N5 violence))	339

S6	TI (((aged or ageing or elder* or senior# or pensioner#) N5 mistreat*)) OR AB (((aged or ageing or elder* or senior# or pensioner#) N5 mistreat*))	291
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S9	TI (((aged or ageing or elder* or senior# or pensioner#) N5 assault*)) OR AB (((aged or ageing or elder* or senior# or pensioner#) N5 assault*))	77
S10	TI (((aged or ageing or elder* or senior# or pensioner#) N5 exploit*)) OR AB (((aged or ageing or elder* or senior# or pensioner#) N5 exploit*))	79
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S16	(S1 OR S2 OR S3 OR S4 OR S5 OR S6 OR S7 OR S8 OR S9 OR S10 OR S11 OR S12 OR S13 OR S14 OR S15)	3,253
S17	S16 - Published Date: 20150101-20191231	777
S18	S17 - Exclude MEDLINE records	559
S19	S18 - Peer Reviewed	466
S20	S19	466
S21	(MH "Diagnosis+")	1,551,538
S22	(MH "Health Screening+")	78,441

S23	(MH "Geriatric Assessment")	10,039
S24	(MH "Questionnaires+")	351,467
S25	(MH "Clinical Assessment Tools+")	198,692
S26	(MH "Interviews+")	194,429
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S29	TI(screening OR detect* OR suspect* OR suspicion OR identif* OR diagnos* OR assessment OR tool OR tools OR report* OR recogni* OR evaluat* OR survey OR surveys OR questionnaire* OR interview*)	621,058
S30	S28 OR S29	2,093,645
S31	S27 OR S30	2,959,323
S32	(S16 AND S31)	2,128
S33	S32 - Published Date: 20150101-20191231	574
S34	S33 - Peer Reviewed; Exclude MEDLINE records	348
Comments		

Search in PsycINFO

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4	(elder* adj5 abus*).ab,ti,kf,jw.	1309

5	(elder* adj5 neglect*).ab,ti,kf.	382
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9	(ostrac* adj5 aged).ab,ti,kf.	2
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20	(mistreat* adj5 elder*).ab,ti,kf.	226
21	(violence adj5 elder*).ab,ti,kf.	172
22	(ostrac* adj5 elder*).ab,ti,kf.	1
23	(bully* adj5 elder*).ab,ti,kf.	4
24	(assault* adj5 elder*).ab,ti,kf.	24
25	(exploit* adj5 elder*).ab,ti,kf.	56
26	(fraud* adj5 elder*).ab,ti,kf.	13
27	(aggress* adj5 elder*).ab,ti,kf.	58
28	(coerc* adj5 elder*).ab,ti,kf.	3
29	(extort* adj5 elder*).ab,ti,kf.	0
30	(intimidat* adj5 elder*).ab,ti,kf.	1
31	4 or 5 or 19 or 20 or 21 or 22 or 23 or 24 or 25 or 26 or 27 or 28 or 29 or 30	1617

32	(maltreat* adj5 senior?).ab,ti,kf.	0
33	(neglect* adj5 senior?).ab,ti,kf.	7
34	(abus* adj5 senior?).ab,ti,kf.	21
35	(violen* adj5 senior?).ab,ti,kf.	13
36	(mistreat* adj5 senior?).ab,ti,kf.	0
37	(ostrac* adj5 senior?).ab,ti,kf.	0
38	(bully* adj5 senior?).ab,ti,kf.	7
39	(assault* adj5 senior?).ab,ti,kf.	2
40	(exploit* adj5 senior?).ab,ti,kf.	3
41	(fraud* adj5 senior?).ab,ti,kf.	5
42	(aggress* adj5 senior?).ab,ti,kf.	7
43	(coerc* adj5 senior?).ab,ti,kf.	1
44	(intimid* adj5 senior?).ab,ti,kf.	0
45	(extort* adj5 senior?).ab,ti,kf.	0
46	32 or 33 or 34 or 35 or 36 or 37 or 38 or 39 or 40 or 41 or 42 or 43 or 44 or 45	64
47	(maltreat* adj5 pensioner?).ab,ti,kf.	0
48	(neglect* adj5 pensioner?).ab,ti,kf.	1
49	(abus* adj5 pensioner?).ab,ti,kf.	0
50	(violen* adj5 pensioner?).ab,ti,kf.	0
51	(mistreat* adj5 pensioner?).ab,ti,kf.	0
52	(ostrac* adj5 pensioner?).ab,ti,kf.	0
53	(bully* adj5 pensioner?).ab,ti,kf.	0
54	(assault* adj5 pensioner?).ab,ti,kf.	0
55	(exploit* adj5 pensioner?).ab,ti,kf.	0
56	(fraud* adj5 pensioner?).ab,ti,kf.	0
57	(aggress* adj5 pensioner?).ab,ti,kf.	0
58	(coerc* adj5 pensioner?).ab,ti,kf.	0

59	(extort* adj5 pensioner?).ab,ti,kf.	0
60	(intimidat* adj5 pensioner?).ab,ti,kf.	0
61	47 or 48 or 49 or 50 or 51 or 52 or 53 or 54 or 55 or 56 or 57 or 58 or 59 or 60	1
62	(maltreat* adj5 ageing).ab,ti,kf.	0
63	(neglect* adj5 ageing).ab,ti,kf.	12
64	(abus* adj5 ageing).ab,ti,kf.	8
65	(violen* adj5 ageing).ab,ti,kf.	7
66	(mistreat* adj5 ageing).ab,ti,kf.	0
67	(ostrac* adj5 ageing).ab,ti,kf.	0
68	(bully* adj5 ageing).ab,ti,kf.	0
69	(assault* adj5 ageing).ab,ti,kf.	0
70	(exploit* adj5 ageing).ab,ti,kf.	2
71	(fraud* adj5 ageing).ab,ti,kf.	0
72	(aggress* adj5 ageing).ab,ti,kf.	2
73	(coerc* adj5 ageing).ab,ti,kf.	1
74	(extort* adj5 ageing).ab,ti,kf.	0
75	(intimidat* adj5 ageing).ab,ti,kf.	0
76	62 or 63 or 64 or 65 or 66 or 67 or 68 or 69 or 70 or 71 or 72 or 73 or 74 or 75	31
77	18 or 31 or 46 or 61 or 76	2370
78	1 or 77	2499
79	exp *Aged/	845
80	exp *geriatrics/	6531
81	((Aging or aged or senior or old*) adj2 (wom#n or m#n or lady or ladies or adult* or citizen* or resident or residents or population*1 or people or person?)).ti,kf.	26307
82	(geriatric* or elder* or old?age* or pensioner*).ti,kf.	16727
83	79 or 80 or 81 or 82	45169

84	(neglect* or ill-treat* or maltreat* or mistreat* or exploit* or fraud* or assault* or crime* or violen* or bully* or intimidat* or aggressi* or coerc* or extort* or stigmati* or ostrac* or abus*).ti,kf.	81873
85	*fraud/ or *homicide/ or *sex offenses/ or *rape/ or *theft/ or *violence/ or *domestic violence/	33776
86	84 or 85	94934
87	83 and 86	1386
88	78 or 87	2797
89	Diagnosis/	33480
90	di.fs.	0
91	mass screening/	0
92	geriatric assessment/	603
93	"Surveys and Questionnaires"/	0
94	Interviews as topic/	0
95	89 or 90 or 91 or 92 or 93 or 94	34057
96	screening.ab,ti,kf.	46081
97	detect*.ab,ti,kf.	97334
98	suspect*.ab,ti,kf.	10980
99	suspicion.ab,ti,kf.	2398
100	identif*.ab,ti,kf.	422567
101	diagnos*.ab,ti,kf.	199923
102	assessment.ab,ti,kf.	193418
103	tool?.ab,ti,kf.	116388
104	report*.ab,ti,kf.	497529
105	self-report*.ab,ti,kf.	87386
106	recogni*.ab,ti,kf.	130738
107	evaluat*.ab,ti,kf.	340042
108	survey?.ab,ti,kf.	195785

109	questionnaire?.ab,ti,kf.	169833
110	interview?.ab,ti,kf.	192944
111	96 or 97 or 98 or 99 or 100 or 101 or 102 or 103 or 104 or 105 or 106 or 107 or 108 or 109 or 110	1548643
112	95 or 111	1549486
113	88 and 112	2070
114	limit 113 to yr="2015-Current"	560
115	(editorial or letter).pt.	0
116	114 not 115	560
Comments		

Search in Embase

Date	**6 May 2019**	
Database	Embase.com	
Search strategy		
#1	'elder abuse'/exp/mj	753
#2	((aged OR ageing OR elder* OR senior* OR pensioner*) NEAR/5 abus*):ab,ti,kw	2661
#3	((aged OR ageing OR elder* OR senior* OR pensioner*) NEAR/5 neglect*):ab,ti,kw	948
#4	((aged OR ageing OR elder* OR senior* OR pensioner*) NEAR/5 'maltreatment'):ab,ti,kw	95
#5	((aged OR ageing OR elder* OR senior* OR pensioner*) NEAR/5 mistreat*):ab,ti,kw	394
#6	((aged OR ageing OR elder* OR senior* OR pensioner*) NEAR/5 violence):ab,ti,kw	526
#7	((aged OR ageing OR elder* OR senior* OR pensioner*) NEAR/5 ostrac*):ab,ti,kw	3
#8	((aged OR ageing OR elder* OR senior* OR pensioner*) NEAR/5 bully*):ab,ti,kw	72

#9	((aged OR ageing OR elder* OR senior* OR pensioner*) NEAR/5 assault*):ab,ti,kw	138
#10	((aged OR ageing OR elder* OR senior* OR pensioner*) NEAR/5 exploit*):ab,ti,kw	113
#11	((aged OR ageing OR elder* OR senior* OR pensioner*) NEAR/5 fraud*):ab,ti,kw	28
#12	((aged OR ageing OR elder* OR senior* OR pensioner*) NEAR/5 aggress*):ab,ti,kw	1085
#13	((aged OR ageing OR elder* OR senior* OR pensioner*) NEAR/5 coerc*):ab,ti,kw	24
#14	((aged OR ageing OR elder* OR senior* OR pensioner*) NEAR/5 extort*):ab,ti,kw	0
#15	((aged OR ageing OR elder* OR senior* OR pensioner*) NEAR/5 intimidat*):ab,ti,kw	4
#16	#2 OR #3 OR #4 OR #5 OR #6 OR #7 OR #8 OR #9 OR #10 OR #11 OR #12 OR #13 OR #14 OR #15	4913
#17	#1 OR #16	5037
#18	'aged'/exp/mj	54 574
#19	'geriatrics'/exp/mj	40 864
#20	((aging OR aged OR senior OR old*) NEAR/2 (woman OR women OR man OR men OR lady OR ladies OR adult* OR citizen* OR resident OR residents OR population*1 OR people OR person?)):ti,kw	108 684
#21	geriatric*:ti,kw OR elder*:ti,kw OR 'old age*':ti,kw OR pensioner*:ti,kw	215 838
#22	#18 OR #19 OR #20 OR #21	355 889
#23	neglect*:ti,kw OR 'ill treat*':ti,kw OR maltreat*:ti,kw OR mistreat*:ti,kw OR exploit*:ti,kw OR fraud*:ti,kw OR assault*:ti,kw OR crime*:ti,kw OR violen*:ti,kw OR bully*:ti,kw OR intimidat*:ti,kw OR aggressi*:ti,kw OR coerc*:ti,kw OR extort*:ti,kw OR stigmati*:ti,kw OR ostrac*:ti,kw OR abus*:ti,kw	188 639
#24	'violence'/exp/mj OR 'fraud'/exp/mj OR 'homicide'/exp/mj OR 'sexual crime'/exp/mj OR 'rape'/exp/mj OR 'theft'/exp/mj OR 'domestic violence'/exp/mj	83 933
#25	#23 OR #24	219 736
#26	#22 AND #25	3858

#27	#17 OR #26	6221
#28	'diagnosis'/exp	6 555 444
#29	'mass screening'/exp	226 144
#30	'geriatric assessment'/exp	14 684
#31	'questionnaire'/exp	640 067
#32	'interview'/exp	251 087
#33	#28 OR #29 OR #30 OR #31 OR #32	7 358 285
#34	screening:ab,ti,kw	678 490
#35	detect*:ab,ti,kw	2 754 057
#36	suspect*:ab,ti,kw	292 526
#37	suspicion:ab,ti,kw	79 116
#38	identif*:ab,ti,kw	3 808 809
#39	diagnos*:ab,ti,kw	3 317 883
#40	assessment:ab,ti,kw	1 269 835
#41	tool:ab,ti,kw OR tools:ab,ti,kw	852 771
#42	report*:ab,ti,kw	4 586 039
#43	'self report*':ab,ti,kw	180 955
#44	recogni*:ab,ti,kw	896 381
#45	evaluat*:ab,ti,kw	4 480 056
#46	survey:ab,ti,kw OR surveys:ab,ti,kw	704 450
#47	questionnaire:ab,ti,kw OR questionnaires:ab,ti,kw	671 237
#48	interview:ab,ti,kw OR interviews:ab,ti,kw	334 295
#49	#34 OR #35 OR #36 OR #37 OR #38 OR #39 OR #40 OR #41 OR #42 OR #43 OR #44 OR #45 OR #46 OR #47 OR #48	15 030 293
#50	#33 OR #49	17 583 470
#51	#27 AND #50	4412
#52	#51 AND [2015-2019]/py	1164

#53	#52 NOT [medline]/lim	461
#54	#53 NOT ('conference abstract'/it OR 'conference paper'/it OR 'conference review'/it)	173
Comments		

Sociological abstract

Database	**Sociological abstracts**	
Search date	09/05/2019	
Search strategy		**Hits**
	(((MAINSUBJECT.EXACT("Elder Abuse") OR AB,TI((aged or ageing or elder* or senior? or pensioner?) NEAR/5 (abus* OR neglect* OR mistreat* OR maltreat* OR violence OR ostrac* OR bully* OR intimid* OR assault* OR exploit* OR fraud* OR aggress* OR extort* OR coerc*))) OR ((MAINSUBJECT.EXACT("Elderly") OR MAINSUBJECT.EXACT("Geriatrics") OR TI((Aging OR aged OR senior OR old*) NEAR/2 (woman OR women OR man OR men OR lady OR ladies OR adult* OR citizen* OR resident OR residents OR population? OR people OR person?))) AND ((MAINSUBJECT.EXACT("Fraud") OR MAINSUBJECT.EXACT("Homicide") OR MAINSUBJECT.EXACT.EXPLODE("Larceny") OR MAINSUBJECT.EXACT.EXPLODE("Sexual Assault") OR (MAINSUBJECT.EXACT("Violence") OR MAINSUBJECT.EXACT("Family Violence"))) OR TI(neglect* or ill-treat* or maltreat* or mistreat* or exploit* or fraud* or assault* or crime* or violen* or bully* or intimidat* or aggressi* or coerc* or extort* or stigmati* or ostrac* or abus*)))) AND ((MAINSUBJECT.EXACT.EXPLODE("Diagnosis") OR MAINSUBJECT.EXACT.EXPLODE("Questionnaires") OR MAINSUBJECT.EXACT.EXPLODE("Surveys") OR MAINSUBJECT.EXACT("Interviews")) OR AB,TI(diagnos* OR assessment OR tool? OR report* OR screening OR detect* OR suspect* OR identif* OR suspicion OR self-report* OR recogni* OR evaluat* OR survey? OR questionnaire? OR interview?)))	294
Comments	Filters: 2015-2019, Peer reviewed	

APPENDIX 57. OVERVIEW OF SEARCH RESULTS

Figure 78 – Flow diagram of the search for systematic reviews

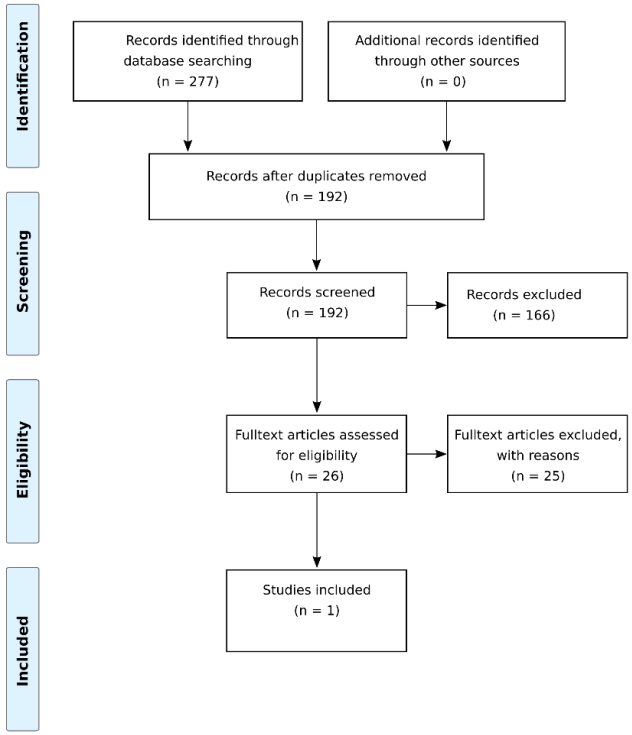
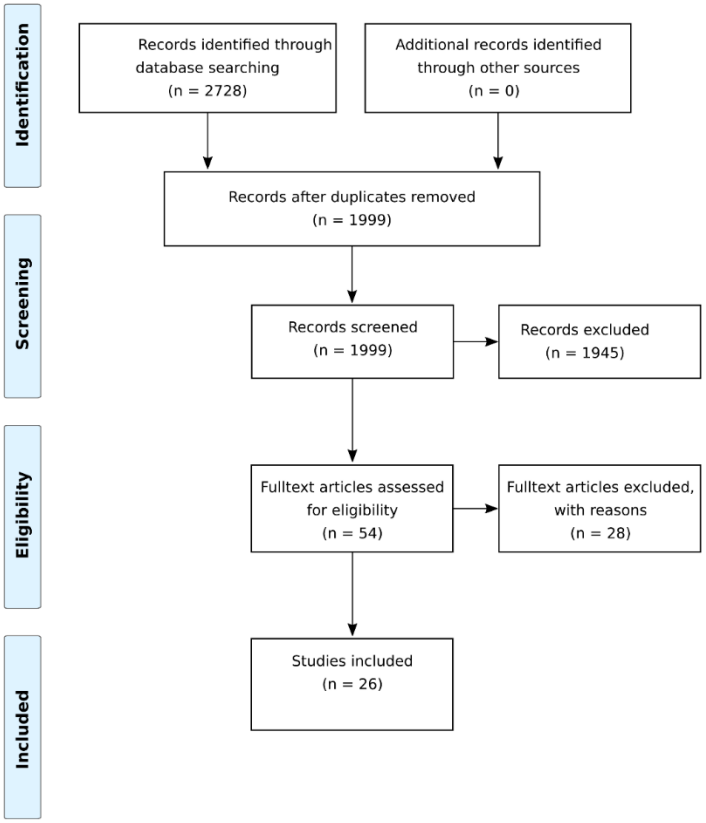


Figure 79 – Flow diagram of the search for primary studies



APPENDIX 58. SELECTION OF SYSTEMATIC REVIEWS

Table 63 – Selection on quick critical appraisal with 4 of the 16 questions of AMSTAR 2 and then full text reading

References	Item 1: PICO	Item 2: review protocol	Item 4: search strategy	Item 8: included studies	Item 9: risk of bias	Included	Excluded	Reason(s) for exclusion
Alt et al. (2011)[213]	**Yes** 2 methods: CIPP (Context, Input, Process, and Product) and another one but it's an implicit PICO	**No** written protocol not clearly stated	**Partial yes** PubMed database National Center on Elder Abuse website (www.ncea.aoa.gov) Personal reference database of a faculty expert in the field of domestic violence	**No** Not described	**No** Not described in methods nor in results		X	PICO + No comparison tools
Ayalon et al. (2016)[196]	**No** not clearly	**No**	**Partial yes** Cochrane Library, Campbell collaborations and ProQuest, etc. between January 2000 and December 2014,	**Partial yes**	**Yes**		X	PICO + No comparison tools. It's about importance of preventing elder maltreatment. 3 types of intervention (see table I): Professionals responsible for preventing elder Maltreatment; Interventions that target older adults who experienced maltreatment

							AND interventions that target carers who maltreat
Baker et al. (2016)[8]	**Yes** Patient or population: Carers of elderly persons Settings: Workforce training Intervention: Educational interventions Comparison: Control - no specific training Outcome: depending on the studies	**Yes**	**Yes** Appendix 56 1 of the SR Bibliographic database searches	**Yes** See in the SR: tables on characteristics of included studies	**Yes** See Figure 3 of the SR	X	Good SR but we take the more recent SR: Gallione 2017
Brijnath et al. (2018)[186]	**No** not clearly	**No**	**Partial yes**	**No**	**No** not described in methods nor in results	X	PICO + It's a rapid review and not a systematic review. Focus groups with experts
Caldwell et al. (2013)[197]	**No** not clearly	**No**	**Partial yes** between May 2011 and August 2011 using PubMed; Ovid/MEDLINE; PsycINFO; CINAHL; Academic Search Premier, Health Source: Nursing/Academic Edition, and Psychology and Behavioral Sciences Collection; and ProQuest	**No**	**No** not described in methods nor in results	X	PICO + Description of different tools but not a SR

Cohen et al. (2011)[198]	**No**	**No**	**Partial yes** PubMed, ProQuest, AgLine and PsycNET; between 1980 and 2011	**No**	**No**	X	PICO + Comparison of tools but it's not a SR. no detailed table to compare each tool but a description of each one. Tools are classified in 3 categories: direct questioning, signs of abuse and indicators of risk for abuse
Cooper et al. (2009)[214]	**No**	**No** not clearly	**Partial yes** Only two bases: PubMed and website + references of all included articles and review articles In/ex criteria, keywords, Search in November 2008	**No**	**No** not described in methods nor in results	X	PICO + weak methodologyTools are presented without a strict comparison between them (no table)
Daly et al. (2011)[199]	**Yes**	**No**	**Yes**	**Yes**	**No** not described in methods nor in results	X	Not a comparison tools. About effectiveness of abuse prevention training programs, etc.

Feltner et al. (2018)[182]	**Yes** See figure 1 of the SR	**Partial yes** there's no mention of written protocol	**Yes** MEDLINE, Cochrane Library, EMBASE, and trial registries through October 4, 2017; references; experts; literature surveillance through August 1, 2018	**Yes**	**Yes** See methods of the SR	X	It's a publication from the full report Feltner 2018
Feltner et al. (2018)[215](full report)	**Yes** See Appendix B Table 1 of the SR	**Partial yes** there's no mention of written protocol	**Yes** MEDLINE, Cochrane Library, EMBASE, and trial registries through October 4, 2017; references; experts; literature surveillance through August 1, 2018	**Yes** See tables 1, 2 and 3 of the SR	**Yes** See methods	X	Not focused on detection tools
Garma et al. (2017)[187]	Yes Focus on health personnel's attitudes	No written protocol not clearly stated	Partial yes 2000-2014, Pubmed, CINAHL, Cochrane, LILACS, Abstracts in Social Gerontology, PsycInfo, etc, + 3y between search and publication	Yes see table 1 of the SR	No Not described in methods nor in results	X	Narrative review, useful information of facilitators and barriers (definitions, knowledge and attitudes)
Haggerty et al. (2011)[216]	Yes But only brief description	No written protocol not clearly stated	No No clear description of methodology	No No clear overview of included studies	No Not described in methods nor in results	X	No systematic review, kind of update of US Task Force 2004
Hirst et al. (2016)[204]	**Yes** RQ 1 in scope (most effective ways for nurses to	**No** existence of written	**Partial Yes** 2000-2013, CINAHL, Cochrane, DARE, Embase, Joanna	**No** lack of details of included studies	**Partial Yes** see table 1 of the SR, but only	X	Search up to 2013 No details on tools, analysis

	identify and assess for abuse) + focus on nursing + population aged 55 and older	protocol not clearly stated	Briggs Institute, Medline, Ovid, PsycInfo 3y between search and publication		total score of QA reported			of included studies needed
Gallione et al. (2017)[3]	**Yes** P Individuals aged 60 and older. No applied restriction with regard to patient gender, race, comorbidity, setting or other characteristics I Detect/assess the risk of elder abuse (physical, psychological, financial, sexual or neglect) using a screening tool O Elder abuse risk assessment/quantification, reduced exposure to violence S Prospective and retrospective observational cohort studies	**Partial yes**	**Yes** MEDLINE, Cochrane, EMBASE and Scopus grey literature '1980–2015'	**Partial yes**	**No** not described in methods nor in results	X		
Kamavarapu et al. (2017)[195]	Yes All adults, including disabilities, focus on institutions	No written protocol not clearly stated	Partial yes Up to 2013, Medline, CINAHL, Embase, PsycINFO, unclear of content experts were contacted + 3y between search and publication	Yes see table 1 of the SR: selection of studies on elderly possible	No Not described in methods nor in results		X	Clients, staff, institutional and environmental risk factors Selection of factors from studies on elderly needed

Killick et al. (2009)[217]	Yes Focus on decisional factors + elderly living in the community	No written protocol not clearly stated	Partial yes 1995-2006, 9 databases Unclear of content experts were contacted +3y between search and publication	No included studies not easily identifiable	No Briefly in methodology mentioned, but no reported in results	X	Only searched until 2006
Knight et al. (2016)[218]	Yes No systematic reporting of the methodology	No written protocol not clearly stated	Partial yes No search date, Medline, PsycInfo, CINAHL, Embase Unclear if content experts were contacted	No included studies not easily identifiable	No Not described in methods nor in results	X	Association between victim of domestic violence and mental health problems
219	Yes Residential care excluded from PICO+ elderly defined as aged 55 and over	No written protocol not clearly stated	Partial yes Up to 2014, AMED, CINAHL, Medline, Cochrane library, SCOPUS, King's fund, NICE + in/excl criteria 3y between search and publication + no consultation of experts	Yes see table 2 of the SR	No not described in methods nor in results	X	Most recent search data + PICO within scope but: only in home setting
220						X	Refers to Nelson 2012
221						X	More recent version available in Feltner, 2018

222	Yes Focus on intimate partner violence, in all women, no subanalysis on elderly	No existence of written protocol not clearly stated	Partial yes Up to 2012, Central , Medline, Embase, DARE, CINAHL, PsycInfo, Sociological abstracts, ASSIA, 5 trials registers, unclear if content experts were contacted	No lack of details of included studies	Yes See table 1 of the SR	X	No comparison of tools
188	Yes Focus on perception, knowledge and attitude of dentists	Yes Protocol registered in the PROSPERO database	Partial yes Up to 2016, Pubmed, LILACS, SciELO, Embase, Web of Science, OpenGrey, Google Scholar Unclear if content experts were contacted	Yes see table 1 + 3 of the SR	Partial yes Risk of bias tool disputable	X	Focus on competence of dentists
223	Yes see flowchart	No written protocol not clearly stated	Partial yes 1990-2011 CINAHL, Medline + hand search, in/excl criteria	Partial yes see table 1 (overview but lack of details)	Yes see table 2 of the SR	X	Focus on prevalence, only brief description of assessment tools

APPENDIX 59. SELECTION OF PRIMARY PAPERS

Table 64 – Overview of the selection of primary studies

References	Included	Excluded	Reason(s) for exclusion	Comment(s)
224		X	Related to the APS procedure	Only a few articles on the APS procedure were included in the critical appraisal
225		X	Full text not available	
226	X			
155	X			
227		X	Related to the APS procedure	Only a few articles on the APS procedure were included in the critical appraisal
228		X	it's a case study and not a presentation of detection tools	
229		X	No description of a detection tool	
230		X	Related to the APS procedure	Only a few articles on the APS procedure were included in the critical appraisal
163	X			
176		X	more relevant to use the more recent publication Cannell 2019	
177	X			
231		X	Only narrative description without study results	
181		X		useful for discussion part
232		X	Procedure instead of a tool	Will be included in the international comparison
152	X			
6		X		useful for discussion part
145	X			
153	X			
233		X	Full text not available	
154	X			
191		X	Three scenarios on elder abuse	Useful for discussion part

234		X	Only in Spanish	
193		X		useful for discussion part
235		X	Description of physical signs only	
156	X			
161	X			
159	X			
162	X			
185	X			
236		X	No description of detection tools	
171	X			
179		X		useful for discussion part
237		X	Description of APS procedure	Only a few articles on the APS procedure were included in the critical appraisal
165	X			
149	X			
238		X	Only in Turkish	Same study protocol as Ozmete, 2017
148	X			
169	X			
164	X			
166	X			
178	X			
239		X	Related to the APS procedure	Only a few articles on the APS procedure were included in the critical appraisal
240	X			
180	X			
170	X			
7	X			
192	X			
241	X			

160	X		
194	X		
242		X	Only in Spanish
158	X		
243		X	No description of detection tools
146		X	Reliability not calculated, assessment of validity was limited

APPENDIX 60. PSYCHOMETRIC PROPERTIES OF DETECTION TOOLS

In order to assess the relevance of their elder abuse detection tool, the authors evaluate the psychometric properties of these tools. According to Alvior [244], "psychometric properties refer to the reliability and validity of the instrument".

Another definition of psychometric properties is given by a technology assessment report of the Agency for Healthcare Research and Quality [245] in the Table 65.

Table 65 – Definition of psychometric properties

Table ES1. Definitions of psychometric properties

Domain	Psychometric Property	Definition
Reliability		Reliability is the degree to which the tool is free from measurement error.
	Internal Consistency	Internal consistency reliability is a reflection of the reproducibility of measurement by different items within a multi-item scale.
	Test-retest Reliability	Test-retest reliability is the degree to which the score of a patient who has not changed remains the same under repeated measurements.
Validity		Validity is defined as the degree to which an instrument measures the construct(s) it is intended to measure.
	Content Validity	Content validity is concerned with the content of the measurement tool and whether it is an adequate reflection of the construct to be measured.
	Construct Validity	Construct validity considers whether the scores produced by the instrument are consistent with the hypothesis of how the tool should behave, assuming the tool is valid.
	Criterion Validity	Criterion validity focuses on the degree to which the scores of an instrument reflect a 'gold standard'.
Responsiveness		The responsiveness of a tool demonstrates the ability of the instrument to detect changes in a patient over time when changes in the construct being measured actually occur.
Interpretability		Interpretability is considered important for the usability of the measurement tool rather than as a psychometric property. It is the degree to which a clinician or researcher can equate a qualitative meaning to an instrument's quantitative score.

Source: Agency for Healthcare Research and Quality [245]

Reliability

Internal consistency is often assessed though the Cronbach alpha's coefficient. According to De Souza et al. [246], it is the most used instrument by researchers since the 1950's. Nevertheless, there is no consensus about its interpretation:

- Some authors consider that a coefficient more than 0.70 is an indicator of a good internal consistency;
- Whereas others consider that a coefficient superior to 0.60 is an indicator of good internal consistency.

Alvior et al. (2013) [244] propose a range of values of Cronbach's alpha and the corresponding descriptions on internal consistency (see Table 66).

Table 66 – Range of values of Cronbach's alpha according to Alvior et al. [244]

Cronbach's alpha	Internal Consistency
$\alpha \geq 0.9$	Excellent
$0.7 \leq \alpha < 0.9$	Good
$0.6 \leq \alpha < 0.7$	Acceptable
$0.5 \leq \alpha < 0.6$	Poor
$\alpha < 0.5$	Unacceptable

(Note: The description is not officially cited and taken only from Wikipedia, but you may confer with your statistician and your panel of examiners. If the value of alpha is less than .05, the items are considered poor and must be omitted).

Source: Alvior et al. (2013)[244]

Cronbach alpha is not the only test currently used for internal consistency: there is the Kuder-Richardson technique (KR-20) too. The two tests are not used for the same goal: "KR-20 is recommended for scales applied only once and for which the answers are dichotomous, for example, right and wrong" whereas Cronbach's alpha "is recommended for measuring instruments that adopt Likert or multiple choice scales and whose categories have an ascending or descending order of values." [133].

APPENDIX 61. DETECTION TOOLS QUESTIONNAIRES AVAILABLE IN OPEN ACCESS

Questionnaire 1 – Vulnerability Abuse Screening Scale (VASS)

VULNERABILITY TO ABUSE SCREENING SCALE (VASS)

Purpose: To identify older women at risk of elder abuse through a self-report instrument.

Instructions: Questionnaire can be mailed to subjects with instructions to answer "yes" or "no".

1. Are you afraid of anyone in your family? Yes ____ No ____
2. Has anyone close to you tried to hurt you or harm you recently? Yes ____ No ____
3. Has anyone close to you called you names or put you down or made you feel bad recently? Yes ____ No ____
4. Do you have enough privacy at home? Yes ____ No ____
5. Do you trust most of the people in your family? Yes ____ No ____
6. Can you take your own medication and get around by yourself? Yes ____ No ____
7. Are you sad or lonely often? Yes ____ No ____
8. Do you feel that nobody wants you around? Yes ____ No ____
9. Do you feel uncomfortable with anyone in your family? Yes ____ No ____
10. Does someone in your family make you stay in bed or tell you you're sick when you know you're not? Yes ____ No ____
11. Has anyone forced you to do things you didn't want to do? Yes ____ No ____
12. Has anyone taken things that belong to you without your OK? Yes ____ No ____

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Schofield, M. J., & Mishra, G. D. (2003). Validity of self-report screening scale for elder abuse: Women's Health Australia Study. *The Gerontologist, 43*(1), 110-120, Table 1.

Source:
https://medicine.uiowa.edu/familymedicine/sites/medicine.uiowa.edu.familymedicine/files/wysiwyg_uploads/VASS.pdf

Questionnaire 2 – Hwalek-Sengstock Elder Abuse Screening Test (H-S/EAST)

H-S "EAST"
The Hwalek-Sengstock Elder Abuse Screening Test *

The Hwalek-Sengstock Elder Abuse Screening Test (H-S "EAST") is a short (15 item) questionnaire for use in health and social service agencies to screen for persons who may be at risk for abuse. It was developed at the request of agencies, which felt that a short test such as this would be useful to them in identifying abused or neglected elders or persons at risk. The EAST is listed below. Also see NOTE following the EAST.

1. Do you have anyone who spends time with you, taking you shopping or to the doctor? [no]
2. Are you helping to support someone? [yes]
3. Are you sad or lonely often? [yes]
4. Who makes decisions about your life -- like how you should live or where you should live? [someone else]
5. Do you feel uncomfortable with anyone in your family? [yes]
6. Can you take your own medication and get around by yourself? [no]
7. Do you feel that nobody wants you around? [yes]
8. Does anyone in your family drink a lot? [yes]
9. Does someone in your family make you stay in bed or tell you you're sick when you know you're not? [yes]
10. Has anyone forced you to do things you didn't want to do? [yes]
11. Has anyone taken things that belong to you without your O.K.? [yes]
12. Do you trust most of the people in your family? [no]
13. Does anyone tell you that you give them too much trouble? [yes]
14. Do you have enough privacy at home? [no]
15. Has anyone close to you tried to hurt you or harm you recently? [yes]

* The response associated with "abuse" has been indicated in brackets at the end of each item. "Abuse" is associated with a response of "no" to items 1, 6, 12, and 14; a response of "someone else" to item 4; and a response of "yes" to all others.

Note: The EAST is still in its developmental stages and has not been completely tested. Further tests of its validity and reliability are under way. Consequently, its effectiveness, and limitations for its use are still not completely known. Hence the authors recommend using it only in conjunction with their direct supervision. Professionals who wish to use the EAST are urged to work with the authors of the measure, not only to insure that the measure is being used appropriately, but also to provide further opportunities to test the EAST. Interested parties can contact the publisher for further information: Melanie Hwalek, SPEC Associates, Ford Building, 615 Griswold, Suite 1505, Detroit, MI 48226; or call 313-964-0500 or email: mhwalek@specassociates.org.

See also: Neale, AV, M Hwalek, MC Sengstock, RO Scott, & C Stahl. "Validation of the Hwalek-Sengstock Elder Abuse Screening Test." *Journal of Applied Gerontology*, 10 (4): 417-429 (1991).

Source:
https://static1.squarespace.com/static/545020a5e4b06fcbba6b1d78/t/55d780d5e4b0feb04b62114b/1440186581216/Hwalek-Sangstock-Scale.pdf

Questionnaire 3 – Elder Abuse Suspicion Index© (EASI): french and german version

EVIDENCE D'ABUS SELON DES INDICATEURS (©) EASI

(Elder Abuse Suspicion Index (©) EASI)

Questions de l'EASI Q1. – Q.5 doivent être posé au patient(e); Q6. est répondu par le médecin. *(Au cours des 12 derniers mois)*			
1) Avez-vous dépendu de quelqu'un pour une des suivantes : Prendre votre bain ou douche, vous habiller, faire vos commissions, faire vos transactions bancaires, ou vos repas ?	OUI	NON	N'a pas répondu
2) Est-ce que quelqu'un vous a empêché(e) de vous procurer de la nourriture, des vêtements, des médicaments, des lunettes, des appareils auditifs, de l'aide médicale, ou de rencontrer des gens que vous vouliez voir ?	OUI	NON	N'a pas répondu
3) Avez-vous été dérangé(e) par les paroles de quelqu'un qui vous ont fait sentir honteux (se) ou menacé(e)?	OUI	NON	N'a pas répondu
4) Quelqu'un a-t-il essayé de vous forcer à signer des papiers ou à utiliser votre argent contre votre volonté ?	OUI	NON	N'a pas répondu
5) Est-ce que quelqu'un vous a fait peur, vous a touché d'une manière que vous ne vouliez pas, ou vous a fait mal physiquement ?	OUI	NON	N'a pas répondu
6) L'abus envers une personne âgée peut être associé à des manifestations telles que: de la difficulté à maintenir un contact visuel, une nature retirée, de la malnutrition, des problèmes d'hygiène, des coupures, des ecchymoses, des vêtements inappropriés, ou des problèmes d'adhérence aux ordonnances. Avez-vous remarqué de telles manifestations aujourd'hui ou au cours des 12 derniers mois?	OUI	NON	Incertain

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Mark J. Yaffe, MD, Université McGill, Montréal, Canada
Maxine Lithwick, MSW, CSSS Cavendish, Montréal, Canada
Christina Wolfson, PhD, Université McGill, Montréal, Canada

VERDACHTS- INDEX MISSHANDLUNG IM ALTER (VIMA)

VIMA-Fragen Fragen 1-5 werden der Patientin / dem Patienten gestellt. Frage 6 wird von der Arztin / dem Arzt beantwortet *(Innerhalb der letzten 12 Monate)*			
1) Waren Sie im Hinblick auf irgendeines der folgenden Dinge auf andere Menschen angewiesen? (alles vom Patienten Angegebene bitte ankreuzen) ○ Baden ○ Anziehen ○ Einkaufen ○ Bankgeschafte ○ Mahlzeiten	JA	NEIN	KEINE ANTWORT
2) Hat irgendjemand Sie daran gehindert, ○ Essen, ○ Kleidung, ○ Medikamente, ○ Ihre Brille, ○ Ihr Horgerat, ○ Medizinische Versorgung zu bekommen oder ○ Mit den Menschen zusammen zu sein, mit denen Sie zusammen sein wollten? (alles vom Patienten Angegebene bitte ankreuzen)	JA	NEIN	KEINE ANTWORT
3) Waren Sie aufgebracht, weil jemand zu Ihnen in einer Weise gesprochen hat, die Sie beschamt hat oder durch die Sie sich bedroht gefuhlt haben?	JA	NEIN	KEINE ANTWORT
4) Hat irgendjemand versucht, Sie zu zwingen, Papiere zu unterschreiben oder Ihr Geld gegen Ihren Willen zu verwenden?	JA	NEIN	KEINE ANTWORT
5) Hat irgendjemand Ihnen Angst gemacht, Sie in einer Weise beruhrt, die Sie nicht wollten oder Sie korperlich verletzt?	JA	NEIN	KEINE ANTWORT
6) **Arzt:** Misshandlung im Alter kann mit Befunden wie den folgenden verknupft sein. Haben Sie irgendetwas hiervon heute oder in den letzten 12 Monaten bemerkt? Geringer Blickkontakt ○ja ○nein ○nicht sicher Zuruckgezogenes Verhalten ○ja ○nein ○nicht sicher			

Mangelernahrung	◯ja	◯nein	◯nicht sicher
Hygieneprobleme	◯ja	◯nein	◯nicht sicher
Schnittverletzungen	◯ja	◯nein	◯nicht sicher
Hamatome, Prellungen	◯ja	◯nein	◯nicht sicher
Unpassende Kleidung	◯ja	◯nein	◯nicht sicher
Probleme mit Einhaltung der Medikation	◯ja	◯nein	◯nicht sicher

Zusatzfrage: Hat das Gesprach mit dem Patienten unter vier Augen stattgefunden?

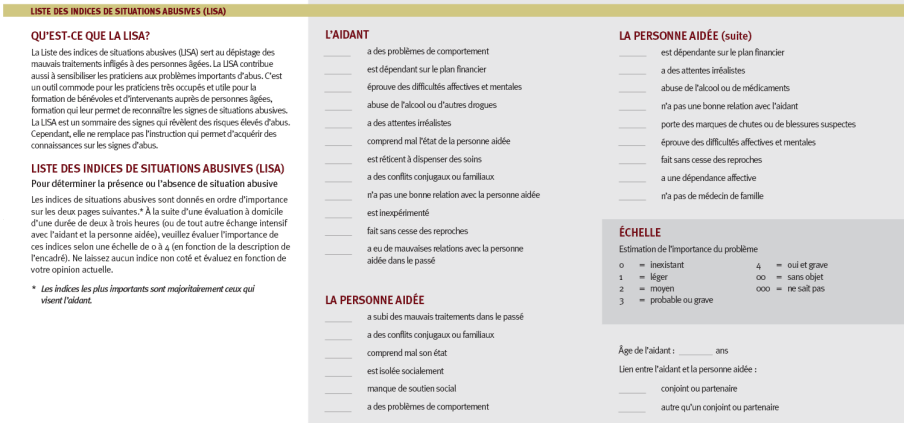
◯ja ◯nein

Wenn nein, erlautern Sie bitte kurz, weshalb nicht:

Thomas Goergen, PhD
Head, Department of Criminology and Interdisciplinary Crime Prevention
German Police University
Muenster, Germany

Source: https://www.mcgill.ca/familymed/research/projects/elder

Questionnaire 4 – Indicators of Abuse (IOA): french* and english versions



LISTE DES INDICES DE SITUATIONS ABUSIVES (LISA)

QU'EST-CE QUE LA LISA?

La Liste des indices de situations abusives (LISA) sert au dépistage des mauvais traitements infligés à des personnes âgées. La LISA contribue aussi à sensibiliser les praticiens aux problèmes importants d'abus. C'est un outil commode pour les praticiens très occupés et utile pour la formation de bénévoles et d'intervenants auprès de personnes âgées, formation qui leur permet de reconnaître les signes de situations abusives. La LISA est un sommaire des signes qui révèlent des risques élevés d'abus. Cependant, elle ne remplace pas l'instruction qui permet d'acquérir des connaissances sur les signes d'abus.

LISTE DES INDICES DE SITUATIONS ABUSIVES (LISA)

Pour déterminer la présence ou l'absence de situation abusive

Les indices de situations abusives sont donnés en ordre d'importance sur les deux pages suivantes.* À la suite d'une évaluation à domicile d'une durée de deux à trois heures (ou de tout autre échange intensif avec l'aidant et la personne aidée), veuillez évaluer l'importance de ces indices selon une échelle de 0 à 4 (en fonction de la description de l'encadré). Ne laissez aucun indice non coté et évaluez en fonction de votre opinion actuelle.

* *Les indices les plus importants sont majoritairement ceux qui visent l'aidant.*

L'AIDANT

- ____ a des problèmes de comportement
- ____ est dépendant sur le plan financier
- ____ éprouve des difficultés affectives et mentales
- ____ abuse de l'alcool ou d'autres drogues
- ____ a des attentes irréalistes
- ____ comprend mal l'état de la personne aidée
- ____ est réticent à dispenser des soins
- ____ a des conflits conjugaux ou familiaux
- ____ n'a pas une bonne relation avec la personne aidée
- ____ est inexpérimenté
- ____ fait sans cesse des reproches
- ____ a eu de mauvaises relations avec la personne aidée dans le passé

LA PERSONNE AIDÉE

- ____ a subi des mauvais traitements dans le passé
- ____ a des conflits conjugaux ou familiaux
- ____ comprend mal son état
- ____ est isolée socialement
- ____ manque de soutien social
- ____ a des problèmes de comportement

LA PERSONNE AIDÉE (suite)

- ____ est dépendante sur le plan financier
- ____ a des attentes irréalistes
- ____ abuse de l'alcool ou de médicaments
- ____ n'a pas une bonne relation avec l'aidant
- ____ porte des marques de chutes ou de blessures suspectes
- ____ éprouve des difficultés affectives et mentales
- ____ fait sans cesse des reproches
- ____ a une dépendance affective
- ____ n'a pas de médecin de famille

ÉCHELLE

Estimation de l'importance du problème

0 = inexistant
1 = léger
2 = moyen
3 = probable ou grave
4 = oui et grave
oo = sans objet
ooo = ne sait pas

Âge de l'aidant : _____ ans

Lien entre l'aidant et la personne aidée :

- ____ conjoint ou partenaire
- ____ autre qu'un conjoint ou partenaire

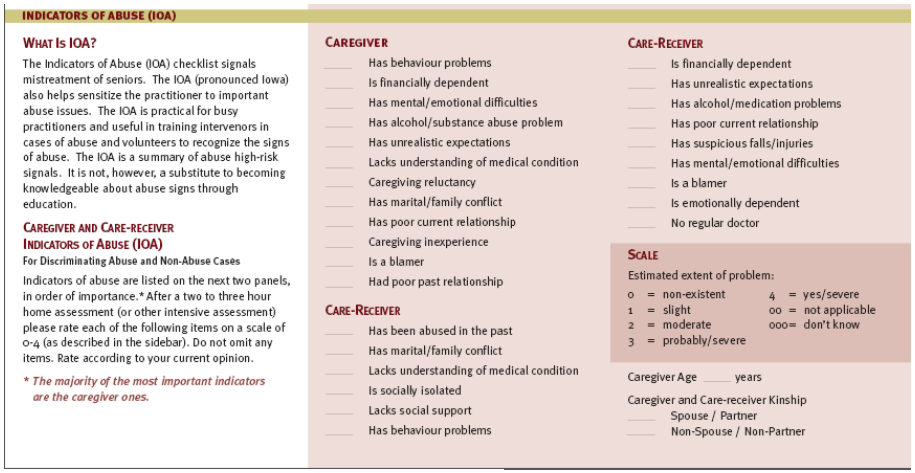
POINTAGE DE LA LISA

La somme des points pour tous les indices (écart de 0 à 108).

INTERPRÉTATION DES RÉSULTATS

Les indices de situation d'abus sont énumérés par ordre d'importance. En général, les indices relatifs à l'aidant ont plus d'importance que ceux qui visent la personne aidée. Cependant, c'est ensemble que ces indices signalent l'existence d'une situation abusive. Ainsi, plus le total des points est élevé (0 -108), plus l'existence de mauvais traitements est vraisemblable. Un total de 16 ou plus donne à penser qu'il y a maltraitance. Plus le total des points est élevé, plus les risques d'abus sont présents. Un résultat totalisant 4 points ou moins indique qu'il n'y a probablement pas de mauvais traitements.

Chaque indice noté entre 1 et 4 devrait faire l'objet d'une évaluation clinique. Cependant, un indice ne peut à lui seul signifier qu'il y a une situation abusive.



INDICATORS OF ABUSE (IOA)

WHAT IS IOA?

The Indicators of Abuse (IOA) checklist signals mistreatment of seniors. The IOA (pronounced Iowa) also helps sensitize the practitioner to important abuse issues. The IOA is practical for busy practitioners and useful in training intervenors in cases of abuse and volunteers to recognize the signs of abuse. The IOA is a summary of abuse high-risk signals. It is not, however, a substitute to becoming knowledgeable about abuse signs through education.

CAREGIVER AND CARE-RECEIVER INDICATORS OF ABUSE (IOA)

For Discriminating Abuse and Non-Abuse Cases

Indicators of abuse are listed on the next two panels, in order of importance.* After a two to three hour home assessment (or other intensive assessment) please rate each of the following items on a scale of 0-4 (as described in the sidebar). Do not omit any items. Rate according to your current opinion.

* *The majority of the most important indicators are the caregiver ones.*

CAREGIVER

- ____ Has behaviour problems
- ____ Is financially dependent
- ____ Has mental/emotional difficulties
- ____ Has alcohol/substance abuse problem
- ____ Has unrealistic expectations
- ____ Lacks understanding of medical condition
- ____ Caregiving reluctancy
- ____ Has marital/family conflict
- ____ Has poor current relationship
- ____ Caregiving inexperience
- ____ Is a blamer
- ____ Had poor past relationship

CARE-RECEIVER

- ____ Has been abused in the past
- ____ Has marital/family conflict
- ____ Lacks understanding of medical condition
- ____ Is socially isolated
- ____ Lacks social support
- ____ Has behaviour problems

CARE-RECEIVER

- ____ Is financially dependent
- ____ Has unrealistic expectations
- ____ Has alcohol/medication problems
- ____ Has poor current relationship
- ____ Has suspicious falls/injuries
- ____ Has mental/emotional difficulties
- ____ Is a blamer
- ____ Is emotionally dependent
- ____ No regular doctor

SCALE

Estimated extent of problem:

0 = non-existent
1 = slight
2 = moderate
3 = probably/severe
4 = yes/severe
oo = not applicable
ooo = don't know

Caregiver Age ____ years

Caregiver and Care-receiver Kinship

- ____ Spouse / Partner
- ____ Non-Spouse / Non-Partner

INDICATORS OF ABUSE (IOA)

SCORING THE IOA

Total the sum of ratings for all items
(range: 0 - 108)

INTERPRETING THE RESULTS

The abuse indicators are listed in rough order of importance. In general, the caregiver indicators carry more weight than care-receiver indicators. However, it is the total list of indicators together that signal abuse. Thus, the higher the total score (0 - 108), the more likely it is that abuse is occurring. Scores close to 16 and higher are suggestive of abuse, and the higher the score the more likely it is that abuse is occurring. Scores of 4 or less indicate that there probably is no abuse.

Each indicator that is rated by the interviewer as being between 1 and 4 on the scale should be explored clinically. However, each individual indicator does not, by itself, indicate abuse.

**In French, IOA is called LISA for "Liste des indices de situations abusives"*
Source : questionnaires sent by one of the authors

Questionnaire 5 – Risk on Elder Abuse and Mistreatment-Instrument (REAMI): french version

Instrument d'estimation de risque : questionnaire

Données personnelles :

Date	
Sexe	□ homme □ femme
Age	
Code postale	
Région de soins	
Cohabitant ?	□ non □ avec partenaire □ avec enfants □ avec autres

Dans quelle mesure êtes-vous d'accord avec les propositions concernant les aînés et leur environnement ? (ne cochez chaque fois qu'une case s.v.p.)

A = En total désaccord C = En accord

B = En désaccord D = En total accord

PARTIE 1

Dans quelle mesure pensez-vous que:

	A	B	C	D
...l'aîné est dépendant d'une personne de soutien[1]? (p.ex. pour les soins, financièrement, administrativement, domicile, ...)				
...l'aîné est isolé ?				
...il y a des signes que l'aîné ne gère plus la situation (p.ex. des signes de surcharge, de fatigue, d'émotivité, d'agitation, d'irritabilité, d'indifférence, d'impuissance, de frustration, d'angoisse, ...)				
... il y a des limites physiques, démence, sentiments dépressifs, dépendance, faible capacité intellectuel, problèmes psychiatriques ou psychosociaux concernant l'aîné ?				
... il y a eu récemment des changements radicaux et stressants dans la vie de l'aîné ? (p.ex. déménagement, décès partenaire, ...)				
... il y a des antécédents de violence dans la famille ?				
Total (additionner le nombre de fois que A et B, C et D a été coché ?)				

PARTIE 2

Dans quelle mesure pensez-vous que :

	A	B	C	D
... la relation entre la personne de soutien et l'aîné est problématique ? (p.ex. stress, dispute, ..)				
... la relation entre la personne de soutien et l'environnement immédiat est problématique ? (p.ex. stress, dispute, tension ... .)				
... la personne de soutien est dépendante de l'aîné?				
... les soins fournis par la personne de soutien à l'aîné sont (trop) lourds ?				
... la connaissance de la personne de soutien pour bien prendre en mains et organiser les soins est insuffisante ?				
... la personne de soutien est isolée ?				
... il y a des signes que la personne de soutien ne gère plus la (p.ex. des signes de surcharge, de fatigue, d'émotivité, d'agitation, d'irritabilité, d'indifférence, d'impuissance, de frustration, d'angoisse, ...)				
... il y a des limites physiques, démence, sentiments dépressifs, dépendance, faible capacité intellectuel, problèmes psychiatriques ou psychosociaux concernant la personne de soutien?				
... la personne de soutien a des problèmes financiers ?				
... il y a eu récemment des changements radicaux et stressants dans la vie de la personne de soutien ?				
Total (additionner le nombre de fois que A et B, C et D a été coché?)				

PARTIE 3

Dans quelle mesure pensez-vous que :

	A	B	C	D
... il y a des signes de violation des droits ? (p.ex. empêcher de lire son courrier, rencontrer des amis, ...)				
... il y a des signes de maltraitance psychologique ? (p.ex. être anxieux, se sentir gêné, se sentir menacé, rabaissé, ...)				
... il y a des signes que l'aide et les soins laissent à désirer ? (p.ex. habits, les courses, repas, ménage, ...)				
... il y a des signes de maltraitance financière ? (p.ex. argent ou des biens à céder contre leur gré, signer des papiers, chasse à l'héritage, changement soudains et inexplicable de la situation financière, ...)				
... il y a des signes de maltraitance physique ? (p.ex. blessures, battu, ...)				
... il y a des signes de maltraitance sexuelle ? (p.ex., attouchements non désirés, obligation de se déshabiller, ...)				
Total (additionner le nombre de fois que A et B, C et D a été coché?)				

Cotation RITI

Prenez les totaux des cellules grises et multiplier par le chiffre correspondant (1, 10 ou 1000). Additionner les résultats.

Partie 1:		X 1	= .....
Partie 2:		X 10	= .....
Partie 3		X 1000	= .....
		Total	= .....

Chiffre	Situation
0	La situation est bonne.
1 / 2/ 3 10 / 11	L'aîné a un risque faible de maltraitance.
4 / 5 / 6 12 jusqu'à 106	L'aîné a un risque modéré de maltraitance. En ce moment il n'y a peut-être pas de maltraitance visible, mais la situation indique un risque modéré, suivre attentivement.
1000 jusqu'à 6106	Il y a des signes que l'aîné est victime de maltraitance. Il y a un grand risque de maltraitance.

[1] Chez les aînés (surtout dans un contexte de soins) il y a souvent une personne de soutien. Cela peut être le partenaire, un des (beaux)enfants, un des voisins, ou un aidant professionnel. En bref, une personne proche de l'aîné et avec qui les liens sont forts.

Source : questionnaire sent by one of the authors

Questionnaire 6 – Risicotaxatie-Instrument (RITI)

Bijlage: Voorbeeldversie RITI

Persoonsgegevens:

Datum	
Geslacht	☐ man ☐ vrouw
Leeftijd	
Postcode	
Samenwonend?	☐ nee ☐ met partner ☐ met kinderen ☐ met anderen

In hoeverre bent u het eens met de volgende uitspraken over de oudere en zijn omgeving? (kruis aan a.u.b.)
A = helemaal niet akkoord C = eerder wel akkoord
B = eerder niet akkoord D = helemaal akkoord

DEEL 1
In welke mate hebt u het gevoel dat:

	A	B	C	D
… de oudere afhankelijk is van een steunfiguur? (bv. voor zorg, financieel, administratief, voor woonplaats…)				
… de oudere geïsoleerd is?				
… er tekenen zijn dat de oudere de situatie niet meer aankan (bv. signalen van overbelasting, oververmoeidheid, emotionaliteit, gejaagdheid, opvliegendheid, onverschilligheid, onmacht, frustratie, angst…)				
…				
…				
Totaal (optellen hoeveel keer wordt A en B, C en D geantwoord?)				

DEEL 2
In welke mate hebt u het gevoel dat:

	A	B	C	D
… de relatie tussen de steunfiguur en oudere problematisch is? (bv. stress, ruzie…)				
… de relatie tussen de steunfiguur en de naaste omgeving problematisch is? (bv. stressvol, spanningen, ruzie…)				
… de steunfiguur afhankelijk is van de oudere?				
…				
…				
Totaal (optellen hoeveel keer wordt A en B, C en D geantwoord?)				

DEEL 3
In welke mate hebt u het gevoel dat:

	A	B	C	D
… er signalen zijn van schending van de rechten? (bv. verhinderd dat de post gelezen wordt, vrienden ontmoeten…)				
… er signalen zijn van emotionele mis(be)handeling? (bv. angstig zijn, beschaamd zijn, zich bedreigd voelen, gekleineerd worden…)				
…				
…				
Totaal (optellen hoeveel keer wordt A en B, C en D geantwoord?)				

Source : questionnaire sent by one of the authors

Questionnaire 7 – Older Adult Financial Exploitation Measure (OAFEM)

Appendix
Scale and Item Information for Client Financial Exploitation.

Subscale Name and Item Stem	Concept Name	Measure/Severity Group	Results of Analyses
In the past 12 months: (Responses: Yes=1, No=2, Suspected=3. Unknown=4)		*Measures based on 79 item analysis*[a]	*Blank means included in 79 item analysis*
1. Has_____ felt entitled to use your money for themselves? AAFeltEntitledToUseEld$ForThemselves	3, Financial Entitlement	-1.36/Entitlement Expectation	Included in 54 Item Analysi
2. Was _____name put on your bank account? AANameOnEldBankAccount	5, Signs of Possible Abuse	-.46/Risk	Included in 54 Item Analysi
3. Have you been financially dependent on others for meeting your basic needs (food, rent, utilities, etc.)? EldFinanDepOnOthersForMeetingBasicNeeds	5, Signs of Possible Abuse	-.31/Risk	
4. Have you had serious problems due to poor money management? EldHadSeriousProbsDueToPoor$Management	6, Risk Factors	-.26/Entitlement Expectation	
5. Have you felt pressured to stay in your current living arrangement because your money is needed for support of others? EPressureStayLivArrang/$NeedSuppOths	5, Signs of Possible Abuse	-.36/Entitlement Expectation	Included in 54 Item Analysi
6. Has_____ been financially dependent on you? AABeenFinanciallyDependentOnEld	5, Signs of Possible Abuse	-1.56/Entitlement Expectation	
7. Have you had to rely on someone else to cash your checks? EldRelyOnSomeoneElseToCashTheirChecks	6, Risk Factors	-.30/Risk	
8. Have you trusted someone else with your money? EldTrustedSomeoneElseWithEld's$		Misfitting item	Deleted from all analyses
9. Have you had a trusted other who might have reasons to exploit you (for example, someone who gambles, is unemployed, has substance abuse problems)? AAReasonsToExploit(Gambles/Unemployed)	5, Signs of Possible Abuse	-.63/Entitlement Expectation	Included in 54 Item Analysi
10. Have you lacked information about financial affairs (for example, do not know where checkbook, ATM, or credit card is. Do not know ATM pin number, name of bank, direct deposit amount, or pension information)? ELackInfoFinanAff(CBook/ATM/CredCd/PIN)	6, Risk Factors	-.31/Risk	
11. Have you had mail piled up, including unpaid bills? EldHadMailPiledUp,IncludingUnpaidBills	6, Risk Factors	-.02/Entitlement Expectation	
12. Have you given _____ access to your financial accounts? EGaveAAaccessTo$Acct		Misfitting item	Deleted from all analyses
13. Have you received calls from bill collectors without knowing why? EReceivCallsFrmBillCollectNotKnowingWhy	5, Signs of Possible Abuse	-.04/Lesser Theft & Scams	Included in 54 Item Analysi
14. Have you had trouble managing your money on your own? EldHasHadTroubleManaging$OnTheirOwn	6, Risk Factors	-.58/Risk	
15. Have you trusted someone new with your money? EldTrustedSomeoneNewWith$	5, Signs of Possible Abuse	.11/Risk	
16. Have you made changes in your will or trust in favor of any family members or individuals? EChangeWill/TrustInFavorOfFamMemb/Indiv	5, Signs of Possible Abuse	.27/Risk	
17. Did _____ give poor reasons for spending your money? PoorReas4SpndE$	3, Financial Entitlement	-.58/Entitlement Expectation	Short Form Item
18. Were family members fighting over your money? EldFamMembersFightOverE$	3, Financial Entitlement	-.26/Entitlement Expectation	Included in 54 Item Analysis
19. Have you written out any checks for someone else to cash? EWrittenOutChecksForOthToCash	5, Signs of Possible Abuse	-.30/Risk	
20. Have there been any sudden changes in your financial management (titles are changed, quit claim deeds, retirements or investments cashed in)? SudChangeInE'sFinanMan(Titles,Deeds)	5, Signs of Possible Abuse	.01/Major Theft & Scams	
21. Has _____convinced you to turn the title of your home over to them? ConvTrnrOvrTitl	2, Abuse of Trust	.53/Major Theft & Scams	Short Form Item
22. Even though you should have enough money, have you had unpaid bills, eviction notice, or utilities shut off? EldShdHaveEnough$ButUnpaidBillsEvictNoticeUtilShutOff	5, Signs of Possible Abuse	-.14/Entitlement Expectation	Included in 54 Item Analysis
23. Have you thought _____ was lying about how they were spending your money? AALyingAbtSpdE$	4, Coercion	-.70/Entitlement Expectation	Short Form Item
24. Has _____ refused to give you an accounting of spending your money? Refus2GivAcct$	5, Signs of Possible Abuse	-.55/Entitlement Expectation	Short Form Item
25. Have there been unexplained disappearances of your money or possessions? UnexplDisappPoss	5, Signs of Possible Abuse	-.75/Lesser Theft & Scams	Short Form Item
26. Have you signed documents without understanding what you were signing? EldSignedDocsWithoutUnderstanding	5, Signs of Possible Abuse	-.09/Lesser Theft & Scams	
27. Have your legal or financial documents been frequently changed? Leg$DoxFreqChng	5, Signs of Possible Abuse	.37/Major Theft & Scams	Short Form Item
28. Has _____persuaded you to sign any documents even though it was not in your best interest? SignDxNotBstInt	2, Abuse of Trust	-.03/Lesser Theft & Scams	Short Form Item

Appendix *(continued)*

Appendix *(continued)*

Subscale Name and Item Stem	Concept Name	Measure/Severity Group	Results of Analyses
29. Has ____ obtained or changed a power of attorney? AAObtain/ChangedPOA	2, Abuse of Trust	.06/Risk	
30. Has____ become the payee on your benefit check and used the money for themselves? PayeeOnChkUse4Sf	1, Theft & Scams	.49/Major Theft & Scams	Short Form Item
31. Has ____ kept you from seeing your own mail? AAKeptEldFromSeeingOwnMail	4, Coercion	.27/Major Theft & Scams	Included in 54 Item Analysis
32. Has anyone had a new interest in your assets? NewInterestInEldAssets	5, Signs of Possible Abuse	.23/Major Theft & Scams	
33. Has____ changed the direct deposit destination so as to benefit themselves? ChngDirDpDestin	3, Financial Entitlement	1.24/Major Theft & Scams	Short Form Item
34. Has ____ had your bills sent to a different address (for example, the trusted other's address) so as to benefit themselves? AASentEBillsToDiffAddrBenefitSelf	3, Financial Entitlement	.73/Major Theft & Scams	
35. Has ____ used your bank pin or account number for their own gain? AAUsedEldBankPINOrAcctNumForOwnGain	1, Theft & Scams	-.07/Lesser Theft & Scams	
36. Have you suspected someone of signing your name without permission? EldSuspectsSomeoneSignNameNoPermission	1, Theft & Scams	-.31/Lesser Theft & Scams	Included in 54 Item Analysis
37. Has anyone been frequently asking you for money? EldFreqAskedFor$	5, Signs of Possible Abuse	-.92/Entitlement Expectation	Included in 54 Item Analysis
38. Has anyone kept asking about your money even though it made you feel uncomfortable? EldAskedAbout$FeltUncomfort	5, Signs of Possible Abuse	-.55/Entitlement Expectation	Included in 54 Item Analysis
39. Did anyone put pressure on you to get a reverse mortgage? EldPressureToGetReverseMortgage	4, Coercion	1.11/Major Theft & Scams	
40. Have you *not been* getting the kind of care that you can afford? EldNotGettingCareTheyCanAfford	1, Theft & Scams	-.04/Lesser Theft & Scams	Included in 54 Item Analysis
41. Has anyone misused your ATM or credit card? MisuseEldATM/CredCard	1, Theft & Scams	.02/Major Theft & Scams	Included in 54 Item Analysis
42. Was there unusual activity in your bank accounts, for example, large withdrawals, frequent withdrawals? UnusActvEBnkAcc	5, Signs of Possible Abuse	-.24/Lesser Theft & Scams	Short Form Item
43. Did ____ mix their funds with your funds? AAMixFundsWithEld	5, Signs of Possible Abuse	.24/Major Theft & Scams	Included in 54 Item Analysis

Appendix *(continued)*

Subscale Name and Item Stem	Concept Name	Measure/Severity Group	Results of Analyses
44. Have there been unauthorized withdrawals from your bank account? UnathW/dEBnkAcc	1, Theft & Scams	-.05/Lesser Theft & Scams	Short Form Item
45. Has ____ tricked or pressured you into buying something that you now regret buying? PresBuyItmRgrtBuy	1, Theft & Scams	.32/Major Theft & Scams	Short Form Item
46. Have you felt cheated after ____ sold something to you? EFeltCheatedAfterAASoldSomethingToE	1, Theft & Scams	.95/Major Theft & Scams	
47. Have you been a victim of a scam that involved giving to bogus charities? EVictimOfScamBogusCharities	1, Theft & Scams	1.20/Major Theft & Scams	Included in 54 Item Analysis
48. Have you been tricked or pressured into selling a valuable possession for less than its worth? AATrick/PressureSellValuPossessLessThanItsWorth	2, Abuse of Trust	.89/Major Theft & Scams	Included in 54 Item Analysis
49. Has an institution misused your funds? InstitutionMisusedEldFunds	1, Theft & Scams	2.21/Major Theft & Scams	
50. Has a health care provider used your name to file false claims? EldHealthcareProvFiledFalseClaims		Misfitting item	Deleted from all analyses
51. Were you talked into making investments that were not in your best interest? ETalkedIntoInvestmtNotInBestInterest	3, Financial Entitlement	.77/Major Theft & Scams	Included in 54 Item Analysis
52. Have you been pressured to modify your will? EPrssr2ModWill	5, Signs of Possible Abuse	.77/Major Theft & Scams	Short Form Item
53. Has ____ forced you to sign legal or financial documents? AAFrcESigLeg$Dx	4, Coercion	.11/Major Theft & Scams	Short Form Item
54. Has ____ coerced you to give them larger than usual gifts (money, cars, homes)? CoerceE2GivBigGft	4, Coercion	.10/Major Theft & Scams	Short Form Item
55. Have you been pressured to co-sign any loans? EPrsrCoSigLoans	4, Coercion	.57/Major Theft & Scams	Short Form Item
56. Have services been withheld by anyone, because they wanted more money? ServWithheldForMore$	4, Coercion	.71/Major Theft & Scams	Included in 54 Item Analysis
57. Have you been convinced to contribute beyond your means to churches or charities? EldContributeBeyondMeansToChurch/Charity	4, Coercion	.92/Major Theft & Scams	Included in 54 Item Analysis
58. Has ____ obtained a new credit card in your name? AAObtainedNewCredCardInEldName	1, Theft & Scams	.63/Major Theft & Scams	
59. Has ____ used your money on themselves instead of for you? AAUsd$OnSlfNotE	2, Abuse of Trust	-.94/Entitlement Expectation	Short Form Item

Appendix *(continued)*

Subscale Name and Item Stem	Concept Name	Measure/Severity Group	Results of Analyses
60. Has____ bought things for you but not given you back your change? AABoughtThingsEldNeverGaveBackChange	2, Abuse of Trust	-.45/Entitlement Expectation	Included in 54 Item Analys
61. Has ____ borrowed money and not paid it back? AABrrw$NotPdBck	2, Abuse of Trust	-1.13/Entitlement Expectation	Short Form Item
62. Has ____said they were buying something for you, but it was really for their own use? AAPrch4EUsdSlf	2, Abuse of Trust	-.06/Lesser Theft & Scams	Short Form Item
63. Has ____ taken your prized belongings (for example, jewelry) without permission? EldPrizedBelongingsTakenWithoutPermiss	1, Theft & Scams	.06/Major Theft & Scams	Included in 54 Item Analys
64. Has anyone switched some of your expensive items for cheaper ones? ExpnsvSwtc4Cheap	1, Theft & Scams	.90/Major Theft & Scams	Short Form Item
65. Has ____overcharged you for work or services that were done poorly or never done? EOvch4WkSrvPoor	1, Theft & Scams	.46/Major Theft & Scams	Short Form Item
66. Did ____ misuse their power of attorney or guardianship? AAMisusePOAOrGuardianship	2, Abuse of Trust	.19/Major Theft & Scams	Included in 54 Item Analys
67. Were you forced into making financial decisions you would not normally make? EForceIntoFinanDecNotNormMade	4, Coercion	-.30/Lesser Theft & Scams	
68. Did you think that ____ has taken advantage of you to get a hold of your resources such as a house, car, or money? TkAdvntE4Resors	2, Abuse of Trust	-.59/Entitlement Expectation	Short Form Item
69. Has ____ tried to prevent you from spending your money in order to maximize their inheritance? PrvntESpnd2MaxInhrt	2, Abuse of Trust	.14/Major Theft & Scams	Short Form Item
70. Has____ lived with you, but refused to pay their share of expenses? AALivedWithEldRefusePayExpenses	3, Financial Entitlement	-.59/Entitlement Expectation	Included in 54 Item Analys
71. Has ____taken your money to do something for you but never did? Tk$2DoSmthgNvrDid	1, Theft & Scams	-.35/Entitlement Expectation	Short Form Item
72. Has ____handled your money irresponsibly, for example, gambling, illegal activities? HndlE$Irrspnsbly	2, Abuse of Trust	-.06/Lesser Theft & Scams	Short Form Item
73. Has ____used love (sex, or intimacy, if applicable) to gain control of your money? AAUsedLove(Sex/Intimacy)ToGainContOfE$	4, Coercion	.12/Major Theft & Scams	Included in 54 Item Analys
74. Has ____ promised companionship in exchange for your money? AAPromisECompanionshipExchFor$	4, Coercion	.27/Major Theft & Scams	

Appendix *(continued)*

Subscale Name and Item Stem	Concept Name	Measure/Severity Group	Results of Analyses
75. Has ____ demanded money from you? AADemanded$FromE	4, Coercion	-.66/Entitlement Expectation	Short Form Item
76. Has ____ used pressure, intimidation, or punishment to try to get your money? AAPressure/Intimid/PunishToGetE$	4, Coercion	-.49/Entitlement Expectation	
77. Did you let ____spend your money on themselves because you were afraid of them? Sp$SfBcEAfraid	4, Coercion	.12/Entitlement Expectation	Short Form Item
78. Has ____ taken advantage of cultural or family expectations to get your resources? TkAdvrCult/FamExp	4, Coercion	-.04/Entitlement Expectation	Short Form Item
79. Has ____ promised you lifetime care but then did not provide it? PrmLifCarNvrPrvd	2, Abuse of Trust	.20/Major Theft & Scams	Short Form Item
80. Has ____ not met your basic needs even though you had enough income? EldBasicNeedsNotMetThoughEnoughIncome	1, Theft & Scams	-32/Lesser Theft & Scams	
81. Has____ felt entitled to use your money for him/herself? AAFltEntitl2E$	3, Financial Entitlement	-1.00/Entitlement Expectation	Short Form Item
82. Have caregivers overcharged you for their services? CaregiversOverchargeEldForServ	1, Theft & Scams	.51/Major Theft & Scams	

Source: https://academic.oup.com/gerontologist/article/50/6/758/630082

Questionnaire 8 – Older Adult Psychological Abuse Measure (OAPAM)

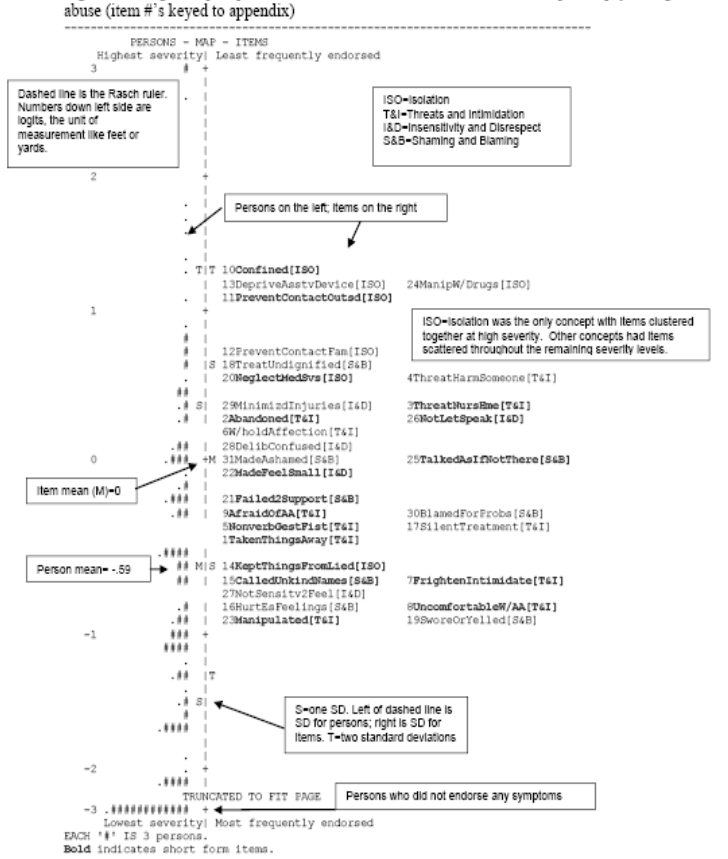
Final Scale and Item Information for Client Psychological Abuse (item #'s keyed to Figure 1)

Response categories are no=0, suspected=1 and yes=2.

Item Number, Full Item, and Item Abbreviation (number and abbreviation are same as in Figure 1)	Concept Name (from expert panel)	Rasch Measure (from client data)	Results of Analyses
Prompt "In the past 12 months , has (NAME OF ALLEGED ABUSER)":		*Measures based on 31 item analysis*	*Blank means included in 31 item analysis*
1. Taken things away or threatened to take things away from you? **(TakenThingsAway)**	Threats and Intimidation	-.44	**Short Form Item**
2. Abandoned or threatened to abandon you? **(Abandoned)**	Threats and Intimidation	.24	**Short Form Item**
3. Threatened to place you in a nursing home when it was not appropriate? **(ThreatNursHme)**	Threats and Intimidation	.33	**Short Form Item**
4. Harmed or threatened to harm someone or something close to you (kids, pets, etc.)? (ThreatenHarmSomeone)	Threats and Intimidation	.54	
5. Used non-verbal behavior such as shaking a fist, pushing, poking, or slapping, to threaten or scare you? **(NonverbGestFist)**	Threats and Intimidation	-.36	**Short Form Item**
6. Manipulated you by withholding affection and love? (WithholdingAffection)	Threats and Intimidation	.17	
7. Behaved in ways that frighten or intimidate you? **(FrightenIntimidate)**	Threats and Intimidation	-.66	**Short Form Item**
In the past 12 months:			
8. Have you been uncomfortable with _____? **(UncomfortableW/AA)**	Risk Factors reclassified as T&I	-.81	**Short Form Item**
9. Have you been afraid of _____? **(AfraidOfAA)**	Risk Factors reclassified as T&I	-.36	**Short Form Item**
In the past 12 months , has NAME ALLEGED ABUSER:			
10. Confined you against your will? **(Confined)**	Isolation	1.31	**Short Form Item**
11. Prevented you from having contact with the outside world via telephone, newspapers, television, or radio, etc.?. **(PreventContactOutsd)**	Isolation	1.08	**Short Form Item**
12. Prevented you from contacting family, friends, or community resources? (PreventedContactFamily)	Isolation	.66	
13. Deprived you of glasses, hearing aids, prosthetics, walker, wheelchair, or any other assistive devices that you needed? (DeprivedOfAssistiveDevices)	Isolation	1.2	
14. Kept things from you or lied about things that you should know about? **(KeptThingsFromEldOrLied)**	Isolation	-.64	**Short Form Item**
15. Called you unkind names or put you down? **(CalledUnkindNames)**	Shaming & Blaming	-.66	**Short Form Item**
16. Deliberately made you feel bad or hurt your feelings? (HurtEldFeelings)	Shaming & Blaming	-.79	
17. Given you the silent treatment? (SilentTreatment)	Threats & Intimidation	-.35	
18. Treated you in an undignified or inappropriate way while assisting you with dressing, eating, bathing and so on? (TreatEldUndignifiedWay)	Shaming & Blaming	.60	
19. Sworn or yelled at you? (SworeOrYelled)	Shaming & Blaming	-.92	
20. Refused or neglected to get medical services that you needed? **(NeglectMedSvs)**	Isolation	.52	**Short Form Item**
In the past 12 months:			
21. Has_____ failed to support you or back you up when you needed it? **(Failed2Support)**	Shaming & Blaming	-.26	**Short Form Item**
In the past 12 months, has the ALLEGED ABUSER:			
22. Made you feel small, for example, treated you like a child? **(MadeFeelSmall)**	Insensitivity & Disrespect	-.07	**Short Form Item**

Item Number, Full Item, and Item Abbreviation (number and abbreviation are same as in Figure 1)	Concept Name (from expert panel)	Rasch Measure (from client data)	Results of Analyses
23. Manipulated or tried to control you in any way? (Manipulated)	Threats & Intimidation	-.91	Short Form Item
24. Manipulated you with drugs or alcohol? (ManipulatedWithDrugs)	Isolation	1.2	
25. Talked about you as if you were not there? (TalkedAsIfNotThere)	Shaming & Blaming	-.04	Short Form Item
26. Not let you speak for yourself? (NotLetSpeak)	Insensitivity & Disrespect	.21	Short Form Item
27. Not been sensitive to your feelings? (NotSensitiveFeelings)	Insensitivity & Disrespect	-.71	
28. Deliberately confused you? (DeliberatelyConfused)	Insensitivity & Disrespect	-.09	Short Form Item
29. Minimized your injuries or complaints? (MinimizedInjuries)	Insensitivity & Disrespect	.3	
30. Blamed you for their problems? (BlamedForProblems)	Shaming & Blaming	-.41	
31. Said something about you that made you feel ashamed? (MadeEldFeelAshamed)	Shaming & Blaming	-.04	

Figure 1. Wright Map of persons and items on the Rasch ruler of client-reported psychological abuse (item #'s keyed to appendix)



Source: https://europepmc.org/article/MED/21173437

Questionnaire 9 – Elder Assessment Instrument (EAI)

:

ELDER ASSESSMENT INSTRUMENT (EAI)

Purpose: To be used as a comprehensive approach for screening suspected elder abuse victims in all clinical settings.

Instructions: There is no "score" for this instrument. A patient should be referred to social services if the following exists: 1) if there is any positive evidence without sufficient clinical explanation, 2) whenever there is a subjective complaint by the older adult of elder mistreatment, or 3) whenever the clinician deems there is evidence of abuse, neglect, exploitation, or abandonment.

1. General Assessment	Very Good	Good	Poor	Very Poor	Unable to Assess
a. Clothing					
b. Hygiene					
c. Nutrition					
d. Skin integrity					
Additional Comments:					
2. Possible Abuse Indicators	**No Evidence**	**Possible Evidence**	**Probable Evidence**	**Definite Evidence**	**Unable to Assess**
a. Bruising					
b. Lacerations					
c. Fractures					
d. Various stages of healing of any bruises or fractures					
e. Evidence of sexual abuse					
f. Statement by older adult related to abuse					
Additional Comments:					
3. Possible Neglect Indicators	**No Evidence**	**Possible Evidence**	**Probable Evidence**	**Definite Evidence**	**Unable to Assess**
a. Contractures					
b. Decubiti					
c. Dehydration					
d. Diarrhea					
e. Depression					
f. Impaction					
g. Malnutrition					
h. Urine Burns					
i. Poor hygiene					
j. Failure to respond to warning of obvious disease					
k. Inappropriate medications (over/under)					
l. Repetitive hospital admissions due to probable failure of health care surveillance					
m. Statement by older adult related to neglect					
Additional Comments:					

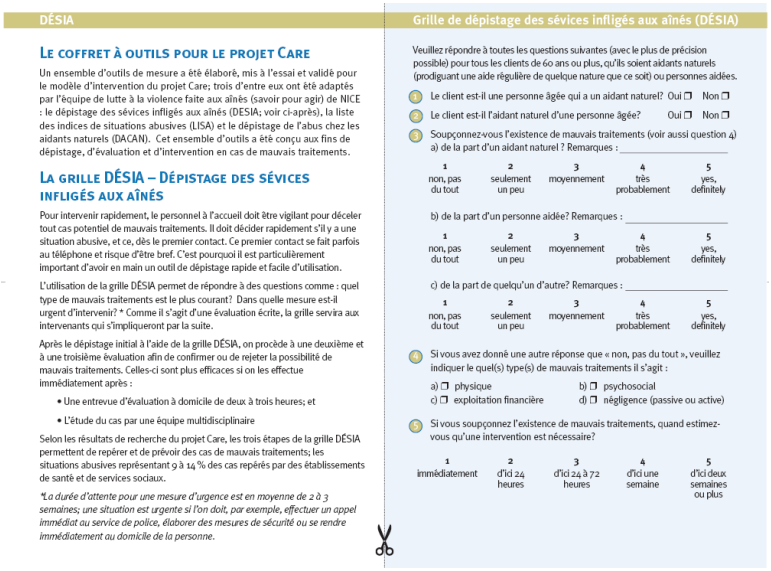
4. Possible Exploitation Indicators	No Evidence	Possible Evidence	Probable Evidence	Definite Evidence	Unable to Assess
a. Misuse of money					
b. Evidence					
c. Reports of demands for goods in exchange for services					
d. Inability to account for money/property					
e. Statement by older adult related to exploitation					
Additional Comments:					
5. Possible Abandonment Indicators	**No Evidence**	**Possible Evidence**	**Probable Evidence**	**Definite Evidence**	**Unable to Assess**
a. Evidence that a caretaker has withdrawn care precipitously without alternate arrangements					
b. Evidence that older adult is left alone in an unsafe environment for extended periods of time without adequate support					
c. Statement by older adult related to abandonment					
Additional Comments:					
Summary	No Evidence	Possible Evidence	Probable Evidence	Definite Evidence	Unable To Assess
Evidence of Abuse					
Evidence of Neglect					
Evidence of Exploitation					
Evidence of Abandonment					
Additional Comments:					

Comments: _____

_____

Source : https://medicine.uiowa.edu/familymedicine/sites/medicine.uiowa.edu.familymedicine/files/wysiwyg_uploads/EAI.pdf

Questionnaire 10 – Brief Abuse Screen for the Elderly (BASE): french* and english versions



DÉSIA

Le coffret à outils pour le projet Care

Un ensemble d'outils de mesure a été élaboré, mis à l'essai et validé pour le modèle d'intervention du projet Care; trois d'entre eux ont été adaptés par l'équipe de lutte à la violence faite aux aînés (savoir pour agir) de NICE : le dépistage des sévices infligés aux aînés (DESIA; voir ci-après), la liste des indices de situations abusives (LISA) et le dépistage de l'abus chez les aidants naturels (DACAN). Cet ensemble d'outils a été conçu aux fins de dépistage, d'évaluation et d'intervention en cas de mauvais traitements.

La grille DÉSIA – Dépistage des sévices infligés aux aînés

Pour intervenir rapidement, le personnel à l'accueil doit être vigilant pour déceler tout cas potentiel de mauvais traitements. Il doit décider rapidement s'il y a une situation abusive, et ce, dès le premier contact. Ce premier contact se fait parfois au téléphone et risque d'être bref. C'est pourquoi il est particulièrement important d'avoir en main un outil de dépistage rapide et facile d'utilisation.

L'utilisation de la grille DÉSIA permet de répondre à des questions comme : quel type de mauvais traitements est le plus courant? Dans quelle mesure est-il urgent d'intervenir? * Comme il s'agit d'une évaluation écrite, la grille servira aux intervenants qui s'impliqueront par la suite.

Après le dépistage initial à l'aide de la grille DÉSIA, on procède à une deuxième et à une troisième évaluation afin de confirmer ou de rejeter la possibilité de mauvais traitements. Celles-ci sont plus efficaces si on les effectue immédiatement après :

- Une entrevue d'évaluation à domicile de deux à trois heures; et
- L'étude du cas par une équipe multidisciplinaire

Selon les résultats de recherche du projet Care, les trois étapes de la grille DÉSIA permettent de repérer et de prévoir des cas de mauvais traitements; les situations abusives représentant 9 à 14 % des cas repérés par des établissements de santé et de services sociaux.

**La durée d'attente pour une mesure d'urgence est en moyenne de 2 à 3 semaines; une situation est urgente si l'on doit, par exemple, effectuer un appel immédiat au service de police, élaborer des mesures de sécurité ou se rendre immédiatement au domicile de la personne.*

Grille de dépistage des sévices infligés aux aînés (DÉSIA)

Veuillez répondre à toutes les questions suivantes (avec le plus de précision possible) pour tous les clients de 60 ans ou plus, qu'ils soient aidants naturels (prodiguant une aide régulière de quelque nature que ce soit) ou personnes aidées.

1. Le client est-il une personne âgée qui a un aidant naturel? Oui ❒ Non ❒
2. Le client est-il l'aidant naturel d'une personne âgée? Oui ❒ Non ❒
3. Soupçonnez-vous l'existence de mauvais traitements (voir aussi question 4)
   a) de la part d'un aidant naturel ? Remarques : _____

1	2	3	4	5
non, pas du tout	seulement un peu	moyennement	très probablement	yes, definitely

   b) de la part d'un personne aidée? Remarques : _____

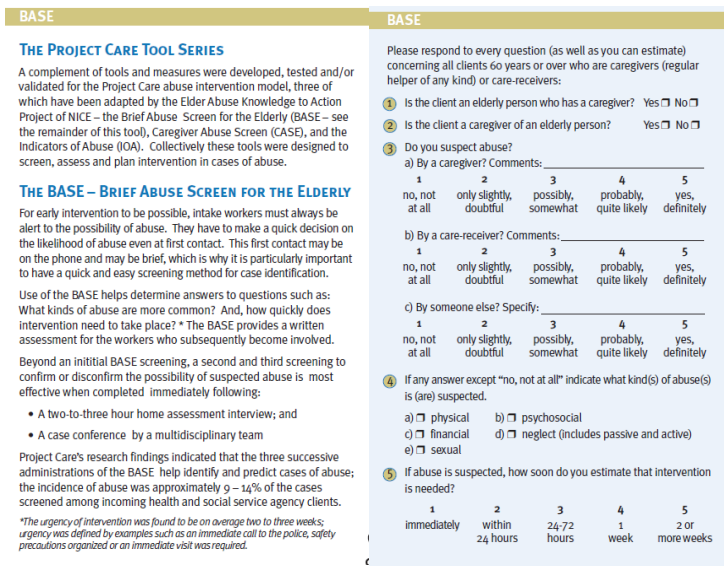
1	2	3	4	5
non, pas du tout	seulement un peu	moyennement	très probablement	yes, definitely

   c) de la part de quelqu'un d'autre? Remarques : _____

1	2	3	4	5
non, pas du tout	seulement un peu	moyennement	très probablement	yes, definitely

4. Si vous avez donné une autre réponse que « non, pas du tout », veuillez indiquer le quel(s) type(s) de mauvais traitements il s'agit :
   a) ❒ physique b) ❒ psychosocial
   c) ❒ exploitation financière d) ❒ négligence (passive ou active)
5. Si vous soupçonnez l'existence de mauvais traitements, quand estimez-vous qu'une intervention est nécessaire?

1	2	3	4	5
immédiatement	d'ici 24 heures	d'ici 24 à 72 heures	d'ici une semaine	d'ici deux semaines ou plus



BASE

The Project Care Tool Series

A complement of tools and measures were developed, tested and/or validated for the Project Care abuse intervention model, three of which have been adapted by the Elder Abuse Knowledge to Action Project of NICE – the Brief Abuse Screen for the Elderly (BASE – see the remainder of this tool), Caregiver Abuse Screen (CASE), and the Indicators of Abuse (IOA). Collectively these tools were designed to screen, assess and plan intervention in cases of abuse.

The BASE – Brief Abuse Screen for the Elderly

For early intervention to be possible, intake workers must always be alert to the possibility of abuse. They have to make a quick decision on the likelihood of abuse even at first contact. This first contact may be on the phone and may be brief, which is why it is particularly important to have a quick and easy screening method for case identification.

Use of the BASE helps determine answers to questions such as: What kinds of abuse are more common? And, how quickly does intervention need to take place? * The BASE provides a written assessment for the workers who subsequently become involved.

Beyond an inititial BASE screening, a second and third screening to confirm or disconfirm the possibility of suspected abuse is most effective when completed immediately following:

- A two-to-three hour home assessment interview; and
- A case conference by a multidisciplinary team

Project Care's research findings indicated that the three successive administrations of the BASE help identify and predict cases of abuse; the incidence of abuse was approximately 9 – 14% of the cases screened among incoming health and social service agency clients.

**The urgency of intervention was found to be on average two to three weeks; urgency was defined by examples such as an immediate call to the police, safety precautions organized or an immediate visit was required.*

BASE

Please respond to every question (as well as you can estimate) concerning all clients 60 years or over who are caregivers (regular helper of any kind) or care-receivers:

1. Is the client an elderly person who has a caregiver? Yes ❒ No ❒
2. Is the client a caregiver of an elderly person? Yes ❒ No ❒
3. Do you suspect abuse?
   a) By a caregiver? Comments: _____

1	2	3	4	5
no, not at all	only slightly, doubtful	possibly, somewhat	probably, quite likely	yes, definitely

   b) By a care-receiver? Comments: _____

1	2	3	4	5
no, not at all	only slightly, doubtful	possibly, somewhat	probably, quite likely	yes, definitely

   c) By someone else? Specify: _____

1	2	3	4	5
no, not at all	only slightly, doubtful	possibly, somewhat	probably, quite likely	yes, definitely

4. If any answer except "no, not at all" indicate what kind(s) of abuse(s) is (are) suspected.
   a) ❒ physical b) ❒ psychosocial
   c) ❒ financial d) ❒ neglect (includes passive and active)
   e) ❒ sexual
5. If abuse is suspected, how soon do you estimate that intervention is needed?

1	2	3	4	5
immediately	within 24 hours	24-72 hours	1 week	2 or more weeks

**In French, BASE is called DESIA for "Grille de dépistage des sévices infligés aux aînés"*
Source : *questionnaires sent by one of the authors*

Questionnaire 11 – Caregiver Abuse Screen for the Elderly (CASE): french* and english versions

QU'EST-CE QUE LE QUESTIONNAIRE DE DACAN?

Le questionnaire de dépistage de l'abus chez les aidants naturels (DACAN) est un instrument de dépistage des sévices infligés aux aînés. Il a été conçu pour être utilisé avec tous les clients qui sont des aidants prenant soin d'aînés, que l'on soupçonne ou non l'existence de sévices. Des réponses affirmatives aux huit questions ci-contre peuvent inciter une discussion permettant de révéler des cas de violence ou de négligence qui seraient autrement passés inaperçus.

En plus de permettre de dépister les cas de sévices infligés par des aidants, les réponses au questionnaire de DACAN peuvent faire ressortir des tendances ou des tensions susceptibles de mener à de la maltraitance dans l'avenir. En pareils cas, une démarche d'intervention proactive et préventive peut contribuer à prévenir l'apparition de mauvais traitements.

Interprétation: Une fois que l'aidant a répondu à toutes les questions, on fait le total des réponses affirmatives. Plus les réponses affirmatives sont nombreuses, plus la probabilité de mauvais traitements est grande. On devrait aussi explorer chaque réponse affirmative pour obtenir plus de renseignements cliniques. L'intervenant devrait demander à l'aidant d'expliquer sa réponse et tenter d'évaluer plus à fond la situation.

Mmes Reis et Nahmiash, PhD, ont créé les outils de dépistage et le modèle d'intervention du projet CARE (dont le DACAN fait partie) dans une agence communautaire locale de santé et de services sociaux (CLSC NDG-Montréal Ouest) pour repérer les victimes de violence et pour établir des protocoles préliminaires et des techniques d'intervention.

DACAN

Veuillez répondre aux questions suivantes, en tant qu'aidant.

1. Trouvez-vous parfois difficile d'inciter _____ à contrôler ses humeurs ou son agressivité? Oui ❒ Non ❒
2. Vous sentez-vous souvent obligé de faire des choses hors de votre tempérament ou de poser des gestes que vous regrettez? Oui ❒ Non ❒
3. Trouvez-vous difficile de faire face au comportement de _____ ? Oui ❒ Non ❒
4. Avez-vous parfois l'impression d'être obligé d'agir avec rudesse avec _____ ? Oui ❒ Non ❒
5. Avez-vous parfois l'impression de ne pas pouvoir faire ce qui est nécessaire pour _____ ? Oui ❒ Non ❒
6. Vous sentez-vous souvent obligé de repousser ou d'ignorer _____ ? Oui ❒ Non ❒
7. Vous sentez-vous souvent fatigué ou épuisé au point que vous ne pouvez pas combler les besoins de _____ ? Oui ❒ Non ❒
8. Avez-vous parfois l'impression que vous devez crier après _____ ? Oui ❒ Non ❒

What Is CASE?

The Caregiver Abuse Screen (CASE) is a screening measure for detecting abuse of seniors. It is intended for use with all clients who are caregivers of seniors, whether or not abuse is suspected. The "Yes" responses on each of the eight CASE items may stimulate discussion that reveals abuse and/or neglect that might otherwise have gone undetected.

In addition to indicating current abuse by caregivers, caregiver responses to CASE may be indicative of tendencies and stresses that could lead to possible abuse in the future. In such cases, a proactive approach to intervention may help prevent the development of abuse.

Interpretation: After a caregiver completes the entire screen, the "Yes" responses are tallied; the more "Yes" responses, the more likely the presence of abuse. Each "Yes" response should also be probed for clinical information. To further assess the situation, the worker should ask the caregiver to explain his or her answer.

Drs. Myrna Reis and Daphne Nahmiash developed the Project CARE screening tools (of which CASE is one) and the intervention model. These were developed in a local community-based health and social service agency (CLSC NDG/Montreal West) to identify suspected abuse victims and to establish preliminary protocols and intervention techniques.

CASE

Please answer the following questions as a helper or caregiver:

1. Do you sometimes have trouble making _____ control his/her temper or aggression? Yes ❒ No ❒
2. Do you often feel you are being forced to act out of character or do things you feel badly about? Yes ❒ No ❒
3. Do you find it difficult to manage _____ 's behaviour? Yes ❒ No ❒
4. Do you sometimes feel that you are forced to be rough with _____ ? Yes ❒ No ❒
5. Do you sometimes feel that you can't do what is really necessary or what should be done for _____ ? Yes ❒ No ❒
6. Do you often feel you have to reject or ignore _____ ? Yes ❒ No ❒
7. Do you often feel so tired and exhausted that you cannot meet _____ 's needs? Yes ❒ No ❒
8. Do you often feel you have to yell at _____ ? Yes ❒ No ❒

**In French, CASE is called DACAN as "Questionnaire de dépistage de l'abus chez les aidants naturels"*
Source : questionnaires sent by one of the authors

Questionnaire 12 – ZARIT FR

Grille de ZARIT©Echelle de pénibilité ou d'évaluation du fardeau

Le questionnaire suivant présente une liste d'affirmations caractérisant l'état habituel des gens qui ont la charge quotidienne de quelqu'un d'autre.

La grille permet une évaluation de cette charge pouvant aller de léger à modéré jusqu'à sévère.
Après chaque affirmation, l'aidant indique s'il ressent cet état :

0 = jamais
1 = rarement
2 = parfois
3 = assez souvent
4 = presque tout le temps

A quelle fréquence vous arrive-t-il de...	Jamais	Rarement	Quelques fois	Assez souvent	Presque toujours
	0	1	2	3	4
1. Sentir que votre parent vous demande plus d'aide qu'il n'en a besoin ?					
2. Sentir que le temps consacré à votre parent ne vous en laisse pas assez pour vous?					
3. Vous sentir tiraillé entre les besoins à votre parent et vos autres responsabilités familiales ou professionnelles?					
4. Vous sentir embarrassé par le(s) comportement(s) de votre parent?					
5. Vous sentir en colère quand vous êtes en présence de votre parent ?					
6. Sentir que votre parent nuit à vos relations avec d'autres membres de la famille ?					
7. Avoir peur de ce que l'avenir réserve à votre parent ?					
8. Sentir que votre parent est dépendant de vous?					
9. Vous sentir tendu en présence de votre parent?					
10. Sentir que votre santé s'est détériorée à cause de votre implication auprès de votre parent?					
11. Sentir que vous n'avez pas autant d'intimité que vous aimeriez à cause de votre parent?					
12. Sentir que votre vie sociale s'est détériorée du fait que vous prenez soin de votre parent?					
13. Vous sentir mal à l'aise de recevoir des amis à cause de votre parent?					
14. Sentir que votre parent semble s'attendre à ce que vous preniez soin de lui comme si vous étiez la seule personne sur qui il puisse compter?					
15. Sentir que vous n'avez pas assez d'argent pour prendre soin de votre parent encore longtemps compte tenu de vos dépenses?					
16. Sentir que vous ne serez plus capable de prendre soin de votre parent encore bien longtemps?					
17. Sentir que vous avez perdu le contrôle de votre vie depuis la maladie de votre parent?					
18. Souhaiter pouvoir laisser le soin de votre parent à quelqu'un d'autre?					
19. Sentir que vous ne savez pas trop quoi faire pour votre parent?					
20. Sentir que vous devriez en faire plus pour votre parent?					
21. Sentir que vous pourriez donner de meilleurs soins à votre parent?					
22. En fin de compte, vous arrive-t-il de sentir que les soins à votre parent sont une charge, un fardeau?					
Sous-totaux					
TOTAL (addition de chaque sous-total, à reporter en page 4)					

Résultats :
Score < 20 : "fardeau" léger
21 < score < 40 : "fardeau" léger à modéré
41 < score < 60 : "fardeau" modéré à sévère
61 < score < 88 : "fardeau" sévère

Source: https://www.hug.ch/sites/interhug/files/structures/soins_palliatifs_professionnels/documents/grillede_zarit.pdf

Questionnaire 13 – ZARIT NL

Vragenlijst voor de voornaamste mantelzorger : burden 1

ZARIT-12 BURDENSCHAAL, NEDERLANDS

Nederlandstalige versie, gevalideerd voor België (Mapi Research Institute, 2007).

Instructies : hieronder vindt u een lijst met uitspraken die weergeven hoe mensen zich soms voelen als ze voor iemand anders zorgen. Duid voor elke uitspraak aan hoe vaak u zich zo voelt: nooit, zelden, soms, redelijk vaak of bijna altijd. Er zijn geen juiste of verkeerde antwoorden.

Vraag	Antwoord-mogelijkheden
1. Vindt u dat u niet genoeg tijd voor uzelf hebt omwille van de tijd die u doorbrengt met uw familielid?	0 Nooit 1 Zelden 2 Soms 3 Redelijk vaak 4 Bijna altijd
2. Vindt u dat u onder druk staat door de combinatie van de zorg voor uw familielid en andere verantwoordelijkheden die u probeert na te komen voor uw gezin of uw werk?	0 Nooit 1 Zelden 2 Soms 3 Redelijk vaak 4 Bijna altijd
3. Bent u boos op uw familielid als u met haar/hem samen bent?	0 Nooit 1 Zelden 2 Soms 3 Redelijk vaak 4 Bijna altijd
4. Vindt u dat uw familielid momenteel een negatieve invloed heeft op uw relatie met andere familieleden of vrienden?	0 Nooit 1 Zelden 2 Soms 3 Redelijk vaak 4 Bijna altijd
5. Voelt u zich gespannen als u samen met uw familielid bent?	0 Nooit 1 Zelden 2 Soms 3 Redelijk vaak 4 Bijna altijd
6. Vindt u dat uw gezondheid geleden heeft onder de zorg voor uw familielid?	0 Nooit 1 Zelden 2 Soms 3 Redelijk vaak 4 Bijna altijd
7. Vindt u dat u omwille van uw familielid minder privacy hebt dan u zou willen?	0 Nooit 1 Zelden 2 Soms 3 Redelijk vaak 4 Bijna altijd
8. Vindt u dat uw sociaal leven geleden heeft onder de zorg voor uw familielid?	0 Nooit 1 Zelden 2 Soms 3 Redelijk vaak 4 Bijna altijd
9. Vindt u dat u de controle over uw eigen leven verloren hebt sinds u zorg draagt voor uw familielid?	0 Nooit 1 Zelden 2 Soms 3 Redelijk vaak 4 Bijna altijd
10. Voelt u zich onzeker over wat u met uw familielid moet doen?	0 Nooit 1 Zelden 2 Soms 3 Redelijk vaak 4 Bijna altijd
11. Vindt u dat u meer zou moeten doen voor uw familielid?	0 Nooit 1 Zelden 2 Soms 3 Redelijk vaak 4 Bijna altijd
12. Vindt u dat u beter voor uw familielid zou kunnen zorgen?	0 Nooit 1 Zelden 2 Soms 3 Redelijk vaak 4 Bijna altijd

Source: https://www.venvn.nl/media/acjfaqc1/zarit-12-burdenschaal-zarit-1980-mri-2007.pdf

Questionnaire 14 – ZARIT DE

Belastungsinventar der betreuenden angehörigen Person (oder Zarit Scale)

Grundsatz

Mit der Zarit Scale kann die materielle und emotionale Belastung der wichtigsten Betreuungsperson gemessen werden. Anhand der folgenden 22 Fragen können Sie ausdrücken, was Sie empfinden und wie häufig. Es gibt weder gute noch schlechte Antworten. Wichtig: Seien Sie ehrlich mit sich selbst und beantworten Sie die Fragen jeweils möglichst objektiv.

Sie können die Fragen alleine beantworten, es ist allerdings sehr ratsam, sich bei der Interpretation der Ergebnisse und der zu ergreifenden Massnahmen begleiten zu lassen. Verschiedene Organisationen bieten dies an.

	Fragen	nie	selten	manchmal	häufig	fast immer
1	Glauben Sie, dass Ihre angehörige Person um mehr Hilfe bittet als sie braucht?					
2	Sind Sie der Meinung, dass Sie durch die Zeit, die Sie mit Ihrer angehörigen Person verbringen, nicht genügend Zeit für sich selbst haben?					
3	Fühlen Sie sich überfordert bei Ihrem Versuch, neben der Pflege Ihrer angehörigen Person Ihren anderen Verpflichtungen gegenüber Familie oder Beruf nachzukommen?					
4	Bringt Sie das Verhalten Ihrer angehörigen Person in Verlegenheit?					
5	Fühlen Sie sich irritiert oder wütend, wenn Sie bei Ihrer angehörigen Person sind?					
6	Glauben Sie, dass Ihre angehörige Person Ihre Beziehungen mit anderen Familienmitgliedern oder Freunden negativ beeinflusst?					
7	Haben Sie Angst, was die Zukunft für Ihre angehörige Person bringt?					
8	Glauben Sie, dass Ihre angehörige Person von Ihnen abhängig ist?					
9	Fühlen Sie sich angespannt, wenn Sie bei Ihrer angehörigen Person sind?					
10	Glauben Sie, dass Ihre Gesundheit unter Ihrem Engagement in der Pflege Ihrer angehörigen Person leidet?					
11	Haben Sie das Gefühl, dass Sie wegen Ihrer angehörigen Person weniger Privatsphäre haben, als Sie es gerne hätten?					
12	Sind Sie der Meinung, dass Ihr Sozialleben unter der Pflege Ihrer angehörigen Person leidet?					
13	Ist es Ihnen wegen Ihrer angehörigen Person unangenehm, Freunde zu Besuch zu haben?					
14	Glauben Sie, dass Ihre angehörige Person von Ihnen erwartet, dass Sie sie pflegen, als wären Sie die einzige Person, auf die sie zählen könnte?					
15	Sind Sie der Meinung, dass Sie nicht genug Geld für die Pflege Ihrer angehörigen Person zusätzlich zu Ihren restlichen Aufgaben haben?					
16	Glauben Sie, dass Sie ausserstande sein werden, Ihre angehörige Person viel länger zu pflegen?					

17	Glauben Sie, seit Sie die Betreuung Ihrer angehörigen Person übernommen haben, die Kontrolle über Ihr eigenes Leben verloren zu haben?					
18	Wünschen Sie sich, die Pflege Ihrer angehörigen Person jemand anderen überlassen zu können?					
19	Haben Sie den Eindruck, dass Sie für Ihre angehörige Person nichts tun können?					
20	Glauben Sie, Sie sollten mehr für Ihre angehörige Person tun?					
21	Sind Sie der Meinung, dass Sie die Pflege Ihrer angehörigen Person besser machen könnten?					
22	Wie häufig empfinden Sie die Pflege Ihrer angehörigen Person als Last oder Belastung?					
	Weisen Sie Ihren Antworten Punkte zu: nie = 0 selten = 1 manchmal = 2 häufig = 3 fast immer = 4					
	Zwischentotal (addieren Sie die Punkte pro Spalte)					
	Total (addieren Sie die Ergebnisse aller Spalten)					

Erläuterung der Punktzahlen

Die Gesamtpunktzahl ist die Summe aller Punktzahlen der 22 Fragen. Sie kann zwischen 0 und 88 liegen.

Gesamtpunktzahl	Bedeutung	Empfehlung
Punktzahl von 0 bis 20	schwache oder keine Belastung	Bei Ihnen ist alles im grünen Bereich. Falls sich die Situation ändert, füllen Sie den Fragebogen erneut aus.
Punktzahl von 21 bis 40	leichte Belastung	Bei Ihnen ist alles noch im grünen Bereich. Behalten Sie aber die Situation im Auge.
Punktzahl von 41 bis 60	mittlere Belastung	Sie scheinen mit der Situation umgehen zu können. Aber Achtung: Ermüdung kann rasch zuschlagen. Zögern Sie nicht, punktuell Hilfe in Anspruch zu nehmen.
Punktzahl über 60	starke Belastung	Warten Sie nicht länger zu, sondern reden Sie über Ihre Situation und bitten Sie um Hilfe. Ihre Gesundheit ist in Gefahr.

Source: http://www.info-workcare.ch/sites/default/files/documents/belastungsinventar_der_betreuenden_angehoerigen_person.pdf

SOURCE: CHAPTER 7: POLICE AND JUSTICE

APPENDIX 62. DESCRIPTION OF POLICE AND JUSTICE SECTORS

In the next sections the police sector and some actors of the sector of justice are described. For a description of the steps in a criminal procedure see Appendix 6.

Appendix 62.1. The police sector

The police sector is under the authority of the Minister of the security and internal affairs and the Minister of Justice.[a] The police sector is divided in two main parts: the local police and the federal police. The local police is composed of 185 police stations covering all the Belgian territory. They aim to meet 7 functions: (i) intervention; (ii) welcome desk; (iii) proximity agent; (iv) victims help; (v) public space management; (vi) research; and (vii) road traffic. In the local police sector, the different type of workers are the proximity agent (inspecteur de proximité), the intervention team (l'équipe d'intervention), the chief superintendent (chef de corps), the proximity superintendent (commissaire de police-direction proximité), and the police assistance service to victims (PASV) (service d'aide policière aux victimes (SAPV) - politiedienst voor slachtofferbejegening). The federal police supports the missions of the local police into two specialized areas: the administrative one and the judicial one.

Appendix 62.2. The justice sector

The Belgian justice sector is composed of 187 judicial cantons (canton judiciaire - justitieel kanton) with 229 justices of the peace (justice de paix - vrederechter) and 15 police tribunals (tribunal de police - politierechtbank); of 12 judicial districts (arrondissement judiciaire - gerechtelijk arrondissement) with 13 district courts (tribunal de première instance - rechtbank van eerste aanleg), 9 labor tribunals (tribunal du travail - arbeidsrechtbank) and 9 business tribunals (tribunal de l'entreprise - ondernemingsrechtbank); of 11 criminal courts (cour d'Assise – Hof van Assisen) among the 10 provinces; of 5 jurisdictions with 5 labor courts (cour du travail – arbeidsrechtbank) and 5 courts of appeal (cour d'appel –Hof van Beroep); and finally of one Supreme Court (cour de cassassion – Hof van Cassatie).[b]

In the Belgian legal system, there are the two different types of magistrates: the judges (magistrats du siege – rechters/zittende magistratuur) and the prosecutors (magistrats du parquet – parketmagistraten: staande magistratuur). The competences of each magistrates vary according to the civil or the criminal (penal) aspect of the situation. The justice of the peace is civil. The judge of the peace is the magistrate the closest to the citizens. The police court is competent to judge road traffic offences. The district courts has very broad competencies in both civil and criminal matters (family tribunal, criminal chamber, youth chamber…). The labor court is competent in labor and social security laws. The business court is competent for contestations between companies. The court of appeal revises the decision of the district courts. The Assisi court is competent for the more serious offences. The Supreme Court is the highest jurisdiction of Belgium. It judges the legality of judicial decisions. It does not rule on the facts but on the procedure. [c]

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a https://www.police.be/5998/fr/a-propos

b https://www.police.be/5998/fr/a-propos

c https://www.tribunaux-rechtbanken.be/fr

Appendix 62.3. Justice of the peace

The judge of the peace is, amongst other function, in charge of the protection of property and people (see for the complete list of competences art. 590 Judicial Code). Through this function he is often in contact with elder persons, most of the time, in a very dependent situation. He can a.o. settle disputes, declare someone mentally incapable and appoint a guardian for the protection of property and/or the person, extend the ban from residence, etc. Although the judge of the peace is only competent for civil offence, he can be the witness of criminal offence and in particular of elder abuse.

Appendix 62.4. House of Justice

House of justice staff is specialized either to help victims or to help perpetrators. They can help victims on his/her own request. Justice assistants reflect on approach and respect. This is the same service than the victim assistance in the prosecutors' offices. There is one justice house per district and despite regionalisation, it remains linked to the public prosecutor's office.

Justice houses also intervene when release on parole is decided during the investigation. The justice houses also help the author to set up probation conditions after the judgment and control the proper conduct of the sentence on probation. Before a sentence of probation, there is a brief information report made by the justice house of a social inquiry at the request of a magistrate. This mini social survey overlooks if a measure is possible. Then a broader social survey whose the scope is assessed by the judge or the prosecutor, considers the different probation possibilities. What is interesting in these surveys is that the justice assistant who did it, is also the one who will provide the "after-sales service" (the follow-up of the probation conditions). In contrary and according to one interviewee, lawyers are likely to propose anything to get the best sentence; and will accept any conditions (even unrealistic) that his/her client could not be able to keep (to escape prison, people are willing to swear anything). The lawyer sees in the short term, the justice assistant sees in the long term. Justice assistants assess the person's resources and use the means at their disposal. They study the feasibility. If the bar is too high, the author, the justice and the society will fail again.

The usual probation conditions are a ban on contact with the abused older person and/or a training in aggression management. It should be also possible to provide training at this time that raises awareness of abuse. However, in practice this is not done. If the judge requires that the author undergoes a training on aggression management, it is at his/her own expense and he/she must find the training him/herself with the help of the justice house and his/her lawyer. One interviewee explains that he/she is not aware of the training offer and that judges do not care about it because they want to make the author accountable. It is up to him/her to look for it (with help). The goal is for there to be an awareness and not to receive everything on a platter.

A justice assistant of a justice house is in charge of 60 to 80 authors' files per year and is paid 50 000 euros to follow the proper conduct of the sentence on probation. In comparison, the cost of the stay of one author in prison without any psych-social management is also 50 000 euros.

APPENDIX 63. INTERVIEW GUIDE

In this section, the interview guides used for the interviews are included. They served as a basis for all interviews. Depending on the respective interviewed person's function or affiliation, questions were adapted or additional questions were added.

Appendix 63.1. Interview guide in French

Questionnaire police / justice

Introduction

Tout d'abord, je voudrais vous remercier pour le temps que vous libérez pour participer à notre projet. Je m'appelle XXX. Je travaille comme chercheur au KCE (Centre fédéral de connaissances sur les soins de santé).

Nous nous rencontrons /je vous rencontre dans le cadre d'une étude sur la maltraitance des personnes âgées et en particulier sur les moyens permettant d'améliorer la prise en charge de la maltraitance envers les personnes âgées.

Par cette entrevue, nous souhaitons/je souhaite récolter votre **expérience professionnelle** en matière de maltraitance des personnes âgées et votre **opinion** sur les obstacles et les solutions possibles pour une meilleure approche de la maltraitance des personnes âgées. Il existe une littérature sur ce sujet, nous l'avons également étudiée, mais cette littérature n'est pas nécessairement transférable à la situation belge. C'est pourquoi nous voulons intégrer les expériences sur le terrain.

Nous rencontrons les acteurs de terrain de la police et du monde judiciaire (juge de paix, procureurs,…) afin de pouvoir approfondir un certain nombre de questions. Nous menons aussi cette recherche auprès des prestataires de soins de santé, des organisations qui s'occupent des personnes âgées maltraitées et des travailleurs de l'aide sociale.

Avant de commencer, je voudrais vous exposer certains **détails pratiques**:

- Premièrement, pour des questions de méthode et même si cela peut paraitre artificiel, je vais lire une série de questions préétablies. Ces questions sont posées de la même façon à toutes les personnes que nous rencontrons.
- Deuxièmement, j'aimerais enregistrer cette conversation dans le souci de ne pas trahir votre parole. Comme ça, en cas de doute, je peux revenir à l'enregistrement si j'ai mal compris ou raté une information. Cet enregistrement me permet aussi d'être plus disponible pour vous écouter. L'enregistrement sera retranscrit et anonymisé. L'analyse se fera sur l'ensemble des informations récoltées auprès des différents participants. Dès que l'enregistrement est retranscrit, il est détruit. (Commencez l'enregistrement en leur demandant s'ils sont bien d'accord).
- Nous garantissons donc votre anonymat: si vous utilisez des noms de personnes ou d'autres informations sensibles au cours de cette conversation, nous les anonymisons.

1. <u>Question préliminaire</u>

Etes-vous confronté à la maltraitance des personnes âgées dans votre travail quotidien d'avocat général?

Y avez-vous été confronté dans vos fonctions précédentes ?

D'après vous, quels sont les magistrats les plus à mêmes d'être confronté à des cas de maltraitance de PA ?

Pouvez-vous décrire une **situation-type**?

Pour vous, que couvre le terme de maltraitance d'une personne âgée ? Identifiez-vous différents types de maltraitance des personnes âgées ?

Relance : Sur quoi vous basez vous pour dire qu'une personne est âgée ?

2. <u>Sujet: **rôle de la justice** dans le processus de lutte contre la maltraitance des personnes âgées</u>

Avant tout, nous voulons parler du rôle du judiciaire dans la prise en charge des personnes âgées maltraitées.

A. Quand un cas de personne âgée maltraitée arrive chez vous, comment cela se passe-t-il ? (L'objectif de cette question est de décrire la procédure à suivre pour un cas établi de maltraitance d'une personne âgée)

   a. De quelle manière avez-vous généralement connaissance d'un cas de maltraitance d'une personne âgée?

   b. Si vous êtes confronté à un cas de maltraitance d'une personne âgée, qu'est-ce que vous faites concrètement ? Quelles sont les étapes de votre démarche ? Quel est votre rôle dans cela?

   c. Est-ce que ça se passe de la même façon si la situation vous semble urgente ou pas ? (Distinguer les cas aigus / non aigus).

   d. Y a-t-il des situations pour lesquelles vous décidez de ne pas prendre de mesure? Sur quelle base ? (Quand décidez-vous d'agir? A partir de quel moment une affaire/cas a-t-elle assez de poids pour prendre des mesures supplémentaires?)

      - Que faire quand les charges ne sont pas suffisantes ?

   e. Y a-t-il un magistrat et/ou un policier de référence pour la violence intra-familiale ? Est-ce que cela pourrait être une solution pour améliorer les prises en charge ?

   f. Lorsqu'un cas de maltraitance envers une personne âgée est établi, de nombreuses personnes âgées maltraitées ne sont pas disposées à prendre des mesures judiciaires, parfois par peur du système, parfois par peur de perdre leur seul contact social (même si il est maltraitant) ou parfois pour protéger leur agresseur. Quelle est votre expérience avec ce type de situation? Dans quelle mesure ce refus de l'ainé maltraité d'aller plus loin dans les démarches a-t-elle une influence sur votre décision d'agir?

   g. Selon vous, existe-t-il des différences d'approche et de procédures entre les régions : Wallonie-Bruxelles-Flandres ? Lesquelles ? A quoi attribuez-vous ces différences ?

B. Quelle est le rôle, la place du secteur judiciaire dans la prise en charge de la maltraitance des PA ?

   Qui est en contact avec les PA ?

   Quelle place pour l'aide aux victimes ?

   Quelle place pour les maisons de justice ?

   Quelle place pour les family Justice Center ?

   Y a-t-il un rôle à jouer pour la médiation ou les transactions ?

3. Sujet : obstacles et facilitateurs :

A. Quels obstacles avez-vous rencontré personnellement dans le traitement d'une affaire de maltraitance?

   a. Relance : Identifiez-vous des obstacles qui relèvent plutôt de problèmes organisationnels comme un manque de soutien, de main-d'œuvre ?

   b. Relance : Identifiez-vous des obstacles plutôt d'ordre personnel comme un manque de formation ?

B. Quels obstacles organisationnels du secteur identifiez-vous dans le traitement d'une affaire de maltraitance?

Comment la justice aborde-t-elle la problématique de la démence ?

Quand il s'agit d'un cas d'épuisement ou de surcharge de l'aidant proche, comment la justice procède-t-elle ?

C. Quels éléments dans la pratique quotidienne des magistrats facilitent la prise en charge d'une affaire de maltraitance ?

D. Dans votre cadre professionnel, comment pourrait-on améliorer la prise en charge de la maltraitance des ainés?

   a. Relance : Sur quoi le gouvernement devrait-il d'abord investir?

   b. Relance : Quelle mesure / changement, pensez-vous, aurait le plus d'**impact** ?

4. Sujet**: évaluation de l'approche globale** du processus de lutte contre la maltraitance des personnes âgées

La maltraitance des aînés est souvent méconnue. Selon l'OMS, seul un cas sur 25 de personnes âgées maltraités est pris en charge.

A. D'après vous, qu'est-ce qui incite une personne âgée à déclarer à la police ou à la justice une situation de maltraitance ?

B. D'après vous, qu'est-ce qui incite un soignant ou un aidant à déclarer à la police ou à la justice une situation de maltraitance ?

   c. i. Relance : Selon vous, la population a-t-elle les connaissances suffisantes des procédures de déclaration à la police et à la justice?

C. Avant qu'une affaire n'arrive dans les mains de la justice, plusieurs autres parties sont déjà intervenues: prestataires de soins, assistants sociaux, organisations qui traitent ou suivent les abus envers les personnes âgées, ligne d'assistance 1712, police:

   d. Comment le contact / la collaboration avec les autre intervenants se passe-t-il/elle?

   - Relance : Qu'est-ce qui se passe bien ?
   - Relance : Qu'est-ce qui ne se passe pas bien ? (Pensez-vous que vous pouvez compter sur leur bon fonctionnement?)
   - Comment décririez-vous l'échange d'informations avec les prestataires de soins de santé, les services d'aide sociale et les organismes spécialisés dans la prise en charge des situations de maltraitance envers les personnes âgées?
   - Y a-t-il parfois des réunions de concertation avec les différents intervenants?
   - L'article 458 sur le secret médical a été complété par le 458 ter afin de faciliter la concertation entre la police, la justice et les soignants autour d'un patient. Comment cet article est-il perçu et utilisé par les procureurs ?

     1. Le Procureur du Roi donne-t-il parfois son accord pour qu'il soit appliqué ?

     2. Pensez-vous qu'une loi devrait être adoptée pour permette systématiquement que l'art 458 ter puisse

être d'application dans les cas de maltraitance de personnes âgées ?

- Y a-t-il des collaborations structurelles entre le parquet et d'autres secteurs en charge des personnes âgées ?
- Avez-vous connaissance de personnes ou d'organismes de référence « maltraitance » auxquelles vous pourriez vous adressez si vous avez des questions sur une problématique de maltraitance ?
- Y a-t-il des contacts avec des juges de paix ?
- Les juges de paix sont des témoins privilégiés de la maltraitance des personnes âgées. Ils sont pourtant peu formés et démunis quant aux possibilités d'intervention. Comment pourrait-on améliorer la communication entre les juges de paix et le parquet/la police ?

D. S'attaquer à la maltraitance des personnes âgées, c'est un processus complet qui inclut les étapes de sensitization, de détection, de prise en charge (signalement/déclaration) et de suivi.

a. Selon vous, quel est le meilleur moyen de sensibiliser le monde judiciaire à la maltraitance des ainés?

b. Selon vous, quel est le meilleur moyen de sensibiliser les proches/l'entourage des personnes âgées aux risques de maltraitance afin qu'ils puissent mieux la détecter (et éventuellement la signaler)?

5. Sujet : impact de la législation et des directives contre la maltraitance des personnes âgées

A. Selon vous, quel est l'impact du secret professionnel dans le déroulement d'une affaire de maltraitance? / Comment le secret professionnel 'interagit' avec le «déroulement» d'une affaire?

B. Dans certaines régions du pays, il existe des feuilles de route locales pour lutter contre la maltraitance des personnes âgées. Le plan étape par étape du SEL WAASLAND, par exemple. (*Apportez la brochure*). Qu'en pensez-vous ? / Dans quelle mesure une telle feuille de route semblerait-t-elle utile dans votre travail?

6. Sujet : Enregistrement des données

Comment les abus envers les aînés sont-ils répertoriés chez vous? Existe-t-il un code spécifique pour l'encodage des situations de maltraitance des ainés?

Comment pourrait-on améliorer l'encodage des données ? Se pourrait-il qu'un second code soit ajouté pour spécifier personnes vulnérables et/ou directement le type de personne vulnérable (PA, enfants, handicapé, femme enceinte,…)

Connaissez-vous le code APA de la police ?

7. Perspectives :

Serait-il possible dans le système judiciaire d'intégrer une sensitization à la maltraitance des PA des auteurs en détention préventive ou en libération conditionnelle ?

Comment pourrait-on envisager qu'un dossier dont l'infraction n'est pas assez lourde pour entrainer une citation puisse mener à une concertation ou une prise en charge psycho-sociale ?

Quelle est la marge de manœuvre de la police face à des situations de maltraitance ? Ont-ils un devoir d'enquête ? Comment pourrait-il orienter vers une prise en charge psychosociale plutôt que vers une déclaration au procureur qui souvent se finit en non lieu ?

Comment la justice pourrait-elle obliger un auteur à suivre un traitement psychologique ?

Comment la justice pourrait-elle aider les organismes de prise en charge des PA maltraitées à « mettre dehors » les co-habitants violents ?

Appendix 63.2. Interview guide in Dutch

Vragenlijst politie / justitie

Introductie

Eerst en vooral hartelijk dank om tijd vrij te maken voor ons project. Ik ben XXX en ik werk als XXX op het KCE (Centre fédéral de connaissances sur les soins de santé).

We hebben contact met u opgenomen in het kader van een studie over **ouderenmishandeling en meer bepaald de maatregelen die kunnen leiden tot een betere aanpak**.

In dit interview willen we graag peilen naar uw **professionele ervaring** mbt ouderenmishandeling en voornamelijk naar wat volgens u vandaag de **voornaamste barrières en oplossingen** zijn voor een betere aanpak van OMB. We hebben al gekeken in de l**iteratuur** wat er in andere landen bestaat maar dat is natuurlijk niet altijd transfereerbaar naar de Belgische context. Vandaar dat we met het terrein willen aftoetsen.

We hebben momenteel **overleg met mensen van politie en justitie** (vrederechter, procureur,…) uit heel het land om dieper te kunnen ingaan op bepaalde vragen uit hun domein. We zullen ook zorgverleners, gespecialiseerde instellingen die zich met ouderenmishandeling bezig houden en organisaties zoals bijv. familiehulp bevragen via een **online vragenlijst**.

Vooraleer we starten, wil ik graag met u een aantal **praktische zaken** overlopen:

- Er zijn een aantal vragen opgelijst die ik **systematisch** zal overlopen. Dit is om de systematiek te kunnen behouden bij alle ondervraagde personen.
- Daarnaast zou ik graag ons gesprek **opnemen** om zo goed mogelijk te kunnen weergeven wat er gezegd is. In het geval ik niet alles kan noteren, kan ik via de opname zaken traceren. Het laat ons ook toe beter te kunnen luisteren. De resultaten van ons gesprek worden op een anonieme wijze weergegeven in een rapport. Uw naam zal niet texto bij een quote worden genoteerd maar uw naam zal wel verschijnen in de colofon van het rapport. (Akkoord vragen voor start registratie)
- We garanderen in elk geval uw **anonimiteit** : indien u toch per ongeluk namen of gevoelige informatie zou vermelden, zullen we die anonimiseren.

1. Voorafgaande vraag

Op welke manier wordt u in uw **dagelijks werk met OMB geconfronteerd**? Kan u een type situatie beschrijven?

Relance : Waarom is ze typisch ?

Relance : Wat betekent voor u de term OMB ? Zijn er verschillende types van OMB?

Relance : Vanaf welke leeftijd of op welke elementen baseert u zich om te zeggen dat het gaat over OMB ?

2. Rol van justitie, politie en vrederechter in het proces van aanpak van OMB

Eerst en vooral willen we het hebben over de **rol van politie/justitie/vrederechter** in de aanpak van OMB.

A. Indien een geval van OMB bij u wordt gemeld, wat gebeurt er dan precies? Wat zijn de stappen? (L'objectif de cette question est de décrire la procédure à suivre pour un cas établi de maltraitance d'une personne âgée)

   c. Op welke manier krijgt u meestal kennis van een geval van OMB ?

   d. Indien u geconfronteerd wordt met een geval van OMB, wat doet u dan concreet? Wat zijn de verschillende stappen? Wat is uw rol hierin?

e. Is er een onderscheid naargelang het om een dringend geval gaat of niet ? (Distinguer les cas aigus / non aigus).

f. Zijn er situaties waarin u besluit geen actie te ondernemen ? Op welke basis? (Wanneer handelt u? Vanaf welk moment is een zaak zwaarwichtig genoeg om bijkomende maatregelen te nemen ?)

- Relance : Heeft u richtlijnen om 'niets te doen' ?
- Relance : Indien het gaat om een geval waar de mantelzorger overbelast is, wat doet u dan ? Is er dan ook een PV en systematisch contact met procureur ?

g. Wie coördineert de zaak ?

h. Is er een referentiemagistraat/inspecteur voor familiaal geweld/OMB?

i. (Politie) Indien OMB wordt vastgesteld zijn veel oudere personen niet bereid om verder te gaan (bijvb. aan te geven, gerechtelijke stappen te nemen). Soms omdat ze bang zijn, soms omdat ze dan het enige sociale contact dat nog overblijft verliezen (zelfs indien die persoon hen mishandelt) of omdat ze de mishandelende persoon willen beschermen (vaak familie).

Wat is uw ervaring met dergelijke situaties? In welke mate heeft de weigering van de mishandelde persoon om verdere stappen te nemen invloed op uw beslissing om te handelen?

a. (Politie) In welke mate wordt er rekening gehouden met de opinie van familieleden in de aanpak ?

b. Bestaat er volgens u een verschil tussen aanpak en procedures in Vlaanderen, Wallonië en Brussel? Welke? Waaraan zijn volgens u deze verschillen te wijten ?

3. Moeilijkheden en faciliterende elementen :

A. Welke moeilijkheden heeft u zelf al ondervonden in de aanpak van OMB ?

a. Relance : Zijn deze moeilijkheden eerder organisationeel, weinig ondersteuning, gebrek aan mankracht ?

b. Relance : zijn er ook eerder persoonlijke moeilijkheden zoals een gebrek aan opleiding ?

B. Welke elementen in uw dagelijkse praktijk helpen de aanpak van OMB vergemakkelijken?

C. Wat zou er in uw domein kunnen worden gedaan om de aanpak van OMB te verbeteren?

a. Relance : Waarin zou de overheid eerst moeten investeren ?

b. *ii. Relance : Welke maatregelen/veranderingen zouden volgens u het meest impact hebben ?*

4. Evaluatie van de globale aanpak van de strijd tegen OMB

OMB blijft vaak onder de radar. Volgens cijfers van de WHO wordt slecht 1 geval van OMB op 25 aangepakt.

A. Wat leidt er volgens u toe dat een oudere persoon een geval van OMB meldt aan politie of justitie? Komen ze vaak in eerste instantie bij u of passeren ze vaak eerst een ander traject?

B. Wat leidt er volgens u toe dat een zorgverlener of een verzorgende/familiehulp een geval van OMB meldt aan politie of justitie ? Komen ze vaak in eerste instantie bij u of passeren ze vaak eerst een ander traject?

a. i. Relance : Denk u dat de populatie in het algemeen/ zorgverleners/ verzorgende genoeg weten welke mogelijkheden er bestaan om aan te geven bij politie en justitie?

C. Voordat een zaak bij jullie komen zijn vaak andere personen al tussengekomen: zorgverleners, sociaal assistenten, organisaties die OMB aanpakken (VLOCO), 1712:

b. Hoe verloopt het contact/de samenwerking tussen jullie en deze partijen ?

- Relance : wat gaat er goed ?
- Relance : Wat gaat er minder goed ? (Kan u rekenen op hun goede werking ?)
- Is er soms overleg/consultaties met de verschillende partijen die zijn tussengekomen ?
- Zijn er structurele samenwerkingen ?
- Kent u een referentiepersoon OMB die u kan contacteren indien u vragen heeft over OMB problematiek ?
- Heeft u soms contact met de vrederechter ?

c. Wordt er informatie uitgewisseld tussen zorgverleners, sociale diensten, gespecialiseerde diensten in de aanpak van OMB ?

d. Heeft u ervaring van Family Justice Centers, "protocol van moed" (ihkv Kindermishandeling)? Zijn deze initiatieven volgens u nuttig in de aanpak van OMB ?

D. De aanpak van OMB omvat verschillende etappes waaronder sensibiliseren, detectie, signaleren, aanpak en opvolging.

e. Wat is volgens u de beste manier om procureurs/vrederechters/politie te sensibiliseren mbt OMB ?

f. Wat is volgens u de beste manier om de naasten/de entourage van oudere personen te sensibiliseren voor de risico's van OMB zodat ze het

5. Impact van wetgeving en richtlijnen met betrekking tot OMB

A. Wat is volgens u de impact van het beroepsgeheim in de aanpak van OMB ? Verhindert dat de communicatie tussen verschillende partijen die tussenkomen ?

B. Er is geen juridisch kader voor gevallen van verwaarlozing en psychologisch misbruik. Hoe zou dit volgens u beter kunnen worden geregeld?

C. In bepaalde delen van het land, bestaan er stappenplannen tegen OMB. De SEL waasland bijvoorbeeld heeft een stappenplan uitgewerkt vooral de verschillende etappes in de aanpak van OMB worden uitgelegd en de contactgegevens van verschillende partijen worden vermeld. (cfr. *brochure*). Wat denkt u van een dergelijk initiatief /in welke mate lijkt een dergelijk instrument nuttig voor uw werk ?

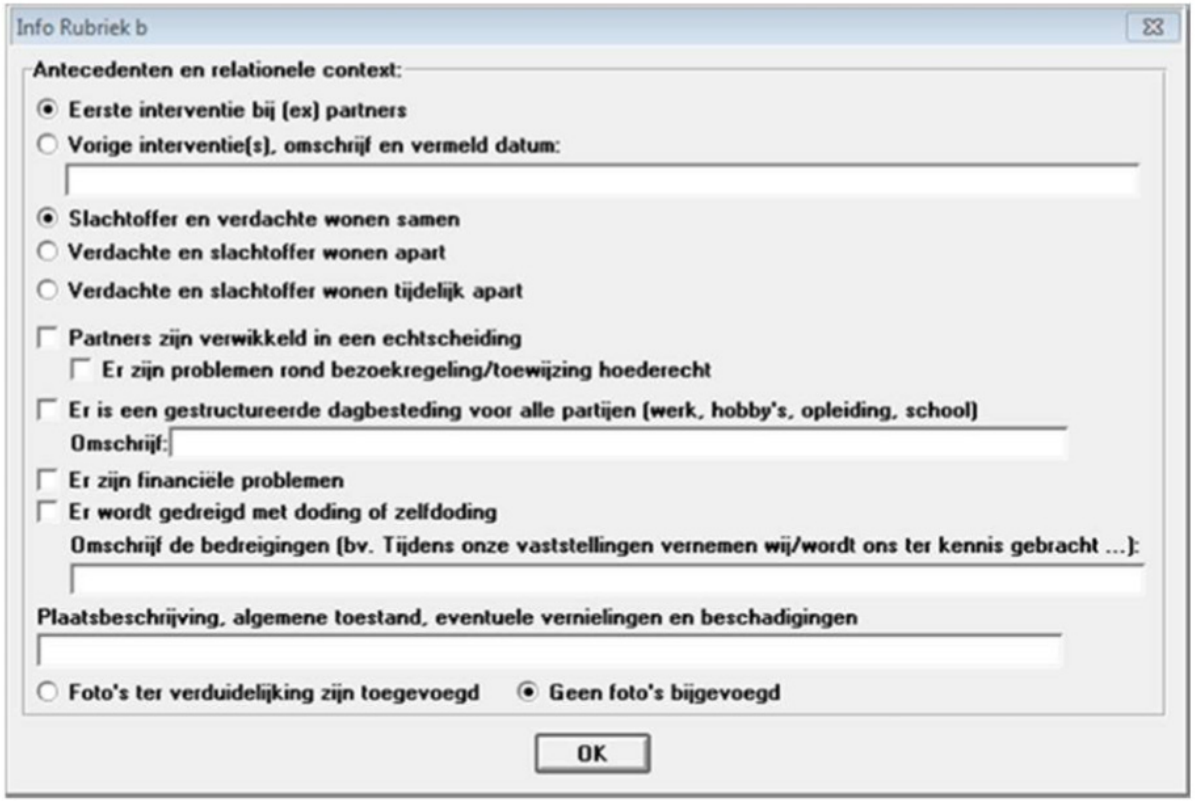
6. Registratie van gegevens

Hoe wordt ouderenmishandeling **geregistreerd**? Zijn er specifieke codes voor situaties van omb ?

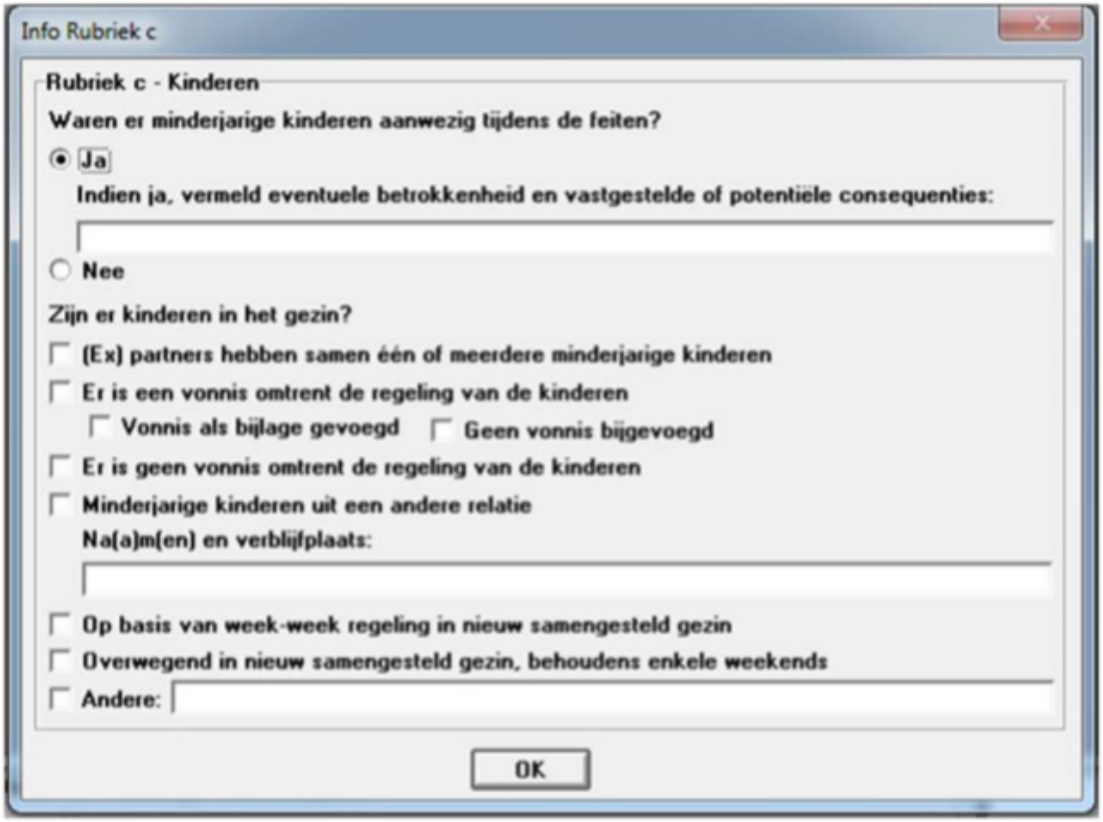
Hoe zou de registratie kunnen worden verbeterd? Zou er een tweede code kunnen worden toegevoegd om kwetsbare personen te identificeren (bijvb. ouderen, kinderen, personen met een handicap, zwangere vrouwen,…).

APPENDIX 64. CHECKLIST INTRAFAMILY VIOLENCE IN THE POLICE ZONE OF ANTWERP

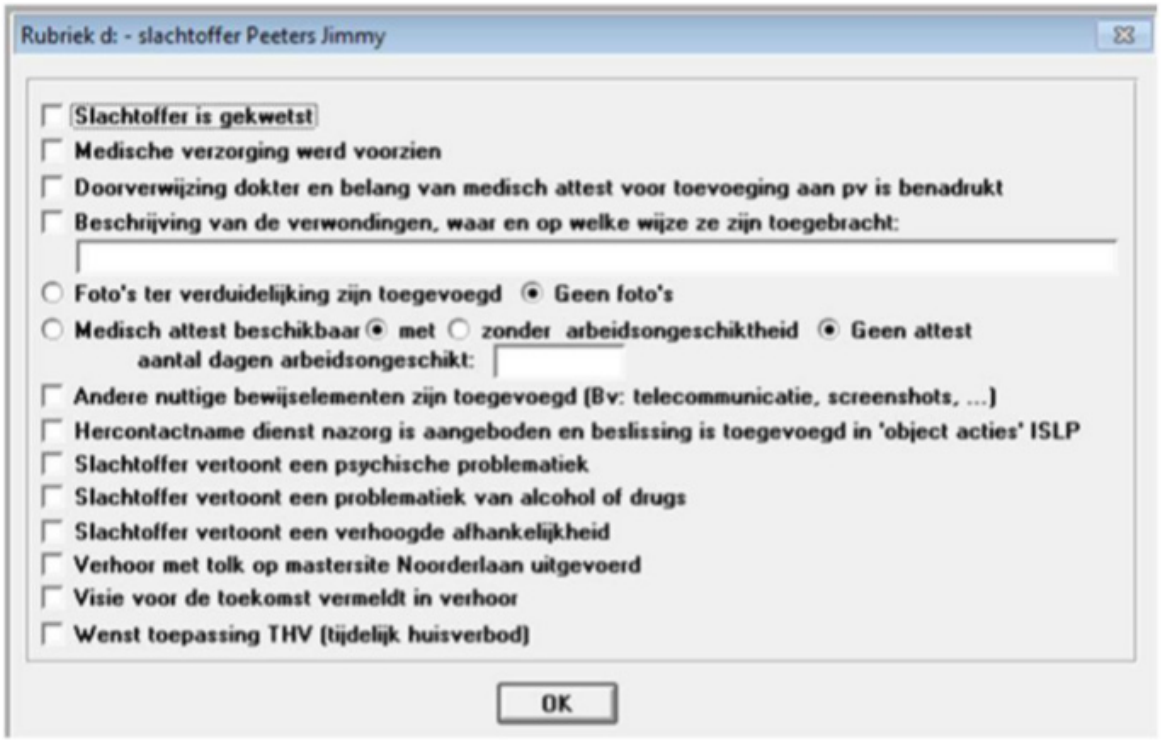



Info Rubriek b
Antecedenten en relationele context:
Eerste interventie bij (ex) partners
Vorige interventie(s), omschrijf en vermeld datum:
Slachtoffer en verdachte wonen samen
Verdachte en slachtoffer wonen apart
Verdachte en slachtoffer wonen tijdelijk apart
Partners zijn verwikkeld in een echtscheiding
Er zijn problemen rond bezoekregeling/toewijzing hoederecht
Er is een gestructureerde dagbesteding voor alle partijen (werk, hobby's, opleiding, school)
Omschrijf:
Er zijn financiële problemen
Er wordt gedreigd met doding of zelfdoding
Omschrijf de bedreigingen (bv. Tijdens onze vaststellingen vernemen wij/wordt ons ter kennis gebracht ...):
Plaatsbeschrijving, algemene toestand, eventuele vernielingen en beschadigingen
Foto's ter verduidelijking zijn toegevoegd
Geen foto's bijgevoegd
OK

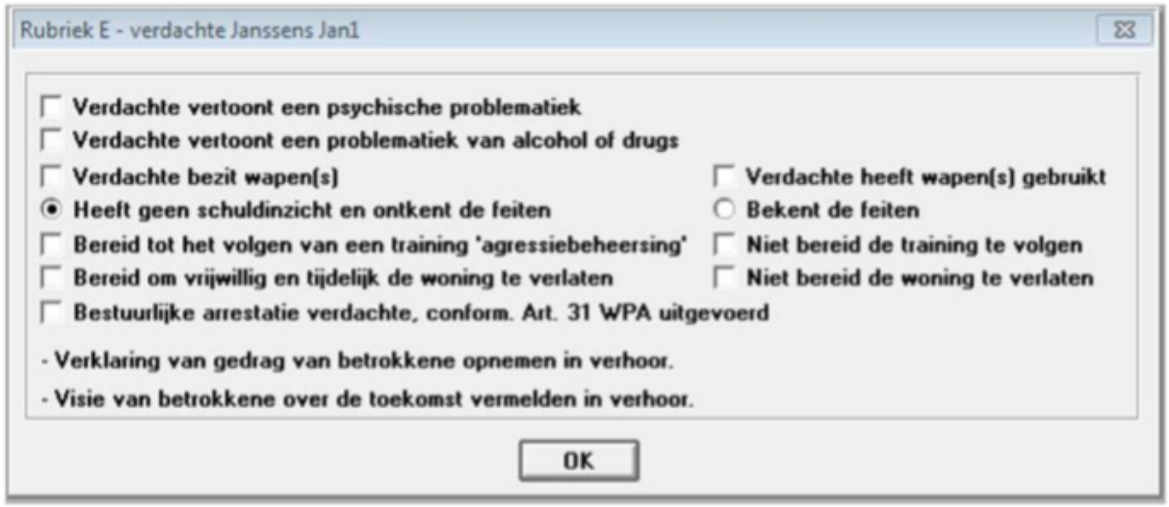
Rubriek c: kinderen



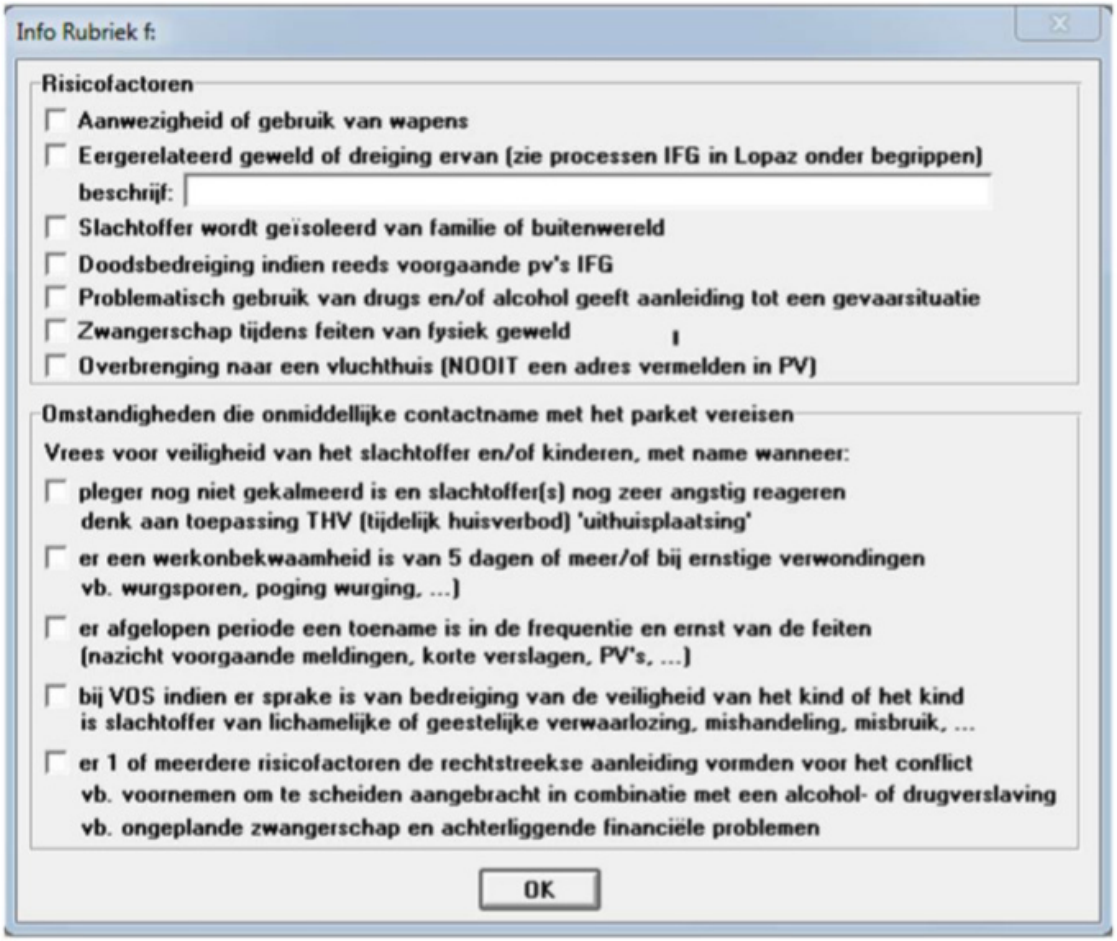
Rubriek d: slachtoffer



Rubriek e: verdachte



Rubriek f: risicofactoren



CHAPTER 8: STAKEHOLDERS AND EXPERTS CONSULTATION ON SPECIFIC ISSUES

APPENDIX 65. STATEMENTS DISCUSSED IN THE GROUPS OF EXPERTS AND STAKEHOLDERS

Table 67 – First set of statements discussed by all participants

	Dutch	French	English
1	Elke organisatie of zelfstandige professional die actief is in de sector van de ouderenzorg en andere relevante sectoren* zou verplicht een Meldcode moeten hanteren en implementeren (=aanpassen aan praktijk + kennis bevorderen onder de werknemers) met betrekking tot ouderenmis(be)handeling. Deze Meldcode is een roadmap aangepast aan de betrokken sector, die bij een vermoeden van mis(be)handeling moet worden gevolgd en die als leidraad dient voor de te nemen stappen.	Toute organisation ou tout professionnel indépendant actif dans le secteur des soins et de l'aide aux personnes âgées ou dans d'autres secteurs pertinents devrait être obligé d'utiliser et de mettre en œuvre un protocole appelé « Meldcode (protocole de signalement) » concernant la maltraitance des personnes âgées. Ce Meldcode serait une feuille de route adaptée au secteur concerné, qui doit être suivie en cas de suspicion de maltraitance et qui sert de guide pour les mesures à prendre.	Any organization or independent professional active in the care and support of older persons or in other relevant sectors should be obliged to use and implement a protocol known as the "Meldcode (reporting protocol)" concerning the abuse of older persons. This Meldcode would be a road map tailored to the concerned sector, to be followed in cases of suspected abuse and to serve as a guide for action.
2	Afgezien van de zeer dringende/ernstige gevallen waarvoor een 112/101-oproep of een aangifte bij de procureur des Konings zou moeten gebeuren, zou er één centraal toegangspunt moeten zijn waar burgers (inclusief ouderen) en professionals hun vermoedens van ouderenmis(be)handeling kunnen melden. Deze structuur moet dan zorgen voor de daaropvolgende aanpak (dispatch, interventie en follow-up).	En dehors des cas très urgents/sévères nécessitant l'appel au 112/101 ou la dénonciation au Procureur du Roi, il devrait y avoir une porte d'entrée unique où les citoyens (y compris les personnes âgées) et les professionnels signalent leurs soupçons de maltraitance envers les personnes âgées. Cette structure devrait ensuite s'occuper de la prise en charge (dispatching des cas, intervention et suivi).	Apart from very urgent/serious cases requiring the call to 112/101 or denunciation to the Public Prosecutor, there should be a single entry point where citizens (including the elderly) and professionals report their suspicions of elder abuse. This structure should then take care of the case management (dispatching of cases, intervention and follow-up).
3	Er zouden juridische beschermingsmechanismen voor kwetsbare ouderen moeten bestaan, net zoals voor minderjarigen. Er zou bijvoorbeeld een organisatie moeten bestaan die een wettelijk mandaat heeft om te kijken of er vanuit de overheid moet worden tussengekomen in de beslissing om hulp te organiseren voor mis(be)handelde ouderen (cfr. Ondersteuningscentrum Jeugdzorg).	Il devrait y avoir des mécanismes de protection juridique pour les personnes âgées vulnérables comme cela existe pour les mineurs. Par exemple, il devrait y avoir une organisation mandatée légalement pour juger si les autorités devraient intervenir dans la décision d'assister une personne âgée maltraitée (cf. Youth Care Support Centre).	There should be legal protection mechanisms for vulnerable older persons as there are for minors. For example, there should be an organisation legally mandated to judge whether the authorities should intervene in the decision to assist an abused older person (see Youth Care Support Centre).
4	Alle professionals in de relevante sectoren moeten regelmatig opleiding krijgen via praktische workshops over	Les prestataires de votre secteur devraient tous suivre des formations continues sous forme d'ateliers	All providers in your area should receive ongoing training in the form of practical

	ouderenmis(be)handeling. De opleiding moeten gegeven worden voor een multidisciplinair publiek en volgens vooraf bepaalde geografische regio's (bijvoorbeeld alle politiekorpsen, stadswachten, zorgverleners, OCMW hulpverleners… van een bepaalde zone volgen samen een workshop).	pratiques sur la maltraitance des personnes âgées. Les formations seraient données pour un public multidisciplinaire et selon des zones géographiques prédéfinies. (p. ex. tous les services de police, les gardiens de la paix, les prestataires de soins de santé, les assistants sociaux du CPAS... d'une certaine région suivront un atelier ensemble).	workshops on elder abuse. The training would be given to a multidisciplinary audience and according to predefined geographical areas. (e.g. all police services, peacekeepers, health care providers, social workers of the OCMW/CPAS, ... from a certain region would follow a workshop together).
5	Alle professionals in de relevante sectoren moeten regelmatig opleiding krijgen via praktische workshops over ouderenmis(be)handeling. De opleiding moeten gegeven worden voor een multidisciplinair publiek en volgens vooraf bepaalde geografische regio's (bijvoorbeeld alle politiekorpsen, stadswachten, zorgverleners, OCMW hulpverleners,… van een bepaalde zone volgen samen een workshop)	Au lieu de financer les campagnes sensibilisant le public au concept de la maltraitance des personnes âgées, il faut investir dans des campagnes qui permettent de mieux faire connaitre les mesures (non répressives pour l'auteur) de prise en charge des situations de maltraitance.	Instead of funding campaigns to raise public awareness of the concept of elder abuse, there is a need to invest in campaigns that raise awareness of (non-repressive for the author) measures to deal with situations of abuse.

The statement presented in the table 2 were discussed in group 1 in Dutch and in group 2 in French

Table 68 – set of statements discussed by the group 1 and 2

	Dutch	French	English
6	De Family Justice centers moeten uitgerold worden in heel Vlaanderen. Daarbij moet hun rol worden uitgebreid naar een centraal meldpunt (zowel voor professionals als voor het publiek) en triagepunt die de gevallen kan dispatchen naar de relevante hulptrajecten (hulpverlening of justitie).	Il devrait y avoir une concertation systématique et structurelle entre les organisations spécialisées dans la prise en charge des personnes âgées maltraitées et les secteurs de la police et de la justice pour tous les cas de maltraitance détectés, comme dans l'exemple des 'Family Justice Centre'.	There should be a systematic and structural consultation between organisations specialising in the care of abused older people and the police and justice sectors in all detected cases of abuse, like in the example of the Family Justice Centre.
7	De huidige mogelijkheden om het beroepsgeheim op te heffen en ouderenmis(be)handeling te melden zijn 1) niet voldoende gekend / gemakkelijk te begrijpen en 2) ontoereikend (bijvb. wanneer er niet onmiddellijk een strafbaar feit is, zoals in het geval van overbelaste mantelzorg met mogelijk risico op mis(be)handeling)	Les possibilités actuelles de lever le secret professionnel et de dénoncer les abus envers les personnes âgées ne sont (1) pas suffisamment connues, ni faciles à comprendre et (2) insuffisantes (par exemple, lorsqu'il n'y a pas d'infraction pénale immédiate, comme dans le cas de soins par un aidant informel surchargé, avec un risque possible de maltraitance).	The current possibilities for lifting professional secrecy and reporting elder abuse are (1) not sufficiently known or easy to understand and (2) insufficient (e.g. where there is no immediate criminal offence, as in the case of care by an overburdened informal caregiver, with a possible risk of abuse).

8	Er zou een wetgevend kader moeten zijn dat de modaliteiten (bijvb. een gemeenschappelijk 'dossier'), waarbinnen het casusoverleg mogelijk is uitwerkt.	Il devrait y avoir un cadre législatif qui élabore les modalités (par exemple, un "dossier" commun), dans lequel la concertation de cas est possible.	There should be a legislative framework setting out the modalities (e.g. a common folder) in which case consultation is possible.
9	Er zouden door de bevoegde overheden protocolakkoorden moeten worden gesloten tussen de sectoren van politie, justitie en hulpverlening om tot een gezamelijke aanpak van OMB te komen. Topics die tot het akkoord kunnen behoren: het opnemen van verantwoordelijkheid door elke actor; de oprichting van een overlegstructuur in elk gerechtelijk arrondissement met als doel de brug te vormen tussen justitie en hulpverlening door vorming en overleg; het uitwerken van een gedragslijn kwaliteitsvolle zorg voor ouderen en het aanpakken van OMB.	Les autorités compétentes des secteurs de la police, de la justice, des soins de santé et de l'aide sociale devraient conclure des protocoles d'accord politique afin de parvenir à une approche commune de la maltraitance des personnes âgées. Les thèmes qui pourraient faire partie de l'accord seraient: la prise de responsabilité par chaque acteur confronté à un cas de maltraitance; la mise en place d'une structure de concertation dans chaque arrondissement judiciaire dans le but de jeter un pont entre la justice et les services sociaux par la formation et la concertation; l'élaboration d'un code de conduite pour des soins de qualité aux personnes âgées et le traitement des maltraitances à l'égard des personnes âgées....	Competent authorities from the police, justice, health care and social welfare sectors should conclude political agreement protocols in order to achieve a common approach to elder abuse. The topics that could be included in the agreement would be: the assumption of responsibility by each actor confronted with a case of abuse; the establishment of a consultation structure in each judicial district with the aim of building a bridge between justice and social services through training and consultation; the development of a code of conduct for quality care of the elderly and the treatment of elder abuse....
10	Een grotere kwaliteit van zorg en meer controle op de kwaliteit van de geleverde zorg zou de kwaliteit van het leven van afhankelijke ouderen verbeteren.	Pour améliorer la qualité de vie des personnes âgées dépendantes, il faut améliorer la qualité des soins et organiser des contrôles sur la qualité des soins.	In order to improve the quality of life of dependent elderly people, the quality of care must be improved and controls on the quality of care must be organised.
11	Er zou een charter van goede zorg moeten geïmplementeerd zijn in alle zorgvoorzieningen en bij alle zorgverleners die met ouderen in contact komen. Het charter zou aanbevelingen moeten bevatten over wat goede zorg betekent voor zorgverleners, managers, de ouderen zelf en hun familie en vrienden.	Il est nécessaire qu'une charte de bientraitance soit ratifiée par toutes les structures et les prestataires et qu'elle contienne des recommandations sur ce que signifie la bientraitance et ce que cela implique pour les prestataires de soins, les manageurs d'institutions, les personnes âgées elles-mêmes et leur entourage.	There is a need for a well-treatment charter to be ratified by all structures and providers and to contain recommendations on what well-treatment means and what it entails for care providers, managers of institutions, older people themselves and their families.

The statement presented in the table 3 were discussed in group 4 in Dutch and in group 3 in French

Table 69 – set of statements discussed by the group 3 and 4

	Dutch	French	English
12	Professionals die te maken hebben met ouderenmis(be)handeling hebben een eenvoudige, korte en holistische detectietool nodig.	Les professionnels confrontés à la maltraitance des personnes âgées doivent disposer d'un outil de détection simple, court et holistique.	Professionals dealing with elder abuse need a simple, short and holistic detection tool.
13	De detectietool en de aanpak die daarbij hoort moeten aangepast zijn aan zeer kwetsbare mensen.	L'outil de détection et la prise en charge qui en découle doivent être adaptés aux personnes très vulnérables.	The detection tool and the resulting care must be adapted to very vulnerable people.
14	Kwetsbare ouderen zouden baat hebben bij een systematische detectie van het risico op mis(be)handeling.	Les personnes âgées très vulnérables devraient bénéficier d'une détection systématique du risque de maltraitance.	Highly vulnerable older persons should benefit from systematic detection of the risk of abuse.
15	Het delen van medische, sociale en civiele gegevens (via een gedeeld hulpmiddel zoals BelRAI met opname van risicofactoren of antecedenten) is essentieel voor een betere detectie en optimale monitoring van ouderenmis(be)handeling.	Un partage des données médicales, sociales et civiles (via un outil partagé tel le BelRAI) reprenant les facteurs de risques ou les antécédents de maltraitance est indispensable pour une meilleure détection et un suivi optimal de la maltraitance des personnes âgées.	Sharing medical, social and civil data (via a shared tool such as the BelRAI) including risk factors or a history of abuse is essential for better detection and optimal monitoring of elder abuse.
16	De meest geschikte noodmaatregel in crisissituaties is de gedwongen verwijdering van de bejaarde uit zijn of haar leefomgeving.	La mesure d'urgence dans une situation de crise la plus adaptée est l'éloignement forcé de la personne âgée de son milieu de vie maltraitant.	The most appropriate emergency measure in a crisis situation is the forced removal of the elderly person from their abusive living environment.
17	Een referentiepersoon in elke structuur van alle sectoren (inclusief justitie en politie) zal de detectie en aanpak van ouderenmisbehandeling aanzienlijk verbeteren	La présence d'une personne de référence au sein de chaque structure de tous les secteurs (y compris la justice et la police) améliorera considérablement la détection et la prise en charge de la maltraitance des personnes âgées.	The presence of a reference person within each structure from all sectors (including justice and police) will greatly improve the detection and management of elder abuse.

APPENDIX 66. SUMMARY OF THE DISCUSSION WITH STAKEHOLDERS

Appendix 66.1. Group 1

The first main opinion of the participants to the group 1 was that there should be an **obligation for every organisation to have a step-by-step plan**. However, there are several conditions for a successful implementation of this idea. Indeed, the obligation of a step-by-step plan is only one aspect of the global policy related to elder abuse. It should be **integrated in a total approach of sensitisation, prevention and training**. Moreover, professionals will solely be motivated to use the step-by-step plan if **a sound follow-up by the relevant organisations responsible for the management of elder abuse is guaranteed**.

In the aim to implement the step-by-step plan, participants suggest that a generic framework for the step-by-step plan should be provided by the government. Then the 1st line zones in Flanders should elaborate the step-by-step plan and concretise this for the respective zone. Finally each organisation can refine and align the plan to the local practice or the specificity of the organisation. For solo professionals, interprofessional consultations should be foreseen to enable shared decision making on what should happen in case of suspicion of elder abuse. It is primordial to foresee financing for these interprofessional consultations.

Instead of a **unique entrance point**, the participants suggest an approach for early management in which the professionals first try to manage help within the health and assistance sectors. The first reflex of the professional should be to question him/herself on how can I organise help. Reporting should come in a second time.

Regarding the respect for the autonomy of the elderly, there is **no legal framework that allows violation of the person's autonomy** (except if the person is not mentally capable). Therefore participants think that professionals should be sensitised and financially supported to have **care consultations (zorgoverleg) with the elder and his/her relatives, informal caregivers**… to discuss the options to solve a problematic situation. The **first line zones could be involved** in the elaboration of such consultation structures.

Participants indicate that training related to elder abuse should be included **in the curriculum of the basic training** of future professionals. Once they are professionally active, continual training should be foreseen on a local level. Generic training related to the concept and **generalities of elder abuse could be provided by VLOCO**. Training aiming at the *local operational issues* (who is who, who can I contact etc.) should be elaborated and **provided within the first line zones** by the local organisations.

Media are very powerful to sensitize and inform the general public. So participants highlighted that more attention should go to '**focussing on what good care for elderly** includes' instead of 'focussing on what can go wrong'. The underlying message should be that **elderly are valuable citizen who merit to be treated with respect**. The media should be sensitised in that way. On top of informing what to do in case of elder abuse, the general public should get the message ' we look for a **solution that will take your worries about your autonomy into account**', instead of putting the focus on repressive measures for the actor. Justice and the local authorities should be sensitised on the **importance of the informal caregiver and about degenerated informal care**.

The opinion of the participants about the role of Family Justice Centres is that the intervention of **Family Justice Centres should be preserved for severe cases** where the collaboration of police, justice and assistance is necessary. What can stay within assistance services, should stay in hand of assistance services. The **focus should stay with prevention and concertation with the professionals, the elder and his entourage** to find a solution. It is of an utmost importance that **professionals can judge on the severity of the case and have a step plan to help them** in this.

Participants notice that there is a lack of knowledge and fear for liability for violation of professional secrecy amongst professionals. This is not surprising since it is very complex and difficult. Therefore a clear guidance in the step plan, identifying when professionals are allowed to talk would be a great help. On top of this, professionals should get the reflex to contact lawyers outside or in the organisation to ask for clarification or help.

Participants explained that there is no need to specify art. 458ter Penal Code and to include the modalities of case concertation (casusoverleg) in law. Indeed, in Flanders the modalities of case concertation are included in a protocol agreement (Protocolakkoord) to create a uniform mode of operation amongst all actors involved in case concertation. The idea is that involved actors can share info about the abused elder but that no one is obliged to do so. In principle the respective elder should consent, but If not he/she should at least be informed that data are shared amongst different actors of the concertation.

According to participants of group 1, there is neither a need for a Protocolakkoord between the sectors of assistance, justice and police to have a common approach related to elder abuse as the primary role to elaborate on a management plan to tackle elder abuse should go to the local authorities. More power should be given to the first line zones to align the approach of the sectors of wellbeing, health care and assistance on the topic of elder abuse. In this, a step-by-step plan could be a good instrument. On a Federal level, elder abuse should be included in the National step-by-step plan against gender-related violence and in the national safety plan.

Participants' main opinion about quality of care is that a correct financing and staffing of the rest- and care homes rather than strengthening control on quality is required. Most of the professionals working in rest-and care homes know very well what good quality care includes. The problems lies with the underfinancing and understaffing of rest- and care homes. Currently financing is perverse: institutions are on the one hand financially stimulated to make elderly more dependent, and on the other hand no means are available to provide sufficient personnel for this care profile. Financing could be differently organised, for instance related to the satisfaction of the elderly.

Appendix 66.2. Group 2

EA management:

Current situations in Belgium:

First, participants of group 2 discussed a lot about the current situation of the collaboration between sectors in Belgium. They highlighted that a silo partitioning exists between the sector of the justice and the sector of care/help. But, recently, the justice asks for more interaction with psycho-social services. A 'COL' in preparation by the justice sector should include a forum between organisations specialized in EA and referent magistrates in the aim to identify the limits of the competence of each other and the grey zone between the sectors of the police/justice and the sectors of the care/help. As an example, 'Respect Seniors', a psycho-social accompanying service which is non neutral as it positions itself at the side of the older person, still refers the most severe cases to the police, the prosecutor or the AVIQ control service.

A participant expressed the need of the police sector to discuss with other sectors about situations outside the policemen competencies (ex: EA cases involving frail people). But as each sector has its own functioning, taking common decision is often very complex. And participants highlighted that troubles of functioning between sectors lead to unproductive discussions instead of centralising the discussion around the abused older person.

Concertation meetings are seen as a potential solution but several barriers were noticed: (i) the attempt to install a Family Justice Centre in Brussels was unsuccessful, probably because of the difference of mentality and philosophy of work compared to Flanders; (ii) the level of transparency between the North and the South of the country is different (from a Brussels point of view); and (iii) concertation meeting cannot be systematically done because the implementation is very cumbersome.

The professional secret was also well debated between participants which conclude that a shared professional secret allows more flexibility but is only possible within a well-functioning team. However, the professional secret is often interpreted differently from one to another, even in a same team, and is sometimes used as a mean to hide a lazy or inappropriate behaviour. So

the professional secret is a brake and a protection in the same time. That is why not all information should be shared but only the needed one.

Then, participants highlighted that the population in general and the care professionals in particular are afraid by the justice sector, especially because abuse is sometimes bilateral. However, the justice offers non repressive means (compensation, non-violence training, work sentence…) decided by a magistrate according to the seriousness of the situation. Moreover, different types of mediation can help: the senior mediation done by some specialized organisations at the request of an older person and the criminal mediation at the request of a magistrate. The participants noticed that each of this process has its limits: the senior mediation is not possible if the power balance between the participants is not respected and the criminal mediation induces an official report with the risk of a citation before the court.

The involvement/consent of the older person in the EA management was also well-debated. The following remarks were given: (i) it is difficult and stigmatizing to establish the decisional capacity of someone (to know if a person is able to decide for himself by himself). (ii) the reporting by a victim (an abused older person) requires to have first established a trusted relationship; (iii) the justice acts for the good of people but not always with their consent; and (iv) doctors are still too paternalistic.

Development and implementation of a step-by-step plan:

A step-by-step plan is globally seen as comforting in the group. According to participants, the plan should include a step in which EA case should be shared with a reference person if he/she has the mean to act and is not overburden. Situations of severe and immediate danger have to be analyse carefully as they should trigger an obligation to act. So the type of actions to do should be clearly described in the plan. Participants also highlighted that the creation of new services should be avoided, existing services should rather be reinforced, and finally the support of a Family Justice Centre should not be a mandatory step in the step-by-step plan but a possibility.

A controversy emerged about a unique entrance point. The following arguments were given: (i) a quick sorting of EA situation is bad as it is needed to let the problem decant and go at the elder's pace before taking a decision about the type of intervention; (ii) a common hotline with the other types of violence is to avoid; (iii) the call receiver should be well-trained to avoid repeated wrong referrals.

Abused older people should be informed about all types of interventions including the repressive and the non-repressive ones. The professional should take the pace of the older people. The senior must be aware and should agree with the interventions. So the first step should be to get the consent of the older person. In case of decisional incapacity, an ethical reflexion is required to know if it is the will or the interest of the senior which is the most important. A legal representative should decide instead of the older person but first a clarification of the legal definition of a person representative has to be done in the Belgian legislation.

Participants suggested that older people should be involved in inter-sectoral concertation meetings if he/she is able to do it, allowing to solve, by their presence, the problem of the professional secret or that the professional secret lift should be adapted to less severe situation.

Finally, as in Belgium the law distinguishes the minor and the adults, a participants highlighted that plans for minors are not appropriate for adults.

EA prevention

Professional training

According to participants, to acquire new competencies, in particular during basic cursus, training should better be delivered to a homogenous audience while continual training should better be organized for a multidisciplinary audience. An experimental multi-sectoral and multidisciplinary training on intra-familial violence issues works already very well in Brussels. However it was highlighted that time constraints impairs the organisation of such large training for professionals. Moreover, outside trainings often attract only motivated persons. So participants suggested that trainers must come on site and training should be free, mandatory and also target solo-professionals.

Small group workshops are judged more popular and useful by participants but again more difficult to organize. Another suggested solution was that external supervisor should participate to the care with staff and correct the well-treatment lack during everyday practice. Participants highlighted that ethical reflexions occurs and are needed every day in elder care, however, this thematic is not included in the basic or continual training of staff.

Finally, participants insisted that training should be followed by logistic and financial means to allow the implementation of the new acquired knowledges and competencies. To facilitate this, the outcome of the training should be common to both the staff and the management before the organisation of the training. In Wallonia and Brussels region, hours of training are planned by the authorities for nursing homes staff (2 days/year or 30 hours/year, respectively).

Public sensitization

Participants highlighted that the priority in sensitization should be the sensitization to ageism which should start at school; be the sensitization of all professionals in elder help and care to geriatrics and gerontology issues; and explain what EA is to the whole population, including the older people, requiring to go in elder place of living to sensitize them.

Practice change in residential settings

According to participants, to improve the quality of care does not necessarily induce an improvement of quality of life. In nursing homes, there are control on restraints, pressure sores and falls but not about maltreatment. To evaluate the well-treatment, it should be better to control the way to care instead of to cure.

AVIQ inspectors control the architectural norms but have no contact with the residents. In addition, AVIQ does not perform a lot of control in nursing homes and the managers are always aware about their visit. Moreover, quality indicators vary from one region to another. Participants suggest to avoid administrative quality criteria like the existence of a life project for each resident in the personal folder because this is a decoy as nobody checks if it is respected; and to do more qualitative controls instead of quantitative control but with the maintenance of the architectural norms.

Participants highlighted that no control exists on ‘at home’ care by solo-professionals. So they suggest to take into account the problematic of ‘at home’ situations of care when the quality of care is questioned.

It was also noticed by participants that the quality of life of elders depends on the quality of life of caregivers and on their motivation. They suggested to improve the attractiveness of the profession of nursing auxiliary instead of hiring people without care vocation for employment rate reason and to improve the work conditions of caregivers in giving them the mean to do their job correctly (training, time…). To take the travel time of caregivers working in ‘at home’ setting into account was given as an example.

The issues about quality of care charters, as the one developed by the EU which gives a quality frame to elder services, were debated. Indeed, a charter was seen as a positive trigger allowing that the staff could easily appropriate the content if they participates to its development. But there is no mean to force the respect of a charter and to use a charter in a mandatory way could induce a shift between the management and the staff. The participants suggested to sensitize actively residents, staff and visitors to the charter of a structure and to involve elder people in the development and implementation of the quality charter.

Concerning the hospital setting, it was noticed that hospitals’ accreditation systems allow a come-back to good practices and a long-term follow-up of the implementation of them although hospitals staff does not like change. Moreover norms in hospitals are not up-to-date regarding the burden to actual patients’ profile (for example, highly anxious patient takes a lot of time to care).

Finally, participants insisted on more trust, transparency and empowerment between stakeholders and gave plenty of solutions about that concern:

- To rise the taboo and the law of silence within residential care settings.
- To develop auto-control of well-treatment by professionals.
- To organise open discussion meetings between residents, families, staff and management about EA concerns.
- To establish freelance residents comity without management control.

- To allow elder to have the opportunity to take risks.
- To allow the elderly to evaluate the quality of care and not only the family because there is a bias related to the decrease of the burden for family when the OP lives in a residential setting.
- To establish ranking of nursing homes to improve the quality by introducing competition.
- To make control report publically available.

Appendix 66.3. Group 3

Main impressions from this group:

- **Obligation to have a step-by-step plan**

  The step-by-step plan as presented did not receive a favourable opinion because of its mandatory nature, probably due to the confusion between the obligation to have a step-by-step plan and the obligation to report. But after having detailed and explained the steps of the step-by-step plan, the professionals confirmed their agreement. Experts fear the risk of standardisation instead of assessing older people on a case-by-case basis.

- **Implementation of the step-by-step plan**

  However, if there were to be a step-by-step plan, it would have to be activated in the case of a clear situation of abuse. Training and sensitization to elder abuse is a prerequisite for the use of a step-by-step plan. The networking, in collaboration with other sectors, is essential.

- **Single entrance door**

  The professionals in the group were very committed to using and supporting existing structures rather than creating new ones or having a single entry point.

  The notion of patient anonymity was also emphasized by the group.

- **Legal protection mechanisms for vulnerable persons**

  Such mechanisms could be useful if the older person has psychiatric or cognitive problems or is unaware that he or she is being abused.

  In any case, multidisciplinary discussion is required before any decision is made and the patient's freedom of decision must be respected. Some patients do not necessarily want to denounce but accept to be helped.

- **Respect for the autonomy of the elderly**

  Respect for the patient's decision is an important key message from this group. Regardless of the seriousness of the situation, the patient must be consulted and his or her opinion must be taken into account.

- **Training for professionals, sensitization and information of the general public**

  Training is essential for understanding the issue of elder abuse. It should be a priority for the managers of the structures. Sensitization and information to the general public is essential, but the message must be clear and practical (where to go for information and how to get help). Sensitization's campaigns will have to be carried out by communication professionals with the collaboration of people in the field. Incorporating law enforcement aspects could be a deterrent. We need to change societies' norms, we talk about weight, about the problem of ageing instead of reflecting a positive image of older people.

  At the level of the justice system, elder abuse must become a priority for law enforcement = public awareness. The Public Prosecutor's Office must be called in.

- **Detection tool**

  A detection tool is not necessary: the experience of professionals in the field, their "common sense" and discussions with colleagues or in multidisciplinary meetings is sufficient. If there was to be a tool, there would need to be a specific tool for each type of professional, not just health professionals (e.g. for the banker), and one that correctly measures the risk of maltreatment (good SN/SP). The group questioned the usefulness of a grid. Some professionals use the EASI detection tool but the questions do not "fit" well into the conversation.

Furthermore, a tool cannot capture the whole situation experienced by the older person.

- **Systematic screening of very vulnerable people**

  The "very vulnerable" category encompasses a lot of very different things, and this was a bit confusing for the group. Routine screening of all people included in the "very vulnerable" category is unmanageable. Furthermore, how do we reach people who are isolated from the health care system? Longitudinal follow-up would be more appropriate than systematic screening.

- **Sharing medical, social and civil data**

  The group was not in favour of data sharing but was more in favour of direct contact with the professional who is following the patient (e.g. the GP). Furthermore, in order to share data, the agreement of the patient must be obtained. This would also mean that certain professionals who are not subject to medical secrecy would have access to the file.

- **Emergency action in a crisis situation**

  The victim does not necessarily have to be removed: the perpetrator can also be removed if possible. Hospitalisation is not the only solution if the victim needs to be removed: the victim can also find refuge with a family member. However, hospitalisation allows the elderly person to build up a network around them: they will be cared for by health professionals and can benefit from social and psychological assistance. Therefore, the advantages of hospitalisation include speed and multidisciplinarity (if the elderly person is hospitalised in geriatrics). Finally, the elderly person cannot be forcibly hospitalised: his or her agreement must be obtained.

- **A reference person**

  A reference person knows the network better (and can pass on the message of the importance given to the issue) but there is a lot of turnover, so if the role of referee is based on the responsibility of one person it is more complicated. According to the group, it is important to support local associations (such as senior listening, senior respect) rather than creating referent positions. There is a need for more networking with existing associations.

For greater efficiency, there should be a regional referent who links the different trades between them.

Appendix 66.4. Group 4

The main impressions from the group 4 concerned 3 topics: the current situation in Belgium, the development of a step-by-step plan, and the implementation of a step-by-step plan.

The participants highlighted that, currently in Belgium, a contrast exists between the Flemish and the French-speaking community. In the Flemish community, financial restrictions led to a minimal specialised service provided by VLOCO and were followed by a political decision to gather all types of violence in a centralised contact point (1712). In the French-speaking community, specialised organisations, such as “écoute seniors”, was further elaborated. These financial restrictions at Flemish side were perceived as a loss of quality of care to the elderly. Other general remarks of the participants concerning the current situation in Belgium are that: EA can also be induced by the healthcare system; the lack of support of informal caregivers leads to overburdening (and increased risk for abuse); residential care setting are ‘for-profit’ organisations with less nurses employed; more elder persons stay at home but financial restrictions in home care could affect this evolution; and financial restrictions induced by the government could lead to more institutional EA. The stakeholders use the RITI scale in their clinical practice as long as no better instrument is available.

According to participants, the elaboration of a step-by-step plan should be done with the involvement of all local stakeholders (multisector and multidisciplinary). This plan should consist of concrete steps. Stakeholders of group 4 preferred one contact point (similar to 1712) but not via FJC. This contact point should be a direct helpline, in order to avoid that different calls are needed before help can be provided. The further management of a case of elder abuse should be discussed with (and even coordinated by) the reporter (if he/she is a care professional). The GP could play a coordinating role.

Decisional autonomy of the elder is considered as very important: decisions about EA management should be taken in agreement with the elder, with respect for his values and also taking into account the potential (negative) consequences of interventions.

The stakeholders prefer a short but comprehensive detection tool, based on scientific evidence, or a toolbox with different specific tools. Also a tool to assess the potential abusive behaviour by the informal caregiver would be an added value in the detection of EA. Finally, step-by-step plan should also incorporate the detection of frailty (kwetsbaarheid) as a risk factor for abuse. While no specific reference person is needed but this role could be added to already existing reference persons.

Concerning the implementation of a step-by-step plan, the participants highlighted that the compulsory aspect of a step-by-step plan is important as it reminds the clinicians and the management to pay attention for this topic. They also warn about the risk for administrative burden and were not convinced by a shared file. A centralised contact point requires sufficient resources and staff, also more contact hours. Training should be provided on a regularly basis next to awareness campaigns for the general public. In particular, professional should be trained in starting a conversation about potential abuse.

APPENDIX 67. ACCEPTABILITY AND FEASIBILITY OF STATEMENTS

Appendix 67.1. Step-by-step plan for the detection and management of elder abuse

Table 70 – Step-by-step plan in case of suspicion of elder abuse

Statements		Acceptable			Not acceptable		
Elke organisatie of elke individuele professional die betrokken is bij de zorg- of hulpverlening bij ouderen moet een plan van aanpak (een leidraad met de verschillende te nemen stappen + praktische en wettelijke informatie) gebruiken bij (vermoeden van) ouderenmis(be)handeling	**Toute organisation ou tout professionnel indépendant impliqué(e) dans les soins et l'aide sociale aux personnes âgées devrait utiliser une procédure de prise en charge (guide reprenant les différentes étapes à réaliser + informations pratiques et légales) en cas de (suspicion de) maltraitance**	91.89% (n= 34) Feasible 91.18%	Not feasible 5.88%	Blanco 2.94%	8.11% (n=3) Feasible 0%	Not feasible 33.33%	Blanco 66.67%
Het gebruik van dit plan van aanpak moet wettelijk verplicht zijn	L'utilisation de cette procédure de prise en charge devrait être une obligation légale	75% (n=27) Feasible 77.78%	Not feasible 11.11%	Blanco 11.11%	25% (n= 9) Feasible 0%	Not feasible 66.67%	Blanco 33.33%
Deze verplichting moet kaderen binnen de erkenning en de controle op de zorgkwaliteit	L'obligation d'utiliser la procédure devrait faire partie des processus d'agrément et de contrôle de la qualité des soins	91.67% (n= 33) Feasible 90.91%	Not feasible 6.06%	Blanco 3.03%	8.33% (n=3) Feasible 0%	Not feasible 0%	Blanco 100%
De algemene principes en het generieke kader van dit plan van aanpak moeten worden vastgelegd door de bevoegde overheden	Les principes généraux et le cadre générique de cette procédure devraient être fixés par les autorités compétentes	88.57% (n= 31) Feasible 83.87%	Not feasible 6.45%	Blanco 9.68%	11.43% (n=4) Feasible 25%	Not feasible 0%	Blanco 75%
De Zorgraden van de eerstelijnszones in Vlaanderen en de SISD (Service Intégré d'Aide à	Les SISD (Service Intégré d'Aide à Domicile) en Fédération Wallonie-Bruxelles et les 'Zorgraden' des 'eerstelijnzones' en Flandre	88.46% (n= 23) Feasible		Blanco	11.54% (n= 3) Feasible		Blanco

Domicile) in Wallonië en Brussel moeten dit generieke kader aan elke geografische zone aanpassen, vooraleer de organisaties of professionelen deze kunnen aanpassen aan hun context	devraient adapter ce cadre générique à chaque zone géographique avant que les organisations ou professionnels indépendants puissent l'adapter à leur contexte professionnel	86.96%	Not feasible 0%	13.04%	33.33%	Not feasible 33.33%	33.33%

Table 71 – General principles of a step-by-step plan in case of suspicion of elder abuse

Statements		Acceptable			Not acceptable		
In het algemeen moet dit plan:	les principes généraux de cette procédure devraient...						
• concrete acties voorstellen	• proposer des actions concrètes	90.91% (n= 30) Feasible 90%	Not feasible 3.33%	Blanco 6.67%	9.09% (n= 3) Feasible 0%	Not feasible 66.67%	Blanco 33.33%
• intersectoraal zijn (met inbegrip van de sector van politie en justitie) en niet enkel intrasectoraal (beperkt tot de sector van de zorg- en hulpverlening)	• être intersectoriels (incluant le secteur de la police et de la justice) et pas uniquement intrasectoriel (limités aux secteurs de l'aide sociale et des soins	94.12% (n= 32) Feasible 84.38%	Not feasible 6.25%	Blanco 9.38%	5.88% (n= 2) Feasible 0%	Not feasible 0%	Blanco 100%
• de oudere op de hoogte houden en zijn akkoord vragen	• tenir la personne âgée au courant et solliciter son accord	88.57% (n= 31) Feasible 77.42%	Not feasible 16.13%	Blanco 6.45%	11.43% (n= 4) Feasible 25%	Not feasible 50%	Blanco 25%
• rekening houden met de globaliteit van de situatie	• tenir compte de la globalité de la situation	93.75% (n= 30) Feasible 90%	Not feasible 3.33%	Blanco 6.67%	6.25% (n= 2) Feasible 0%	Not feasible 50%	Blanco 50%
• de mogelijkheid bieden om de anonimiteit te garanderen	• offrir la possibilité de protéger l'anonymat	91.18% (n= 31) Feasible 80.65%	Not feasible 12.90%	Blanco 6.45%	8.82% (n= 3) Feasible 33.33%	Not feasible 33.33%	Blanco 33.33%

Table 72 – Procedure behind the step-by-step plan in case of suspicion of elder abuse

Statements		Acceptable			Not acceptable		
Het generieke kader van dit plan van aanpak moet het volgende bevatten...	Le cadre générique de la procédure de prise en charge devrait inclure...						
• de (verplicht) te volgen stappen	• les étapes (obligatoires) à suivre	90.36% (n= 29) Feasible 89.66%	Not feasible 3.45%	Blanco 6.90%	9.38% (n= 3) Feasible 0%	Not feasible 33.33%	Blanco 66.67%
• een 'toolbox' met detectietools en evaluatie van risicofactoren - te gebruiken als beslissingshulp bij vermoeden van mis(be)handeling - en een leidraad voor het voeren van het gesprek met de slachtoffers en hun omgeving	• une 'boîte à outils' contenant des outils de détection et d'évaluation des facteurs de risque -à utiliser comme aide à la décision en cas de suspicion de maltraitance- et un guide expliquant comment mener une conversation avec les victimes et leur entourage	96.88% (n= 31) Feasible 96.77%	Not feasible 0%	Blanco 3.23%	3.13% (n= 1) Feasible 0%	Not feasible 0%	Blanco 100%
• een bijlage met alle praktische informatie over de contactpersonen van de geografische zone	• une annexe contenant toutes les informations pratiques sur les personnes de contact dans la zone géographique	97.06% (n= 33) Feasible 90.91%	Not feasible 0%	Blanco 9.09%	2.94% (n= 1) Feasible 0%	Not feasible 0%	Blanco 100%
• juridische informatie over de mogelijkheden om het beroepsgeheim op te heffen en een verwijzing naar een externe instantie/persoon die juridisch advies kan geven	• des informations juridiques sur les possibilités de lever le secret professionnel et une référence à un organisme/personne externe capable de fournir des conseils juridiques	93.94% (n= 31) Feasible 93.55%	Not feasible 0%	Blanco 6.45%	6.06% (n= 2) Feasible 0%	Not feasible 0%	Blanco 100%
• een discussiefase binnen een multidisciplinair team	• une étape de discussion en équipe multidisciplinaire	96.97% (n= 32) Feasible 68.75%	Not feasible 12.50%	Blanco 18.75%	3.03% (n= 1) Feasible 0%	Not feasible 0%	Blanco 100%

• het aanduiden van een referentiepersoon ouderenmis(be)handeling - opgeleid in de strijd tegen mis(be)handeling - en tot wie zorg-en hulpverleners zich kunnen wenden bij (vermoeden van) mis(be)handeling	• la désignation d'une personne de référence en matière de maltraitance des personnes âgées - formée à la lutte contre la maltraitance - et vers qui les prestataires de soins et d'aide peuvent se tourner en cas de (suspicion de) maltraitance	93.94% (n= 31) Feasible 80.65%	Not feasible 6.45%	Blanco 12.90%	6.06% (n= 2) Feasible 0%	Not feasible 50%	Blanco 50%
• het aanduiden van (een) gespecialiseerde organisatie(s) als tussenpersoon voor het evalueren van de situatie, de aanpak en de follow-up	• la désignation d' (une) organisation(s) spécialisée(s) en tant que relais pour l'évaluation de la situation, la prise en charge et le suivi	87.50% (n= 28) Feasible 78.57%	Not feasible 3.57%	Blanco 17.86%	12.50% (n= 4) Feasible 25%	Not feasible 50%	Blanco 25%

Table 73 – Different steps of a step-by-step plan for the detection and management of elder abuse

Statements		Acceptable			Not acceptable		
Dit plan moet o.a. de volgende stappen bevatten...	La procédure devrait notamment inclure les étapes suivantes...						
• een detectiefase, op basis van een aantal alarmsignalen	• une étape de détection, sur base de signaux d'alerte	96.88% (n= 31) Feasible 83.87%	Not feasible 3.23%	Blanco 12.9%	3.13% (n= 1) Feasible 0%	Not feasible 0%	Blanco 100%
• een fase waarbij het (actuele, zekere en ernstige) gevaar wordt ingeschat	• une étape au cours de laquelle le danger (réel, certain et grave) est évalué	90.93% (n= 29) Feasible 82.76%	Not feasible 6.90%	Blanco 10.34%	9.38% (n= 3) Feasible 0%	Not feasible 33.33%	Blanco 66.67%
• een overlegfase met de oudere	• une étape de discussion avec la personne âgée	93.75% (n= 30)			6.25% (n= 2)		

		Feasible 80%	Not feasible 6.67%	Blanco 13.33%	Feasible 0%	Not feasible 50%	Blanco 50%
• een overlegfase met de omgeving van de oudere	• une étape de discussion avec l'entourage de la personne âgée	86.67% (n= 26) Feasible 73.08%	Not feasible 11.54%	Blanco 15.38%	13.33% (n= 4) Feasible 25%	Not feasible 25%	Blanco 50%
• een overlegfase binnen een multidisciplinair team of de mogelijkheid voor individuele zorgverleners om een gespecialiseerde organisatie te contacteren voor advies of overleg	• une étape de discussion en équipe multidisciplinaire ou la possibilité pour les professionnels indépendants de contacter une organisation spécialisée pour demander un avis ou une concertation interprofessionnelle	96.88% (n= 31) Feasible 77.42%	Not feasible 3.23%	Blanco 19.35%	3.13% (n= 1) Feasible 0%	Not feasible 0%	Blanco 100%
• een beslissingsboom met alle te ondernemen acties	• un arbre décisionnel sur les actions à mener	93.55% (n= 29) Feasible 82.76%	Not feasible 0%	Blanco 17.24%	6.45% (n= 2) Feasible 0%	Not feasible 50%	Blanco 50%

Appendix 67.2. Centralised contact point

Table 74 – Centralised contact point

Statements		Acceptable			Not acceptable		
Er moet een gecentraliseerd contactpunt zijn, waar de oudere of zijn familie hulp kan inroepen bij (vermoeden van) ouderen-mis(be)handeling, buiten de gevallen waar een oproep naar 112/101 (personen in gevaar) noodzakelijk is	**Il devrait y avoir un point de contact centralisé permettant à la personne âgée elle-même ou à ses proches de demander de l'aide en cas de (suspicion de) maltraitance, en dehors des cas nécessitant l'appel au 112/101 (personne en danger)**	88.24% (n= 30) Feasible 93.33%	Not feasible 0%	Blanco 6.67%	11.76% (n= 4) Feasible 0%	Not feasible 100%	Blanco 0%

Table 75 – Types of centralised contact point

Statements		Acceptable			Not acceptable		
Dit centrale contactpunt moet het volgende zijn...	Ce point de contact centralisé devrait être...						
• een nieuw uniek nationaal nummer dat 7d/7 en 24u/24 toegankelijk is en enkel bestemd is voor ouderenmis(be)handeling	• un nouveau numéro d'appel national unique ouvert 7j/7 et 24h/24 et uniquement dédié à la maltraitance des personnes âgées	51.61% (n= 16) Feasible 75%	Not feasible 12.5%	Blanco 12.5%	48.39% (n= 15) Feasible 6.67%	Not feasible 60%	Blanco 33.33%
• de nationale of regionale hulplijnen (1712, 106, 107)	• les centres d'appel nationaux ou régionaux actuels (1712, 106, 107)	57.14% (n= 16) Feasible 75%	Not feasible 0%	Blanco 25%	42.86% (n= 12) Feasible 8.33%	Not feasible 50%	Blanco 41.67%
• De organisaties gespecialiseerd in de psychosociale aanpak van mis(be)handeling (CAW, Brussels Meldpunt OMB, Ecoute Seniors, Respect Seniors)	• les organismes spécialisés dans la prise en charge psycho-sociale des cas de maltraitance (Ecoute Seniors, Respect Seniors, CAW, Brussels Meldpunt OMB)	70.37% (n= 19) Feasible 78.95%	Not feasible 0%	Blanco 21.05%	29.63.% (n= 8) Feasible 25%	Not feasible 37.5%	Blanco 37.5%

Table 76 – New centralised contact point

Statements		Acceptable			Not acceptable		
Als een nieuw uniek nationaal nummer het centrale contactpunt zou zijn, moet de organisatie achter dit nummer...	Si un nouveau numéro d'appel national unique devient le point de contact centralisé, l'organisation gérant ce numéro unique devrait...						
• **de tijd kunnen nemen om een vertrouwensrelatie met de melder op te bouwen**	• permettre de prendre le temps d'instaurer un lien de confiance avec l'appelant	80.77% (n= 21) Feasible 66.67%	Not feasible 9.52%	Blanco 23.81%	19.23% (n=5) Feasible 0%	Not feasible 80%	Blanco 20%
• **de anonimiteit van de melder kunnen garanderen om personen die vergeldingen vrezen, te kunnen geruststellen**	• permettre de garder l'anonymat de l'appelant afin de rassurer les personnes qui craignent des représailles	86.21% (n= 25) Feasible 68%	Not feasible 4%	Blanco 28%	13.79% (n=4) Feasible 25%	Not feasible 50%	Blanco 25%
• **beschikken over competent personeel dat de triage doet tussen gevallen waarbij een onmiddellijke melding aan de Procureur des Konings noodzakelijk is, of waarbij enkel een interventie door een gespecialiseerde organisatie nodig is (CAW, Brussels Meldpunt OMB, Ecoute Seniors, Respect Seniors)**	• disposer d'un personnel compétent pour trier les dossiers nécessitant une notification immédiate au Procureur du Roi de ceux qui nécessitent d'abord uniquement l'intervention d'un organisme spécialisé dans la prise en charge psycho-sociale (Ecoute Seniors, Respect Seniors, CAW, Brussels Meldpunt OMB)	85.19% (n=23) Feasible 65.22%	Not feasible 0%	Blanco 34.78%	14.81% (n=4) Feasible 0%	Not feasible 50%	Blanco 50%
• de oproep meteen doorschakelen naar de gespecialiseerde organisaties	• directement transférer l'appel vers les organisations spécialisées	70.83% (n= 17) Feasible 52.94%	Not feasible 5.88%	Blanco 41.18%	29.17% (n=7) Feasible 14.29%	Not feasible 42.86%	Blanco 42.86%

Table 77 – Current contact points as centralised contact point for elder abuse

Statements		Acceptable			Not acceptable		
Als de huidige nationale of regionale hulplijnen (1712, 106, 107) het centrale contactpunt zouden zijn, moeten zij...	Si les centres d'appel nationaux ou régionaux actuels (1712, 106, 107) deviennent le point de contact centralisé, ils devraient...						
• de tijd kunnen nemen om een vertrouwensrelatie met de melder op te bouwen	• pouvoir prendre le temps d'instaurer un lien de confiance avec l'appelant	92.59% (n= 25) Feasible 72%	Not feasible 8%	Blanco 20%	7.41% (n=2) Feasible 0%	Not feasible 0%	Blanco 100%
• de anonimiteit van de melder kunnen garanderen om personen die vergeldingen vrezen, te kunnen gerust stellen	• permettre de garder l'anonymat de l'appelant afin de rassurer les personnes qui craignent des représailles	86.67% (n= 26) Feasible 73.08%	Not feasible 0%	Blanco 26.92%	13.33% (n=4) Feasible 0%	Not feasible 25%	Blanco 75%
• beschikken over personen gespecialiseerd in ouderenmis(be)handeling	• disposer de personnes spécialisées dans la maltraitance de personnes âgées	93.10% (n=27) Feasible 81.48%	Not feasible 0%	Blanco 18.52%	6.9% (n= 2) Feasible 0%	Not feasible 0%	Blanco 100%
• beschikken over competent personeel dat de triage doet tussen gevallen waarbij een onmiddellijke melding aan de Procureur des Konings noodzakelijk is, of waarbij enkel een interventie door een gespecialiseerde organisatie nodig is (CAW, Brussels Meldpunt OMB, Ecoute Seniors, Respect Seniors)	• disposer d'un personnel compétent pour trier les dossiers nécessitant une notification immédiate au Procureur du Roi de ceux qui nécessitent d'abord uniquement l'intervention d'un organisme spécialisé dans la prise en charge psycho-sociale (Ecoute Seniors, Respect Seniors, CAW, Brussels Meldpunt OMB)	89.66% (n=26) Feasible 73.08%	Not feasible 3.85%	Blanco 23.08%	10.34% (n=3) Feasible 0%	Not feasible 0%	Blanco 100%

• hun openingsuren en -dagen uitbreiden (1712)	• étendre leurs jours et heures d'ouverture (1712)	88.89% (n= 24)	Feasible 66.67%	Not feasible 16.67%	Blanco 16.67%	11.11% (n= 3)	Feasible 0%	Not feasible 0%	Blanco 100%
• de oproep meteen doorschakelen naar de gespecialiseerde organisaties	• directement transférer l'appel vers les organisations spécialisées	72.73% (n= 16)	Feasible 62.50%	Not feasible 6.25%	Blanco 31.25%	27.27% (n= 6)	Feasible 16.67%	Not feasible 33.33%	Blanco 50%

Table 78 – Specialised organisations as contact point

Statements		Acceptable				Not acceptable			
Als de organisaties gespecialiseerd in de psycho-sociale aanpak van mis(be)handeling (CAW, Brussels Meldpunt OMB, Ecoute Seniors, Respect Seniors) het centrale contactpunt zouden zijn, moeten zij...	Si les organismes spécialisés dans la prise en charge psycho-sociale des cas de maltraitance (Ecoute Seniors, Respect Seniors, CAW, Brussels Meldpunt OMB) sont le point de contact centralisé, ils devraient...								
• hun openingsuren en -dagen uitbreiden	• étendre leurs heures et leurs jours d'ouverture	88.46% (n= 23)	Feasible 47.83%	Not feasible 21.74%	Blanco 30.43%	11.54% (n= 3)	Feasible 0%	Not feasible 66.67%	Blanco 33.33%
• elk geval van mis(be)handeling aanpakken, ook deze waarvoor een oproep naar 112/101 of een melding bij de Procureur des Konings nodig is	• prendre en charge tous les cas, y compris les cas ayant nécessité un appel au 112/101 ou une notification au Procureur du Roi	76% (n= 19)	Feasible 52.63%	Not feasible 15.79%	Blanco 31.58%	24% (n= 6)	Feasible 0%	Not feasible 83.33%	Blanco 16.67%

• de zeer dringende of zeer ernstige gevallen doorsturen naar 112/101 of naar de Procureur des Konings	• référer les cas très urgents et/ou très sévères au 112/101 ou au Procureur du Roi	88.46% (n= 23) Feasible 65.22%	Not feasible 4.35%	Blanco 30.43%	11.54% (n= 3) Feasible 0%	Not feasible 66.67%	Blanco 33.33%

Appendix 67.3. Professional secrecy and inter-sectoral consultation

Table 79 – Legal basis behind the professional secrecy

Statements		Acceptable			Not acceptable		
Om te weten of hun beroepsgeheim kan worden opgeheven, moeten professionals zich kunnen wenden tot een gespecialiseerde organisatie (bv CAW, Brussels Meldpunt OMB, VLOCO, FJC, Respect Senior, Ecoute Senior, ...)	Les professionnels devraient avoir accès à un service spécialisé leur permettant d'évaluer s'ils peuvent lever leur secret professionnel (par exemple via Respect Seniors, Ecoute Seniors, CAW, Brussels Meldpunt OMB, VLOCO, FJC, ...)	93.55% (n=29) Feasible 82.76%	Not feasible 3.45%	Blanco 13.79%	6.45% (n= 2) Feasible 0%	Not feasible 50%	Blanco 50%
De wettelijke regels inzake het beroepsgeheim moeten uitdrukkelijk voorzien dat deze niet gelden wanneer een geval van (vermoeden van) verwaarlozing, mishandeling of misbruik wordt gemeld over iemand die gezien zijn leeftijd als kwetsbaar wordt beschouwd, bij overheids-, medisch-sociale of gerechtelijke instanties (en niet alleen bij de Procureur des Konings, zoals nu het geval is)	Les règles légales relatives au secret professionnel devraient préciser explicitement que le secret professionnel ne s'applique pas lorsque des (soupçons de) privations, sévices ou abus envers une personne considérée comme vulnérable en raison de son âge sont signalés aux autorités administratives, médico-sociales ou judiciaire (et pas seulement au Procureur du Roi comme c'est actuellement le cas)	89.29% (n= 25) Feasible 88%	Not feasible 0%	Blanco 12%	10.71% (n= 3) Feasible 33.33%	Not feasible 33.33%	Blanco 33.33%

Table 80 – Types of inter-sectoral consultation

Statements		Acceptable			Not acceptable		
Om de politie, Parketten, rechters en de psycho-medico-sociale diensten in staat te stellen om complexe individuele zaken af te handelen, is het belangrijk om te beschikken over...	Afin de permettre à la police, aux Parquets et aux juges ainsi qu'aux services d'accompagnement psycho-médico-sociaux de traiter des cas individuels complexes à la frontière de leurs compétences respectives, il serait important d'avoir à disposition...						
• Overlegplatformen tussen de gespecialiseerde organisaties (CAW, Brussels Meldpunt OMB, VLOCO, Respect Seniors, Ecoute Senior,) en de magistraten, met de mogelijkheid om ook anonieme gevallen te bespreken	• Des plateformes de discussion entre les organisations spécialisées (Respect Seniors, Ecoute Senior, CAW, Brussels Meldpunt OMB, VLOCO) et les magistrats, avec la possibilité de discuter de cas anonymes	93.75% (n= 30) Feasible 70%	Not feasible 10%	Blanco 20%	6.25% (n= 2) Feasible 0%	Not feasible 50%	Blanco 50%
• Een permanente structuur in elk gerechtelijk arrondissement voor intersectoraal overleg over complexe gevallen, zoals het 'ketenaanpak' model of Family Justice Centers	• Une structure permanente dans chaque arrondissement judiciaire pour accueillir des concertations intersectorielles de cas complexes, sur le modèle 'ketenaanpak' ou des 'Family Justice Center'	100% (n= 32) Feasible 75%	Not feasible 3.13%	Blanco 21.88%	0% (n= 0)		

Table 81 – Inter-sectoral consultation like in Family Justice Centres

Statements		Acceptable			Not acceptable		
Nadat ze zijn opgezet, moeten de structuren voor intersectoraal casusoverleg (zoals Family Justice Center)	Si des structures de concertations intersectorielles de cas (type Family Justice Center) sont mises en place, elles devraient...						
• ook hulpvragen van professionals uit de zorg- en hulpverlening aanvaarden	• également accepter les demandes d'aide provenant de professionnels de la santé et de l'aide	83.87% (n= 26) Feasible 61.54%	Not feasible	Blanco 26.92%	16.13% (n= 5) Feasible 20%	Not feasible	Blanco 40%

				11.54%			40%
• voorbehouden worden voor complexe gevallen (meervoudige problematiek) van mis(be)handeling. Zij moeten de minder complexe gevallen doorsturen naar de bevoegde diensten	• être réservées aux cas complexes (problématiques multiples) de maltraitance et transmettre les cas moins complexes vers les services compétents	82.76% (n= 24) Feasible 70.83%	Not feasible 0%	Blanco 29.17%	17.24% (n= 5) Feasible 60%	Not feasible 20%	Blanco 20%
• zich ervan verzekeren dat de overeengekomen hulpmaatregelen voor de oudere werden doorgevoerd en nagaan of ze ook daadwerkelijk een effect hebben (case management)	• veiller à ce que les mesures d'aide convenues soient bien mises en place et qu'elles aient un impact réel (case management)	96.55% (n= 28) Feasible 71.43%	Not feasible 7.14%	Blanco 21.43%	3.45% (n= 1) Feasible 0%	Not feasible 100%	Blanco 0%
• de opleiding organiseren van de zorg- en hulpverleners binnen hun geografische zone (gerechtelijk arrondissement)	• organiser la formation des professionnels dans le domaine de la santé et de l'aide dans leur zone géographique (arrondissement judiciaire)	79.31% (n= 23) Feasible 82.61%	Not feasible 0%	Blanco 17.39%	20.69% (n= 6) Feasible 16.67%	Not feasible 50%	Blanco 33.33%

Appendix 67.4. Decisional autonomy

Table 82 – Decisional autonomy of the elder

Statements		Acceptable			Not acceptable		
Bij alle gevallen van mis(be)handeling, moet men...	Dans tous les cas de maltraitance, il faudrait...						
• de verschillende mogelijke interventies bespreken met de oudere	• expliquer à la personne âgée les différentes possibilités d'interventions adaptées à sa situation	100% (n=35) Feasible 74.29%	Not feasible 5.71%	Blanco 20%	0% (n= 0)		

• overleggen met de familie, vertrouwenspersoon/wettelijke vertegenwoordiger/bewindvoerder van de oudere	• discuter avec la famille de la personne âgée ou sa personne de confiance/représentant légal/administrateur de la personne	93.75% (n=30) Feasible 73.33%	Not feasible 6.67%	Blanco 20%	6.25% (n= 2) Feasible 0%	Not feasible 0%	Blanco 100%
• zich de vraag stellen of de wil van de oudere of zijn belang primeert	• se poser la question de savoir si c'est la volonté de la personne âgée qui prime ou si c'est son intérêt	97.06% (n= 33) Feasible 72.73%	Not feasible 9.09%	Blanco 18.18%	2.94% (n= 1) Feasible 0%	Not feasible 0%	Blanco 100%

Table 83 – Conditions for non-compliance to the will of the elder

Statements		Acceptable			Not acceptable		
Meerdere stappen zullen nodig zijn om te beslissen of een oudere sowieso beschermd moet worden, zelfs tegen zijn wil in...	Plusieurs étapes seraient nécessaires pour décider si une personne âgée doit être protégée d'office, même contre son gré:						
• zich systematisch afvragen of de voorwaarden van art. 422bis (hulpverleningsplicht in geval van groot en reëel gevaar) of de noodtoestand (mogelijkheid om het beroepsgeheim naast zich neer te leggen bij ernstig, actueel en zeker gevaar) voldaan zijn zodat men de noodzakelijke hulp kan organiseren	• se demander systématiquement si les conditions de l'article 422bis du code pénal (obligation d'assistance en cas de danger majeur et réel) ou de l'état de nécessité (possibilité de lever le secret professionnel en cas de danger grave, actuel et certain) sont remplies pour que l'aide indispensable soit organisée	93.94% (n=31) Feasible 77.42%	Not feasible 3.23%	Blanco 19.35%	6.06% (n= 2) Feasible 50%	Not feasible 50%	Blanco 0%
• een inschatting maken van de kwetsbaarheid, de beslissingsautonomie en de functionele onafhankelijkheid van de oudere	• établir le statut actuel de vulnérabilité, d'autonomie décisionnelle et d'indépendance fonctionnelle de la personne âgée	97.06% (n=33) Feasible 72.73%	Not feasible 9.09%	Blanco 18.18%	2.94% (n= 1) Feasible 0%	Not feasible 100%	Blanco 0%
• een ethische reflectie houden met de professionals uit de eerste en tweede lijn over de restcapaciteiten van de oudere:	• mener une réflexion éthique avec les intervenants de 1° et de 2° lignes sur les capacités résiduelles de la personne âgée:	96.77% (n=30) Feasible		Blanco	3.23% (n= 1) Feasible		Blanco

	wat men in zijn plaats moet doen, waarin men hem moet ondersteunen en wat hij zelf nog kan inschatten	ce qu'on devrait faire à sa place, ce pour quoi il faudrait l'épauler et ce qu'elle pourrait assumer elle-même	76.67%	Not feasible 10%	13.33%	0%	Not feasible 0%	100%
•	De GDT (Geïntegreerde Diensten Thuisverzorging) of de Zorgraden van de eerstelijnszones moeten bijeenkomsten rond dergelijke multidisciplinaire ethische discussies organiseren	• Les SISD (Service Intégré de Soins à Domicile) ou les 'Zorgraden' des 'eerstelijnzones' devraient être les organisateurs de ces réunions de discussion éthique multidisciplinaires	68% (n=17) Feasible 82.35%	Not feasible 5.88%	Blanco 11.76%	32% (n= 8) Feasible 25%	Not feasible 37.5%	Blanco 37.5%

Appendix 67.5. Training

Table 84 – Training for police and justice

Statements		Acceptable			Not acceptable	
De opleidingscentra voor politie en justitie (procureurs, vrederechters, ...) moeten specifieke opleidingen organiseren...	Les centres de formation continue au sein de la police et de la justice (procureurs, juges de paix, …) devraient proposer des formations spécifiques...					
• over noties van ouderenmis(be)handeling	• sur la maltraitance des personnes âgées	100% (n=31) Feasible 80.65%	Not feasible 3.23%	Blanco 16.13%	0% (n= 0)	
• over repressieve en niet-repressieve maatregelen bij mis(be)handeling	• sur les mesures répressives et non répressives en cas de maltraitance	100% (n=31) Feasible 80.65%	Not feasible 0%	Blanco 19.35%	0% (n= 0)	
• over noties van een kwetsbaar persoon, misbruik van de zwakke toestand van personen en wilsonbekwame personen	• sur les notions de personne vulnérable, d'abus de faiblesse et de personne incapable	100% (n=30) Feasible 83.33%	Not feasible 0%	Blanco 16.67%	0% (n= 0)	

• over de verplichting om hulp te verlenen (art 422 bis van het Strafwetboek)	• sur l'obligation de porter assistance (article 422 bis du Code pénal)	100% (n=30) Feasible 80%	Not feasible 0%	Blanco 20%	0% (n= 0)		
• over het bestaan van een plan van aanpak bij (vermoeden van) ouderenmis(be)handeling	• sur l'existence d'une procédure de prise en charge en cas de (suspicion de) maltraitance	100% (n= 32) Feasible 78.13%	Not feasible 6.25%	Blanco 15.63%	0% (n= 0)		

Table 85 – Training for care professionals

Statements		Acceptable			Not acceptable		
Elke professional betrokken bij de zorg rond ouderen moet...	Tout professionnel impliqué dans la prise en charge des personnes âgées devrait...						
• een opleiding krijgen over de kenmerken van oudere personen (cursus geriatrie en gerontologie)	• Avoir une formation sur les spécificités des personnes âgées (cours de gériatrie et de gérontologie)	96.88% (n=31) Feasible 74.19%	Not feasible 3.23%	Blanco 22.58%	3.13% (n= 1) Feasible 0%	Not feasible 100%	Blanco 0%
• een opleiding krijgen over noties van mis(be)handeling	• Avoir une formation sur la notion de maltraitance	100% (n=32) Feasible 81.25%	Not feasible 0%	Blanco 18.75%	0% (n= 0)		
• weten dat er een plan van aanpak bij (vermoeden van) ouderenmis(be)handeling bestaat	• Avoir connaissance de l'existence d'une procédure de prise en charge en cas de (suspicion de) maltraitance	100% (n=31) Feasible 83.87%	Not feasible 0%	Blanco 16.13%	0% (n= 0)		

• op de hoogte zijn van de verplichting van hulp te verlenen (art 422 bis van het Strafwetboek)	• Avoir connaissance de l'obligation de porter assistance (Art 422 bis du code pénal)	100% (n=30) Feasible 83.33%	Not feasible 0%	Blanco 16.67%	0% (n= 0)		
• noties hebben over de wettelijke concepten van een kwetsbaar persoon, misbruik van de zwakke toestand van personen en wilsonbekwame personen	• Avoir des notions sur les concepts légaux de personne vulnérable, d'abus de faiblesse et de personne incapable	100% (n=32) Feasible 78.13%	Not feasible 3.13%	Blanco 18.75%	0% (n= 0)		

Table 86 – Practical aspects related to the training for care professionals

Statements		Acceptable			Not acceptable		
De opleidingen van de zorg- en hulpverleners rond ouderenmis(be)handeling moeten...	La formation du personnel de soins et d'aide concernant la maltraitance des personnes âgées devrait...						
• opgenomen zijn in de basisopleidingen	• être incluse dans le cursus d'obtention du diplôme (formation de base)	94.12% (n=32) Feasible 71.88%	Not feasible 9.38%	Blanco 18.75%	5.88% (n= 2) Feasible 50%	Not feasible 0%	Blanco 50%
• regelmatig opgefrist worden in voortgezette opleidingen	• être entretenue par des formations continues très régulières	100% (n=31) Feasible 77.42%	Not feasible 6.45%	Blanco 16.13%	0% (n= 0)		
• mogelijk gemaakt worden door een verhoging van het aantal uren gesubsidieerde opleiding	• être rendue possible par une augmentation du nombre d'heures de formation subventionnées	96.43% (n=27) Feasible 59.26%	Not feasible 22.22%	Blanco 18.52%	3.57% (n= 1) Feasible 0%	Not feasible 100%	Blanco 0%

• de identificatie van een geval van mis(be)handeling en het plan van aanpak bevatten	• traiter de l'identification des cas de maltraitance et de la procédure de prise en charge	100% (n=31) Feasible 77.42%	Not feasible 0%	Blanco 22.58%	0% (n= 0)		

Table 87 – Principles of continuing education on elder abuse

Statements		Acceptable			Not acceptable		
De voortgezette opleidingen over ouderenmis(be)handeling moeten de volgende principes volgen...	Toute formation continue sur la maltraitance des personnes âgées devrait suivre les principes suivants...						
• passen binnen een gemeenschappelijk project tussen zorgverleners en hun directie	• s'inscrire dans un projet commun entre les prestataires et leur direction	86.67% (n=26) Feasible 69.23%	Not feasible 3.85%	Blanco 26.92%	13.33% (n= 4) Feasible 25%	Not feasible 50%	Blanco 25%
• ondersteund worden met logistieke middelen om hetgeen geleerd werd in de praktijk om te zetten	• être suivie de moyens logistiques permettant la mise en oeuvre des apprentissages	100% (n=29) Feasible 72.41%	Not feasible 10.34%	Blanco 17.24%	0% (n= 0)		
• een multidisciplinair (artsen, verpleegkundigen, maatschappelijk werkers, managers, ...) en multisectoraal (politiebeambte, vrederechter, ambulancier, zorgkundige, ...) publiek samenbrengen	• réunir un public multidisciplinaire (médecins, infirmières, assistantes sociales, managers, ...) voire multisectoriel (policiers, gardiens de la paix, ambulanciers, assistants sociaux, aides-soignants, …)	100% (n=31) Feasible 74.19%	Not feasible 9.68%	Blanco 16.13%	0% (n= 0)		
• combineren van online tools, workshops en omkadering binnen de praktijk (supervisie op het terrein)	• combiner outils en ligne, ateliers de mise en situation et encadrement pratique (supervision sur le terrain)	100% (n=29) Feasible 72.41%	Not feasible 10.34%	Blanco 17.24%	0% (n= 0)		

• gegeven worden door een externe lesgever (de referentiepersoon van de geografische zone) op de werkplek	• être donnée par un formateur extérieur (personne référente de la zone géographique) sur le lieu de travail	90.63% (n=29) Feasible 65.52%	Not feasible 6.9%	Blanco 27.59%	9.38% (n= 3) Feasible 33.33%	Not feasible 33.33%	Blanco 33.33%
• gratis zijn via een financiering door de bevoegde overheden	• être gratuite suite à un financement par les autorités compétentes	93.33% (n=28) Feasible 53.57%	Not feasible 14.29%	Blanco 32.14%	6.67% (n=2) Feasible 0%	Not feasible 100%	Blanco 0%

Appendix 67.6. Awareness

Table 88 – Aims of awareness

Statements		Acceptable			Not acceptable		
Sensibiliseringscampagnes moeten...	Les campagnes de sensitization devraient...						
• het fenomeen van mis(be)handeling en leeftijdsdiscriminatie aankaarten	• aborder le phénomène de maltraitance et aussi l'âgisme	100% (n=29) Feasible 86.21%	Not feasible 0%	Blanco 13.79%	0% (n=0)		
• toelaten om mis(be)handeling en de aanpak ervan beter te kunnen inschatten	• permettre de mieux identifier les situations de maltraitance et de mieux connaitre les actions à mettre en oeuvre	100% (n=31) Feasible 80.65%	Not feasible 0%	Blanco 19.35%	0% (n=0)		
• uitleggen wat de verschillen in aanpak zijn tussen de gespecialiseerde organisaties en bij justitie (gericht op bemiddeling en/of bestraffing)	• expliquer quels sont les types de prise en charge proposés par les organisations spécialisées (interventions psycho-sociales) et la justice (réparatrice et/ou punitive)	87.88% (n=29) Feasible 72.41%	Not feasible	Blanco 24.14%	12.12% (n=4) Feasible 25%	Not feasible	Blanco 25%

				3.45%			50%
• informatie geven over het centrale contactpunt	• donner des informations sur le point de contact centralisé	93.75% (n=30) Feasible 76.67%	Not feasible 0%	Blanco 23.33%	6.25% (n=2) Feasible 0%	Not feasible 50%	Blanco 50%
• informeren over de noodzaak tot multidisciplinair en intersectoraal overleg bij de meerderheid van de gevallen van (vermoeden van) mis(be)handeling	• informer de la nécessité de mener des concertations multidisciplinaires et intersectorielles dans la majorité des cas de maltraitance avérée ou suspectée	86.67% (n=26) Feasible 73.08%	Not feasible 3.85%	Blanco 23.08%	13.33% (n=4) Feasible 25%	Not feasible 50%	Blanco 25%

Table 89 – Target public for awareness campaigns

Statements		Acceptable			Not acceptable		
Sensibiliseringscampagnes moeten zich richten tot...	Les campagnes de sensitization devraient cibler...						
• de beleidsmakers, die er een prioriteit van moeten maken	• les politiques, qui doivent en faire une priorité	83.33% (n=25) Feasible 64%	Not feasible 16%	Blanco 20%	16.67% (n=5) Feasible 0%	Not feasible 80%	Blanco 20%
• de professionals van het terrein zodat zij voortdurend herinnerd worden aan wat ze in de voortgezette opleidingen hebben gezien	• les professionnels de terrain afin d'entretenir les éléments acquis lors des formations continues	100% (n=31) Feasible 80.65%	Not feasible 3.23%	Blanco 16.13%	0% (n=0)		
• het brede publiek, om situaties van mis(be)handeling beter te kunnen inschatten en beter op de hoogte te zijn van de verschillen in aanpak	• le grand public afin de mieux identifier les situations de maltraitance et de prendre connaissance des différents types de prise en charge	96.77% (n=30) Feasible 66.67%	Not feasible 16.67%	Blanco 16.67%	3.23% (n=1) Feasible 0%	Not feasible 0%	Blanco 100%

• het jonge publiek in de scholen, om de maatschappelijke kijk op ouderen te verbeteren	• le jeune public, dans les écoles, afin d'améliorer la vision sociétale de la personne âgée	83.87% (n=26) Feasible 76.92%	Not feasible 0%	Blanco 23.08%	16.13% (n=5) Feasible 0%	Not feasible 80%	Blanco 20%

Table 90 – Types of awareness

Statements		Acceptable			Not acceptable		
De sensibilisering rond mis(be)handeling en de strijd ertegen moet worden ondersteund door...	La sensitization au phénomène de maltraitance et la lutte contre celui-ci devraient être soutenues par...						
• de thematiek in de volgende versie van het nationaal plan tegen alle vormen van gender-gerelateerd geweld op te nemen	• l'inclusion de cette thématique dans la prochaine version du plan national de lutte contre toutes les formes de violence basées sur le genre	77.78% (n=21) Feasible 80.95%	Not feasible 0%	Blanco 19.05%	22.22% (n=6) Feasible 16.67%	Not feasible 16.67%	Blanco 66.67%
• het uitdrukkelijk te vermelden als een deel van het nationaal veiligheidsplan (en niet indirect als onderdeel van intrafamiliaal geweld)	• sa mention explicite comme sujet à part entière dans le plan national de sécurité (et non pas implicitement dans les cas de violence intra-familiale)	88.89% (n=24) Feasible 70.83%	Not feasible 4.17%	Blanco 25%	11.11% (n=3) Feasible 0%	Not feasible 33.33%	Blanco 66.67%
• de financiering van televisiecampagnes op regelmatige tijdstippen door de bevoegde overheden	• le financement de campagnes télévisuelles régulières par les autorités compétentes	88.89% (n=24) Feasible 83.33%	Not feasible 0%	Blanco 16.67%	11.11% (n=3) Feasible 0%	Not feasible 33.33%	Blanco 66.67%
• de uitwerking van een preventieplan per zone, door de lokale (overheids- en gerechtelijke) instellingen, de gespecialiseerde organisaties en eerstelijnszones/SISD	• l'établissement d'un plan de prévention zonal élaboré par les autorités locales (administratives et judiciaires), les organisations spécialisées et les SISD/eerstelijnzones	92.59% (n=25) Feasible 76%	Not feasible 4%	Blanco 20%	7.41% (n=2) Feasible 0%	Not feasible 0%	Blanco 100%

Appendix 67.7. Quality of care

Table 91 – Actions for the quality of care

Statements		Acceptable			Not acceptable		
Een groot aantal acties zouden de zorgkwaliteit in de zorg- en hulpverlening voor ouderen verbeteren, namelijk...	De nombreuses actions permettraient d'améliorer la qualité des soins dans les structures de soins et d'aide aux personnes âgées						
• aan de accreditatienormen criteria rond levenskwaliteit toevoegen	• Compléter les normes d'agrément par des critères de qualité de vie	100% (n=26) Feasible 73.08%	Not feasible 3.85%	Blanco 23.08%	0% (n=0)		
• controle op de naleving van de normen tijdens onaangekondigde bezoeken	• Contrôler le respect des normes lors de visites inopinées	80.77% (n=21) Feasible 66.67%	Not feasible 0%	Blanco 33.33%	19.23% (n=5) Feasible 0%	Not feasible 40%	Blanco 60%
• het openbaar maken van de resultaten van de controlebezoeken	• Rendre publics les résultats des visites de contrôle	66.67% (n=16) Feasible 56.25%	Not feasible 12.50%	Blanco 31.25%	33.33% (n=8) Feasible 0%	Not feasible 37.5%	Blanco 62.5%
• het verplichten van de rapportage van indicatoren rond het risico op mis(be)handeling (personeelsverloop, arbeidsongeschiktheid van het personeel, ongewenste voorvallen bij ouderen of hun familie, zelfmoordpogingen, enz.)	• Rendre obligatoire la notification d'indicateurs de risque de maltraitance (turnover du personnel, incapacités de travail du personnel, évènements indésirables impliquant une personne âgée ou sa famille, tentatives de suicide, ...)	83.33% (n=20) Feasible 65%	Not feasible 5%	Blanco 30%	16.67% (n=4) Feasible 0%	Not feasible 0%	Blanco 100%
• het meten van de tevredenheid van ouderen	• Mesurer la satisfaction des personnes âgées	92.86% (n=26) Feasible	Not feasible	Blanco	7.14% (n=2) Feasible	Not feasible	Blanco

		65.38%	11.54%	23.08%	0%	0%	100%
• het opzetten van een "rugzak"-financieringssysteem waarbij elke oudere zijn of haar eigen budget voor zorg- en hulpverlening beheert	• Instaurer un système de financement 'sac-à-dos' où chaque personne âgée gèrerait son budget dédié aux soins et à l'aide	70.59% (n=12) Feasible 41.67%	Not feasible 8.33%	Blanco 50%	29.41% (n=5) Feasible 0%	Not feasible 100%	Blanco 0%
• het opnemen van verbeteringen van onafhankelijkheid en autonomie van de oudere in de criteria voor financiering	• Inclure dans les critères de financement les améliorations acquises par la personne âgée en termes d'indépendance et d'autonomie	86.96% (n=20) Feasible 50%	Not feasible 20%	Blanco 30%	13.04% (n=3) Feasible 0%	Not feasible 66.67%	Blanco 33.33%
• het invoeren van een leercultuur, zoals in de ziekenhuizen, waar er een intern systeem van overleg wordt opgezet, om fouten te bespreken	• Instaurer, comme dans les hôpitaux, une culture de l'apprentissage à partir des erreurs en développant en interne un système de discussion autour des évènements indésirables	95.55% (n=28) Feasible 64.29%	Not feasible 3.57%	Blanco 32.14%	3.45% (n=1) Feasible 0%	Not feasible 100%	Blanco 0%
• het uitwerken en opvolgen van praktijkrichtlijnen rond (farmacologische en fysieke) fixatiemaatregelen	• Elaborer et suivre des guides de bonnes pratiques concernant la contention physique et chimique	100% (n=29) Feasible 72.41%	Not feasible 0%	Blanco 27.59%	0% (n=0)		
• het koppelen van elke opleiding van het personeel rond mis(be)handeling aan organisatorische maatregelen, ondersteund door de directie	• Associer toute formation du personnel concernant la maltraitance à des mesures de changement du fonctionnement interne soutenues par la direction	100% (n=28) Feasible 71.43%	Not feasible 3.57%	Blanco 25%	0% (n=)		
• het opstellen van een charter van goede praktijk, dat een positieve boodschap brengt en waarbij het personeel betrokken wordt, om de naleving van dit charter te verbeteren	• Rédiger une charte de bientraitance véhiculant un message positif en impliquant le personnel, afin d'améliorer l'adhésion aux messages qu'elle porte	92.86% (n=26) Feasible 76.92%	Not feasible 0%	Blanco 23.08%	7.14% (n=2) Feasible 0%	Not feasible 100%	Blanco 0%
• het koppelen van het opstellen van een kwaliteitshandboek aan organisatorische	• Associer l'élaboration d'une charte de qualité à des mesures pratiques soutenues	96.67% (n=29)			3.33% (n=1)		

	maatregelen, die ondersteund worden door de directie voor de uitwerking ervan	par la direction et permettant sa mise en oeuvre	Feasible 72.41%	Not feasible 3.45%	Blanco 24.14%	Feasible 0%	Not feasible 100%	Blanco 0%
•	het openlijk bespreken van gevallen van mis(be)handeling binnen de equipe en met de oudere en zijn entourage	• Discuter ouvertement des situations maltraitantes en équipe et avec la personne âgée et son entourage	100% (n=28) Feasible 71.43%	Not feasible 3.57%	Blanco 25%	0% (n=0)		

Table 92 – Support for informal caregivers

Statements		Acceptable			Not acceptable		
De overheden moeten investeren in het ondersteunen van de mantelzorgers. De Scandinavische modellen kunnen hiervoor model staan.	Les autorités devraient investir davantage dans le soutien des aidants. Les modèles scandinaves pourraient servir d'exemple à cet égard.	100% (n=28) Feasible 75%	Not feasible 3.57%	Blanco 21.43%	0% (n=0)		
Het beroep van zorgkundige en verpleegkundige moet sterk geherwaardeerd worden en veel aantrekkelijker worden gemaakt	Les professions d'aide-soignant et d'infirmier devraient être fortement revalorisées et rendues beaucoup plus attractives pour les personnes ayant la vocation de prendre soin	100% (n=32) Feasible 71.88%	Not feasible 6.25%	Blanco 21.88%	0% (n=0)		

Appendix 67.8. Detection tools

Table 93 – Detection tools

Statements		Acceptable			Not acceptable		
Professionals in de zorg en hulpverlening moeten over detectietools kunnen beschikken om hen te helpen een beslissing te nemen bij een vermoeden van ouderenmis(be)handeling	Les professionnels du secteur des soins et de l'aide sociale devraient disposer d'outils de détection pour les aider à prendre une décision en cas de suspicion de maltraitance envers une personne âgée	100% (n=32) Feasible 81.25%	Not feasible 3.13%	Blanco 15.63%	0% (n=0)		
De detectie van ouderenmis(be)handeling kan in twee stappen gebeuren: 1/ beoordelen of er sprake is van dreigend gevaar en, 2/ indien er geen dreigend gevaar is, de evaluatie vervolledigen, zodat de professional voldoende elementen heeft voor een teamgesprek en multidisciplinaire besluitvorming	La détection des situations de maltraitance pourrait être réalisée en deux étapes: 1/ évaluer s'il y a danger imminent et, 2/ s'il n'y a pas danger imminent, compléter l'évaluation afin de permettre au professionnel d'avoir suffisamment d'éléments pour alimenter une discussion en équipe et une prise de décision pluridisciplinaire.	100% (n=32) Feasible 81.25%	Not feasible 3.13%	Blanco 15.63%	0% (n=0)		
Een "toolbox" met de verschillende detectietools die in de literatuur worden beschreven, en die betrekking hebben op alle soorten van ouderenmis(be)handeling, moet beschikbaar zijn voor alle professionals van de zorg- en hulpverlening	Une 'boîte à outils' reprenant les différents outils de détection décrits dans la littérature et concernant tous les types de maltraitance devrait être à disposition de tous les professionnels du secteur des soins et de l'aide sociale	96.77% (n=30) Feasible 80%	Not feasible 3.33%	Blanco 16.67%	3.23% (n=1) Feasible 100%	Not feasible 0%	Blanco 0%
Elke oudere met meerdere risicofactoren voor mis(be)handeling (cognitieve achteruitgang van de oudere, emotionele instabiliteit van de hoofdverzorger, enz.) moet systematisch uitgebreid geëvalueerd worden	Toute personne âgée présentant plusieurs facteurs de risque de maltraitance (déclin cognitif de la victime, instabilité émotionnelle de l'aidant principal, ...) devrait systématiquement faire l'objet d'une évaluation complète	86.67% (n=26) Feasible 61.54%	Not feasible 19.23%	Blanco 19.23%	13.33% (n=4) Feasible 0%	Not feasible 0%	Blanco 100%

Appendix 67.9. Reference person

Table 94 – Reference person

Statements		Acceptable			Not acceptable		
De referentiepersoon voor de strijd tegen OMB en tot wie zorgverleners en hulpverleners zich kunnen wenden bij (vermoeden van) ouderenmis(be)handeling moet...	La personne de référence formée à la lutte contre la maltraitance et vers qui les prestataires de soins et d'aide pourraient se tourner en cas de (suspicion de) maltraitance devrait...						
• aanwezig zijn in elke instelling en personeelslid van de instelling zijn	• être présente dans chaque institution et faire partie du personnel	76.67% (n=23)	Feasible 60.87%	Not feasible 21.74% / Blanco 17.39%	23.33% (n=7)	Feasible 14.29%	Not feasible 57.14% / Blanco 28.57%
• afkomstig zijn uit de eerstelijnszones of uit de GDT/SISD	• provenir des zones de première ligne (eerstelijnzone) ou des SISD (service intégré de soin à domicile)	63.64% (n=14)	Feasible 78.57%	Not feasible 0% / Blanco 21.43%	36.36% (n=8)	Feasible 25%	Not feasible 37.50% / Blanco 37.50%
• afkomstig zijn van gespecialiseerde organisaties (CAW, Brussels Meldpunt OMB, VLOCO, Respect Senior, Ecoute Senior, FJC, ...)	• provenir des organisations spécialisées (Respect Seniors, Ecoute Seniors, VLOCO, Brussels Meldpunt Ouderenmis(be)handeling), Centrum voor algemeen welzijn (CAW), FJC, ...)	92.31% (n=24)	Feasible 75%	Not feasible 4.17% / Blanco 20.83%	7.69% (n=2)	Feasible 0%	Not feasible 0% / Blanco 100%

Table 95 – Missions of a reference person

Statements		Acceptable			Not acceptable		
In een afgebakend geografisch gebied, moet de referentiepersoon...	Dans une zone géographique définie, la personne de référence devrait ...						
• permanente vorming geven over ouderenmis(be)handeling	• donner les formations continues concernant la maltraitance des personnes âgées	93.10% (n=27)	Feasible 81.48%	Not feasible 3.70% / Blanco 14.81%	6.90% (n=2)	Feasible 0%	Not feasible 100% / Blanco 0%
• tijdens deze opleidingssessies een persoonlijke band met de zorgverleners tot stand brengen	• établir un lien personnalisé avec les prestataires lors de ces formations	96.43% (n=27)	Feasible 70.37%	Not feasible 14.81% / Blanco 14.81%	3.57% (n=1)	Feasible 0%	Not feasible 100% / Blanco 0%
• intervisies (= bijeenkomsten tussen hulpverleners en zorgprofessionals (en andere relevante sectoren)) organiseren en eraan deelnemen om ervaringen uit te wisselen en samen na te denken over hun professionele houding aan de hand van een case study	• organiser et participer à des intervisions (rencontres entre professionnels de l'aide et du soin (et d'autres secteurs concernés) afin d'échanger leurs expériences et de réfléchir collectivement sur leurs conduites professionnelles au travers d'un cas pratique)	100% (n=30)	Feasible 74.19%	Not feasible 6.45% / Blanco 19.35%	0% (n=0)		
• supervisies/toezicht uitvoeren op zorgverleners op het terrein	• réaliser des supervisions/encadrements des prestataires sur le terrain	82.14% (n=23)	Feasible 60.87%	Not feasible 13.04% / Blanco 26.09%	17.86% (n=5)	Feasible 0%	Not feasible 100% / Blanco 0%
• simulatieworkshops organiseren	• réaliser des ateliers de mise en situation	96.30% (n=26)	Feasible 76.92%	Not feasible 3.85% / Blanco 19.23%	3.70% (n=1)	Feasible 0%	Not feasible 100% / Blanco 0%

• tenminste eenmaal per jaar contacten onderhouden met de relevante actoren in de andere betrokken sectoren (politie, justitie, bewindvoerders, enz.)	• avoir, au moins une fois par an, des contacts avec les acteurs référents des autres secteurs concernés (police, justice pénale, justice de paix, administration de biens, …)	100% (n=30) Feasible 83.33%	Not feasible 3.33%	Blanco 13.33%	0% (n=0)			
• kennis hebben van de wetgeving inzake ouderenmishandeling (regels inzake schuldig verzuim, het beroepsgeheim, enz.)	• avoir des notions sur la législation en lien avec la maltraitance des personnes âgées (obligation d'assistance, lois sur le secret professionnel, ...)	100% (n=31) Feasible 83.87%	Not feasible 3.23%	Blanco 12.90%	0% (n=0)			

Appendix 67.10. Coordination and interaction during the management of elder abuse

Table 96 – Coordination and interaction during the management of elder abuse

Statements		Acceptable			Not acceptable		
Bij het nemen van maatregelen moeten zowel eerstelijnswerkers (hulpverleners en zorgverleners en/of politiebeambten) als tweedelijnswerkers (gespecialiseerde organisaties en/of het Parket) als de oudere en zijn entourage betrokken worden	La planification des interventions durant la prise en charge devrait inclure les intervenants de première ligne (les prestataires d'aide et de soins et/ou les policiers) et de deuxième ligne (les organisations spécialisées et/ou le Parquet) ainsi que la personne âgée et son entourage	80% (n=20) Feasible 85%	Not feasible 5%	Blanco 10%	20% (n=5) Feasible 0%	Not feasible 100%	Blanco 0%
Bij de uitvoering van interventies moet(en) de eerstelijnsprofessional(s), die dicht bij de oudere staat (staan), betrokken worden en/of de zorg- en hulpverlening coördineren	Lors de la mise en place des interventions, le(s) professionnel(s) de première ligne, proche(s) de la personne âgée, devrai(en)t être impliqué(s) et/ou assurer la coordination des soins et de l'aide.	100% (n=27) Feasible 74.07%	Not feasible 3.70%	Blanco 22.22%	0% (n=0)		
Als er ondanks adequate psychosociale zorg (=complex geval), nog problemen zijn, moeten professionals een Family Justice Center (FJC) of een soortgelijke structuur kunnen contacteren, voor een nieuwe risicobeoordeling en een nieuwe intersectorale aanpak.	En cas de difficulté malgré des soins psycho-sociaux adéquats (cas complexes), les professionnels devraient pouvoir contacter un Family Justice Center (FJC) ou une structure similaire afin de bénéficier d'une nouvelle évaluation des risques et d'une nouvelle approche intersectorielle.	100% (n=28) Feasible 78.57%	Not feasible 0%	Blanco 21.43%	0% (n=0)		

APPENDIX 68. ANALYSIS OF THE ONLINE SURVEY

Grands thèmes	Thème	Nombre de commentaires
Procédure de prise en charge	Procédure de prise en charge	6
	Principes généraux de la procédure de prise en charge	11
	Procédure de prise en charge	11
	Etapes de la procédure de prise en charge	12
Point de contact centralisé	Point de contact centralisé	12
	Type de point de contact centralisé	14
	Point de contact centralisé	8
	Si les centres d'appels nationaux et régionaux actuels (1712, 106, 107) deviennent le point de contact centralisé	6
	Si les organismes spécialisés dans la prise en charge psycho-sociale des cas de maltraitance sont le point de contact centralisé	8
Secret professionnel	Secret professionnel	8
Concertation intersectorielle	Type de concertations intersectorielles	4
	Concertations intersectorielles de type Family Justice Center	5
Autonomie décisionnelle	Autonomie décisionnelle des personnes âgées maltraitées	7
	Aspects pratiques inhérents aux situations où la volonté de la personne âgée n'est pas respectée	9
Formation	Formation dans le secteur de la police justice	4
	Formation dans le secteur des soins et de l'aide	6
	Les aspects pratiques dans le secteur des soins et de l'aide	4
	Les principes des formations continues	3
Sensitization	Les objectifs de la sensitization	5
	Le public cible de la sensitization	7
	Les techniques de sensitization	3

Qualité des soins	Les actions visant la qualité des soins	10
	Soutien aux aidants formels et informels	4
Outils de détection	Outils de détection	6
Personne de référence	Personne de référence	5
	Missions de la personne de référence	6
Coordination	Coordination et interactions durant la phase de prise en charge	5

Table 97 – The number of comments analysed per theme.

Procédure de prise en charge	40
Point de contact centralisé	48
Secret professionnel	8
Concertation intersectorielle	9
Autonomie de décision	16
Formation	17
Sensibilisation	15
Qualité des soins	14
Outils de détection	6
Personne de référence	11
Coordination	5

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