



Elder abuse

Experience and status quo in Germany

12th March 2010

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MDS

History

- 1974 Homes Act: Protection of „interests and needs“ of residents of LTC- disabled Homes: efficacy of this public administration depend on the political will

Means of this home supervisory authority:

- Fines
- Work prohibition for management or certain persons
- Compulsory closing of the facility
- Severe Criticism: no care experts involved

History (2)

- 1994 Social LTCI: high relevance: protection of persons in need of care
- MDK- Tasks: Quality inspections and consultations:
- Several reform acts: until 2011: each facility is inspected once a year, without prior announcement
- 10.000 LTC homes and 12.000 care services
- MDK Inspections 1998-2009: 42.000
- Severe Criticism: good skilled care experts involved

Experiences in Germany

- No rely on desired result by measures that are merely voluntary
- long-term care is a commercial business and subject to mechanisms of the market
- many of the businesses involved are non-profit organisations
- No rely on any self-regulating forces of the sector

Experiences

MDK Inspections include:

- quality of the structures and processes of the institution
- physical examination of the nursing status of care recipients by physicians and experienced nurses
- interviews with persons receiving long-term care
- Constant rise in quality in recent years, and a lot of improvement is still necessary

Experience

- Visitor, consultancy and support service units which provide service to elderly people
- Legal guardians professionals and volunteers
- number and mission vary from one region to the next

One Personal Experience

- Many Complaints about the situations in care homes

Who is complaining:

- Relatives, family members: often when the person in need of care is dead
- (former) colleagues employed in care homes (often anonymous)

Much more interesting is:

Who is not complaining?

Solution of the puzzle

- No complaints from those who are daily in a care home
- Medical Practitioners (GP)
- Pharmacists
- Priests

...professionals belonging to our target-group

Conclusions

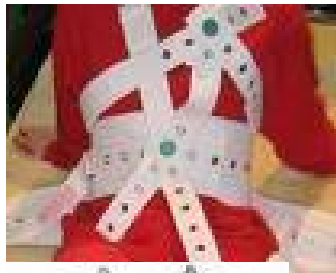
Related to the aims of the EC Project:

- No public system with explicit and direct aim at monitoring the abuse of elderly persons in Germany
- No evidence-based indicators for preventing their abuse neither as a general mechanism in the German public health sector nor in long-term care
- But a range of systems with indirect relation to abuse of elderly persons

Fixierung ist Gewalt an Pflegerbedürftigen



**Rechtlich gerechtfertigte Gewalt:
bleibt für die Betroffenen Gewalt**



FEM in Deutschland?

Entwicklung von FEM

- Vergleich 1998 zu 2008:
Anstieg richterliche Genehmigung von FEM
145 %
- 2008 91.800 bundesweit (neu) genehmigte FEM.
Angaben zur Anzahl aller genehmigten FEM: fehlen
(Betreuungszahlen 2006-2008).
- **Im Vergleich: Zahl der Heimplätze insgesamt : ca. 713.000** (2004, BMFSFJ)
- 2009: Studie der Unis HH&Witten: fast 4000 Heimbewohner in 36 Einrichtungen zu FEM:
- FEM, bei denen es „keiner richterlichen Genehmigung bedarf, da der zuständige Richter die FEM als nicht genehmigungspflichtig erachtet“ (Köpcke unveröff. 2009)

Entwicklung der FEM 1998-2008

Verhältnis Genehmigungen:Ablehnungen durch AG

	1998	2000	2002	2008	Veränderungsquote 1998-2008
Fixierungen	40.337	56.234	71.913	98.823	145%
davon genehmigt	38.846	54.060	66.888	91.823	136%
davon abgelehnt	1.491	2.174	5.026	6.476	334%
Ablehnungsquote	3,7	3,9	7,0	6,6	

FEM Krankenhaus und Psychiatrie

- Grundsätze des § 1906 Abs. 4 BGB gelten auch im Krankenhaus & psychiatrischen Abteilungen vgl. J. Gelübke
- Nur die Gefahr für Leib und Leben rechtfertigt in engen Grenzen Freiheitsentzug und Fixierung
- **Besondere Anforderungen in der Betreuung fixierter Patienten**
- Sitzwache
- Sichtkontakt
- regelmäßiger Kontakt

- **Validationstechniken**

Aus: Dr. W. Wittgens, Chefarzt der Abt. Psychiatrie, Krankenhaus Elbroich

In der Psychiatrie gelten für Fixierungen andere Maßstäbe und Gesetze?

Zulässig bei

- Einwilligung
- Gefahr im Verzug (Selbstgefährdung)
- Genehmigung durch Betreuungsgericht

Vermeidungsmöglichkeiten

- Deeskalationsstrategien
- Wissen um Krisenhafte Zuspitzungen
- Kenntnisse im Umgang mit Aggression & Gewalt

In der Psychiatrie gelten für Fixierungen andere Maßstäbe und Gesetze?

In krisenhaften Zuspitzungen

- **Was bedeutet Fixierung für den Betroffenen?**
- **Fachwissen als Mittel für humanitäre Pflege**
- **Sorgfältige Handhabung & Dokumentation**
- **Gründe, Dauer, Umfang, Ziel der Fixierung**
- **Durchführung nach Standard**
- **Überwachung und Kontrolle; Anpassung an Verfassung des Patienten**
- **Danach: Aufarbeitung der Situation mit (Mit-) Patient und Reflexion im Team**

Beispiel AG Delmenhorst

- Bei Bettgitter: FEM nur, wenn dies so hoch, dass Betroffene unter Berücksichtigung seiner körperlichen Fähigkeiten am Verlassen des Bettes gehindert wird
- Andernfalls: Schutz vor unbeabsichtigtem Herausrollen
- IdR Schutzmaßnahme, „wenn die Bettgitter niedriger als ca. 25 cm sind“
- Wo ist die Betroffenenperspektive des BtG
- Woher diese Erkenntnisse? Delmenhorster Studien?
- FEM und Schutzmaßnahme: Schutz ist positiv; Schutz durch Gitter
- Sturzhöhe und Ausmaß der Verletzungsgefahr
- Alternativen zum Schutzgitter FEM werden erst gar nicht ventiliert: niedriges Bett, Matratze vor dem Bett, Bodenpflege etc)

Die Ursachen für Fixierungen

- Die Unkenntnis von Alternativen bei Gericht Betreuern, Pflege, Ärzten?
- Hausintrinsische Faktoren: kompetenter Umgang mit Menschen mit Demenz?
- „Hausgeist“: Gleichsetzung Fixierung=Verantwortungsbewußtsein
- Nicht: die Risikostruktur der Bewohner/Patienten
- Nicht: die meisten Begründungen der FixiererInnen
- -siehe gleich-
- Nicht: der gerne behauptete Theorie-/ Praxis-Gegensatz
- Denn: die Theorie dieser Praktiker...

FEM und Demenz (aus GrdsStn Demenz)

- falsche, den Bedürfnissen von MmD nicht angepasste Betreuung B chronischer Stress
- Einschränkungen der Bewegungsfreiheit - v.a. Fixierungen- verstärken bei MmD das Gefühl des Ausgeliefertseins, der Hilflosigkeit, erschweren ihm das Verständnis der Situation
- Immobilisierung kann die Entwicklung psychotischer Symptome begünstigen
- bereits nach wenigen Stunden der Fixierung werden Halluzinationen & Wahnvorstellungen beobachtet, meistens verbunden mit erheblicher Unruhe und Aggressivität (Wojnar, J 2007)
- Fixierung wird so zur self-fulfilling-prophecy

Beziehung von Pflegefachlichkeit, ethischem Verhalten und Recht

- stressfreie Betreuung von MmD: Identifizierung der Ursachen von herausforderndem Verhalten
- hieraus Alternativen zu FEM ableiten
- Erst wenn diese pflegefachliche Analyse keine Alternativen mehr zuläßt, ist für Betreuungsrichter wie für Betreuer die freiheitsentziehende Maßnahme als „erforderliche“ ultima Ratio gegeben
- Angewandte Pflegefachlichkeit wird so ethisch zur Grundlage für rechtliche Entscheidungen.

Begründungen von PFK für Fixierungen

- Verhalten kontrollieren
- Sicherheit gewährleisten (Schutz vor Fremd- und Eigengefährdung)
- Medizinische Versorgung garantieren

Thomas et al. 1995; Karlsson et al. 1998; Hantikainen V 1998

„Fixierungen führen bei sturzgefährdeten Bewohnern zur Sturzreduktion“:

80 % der befragten Pflegenden stimmen dem zu/sehr zu
10 % nicht oder überhaupt nicht

Suen LKP et al. JAN 2006; 55: 20-8

Von denselben Befragten würden für sich ein Verweigerungsrecht bei Fixierungen im Heim reklamieren: **85 %**

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Qualifikation des Personals = Juristische-In-House-Schulungen ?

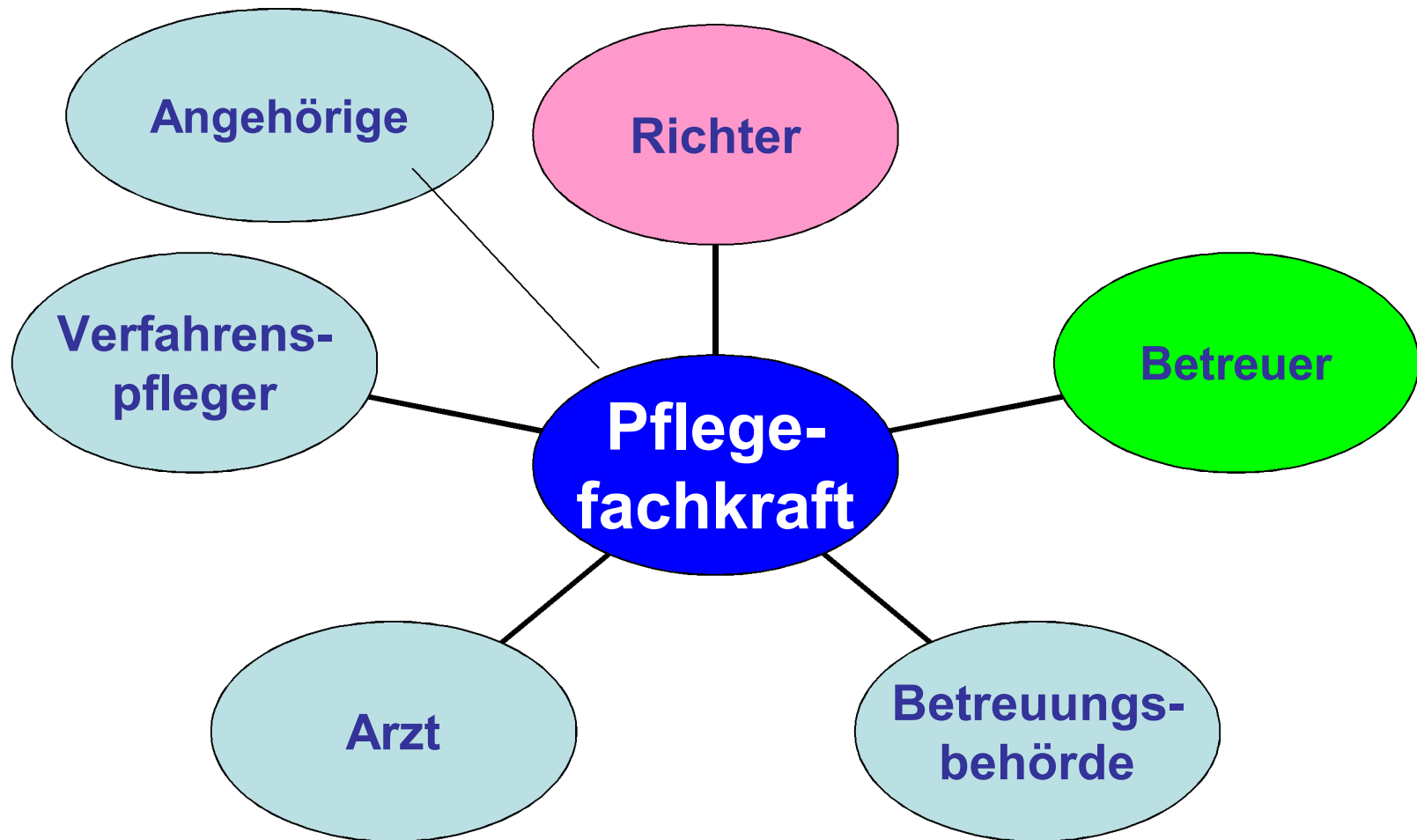
- Seit Jahren: Karawanen von Rechtsanwälten ziehen durch Heime
- verbreiten Angst und Schrecken
- „Mit einem Fuß im Gefängnis“
- Haftungsfragen:
- Sicherheit beim Bewohner
- Sicherheit der Angehörigen
- Sicherheit des Personals
- Sicherheit ??????



Das Sicherheitsdenken in Pflegeheimen sorgt für eine Haltung

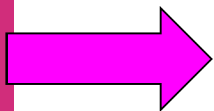
- **Positive Verstärkung durch Gerichte:** im Antrag Genehmigung § 1906 Abs.4 BGB steckt auch:
- **wir müssen Stürze vermeiden (Heim):**
Genehmigung FEM: Weniger Stürze - na klar
- Die Logik: wo **Schaden = da Schuldiger für Stürze**, weil keine Fixierung vorgenommen wurde
- Botschaft: **Nichtfixierung = unverantwortlich** und bedarf der Rechtfertigung
- **PFK = Fixierungsverantwortliche;** Richter muß sich auf deren fachliche Einschätzung verlassen

Entscheidungsnetzwerk bei Fixierung



Verhältnis von Entscheidung und Beratung bei FEM

- Richter genehmigt FEM: ist abhängig von Infos und Einschätzungen der PFK
- Betreuer berät sich mit PFK, stellt Antrag
- Betreuungsbehörde: Infos zur Stellungnahme aus Heim/PFK
- Arzt: wer beurteilt: z.B. Erforderlichkeit nächtlicher Fixierung: PFK
- Verfahrenspfleger = Rechtsanwalt



**PFK = entscheidet alleine,
Nämlich ob der E-Prozess in Gang kommt**

Zur Erinnerung: Was will die PFK?

- 1.,2., und 3.: Sicherheit !
- Bisherige Lösung: was kann die PFK tun, um Sicherheit zu erlangen?
- „Sicherheit für wen?“ ist hier noch nicht Thema
- **Anderer Weg: Was könnten die anderen Beteiligten zum Sicherheitsbedürfnis der PFK beitragen?**



Wir brauchen neue Signale; von vielen

- Wo? Vor Ort: Landkreis, Kommune, Träger
- Wer? BtGericht, Behörde, Heime, Betreuer, Angehörige
- Was?
- **Signal 1:** Vermeidung von FEM in der Pflege ist gewollt und zu begrüßen

Wir brauchen neue Signale

- **Signal 2:** Alle Beteiligten bestärken die Pflegeeinrichtungen bei Anstrengungen, FEM zu vermeiden bei vermeintlich höherem Haftungsrisiko
- **Signal 3:** Angebot an die Pflegeheime: Entscheidungen von FEM-Verzicht werden gemeinsam mitgetragen

Neue Signale 4 und 5

- **Signal 4:** Pflegeheime verpflichten sich, **jede** einzelne **Fixierung regelmäßig** kritisch zu **überprüfen**
- **Signal 5:** Gemeinsam ständig **Austausch** und **Erweitern des Wissens** im Landkreis
- **Erste Konsequenz:** Neuausrichtung der Funktion des **Verfahrenspflegers:** pflegerische Fachlichkeit und Betroffenenperspektive; geschult von Btbehörde, Heimaufsicht und in LTC ausgewiesener Pflegewissenschaft

Neuausrichtung des Verfahrenspflegers

- **Besondere fachliche Kompetenz: Er ist der Botschafter des Neuen Klimas: FEM-Vermeidung**
- **Neben starrem Sicherheitsdenken: Alternativen führen zur Vermeidung von FEM**
- **Anbindung an AG und Btbehörde: Angebot an Heime: gemeinsame Verantwortungsübernahme**
- **Stärkung der Handlungssicherheit der Heime: gegen Vorwürfe, gegen Haftungsansprüche**
- **Bei Restrisiko: Vermeidung von FEM durch Minimierung des Haftungsrisikos mittels Verteilung der Verantwortung auf viele Schultern**
- **Handlungssicherheit erweitern, auch ohne Beteiligung des Gerichts : Heimaufsicht = Multiplikator**

Das ist der „Werdenfelser Weg“

- Eingang Fixierungsantrag beim AG (Eilverfahren):
- Vorläufige Entscheidung binnen 6 Wochen
- zeitgleich: Gericht beauftragt o.g. Verfahrenspfleger
- VfPfl ⇒ Einrichtung: Recht, Vermeidungsstrategien, Fachwissen = Basis für Diskussion „auf Augenhöhe“
- Alternativen („auf Probe“) werden mit Pflege und Angehörigen vereinbart
- Diskussion: Risiko vs. Verschlechterung und Verlust an Lebensqualität
- VfPfl bestätigt ggü. Gericht & Heim: fachliche Prüfung ergab: man geht bestimmtes Risiko mit Billigung des Gerichts oder: es gab keine Alternative zu Fixierung
- Innerhalb 6 Wochenfenster: i.d.R. gemeinsame Empfehlung von Heim und VfPfl

„Werdenfelser Weg“(2) Inhalt Schlußbericht

- Umfang der Tätigkeit
- Reduzierte Problembeschreibung (Sturz bei Nacht)
- Einschätzung: erkennbarer Wunsch, sich fortzubewegen: Einschränkungen? Leidensdruck?
- Stichworte: welche alternative Maßnahmen wurden erwogen/ ausprobiert ?
- Welche Maßnahme minimiert das bestehende Risiko?
- Abwägen: Verschlechterung der Lebenssituation bei FEM
- Zusammenfassung Empfehlung (2 Sätze)
- Verfahrenspflegschaft bleibt aufrecht erhalten (Folge)

„Werdenfelser Weg“(3)

- **Kein statistisches Material (Multiplikatorenseminar im Mai in Erkner)**
- **Stabilisierung der Anträge auf sehr niedrigem Niveau**
- **Spürbarer Erfolg:**
 - **Engagement & Ideen der Pflege: fühlen sich ernst genommen**
 - **Heimleiter: Offenheit, Kooperationsbereitschaft, Ehrgeiz**
 - **Gemeinsames Auftreten der Behörden LRA und AG**
 - **Fachkompetenz und Engagement der VfPfl (auch abends)**

Klassische WIN-WIN-Situation

<http://www.lra-gap.de/550.0.html>

Fazit: FEM in Heimen

- Tut Euch zusammen vor Ort: Gerichte, Behörden, Angehörige, Heime
- Schafft eine neue Kultur des
„Wir lassen es bleiben“
- Oder nach dem (inzwischen wieder abgeschafften)
Leitsatz der Diakonie Düsseldorf:

Doch, doch: das geht

- Doch, doch: das geht
- Doch, doch: **das geht**



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Evil is knowing better, but willingly doing worse.

Philip Zimbardo: The Lucifer Effect, 2007

**Evil is the exercise of power
to
intentionally
harm (psychologically)
hurt (physically)
destroy
commit crimes against humanity.**

http://www.ted.com/talks/philip_zimbardo_on_the_psychology_of_evil.html; 2008



Besten Dank für Ihre
Aufmerksamkeit

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Elderly abuse in the Netherlands



Elderly abuse; a relevant issue...

- Prevalence figures:
- ~ 6 % of non-demented elderly, living at home is victim of elderly abuse.

The prevalence of the various types of elder abuse was:
verbal aggression 3.2%, physical aggression 1.2%, financial mistreatment 1.4%, and neglect 0.2%

- ~ 11% of demented elderly living at home is victim of physical aggression; and
- ~ 30% of demented elderly living at home is victim of verbal aggression...

Comijs et al. 1998; Pot et al. 1996.

Long-term institutional care?

- No reliable figures about elderly in residential care settings, such as nursing homes.
- However: a study of Bardelmeyer et al (2007) showed that in nursing homes, during a period of 2 years, 42,8% of the nursing home physicians had been confronted with elderly abuse.

This mainly concerned physical and psychological (including verbal) abuse.

Most cases occurred in psychogeriatric wards.

Perpetrators mainly were nursing personnel, family/visitors and co-residents.

Reasons for elderly abuse were personal problems of the perpetrator, overburdening of nursing personnel or family and lack of knowledge to handle a disabled older person.

Elderly abuse became a political topic in The Netherlands in 1992

- 1992: Initiation of the development of reporting centres and consultation centres for elderly abuse all over the country;
- 1996: Start of National Support Centre Combating Elder Abuse (LSBO) by Ministry of Health, Welfare and Sports; aim was to break the taboo on elderly abuse;
- 2003: Stop funding of LSBO; then 2/5 of the desired reporting centres had been developed; focus of government was laid on domestic violence in general;
- 2004: The existing reporting centres set up the National Platform Combating Elder Abuse (LPBO); the reporting centres start with quarterly reporting of cases of elder abuse to NIZW-care, now Vilans, a knowledge centre on chronic care, who supported LPBO, to achieve country wide data on elder abuse.

What happened more?

- 2006-2007: **Campaign Stop Elder abuse.**
 - Executed by VILANS, MOVISION and LPBO

AIM: in 1,5 year every municipality should have an information point on combating elder abuse, fulfilling tasks of publicity and referral to professional caregivers or institutions;

An ambassador on elderly abuse was appointed to challenge and support municipalities and other relevant actors; (still active!!)

Brochure: " You only see it, when you believe it"

Now 95% of municipalities have such an information centre!

Data from reporting centres on elderly abuse: 2006, 2007, 2008...; gathered by LPBO:

AGE (victim):	2006:	2007	2008
	368 cases	366 cases	662 cases!
65-69	11%	20%	25%
70-79	35%	31%	39%
80-89	48%	41%	27%
90 +	6%	8%	8%

Data from reporting centres on elderly abuse: 2006, 2007, 2008...; gathered by LPBO:

- Type of abuse: (combinations are possible!) psychic (45-50%); physical (40%), financial (32%), rest category incl. violation of personal rights, sexual abuse, neglect etc. (18%)
 - Reports mostly by professional (> 70%)
 - Victims mostly female (70-75%)
 - Most victims live together with family member (partner or child)
 - Perpetrator: (ex)partner (39%); (grand)child (42%); neighbor/acquaintance (11%), professional (3%-5%)
 - Intent to abuse: deliberately (75%); derailed care by too high care burden (at home) (25%)
- No specific data on health care settings!**

What happened more?

2007: Social Support Act (=WMO) comes into force.

- Under this Act, the municipalities are now responsible for setting up social support.
- The aim of the Social Support Act is participation of all citizens to all facets of the society, whether or not with help from friends, family or acquaintances; the perspective is a coherent policy in the field of the social support and related areas.

Municipalities now have the opportunity to develop a cohesive policy on social support, living and welfare along with other related matters.

- The Ministry of Health, Welfare and Sport defines the framework in which each municipality can make its own policy, based on the composition and demands of its inhabitants. **And... this also counts for elderly abuse!!**

What happened more?

- 2007: focus more and more on domestic violence; next to reporting centres for elderly abuse and municipal information points on combating elder abuse, also supporting centres on domestic violence were created (often combination now).
- 2008: website related to domestic violence launched: **www.huisverbod.nl** next to www.huiselijkgeweld.nl en www.steunpunthuiselijkgeweld.nl
- 2009: The Temporary Restraining Order Act comes into force

A "Temporary Restraining Order" is ordinarily issued after an "ex parte appearance" (an appearance in court by one party without the other being present). The Temporary Restraining Order is an order of the court that states that a perpetrator of domestic violence is to refrain from particular acts and to stay away from particular places; (e.g. a domestic ban to forbid someone to enter his/her home);

This law can also be used in case of elderly abuse!

2009: Next to other materials a *guideline on elderly abuse* was launched. Follow-up trajectory starts after Stop Elder Abuse had finished 2007.

What happened more?

2010: The *SIGN CODE Domestic Violence and Child abuse* was presented to alert professionals in different social fields (health care, welfare, education, justice etc.) on cases of abuse and to stimulate them to report these cases to local or regional report centres.

(including elderly care professionals!)

2010: January; EuROPEAN (European Reference framework Online for the Prevention of Elderly Abuse and Neglect) has started!!

www.preventelderabuse.eu

AIM: to prevent and attack elderly abuse, by gathering information on European level about the prevention and management of elderly abuse in different countries:

Poland, Greece, Ireland, Austria, Slovenia, Slovakia, Czech Republic and The Netherlands...

Our project must collaborate with this one....??!

Issues:

- The right and uniform definition of elderly abuse and its types;
- How to screen on elderly abuse; which validated screening tool is most appropriate to use in different settings (e.g. community, residential care etc.)
- The way of registration of cases of elderly abuse in the community, health care settings etc.;
- Achieve comparable registrations on elderly abuse in different countries;
- Optimal policy to prevent elderly abuse including: registration, prevention, management and education of the public (incl. the elderly themselves) and the professionals.
- and an important point remains ...:

Optimizing willingness to report elderly abuse!!



- Report centres probably report only ‘the tip of the iceberg’

And:

- To address the difference between *elderly abuse* and *bad quality of health care services*;
- *Activating societal organizations (incl. health care organizations) and professionals remains very important..!!*
- *My own experience:*
when we did our study on elderly abuse in long-term care settings and reported about it (e.g. in the media), we faced a lot of denial by nursing home organizations themselves, or excuses by calling lack of resources and good quality personel as a logical reason for it; subsequently nursing homes expressed a shirking of responsibility to the government!

the government, on the other hand does not like reports of elderly abuse because of facing the blame of provinding to less resources to long-term care institutions...! Subsequently no funds for further research were provided.

**A lot of work has to be done!
I wish you all a lot of creativity!**



Worth 1000.com



FunnyfileZ.nl



Short overview Austria – The care system and elder abuse

Kick-off meeting „Preventing Elder Abuse“

11/12 March, Essen, Germany

Charlotte Strümpel, Monika Wild



Main pillars of the Austrian care and nursing system

- Family/informal care and nursing
- Institutional/formal care and nursing provisions:
 - home care
 - semi-inpatient care
 - in-patient care
- 24-hour-care



Recipients of Care Allowance

(31.12.2008)

	Federal		Provincial	
	Men	Women	Men	Women
Level 1	22.102	55.902	4.272	9.084
Level 2	41.656	79.931	6.512	13.715
Level 3	19.892	39.199	4.161	7.538
Level 4	18.773	36.108	2.782	5.193
Level 5	9.191	19.351	1.583	3.159
Level 6	3.669	6.541	1.633	1.901
Level 7	1.984	4.246	831	1.264
Sum	117.267	241.278	21.774	41.854
Total	358.545		63.628	

Gesundheits- und Soziale Dienste



The care system in Austria: Informal care

- 80 % of those in need of care are cared for by their relatives at home
- In 2005 25 % of these carers were supported by professional services
- App. 80 % of carers are women and 90% are related with the person in need of care
- The average age of carers:
women: 58 years; men: 61 years

Source: ÖBIG, 2005



Nursing homes

- 70.107 people were cared for in 773 nursing homes in 2008
- 339 public facilities: 36.124 people in need of care
- 307 private facilities: 28.378 people in need of care
- 67 confessional facilities: 5.605 people in need of care
- 70.107 places are classified in:
 - 35.944 nursing places
 - 19.917 residential places with care services
 - 14.246 residential places



Quality standards for nursing homes according to the agreement between the federation and the provinces

- **Size of nursing homes:** familiar and manageable structures
- **Rooms:** should be accessible for people with a disability, include shower facilities and be primarily single rooms
- **Infrastructure:** rooms for therapy, rooms for day care visitors, rehabilitation facilities, broad provision of services (e.g. hairdresser, foot care)
- **Personnel:** enough professional staff and support staff
- **Visiting rights:** visitors should be welcome any time
- **Site and neighbourhood:** as integrated in the community as possible
- **Medical care:** free choice of doctors
- **Supervision:** provinces have to ensure the supervision and legal protection of the residents

Source: 15a B-VG



Standards

- Each province has guidelines for community help and care
- There are guidelines for semi-residential facilities and provincial laws and regulations for nursing homes
- Each province has an inspection body within the regional administration – thus, systems differ between provinces



Existing laws concerning quality in long-term care

- Federal Law on the protection of personal freedom in residential care institutions
- Consumer Protection Law concerning mandatory contracts between residential homes and their residents



Federal quality initiatives

- The Federal Ministry of Labour and Social Affairs initiated a „National Quality Certificate for Nursing Homes“
- Quality assurance in home care – assessment of recipients of care allowance by nurses



Importance of elder abuse in Austria

- In the last years issue of elder abuse has been receiving more and more attention (e.g. Area „Violence against older people“ within the „Plattform against Violence within the Family“)
- Domestic violence against older people, specifically older women is a new topic (4-5 years)
- Federal Social Ministry commissioned a survey of experts on elder abuse



Who discusses elder abuse in Austria?

- Ministries (mainly: Health and Social Affairs) and other public bodies (provincial and municipal level)
- Non-Profit Organisations
 - Victim protection organisations
 - Social service organisations
- Professionals: social workers, nurses, psychotherapists
- Universities, research institutions
- Patient advocates

Issue is not present in:

- Senior organisations
- Media (exception: spectacular cases)



Who comes into contact with potential victims?

- Social services (specially those catering to older people in their own homes)
- Doctors
- Informal networks (neighbours, friends, relatives, volunteers,.....)
- Victim protection organisations



Political initiatives

- Platform against violence within the family (Initiated and supported by Federal Ministry; members: representatives in individual provinces)
- Commission and co-funding of studies (Ministries, City of Vienna)
- Several initiatives by City of Vienna to create networks on violence against older women



Discussion on elder abuse

- Discussion about violence in LTC has a long tradition
 - Structural violence and
 - Personal violence
- Discussion about violence against older people within the family has just come up in the last few years
- Discussion about violence in home care is not a big topic in the public, but within the provider organisations training and awareness raising has been put into place in the last few years



Breaking the Taboo - Objectives

- Raising awareness on violence against older women in families
- Empowering health and social service staff that works in people's own homes to recognize abusive situations and to help combat them
- Developing awareness raising workshops, conferences and brochures
- Developing tools and strategies to improve early recognition of violence against older women in the family



Aus Liebe zum Menschen.

ÖSTERREICHISCHES ROTES KREUZ

Breaking the Taboo - Partners

Coordination

- Austrian Red Cross (AT)

Main partners

- Research Institute, Viennese Red Cross (Austria)
- Jagiellonian University, Krakow (Poland)
- Emmeerre (Italy)
- THL Research and Dev. Centre for Welfare and Health (Finland)

Collaborating partners

- LACHESIS, (Belgium)
- CESIS, (Portugal)
- ISIS – Sozialforschung, (France)

Evaluation

- ISIS – Sozialforschung: Institut für Soziale Infrastruktur (Germany)



Gesundheits- und Soziale Dienste



Breaking the Taboo - Methods of research phase

- Literature overview
- Interviews n= 59 (AU 14; I 16; FIN 10; PL 19)
 - Home helpers, nurses, social workers, nurse assistants
 - Managers of the home help services
- Surveys n= 141 (AU 28; I 38; FIN 35; PL 40)
 - Health and social service providers (mainly home help and care),
 - Organizations dealing with abuse (crisis centers, hotlines, women's shelters)
 - Training and educational institutions



Breaking the Taboo- Experience with abuse

- Staff working with older women are mostly aware that elder abuse exists
- Some forms of abuse are not always recognized to be abuse
- Reported cases are rare
- Perception differs between managers and staff



Breaking the Taboo - Barriers for recognizing abuse and acting accordingly

- **Lack of privacy with client**
- **Victim denies abuse**
- **Dementia – difficulties to communicate**
- **Avoid conflict with family members**
- **Lack of training and experience**
- **Lack of time**
- **There are no clear procedures in place for staff to follow**
- **Problems while cooperating with other agencies**

Breaking the Taboo – Concrete project results

- Awareness raising brochure for community help and care staff in seven languages
- Summary and recommendations in seven languages
- European report and country reports in English
[To download reports:
<http://www.rotekruz.at/pflege-betreuung/weitere-projekte/#c2500>]
- Workshops in four countries
- Awareness raising conference in four countries

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Gesundheits- und Soziale Dienste



Breaking the Taboo – Workshop contents

- Why is violence within the family an issue for community health and social service professionals?
- What are we dealing with? Definitions
- Risk factors for violence against older women within families
- Recognizing abuse: signs, aspects to address in a first conversation, how to deal with doubts
- Strategies for staff members: who to report to and how?





Breaking the Taboo - Recommendations on organisational level

- **Developing clear organisational policies**
- **Offering training and education of staff**
- **Securing appropriate working conditions**
- **Enabling multi-disciplinary cooperation and communication**



Breaking the Taboo - Recommendations on policy level

- **Raising awareness**
- **Enforcing prevention and early detection**
- **Supporting networking initiatives**
- **Creating adequate structures**
- **Improving the legal framework**
- **Encouraging further research**
- **Securing sustainable funding**



Breaking the Taboo - Acknowledgements

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Centro de Estudos para a Intervenção Social



Elder abuse experience and status quo in Luxembourg

Essen, 12 mars 2010



- ▶ Le contenu de cette présentation est tout à fait subjectif et basé sur mon expérience personnelle



- ▶ Actuellement, aucune instance n'a une mission spécifique de prévention et de réponse à la maltraitance des personnes âgées
- ▶ Il n'existe pas de recensement systématique du problème
- ▶ Il n'existe pas de recensement statistique du problème



- ▶ Nous savons que le phénomène existe mais nous n'avons aucune idée de son ampleur
- ▶ La maltraitance révélée (par les plaintes) est connue mais n'est pas quantifiée
- ▶ A côté de cela, il existe certainement une maltraitance cachée dont on a aucune idée



- ▶ Les principaux témoins de maltraitance sont
 - La famille
 - Le médecin traitant
 - Les services sociaux
 - Les services d'aide à domicile
 - Les soignants
 - Les partenaires sociaux



- ▶ Souvent, les problèmes sont résolus discrètement
- ▶ Ils sont parfois signalés
- ▶ Il arrive aussi qu'ils ne soient pas résolus, ni signalés.



- ▶ La maltraitance reste un problème tabou et latent
- ▶ Episodiquement, il suscite de l'intérêt
 - B** Notamment parce que des situations individuelles de maltraitance sont signalées
 - B** Ces situations peuvent concerner de la maltraitance par des professionnels, à domicile ou en institutions
 - B** Elles peuvent concerner de la maltraitance par des proches



- ▶ A titre d'exemple de la réserve par rapport au problème de la maltraitance, je citerai une journée qui a été organisée par le Ministère de la famille en décembre 2009 et dont le thème était la "bientraitance"
- ▶ Lors de cette journée, seuls sont intervenus les services d'aide à domicile
- ▶ Les établissements stationnaires sont restés très discrets sur la question.



- ▶ Pourtant, la maltraitance existe et régulièrement, des situations sont signalées aux instances officielles:
- ▶ Au niveau de la Cellule d'évaluation, les situations signalées concernent
 - Abus financiers
 - Abus de droit
 - Négligence
 - Violence verbale
 - Beaucoup plus rarement: violence physique



- ▶ Les principaux récepteurs de plaintes en ce qui concerne la maltraitance des personnes âgées sont
 - =>les réseaux d'aides et de soins à domicile
 - =>le Ministère de la Famille et de l'Intégration
 - =>la Cellule d'évaluation et d'orientation de l'assurance dépendance
 - =>certains responsables de Maisons de soins
- ▶ Les instances officielles sont rarement la police ou la justice



- ▶ Le Ministère de la Famille et de l'Intégration sociale
 - Est en charge de la politique pour les personnes âgées
 - A la tutelle des prestataires d'aides et de soins
 - Fait régulièrement des visites de contrôle en ce qui concerne le fonctionnement des structures et infrastructures pour les personnes âgées.
- ▶ Constitue un témoin privilégié du problème mais actuellement, les résultats ne sont pas codifiés en vue d'un traitement systématique.



- Au niveau du Ministère de la Famille a été instauré un système d'aide téléphonique: le senioren- telefon est accessible pour toutes les questions relatives aux personnes âgées.
- Il avait été instauré principalement pour aider les personnes à trouver une place en établissement
- Il répond de plus en plus à d'autres formes de détresse des personnes âgées et de leur famille.



- ▶ Au niveau du senioren- telefon, il existe un système d'enregistrement des faits signalés
- ▶ Ce système pourrait être exploité pour évaluer la maltraitance révélée



- ▶ Au niveau de la Cellule d'évaluation et d'orientation de l'assurance dépendance, des plaintes sont régulièrement formulées
 - Par les prestataires pour signaler des mauvais traitements à domicile
 - Par les personnes âgées ou leur famille pour signaler des mauvais traitements de la part de professionnels, à domicile et en institution



- ▶ Au niveau des professionnels des réseaux d'aides et de soins à domicile
 - De nombreux soignants étaient désemparés car ils étaient impuissants à apporter une solution aux problèmes constatés
 - Les problèmes étaient la plupart du temps transmis à la Cellule d'évaluation et d'orientation de l'assurance dépendance



- ▶ Au niveau de l'assurance dépendance, toutes ces plaintes étaient traitées individuellement mais elles étaient rarement recensées, ni au niveau du contenu de la plainte, ni au niveau de la réponse apportée.



- ▶ Des systèmes de gestion des plaintes commencent à se mettre en place
 - Dans les réseaux d'aides et soins à domicile
 - Au Ministère de la Famille et de l'intégration
 - A la Cellule d'évaluation et d'orientation de l'assurance dépendance
 - Dans les établissements d'aides et de soins



Au niveau des réseaux d'aides et de soins

- ▶ L'approche est positive: les services parlent de mesures de « bientraitance »
 - Des mesures de la satisfaction des « clients » ont été réalisées par les services
 - Des mesures de la qualité des soins apportés sont réalisées
 - Des équipes psycho-sociales accompagnent les soignants
 - Les soignants suivent des formations aux démarches éthiques



Au niveau des réseaux d'aides et de soins

- ▶ Accompagnement des aidants informels
- ▶ Formation des aidants informels



Au niveau des établissements d'aides et de soins

- ▶ Obligation d'instaurer des chartes d'accueil



Au niveau du Ministère de la famille

- ▶ Mise en place progressive d'un système d'enregistrement des plaintes
- ▶ Mise en place progressive d'un système d'enregistrement des réponses aux plaintes
- ▶ Mise en place de cercles de qualité où le thème de la bientraitance est abordé



Au niveau de la cellule d'évaluation

- ▶ Élaboration d'une charte de valeurs
- ▶ Formation aux dilemmes éthiques
- ▶ Elaboration d'une charte d'accueil avec des systèmes systématique de contrôle du respect des engagements
- ▶ Réalisation de deux études sur la satisfaction des bénéficiaires à domicile
- ▶ Instauration d'un système de recueil et de gestion des plaintes



Au niveau de la cellule d'évaluation

- ▶ Instauration d'un système de promotion et de contrôle de la qualité des démarches des professionnels de la Cellule
- ▶ Instauration d'un système de promotion et de contrôle de la qualité des soins apportés par les prestataires



Au niveau de la politique générale du gouvernement

- ▶ Pour la première fois, la déclaration gouvernementale aborde le problème de la protection de la personne démente
- ▶ Il est projeté d'instaurer un groupe interministériel – Ministère de la famille/ Ministère de la Justice – pour envisager de nouvelles formes de protection juridique de la personne démente.



En conclusion

- ▶ Actuellement, au niveau du Luxembourg, on constate que le problème commence à être pris en compte
- ▶ Toutefois, les réponses restent encore en germe



En conclusion

- ▶ La motivation de la cellule d'évaluation à participer à ce projet
 - Nécessité de coordination et de systématisation des démarches éparses
 - Nécessité de donner une publicité au problème

ELDER ABUSE

Fundación INGEMA

Instituto Gerontológico Matia



instituto gerontológico matia

■ ■ How important is this topic in Spain?

- In Spain, the elder abuse has started to be a more significant social problem since few years ago and sensitivity and awareness of it has enhanced both from general society and from professionals involved in elder care.
- However, greater work of this issue tackles community or domestic elder abuse. It lacks studies about institutional elder abuse.

■ ■ Who is discussing this subject and how is it discussed?

- Legal and/or political level:
 - Spanish Organic Law against Gender Violence
 - Personal Autonomy Promotion Law and Attend of people in dependency situation
 - Elder General Management of Madrid Town Hall

Who is discussing this subject and how is it discussed?

- Spanish Organic Law against Gender Violence
 - Stated in 2003.
 - Focuses on physical and psychological violence and includes violence in domestic and institutional setting.
 - However, it emphasizes above all punitive aspects and the majority situations of elder abuse finish with other different types of interventions like provide resources, decrease stress or depression and so on.

Who is discussing this subject and how is it discussed?

- Personal Autonomy Promotion Law and Attend of people in dependency situation
 - Stated in 2006.
 - Focuses on dependent people including older in dependency situation and one of its objectives is explicitly the defence of their rights.
 - “Human rights and fundamental freedom with respect their dignity and intimacy”.

Who is discussing this subject and how is it discussed?

- Elder General Management of Madrid Town Hall
 - Program for detection of elder abuse.
 - Elder abuse cases are detected by Samur Social, Caregiver program, helpline, emergency service, Social Services and/or isolation program.
 - People responsible of this program include a psychologist and a social worker who contact with social worker of the area that elder belong and comment the case with his/her.
 - At the same time, information of this case is analyzed by them.
 - They propose the first visit to elder and go to his/her home, if is possible, together with social worker of the area that elder belong. The aim of this visit is to know more information about elder, caregiver, if he/she exists, or about the person who lives with elder.

Who is discussing this subject and how is it discussed?

- Elder General Management of Madrid Town Hall
 - After second or third visit they start the evaluation with Social Work Evaluation Form (SWEF) and Elder Abuse Suspicion Index (EASI), if is possible, as well as cognitive impairment and depression are assessed.
 - Then, the intervention is design by social worker and psychologist. Social worker focuses on well done education and possible resources and psychologist focuses on training of different strategies like social skills, relaxation, behavior modification and so on.

Who is discussing this subject and how is it discussed?



- Research level

- Following the indications stated in the International Madrid Action Plan on Ageing (MIPAA), as main results from the II World Assembly on Ageing (Madrid, April 2002), and after knowing the results of the study called “Missing Voices: Views of older people on elder abuse”, in which older people, as well as primary care professionals from 8 different countries participated, Spain started a solid research line on elder abuse in 2003. That initiative was created from a cooperation strategy between IMSERSO and Geriatric and Gerontology Spanish Society (SEGG), which has generated, to the present moment:

- Firstly, a qualitative study, following the indication of the report from “Missing Voices”, which aim was to analyse perceptions, attitudes and beliefs of the elderly and care professionals towards elder abuse in Spain. The results have been published in “Vejez, Negligencia, Abuso y Maltrato. La perspectiva de los mayores y de los profesionales”.

Who is discussing this subject and how is it discussed?



- Secondly, following other recommendation of “Missing Voices” study, which focused on the importance of the development of didactical material to professionals in order to tackle the elder abuse, it was developed the publication of “Elder Abuse: Action Guide” (Barbero, Barrio, Gutiérrez, Izal, Martínez, Moya, Pérez-Rojo, Sánchez del Corral and Yuste, 2005). This guide is supposed to be a professional tool for the prevention and detection of elder abuse, and, in case this has occurred, to the informed and conscious intervention with the victim and with the responsible of the abuse, independently if they are professionals or family members. Different institutions have developed other guides too.

Who is discussing this subject and how is it discussed?

- Research level
 - Spain is also part of the initiative “Project Global Answer to Elder Abuse, including Neglect” promoted by World Health Organization (WHO) and the Centre Interfacultaire de Gérontologie de l’Université de Genève (CIG-UNIGE). That worldwide project had as main result the validation of a tool for the detection of suspicion of elder abuse that had been created in Montreal.
 - This study had two phases. The first phase had two objectives.
 - Develop a culturally and linguistically appropriate instrument to suspect elder abuse modelled on the *Elder Abuse Suspicion Index* (EASI). EASI is an instrument that was developed and tested in Montreal. EASI consists of a few brief, direct questions (five questions asked of the patients and one asked of doctors) asked in the course of any office doctor-patient encounter, and formulated in doctor-friendly language. It is readily applicable to cognitively intact seniors (65+ years old) in order to generate a level of sufficient suspicion to justify referral to community experts in elder abuse such as social workers. EASI was designed not to necessarily “detect cases” – but at least to raise suspicion of the occurrence of elder abuse.
 - Help familiarize family doctors with elder abuse through the repeated use of a simple set of questions. For it, focus groups were carried out to knowing the validity of the EASI in different cultural and geographical contexts, and to assess its acceptance and usefulness among primary care professionals and older patients in other places than Canada.

Who is discussing this subject and how is it discussed?



- Research level
 - The second phase to this study was carried out to Pérez-Rojo, Izal & Montorio and was the validation of the EASI. This study had two general objectives:
 - Checking whether a tool, EASI, helps to detect elder abuse in community setting between elder that assist to Primary Health Care and/or Social Services centers.
 - Knowing the prevalence of suspicion elder abuse.
 - The specific objectives were a) EASI adaptation and validation, b) knowing the elder abuse and neglect prevalence in older without cognitive impairment in community setting and c) knowing elder abuse risk factors
 - The study included two phases: in the first phase, primary care professionals (general practitioners or nurses) or social workers applied EASI in individual interview to elder without cognitive impairment. 396 elder participated in this phase. In the second phase, psychologists or social workers applied The Social Work Evaluation Form (SWEF), which is a tool wider than EASI. 340 elder participated in this phase.

Who is discussing this subject and how is it discussed?



- Research level
 - The results show elder abuse suspicion is a multidimensional phenomenon and it should be considered like a phenomenon with different categories: neglect, economic abuse and interpersonal abuse (psychological and physical and sexual abuse). EASI is a useful tool because it helps to increase the professional sensitivity to elder abuse and permit the detection of six out ten cases of elder abuse suspicion confirmed. However according to the results, the EASI statistic utility is warranted in social services centers but not in primary health care centers because its sensitivity in this setting was very lower.
 - It has found a elder abuse suspicion prevalence of 12.1%. This percentage was very similar to it obtained in the original study by Canadian researchers (11.9%). Psychological abuse was the most frequent type of abuse and it was frequent the simultaneous presence of different types, especially psychological abuse and physical and sexual abuse. Women are the most frequent victims of elder abuse than men, and spouses are the most frequent responsible of elder abuse.
 - According to the results, the elder abuse risk factors included characteristics belonging to elder, responsible and context situation. The characteristics to belonging elder were to be women, to have poor health perceived, to get sad, to be isolated and to be dependent economically of other person. The characteristics belonging to responsible were substance abuse, cognitive disorders and to be good health. And, finally, the characteristics belonging to context situation were to have poor quality previous relationship with career, to have family conflicts or to have living arrangements problems. These risk factors should be take account to prevention, detection and intervention in elder abuse situations.

Who is discussing this subject and how is it discussed?



• Research level

– Moreover this group of researchers also has tackled elder abuse by informal caregivers. They analyzed on the one hand, risk factors associated to elder abuse in elderly dementia caregivers and on the other hand, the differential efficacy of two interventions for dementia family caregivers aimed at the reduction of risk of abuse.

- Firstly, they analyzed the discriminative capacity of several risk factors of elder abuse and neglect, in order to identify what characteristics distinguish between caregivers with a high or low risk of abuse and neglect. The combination of caregiving impact, frequency of aggressive behaviors by care recipients, stress related to provocative and aggressive behaviors, the frequency of provocative behaviors, interpersonal burden, autoefficiency expectations, quantity of help received and depression were characteristics distinguish between caregivers with a high or low risk of abuse and neglect.
- Secondly, they compared the effectiveness of two interventions for dementia family caregivers: a cognitive-behavioral program (CBP) aimed at managing and reduction of caregiver stress and a problem solving program (PSP) aimed at coping and reduction of behavioral problems by elder with dementia (e.g. aggressiveness, deambulation and so on). Both programs were compared in their capacity to reduce the risk of elder abuse by informal caregivers. Although both programs were not designed specifically to prevent the risk of elder abuse, they focus on variables related with it like caregiver stress and depression, aggressiveness by older people with dementia and so on.

Who is discussing this subject and how is it discussed?



- Research level
 - No significant differences were found between these groups (CBP, PSP and control group) at pre-intervention, post-intervention and follow-up assessment.
 - Finally, they also assessed the intra-group differences at pre-intervention, post-intervention and follow-up assessment. And only the caregivers in the PSP program showed significantly less risk of elder abuse at post-intervention and at follow-up. These results may be explained by previous findings in which the problematic behaviors are one of the main risk factors of elder abuse and, this program provides the education on Alzheimer's Disease fitting expectations and knowledge of the caregivers.
 - It should be pointed out that the scope of conclusions that can be drawn from the results of this study is limited.
 - This is the only study in Spain focus on the intervention of elder abuse.

Who is discussing this subject and how is it discussed?



- Research level
 - Other institutions have carried out projects to assess the prevalence of elder abuse, although all these studies tackle community elder abuse and none of them institutional elder abuse. There is a lack of investigation about this issue.
 - Now and regarding the Basque Country, INGEMA is carrying out a project for knowing the prevalence of the elder abuse suspicion in community setting and developing a wide elder abuse strategic plan in the Basque Country (Spanish autonomous region with 401.664 elderly people) which will include the appropriate actions to help in the detection, prevention and intervention of elder abuse.

Who is discussing this subject and how is it discussed?



- Organizations level
 - Because of the problematic current situation with respect to promotion and warrantee of the dependent elder rights and specifically the rights of elder with dementia as well as their caregivers a permanent seminary was developed in Basque Country. This seminary is leaded by INGEMA and Hurkoa Foundation and tackled “Elder and their caregivers’ rights and prevention on inadequate care”. In this seminary participate different professionals of community and institutional setting and different disciplines (health care, social and institutional).
 - The objectives of this seminary are:
 - Knowing the current situation of dependent elder with dementia´s rights and their family caregivers when live in their home or in institutions.
 - Checking good practices of priority and basic rights.
 - Implementing measures for the promotion of rights.
 - Disseminating knowledge to other institutions and organizations.

Who is discussing this subject and how is it discussed?



- Organization level
 - This seminary meets every three-monthly and bring their ideas together. They have dealt four areas:
 1. Elder and their caregivers´ rights and barriers of them.
 - They have related elder´s rights and institutional characterists.
 2. Inadequate care in health care setting.
 3. Inadequate care in social care setting.
 4. Inadequate care in community setting.
 - They have developed tools for elder abuse in the community and institutional setting.
 - Moreover, The Association ALMAMA (Association of Fight Against Elder Abuse) which has a website and its aim is help elder that live a elder abuse situation in everywhere setting. It is the only association that exists in Spain directed to tackle exclusively elder abuse. It came up at 2009.

Who is discussing this subject and how is it discussed?



- Training level
 - Different workshops, congress, conferences and courses have been carried out for professionals of several disciplines (health professionals, social workers, psychologists, lawyers and so on) but none of them for elder people or for informal caregivers.

Who is discussing this subject and how is it discussed?



- Website level
 - Two interesting sites in internet tackled elder abuse.
 - The website Portal Mayores (www.imsersomayores.csic.es) which is a free access scientific website specialist in Gerontology and Geriatrics, developed by Scientifics Researches Major Council (CSIC) and Social Services and Elder Institute (IMSERSO) for academic and scientific setting, social services, elder themselves and the society in general. It was created in 2001 and has a section about elder abuse with general information, links, scientific articles, documents, bibliography and so on.
 - “Putting in their skin” is a web campaign. The aim of this campaign is working for wellbeing of our elder. It has been acknowledged by INPEA as a current action in Europe that search to make aware the population about the importance to stop elder abuse.

Who can come in contact with potential victims of elder abuse?



- The own victim of elder abuse can come in contact with resources or professionals for asking help.
 - Helpline like 016 that is a telephone number that helps women that are victims of abuse independently of their age.
 - Moreover, some communities have a telephone number of elder attention. It is a free service in the frame of the policies of personal autonomy promotion and prevention of possible risk situations.
 - They also can call police too, if it is necessary.
- Family, friends and neighbors can come in contact with available resources or professionals if they know a situation of elder abuse.
- Professionals of social services or health services, specially primary care professionals or general practitioners can come in contact with potential victims of elder abuse when the possible victim attend to an appointment with them or when they go to elder's home.

■ ■ How do they deal with these situations?

- It depends on the type of situation.
- Possible alternatives.
 - Professionals, independently of their discipline, can collect data about the situation and make a decision about it.
 - If they believe elder is being abused they can come in contact or refer the case to police, Social Services, attorney general, etc. For example, if general practitioners found signs of physical abuse they can fill out a form and send it to attorney general.
- However elder abuse does not have the importance of those other types of violence for several reasons, like for example it is more hidden because of different barriers (negation, for example), is more frequent inside the elder's home, presence of ageism and negative stereotypes (for example, a bruise on an arm is perceived differently whether it is on an older person or a child that presents it).

Differences between family-care, home-care and institutional long term-care

- People that provide care.
 - While in family care the person that provide care is probably a relative of elder (informal caregiver), in home-care and institutional long-term care is a professional (formal caregiver).
- Training of people that provide care.
 - Informal caregiver hasn't any training about the necessities and about how care to elder while formal caregivers should have necessary training for well done their work.
- Help provide to elder can be different.
 - In home-care the majority of help can be directed to housework but in family-care and institutional long term-care can be directed to housework but also personal care.
- Motives of care can be different too.
 - In home care and institutional long-term care, professionals care elder because is their job but in family-care motives are very different like reciprocity, love, obligation, social approbation, familism and so on.



**THANKS FOR YOUR
ATTENTION**

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