Discussing Screening for Elder Abuse at Primary Health Care levels

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Discussing Screening for Elder Abuse at Primary Health Care level

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Based on the MSc dissertation by the same author
under the supervision of Philippa Sully
Interprofessional Practice: Society, Violence and Practice
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Contents

Foreword

Elder Abuse is a violation of Human Rights and a significant cause of injuries, illness, lost productivity, isolation and despair.

"Active Ageing Policy Framework" (WHO, 2002)

In 2000, the Ageing and Life Course Programme (ALC) of the World Health Organization (WHO) in Geneva, Switzerland, identified elder abuse as a priority theme for its activities. It was clear to us that this was a neglected social and health problem that most societies would deny rather than confront. The parallel with domestic violence, child abuse and violence against women some thirty years earlier was evident. Awareness of these societal problems surfaced only once campaigns were organized based on solid evidence. For that, research was crucial – in its absence, denial prevails.

Although back in 2000 a few countries had already started efforts to expose the ugly face of elder abuse, on a global scale little had been done. We then sought financial support from the Government of Japan for a multi-country study and invited the International Network for the Prevention of Elder Abuse (INPEA) as a partner. This resulted in a seminal publication "Missing Voices – views of older persons on elder abuse", a widely quoted reference that reflected in quality the wisdom of its main author, Professor Gerry Bennett – a Giant in the field so much missed by us all.

In October 2002, WHO launched the *World Report on Violence and Health* which devoted a detailed section to elder abuse. A month after, ALC launched the "Toronto Declaration for the Global Prevention of Elder Abuse" in partnership with INPEA, academic institutions and the Ontario Provincial Government. The reference to "Toronto" not only indicated the location where the Declaration was conceived but also acknowledged the groundbreaking work conducted in Ontario under the leadership of Elizabeth Podnieks.

In 2004, ALC invited the Geneva International Academic Network, the University of Geneva and partners from seven additional countries to conduct the "Global Response to Elder Abuse and Neglect through the PHC Sector", capitalizing on pioneering work done in Montreal. Its final report has now been released and can be found on our website: http://www.who.int/ageing/en/

This literature review was initiated by Silvia Perel-Levin while she was a member of the ALC programme and completed as her MSc dissertation at City University, London. Her competent critical appraisal of the literature will no doubt contribute positively to a much-needed debate on this particular dimension of elder abuse.

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This paper is dedicated to the memory of my friend and mentor, Gerry Bennett – a humanistic doctor and advocate of the rights of older people – who, sadly, did not live to enjoy old age.

Executive Summary

This paper presents a critical review of the literature, discusses what is needed in order to advance knowledge by Primary Health Care (PHC) workers about elder abuse and makes recommendations about detection as a first step for the management and prevention of elder abuse.

Reflecting the complexities of elder abuse and the multiple barriers to tackle it, literature from various domains was used to explore current knowledge on elder abuse along with its relationship to other types of violence, especially domestic violence. The conscious and unconscious barriers that prevent health care professionals from detecting and managing abuse and what can be done to overcome these barriers are discussed.

While elder abuse is not a new phenomenon, the speed of population ageing worldwide will lead to its increase in absolute terms unless action is taken to prevent it. Elder abuse has devastating consequences for older persons such as poor quality of life, psychological distress, multiple health problems and increased mortality. Widespread ageist attitudes permeate all aspects of life, acting as a societal background to abuse and discrimination against older persons. Gender aspects of elder abuse are obscured by sexist attitudes at all levels of society. Sexism and ageism together place older women as the most vulnerable to elder abuse.

This review takes into consideration the debate among health care professionals about screening for domestic violence following the lack of recommendations by screening committees in Canada, the United Kingdom of Great Britain and Northern Ireland and the United States of America. Controversies regarding definitions of elder abuse and screening reveal, among other issues, the supremacy of the medical model and evidence-based medicine. This review challenges such supremacy and proposes instead a humanistic model.

Elder abuse is a violation of human rights. PHC has an important role in identifying, managing and preventing its occurrence by increasing the level of patients' trust in their carers. This review argues that by implementing routine screening practice and by consciously working with other services in the community, elder abuse can be prevented or at least, managed properly. Interdisciplinary research and practice that acknowledge the person in context, and are based on trust and effective communication between all parties involved, will go a long way to overcoming barriers to tackling and preventing abuse against older persons in all its forms.

1. Introduction

Older people are the fastest growing segment of the population world-wide *(1, 2)*. Globally, the number of persons aged 60 years or over is expected to almost triple within the next few decades, from 672 million in 2005 to nearly 1.9 billion by 2050 *(2)*. The very old group – aged 80 and over – who are at special risk of being abused, will increase even faster. For example, in the United Kingdom of Great Britain and Northern Ireland, by 2025, the number of people over the age of 80 years is expected to have increased by almost 50% and the number of people over 90 years is expected to have doubled *(3)*. While elder abuse is not a new phenomenon, the speed of population ageing world-wide is likely to lead to an increase in its incidence and prevalence *(4, 5)*. Elder abuse has devastating consequences for older persons such as poor quality of life, psychological distress, and loss of property and security. It is also associated with increased mortality and morbidity *(6)*. Elder abuse is a problem that manifests itself in both rich and poor countries and at all levels of society *(1)*. As such, it demands an orchestrated interdisciplinary response. From a health and social perspective, unless PHC services, legal and social services and other sectors of society are well equipped to identify and deal with the problem, elder abuse will continue to be underdiagnosed and overlooked.

Background

Elder abuse, like other types of interpersonal violence, remained hidden and taboo throughout history. It was after child abuse and domestic violence began to be discussed publicly in the 60s and 70s that elder abuse, which initially was called "granny battering", emerged as a form of family violence *(7-10)*. While the abuse of older people was first described in British scientific journals in 1975 *(11, 12)*, scientific and legal action was, and by large, first developed in the United States of America. In 1990, the first, and to date only, prevalence study on elder abuse was published in the United Kingdom *(13)*. Elder abuse, a very complex issue with diverse definitions and names, has been very slow to capture the public eye and public policy. Since it is manifested at many levels (physical, psychological, legal, social), it requires the involvement of different types of professionals.

Information on the prevalence of elder abuse is based on a small number of population-based studies that have been conducted in developed countries. These studies suggest that between 4% and 6% of older persons have experienced some form of abuse in the home. Older persons are also at risk of abuse in institutions such as hospitals, nursing homes and other long-term care facilities, but no large scale measuring studies are available *(7, 10)*.

A panel to review the risk and prevalence of elder abuse, commissioned by the National Research Council in the United States *(14)*, stressed many weaknesses in current research on elder abuse such as a lack of sound theoretical frameworks, unclear and

inconsistent definitions and measures and a lack of population-based data. Among the many factors accounting for deficiencies, the panel pointed out little funding and few researchers, methodological and ethical uncertainties, and divergent research traditions in the fields of gerontology and family violence.

Participants in a multi-country study on the views and perceptions of older persons and PHC workers on elder abuse, recommended that PHC workers are assisted in recognising signs of abuse among older persons *(7)*.

The 2004 report of the United Kingdom House of Commons Health Committee estimated that at least half a million older persons suffer abuse in the United Kingdom and acknowledged that elder abuse remains a hidden issue. The Health Committee showed concern at the lack of training on elder abuse for nurses and care workers and called for the identification of abuse of older persons and other vulnerable adults and for interventions to be included in the nursing curriculum (15). For many years, professional associations have recommended routine screening and the adoption of standardised protocols for the identification of and interventions on family violence (16–19). However, while screening in paediatric settings is widely accepted, equivalent practice focusing on the adult population has not been adopted widely and has never been evaluated properly.

The Canadian Task Force on Preventive Health Care stated in 2003 that there was insufficient evidence to recommend for or against routine universal screening for violence against women *(20, 21)*. The United Kingdom National Screening Committee decided early in 2004, based on a report by Ramsay et al. *(22, 23)*, that screening adults for domestic violence should not be introduced as a routine practice *(24)*. In the same year, the United States Preventive Services Task Force *(25, 26)* stated that it could not find enough evidence to determine the balance between the benefit and harm of screening for family and intimate partner violence among children, women and older adults and therefore did not recommend one way or the other.

There is currently a heated debate among health professionals around the issue of screening for family violence, including elder abuse. A review of existing tools and a critical appraisal of the different barriers and views may facilitate the introduction of detection and intervention strategies at the PHC level.

Within the PHC context, elder abuse can be first identified – or ignored altogether. PHC workers are in an ideal position to recognize, manage and help prevent elder abuse and neglect *(5, 10, 27)*. However, most of them do not diagnose it, as it is not part of their formal training and does not appear in their list of diagnoses *(10)*. PHC, legal and social services are ill-equipped to identify and deal with the problem. Although awareness of the problem has increased in the past few years, elder abuse continues to be underdiagnosed and overlooked.

A critical review of the literature

In this critical review, current knowledge as well as practice on elder abuse recognition by PHC workers are explored with an emphasis on its relationship to domestic violence. Current debates over screening tools looking at the principle of "benefit versus harm" invariably leads to an exploration of the many barriers to screening. Definitions of elder abuse and screening and theoretical frameworks that underpin work on elder abuse are discussed, and how these relate to the screening debate and the relevance of interdisciplinary work are explored. Furthermore, the relationship between elder abuse and gender and issues related to the capacity building of PHC workers are presented. The aims of this discussion paper are:

- to raise awareness about the issues and debates around screening older patients for elder abuse;
- to identify what research and training are needed in order to advance knowledge among PHC workers about elder abuse;
- to make recommendations to researchers, practitioners and policy-makers for the detection, management and prevention of elder abuse towards policy development.

Literature review questions

A breakdown into various components and questions is required in order to analyse the complexities involved in elder abuse and to explore how the different issues interrelate. The following questions are explored through a critical exposition of the literature.

- What is elder abuse?
- What is screening?
- What are the main barriers among health care professionals to detect and manage elder abuse and what can be done to overcome them?
- What are the commonalities and differences with regard to screening for elder abuse and domestic violence?
- How can the evidence gathered from the literature inform the development of sound policy and practice for the detection and management of elder abuse?

Search strategy: inclusion and exclusion criteria

Given the wide implications of elder abuse and domestic violence, the different fields of study and stakeholders involved, several searches were performed as issues emerged from the literature. The initial search was performed in the electronic databases Medline, CINAHL, AgeLine, PsycINFO and PubMed. Additional handsearches of selected journals, books and web sites of governmental, intergovernmental, academic and civil society organisations were conducted. Finally, many references were identified through reference lists from previously selected publications, personal recommendations by colleagues or teachers and general internet searches through Google.

The key words used were: "elder abuse", "elder mistreatment", "abuse of the elderly", "violence against the elderly", "domestic violence screening", "violence against women", "ageing women", "domestic violence and older women", "screening tools", "elder abuse detection tools" and "rights of older persons". Also, the following combinations of key words were used: "elder abuse + screening", "elder mistreatment + screening". The search was limited to the years 1995–2005. However, due to the paucity of primary research on elder abuse, a number of significant publications before 1995 were also included.

The literature selected for the analysis was drawn from primary research studies (both qualitative and quantitative), study reviews, scientific and professional journal editorial and opinion articles, policy reports and specialized books published in English, mainly from Canada, the United Kingdom and the United States. Some studies from Australia and South Africa were also included. Reflecting the ecological theory underpinning this paper, flexibility was applied regarding the fields of the studies to be included, and their methodologies, as long as they were relevant to the issues of elder abuse in domestic settings, the right for health of older persons, screening tools for elder abuse, barriers to detection of elder abuse and domestic violence and significant contributions to practice, including interprofessional practice. As most, if not all, literature and debate on screening barriers concentrate on domestic violence it was crucial to include studies from that field in order to analyse the implications for elder abuse.

Although elder abuse in institutional settings such as nursing homes, long-term care institutions, hospices and hospitals is believed to be highly prevalent, it has not been included in this review. This in no way implies that it is less important. On the contrary, it requires specific and detailed attention. The focus on domestic settings and PHC reflects the fact that despite scandalous stories depicted often in the media about institutions, the majority of older persons are independent, are living in the community and can be victims of elder abuse anywhere, principally in their own homes. Studies conducted in emergency departments were included only if they related to screening procedures and attitudes.

Literature on child abuse was excluded, except when being compared to elder abuse. The same applies to literature on abuse of

pregnant women and adolescents. However, while studies on antenatal care were excluded, studies of perceptions and attitudes of health care professionals and women on screening at gynaecological and antenatal settings were included, because the processes are similar and because the majority of studies on screening for intimate partner and sexual abuse are conducted in those settings. More importantly, it reflects the fact that older women may also be victims of sexual abuse and may independently also see gynaecologists who in fact can fulfil the function of first point of contact like emergency departments, for women of any age.

Methodology for analysis

A content analysis was performed. Because of the variety of types of source, the main objective of the content analysis was to identify major and recurrent themes related to the aims and questions of the study. Through the reading, new themes were identified and evaluated. Because of the paucity of primary research on elder abuse outside the United States, such themes that emerged from the reading seemed appropriate to be discussed critically as they explain the lack of focus on elder abuse in primary research while still looking at the "big picture".

2. Elder Abuse

Definitions

There is controversy around the term "elder abuse". Other terms often used include "elder mistreatment" and "inadequate care of the elderly". Consequently, there is no consensus as to how to define elder abuse. Lack of agreed definitions reflects the different theories on which elder abuse definitions and interventions have been based over the past 25 years *(4, 28)*. The United Kingdom's Department of Health document *No secrets (29)* defines abuse as "a violation of an individual's human and civil rights by any other person or persons". *No secrets* does not relate specifically to elder abuse but concerns all vulnerable adults.

The United Kingdom's Action on Elder Abuse developed a definition subsequently adopted by International Network for the Prevention of Elder Abuse and used by the World Health Organization (WHO) *(7, 10, 30)*: "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". It is important to note that elder abuse in this definition excludes random acts of violence or criminal behaviour against older people. The harm of elder abuse overlaps with, but is not necessarily synonymous with, criminal acts *(31)*. A trusting relationship between the abused and the abuser – such as partners, children, in-laws, grandchildren, nurses, social workers and home helps – is at the heart of the issue. Such a relationship may be formal or informal, undertaken voluntarily or imposed by a legal or social custom. Elder abuse is seen as a betrayal of trust *(14)*.

Although there is no consensus on a definition, most literature so far attributes to elder abuse five types or categories: physical, psychological/emotional, financial, sexual, and neglect *(7, 8, 10, 32–35)*, as shown in Table 1. Some literature also includes as a category *Violation of rights*, denying an older person rights conferred on her/him by law or legal process *(34)*. Each type of abuse may occur singly or in combination, and in a range of settings, such as people's own homes, where the vast majority of older people live, day centres, hospitals and nursing homes *(29, 31)*.

The definitions and categories described have been developed by health or social care professionals in the United Kingdom and United States. But definitions require a cultural context. For example, in some traditional societies, older widows can be subject to cruel practices such as abandonment, sequestration of property, sexual violence, forced marriages, accusations of witchcraft and ejection from their homes. These acts of violence, customs embedded in the social structure, need to be considered in the broad context of elder abuse and a human-rights approach *(7)*.

In addition, older people's perceptions are crucial in defining abuse, its identification and interventions. In the study by WHO/International Network for the Prevention of Elder Abuse *(7)*, older persons classify abuse

under three broad categories:

- neglect, including isolation, abandonment and social exclusion;
- violation of human, legal and medical rights;
- deprivation of choices, decision, status, finances and respect.

Types of abuse	Characteristics	Examples
Physical abuse	The infliction of pain or injury	Slapping, hitting, kicking, force-feeding, restraint, striking with objects
Psychological / emotional abuse	The infliction of mental anguish	Verbal aggression or threat, threats of institutionalization, social isolation, humiliating statements
Financial / material abuse	The illegal or improper exploitation and/or use of funds or resources	Theft of cheques or money, coercion to deprive the older person of his or her assets, such as forcible transfer of property
Sexual abuse	Non-consensual contact of any kind with an older person	Suggestive talk, forced sexual activity, touching, fondling with a non-consenting competent or incompetent person
Neglect	Intentional or unintentional refusal or failure of designated caregiver to meet needs required for older person's well-being	Failure to provide adequate food, clothing, shelter, medical care, hygiene or social stimulation

Table 1: Types of elder abuse

What is "old"?

Different age cut-offs are used in different parts of the world to define an older person. In North America and Europe, generally the cut-off age is 65 years. However, retirement ages vary in these regions too. In some societies, it is a function of becoming a grandparent, or the degree of disability or dependence and not the chronological age that makes a person old. The United Nations standard to describe older people is 60 years *(1)*. As people live longer and fewer babies are born, the oldest-old (people aged 80 years or over) are the fastest-growing segment of the world population and are expected to increase in number worldwide from 86 million in 2005 to 394 million in 2050 *(2)*. They often become more vulnerable and/or frail, as a range of health problems such as stroke and dementia become more prevalent

at very old ages *(3)*. Furthermore, in societies where youth is glamorized and glorified, older people become vulnerable to social exclusion.

Theoretical models of elder abuse

Several broad theoretical models have been drawn from psychology, sociology, feminism and the fields of child abuse and domestic violence in attempts by researchers to explain the causes of elder abuse *(28, 32, 35-38)*:

- *Situational theory* claims that an overburdened and stressed caregiver creates an environment for abuse.
- *Exchange theory* addresses reciprocity and dependence between the abused and the perpetrator. It suggests that abuse can occur within a framework of tactics and responses in family life.
- *Intra-individual dynamics (psychopathology) theory* claims a correlation between a mentally or emotionally disturbed abuser and abuse.
- *Intergenerational transmission or social learning theory* states that an adult's behaviour relates to learned behaviour as a child, thus reverting to the same pattern in adulthood.
- *Feminist theory* is based on domestic violence models, highlighting the imbalance of power within relationships and how men use violence as a way to demonstrate power.
- *Political economic theories* have criticised the emphasis on individualistic theories, claiming that structural forces and the marginalisation of elders within society have created conditions that lead to conflict and violence.

It has become apparent that no single model or theory can explain such a complex issue as elder abuse as research has never been able to validate them *(14, 31, 32)*. In response to the inadequacy of any single model and in order to accommodate the multiplicity and complexity of factors associated with elder abuse, researchers have turned to the *ecological model (32, 39, 40)* in line with child abuse, youth violence and intimate partner violence *(41)*.

The ecological model explores the interactions between the individual and contextual factors. It considers violence as the result of the complex interplay between the person's individual characteristics (i.e. biology, personal history), close interpersonal relationships, characteristics of the community in which the person lives or works and societal factors such as policies and social norms. The ecological model allows elder abuse to be linked to broader social issues.

Single theories that focus on caregiver stress reflect the fact that elder abuse has been defined and conceptualized mostly by professionals who deal with frail and vulnerable populations *(28, 42)*. Gender issues often become obscured. The focus on the "caring" fixes the attention on vulnerability related to age rather than on the context of family violence or the wider contexts of sexism and ageism – the discrimination and stigmatization of older people. McCreadie *(31)* claims that rigour is needed in the language in order to clarify what is understood by "care" and "vulnerability", that "carer" should not be used as an euphemism for abuser and that we should not confuse "caring" with co-residence. As for vulnerability, McCreadie *(31)* reminds us that people who are vulnerable are not necessarily at risk and that those at risk are not necessarily vulnerable.

Theories of elder abuse and research need to focus on the extent of ageism, marginalization and sexism in society and their impact on abuse. Elder-abuse theories have for a long time ignored the views and perceptions of older persons themselves. Research increasingly includes older persons in designs of studies through participative and action research *(43)*, or by gathering views and perceptions of older persons on their health needs and services *(3)*, on the needs and perceptions of elders of minority ethnic groups *(44–47)* and on possible interventions *(7, 48)*. However, the development of such research is slow, sporadic and small-scale, requiring an urgent and ongoing effort to correct such a situation *(49)*, which has a clear impact on the development of practice. Development of interprofessional theory that takes into account the interaction between the different levels of the ecological model may

help in understanding the complexities of elder abuse and allow appropriate action to be taken.

Elder abuse and family violence

Along with discrepancies regarding definitions, terminology and causes of elder abuse, there are controversies around which field elder abuse properly belongs to. Should elder abuse really be treated as a separate entity, or is it a branch of family violence, like child abuse and domestic violence? Similarities and differences with both child abuse and domestic violence are apparent both in the attitudes of the researchers and in public policies and services.

Elder abuse is similar to and yet different from other types of family violence, and sufficient evidence suggests that a separate field of study is appropriate. However, this does not mean that elder abuse should be studied in isolation. Age alone does not define elder abuse. If, for example, a woman is a victim of intimate partner violence, just because she is over 65 years old does not constitute a case of elder abuse *(14)*. Older women may in fact experience abuse at the hands of their partners throughout life. But as Dyer, Connolly & McFeeley *(50)* point out, whereas children and younger victims of domestic violence are generally healthy and not expected to die, older people, who may be suffering additional health problems, are more vulnerable to death caused by abuse. Nevertheless, when an older person dies, the cause of death is often not analysed as carefully as the death of a younger person.

Victims of abuse share similar characteristics, such as fear of retaliation and stigmatization, desire not to leave home or desire to protect the abuser, emotional distress and, in cases involving persons with diminished capacity, difficulties in communicating the abuse. As violence has serious and similar consequences for human beings, both the abused and the abuser, it is natural that the fields of study are compared. However, despite the similarities across the life-course, there are profound differences of approach as to what kinds of interventions are appropriate and what services are available for the different groups *(32, 51, 52)*. These differences need to be seen at each level of the ecological model, and especially in the interaction between them. The social situation of older persons is very different from that of children and younger women. Whereas higher numbers of women are abused at any age, older frail men are at much higher risk of abuse than younger men.

Often, a paternalistic approach comparing elder abuse to child abuse places the emphasis of the response on protection by social services. But older persons, even the frailest and in need of protection services, are adults with a long life experience. To infantilize their situation is considered by older persons as abuse *(7)*. Earlier literature (as cited by Bennet et al. *(32)*) views the development of a separate field for elder abuse as ageist, as it separates older people from other adult citizens. On the other hand, some professionals claim that specific characteristics of old age require separate, specialized services *(51)*. In addition, organizations that represent older people advocate for policies and services that are specific to their needs *(53)*, in response to the ageist attitudes of the general services and of society in general. Therefore, while older persons are adults, the discrimination and specific forms of abuse they suffer require specific understanding and responses justifying a separate field of study. In practice, however, at the PHC level, the detection of abuse and interventions and/or referrals, at most ages, is generally at the hands of the same professionals who are in need of specific training to deal with elder abuse. Today, interventions and protocols for child abuse are much more defined than those for domestic violence and elder abuse *(54, 55)*. Consequently, practitioners may feel that their intervention is undermined because of lack of clear policies and effective interagency liaison *(54)*. As research on screening tools for elder abuse is currently very limited, an understanding of the debate and attitudes on screening tools for domestic violence may inform practice and research on elder abuse.

Elder abuse and gender

The gender aspects of elder abuse and the overlaps with domestic violence in particular necessitate a deeper discussion. Women live longer than men almost everywhere. In 2002, there were 678 men for every 1000 women aged 60 years and over in Europe. At age 80 years and over, the world average was below 600 men for every 1000 women, while in developed countries women aged 80 years and over outnumbered men by more than two to one *(1)*.

Although women have the advantage of longevity, they are more likely than men to experience domestic violence and discrimination in access to basic services, such as education, health care and social security, resulting in a cumulative status of ill-health, which, due to women's second-class status, is often neglected or ignored *(1)*. Therefore, it is critical to analyse the abuse of older women not only within the context of population numbers where women outnumber men but also in the context of a life-course of discrimination, oppression and abuse.

Older women victims of domestic violence mostly fall between the cracks as generally they are overlooked by both the domestic violence and older people's services *(56–58)*. Programmes for victims of domestic violence generally serve women under 50 years, while geriatric medicine and adult protection services have focused primarily on the frail and most vulnerable. Although both domestic violence and elder abuse research would be expected to cover the abuse of older women, researchers often exclude these victims from their target populations *(56, 59)*, reinforcing the perception of older women as frail and sexless. But many of the risk factors present in abusive couple relationships are the same regardless of age, and the majority of reported abuse among older couples had in fact been going on for many years *(60, 61)*.

The term "elder abuse" is gender-neutral, obscuring the fact that the majority of abused elders are women and offenders are usually, although not exclusively, men *(8, 56, 62–64)*. Past studies have shown older men to be equally at risk *(51)*, but currently these are in the minority. Men appear more likely than women to abuse *(8, 64)*, and an incidence study conducted in the United States reported that older women were more likely to be the victims of all categories of abuse, except for abandonment *(65)*. Studies comparing intimate partner violence in later life to parent abuse show that partners are more likely than adult children to physically abuse, whereas adult children are more likely than partners to abuse financially *(63, 66)*. Thus, "engendering" the study and interventions on elder abuse is imperative.

Some writers remind us of the different origins of the fields: the domestic violence movement grew out of grass-roots feminist organizations in the United States, whereas elder abuse grew out of the professional concerns of health and social services *(32, 50, 56, 57, 64, 67)*. These separate origins of the movements are often used to explain why elder abuse has traditionally been related more closely with issues of caregiving for frail and dependent older persons. However, research does not support caregiver stress, or dependence, as primary causes of abuse *(56, 68)*. In fact, in many cases, the dynamics of power and control appear to be similar to those experienced by younger abused women *(59, 69, 70)*. It has been proposed that elder abuse should be examined more closely in the framework of power within gender relations and the oppression of women in society, rather than within the framework of age and family relations *(71)*, in line with feminist theories. But older women have suffered double discrimination: on the one hand, the feminist movement has for too long excluded older women from their cause and has been accused of being ageist *(67)*, and on the other hand, it has been claimed that most elder abuse research has been done by men *(72)*.

As with domestic violence against younger women, intervention with older women is very complex *(73)*. A qualitative study of intimate

partner violence among women aged 55 years and over *(74)* describes why women remain in abusive relationships. The reasons are the same as for younger women, but magnified as a result of ageing, generational cohort, historical and cultural reasons. Leaving the partner may not be an option for older women: they do not find support groups with younger women helpful, as they have different life experiences, and shelters filled with children and/or not adapted to some older women's special needs may result in older women returning to their abusers.

Placing elder abuse only within the context of inadequate care not only obscures the problem of domestic violence *(56)* but also raises concerns about the degree of "compassion" with the caregiver approach *(75)*. By understanding how difficult and stressful it is to look after a frail and dependent relative, one is at risk of overidentification with the "caregiver" while leaving the abused at risk, a situation that mirrors identification with a male-dominated patriarchal society, where the safety and needs of women are overlooked.

Gender and care cannot be seen in isolation and need to be analysed within the ecological model in order to avoid single or biased interpretations and to make sure that all older women, whether they are independent or dependent, physically and mentally able or impaired, are cared for. A truthful rights-based analysis of the gender aspects will also have to consider the instances in which older men are abused and in which women are also abusers *(8, 32, 76)*.

A human rights approach

At the very core of abuse are fundamental loss of respect and deprivation of basic human rights as set out in the Universal Declaration of Human Rights in 1948, consequent international treaties and national human rights acts. Recognizing abuse as a human-rights problem focuses attention on governments' legal obligations to comply with signed treaties *(77)*. The prevention of elder abuse is part of governments' responsibilities to care for all people in their respective societies *(7)*. For example, a qualitative study in the United Kingdom exploring older people's perspectives on dignity reveals that older people are being treated in undignified ways. Dignity was described in terms of "identity", "human rights" and "autonomy" *(78)*. Autonomy is the perceived ability to control, cope with and make personal decisions about how one lives on a day-to-day basis, according to one's own rules and preferences *(1)*.

Widespread ageism across all sectors of society, including the health care sector, can be recognized as an important factor both in the cause and in the identification, management and prevention of elder abuse. The United Nations Secretary-General's Report *(79)* prepared for the 2002 United Nations Second World Assembly on Ageing in Madrid acknowledges the role of both sexism and ageism as contributing factors for elder abuse; abuse of older persons is seen within the "broader landscape of poverty, structural inequalities and human rights violations" that disproportionately affects older women worldwide.

The Madrid International Plan of Action on Ageing *(80)* calls for changes in attitudes, policies and practices at all levels and in all sectors in order to ensure that people everywhere are able to age with security and dignity, as citizens with full rights. The Madrid Plan of Action is based on the United Nations Principles for Older Persons adopted in 1991 by the United Nations General Assembly *(81)*. These principles elaborate the rights of older persons in the areas of independence, participation, care, self-fulfilment and dignity. The slogan "To add life to the years that have been added to life" encapsulates the totality of efforts towards a just society for all ages.

During the United Nations Second World Assembly on Ageing in Madrid, WHO launched its policy framework on active ageing *(1)*. The active ageing approach is based on the recognition of human rights and the United Nations Principles of Older Persons. It shifts away from a "needs-based" approach (which

assumes that older people are passive targets) to a "rights-based" approach that recognizes the rights of people to equality of opportunity and treatment in all aspects of life as they grow older. It supports their responsibility to exercise their participation in all aspects of community life.

Although the domains of public health and human rights frequently overlap, effective interventions are hampered by the lack of an active integration of human-rights principles in health care *(77)*. Legal frameworks, health care and social services need to be applied with a strong sense of equity, reinforcing the civil and human rights of all people, regardless of sex, ethnic origin, socioeconomic status and age.

3. Screening

Definitions

The WHO Cancer Programme website *(82)* defines screening as the "*presumptive identification of unrecognized disease or defects by means of tests, examinations, or other procedures that can be applied rapidly*". It also claims that "*the success of screening depends on having sufficient numbers of personnel to perform the screening tests and on the availability of facilities that can undertake subsequent diagnosis, treatment, and follow-up*".

The United Kingdom National Screening Committee *(83)* describes screening as:

> a public health service in which members of a defined population, who do not necessarily perceive they are at risk of, or are already affected by a disease or its complications, are asked a question or offered a test, to identify those individuals who are more likely to be helped than harmed by further tests or treatment to reduce the risk of a disease or its complications.

Screening, according to the above definition, is a public health service, and the appraisal of screening tests is done with scientific rigour. Screening tests are generally evaluated according to their predictive values of positive and negative and their sensitivity and specificity. *Sensitivity* refers to the effectiveness of a test in detecting those who suffer the condition and *specificity* to the effectiveness of the test in recognizing those that are free of the condition *(82)*. Screening tests aim for a high sensitivity and specificity, which will provide the likelihood of a correct result.

The United States Preventive Services Task Force *(26)* defines screening for violence as:

> assessment of current harm or risk of harm from family and intimate partner violence in asymptomatic persons in a health care setting. Individuals presenting with injuries from family violence undergo a diagnostic, not screening, evaluation. Universal screening means assessing everyone; selective screening indicates that only those who meet specific criteria are assessed.

It is important to distinguish between *screening*, directed at the entire population potentially at risk, whereby individuals are put into an "elevated probability" group for further evaluation, and *case finding,* or *diagnostic evaluation* whereby an actual designation of elder abuse is made based on indicators raising the suspicion of abuse. In both research and practice, the two approaches encompass different levels of rigour and investigation *(14, 84)*.

Although screening in public health is a well-defined evidence-based issue, throughout the literature one encounters different uses and interpretations. The term is often used indiscriminately and may at times confuse the debate. In the field of violence, screening is generally referred to as the action by which professionals detect abused individuals while excluding (screening out) the non-abused individuals. Screening for domestic violence and elder abuse pose methodological challenges

that make it difficult to match the public health definition. Therefore, it could be questioned on the one hand why efforts are invested in trying to "convince' national task forces to recommend such screening. But on the other hand, the question could be why screening should be defined only in the narrow sense of evidence-based medicine.

The uses of the term "screening" are one expression of the differences between professions, each with their corresponding language or "jargon", compounding the difficulty in determining where elder abuse belongs. Through the medicalization of terms, the hierarchical nature of health care becomes apparent; that is, the medical model used in public health is more dominant and more powerful than others. In order to advance interdisciplinary cooperation in line with the ecological model, communication and language are key elements that need to be clarified so that all the professionals involved understand what is at stake and can work together towards solutions.

Benefit versus harm

The basic principle of screening programmes is that they "*do more good than harm*" (*22*). Among the criteria used by most countries to assess a screening programme are the following:

- The condition should be an important health problem, well understood and with a known risk factor, or indicator.
- The test should be simple, safe and validated
- The screening test should be acceptable to the population.
- There should be available effective interventions to follow up.
- There must be evidence from reliable randomized controlled trials that the screening programme reduces mortality or morbidity and is cost effective.
- There are adequate staff available.
- There should be evidence that the complete screening programme (from test to intervention) is "*clinically, socially and ethically acceptable to health professionals and the public*" *(85)*.

The choice in the order of the words – "clinically" first "socially" second and "ethical" third – reflects again the supremacy of the clinical medical model.

Screening has been described as "a double-edged sword, sometimes used clumsily by the well-intended" *(86)* as the value of screening for diseases such as cancer and others is also debated *(87)*. Since screening may benefit a minority and possibly harm others, it is believed that the benefits must outweigh the risks before introducing a national screening programme *(88)*.

The United States Preventive Services Task Force *(26)* makes clear that it evaluates the balance of benefits and harms based exclusively on the quality and magnitude of the evidence. The literature review *(25)* that led to the Task Force's 2004 recommendation did not find any studies that provide data on possible adverse effects of screening or interventions. The Task Force claims that false-negative tests may discourage clinicians from seeking further history and prevent identification of those individuals who are truly at risk. False-positive tests, on the other hand, can lead to labelling and punitive attitudes as well as psychological distress, and might lead to family tension, loss of personal residence and financial resources and loss of autonomy for the victim.

However, evidence-based medicine is also debated from within the medical profession. There are voices declaring that personal preferences, psychosocial factors, comfort and reassurance, for patients are essential elements of clinical decisions in humanistic care *(89, 90)*. It is not the principle of practice based on the best evidence that is criticized but rather the dogmatism of applying the same "evidence" and approaches, such as randomized control trials, to all settings and conditions when it is apparent that they do not always fit. When dealing with abuse, the harm–benefit paradigm needs to be seen from a humanistic view, both patient- and practitioner-centred, in order to advance good practice.

Detecting elder abuse

Several tools for detecting elder abuse have been developed, almost exclusively in North America. Among the various tools, few are accepted for wide application in clinical settings. They are regarded as being not accurate, or specific, or sensitive or reliable enough to be officially adopted and recommended *(91)*. Despite the lack of widely accepted tools, the American Medical Association calls on all clinical settings to follow a routine screening protocol *(16)*. In the absence of validated tools for PHC settings, it is difficult to make comparisons or evaluate their applicability in settings other than that where it was tested in the first place. However, it is important to mention them as they provide the evidence on which future research should build.

The main approach to detection of elder abuse has been through identifying high-risk factors. Research published in the past decade has repeatedly described several risk factors that appear to increase the likelihood of abuse *(62, 84, 92-94)*. The complexity of the task related to risk assessment emphasizes the crucial role of the doctor's judgement in identifying abuse. Two surveys of general practitioners conducted by McCreadie et al. *(95)* in London and Birmingham, England, revealed that less than half the general practitioners had identified a case of elder abuse in the previous year. These studies seem to indicate that general practitioners' personal knowledge of at least five risk factors paired with a long-term doctor-patient relationship, especially through home visiting, facilitates diagnosis of abuse.

The main risk factors for elder abuse are generally considered to be:

- social isolation of the abused person and/or the family;
- frailty of the victim, functional disability and cognitive impairment;
- pathology of the abuser, such as alcohol or other substance abuse, cognitive impairment and mental-health problems;
- caregiver stress or anger
- dependence of the victim on the abuser (e.g. the caregiver is the abuser) or dependence of the abuser on the victim (e.g. an adult child with financial dependence on the parent is the abuser).

The risk factors listed above are as critiqued earlier, gender-neutral and do not consider the possibility of non-dependent older persons being abused. Findings of the one study to date on the incidence of abuse among postmenopausal women suggest that there is a transition in the risk factors for abuse of women as they age. As long as the woman remains independent, risk factors are like those for domestic violence; if she becomes dependent, then the risk factors become those of caregiver abuse and neglect *(96)*. It would be important to research to what extent older women do in fact suffer the double burden of risk factors.

Since older persons may present signs and symptoms of a multiplicity of factors due to ageing, such as frail skin, or a fall, or confusion, it is very important to always think broadly in each circumstance and to be alert in order to provide for the safety of the patient and optimal care and to avoid false accusations *(5, 34)*. Functional impairment, in addition to being a risk factor in itself, may diminish greatly the capacity of older people to defend themselves *(92)*. An increased awareness of the psychosocial reality of the patient will assist in understanding the contextual factors that may be strong predictors of abuse.

Existing tools for detecting elder abuse

Few published validated instruments exist. One such tool is the Hwalek-Sengstock Elder Abuse Screening Test (HSEAST) *(25, 97)*, which addresses the various types of elder abuse and is a self-report measure. The instrument has 15 items in three domains: violation of personal rights or direct abuse, characteristics of vulnerability, and potentially abusive situations.

Three validated instruments have been developed by Reis & Nahmiash:

- *The Brief Abuse Screen for the Elderly (BASE) (68)* is a simple tool comprising five brief questions. The respondent here is the practitioner following an assessment of the patient.
- *The Caregiver Abuse Screen (CASE) (98)* consists of eight questions to caregivers. It is used to detect abuse in cognitively impaired adults. It does not address the patient directly. Although this tool may facilitate the difficult task of interviewing a suspected abuser, it assumes only the caregiver model and ignores the autonomy of the patient.
- *The Indicators of Abuse Screen (IOA) (68)* is a 48-point checklist of problem indicators for abuse that is completed by health care professionals in the context of a comprehensive home assessment. The tool addresses the patient directly. The tool builds on the professional's assessment skills. For example, some of the items to be checked by the professional are whether the patient has behavioural problems, alcohol or medication problems or poor current relationships. This is clearly not a screening tool for the clinical setting, but it has been recognized as a potentially good research instrument *(28)*.

The *Elder Assessment Instrument (EAI) (99)* includes a general assessment of the older person as well as specific physical, social and medical assessments and level of independence in lifestyle. It has been used by elder abuse teams and nurses in the emergency departments.

More recently, the *Elder Abuse Suspicion Index (EASI) (100)* was developed with the goal of establishing a reasonable level of suspicion in order to justify referral to an appropriate community service (such as a social worker) for in-depth assessment. The theory behind this is that a simple tool can grant the patient permission to talk and can generate a level of suspicion and not necessarily a diagnosis. It is aimed at general practitioners, general internists and geriatricians with the intention to expand and test it also with social workers and nurses. It is a short five-question tool directed at the older person, with one observation item to be completed by the doctor.

Through the tools described, the difference of approaches towards screening and assessment, and the underlying theories, are noticeable. Only two tools (H-S/EAST and EASI) target the older person with direct questions. The heavy influence of the caregiver model in the design of the other tools is evident. Table 2 on the next page shows a simple comparison of the tools mentioned above. The validation column in the table represents the setting where a thorough assessment was performed to compare the results with those from the setting where the tool was originally used in order to validate, or not, the tool.

Evaluations of the general acceptability of the tool were performed only with the professionals who participated in the studies. No study evaluated acceptability of the tools by older persons. One of the benefits of using screening tools is, indeed, the raising awareness of elder abuse among service providers, but non evaluation of the acceptability by the patients themselves is not only is against the principles of screening, but also against a rights-based approach. Quigley *(101)* proposes that practitioners ask themselves whether suspected cases of abuse involve violation of human rights as a requirement to achieving a fair screening system for elder abuse.

Elder abuse takes place within a context and, without a comprehensive assessment of the bio/psycho-social context of elder abuse, any screening or assessment instrument has significant limitations *(28)*. An effective tool would be one that uses an interdisciplinary approach and participatory research from the start of its development. The more disciplines, and the more older people are involved in the design and refinement of a tool, the better the tool will be accepted by both professionals and patients. It will also improve the interprofessional practice on referrals and interventions.

Tool	Characteristics	Validation setting
H-S/EAST Hwalek-Sengstock Elder Abuse Screening Test as cited by Nelson et al. *(23)*	15 items Older person is the respondent. To identify situations likely to be or become abusive or neglectful.	100 elders living in public housing
BASE The Brief Abuse Screen for the Elderly *(68)*	Five items Filled by trained practitioner. To assess likelihood of abuse with caregiver/elder.	Home assessment of health and social services agency cases.
CASE Caregiver Abuse Screen *(98)*	Eight items (specifically worded to be non-blaming). Caregiver as respondent. To identify potentially abusive caregivers.	44 known abusive caregivers and 45 non-abusive caregivers receiving care from a social services centre.
IOA Indicators of Abuse Screen *(68)*	29 items Trained practitioner to assess caregiver and elder. To identify abuse among health and social services clients.	Home assessment of 341 health and social services agency cases (age 55 and older).
EAI Elder Assessment Instrument (revised) *(99)*	44 items Trained nurses to identify individuals at high risk of abuse or neglect who should be referred for further assessment.	Acute care.
EASI *(100)* Elder Abuse Suspicion Index	Six items (five questions and one observation) Older person as respondent. To assess likelihood of abuse.	Home assessment of 663 respondents by social workers.

Table 2: Examples of tools for detecting elder abuse (adapted from *(14)* pages 166-167)

Should we screen? The debate

The United States Preventive Services Task Force *(25, 26)* could not find enough evidence to determine the balance between the benefit and harm of screening for family and intimate partner violence among children, women or older adults and, therefore, did not recommend one way or the other. The United Kingdom National Screening Committee was more categorical in its short 2004 statement that screening for domestic violence "should not" be introduced *(24)*. The United Kingdom National Screening Committee based its decision on a report commissioned from Ramsay et al. *(22)*. The British Medical Journal article "Should health care professionals screen women for domestic violence?" *(23)* is the summary of the 2001 appraisal of the evidence. The statements by the screening commissions and the evidence they used triggered letters with responses, editorials and articles published in scientific journals arguing both for and against screening *(102–104)*. The United Kingdom National Screening Committee, and the evidence on which it based the recommendation, does not relate at all to elder abuse; nor does it mention older women in relation to domestic violence.

The systematic review by Ramsey et al. *(22)* focuses on three criteria:

- whether screening is acceptable to women and to health professionals;
- whether there are effective treatments or interventions for women identified in health care settings;
- whether screening programmes increase the proportion of women identified.

The reviewed studies show that most women find screening acceptable; however, only a minority of PHC practitioners find it acceptable. This fact raises some concerns about the level of responsiveness of health care to the needs of the patients. Regarding interventions studies, no randomized control study was identified. Although a small increase in the rate of identification when screening programmes are in place is revealed by the studies, the authors of the systematic review quote it in a negative way as "only modest" therefore not justifying a recommendation for screening. But a modest increase is still an increase; it is interesting to note the framing of statements that imply defeat when in fact they could be interpreted as a success.

Most of the studies that met the inclusion criteria for the review by Ramsey et al. *(20)* were from the United States. As it becomes imperative for more research to be performed, a recommendation for lack of action may have negative consequences in practice and develop anti-task behaviours *(105)* as the primary task of care is sometimes forgotten behind the lack of properly designed studies. The belief that the solutions clarifying the issues on screening for family violence will be found only through future proper scientific research – which is not necessarily in the pipeline – seems to exempt professionals from immediate action. Domestic violence is the healthcare problem that probably endangers women more than any other and still is the one for which routine screening does not take place *(106)*. In blaming bad studies and the lack of evidence, it is in fact the patients, suffering here and now, who are being punished.

Screening, as defined in public health, refers to a standardized test or question that does not change from place to place and that has the ability to identify a condition with good sensibility and to provide an effective response *(107)*. One of the problems of the evaluation of screening programmes for domestic violence, especially that in the United Kingdom *(22, 23)*, is that the inclusion criteria for evaluation are often set in isolation within health care settings without considering the wider social network and community services. While the issue of debate is indeed screening at health care settings, the evaluation of outcomes needs to be followed up beyond health care settings and within the context of interprofessional feedback. Lachs' provocative response to the United States Preventive Services Task Force reflects the issues described *(27)*:

…for some conditions that clinicians regularly

encounter, robotic devotion to evidence-based medicine risks dehumanizing certain aspects of doctoring. Any clinician who has extricated a family violence victim from an abusive situation understands this. If we had the tools to measure an "effect size" in such situations, it would make the benefits of controlling hypertension or diabetes look paltry by comparison.

The United States Preventive Services Task Force argument requiring scientific proof of generalizability is seen by Coker *(108)* as a legitimate challenge raising the questions of what is ethical in violence research. Evidence-based medicine considers it unethical to perform screening without having proper evidence of randomized trials for which the only way to perform a trial is through an intervention group and a control group. Others consider it unethical to perform randomized trials using control groups, i.e. consciously not assessing or offering interventions to a whole group. Coker challenges in turn the medical establishment to invest resources and conduct more research, claiming that since so few health care providers currently do screen, randomization of settings may still be conducted ethically, provided that all health care settings have information about community resources widely available and easy to see, such as in waiting rooms and toilets *(108)*.

This discussion on ethics extends to issues of confidentiality, reporting and autonomy, demonstrating the degree of sensitivity and complexity involved and that in fact require an increase in action rather than the opposite. The question may not be whether to screen but how to find the balance between opposing points of view, through proper communication and compromise. Scientific rigour and humanistic care need to exist side by side and be mutually beneficial.

Primary health care

Younger women attend antenatal services more often than other services. Although menopausal and older women also attend gynaecological services *(109)*, PHC may, for many abused people, be the only place of contact beyond reproductive age. Abused women have a 50–70% increase in gynaecological, central nervous system, irritable bowel and stress-related problems as well as chronic pain such as headaches or back pain *(110)*; however, injuries that may normally be considered as the most obvious indicator may not identify women who suffer long-term problems related to abuse *(108, 110–114).* Postmenopausal women have been shown to be exposed to abuse at similar rates to younger women, resulting in serious threats to their health *(96)*. Evidence has shown the high burden of elder abuse in both mortality and morbidity. An important and widely cited longitudinal study by Lachs et al. *(6)* demonstrated the independent impact of elder abuse on increased mortality. This study stresses the important role of doctors in identifying those at risk, initiating interventions and liaising with community services, as early identification and appropriate interdisciplinary response can save lives.

There is evidence that abused persons visit PHC settings more often than those who are not abused *(109, 115–118)*. In the United Kingdom, over 90% of the population comes into contact with PHC services within five years *(119)*. The older the person, the higher the risk of chronic diseases *(1)*, and therefore PHC becomes a usual and natural point of contact, implying an ongoing relationship of trust. Elder abuse cannot be addressed unless it is detected. Although PHC professionals are ideally placed to identify violence and elder abuse, in the United States for example only 2% of reported cases come from doctors *(120)*; despite efforts to improve detection, less than 10% of PHC doctors routinely screen for domestic violence during regular clinic visits *(115)*.

Routine screening or routine enquiry?

The significance of words should not be taken lightly. While the term "screening" may have a specific meaning in public health, it also implies a stronger attitude involving follow-up. The term "enquiring" may be interpreted as a

softer attitude of just asking and not necessarily following up. The critical point in screening is that it is a first step, not an end in itself, and the language used needs to be understood by all professionals involved.

Most health professional bodies in the United Kingdom have recommended protocols and guidelines for identifying and responding to domestic violence in health settings (as cited by Bacchus et al. *(121)*), but they do not necessarily recommend it as a routine practice, despite the fact that substantial qualitative evidence supports the potential benefits *(119, 122)*. A new handbook by the United Kingdom Department of Health, however, recommends moving towards routine enquiry *(123)*.

If routine enquiry does not fulfil accepted principles for screening programmes, then it is claimed to be confusing to view such enquiry as screening *(107, 117, 119)*. Although many researchers would claim that case-finding is more appropriate than routinely asking about violence, Bradley et al. *(117)* propose routine enquiry as a way of uncovering a hidden stigma, claiming that case-finding and targeted questioning may in fact increase stigma and fear of retaliation. It is difficult to predict an exact profile of an abused person, as evidence shows that abuse affects all ages and all socioeconomic levels of society *(122)*. Thus, by enquiring only under suspicion, the risk of prejudice and stigma may increase, i.e. if a person belongs to a lower socioeconomic status or minority group, then the health care practitioner may suspect more than in a person of higher social status. Therefore, an important and justified objective of universal routine screening is naming and accepting the problem as well as assisting in destigmatizing the issue.

Acceptability by patients

As described above, the debate develops around the issues of benefit–harm and ethical considerations; the existence – or lack of – proved effective interventions, the validity of the screening tests and the acceptability of screening to both professionals and the public.

Acceptability refers to the extent to which those for whom the test is designed agree to be tested *(82)* and whether professionals agree and in fact use it. In a patient-centred approach, acceptability should be the first question to check and from which further research and practice should depart. Understanding how patients, of all ages, feel about disclosing their experiences of abuse can better guide the design of research and training programmes of PHC workers.

Studies on women's perceptions of and attitudes towards screening and interventions for domestic violence have demonstrated that most women either favour or do not mind being asked whether they have experienced violence, especially if it is done routinely and sensitively *(70, 117, 124–137)*. Howe et al. *(134)* also showed that at hospital accident and emergency departments, particularly older patients supported a more active role for health professionals in cases of violence. The proportion of patients who would disclose, if asked directly, increased with age. But few women recall being asked, and medical records do not show evidence of disclosure *(117, 135)*. Mechanisms for minimizing the potential negative effects of screening need to be in place, as safety is the most important factor in women's acceptability to disclose abuse *(129)*. Women favour routine enquiry as long as it is conducted in a safe environment by trained, empathetic, compassionate and nonjudgemental health professionals *(124, 130, 137)*.

Many abused women report being relieved at finally being able to tell somebody. But regardless of whether women accept being asked about abuse, they will probably not disclose abuse unless they are ready to do so *(126, 133, 137)*. Therefore, understanding the stages that women may go through before being able to talk about abuse reinforces the argument for routine screening. Routine screening provides permission for when victims are ready to disclose. It also reinforces the argument for interprofessional practice: in an age of great specialization, general practitioners,

nurses and any other PHC professionals are not expected to "know it all" and "solve it all". However, they can be expected to liaise with colleagues and other specialists so that processes can be reflected upon and better understood.

Almost no studies have checked the acceptability by older women to being questioned about abuse. In a study by Zink et al. *(70)* on the health care needs and experiences of older women in abusive relationships, women reported being seen by their health care providers along with their spouses; few were given the time to have private conversations with the provider, and few felt comfortable talking about abuse in these situations. Researchers suggest that providers should be sensitive to the generational taboos around domestic violence and pick up on hints or clues to assist older women to disclose abuse. They should also avoid ageist assumptions and screen older women as well as younger patients *(61, 70)*.

It becomes clear that when older women are asked, they specifically say what they would expect from the health care and what is acceptable to them. A report on focus groups conducted in Scotland *(48)* quotes an older woman:

> You don't actually ask for help like that but I think the doctors miss it, when you go constantly to the doctors. And you know they just don't ask the questions "Why are you always in here? Is there something wrong at home?" And you would tell that, you know, in a safe, private room where you know it won't go any further. But they never did – they never did.

Barriers to screening

Interpersonal violence is an important health problem *(61, 110, 113, 138-141)*, but the complexity of the issues clearly creates a range of views, and anxieties, as to how to tackle them, by whom and when. The generic title "barriers to screening" found extensively in the literature, mostly through qualitative studies, encapsulates the difficulties of health care professionals in the detection and management of abuse beyond the medical evidence-based point of view. Often, the barriers to disclosure described by women patients parallel those of health care staff *(126, 142)*. For example, fear of retaliation by the partner, one of the main barriers among women, will be shared by practitioners. Health care practitioners express fear of violence either or both against the patient and/or themselves.

Studies exploring PHC practitioners' attitudes to domestic violence reveal several barriers that staff perceive as preventing them from "comfortably" intervening with violence victims, such as "fear of offending", "powerlessness", "fear of retaliation" and "tyranny of time". The image of "opening Pandora's box" appears repeatedly *(115, 128, 143–149)*. Detecting abuse among older patients presents added complications and complexities in distinguishing between abuse, ageing-related physical conditions and memory impairments *(5, 150, 151)*. Lack of effective interventions, mandatory reporting and lack of appropriate knowledge are also commonly mentioned barriers. In some cases, nurses and medical assistants seem to feel more comfortable than doctors in enquiring about abuse, but they share the sense of lack of education on the issues and, especially, lack of referral contacts with other professions outside the PHC setting *(146)*.

Roberts *(152)* cites dictionary definitions of care as "*ranging from affection and solicitude, to caution, responsibility, oppression of the mind, anxiety and grief*". PHC staff can feel all these ways at work and they need institutional and social recognition and support to carry out difficult tasks effectively. Working closely with suffering and death can lead to various anxieties connected with the burden of the work. Many defence mechanisms are used by organizations to control anxieties instead of acknowledging them as a normal part of work *(153)*. Caring for older people brings with it particular stresses. In parallel with the way in which older people

are excluded from society, working with them is considered to be low status among the health care professions. The efforts of staff need to be recognized and their feelings heard in order to improve the quality of life of all involved *(32, 152)*.

Recommending the introduction of elder abuse or domestic violence routine detection tools by itself will not be enough. For professionals to be able to use the tools effectively, they need to be trained to be aware of the problem and its signs, symptoms and consequences. In addition, they need to be prepared to intervene when a case of abuse or neglect is detected. Above all, they need the confidence to overcome barriers that prevent detection and intervention. Elder and domestic abuse are complex issues and will always be "competing" with other, more established health care issues, such as cardiovascular diseases, cancer and acute care, adding to the difficulty for health care providers in dealing with a social chronic problem while medicalizing it. However, as already mentioned, several chronic conditions, including mental health problems *(61, 110)* may result from long-lasting abusive relationships with a consequent increase in medical consultations.

It has been proposed that instead of viewing violence as a disease, it may help PHC practitioners to see violence as a risk factor for a long list of diseases, in the same way that tobacco and alcohol are viewed *(107, 128, 154)*. This approach may help PHC workers understand the relevance of screening, as it would assist them in comprehending the emerging and/or recurring conditions of their patients that would otherwise have remained unspoken. They could enquire about abuse in all routine medical history-taking along with questions on smoking and excessive alcohol consumption. In fact, abuse may be a factor in itself for excessive smoking and/or drinking *(110)*, increasing the relevance of making the connections. However, this approach will not solve the underlying difficulties and barriers.

The medicalization of domestic violence is often blamed for the silence *(118, 145)*, with claims that medical language and hierarchies in health care settings are responsible for many of the difficulties. While talking in terms of "prevalence in patients", medicine distances itself from the social framework and the experiences of patients. It has been claimed that techniques used by the medical model "institutionalise socially sanctioned hierarchies of domination and control, techniques that mimic the dynamics of abuse and battering" *(145)*. Clinicians trained within that model would find it difficult to provide the support that abused patients most need and look beyond the injury itself to take into consideration what may have really been the cause *(124, 145, 155)*. The task is not an easy one for the health professionals who do ask. Expectations to "fix" situations and achieve good outcomes, and their inability to do so, create feelings of helplessness, burnout and professional incompetence *(107, 128, 148, 149, 156)*.

Institutional and structural barriers hinder the efforts of health care staff, such as management and organizational changes, lack of support and lack of proper communication. Only 26% of respondents to a survey by the United Kingdom Community and District Nursing Association *(157)* reported receiving any staff-support scheme by their employer when dealing with elder abuse, and even fewer (19%) reported having a scheme for those dealing with domestic violence. Health care professionals also see themselves as abused by the system; especially working with older persons is considered "second class", with lower wages and less qualified staff than in other areas *(7)*.

Health care professionals' difficulties in tackling abuse may also be due to possible past personal or professional experiences with violence resulting in powerful feelings. It can be assumed that it is a normal reaction to have strong feelings when listening to experiences of abuse; the problem is the failure to acknowledge the feelings and their impact *(145, 149, 158)*. Knowing that abuse is prevalent, it is logical to suppose that a large percentage of health care professionals are part of the statistics, either as abusers or as victims of abuse. They

do not escape from social and cultural norms regarding sexism or their own ageist attitudes and behaviours; their own biases may be an obstacle in identifying abusive situations and provide appropriate assistance. Unless the PHC system and society as a whole acknowledge personal feelings and staff experiences, it will be difficult to expect all health care staff to behave according to protocols.

Trust

A trusting relationship between the health care practitioner and the patient can make all the difference in breaking the cycle of abuse. Many women express their lack of trust in PHC professionals. Rodriguez, Szkupinski & Bauer *(124)* describe an "*unspoken agreement*" or a "*code of silence*" in the words of a participant of the study. This is represented in three ways: the patient does not seek health care, the patient does not disclose and the health care practitioner does not ask. In another study, some women who had actually disclosed domestic violence regarded health visitors as more sympathetic and in general more helpful than general practitioners and accident and emergency staff *(121)*. It should be noted that, in addition to health visitors, general practitioners and nurses perform home visits, especially when dealing with frail older people *(34, 95)*. Thus, it is the knowledge of the living environment and the personal ongoing relationship that inspires trust, and not the profession itself. The sex of the practitioner does not seem to be an important factor or barrier *(115, 126)*. It is the feeling of being cared for, not judged, not looked over but listened to, that is important.

Five dimensions can be identified in health care practitioner behaviour that are essential for the building of trust with their patients and that contribute to disclosure: open communication, professional competency, a friendly practice style, a caring attitude and emotional equality *(159)*. A victim of abuse can experience dramatic relief when a health care professional verbally recognizes an emotional state the patient is in or helps the patient express an emotion. These emotions can often be recognized from clues in the patient's or abuser's behaviour, these clues sometimes being like "*cries for help*" *(160)*.

Health care may be more sophisticated than ever before, but at the core of the profession is the basic human relationship. "*Simple is beautiful*" as Schattner *(161)* puts it. Often, health care professionals waste time and money ordering a battery of tests for an undiagnosed condition when, in fact, a good diagnosis could have been made had there been an attempt to listen to and trust the words, the expressions and the hints given by the patient. Validating the experience, helps the abused woman move forward *(137, 162–164)*.

Communicating with older persons may also require more patience and understanding of the possible generational and cultural barriers for bringing up a taboo issue. A crucial concern when communicating with a frail older person, regardless of whether that person is suffering from cognitive impairment or not, is to make sure that the caregiver does not dominate the conversation, by holding separate interviews with both the patient and the caregiver *(32, 165, 166)*.

Confidentiality is an important concept that is much present in the literature as a major barrier for identification and/or disclosure of abuse and impacting the relationship of trust *(159)*. The concept is often used indiscriminately while it refers to different situations. This creates confusion as to what is really meant by it, and when and how confidentiality rules need to be followed. Confidentiality can be related to the stage the woman is in, building the relationship so that the woman can disclose and also take appropriate action *(137)*.

However, confidentiality needs to be analysed above all from a safety point of view; processes and procedures need to be clarified from the start; that health care practice is not performed in a vacuum; what exactly confidentiality means and what are its limitations. Interprofessional consultation is done in order to provide optimal care, which often is beyond the ability of the

individual practitioner. Confidentiality then is kept within the context of a team.

Good judgement, sensitivity and caution are needed to discern when confidentiality is essential to keep the patient safe and when it is in fact "*colluding*" *(167)* with the offender by not taking the necessary action to distance the patient from the abuser. Open, honest communication between the health care provider and the patient, involving mutual trust and shared decision-making, contributes to the empowerment process and better resolution of the issue.

Communication between different care professionals

The barriers that prevent a trusting relationship between a PHC practitioner and a patient, as described above, parallel the barriers that prevent good work across disciplines *(142)*. The nature of primary care, involving a number of organizational and professional boundaries, may provide a challenge for many practitioners. However, it also provides an opportunity to develop good practice on elder abuse and violence through sound interprofessional partnerships.

Although the recognition of violence and elder abuse as a public health issue is an important step for developing good practice, the dangers of overmedicalization, looking at violence from only an injury or clinical point of view, become evident *(118)*. Abuse often coexists with other social problems, which PHC may not be equipped or may not have time to deal with. Understanding that nobody expects health care settings to fix all the problems is an important step to improving communication and collaboration among different professions, both within the PHC and with social services, the police, legal services, voluntary organizations, and women's and older people's interest groups.

D'Avolio et al. *(116)* describe some extremes in the way health care staff communicate about screening for abuse. In some cases, staff would adopt a "don't ask, don't tell" attitude as a justification to avoid screening, while in others staff would be so passionately committed that they would screen universally and routinely but would remain so protective of their patients, to the point of not involving their colleagues in cases of identified domestic violence. These behaviours clearly parallel the relationship between abused women, and/or people close to them, with care providers, and could be discussed, acknowledged and dealt with in a regular team reflective practice sessions. Feelings of isolation and marginalization may also abound among members of staff who may be perceived as "more caring" than others, becoming unpopular *(116)*. The feelings of isolation can be present at a specific workplace but also in the wider context of society in general. Competition among professionals is common within a certain group and across the boundaries of professions. Members feel loyal to their original group and tend to be competitive with others. Appropriate managing of dual or multiple memberships for the good of the task and effective collaborative practice is critical *(168)*.

Reporting is much debated and is mentioned by doctors as a barrier to enquiry and disclosure. Doctors – and patients – do not know where the reporting will take them, and do not want to work through bureaucratic papers and deal with the police *(19, 128)*. Mandatory reporting is another issue of controversy and is in force, for elder abuse, in most states in the United States. It has been proposed that instead of considering the report as an investigation, it can be framed as the attempt to determine what services are available that might benefit the abused older person *(92)*. There is some evidence to suggest that by reporting to the authorities, a strong signal is sent to the abuser, and as a consequence, domestic violence declines *(169)*. Maintaining support to the victim and follow-up may have a lasting effect. Clarity as to what reporting entails and appropriate implementation and compliance will only be achieved only through a dialogue between the professions. Reporting, confidentiality and information-sharing are crucial issues that necessitate a clear code of conduct among professional teams.

Sharing information is particularly relevant to the recognition and identification of cases of abuse when sharing can prevent acts of abuse and save lives, reflecting the need for good interprofessional communication *(167)*. Part of the debate on sharing information revolves around the balance between individual and public interests, between a person's or group's human rights and public health and safety *(170)*. It is important to note here that different human rights are interrelated, and they can very rarely be seen in isolation *(171)*; so while well-intentioned health professionals may be protecting a patient's right to privacy, at the same time they may be violating a patient's right to safety and security. In this context, public health and human-rights fields work together towards the same goal of protecting people's right to life, free of abuse.

Different professions have been trained within specific languages, codes of conduct and behaviours, which sometimes seem impossible to bridge. In these times of information technology, there are technical ways to improve information-sharing and communication, while taking important safeguarding precautions *(167, 170)*. What is needed is the will to adapt to the needs of both individual clients and society, so that PHC can better help victims of abuse and prevent future abuse. Appropriate management and not just coordination is needed for successful collaboration *(168)*. What a PHC setting does with the information that may be collected through routine screening for abuse, and how the interprofessional response is managed, can make a difference.

Formal referral protocols, such as those in use in the United States for many years, enable interdisciplinary interaction. The experience has led to the formation of multidisciplinary teams for all aspects of elder abuse, from screening, identification and assessment through to interventions and follow-up *(58, 172, 173)*. The strength is that they acknowledge the limitations of each discipline while taking into consideration the different points of view in order to assess fully the situation of suspected or confirmed abuse, therefore sharing the responsibility. Some teams have succeeded in breaking the barriers that had previously prevented helpful interactions.

Interventions

While early identification of abuse is essential, the efficacy of routine screening ultimately will depend on effective interventions. Intervention does not mean fixing the problem but rather naming and accepting it and the limitations of the PHC level, leading to referral and interprofessional cooperation. The same ecological model that is applied to understanding the nature and causes of abuse will assist when planning appropriate interventions that take into account each of the individual, relationship, community and society levels.

When abuse is identified, the highest priority is to ensure the safety of the older person while respecting the person's autonomy *(31, 92)*. The conflict that may arise in accommodating both autonomy and safety, as it may be the case that the older person refuses intervention, reinforces the need for greater communication skills of practitioners and the building of trust with their patients and with colleagues. More emphasis on elder-abuse prevention and management through the adoption of interdisciplinary community-based approaches is increasingly recommended *(1, 3, 14, 15, 29, 79, 80, 123, 174)*. However, in order to overcome multiple barriers that prevent successful partnerships and interdisciplinary practice, it is crucial to understand how organizations work and the conscious and unconscious processes and anxieties involved when working with and for people. Knowledge of available services, acknowledging the strengths and limitation of each service while maintaining effective interprofessional practice, contributes to raising awareness about elder abuse and developing the confidence and mechanisms for addressing it effectively.

Training

Despite the lack of recommendations to screen, screening committees in North America and Europe call on health services to promote education and training, to be aware of the serious impact of violence on women's health and to identify and support abused women. Professional training has the potential of increasing the knowledge, levels of comfort and identification among practitioners; however, without situating abuse within the broader sociocultural context and without structural changes that allow for continuing education, supervision and support, little change will occur.

It has been shown that the introduction of screening protocols improves rates of detection *(106, 175)*. However, efforts have been difficult to sustain *(21, 107, 175–177)*. Therefore, it might be argued that the introduction of routine screening and referral protocols is not worth the effort. In fact, the opposite may be the case, strengthening the argument for continuing training and supervision. In order to successfully implement, and sustain, routine questioning and intervention, staff need continuous support and updating of the available resources. D'Avolio et al. *(116)* report that when they provide refresher courses and interact personally with staff, the rates of screening go up.

Most literature highlights the need for training on family violence and elder abuse, as reported either by nurses, researchers, doctors or committees *(7, 15, 24, 94, 141, 148, 156, 157, 178)*. The important issue is to develop and implement effective and continuing training from undergraduate studies and throughout a lifetime career that can have an impact at all levels of practice. Many articles describing signs and symptoms of elder abuse have been published, but they have little if any impact. Health and social services staff need greater skills and knowledge in order to manage elder abuse effectively, and suitably targeted educational seminars designed to fill knowledge gaps can improve practice, while simply distributing printed materials is ineffective *(179)*. It has also been proven that limited training through lectures about intimate partner violence does not have a significant impact on screening behaviours, whereas training sessions plus the provision of screening questions and referrals protocols appears to be more effective *(147)*.

Education and training are much more than just reviewing signs and symptoms to recognize abuse; a deeper and reflective understanding of the complex mechanisms involved in both learning and practice are invaluable. Continuing training with a focus on dissipating PHC staff's misconceptions about the extent and aspects of domestic violence may increase screening rates and clearly improve practice *(148, 175, 180)*. It has been proposed that training should include the opportunity to reflect on the nurse's own experiences and attitudes and offer personal counselling if needed *(158, 181)*. A project coupling qualitative research with educational tools was carried out by Nicolaidis in Seattle *(163, 164)*. A video was produced featuring women who had experienced abuse talking about their views on the doctor–patient relationship and clearly saying to the camera how they would have liked the relationship to develop. This kind of training may be useful to break the formality of lectures and can be used as a basis for doctors to "listen and look" and then discuss and reflect with their peers on their own professional experiences. One added value of this project is its participatory nature. The women who were interviewed for the qualitative study also participated in the writing of the script and editing of the video.

As mentioned, nurses sometimes may feel more comfortable enquiring about abuse than doctors and patients sometimes may feel more comfortable with the nurse, or the doctor or an assistant. This point is crucial in understanding the relevance of interprofessional training, which in turn would improve team practice. Both training of teams within an organization and interagency training need to be considered. Pritchard *(156)* stresses the importance of involving statutory, voluntary and independent sectors in training plans. Interprofessional training sessions are a good opportunity to

clarify codes of conduct, procedures, language and other practice issues. They also promote personal connections, which contribute to reducing prejudice and stereotypes that exist among different professions and between professionals and clients.

According to the ecological model, the barriers to deal with abuse are at the personal, interpersonal, community and societal level. Therefore, interventions for overcoming the barriers also need to be implemented at all levels. Education and training programmes can be developed with partners across society. A good relationship with the media and the entertainment industries, for example, provide good opportunities for mass media awareness and educational campaigns that reach abused people, abusers, teachers, service and care providers and policy-makers.

4. Conclusions and implications for action

General conclusions

Elder abuse is a violation of human rights that affects every aspect of the older person's life. PHC has an important role in identifying, managing and preventing its occurrence by increasing the level of trust with patients, implementing routing screening practice and effectively working with other services in the community. Beyond the required scientific and legal responsibilities, a humanistic approach within a human-rights framework to health care is needed.

This review has attempted to place elder abuse within the theoretical framework of the ecological model, placing the person within the contexts in which s/he lives. Research, education and practice focused at each level of the ecological model, taking into account all of its levels, may simplify the task of tackling the complex issues. Multiple barriers have been identified that have an impact on the recognition of elder abuse by PHC workers. These barriers exist at all levels of the ecological model.

At the societal level, widespread ageist attitudes permeate all aspects of life. This is translated into abuse and discrimination against older persons in society, including in health care settings. Gender aspects of elder abuse are obscured by widespread societal sexist attitudes. Sexism and ageism together place older women as the most vulnerable.

Older people are not a homogeneous group. The study of elder abuse needs to recognise the life course experiences of a person, the context of family relationships and possible life-long experiences of abuse. Situations of frailty and dependence of the older person, while a contributing factor to abuse, should be understood within the overall context of the relationship between the abused and the abuser along with the characteristics of the abuser. As there are multiple types of abuse, elder abuse is not just one single problem but a myriad of problems requiring a myriad of responses.

Improving trust and communication are central for dealing effectively with abuse and parallel processes are observed throughout all relationships: between the victim and the abuser, between the victim and health care practitioners, between different professions both within health care and outside, and also between governments or policy levels and the public.

Lack of agreement on the language used and definitions have been addressed throughout this review as stumbling blocks for effective practice. It is crucial not to confuse the philosophical discourse and the realities of everyday practice; while definitions are important in that they synthesize the central themes on which research and practice should be based, parallel action to help current sufferers is imperative. Beyond the lack of agreement on how to define elder abuse, a critical example is the discussion on whether *screening* or *enquiry* should be applied. The supremacy of the medical model, with its implications of objective scientific

meaning, is challenged. Language is not owned by any one discipline: it evolves within social and historical contexts.

The narrow interpretation of evidence-based medicine, while having incontestable strengths, consistently prevents PHC workers from adopting a more humanistic care approach. This is clearly evident by the virtual absence of violence and elder abuse in educational curricula of the health care professions.

The ethical concerns around screening for violence are legitimate and should precede the clinical arguments. The overall harm of not asking about abuse is markedly greater, both with regard to the danger of leaving a victim at risk and in the development of a relationship of trust, than the harm resulting from lack of scientific evidence for routine screening.

Conversely, the benefits of opening up a communication channel pursuing healing beyond the clinical aspects of treating an injury or disease are much greater than the benefits of scientific rigour. The high association between abuse, health problems and mortality, low levels of suspicion and low levels of self-reporting, together with the evidence gathered of high acceptance by patients, makes it ethically unacceptable not to screen routinely for elder abuse.

However, the lack of recognition of abuse by PHC professionals cannot be blamed solely on the medical model and lack of education. Unconscious processes that health care providers experience while confronted with abuse, along with multiple institutional and organizational barriers, require special attention. It is crucial to acknowledge the feelings of health care workers and see them as part of society, not above it. Interdisciplinary training and practice have been recognized as imperative to overcome these barriers and to deal effectively with elder abuse from a human-rights approach.

Limitations of the current review

This review has some important limitations. Since specific literature on the acceptability by older persons of screening and on barriers to dealing with elder abuse is scarce, this review has looked at the literature on domestic violence. Therefore, it draws conclusions that need to be treated with caution in order to avoid falling into the same professional biases that were critiqued in this paper. However, as PHC settings are confronted with both domestic violence and elder abuse, the unconscious processes and institutional barriers identified in the review can stimulate specific research and practice.

This review did not analyse all aspects of elder abuse. Rather, it concentrates on the multiple barriers related to its recognition. However, without understanding the complexities of elder abuse itself, the task of identifying it will fail. This review does not pretend to have covered all available literature and, therefore, generalized conclusions could not be made.

Implications for action

The report on elder abuse by the United Kingdom House of Commons health committee *(15)* has created an expectation for action, which in fact is taking place, such as the current large-scale national prevalence study of elder abuse currently taking place, involving several disciplines. While practice, research and training are closely interrelated, for practical reasons they are divided here in separate subsections and are listed as points for action.

Policy and practice

Ultimately, the only way to know how to improve screening and referrals and to overcome the multiple barriers is practice, and sound interdisciplinary action has been recognized as an imperative for good practice.

- Policy change is needed to address ageism and elder abuse.
- Screening is a first step. When elder abuse is suspected, further assessment and

appropriate referrals must follow. Referrals and ongoing contact with the voluntary sector need to be part of the process.

- Formal and clear procedures and mechanisms, regular case reviews, peer staff development and regular reflective practice need to be in place in order to sustain the implementation of a successful screening programme.
- The more disciplines and older persons are involved in the design and refinement of a screening tool, the more the tool will be accepted by both professionals of different disciplines and patients.
- Sensitivity and trust-building are key for good practice. Changes are needed at the relationship levels: between practitioners and patients; between practitioners, between practitioners and health administrators and policy-makers.
- Issues of confidentiality, reporting and information-sharing need to be discussed, agreed and formalised.
- Interdisciplinary reflective practice and routine supervision need to be implemented in order to deal effectively with abuse cases, discuss possible suspicions, clarify procedures and overcome personal barriers.
- Interdisciplinary practice needs to include the media and policy-makers in order to raise awareness of the widespread magnitude of elder abuse and to publicly condemn it.

Research

- Both quantitative and qualitative research is needed in order to understand the different types of elder abuse and how they interact with each other.
- A crucial gap in elder-abuse research is the missing voices of older persons themselves and specifically regarding acceptability for implementation of routine screening. Qualitative research at PHC settings with both older women and older men using a gender-sensitive approach may shed light on their views.
- Participatory processes and action research involving older people's groups should be considered to bring forward the research agenda.
- Population-based studies involving large and representative samples and using standardized methodologies are necessary to properly estimate the scale of elder abuse and to design appropriate policies.
- Further research on the effects of menopause on domestic violence should be conducted in order to check to what extent the risk factors add to a double burden of morbidity among older women.
- Research to test the effectiveness of using screening tools by the different PHC professions is required alongside ongoing evaluations on the interactions between professionals and with the voluntary sector.
- Observation and identification of crucial points when implementing a screening and referral programme, may inform the specific type of supervision that is needed.

Training

While basic education on elder abuse needs to be included in the formal curricula of the caring professions, education needs to move beyond the recognition of the signs and symptoms of abuse and neglect. Careful consideration to the great complexity of ethical issues faced by care providers, including their own feelings, while facing abuse needs to be given.

- Interdisciplinary and interagency training sessions are crucial for implementing screening and referral procedures successfully.
- Training needs to incorporate wider societal issues and barriers, such as gender dimensions and ageism, as well as an opportunity for reflection on personal attitudes and on group processes.
- Older persons, including survivors of elder abuse and domestic violence, should be involved in educational activities.
- Home visits and outreach to the community

could be a central element of formal training, as personal knowledge of the older person's environment increases patient–practitioner trust.

- Outreach and training with other professions other than primary care could be considered. For example, training seminars of judges on elder abuse has proved very successful in the United States. School teachers could be a good target group for training to promote intergenerational solidarity.
- Creative educational venues that involve innovative partnerships across society such as television networks and industry/workplaces, need to be explored more.

Concluding remarks

Older persons need to be aware of their rights. In this regard, PHC settings and professionals can be advocates for older people. PHC workers should screen for elder abuse as a necessary first step in a chain of interventions. But its complex implementation needs to be accomplished within an interdisciplinary framework, ongoing research, evaluation and capacity building.

Beyond any personal agendas and different theories that may underline practice, PHC workers have chosen a caring profession because they care. Health care cannot be seen in a bubble or above or outside the rest of society. Health care needs to adapt to the needs of its patients/clients while forging partnerships and taking into consideration the professionals' own feelings and the realities in which they live.

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This paper presents a critical review of the literature, discusses what is needed in order to advance knowledge by Primary Health Care (PHC) workers about elder abuse and makes recommendations about detection as a first step for the management and prevention of elder abuse.

It takes into consideration the debate among health care professionals about screening for domestic violence following the lack of recommendations by screening committees in the United States, Canada and the United Kingdom. Controversies regarding definitions of elder abuse and screening reveal, among others, the supremacy of the medical model and evidence-based medicine. This review challenges such supremacy and, instead, proposes a humanistic model.

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