ONPEA Core Curriculum & Resource Guide

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Overview

ONPEA Core Curriculum & Resource Guide

The ONPEA curriculum and resource guide has been designed to reflect a wide variety of views and perspectives about Elder Abuse provided by stakeholders in Ontario. This guide also provides information about the many networks, organizations, projects, and subsequent resources and successes.

The guide offers relevant and usable information to help all those who interact with seniors continue to create and maintain an environment of safety and trust in which the senior may choose to live with dignity and respect.

The Ontario Network for the Prevention of Elder Abuse (ONPEA) has produced this resource guide as part of the training priority of Ontario's Strategy to Combat Elder Abuse. The plan for enhancing the capacity of those that work directly with seniors to recognize and respond to elder abuse includes a variety of learning methods and job aides and the development of e-learning tools that will align with the information presented in this resource guide.

ONPEA is dedicated to raising awareness of elder abuse and neglect through public education, professional training, advocacy, and service coordination. For more information about ONPEA visit: www.onpea.org

Goals of Core Curriculum & Resource Guide

The goals of this resource guide align with the goals of the training priority of Ontario's Strategy to Combat Elder Abuse. Through the use of a three-question template and a variety of learning strategies the main goals for the ONPEA elder abuse training programs are to enhance the capacity of those working with seniors to:

1. Develop an understanding of the multifaceted nature of elder abuse.
2. Recognize indicators of abuse.
3. Interact with the senior at risk.
4. Report and reflect on interactions with the senior at risk.
5. Provide supportive care/service strategies.
6. Work as a team to support the senior at risk.
7. Work with communities to support the development of prevention strategies

Structure of Curriculum & Resource Guide

Many excellent resources currently exist regarding elder abuse; these include awareness and education programs, scholarly papers and publications, and internet-based training and information to name a few. To some, the sheer volume of information may be overwhelming and present challenges in terms of distilling best practices and the most meaningful ways to change practice at an individual, team, and organizational level.

This guide is structured to assist educators, facilitators of change, and a **wide-range of learners** to develop a common vision, common language, and common approach to the recognition and prevention of elder abuse and to continually improve related practices. The following describes the template used to shape each chapter of the curriculum into a user-friendly, practical, and actionable format.

General to In-Depth Materials

Given the diverse audience that may benefit from using this Resource Guide, content has been structured and identified through the use of icons to:

Indicates **general information and/or overview** of the topic or 'foundational' concept(s) to develop a common vision, understanding, and approach.

Indicates **specialized information** and discussion that will be helpful for a specific field, for example, a focus on unregulated workers and volunteers in the community or in long-term care homes, or experienced practitioners such as regulated health professionals in emergency departments and family physicians. Information may also target senior leaders that are accountable for enabling practice change to occur within an organization.

Indicates **Learning tools** are available such as laminates, slides, fact sheets etc.

Indicates **Actionable** items and provided at the end of each chapter.

Note: The terms Older Adult, Older Person, and Senior are used interchangeably in this resource guide

ONPEA Template to Guide Thinking Through Complex Issues

Understanding
The key issues of elder abuse which in-turn leads to the ability to recognize, interact and respond. Each situation is unique.

Recognize indicators of abuse
- Why is this situation causing me concern?
- What am I observing?

Interact with the senior at risk
- How do I feel about this situation/the alleged abuse?
- What are the values, wishes, goals of the person?
- Is the senior making the decisions?

Respond
- What resources are required?
- What are my responsibilities?
- What is my role on the team?

Reflection
Stop and think about the situation to promote a better understanding of the issues on an individual, team, organization, and systems level; this can contribute to better responses and the prevention of elder abuse.

This template can help guide thinking through a complex issue; it is an iterative process. Understanding grows with experience and reflection and helps with next situation.

Chapter 1

Introduction to the Ontario Network for the Prevention of Elder Abuse (ONPEA) and The Provincial Elder Abuse Curriculum

Understanding
The key issues of elder abuse which in-turn leads to the ability to recognize, interact and respond. Each situation is unique.

Recognize indicators of abuse
- Why is this situation causing me concern?
- What am I observing?

Interact with the senior at risk
- How do I feel about this situation/the alleged abuse?
- What are the values, wishes, goals of the person?
- Is the senior making the decisions?

Respond
- What resources are required?
- What are my responsibilities?
- What is my role on the team?

Reflection
Stop and think about the situation to promote a better understanding of the issues on an individual, team, organization, and systems level; this can contribute to better responses and the prevention of elder abuse.

Chapter One: Introduction to the Ontario Network for the Prevention of Elder Abuse (ONPEA) and The Provincial Elder Abuse Curriculum

What is Elder Abuse?

The World Health Organization (2002) defines abuse of older adults as "a single or repeated act, or lack of appropriate action, occurring in any relationship where there is an expectation of trust that causes harm or distress to an older person."

Elder abuse can take place in the home, in a residential setting, long term care home, or in the community.

Financial abuse and emotional abuse are by far the most common forms of elder abuse. Neglect and physical abuse are less frequent.

Elder abuse is often referred to as the "hidden crime".

What is the cost to the person and society?

Abuse in later life has widespread health, economic and social costs, and implications to the individual, society, government and businesses. Costs also relate to community services, justice, prevention, education, and research. The effect of abuse on seniors can differ significantly from younger adults, partly because of changes in a senior's health and his or her ability to rebuild resources in later life (Spencer, 2000).

"Injuries sustained from abuse or neglect can have serious implications to a senior's health and independence" (Spencer, 2000 p. 5). Lachs et al., (1998) and Lachs (1998) found that older persons subjected to abuse such as physical pain, injury, or mental anguish were at significantly higher risk for death than non-abused older persons.

Health costs (monetary values) may negatively affect seniors' rates of hospitalization, need for community health services and medications (e.g., tranquilizers, antidepressants), and rates of institutional placement (Spencer, 2000; Enhancing Safety and Security for Canadian Seniors: Setting the Stage for Action, 2006). Seniors who do seek assistance may also require access to a multitude of health-related services such as geriatric assessment (short stay assessment and treatment units, competency assessments), case management services, hospitalization, use of day hospitals, and rehabilitation centres to name a few (Spencer 2000). In an otherwise productive, self-sufficient individual, a single incident of abuse can move an older person into a downward spiral with many complicated health conditions that can eventually lead to death.

Because many older people have fewer support systems and reserves, the social impact of abuse may be increased. The overall impact of abuse in later life affects the senior and his or her family, friends, communities, and businesses. The senior may experience pain, anguish, grief, humiliation, damaged self-confidence or self-esteem, and loss of faith in family or friends.

In communities where there has been a tradition of respect to older members, undermined social norms and breakdown of community closeness are other social effects (Spencer, 2000).

Loss of financial resources often takes away or reduces the senior's choices (where and how to live) and can undermine the senior's quality of life (Spencer, 2000). "Abuse in later life creates opportunity costs for seniors as well. For example, assets and resources lost through financial abuse mean that the senior has far less for basics of housing, food, medications and transportation, let alone leisure activities, or resources to pass onto family or others at death." (Spencer, 2000 p.4).

The extent and cost of elder abuse can only escalate given the demographics of an aging population with fewer children available as family caregivers and an ever-growing need for quality care giving.

Can elder abuse be prevented?

Abuse rarely stops without intervention. One strategy is for communities to work together with seniors to develop practical strategies to promote choice, well-being, and living safely in the community.

Education programs for workers and the public to Recognize, Interact, and Respond also contribute to the prevention of elder abuse. More specifically, service providers can work with the senior to:

- Learn more about his or her rights and responsibilities
- Build or regain his or her confidence and skills
- Reduce social isolation; increase social activity
- Learn how to access available community resources
- Learn strategies to protect themselves from abuse

Note! A key component of staff education programs is organization commitment and support for the learner, for the team, and for organizational change.
See CHAPTER 8 for important details.

Seniors should be able to access services and support programs at many different entry points, including services in both the violence against women and the seniors sector (ONPEA, 2006).

Researchers generally agree that the state of knowledge regarding elder abuse is about three decades behind the state of knowledge on child abuse and about one decade behind that of domestic violence. To properly detect elder abuse, health care and other professionals need to understand the aging process, including age related changes.

Ontario Network for the Prevention of Elder Abuse (ONPEA)

The Ontario Network for the Prevention of Elder Abuse (ONPEA) was incorporated in 1992, establishing a provincial non-profit, charitable organization dedicated to the prevention of elder abuse and neglect. Through the years, ONPEA has worked with various organizations to promote awareness and education of elder abuse through hosting provincial and international conferences, developing educational resources, launching inter-generational initiatives, building community support groups, working with faith groups and delivering the Provincial Elder Abuse Strategy. ONPEA's academic links with the University of Toronto and Ryerson helped establish a body of research in this field. Through the work of Dr. Elizabeth Podnieksand others, national and international ties and collaborations were developed.

ONPEA oversees the training priority of Ontario's Strategy to Combat Elder Abuse. The main goals for the ONPEA training program are to enhance the capacity of those working with seniors (paid workers and volunteers) to recognize and respond to elder abuse by:

1. Developing an understanding of the multifaceted nature of elder abuse.
2. Recognizing signs and symptoms of abuse.
3. Interacting with the senior at risk.
4. Documenting and evaluating interactions with the senior at risk.
5. Providing supportive care/service strategies.
6. Working as a team to support the senior at risk.
7. Working with communities to support the development of prevention strategies.

ONPEA connects with seniors to develop practical strategies to promote choice, wellbeing, and living safely in the community.

Background

Ontario's Strategy to Combat Elder Abuse, launched in 2002, was developed with advice from the private and public sectors through the Round Table on Elder Abuse; it addresses three key priorities:

1. Coordination of Community Services: Strengthening communities across the province by building partnerships, promoting information sharing and supporting efforts to combat elder abuse
2. Training for Front-Line Staff: Training for front-line staff from various sectors, who work directly with seniors, to prepare and support them in recognizing and responding to elder abuse.
3. Public Education to Raise Awareness: Develop a province-wide public education campaign that promotes awareness of abuse of seniors and provides information on how to access services.

The Ontario Network for the Prevention of Elder Abuse, the Ontario Seniors' Secretariat, and the Ministry of the Attorney General have been partners in the implementation of the Strategy.

A key component in ONPEA's success to date has been the role of the Regional Consultants (see Appendix A). Over the past four years a large part of their role has been devoted to building relationships and networks. These established connections now serve as an efficient vehicle for assisting with the local implementation plans for the new curriculum, training, and materials to a wide range of audiences. Regional Consultants are also responsible for the distribution and evaluation of training, materials, and job aides. The consultants also link with stakeholders and other provincial education initiatives to circulate the core curriculum to the broadest audience.

ONPEA Leadership Role in Learning and Development

The Ontario Network for the Prevention of Elder Abuse houses extensive knowledge and experience and provides expertise, practical steps to combat elder abuse, and linkages to other pertinent resources. In its leadership role, ONPEA provides a Learning Resource Centre that serves seniors, the general public, professionals, and private businesses by:

1. Providing core curriculum that serves as the foundation for all its training programs. The curriculum builds on ONPEA's primer, The Abuse of Older Adults (Basic Introduction I and II).
2. Responding to learning needs and aspirations of a large-range of audience with high impact and practical training strategies.
3. Making linkages with seniors and other partners and sharing resources.
4. Supporting the work of the Regional Consultants.
5. Evaluating its results and continually improving its training programs.

ONPEA understands that although training can be a vehicle for large-scale system change, it also acknowledges that training is just **one part of a larger solution** to improving practices. ONPEA has embraced a broader performance improvement approach to develop its comprehensive training program; this includes consideration of other factors that influence performance at an individual learner level, team, organization, and systems level. Influencing factors include consideration of an organization's culture, supporting policy and procedures, resources, responsibility, authority, reinforcement and coaching the transfer of new skill and knowledge into day-to-day practices. By proactively managing these factors ONPEA increases the likelihood of changes in practices related to the recognition and response to elder abuse (also see Chapter 8: Taking Action).

Training Program Principles

Training programs emerging from ONPEA are learner-focused and:

1. Provide clear performance expectations.
2. Identify essential supports for the end-users.
3. Focus on the development of individual capability.
4. Use best knowledge and practices.
5. Are user-friendly.
6. Make the best use of resources.
7. Create strategies to nurture and sustain gains.

Ethical Principles

The guiding ethical principles presented in this resource guide align with a rights-based philosophy. A rights-based philosophy believes that the senior has the right to self-determination. A senior, like all capable adults, has the right to make his or her own decisions, based on his or her own values and beliefs.

Every senior has:

- The right to accept or reject help.
- The right to be treated with dignity.
- The right to have his or her privacy respected.

Anyone interacting with an older adult follows his or her lead and assistance is based on letting the person make his or her own decisions (The Council on Aging - Ottawa-Carleton, 1995).

Adults have the right to:
(International Federation on Ageing, 1999)

1. Basic requirements for life: to be guaranteed food, shelter, clothing, health care and social interaction
2. Autonomy/self-determination: to live life as they wish and control their affairs to the full extent of their ability
3. Safety and protection: to live their lives free from abuse
4. Freedom: to accept or refuse assistance, intervention or medical treatments, and to live at risk, provided they are competent to choose and do not harm others
5. Privacy: to share only that which they wish to share
6. Confidentiality: to be assured information, which becomes known about them, will only be shared with other professionals after providing informed consent
7. Dignity and Respect: to have their dignity and information respected
8. Access to Information: to be able to access the information necessary to make meaningful and informed choices; and to be fully informed about their civil and legal rights

Each senior has the right to expect that services and interventions will enhance his or her capacity to maintain control of his or her destiny and decision-making as well as preserve and maintain quality of life. Services and interventions need to address:

- Cultural diversity
- Language barriers
- Religious beliefs
- Lifestyle choices
- Poverty
- Disabilities
- Educational background

Situations may arise when it is not possible to respect a person's request for confidentiality of disclosure or to engage in dialogue to ascertain the senior's wishes. Situation examples include:

Imminent risk for serious harm to the life of the older person or he or she is at serious risk for injury

The older adult that lacks the capacity to make decisions about personal care and/or managing property

Long-term care homes legislated requirement to report abuse of a resident

Where there is a legislated requirement for regulated health care professionals to report if they believe another regulated health care professional has sexually abused an older adult for whom they are providing services.

Wherever possible, staff should try to ensure that the older adult understands the need for staff to report in these circumstances so that he or she does not feel that his or her confidentiality is being betrayed.

Aboriginal Issues

Within the Aboriginal communities (First Nations on-reserve/off-reserve, Non-status, Metis and Inuit), the concept of elder is associated with someone who is rich spiritually, and wise in the history, traditions and practices of their culture. The elder is seen as a leader and can be of any age, not necessarily an older adult. The essence of elder abuse may be better captured within this group by naming it the mistreatment and abuse of older adults or seniors (NCFV, 2006).

In order to understand the cycle of abuse in Aboriginal communities, the experience suffered by many Aboriginal people attending residential schools must be understood. The term "residential schools" generally refers to a variety of institutions (industrial schools, boarding schools, residential schools and more) that grew out of Canada's missionary experience, and later, the Federal Government began to play a role.

Aboriginal children were taken from their homes, without parental consent, and placed in the schools with the intent of "teaching them to be productive members of Canadian society". They suffered various forms of abuse (sexual, physical, violation of rights, neglect, and emotional/ psychological) at the hands of people in positions of authority, trust and those with care-giving responsibilities. Upon leaving the residential school, as young women and men, many transferred their experience onto other members of their family and community by being abusers themselves. This initiated a cycle of abuse within the family and the community.

Understanding Ethics and Biases

The following factors require consideration where a person is uncertain or conflicted about what is the right thing to do. The list of factors is not exhaustive or in any order of importance or priority. These factors are interrelated and may compound the impact of one's interaction with the senior. In dealing with these factors, the worker needs to be aware of his or her own personal and professional ethics and biases and how these may influence his or her decision-making with the senior.

1. Culture, values and language differences

- Always consider personal attitudes and biases.
- Define differences between law, ethics and moral responsibility; each situation is unique.
- Involve various disciplines, agencies, and individuals; each will have their own protocols, policies and views. Agency approaches may produce conflict if they bring different values and philosophies to abuse prevention, for example, protectionism versus self determination. (Refer to Chapter 7 for more details.)

2. Respect for the privacy of the family

- Be aware of each family's history.
- Think about the value placed on a long-standing family relationship; consider what the degree of harm must be before intervention is justified.

3. Ageism

- View the older adult as any other member of society. Bias about age may create assumptions about capacity and value of the older person; this may in-turn influence a worker's interactions with the older person.
- Consider the interventions utilized with younger persons exhibiting risky behaviours (e.g. excessive drinking, smoking, poor eating habits); these may be to provide information, education, and suggest alternate behaviours. To respond differently to an older person (e.g. making the choice for the person's "own good") is an example of "ageism".

4. Capacity

- Balance between the capacity of the person and his or her right of independence is critical.
- Determine who has the right and ability to make decisions for the older adult if he or she is mentally incapable
- Determine when protectionism prevails over an individual's right.

5. Protecting self versus self-determination for the older adult

- Consider the rights of the older person to make decisions and how his or her decisions may conflict with the worker's concern for his or her own safety (e.g. fear of legal liability, loss of livelihood).

Understanding Ethnic-Cultural Issues

According to McGregor (1995), many of the issues associated with elder abuse in the general population are also found to be present in abusive situations in ethnic-cultural communities. Problems include adapting to life in Canada as well as inter-generational differences in values, beliefs and expectations. These differences can create circumstances that can lead to abuse such as in the case of sponsorship breakdown; this occurs when the relationship between children and the older parents that they sponsor deteriorates to the point where immigrants cannot look to their sponsor for support of any kind (McGregor, 1995). Older adults may end up marginalized, isolated, and destitute.

Women in some cultural communities are more oppressed than in others. New Canadians bring a new set of issues that we may not have thought about yet!

Respecting Diversity

(CAMH, 2006)

The senior population is one of the most heterogeneous populations due to the variety of life experiences encountered. When ethnicity, with its own traditions and responses to health care, family dynamics etc., is added, the complexity in dealing with issues of elder abuse is heightened. Consider that in Canada, there are over 200 ethno-cultural groups (National Advisory Council on Aging, 2005).

To respect the differences is to acknowledge, for example, language, religion, custom, sexual orientation, socioeconomic status, and to be aware of personal attitudes and biases to these factors.

Cultural diversity may influence the manner in which an individual presents him or herself (e.g. clothing, body language, etc.) and the way in which the professional is perceived or welcomed into a family situation. Barriers, attitudes, and biases are held and experienced by both the worker and the senior.

Understanding some of the behaviours, attitudes, and family groupings of various ethnocultural populations will assist the worker in being an effective resource for the senior.

Chapter One: Introduction to the Ontario Network for the Prevention of Elder Abuse (ONPEA) and the Provincial Elder Abuse Curriculum

The following chart provides the reader with action steps:

ITEM	ACTION
ONPEA 3 question template.	Memorize. Share with others today.
Awareness and understanding of senior's rights.	Demonstrate integration into day-to-day practices.
Awareness and understanding of ethical issues.	Identify potential ethical conflicts in your practice. Reflect on appropriate action.
ONPEA contact information.	Add to your resource list.

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Appendix A: Role of the Ontario Regional Elder Abuse Consultants

What Regional Consultants do for Seniors:

- Provide education and awareness sessions and educational materials to seniors about abuse prevention
- Link seniors with peer support and inter-generational programming
- Take calls from seniors and their families about abuse and refer to appropriate agency
- Consult with agencies like the police and CCAC re abuse of seniors

Regional Consultants also:

- Support local elder abuse committees and networks and strengthen partnerships among them
- Facilitate and undertake education and training initiatives for professionals, volunteers, and seniors
- Promote information-sharing among professionals and volunteers working with abused seniors
- Develop model protocols on issues such as information sharing among service providers working with abused seniors.

The Regional Consultants are organized by regions set by the Ministry of the Attorney General: North West, North East, Central West, Central East, East, and the Greater Toronto Area.

Chapter 2

Understanding Elder Abuse

Understanding
The key issues of elder abuse which in-turn leads to the ability to recognize, interact and respond. Each situation is unique.

Recognize indicators of abuse
- Why is this situation causing me concern?
- What am I observing?

Interact with the senior at risk
- How do I feel about this situation/the alleged abuse?
- What are the values, wishes, goals of the person?
- Is the senior making the decisions?

Respond
- What resources are required?
- What are my responsibilities?
- What is my role on the team?

Reflection
Stop and think about the situation to promote a better understanding of the issues on an individual, team, organization, and systems level; this can contribute to better responses and the prevention of elder abuse.

Chapter Two: Understanding Elder Abuse

Public Service Announcement Videos

Understanding the Problem – The Big Picture

There is no clear explanation for why some people hurt or take advantage of others. Elder abuse is a complex problem and crosses cultures, religions, and socioeconomic statuses; it can happen anywhere, any time, and to any senior. Understanding what abuse is and being able to recognize it is the first step in prevention.

The three main causes of elder abuse are:

1. Interpersonal Power and Control

All abusive relationships, regardless of age, are about power and control. The abuser may try to keep control over the victim by using threats, intimidation or coercion. The more someone is vulnerable, the more likely he or she could be taken advantage of in some way (Brandl & Horan, 2002; Horsman, 2005).

2. Isolation

Isolation is one way the abuser controls the victim and helps ensure that the abuse is kept hidden. The older victim is kept isolated by the abuser from other friends and family, from their social network, and community (Groh, 2003).

3. Dependency

The abuser is often dependent upon the abused for financial support and sometimes emotional support. The victim may also be dependent upon the abuser for physical care and activities of daily living (Horsman, 2005).

Other factors that will contribute to understanding elder abuse include:

4. Knowledge of the Aging Process

Advancing technologies in medicine and other fields have made it possible for the majority of seniors to remain healthy longer than preceding generations.

To detect abuse in seniors, workers across all sectors need some appreciation of the aging process and knowledge of the indicators of abuse or neglect. Health care workers and certain professions in particular require a level of assessment skills to identify age-related changes and indicators of abuse or neglect. Dyer, Connolly, and McFeeley (2003) note that in the medical and forensic science fields alone, knowledge regarding elder abuse is running about three decades behind that on child abuse and about one decade behind that of domestic violence.

Understanding the extent of the problem and finding ways to reduce the risk of abuse for older people requires ongoing education to workers and the public.

5. The Aging Population

The fastest growing segment of the population is over the age of 65. (Statistics Canada, 2006).

For the first time in history the 65+ population will outnumber those under the age of 15 by 2015. In 2005 persons aged 65+ made up 13% of the Canadian population (14 million). Projections indicate that by 2031, 65+ will make up 23% to 25% of the population; 1 out of every 4 Canadians will be over the age of 65 (Statistics Canada, 2006).

The effects of this aging trend are far reaching and continue to be researched and published. As people live longer in Canada, the incidence of age-related illnesses, injuries and abuse are expected to rise. These statistics will have a significant impact on community and government resources. Priorities and policies will be determined by this demographic shift and the issue of elder abuse is one of these important public policies.

Close to Home

Researchers and those working in the field of elder abuse use different definitions and different age ranges to describe abuse; this helps to explain the wide range of frequency found in the literature. According to experts (Lachs & Pillemer, 2004; Stats Canada, 2000) it is conservatively estimated that 2-10% of older adults will experience one or more forms of abuse at some point during their senior years; this represents between 148,000 and 370,000 older adults in Canada today. The rate of abuse among certain subpopulations of vulnerable seniors (e.g., among cognitively impaired seniors or physically dependent seniors) may be three to four times higher than the rate found in the general senior population. (Cooney & Mortimer, 1995; Compton, Flannagan & Gregg, 1997).

What does this mean? Using a figure of 10% for Ontario means that up to 160,000 older adults are suffering some form of abuse in this province. For those who work with seniors on a daily basis, at least 1 out of every 10 seniors will experience some form of abuse. Many front line workers speculate under reporting of elder abuse and realize that most victims do not want to report this type of abuse due to the sensitive nature of the issue and the fears associated with disclosing abuse. (See Chapter 6, page 63 for more details)

Regardless of how abuse is defined, it is clear that even one case of elder abuse is too many.

6. Ageism

Ageism contributes to abuse of the older person. Ageism is defined by Butler (1975) as discrimination on the basis of age that:

- Makes assumptions about capacity.
- Removes decision-making process.
- Ignores older person's known wishes.
- Treats older adult as a child.

7. Location

Elder abuse occurs everywhere; it is not limited by ethnicity, culture, wealth, or age. Elder abuse can occur in any setting including the community, personal residences, as well as in long-term care homes. A common misconception, reinforced by powerful media attention, is that most abuse happens in an institutional setting. While abuse does occur in long-term care homes and other institutions; the majority of older Canadians currently live in private dwellings.

Currently there are only 287,000 seniors across Canada living in institutions (Statistics Canada, 2003) therefore the majority of abuse actually occurs in private dwellings. In 2001, 14% of people over the age of 75 lived in long term care homes (NACA, 2005).

Understanding the Abuse Continuum

Abuse is rarely a one-time occurrence. If not addressed, it can escalate in frequency and severity. Anne Sclater, M.D. (2000) suggests elder abuse does not occur as an isolated incident; rather it is recurrent in up to 80% of cases. All forms of abuse can progress from minor incidents to situations where medical treatment would be necessary and/or death is imminent.

When examining the effects of elder abuse, it is important to understand that typically minor assaults or abuses may result in minor harm or may result in serious consequences such as death. The concept of an abuse continuum is often used to enhance the understanding of the impact these typically minor incidents have on a senior, for example, telling the person he or she is useless. While the person may not have endured serious physical harm, the incidents are still considered abusive and should be treated as seriously as more harmful examples of abuse. In addition, minor incidents of abuse can escalate and progress to more severe encounters.

Understanding the Types of Abuse

There are many different ways to categorize abuse. The definitions below are commonly accepted; however, are not legal terms. The intent of these definitions is to assist the person, family, and care providers in recognizing the abuse of older adults (Wahl & Prudy, 2005; McDonald & Collins, 2000; Dept of Justice Canada, 2006).

Types of Abuse

1. Financial
2. Neglect
3. Violation of Rights
4. Physical
5. Sexual
6. Emotional/ Psychological Abuse
7. Systemic Abuse

1. Financial

The most common form of elder abuse, financial abuse is defined as any improper conduct, done with or without the informed consent of the senior that results in a monetary or personal gain to the abuser and/or monetary or personal loss for the older adult. Financial abuse includes:

- **Misusing a senior's property and/or funds.**
- **Theft, forgery, fraud, or scams.**
- **Misusing Power of Attorney.**
- **Refusing to move out of the senior's home when asked .**
- **Sharing the senior's home without paying a fair share of the expenses.**
- Unduly pressuring a senior to:
  - Buy alcohol or drugs
  - Move from, sell, or relinquish his or her home or other personal property
  - Make or change a will
  - Sign legal documents that they do not fully understand
  - Give money to relatives or caregivers
  - Engage in paid work to bring in extra money
  - Care for children or grandchildren

Professionals in banks or other financial institutions can be critical in the detection of financial abuse because of their unique relationship with seniors and knowledge of account and spending patterns. Often, these professionals may become aware of financial abuse before any others.

Seniors may also fall prey to con artists and fraudsters. This would not be considered financial abuse when the con artist is a stranger to the senior and has no relationship with him or her. Please refer to Appendix A for more information on this related topic.

2. Neglect

Neglect is defined as not meeting the basic needs of the older person; it is looked at in two different categories:

1. Active neglect: the deliberate withholding of care or the basic necessities of life.
2. Passive neglect: the failure to provide proper care due to lack of knowledge, experience or ability

Both types of neglect are considered criminal offences although the motivation for the abusive behaviour is often different. Caregivers who passively neglect an older adult may be doing their best to provide care for a loved one but may not have the knowledge, skills or resources to provide adequate care, including being unaware of how to access local resources and information. In addition, caregivers who passively neglect also may be misguided by inaccurate or outdated information; for example they may believe that keeping a person restrained all day while they are at work keeps the older adult safe from harm.

Those who engage in active neglect make a deliberate choice to withhold care and are aware that their actions are not in the best interest of the older person.

Neglect can be:

- Withholding care or medical attention.
- Leaving a person in an unsafe place.
- Over or under medicating.
- Not providing food or liquids.
- Not providing proper clothing or hygiene.
- Untreated bedsores.
- Abandonment.
- Restraining the older person.

3. Violation of Rights

The violation of rights is the denial of a person's rights as set out in the Charter of Rights Freedoms and Provincial Legislation.

Violation of Rights can be:

- Denying a person privacy in his or her home environment.
- Withholding information to which the person is entitled.
- Denying a person visitors; denying phone calls.
- Restricting a person's liberty/not letting him or her go out and/or socialize.
- Censoring a person's mail.

4. Physical Abuse

Physical abuse is any act of violence or rough handling that may or may not result in physical injury but causes physical discomfort or pain.

Physical Abuse can be:

- Pushing, shoving.
- Hitting, slapping, poking.
- Pulling hair, biting, pinching.
- Spitting at someone.
- Confining or restraining a person inappropriately.
- Unusual patterns of injuries.
- Unexplained injuries such as broken bones, bruises, bumps, cuts, burns, welts, grip marks.

Often the abuser will try to keep the abuse hidden, thus signs of physical abuse may be quite subtle or covered by clothing. It is telling to look for grip marks or bruises on the older person's forearms.

Stats Canada (2000) indicates that 68% of seniors who reported physical abuse stated that they were physically assaulted by a family member.

Medical Abuse

(U.S. Department of Health and Human Services, 2004).

Medication or medical abuse is often grouped under physical abuse; this form of abuse can inflict severe harm or even result in the death of the older adult.

Withholding medication or prescriptions may inflict severe pain and hardships that is extremely abusive to the older adult; it may trigger other serious health and safety complications. For example, withholding blood pressure medication can provoke dizziness and loss of balance which may then result in falls. On the other hand, overmedicating an older adult is equally abusive if the side effects of the medication become more acute and render the older adult unable to function.

Sometimes a person living with dementia will present with behaviours that may be challenging for the care providers and/or family members. Dementia is a loss of intellectual functions (such as thinking, remembering and reasoning) of sufficient severity to interfere with a person's daily functioning. Often a person living with dementia who is exhibiting challenging behaviours, is labelled as being "difficult" and may be sedated. Such practice is considered to be abusive because it takes away the rights of the older adult to interact and participate in daily living activities. It is extremely important for the caregiver and/or family member to **understand** that behaviours for a person living with dementia are a form of communication. The duty of the care provider is to understand what the person is trying to communicate.

Family members also need support and knowledge about the disease in order to understand the behaviours and thus interact effectively. The local Alzheimer Society has a wealth of resources and supports to assist family members in understanding the disease and in learning effective coping strategies. See Appendix B for contact information Alzheimer Society Public Education Coordinators.

Examples of medication misuse may include:

- Not filling a prescription
- Skipping doses, doubling dosing, or taking/giving medications at the wrong time
- Stretching medication to last longer or discontinuing earlier than directed
- Giving or taking extra doses when it is not prescribed Signs and symptoms of medication abuse may include:
- Changing in eating patterns
- Changes in sleeping patterns
- Poor hygiene
- Slurred speech
- Incontinence or difficulty urinating
- Blurred vision
- Dry mouth
- Tremors, shakiness
- Frequent falls and bruising
- Malnutrition

Use of Chemical Restraints

One form of physical abuse can be the use of medications as a method of restraining a person. A study sponsored by the Alberta Heritage Foundation for Medical Research reviewed the pattern of prescribing tranquilizers to residents in long term care homes. The ratio for prescribing tranquilizers was found to be much higher in Canada than in the United States or Europe. Some health care professionals believed that these medications were necessary in order to provide good care to residents, especially if they presented with difficult/aggressive behaviours or dementia. Other health care professionals felt that the overuse of tranquilizers could be considered as a form of physical abuse, where these drugs are used as chemical restraints (Hagen et al., 2005).

Persons living with dementia experience many changes as the disease progresses. When we begin to understand why the behaviour is occurring, the need for a chemical restraint is virtually non-existent. There are people with dementia who are labelled “difficult to manage”. While their actions can sometimes be ‘challenging’ to care providers, the person with dementia is in fact responding to people and/or things occurring in their environment. The responsibility of care providers is to better understand the person with dementia in order to eliminate opportunities for abuse.

Use of Physical Restraints

Another form of physical abuse is the unnecessary use of physical restraints. Physical restraints can be anything that intentionally limits or restricts a person's movements, and over which the person has no control. A person is restrained if he or she cannot remove a physical device, leave a specific area, or refuse a chemical restraint ***(Monticone, 2000)***.

Physical restraints can be either physical devices, such as tying someone to a bed or chair, or environmental restraints, such as locks and barriers to prevent a person from moving about freely.

A restraint would be considered something that the older adult cannot remove themselves (i.e. a bed-rail on a hospital bed that the older adult can raise or lower as desired would not be a restraint). If the older adult could not raise or lower it, it could be considered a restraint.)

Criteria for the use of restraints are very specific. Restraints may be used only if there is a significant risk that the older adult or another person would suffer serious bodily harm if the restraint was not in use, if other alternatives had been considered or tried and had been ineffective, if the older adult or, if incapable, the substitute decision maker, has consented to the use of restraints.

Restraint use must be for the safety of the older adult. Restraints cannot be used as a form of punishment, or for the convenience of staff, and their use must be reviewed regularly ***(Proposed Bill 140 Long-Term Care Homes Act, 2006, sections 27-31)***.

5. Sexual Abuse

Sexual abuse is defined as any sexual behaviour directed toward an older adult without that person's full knowledge and consent; it includes coercing an older person through force, trickery, threats or other means into unwanted sexual activity.

Sexual abuse also encompasses sexual contact with elders who are unable to grant consent and unwanted sexual contact between service providers and their elderly clients.

Sexual violence is made up of a continuum including rape, incest, ritual abuse, marital or partner rape, sexual exploitation, unwanted sexual contact, sexual harassment, exposure, and voyeurism.

Sexual Abuse can be:

- Unwanted touching, sexualized kissing and fondling.
- Making sexual remarks and/or suggestions to another person.
- Forcing a person to touch another person in the genital area.
- Forcing a person to perform a sexual act.
- Forced intercourse/rape.
- Coerced nudity and sexually explicit photographing.

According to Vierthaler, Dowd Eisenhower & Rumburg (2004), if older adults have experienced prior sexual abuse as children or in other settings, they may experience triggers of the abuse, for example:

- Major life changes such as moving to a long-term care facility.
- Being out of control of a situation.
- Television and movie violence.
- Seeing someone who looks like assailant.
- Sexual advances.
- Reading or hearing about other sexual assaults.
- Action, smell or sound, that reminds elder of the assailant or the place where assaulted.

Conditions such as dementia can make an individual more sensitive to triggers and/or bring up recessed memories.

Remember, it is important to consider factors that can influence an older adult's recovery from sexual abuse including social/cultural influences, previous experiences with stress, success in coping with previous crisis, immediate contacts after abuse, support systems, relationship with offender, degree of violence, type of sexual violence, and their perceptions of the abuse ***(Vierthaler, Dowd Eisenhower & Rumburg, 2004).***

6. Emotional/Psychological Abuse

Emotional/Psychological abuse is any action, verbal or non-verbal, that lessens a person's sense of identity, dignity and self-worth.

Emotional/psychological abuse can be:

- Words or actions which put a person down, are hurtful, make a person feel unworthy.
- Not considering a person's wishes.
- Not respecting a person's belongings or pets.
- Denying access to grandchildren or friends.
- Threatening, for example, telling the person you will put them in a "home".
- Treating a senior like a child.

According to the World Health Organization (2002), many older seniors report psychological/ emotional abuse to be the most harmful. Many reported that physical scars could heal but psychological scars festered and were the most difficult to deal with.

7. Systemic Abuse

Systemic abuse, as defined by Ottawa Health Services (1997) refers to institutional or government policies and regulations creating or facilitating harmful situations. Examples of systemic abuse include government cutbacks in healthcare, lack of appropriate accommodations for seniors, low pensions, etc., all of which deprive the senior of the ability to choose an appropriate caregiver or living situation.

Understanding the Risk Factors for Abuse

Abuse is a multifaceted issue, often involving a complex interaction between many factors. The existence of any or all of these risk factors for abuse does not indicate the existence of abuse. Rather, they should be looked upon as potential indicators for abusive behaviour.

1. History of Abuse in Family/Domestic Violence

There is a tendency to place abuse into silos such as child abuse, woman abuse, and elder abuse. However, family/domestic violence can cross over all age groups. Domestic violence will grow old with women (Hightower, Smith, & Hightower, 2001); a woman who has been abused for 30 years will not suddenly be safe when she turns 65 years old.

Some studies suggest that a significant percentage of elder abuse cases may be related to continued domestic violence. For example, a study in British Columbia found that of 542 cases of abuse of older adults in Vancouver, 74% were women ***(Pittaway & Gallagher, 1995)***.

Older women are at greater risk of abuse due to increased social isolation, cultural norms, familial status, disadvantage or disability ***(ONPEA, 2006)***.

Violence in the context of domestic violence 'grown old' is directed primarily against women, with the male spouse being the primary abuser. However as women age and the adult children become the caregivers, they may model the abusive patterns of the father. Studies have found (Hightower, Smith, & Hightower, 2001) that often adult children fulfill the role of the abusers when the abusive spouse is no longer in the home. Crichton et al. (1999) found that half the cases of abuse in their study involved the adult child as the abuser.

2. Increased Vulnerability

There are many changes with aging that may place an older person at a higher risk for abuse. For example:

- Increased physical frailty or reduced mobility may impact the senior's ability to recover from abuse.
- A chronic health condition, such as a stroke or loss of vision or hearing may impact a person's ability to communicate and report abuse.

- Dependence on the caregiver for physical and medical care can make them more vulnerable to abuse, and may result in the older person being reluctant to report abuse in case it makes the situation worse or leaves them without care.
- Caregivers may have poor understanding of presenting medical conditions, (e.g. Alzheimer Disease and related dementias) and may lack knowledge to properly care for senior and/or respond appropriately to behaviours.

3. Diminished Capacity to Make Decisions

In addition to increased physical vulnerability (or perhaps in some cases as a result of it) the senior may have a diminished ability to make decisions. The person may:

- Suffer from memory lapses, loss or dementia
- Lack appreciation/understanding of the facts
- Not appreciate consequences of a decision or lack of a decision

The senior with a diminished ability to make decisions may be coerced into making high risk decisions that allow abusers access to his or her home, finances, etc. Furthermore, a diminished ability to make decisions may make it less likely or more difficult for the senior to report any abuse to a trusted individual.

4. Isolation

When a senior is unable to connect with a broader social network or lacks ability to or is prevented from calling friends and family on phone or inviting them over to visit, the person is in a high risk situation for abuse. The person may be isolated by language and culture, or isolated due to the actions of a past or current abuser.

Isolation is a dangerous situation for anyone, as a person lacks:

- Ability to communicate due to illness or disease.
- Mobility to get out of house independently.
- Access to transportation to attend programs or community events.
- Financial resources to attend programs, or to move out of abusive residence.

A Note about Self Neglect

(Maclean, 1999)

Self neglect is not considered to be the same as elder abuse. An older person engaging in self neglect is causing harm to themselves as opposed to being harmed by someone else. However this should not rule out the possibility of elder abuse also being present.

Self neglect may also be referred to as Diogenes Syndrome, Senile Breakdown or Senile Squalor. Abrams et al., (2002) state self neglect is a "multifaceted behavioural entity involving inability or refusal to attend adequately to one's own health, hygiene, nutrition or social needs; it is distinguished from neglect proper, which is a form of elder abuse".

In keeping with the individual's right to choose, an adult (regardless of age) may choose to live in conditions that may be viewed by others as inappropriate or unsafe. The person may not have information as to how to properly care for him or herself or know where to find assistance to improve self care. Having such information does not mean the self-neglect will be resolved.

Understanding more about the Abused

According to Spencer (2002), the most common abused older adult is:

- Over the age of 75
- Widowed or living alone
- Socially isolated
- Under the control or influence of the abuser
- With some degree of mental incapacity and some degree of physical frailty

Work done by Podnieks and colleagues (1990) on elder abuse and neglect found the rate of abuse and in particular physical abuse to be higher towards men than women. This work echoed findings by Pillimer and Finkelhor (1988) in the U.S.A. using similar methodology; these findings were published in the early nineties. It should be noted that there may be a perception that women are more often abused than men, however, when compared on a percentage of population by gender, that is not the case; more senior women are abused because they constitute a higher number of the 65+ population.

Avoid assumptions! Any senior may be abused, even if he or she does not fit the typical profile. The key is to identify high-risk situations and to consider atypical situations. Remember! Abuse crosses all borders and can happen to anyone.

Understanding the Abuser

Abusers vary in gender, educational level, religious affiliation, as well as social, cultural and economic backgrounds. They can be a family member, relative, close friend, volunteer, paid caregiver or professional caregiver at any level. Stats Canada (2000) reports that 42% of abusers are the adult children and 31% are the spouses when family members were listed as the abuser. Commonalities do tend to exist however in the disposition of an abuser. Abusers may experience one or all of the following (Cooney & Mortimer; 1995):

- Feels angry, frustrated, resentful
- Lacks self confidence
- Job dissatisfaction
- Likes to exert control and bully others
- Difficulty controlling anger
- Substance abuser: drugs, alcohol
- Addicted to gambling or other compulsive behaviours
- Family/relationship problems
- Health problems: fatigue, depression, stress, mental illness
- Financial problems
- Former victim of abuse
- Dependency on the older person for assistance (financially dependent upon the older adult, or dependant for childcare or household management)
- Limited coping capacity
- Objectifies the older person; does not respect the older person as a valued human being.

Abuse is always wrong. None of these traits or situations can be accepted as excuses or rationale for abuse. A senior needs to understand his or her rights to age in a safe and dignified environment along with the rights to choose, to communicate and to confidentiality.

Remember to avoid assumptions! An abuser may have no visible dysfunctional traits. Do not let personal biases or stereotypes lead to judging who could or could not be an abuser. As with any abuse, an abuser of older adults will try to keep the abuse hidden from the public because he or she knows the abusive treatment is wrong and would not be accepted by others.

Chapter 2: Understanding Elder Abuse

Understanding what abuse is and being able to recognize it is the first step in prevention.

The following chart provides the reader with action steps:

Item	Action
Major causes of abuse	Identify 3 major causes and identify which may be factors in your setting.
Types of Abuse	Keep a copy of 7 categories of abuse near your work station for easy reference.
Risk Factors	Be familiar with the 4 major risk factors and determine which might be most relevant in your setting.
Abuser	Recognize factors that may alert you to a potential abuser.

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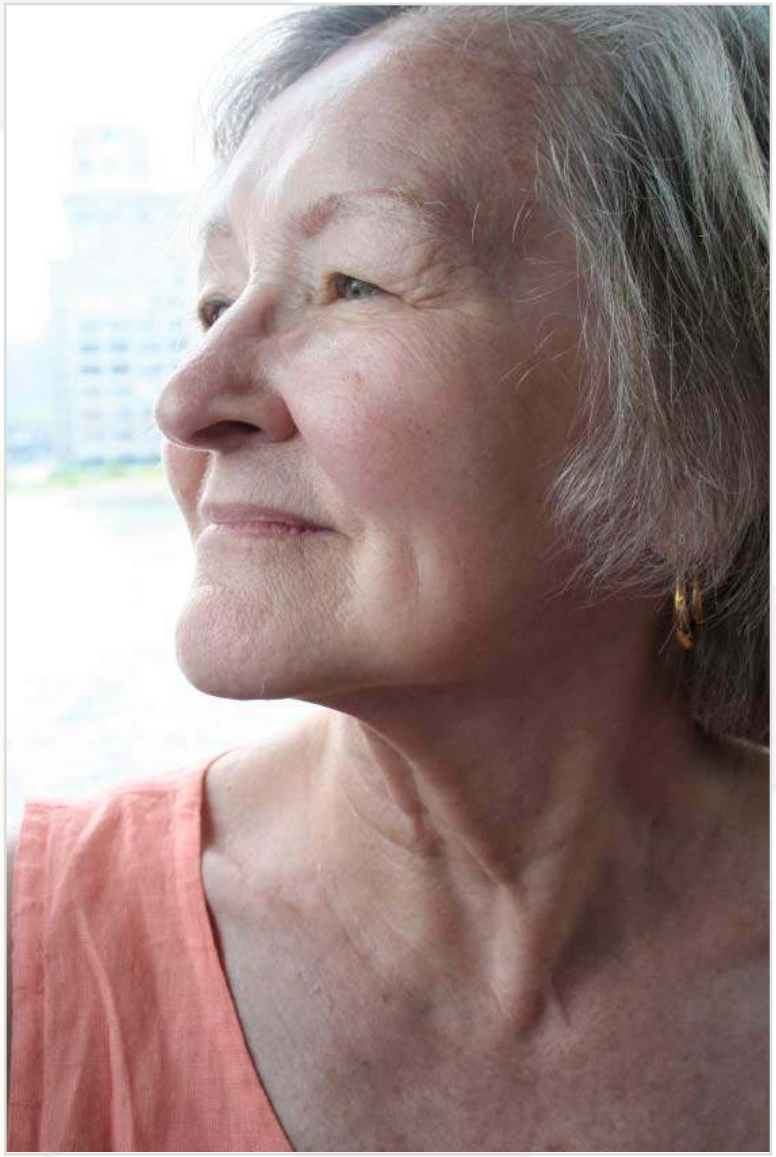


Appendix A: Frauds and Financial Abuse

With age comes wisdom and experience, but often this is not enough to protect the senior from falling prey to con artists and fraudsters. Social workers, lawyers, and law enforcement have identified the following reasons for putting seniors at greater risk of financial abuse: (retrieved from The Heads Up Fraud Prevention Association, Oct. 2006)

- More leisure time. People are living longer and often retiring earlier. This can easily translate into empty hours that can easily be filled with reading mail, taking phone calls, responding to unsolicited advertisements on the Internet from strangers offering "money saving" deals, "no risk" investments and "big cash" prizes and rewards.
- Isolation. Seniors often have a shrinking pool of individuals that they associate with and less mobility for a number of reasons. This leaves the senior vulnerable for con artists and fraudsters who are willing to provide a friendly face or voice as a means to an end.
- Anxiety. With the increase in life expectancy and the effects of inflation seniors are often concerned about not having enough funds to maintain their lifestyle, or worried about having an inheritance for their children and loved ones.
- Income and assets. While seniors as a group are not the big salary earners, they have fewer expenses and generally more assets and discretionary income. This makes them an attractive target for con artists and fraudsters.
- Jurisdictional issues. The advance of technology allows con artists and fraudsters to operate in venues outside of local jurisdictions. The additional burden of cross border investigations and litigation is often beyond the resources of the local police department.
- Low risk activity . As far as criminal activities, robbing a bank generally nets a small return with the possibility of personal harm and a high risk of incarceration. Identity theft, on the other hand, pays out an average of $3,000 per incident and about $30,000 per identity, with a low risk of personal harm or incarceration.

Appendix B: PRC and PEC Resources

Know your local resources for Alzheimer Disease and Related Dementias!

Psychogeriatric Resource Consultants (PRCs) : alzheimerontario.org/local/files/Web%20site/Strategy/9.01-ASO-PRCs-060609.pdf

Alzheimer Society Public Education Coordinators (PECs): alzheimerontario.org/local/files/Web%20site/Strategy/9.01-ASO-PECs-060609.pdf

Chapter 3

Understanding the Legal Issues

Understanding
The key issues of elder abuse which in-turn leads to the ability to recognize, interact and respond. Each situation is unique.

Recognize indicators of abuse
- Why is this situation causing me concern?
- What am I observing?

Interact with the senior at risk
- How do I feel about this situation/the alleged abuse?
- What are the values, wishes, goals of the person?
- Is the senior making the decisions?

Respond
- What resources are required?
- What are my responsibilities?
- What is my role on the team?

Reflection
Stop and think about the situation to promote a better understanding of the issues on an individual, team, organization, and systems level; this can contribute to better responses and the prevention of elder abuse.

Chapter Three: Understanding Legal Issues

Introduction

Any discussion about the legal issues related to abuse begins with the understanding that being a senior does not take away one's right to make one's own decisions. Seniors have a fundamental right to control their lives and to speak up as they choose. Understanding legal issues must be built on the premise that seniors have the right to make their own decisions about property, personal care, health treatments, etc. Cases in which the individual is incapable of making his or her own decision are to be determined on a situation-specific basis.

Aspects that have an impact on interacting with an individual include:

- Understanding the legislation/ statutes affec ting seniors with whom a worker/volunteer comes in contact (e.g Long Term Care Homes Act; Substitute Decisions Act; Health Care Consent Act);
- Responding to the needs of the individual who may be experiencing a situation of abuse;
- Knowing how to find community supports that may be able to assist.

While it may or may not be considered illegal, abuse is wrong because it is a controlling behaviour which frightens or intimidates and violates a person's basic right to feel safe.

Mental Capacity

1. Mental Capacity: What is it?

A person is presumed to have capacity unless there is evidence to question that capacity for any purpose and a decision needs to be made. Mental capacity is always measured in relation to a particular situation/decision.

"A person is entitled to rely upon the presumption of capacity with respect to another person unless he or she has reasonable grounds to believe that the other person is incapable of entering into the contract or of giving or refusing consent, as the case may be. (Substitute Decisions Act, 1992, c. 30, s. 2 (3)"

An individual is not mentally incapable because they are eccentric, or refuse service or treatment, or are not functional (e.g. have difficulty speaking; are frail; have language difficulties). One cannot infer that a person is mentally incapable simply because he or she has a physical disability and appears to have problems "coping". A service provider may consider the person "at risk" because of his or her functional abilities, but this is not the criteria for determining that person to be incapable.

The 'ability' to understand and the 'ability' to appreciate the consequences of the decision is the legal test of capacity in Ontario and not whether the person chooses to place him or herself at risk. There is no standard or clinical test that measures mental capacity and therefore, no test is included as the standard in legislation.

Legal Definitions

Capacity to manage property (Substitute Decisions Act)

"A person is incapable of managing property if the person is not able to understand information that is relevant to making a decision in the management of his or her property, or is not able to appreciate the reasonably foreseeable consequences of a decision or lack or decision."

For example, a person may be a poor money manager because he or she makes decisions that are perceived as unwise; however, that person is not mentally incapable as he or she may have the ability to understand information about property management and have the ability to appreciate the consequences of his or her decisions. A person may be capable of carrying out day to day finances (e.g. paying rent, shopping for food) but incapable of managing extensive assets or a business.

Capacity for personal care (Substitute Decisions Act)

"A person is incapable of personal care if the person is not able to understand information that is relevant to making a decision concerning his or her own health care, nutrition, shelter, clothing, hygiene or safety, or is not able to appreciate the reasonably foreseeable consequences of a decision or lack of decision."

The results of a person's functional assessment are not directly relevant to determining if that person has the ability to understand and appreciate the consequences of his or her decision regarding personal care. For example, the person may choose to live in unhygienic conditions but is able to understand and appreciate the consequences of his or her decisions.

Capacity in respect to treatment, admission to a care facility, or a personal assistance service (Health Care Consent Act)

"A person is capable with respect to a treatment, admission to a care facility or a personal assistance service if the person is able to understand the information that is relevant to making a decision about the treatment, admission or personal assistance service, as the case may be, and able to appreciate the reasonable foreseeable consequence of a decision or lack of decision."

A person may be able to consent to some simple and obvious treatments (e.g. care for a cut) but lack the capacity to consent to more complex treatments (e.g. an operation). Likewise, a person may be incapable of making a decision about where to live, but be capable of making decisions about hygiene, clothing and nutrition.

2. Who determines mental capacity?

This is a complex question to which the best answer is: It depends on what type of capacity is being assessed and what decision needs to be made.

We all assess capacity in interacting with an individual; it is not always a formal procedure. The presumption is that one has capacity unless there are indicators that there is not capacity. For the most part, in communicating on a one-to-one basis with a person, there is no need to assess for or determine if there is capacity. One deals with the individual in the 'here and now'.

The law specifies those that can assess for capacity for certain purposes.

The Health Care Consent Act, 1996 (Schedule A. 40(1), defines those health professionals that may act as evaluators for capacity for admission to LTC homes or capacity to consent to personal assistance services. These professionals are most likely to provide direct service to seniors in the community and health care facilities. Before a person is admitted into a long term care home, he or she must be assessed as having health and functional needs of the level required for admission.

For consent to treatment, where the individual does not understand and appreciate the consequences of his or her decision (or lack of decision), the health practitioner offering treatment or one health practitioner on behalf of the team providing care must assess capacity in respect to the treatment that they are offering or to a plan of care. This is not a 'formal' assessment and is issue specific. (A prescribed list can be found in the Health Care Consent Act, 1996, subsection 2(1))

If an individual has drafted a power of attorney for property and included in it a requirement that the power of attorney should not come into effect until he or she has been assessed as incapable to manage property, and the method of assessment is not specified in that document, then the Substitute Decisions Act, s.9 (3) specifies that a capacity assessor must be used to assess capacity.

Capacity assessors do NOT assess capacity in most instances. They assess capacity:

1. In respect to property, if the POA document states that the document does not come into effect unless there is an assessment and the POA document states that this assessment is to be done by a capacity assessor (the grantor of the POA can specify that the assessment be done by someone other than a capacity assessor or can name an assessor to do it)
2. In respect to property, if the POA for property document states in it that the POA will not come into effect unless there is an assessment of incapacity but the document is silent as to who should do that assessment - capacity assessors are the default (see SDA s 9(3)).

3. For personal care if the POA personal care includes a clause that the POA personal care is not to come into effect until the person is assessed by a capacity assessor (so an explicit direction in the POA document that requires a capacity assessor to be used)
4. For personal care if the POA personal care includes a clause that the POA personal care does not come into effect until the person is assessed as incapable for personal care -- but the document does not specify who should do that assessment -- so the legislation says that the default is that the assessment is done by a capacity assessor (SDA s 49(2)).
5. Capacity assessors cannot do an assessment if the person refuses to be assessed (SDA s.78). The person does not need to consent; he or she just has to not refuse.

Powers of Attorney

1. Continuing Power of Attorney for Property is the authority for the attorney to do anything with respect to property that the grantor could do except make a will. However, the Continuing Power of Attorney for Property may LIMIT the scope of the authority by what is written in the document. The Continuing Power of Attorney for Property comes into effect immediately, regardless of capacity, unless a clause has been included that states that the attorney does not get authority until an assessment of capacity is performed . There may be other exceptions such as time limitations. More than one attorney can be named as acting "jointly and sevrally" meaning that they can act together or they can act SEPARATELY. It is only when more than one is named and the document specifies that they must act jointly all the time that they must act together. Power of Attorney can be revoked by the grantor when mentally capable. The Attorney has the responsibility of maintaining accounts and records of transactions, dates, and reasons for payments, made on behalf of the grantor including money, property, and investments.
2. Power of Attorney for personal care is the authority to make dec isions about health care and medical treatment, diet, housing, clothing, hygiene and safety, only when the person becomes mentally incapable of making them him or herself.

Free pamphlets on Powers of Attorney are available from Community Legal Education Ontario (**Tel: 416-408-4420**) and can be found on their web site (www.cleo.on.ca)

Substitute Decision-Makers

If a person becomes mentally incapable of making personal care decisions, someone else must make them. That person is the Substitute-Decision Maker (SDM). The SDM is expected to make decisions based on the incapable person's known wishes (based on expressed thoughts when the person was capable).

An attorney named in a Power of Attorney is a type of substitute decision maker for the purposes as described above.

Other substitutes: Under the Health Care Consent Act: When a person is unable to provide consent for treatment (anything done for a health related purpose, including, for example, any care plan or course of treatment) consent must be obtained from the SDM. In the absence of a named SDM, there is a hierarchy of ranking (See Appendix A). Only in the absence of a willing and capable SDM or the absence of agreement of two equally ranked SDM's, does the PG&T take responsibility.

Intervention under the law

Role of Police

Concerns about suspected or actual abuse should be reported to the police for investigation. A person reporting abuse may remain anonymous, however, it is often useful for the police to have a contact number in case they require some clarifying information. The person reporting the abuse can request that his or her identity be kept anonymous from the abuser but it may be divulged through the Freedom of Information or a court proceedings.

The police will determine whether or not to investigate a report based on many different factors. Investigations include gathering all relevant evidence and interviewing all potential witnesses. Relevant evidence may be a signed statement from the abused senior, statements from others that may have evidence, such as, family, friends, neighbours, caregivers, medical reports, financial records and photographs of the injuries.

Police can lay Criminal Code charges if they have reasonable grounds to believe a crime has been committed. Additional support can be provided by the Victim Crisis Assistance and Referral Services (VCARS) and/ or the Victim/Witness Assistance Program (VWAP). VCARS is a community response program providing immediate on-site service to victims of crimes or tragedies, 24 hours a day, seven days a week. With consent from the victim, police officers can call on VCARS to send a team of trained volunteers to provide on-site, short-term assistance to victims and make referrals to community agencies for longer-term assistance. VWAP services are available to the most vulnerable victims and witnesses of crime from the time charges have been laid until disposition of the court case.

Should the abused senior be asked to testify in court, the Victim/Witness Assistance Program will assist him or her throughout the court process. The police can be helpful in connecting the abused senior to these important supports.

Even if the abuse is not a criminal matter, the police can be very helpful in connecting the senior to various supports such as community resources and make referrals to other agencies as needed. The police can provide information about the criminal process and what is involved for the victim or witness. They can explain the workings of the criminal justice system and what to expect with respect to possible outcomes and options. Many police departments have officers who specialize in seniors issues, sometimes referred to as Seniors Support Officers (SSO) who are well informed about abuse. Seniors and the general public are encouraged to call to talk about their concerns and these officers can provide them with valuable information about different options and resources.

Ontario has also developed a province wide Seniors Crime Stoppers program to allow anyone to anonymously report incidents of elder abuse. This information will be forwarded to the police without fear of the caller being identified. To report an incident of elder abuse anonymously call – Seniors Crime Stoppers at **1-800-222-TIPS**.
www.opp.ca/Intranetdev/groups/public/documents/publicrelations/opp_000408.pdf

Role of the Criminal Code

In Canada, certain categories of abuse, such as fraud, assault, sexual assault, uttering threats and criminal harassment are crimes under the Criminal Code of Canada. Elder abuse is not a separate set of offences but covered by the current code. Something that is a Criminal Code offence does not cease to be an offence because the person is a senior.

Some of the ***Criminal Code*** provisions that may apply in cases of **financial abuse** include:

- theft – ss.323, 328-332, 334
- abuse of Power of Attorney –s.331
- criminal breach of trust – s.336
- extortion – s.346
- forgery – s.366
- fraud – s. 380 (1)

Some of the ***Criminal Code*** provisions that may apply in cases of **physical and sexual abuse** include:

- failure to provide the necessities of life – s.215
- criminal negligence causing b odily harm or death – ss. 220-221
- unlawfully causing bodily harm – s.269
- manslaughter – ss.234, 236
- murder – ss. 229-231, 235
- counselling suicide – s.241
- assault – ss.265-268
- sexual assault – ss.271-273
- forcible confinement – s.279 (2)
- breaking and entering – s.348
- unlawfully in a dwelling – s.349

Some of the ***Criminal Code*** provisions that may apply in cases of **psychological abuse** include:

- criminal harassment – s.264
- uttering threats – s.264.1
- harassing telephone calls – s.372 (2) & (3)
- intimidation, threatening – s.423

Some of the ***Criminal Code*** provisions that may apply in cases of **neglect** include:

- criminal negligence causing bodily harm or death – s.220 (21)
- breach of duty to provide necessaries. s.215

The Criminal Code also includes a provision (s. 718.2) that requires the court to take into account for the purpose of sentencing as aggravating factors evidence that the offence was motivated by age- or disability-based bias, prejudice or hate.

Legal Reporting

By law, all persons, other than residents of a long term care home, who have reasonable grounds to suspect that abuse or neglect of a resident has occurred or may occur are obligated to immediately report to the Director. The Long Term Care Homes Act, 2006, states that:

"The licensee must protect residents from abuse by anyone and from neglect by the licensee or staff.

The licensee must ensure that there is a written policy in place to promote zero tolerance of abuse and neglect of residents and that the policy is communicated to all staff, volunteers, residents, substitute decision-makers, family members and others visiting the long-term care home.

The licensee must have a written complaints procedure and Alleged or suspected incidents of abuse and neglect … must be immediately investigated by the licensee and appropriate action must be taken by the licensee in response. actions taken in response must be provided by the licensee to the Director.

This legislation is currently under review. Please refer to Bill 140 for details (www.ontla.on.ca/web/bills/bills_detail.do?locale=en&BillID=464). The Ministry of Health and Long-Term Care has the authority to investigate reports of abuse. It is the responsibility of those dealing with individual residents of long term care homes to be conversant with the legislation.

Community Support Resources

Role of ONPEA

ONPEA does not provide legal advice. This chapter provides links to appropriate legal resources and suggests areas that should be incorporated into policies and procedures.

Anyone working in the field of elder abuse requires an understanding of the legal terminology and the implications on capacity for substitute decision makers. In order to work effectively with seniors in the prevention of abuse, all workers require a general understanding of the legal implications and obligations of their role and an understanding that certain abusive behaviours are illegal.

Organizations and staff working with seniors must keep abreast of legislation and their responsibilities.

The Role of the Regulated Health Professional

Regulated health professionals can play a central role in the prevention and early intervention of elder abuse. Knowing about the indicators of abuse will assist health professionals in determining if abuse is taking place. Health professionals are in a unique position, based on trusting relationships that may be developed over time with the senior, and the possibility of being the only person who can intervene appropriately and constructively when abuse is suspected

Regulated health professionals have a responsibility to understand and be knowledgeable about their obligations to report suspected or observed incidences of elder abuse when working in a long term care home (see Legal Reporting below for more information). Ontario's 23 self-regulated health professions have Colleges which are governing bodies that set the standards for skills, knowledge, and performance for their members. Ontario laws administered by the Ministry of Health and Long-Term Care set the legal framework for regulated health professions, but the colleges are independent of the Ministry. For a list of regulated health professionals in Ontario visit: www.health.gov.on.ca/english/public/program/pro/pro_mn.html

The Role of the Physician

Physicians often hold a unique position of trust with their elderly patients. Patients may have a level of comfort in disclosing to their physician about the abuse. The physician may also be in a position to note some of the physical signs e.g. bruising, fractures and medical e.g. malnutrition, dehydration signs of abuse that may be hidden from others. Patients may deny the abuse because of embarrassment and fear of abandonment from the family. (See Chap 5 for details.) It is not unusual for caregivers and/or children to accompany the older person to the medical appointment. As they may be the abusers, it is vital to ensure privacy for the patient especially if abuse is suspected.

Ontario only has mandatory reporting legislation for physicians as it applies to residents of a Long Term Care Homes. Therefore, if a long-term care home resident attends the office of a physician (practicing medicine in Ontario), and that physician suspects that the resident is being abused by anyone, there is a statutory obligation to report the suspicion to the Director of the Home.

Community Information Centres

Communities have various supports in place including Elder Abuse Committees and Networks in many locations. Local telephone directories and the internet can help locate supports. For example, 211 Ontario is an online resource to help locate services in Ontario. www.211ontario.ca/main.htm

Be aware, elder abuse services are not necessarily named as such; however, many community organizations provide these services, for example, Family Services, Public Health, Community Care Access Centres.

Community Legal Clinics

The Advocacy Centre for the Elderly (ACE) and the Community Legal Education Ontario (CLEO) are excellent resources. Legal clinics across the province provide legal assistance on a variety of issues. ACE is a specialty clinic, dealing with elder abuse as one of its focuses. For the most current legal information, please contact:

Advocacy Centre for the Elderly 2 Carlton Street, Suite 701 Toronto, Ontario M5B 1J3 Tel: 416-598-2656 www.advocacycentreelderly.org	**Community Legal Education Ontario** Tel: 416-408-4420 www.cleo.on.ca For Legal Assistance: Cleonet

Legal advice and help may be available without charge from community legal clinics; this resource can be found in local telephone directories under “Legal Aid” or “Lawyers”. Information regarding Legal Aid Ontario can be found at: www.legalaid.on.ca

Community Care Access Centres (CCACs)

Long term care services are provided through CCACs across Ontario. Services provided may help a senior to live more independently, may provide emotional support and links to local support, for example, professional services, homemaking, meals, and assistance with physical activity. CCAC locations and telephone numbers can be found in the local telephone directory and also online at www.oaccac.on.ca

Office of the Public Guardian and Trustee (OPGT)

The Office of the Public Guardian and Trustee is part of the Family Justice Services Division of the Ministry of the Attorney General in Ontario. The OPGT is responsible for protecting mentally incapable people; other responsibilities include protecting the public's interest in charities, searching for heirs, investing perpetual care funds, and dealing with dissolved corporations.

In cases of financial or personal abuse, the OPGT can apply to the court to become the abused senior's guardian on a temporary basis. The OPGT can also help the person get access to other services. They can intervene only if the person is believed to be mentally incapable and is at risk of harm or experiencing harm. There must be evidence/ reason to believe that the person is incapable before the OPGT will investigate.

The OPGT provides a range of helpful and current resources online at: www.attorneygeneral.jus.gov.on.ca The Guardian Investigation Unit can be reached at 1-800-366-0335 or 416 -327-6348. The purpose is to determine whether the OPGT should apply for temporary guardianship of the person or property to prevent any harm from occurring. Alternative, less intrusive options are preferable.

The Role of the Department of Justice Canada

An important strategy to prevent and respond to elder abuse is public legal education and information to address the issues. Such education and information includes providing older adults, care givers and service providers with plain language, accessible information about older adults' legal rights and the criminal justice system (The Department of Justice, 2006).

The Department of Justice also supports public legal education and information programs across Canada to educate the public about family violence, including abuse of older adults (e.g., The Community Legal Education Ontario (CLEO) and the Advocacy Centre for the Elderly publish a booklet entitled Elder Abuse: The Hidden Crime, which is available online and updated regularly).

"The Department of Justice Canada together with its partners - including provincial and territorial governments, non-governmental organizations and the private sector – addresses abuse of older adults through strategies that include legal reform, public legal education and information, research, and support for programs and services. The Department's efforts have included involvement in the federal government's Family Violence Initiative and the National Crime Prevention Strategy.

"Through the National Crime Prevention Strategy and the Justice Partnership and Innovation Fund, the Department of Justice Canada supports community-based initiatives to address the issue of abuse of older adults. These projects may include, for example, awareness-raising activities, peer counselling programs, advocacy programs, or the establishment of community-based networks to consult and take action on the issue of abuse of older adults.

Chapter 3: Understanding Legal Issues

Item	Action
Relevant Legal	Understand the legislation and regulations related to your role, organization.
Roles	Create a resource list of legal and community resources in your area.

Chapter Three References

Department of Justice Canada www.justice.gc.ca/eng/pi/fv-vf.

Tremayne-Lloyd, T., & Rosen, L. (2000). Elder Abuse: What you should know and what to do. ***Geriatrics and Aging***. Vol 3(5).

Wahl, J. & Purdy, S. (2005). Elder Abuse: The Hidden Crime. 8th ed. Toronto: Advocacy Centre for the Elderly and Community Legal Education Ontario. Retrieved January 2007 from www.cleo.on.ca/english/pub/onpub/PDF/seniors/elderab.pdf

Statistics Canada, 2004 Retrieved from: www.statcan.ca.

World Health Organization/INPEA (2002). Missing Voices: Views of Older Persons on Elder Abuse. Geneva, WHO. Retrieved October 23, 2006 from: whqlibdoc.who.int/hq/2002/WHO_NMH_VIP_02.1.pdf

Resources

The Government of Ontario website (www.gov.on.ca) provides links to the E-Law website (www.e-laws.gov.on.ca) where you can find current legislation relevant.

Chapter 4

Recognize and Assess

Understanding

The key issues of elder abuse which in-turn leads to the ability to recognize, interact and respond. Each situation is unique.

Recognize indicators of abuse

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

Interact with the senior at risk

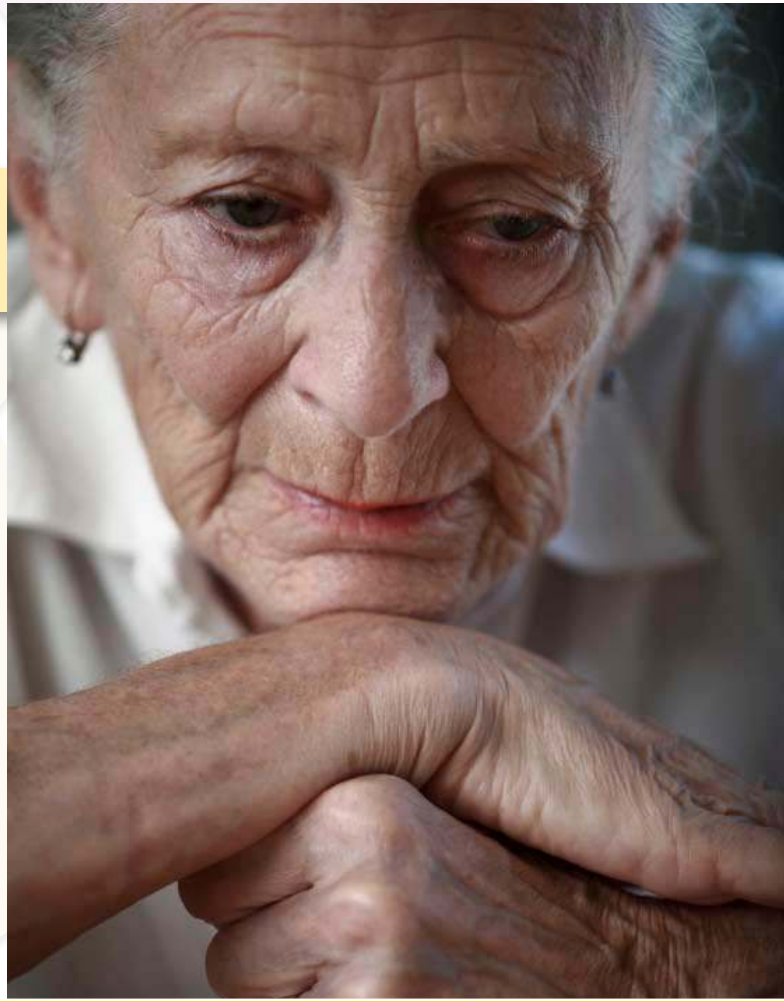
- How do I feel about this situation/the alleged abuse?
- What are the values, wishes, goals of the person?
- Is the senior making the decisions?

Respond

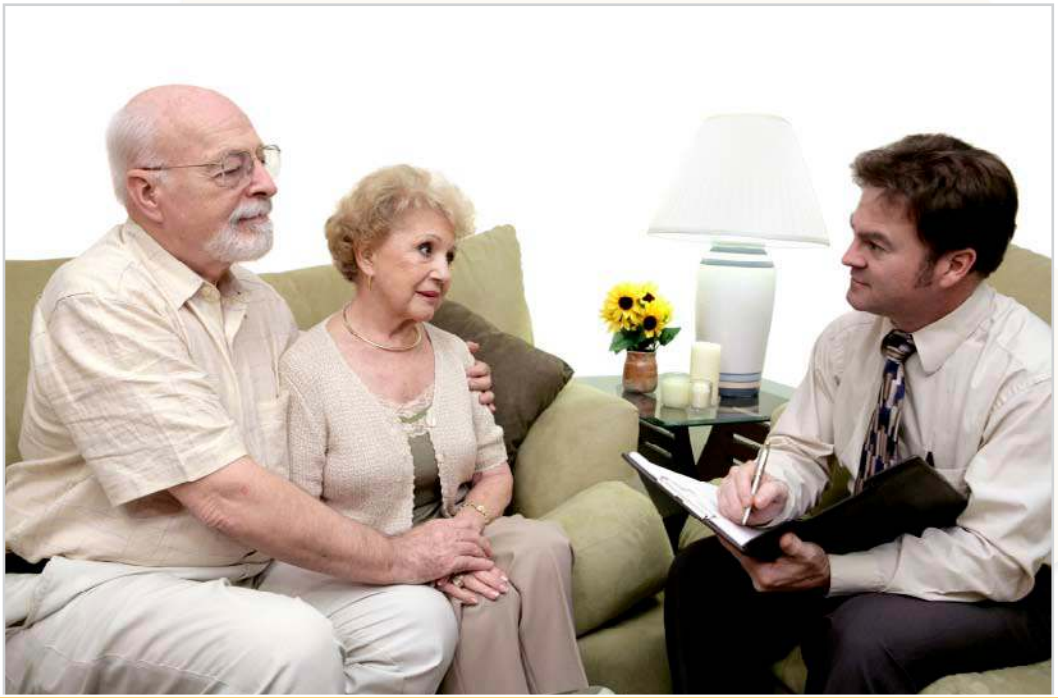
- What resources are required?
- What are my responsibilities?
- What is my role on the team?

Reflection

Stop and think about the situation to promote a better understanding of the issues on an individual, team, organization, and systems level; this can contribute to better responses and the prevention of elder abuse.



Chapter Four: Recognize and Assess



Recognize and Assess

Introduction

With an understanding of the types of elder abuse, the risk factors associated with abuse as well as its legal issues that were described in the previous chapters, individuals working with seniors need to be knowledgeable and prepared in recognizing signs and behaviours to determine if abuse is actually taking place. There is often evidence provided to workers either by a senior's personal disclosure or through observations such as the living environment, financial circumstances, family relationships, or communication.

This chapter will enable workers to gain a better understanding and appreciation of the importance in **recognizing** the indicators of abuse and provide information on screening for elder abuse through the use of general questions to conduct assessments with the senior and/or abuser.

Two important questions to help recognize indicators of abuse are:

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

Recognition of Elder Abuse

Elder abuse is a hidden crime; it is often difficult to detect. Understanding the issues and the potential for abuse allows for more focused observations and assessment of the situation.

Often the abuser will try to conceal evidence that abuse is taking placetherefore making it a challenge for individuals to identify abuse of older adults. Given these circumstances, professionals, volunteers, or concerned family and friends need to be alert to the signs and subtle changes in behaviours in order to uncover the problem.

Before a final conclusion is determined, workers need to review personal values and experiences that may have lead to assumptions in their perceptions of the situation and also clarify with the senior the issues and signs that are being observed to ensure that misinterpretation hasn't occurred. For example, a situation that may have several causes such as frequent falls may be due to a balance/medical issue or could be a sign of abuse (Ryan, 1996). Abusive and neglectful caregivers often attribute intentional bruising to accidental falls.

Not all indicators will prove there is abuse. Other disease processes or medications may cause similar signs, symptoms, and changes in behaviour. Knowing the red flags or abuse indicators can help determine the level of risk or suspected abuse of an older adult.

Role of the Regulated and Non-regulated Workers, Volunteers

Regulated and non-regulated workers and volunteers usually work closely with seniors either directly in the home (providing therapy, personal care, home making, etc) or in the community providing (e.g. meals on wheels, wound care, volunteer driving) putting themselves in a position of having the opportunity to **Recognize** if abuse is taking place. Working directly with a senior over a period of time allows workers and volunteers to develop a relationship and sense of trust with the senior. This trust may help a senior to disclose abuse to the worker or volunteer; they may also be a witness to an incident of abuse. Such is the same volunteer driving a senior to his or her medical appointments for 6 months. When travelling to and from appointments there is time to talk about personal issues; during such times a driver may hear disclosures of abuse.

Front line workers and volunteers should refrain from making assumptions or drawing conclusions before all the facts are known. However, if a person has a suspicion that makes him or her feel uncomfortable, causes concern that something may not be right, or has an "awkward feeling", then he or she should trust their instincts. The worker should follow-up on these concerns with the supervisor to ensure the safety and well-being of the older adult.

Non-regulated workers should refer any suspected cases of elder abuse to their supervisor. Regulated workers may also be required to discuss cases of abuse with a supervisor or case manager however they are also obligated by college regulations to follow up with any cases of abuse. Regulated and non- regulated workers are responsible for understanding the policies and procedures related to elder abuse including how and who to report to in the organization. Senior leadership in organizations are responsible for providing opportunities for the workers to learn the policies and procedures and encourage dialogue and understanding of this complex issue (see Chapter 8).

Keep in mind, volunteers, personal support workers, students, and visitors working in Long Term Care Homes are mandated to report any suspected incidence of elder abuse to the MOHLTC. Their organizations also have policies and procedures in place for them to report their findings to their immediate supervisor (see Chapter 3). Please note that the legislation is currently under revision. Visit: www.health.gov.on.ca/english/public/legislation/ltc_homes/ltc_homes.html

Remember, two questions to help **recognize** indicators of abuse are:

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

Formulating General Questions about Elder Abuse

The Elder Abuse Assessment and Intervention Reference Guide, adapted by Advocacy Center for the Elderly (2006) and the Seniors Resource Centre Association of Newfoundland and Labrador (2006) provide a set of questions to guide the service provider when exploring abuse. Open ended questions allow the senior to provide a more detailed response rather than just yes or no.

- How is everything going at home? Has anyone at home ever hurt you?
- Do you feel safe? Is there something that you would like to share with me?
- Has there been a recent incident causing you concern? Tell me about it.
- Has anyone ever tried to take advantage of you?
- Has anyone ever made you do things you didn't want to do?
- Do you make decisions for yourself or does someone else make decisions about your life, like how or where you should live?
- Are you alone a lot? Has anyone ever failed to help you take care of yourself when you needed help?
- I noticed yesterday that your son/daughter seemed very upset with you. D oes he always treat you like that?
- It must be hard for you to look after…?

Encourage elaboration.

Clarifying Questions

A senior who seeks medical help with inexplicable injuries should be assessed for the possibility of abuse (Tremayne-Lloyd, Rosen, 2000). Health professionals can obtain detailed information on the senior's medical condition, speak directly with the senior to obtain a history of the situation, perform a physical exam, and perhaps gather information on the abuser (Pearsal, 2005).

If a person identifies signs of abuse and/or suspects an older adult is living at risk of abuse, then an assessment should be completed. The following questions/chart provides examples of possible signs of abuse and will assist in developing a more complete picture of the situation (McDonald & Collins, 2000; Pearsal, 2005; Seniors Resource Centre Association of Newfoundland and Labrador, 2006; Levine, 2003).

Remember:
- Why is this situation causing concern?
- What are you seeing, hearing?

TYPE	Recognize Red Flags	Questions for the Worker	Questions for the Senior
Financial	• Change in senior's appearance; presenting somewhat dishevelled. • Appears confused about his/her banking. • Banking occurs in presence of relative/caregiver/stranger who may be getting money from the senior or changing accounts to include them.	• Does the senior appear to live in a different standard than the others living in the house? • Has there been a sudden change in standard of living, change of residence or living arrangement? • Does the senior refuse to spend money without consulting family? • Is there an unexplained or sudden inability to pay bills, account withdrawals, changes in their will, establishment of Power of Attorney, or disappearance of possessions?	• Have you ever been asked to sign papers you didn't understand? Tell me about it. • Does anyone ever take anything from you or use your money without permission? Can you give me an example? • Who does your finances? Are you comfortable with how they handle your finances? • Do you have any close family members who abuse drugs/ alcohol or have a psychiatric or mental illness? Tell me how this affects you.

TYPE	Recognize Red Flags	Questions for the Worker	Questions for the Senior
Physical	• Change in hygiene, grooming. • Inappropriate dress for the season. • Skin shows signs of dehydration, lacerations, burns, bites. • Bruises in unusual locations (e.g. breast, chest, abdomen, extremities; patterns of injury; bruises distant from site of injury. • Presence of abrasions. • Multiple admissions for fractures, unexplained injuries, history of 'accidents'. • Fractures of head, spine, and trunk, and rotational or spiral fractures are more likely as a result of assault. **Note**: Careful screening is necessary to determine if injury is a result of changes related aging (e.g. thinning, sensitive skin) or as a result of physical abuse.	• Is the senior anxious around the caregiver? • Is the senior physically isolated from everyone with no access to a phone or a lifeline? • Is there evidence of poor hygiene, a lack of medical aids? For example, requires a walker or hearing aid and does not have it. • Are there unexplained injuries (for instance, grip marks on the forearms)?	• Does anyone ever touch you without your consent? • Can you tell me about a time recently when someone made you do things you didn't want to do? • Does anyone close to you ever try to harm or hurt you? Tell me about it • Do you have any close family members who abuse drugs and/or alcohol, or have a psychiatric or mental illness? Tell me how it affects you?

TYPE	Recognize Red Flags	Questions for the Worker	Questions for the Senior
Sexual	• Difficulty sitting or walking. • Bloody or stained clothing. • Bruising and swelling in vaginal/ rectal area. • Unexplained venereal disease or genital infections . • Reddened, itching, painful genital area, vaginal/anal bleeding, genital infections, and venereal diseases. • Behavioural changes such as withdrawal, fear, depression, anger, insomnia, increased interest in sex or aggressive behaviour.	• Is there evidence that other abuse is happening as well? • Have you conducted STD testing? • Ask senior about the nature and quality of the relationship with the caregiver and the conditions of the home • Have you spoken to the senior about safety planning and community resources? • Have you documented all the evidence? Files could be used for court/prosecution in the future. Use quotes from senior.	• Does anyone ever touch you without consent? • Can you tell me about a time recently when someone made you do things you didn't want to? • Are you alone a lot? • Does anyone close to you ever try to harm or hurt you? Tell me about it. • Do you have any close family members who abuse drugs and alcohol or have a psychiatric or mental illness? Tell me how it affects you?
Psychological	• Communication includes changes in tone of voice, verbal aggression, insults, threats, lack of eye contact or glaring at the senior as he or she speaks. • Depression, fear, anxiety or withdrawal. • Behaviour changes when caregiver enters or leaves the room.	• Have you noticed sudden changes in the older adult's behaviour (e.g. depressed rather than content)? • Does the senior appear fearful of family and/or caregivers? • How do family members behave toward the older adult? Are they verbally abusive? Do they always speak for the older person?	• Can you tell me about a time recently when someone talked to or yelled at you in a way that made you fell bad about yourself? • Does anyone ever scold or threaten you? Can you give me an example? • Does anyone ever tell you that you're sick when you know you aren't? Can you give me an example? • When was the last time you got to see relatives or friends? • Do you have any access to a telephone? If not why not?

TYPE	Recognize Red Flags	Questions for the Worker	Questions for the Senior
Neglect	• Inadequate staffing in institutions; improper feeding techniques can lead to choking, aspiration, pneumonia. • Poor nutritional status; burns (e.g. sunburn). • Prescriptions not filled appropriately (e.g. inadequate time frame between prescriptions). • "Doctor-shopping"; pattern of missed/cancelled appointments. • Lack of privacy; caregiver is always present at visits and reluctant to leave senior to speak privately. • Needed medical/health aids not obtained. • Untreated medical condition due to caregiver not seeking assistance.	• Does the family/caregiver appear indifferent to the needs of the senior? • Is there evidence of no company/ visitors coming to see the senior? • Is the senior left alone for long periods of time with no stimulation or any other activities provided? • Are service providers never left alone with the pers on? Does someone else always answer questions on behalf of the senior? • Does the person live in the basement while the rest of the family lives upstairs? Is the senior physically able to climb the stairs to get to the rest of the house? • Are seniors living in unsafe living conditions such as filth, fire hazards, no heat, hoarding, etc?	• Are you getting all the help you need? • Are you having any problems getting to your doctor's office, pharmacy, etc? • Are you alone a lot? • Does anyone ever let you down when you need help? • Do you feel that your food, clothing, and medications are available to you at all times? • When was the last time you got to see relatives and/or friends? • Do you have ready access to a telephone? If not why not? • Do you have the glasses/ dentures/ cane that you need? If not why?

Further information for Banking and Pharmacists can be found in the Appendices:

- Guidelines for Banking Representatives **Appendix A**
- Guidelines for Pharmacists **Appendix B**:

Formulating Questions for Suspected Abuser

Working with a suspected abuser is a very delicate situation and should only be undertaken by a qualified professional possessing the appropriate skills and training (Seniors Resource Centre Association of Newfoundland and Labrador, 2006).

- What does _____ (senior's name) need help with every day?
- Are you and ___(senior's name) aware of the kinds of help available in the community?
- How do you and ____(senior's name) handle disagreements?
- What expectations does ____(senior's name) have of you?
- Most caregivers find their role stressful. I sense caring for _____(senior's name) is stressful for you. Is this recent or has this been this way for some time?
- How do you react under stress?
- Do you tell people you care about when you are feeling stressed?
- When you are angry/resentful/frustrated with ____ (senior's name) have you ever felt out of control? What did you do?
- Do you feel able to ask for help from others when you feel you need a break?
- Is caring for ___(senior's name) different than you thought it would be?
- How do you feel you are managing the present situation?
- How is ____ (senior's name) involved in decisions and determining his/her care?

Elder Abuse Assessments

Front line workers are in a unique position to not only detect but intervene in cases of elder abuse as they have the opportunity to develop an on-going relationship with the older adult. Front line workers who have developed a trusting relationship with the older adult may be able to speak with him or her about the suspected abuse. They can help facilitate early identification or prevention, or simply help reduce the isolation experienced by older adults, by asking questions about potential abuse, and then discussing options for service and action.

Front line workers need to recognize the importance and feel confident in asking about abuse. A simple question such as "Is somebody in your life taking advantage of you or mistreating you?" could eventually lead to a disclosure of abuse.

As the issues of elder abuse become better understood, it will be important to delve deeper into the situation for specific signs of potential abuse. As the 'detective', assessment involves both dialogue and observation, and is an on-going process; it will likely take many visits.

Sensitivity to language and cultural differences is important in information gathering. Keep in mind, one's own values can influence perception of the situation; for this reason, always clarify any uncertainties with the senior.

Assessments can be an important tool for confirming if a senior is being abused and guides a health professional in developing intervention plans. Health professionals who suspect elder abuse should be conducting elder abuse assessments, especially if there is physical evidence that abuse has taken place. This documentation can be critical, when charges are laid against an abuser and evidence is required for court purposes. "The use of biomarkers for elder abuse is vital to the medical and legal determination of whether elder abuse or neglect has occurred" (Pearsal, 2005 p.183). Biomarkers include abrasions, bruising, fractures, restraints, weight loss, burns, mental health problems and sexual abuse. Health professionals also need to be able to determine if the signs they are observing are due to abuse or the process of aging. A physician's comprehensive notes, discussions and advice to a senior is important to document which will help make this distinction (Pearsal, 2005). Intervention options are outlined in Chapter 7.

Other things to keep in mind during an assessment include:

• Being aware of vision, hearing, or language deficits. Information gathering is most effective when conducted in an environment which promotes working with the senior in a relaxed, non-judgmental, supportive approach.

- Using simple and direct questions that will help to substantiate or dispel suspicions.
- Ensuring privacy and confidentiality

It is vital to respect the older adult's wishes. If he or she does not want to talk about the issues, do not persist. Reassure the senior that he or she can discuss anything in the future, with the right to privacy and confidentiality. It is not expected that health care professional be the expert on elder abuse, however having a general understanding of the issue, how to assess a situation, and knowing the community services to refer a senior for help is vital to protecting his or her health and safety.

Interviewing Techniques

There are a few key issues that front line workers need to consider prior to asking an older adult about elder abuse.

Knowing how to ask questions, approaches to use with older adults as well as documenting facts are particularly important prior to speaking with the older adult. Below are some quick reference tips. Further information on documentation and intervention are outlined in Chapter 7.

Questioning Tips

- Start with non-threatening questions regarding the senior's perception of home safety and progress to more specific questions.
- Avoid confrontations, expressions of disgust, horror or anger.
- Avoid "putting down" the abuser.
- Keep questions simple and direct.

Communication Tips

- Talk less listen more, allow them to talk at their own pace.
- Offer support, discuss options, but do not give advice.
- Be alert to inconsistencies and discrepancies.
- Be mindful of hearing difficulties, language barriers, cultural and religious values.
- Take time while talking to the older person. Allow time for the person to get his or her thoughts together and respond to questions before speaking to the person again.
- Check if the person can hear the conversation; some people have impaired hearing but don not like to admit to it.

Interview Process

- Make an appointment with the person to arrange for the interview.
- Interview the senior and alleged abuser separately, as soon as possible following the disclosure of abuse.
- Interview the victim first as this provides the victim a feeling of support and minimizes any bias from the abuser.
- Minimize the possibility of being overheard or interrupted.
- Conduct the interview in a calm unhurried manner, using open ended questions whenever possible.
- Refrain from jumping to conclusions before all the facts are known. Record verbatim the comments from the senior and suspected abuser.
- Pay particular attention to any discrepancies and inconsistencies in the accounts of abuse obtained from the senior, the alleged abuser, and other information sources.
- Ask the senior's permission to contact other involved service agencies, family members, or friends for collateral information.

Assessment Tools

A wide range of assessment tools are used by various agencies for different purposes. Before using any tool it is important to determine the purpose in administering it. The following provides information on how to evaluate a tool to determine if it meets your assessment needs.

Evaluation of Elder Abuse Screening Materials

(Wahl, 2005)

There are a wide variety of materials on elder abuse risk assessment/screening that may be found on the internet, in the library, in conference handouts, through literature searches. Many of these are from other jurisdictions (the USA, other provinces, other countries). These materials may be useful in developing tools to fit the needs of your CCAC, other service provider agencies and other organizations. However, caution must be exercised in using any tool "as is". Some tools will not reflect Ontario law and legislation that must be taken into consideration in your service delivery. Some tools may lead the user down a "path" that will not be appropriate considering the "values" related to service delivery at your CCAC, agency or organization. Some tools may be useful but need some modification and adaptation to fit your own community. This template is a list of questions/issues that you may want to consider in evaluating risk assessment/ screening tools.

1. Ageism -Any tools used should not be "ageist" or stereotype seniors as "children" or people for whom the CCAC, agency or organization must make decisions. The tool should support the image of seniors as adults, as persons who have the right to control their own lives, to make their own decisions.

- When you read the tool, what kind of image of seniors is presented?
- Does the tool direct you more to seeing the senior as an adult or as a child?
- Does the tool lead you to looking at the senior as a person who should be able to make his or her own decisions (although they may need supports to so act)?
- Does the tool lead you to looking at options to support that senior to make decisions for him or herself?
- If the senior is not mentally capable for the relevant decisions, does the tool still lead you to look at the senior as an adult who needs to be a "participant" in what decisions are made for him or her by his or her substitute decision maker (SDM), whose capacities, however limited, need to be respected, whose past capable wishes need to be followed and present "incapable" wishes still taken into consideration, even if the incapable wishes are not determinative of the direction that you or the SDM may have to follow?

2. Vulnerability - Vulnerabilities (cognitive impairment, physical frailty, physical and mental disabilities, limited finances) may make a senior to be more "at risk" and less able to act independently to address the abuse he or she is experiencing. The vulnerability may increase the need for supports or for direct assistance to exercise options to end the abuse.

- Does the tool help you identify the vulnerabilities of the senior?
- Does the tool help you identify the strengths and abilities of the senior?
- Does the tool lead you to options to help the senior compensate for the identified vulnerabilities/reduce the vulnerabilities?

3. Victim Blaming - A danger in elder abuse situations is to "blame the victim" and excuse the abuser, especially in situations of caregiver stress. Harm to the senior by a stressed caregiver is still abuse, not justifiable behaviour by a stressed caregiver.

- Does the tool help you be clear as to "who is the client" in the abuse situation? ("Client" being the person from whom you take direction).
- Does the tool ask questions that "victim blame" and lead you to excuse the abuser? (I.e. questions like "What behaviours of the senior cause you to hit them or lose your temper?").
- Does the tool help you view the abuse from the point of view of the senior (victim) as well as the abuser in caregiver stress situations?

4. Family Dynamics -Many incidents of elder abuse are situations in which the abuser is a close family member, relative, or friend that acts as "family" to that senior. The senior may want to maintain the family relationship despite the abuse. There is a need to understand the family dynamics in order to help the senior determine options to address the abuse. The family dynamics are also important in determining from whom the CCAC/gency/ organization takes direction if the senior is not mentally capable of doing that him or herself.

- Does the tool help you get information on the "family" involved with the senior and an understanding of the family dynamics, especially on decision making, control, authority and influence over the senior's life?
- Does the tool help you identify all the family - not just blood/marriage relatives but others playing a familial role in the life of the senior?
- Does the tool lead you to options that take the family dynamics into consideration without justifying or excusing the abuser's actions?

- Does the tool use labels (caregiver, care receiver, care recipient) in a way that labels all seniors in the same way, all family members in the same way without taking into account individual differences? (i.e. in some situations the senior is the care giver and family member the care receiver and not the opposite way) .
- Does the tool guide you to understand who would be the SDM for the senior if incapable and what to do if the SDM is the abuser?

5. Legal Issues - Many tools are from other jurisdictions (other provinces, other countries) which have legislation that addresses abuse/ capacity/confidentiality or service responsibilities etc. in a way that is different than in Ontario. If used in Ontario as is, out of context of the legal framework in which it was meant to operate, the tool may not have the same utility. It may lead you to options that are not appropriate or available in the Ontario context.

It may use terminology that is the same or similar as in Ontario but which has a different "legal meaning"(ie the terms "power of attorney" and "capacity"). Legislation is always changing and even tools created in the Ontario context may be out of date and reflect old law instead of current law.

- Does the tool reflect the law/legislation of Ontario?
- Does the tool use language that reflects Ontario law and which has the same meaning as under Ontario law?
- Does the tool lead you to options that are available under Ontario law?
- Does the tool reflect the law as it is at this time in Ontario?

6. Values - People working in the area of elder abuse have many different approaches to abuse. The different approaches are reflections of different core values. For example, some approaches are more paternalistic; some are more empowering. The direction the tool leads you reflects the values behind the tool.

- What values is the tool based on?
- From the way the tool leads you to options, what values are expressed in that passage and in the options that it offers?
- Are the values that are reflected in the tool the ones that the CCAC/agency /organization wants to reflect in its practices?

7. Options - There are many different options that are available to help victims of abuse. The tools used should lead you to a variety of options, and not just one "solution". Not all options fit all people. Not all options fit every type of abuse. If a tool directs you to "one" right answer (i.e. that the family must be kept together always; that the senior must be "placed"; etc), it should be questioned whether that tool is adequate as it does not lead to a range of possibilities.

- Does the tool lead you down one path on a decision tree or does it lead to a range of options?
- Does the tool help you identify both the flaws and benefits in options, even in options that seem on their face laudable or ultimately worthwhile?
- Does the tool help you identify the benefits and flaws in options that seem on their face NOT initially worthwhile or laudable?

Assessment Tools and Materials

There are several assessment tools designed to screen for elder abuse. For sample tools and links to tools, check the ONPEA website: www.onpea.org

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Appendix A: Guidelines for Banking Representatives

Role

- To establish a relationship, trust, with the senior.
- To identify a senior that may be taken advantage of financially (front line tellers and financial planners (i.e. Estates Trustees,).
- To provide an opportunity for the senior to connect with others - while conducting their banking affairs.
- To help spot possible financial abuse, by getting to know senior customers.
- To encourage seniors to avail themselves of the added protection of direct deposit, direct payment of bills, on-line banking and advice about powers of attorney, the financial ramifications of joint accounts and other banking services.

Potential Causes for Concern: (What might alert you to potential elder abuse)

- A normally well dressed senior presents with a somewhat disheveled appearance.
- Banking activity is suspicious, e.g. large withdrawal not regular for client.
- Senior seems confused about banking; unclear.
- Pattern of activity is unusual; e.g. sudden increases in incurred debt or overdrafts.
- Senior appears with relative, caregiver or strangers and giving them money, or changing the account to include them.
- Family seem to feel a false sense of entitlement (e.g. “I deserve it”).
- Someone (other than the senior) has easy access to funds or property.

Confirmation/Clarification (Questions to ask)

- Why is this situation causing concern?
- Who does your finances? Are you comfortable with how they handle your finances?
- Do you understand the papers you have signed?
- Has anyone ever taken or used your money without permission?

Action

- Offer “senior friendly” services; e.g. material in large print, quiet special banking area with seating, employees trained to respond to seniors’ needs.
- Provide senior with information and advice on banking services that might limit potential abuse.
- Try to speak to the senior alone to ensure that undue influence is not being exerted.
- Ensure senior has time to think about activities and changes they may wish to make.
- Understand the financial institution’s policies and procedures related to suspected abuse.

Appendix B: Guidelines for Pharmacists

Role
• Be an outside contact for the seniors. • Educate and advise the senior on medication use and misuse. • Identify suspicions of abuse.
Potential Causes for Concern
• Witness a caregiver, family member, belittling or threatening the senior. • Become aware that the senior becomes nervous or agitated when a particular person is present. • Sudden changes in payment methods. • Misuse of medication; e.g. prescriptions not being refilled, increases in refill requests, senior refuses needed medications. • Senior shows signs of dehydration, malnutrition, poor hygiene, inappropriate dress for the weather. • Delivery drivers observe unsafe living conditions e.g. deteriorating premises, lack of heat, filth.
Confirmation/Clarification
• Is everything OK? • Does someone, other than you, manage your medications? • How are you supposed to take medications? Are you able to manage them on your own?
Action
• Follow your firm's policies and procedures. • Document your observations if you suspect a problem. • Provide information about products and services to the senior. • Provide resource materials to the senior with names and numbers, to get help if needed. • Speak to the senior alone, in a non-threatening and non-judgmental manner, if there are potential safety issues.

Chapter 5

Interacting with the Senior at Risk

Understanding
The key issues of elder abuse which in-turn leads to the ability to recognize, interact and respond. Each situation is unique.

Recognize indicators of abuse
- Why is this situation causing me concern?
- What am I observing?

Interact with the senior at risk
- How do I feel about this situation/the alleged abuse?
- What are the values, wishes, goals of the person?
- Is the senior making the decisions?

Respond
- What resources are required?
- What are my responsibilities?
- What is my role on the team?

Reflection
Stop and think about the situation to promote a better understanding of the issues on an individual, team, organization, and systems level; this can contribute to better responses and the prevention of elder abuse.

Chapter 5: Interacting with the Senior at Risk

Introduction

The most critical component of interaction is to **ask** the older person about abuse. For example, a professional, family member or friend can ask if the person feels safe, pressured, taken advantage of or if he or she is treated badly. Asking the person about abuse aligns with the guiding ethical principles discussed in Chapter 2 and is critical to understanding how best to work with the older person to manage the situation.

Assisting the abused person to have a sense of control over the situation is an important focus for the worker, while being sensitive to the wishes of the person. The worker may need to restrain personal feelings or desires to "take over and fix" the situation; the older person's autonomy is paramount. Additionally, in "taking over" the worker may enhance the feelings of vulnerability or victimization the person may be experiencing as a result of the abuse. By following the direction and wishes of the senior, the worker may help the senior regain some control.

Questions to ask when interacting with the senior at risk:

- How do I feel about this situation/the alleged abuse?
- What are the values, wishes, goals of the person?
- Is the senior making the decisions?

Interacting with the Senior Experiencing Abuse

(Basu & Ranjy, 1992)

The older person may feel isolated from the community, especially if it is difficult for the person to leave the home. Workers providing services for the person in the home may be the only contact the person has with the community apart from the family or caregiver. The close individual care that a service worker provides offers an opportunity for the person to develop a relationship of trust with that worker. Those whose job it is to deliver meals or provide friendly visiting, offer another opportunity for companionship with the senior and for a relationship of trust to develop. As a result of this relationship, with respect to abuse, the person is most likely to first confide in the service worker or volunteer. Consequently, service providers and volunteers are the most likely to be in a position to observe or suspect that abuse is occurring.

Personal Disclosure of Abuse and Response

(Hamlet, 1990)

If a person is being abused, it takes courage to disclose to someone. As discussed previously, the older person often feels ashamed, humiliated and fearful. By anticipating these feelings, the service worker or volunteer can engage the senior in a way that respects personal values, wishes, goals, right to make decisions, and accept or decline assistance. If abuse is suspected, refer to Chapter 4 for questions to facilitate dialogue. As a person is disclosing use the 3A's in your interaction with the senior.

The 3 A's

- **A**ctive listening and reassurance.
- **A**sk the older person what he or she wants.
- **A**ction according to wishes and follow-up.

Active Listening and Reassurance

1. The first task when meeting with a senior is to establish a relaxed and nonthreatening atmosphere. Remember to listen carefully to what the senior is saying without interrupting in order to provide the person with as much time as needed to make this painful disclosure.

2. Non-verbal communications such as gestures of understanding or small encouragers such as "I understand" or "It must be difficult for you" or "Take your time, I know this is difficult to talk about" may be helpful.

3. Reassurance can help the senior know confidentiality and wishes will be respected and that the worker appreciates how difficult and painful the disclosure is to make; however, a service worker should explain any limits on client confidentiality to the senior during his or her first encounter. When working in a situation for example, such as a nursing home or long-term care home, that mandates a worker to report abuse (harm), the worker must inform the senior that whatever is disclosed will have to be reported as per the legislative requirements.

4. The worker receiving the disclosure should always believe what the older person is saying and display this belief through appropriate body language. In particular, facial expressions and body language should be calm and neutral. Avoid actions that suggest discounting the person such as challenging the person's memory and at all times remember it is a very painful and traumatic event to share the issue of abuse with someone. Remember, avoid showing any negative reaction to the abuser or to imply blame. The senior may feel protective of the abuser and may not disclose if he or she feels harm will come to the abuser.

5. The senior may have kept the abuse secret or hidden because he or she is used to not being believed. As such, the senior may share information in pieces, starting with a small amount of information in order to gauge the reaction of the service worker. Regardless of the amount of information the person offers, after listening to the disclosure, the worker needs to reassure the older person and let them know that he or she is not to blame in any way. Remember, victims of abuse sometimes feel that they have done something to deserve this treatment. The senior may find it helpful to know that he or she is not alone in the experience of abuse; by assuring the person that similar abuse had happened to others, it may be easier for the person to continue sharing.

6. In addition to listening openly, respectfully, and with assuring body language, the service provider may ask some open -ended questions that may assist the person in talking about the situation. However, the service provider has to develop a relationship of trust with the senior before asking these questions. By being patient and building trust with the person, the worker can provide the person with an opportunity to open up, when he or she is ready.

7. The person may also be more inclined to disclose in a comfortable, non-threatening environment. Some tips to set up a comfortable non-threatening environment include:

- Interview caregiver and senior separately where possible.
- Ideally include a home visit.
- Avoid language or terminology that the older person may not understand such as technical terms etc.
- Talk to the person when you can be alone with him or her.
- Eliminate or reduce distractions in the room in which you are talking.
- Check to see that the senior has any necessary aids for communication (i.e. hearing aids, glasses, communication board, etc.).
- Be sensitive to gender and cultural norms (e.g. a female may prefer speaking to another female and a male may prefer another male).
- Be sensitive to language barriers; have a service provider who can speak the senior's language.
- Try to help the person relax (offer them, or ask for, some tea or coffee, make "small talk", etc.).
- If you do not know this person well try to find out more about who they are and their personal history.
- Don't just focus on the possible abuse - relate to the person as a person not as a victim.

Ask the Older Person What He or She Wants

1. Perhaps the most critical, is for the worker to **ask** the older person what he or she wants to do and how the worker can assist. The senior may wish to have a trusted friend or family member present to offer support. Sometimes an abused older person just wants opportunity to share his or her experiences with someone else, without any further action, or it may take months before the person is ready to take action. Anne Sclater MD (2000), "Most elderly people value autonomy above personal safety and comfort, and would rather have inadequate care with families than the best of institutional care." If the senior chooses to do nothing about an abusive situation, provide them with the information in case they change their mind later on.

2. The person can make informed decisions if they are provided with accurate information about:

- Options that are available to them.
- The full process of how they can be accessed.
- What may be expected of the person.
- Steps that may be involved in moving ahead.
- Costs (if any) that might apply.
- Available support and follow-up is available.

Remember! It starts with asking the person and carefully listening to the response.

3. The worker needs to be prepared: As mentioned previously in this section, it takes a great deal of courage for a senior to disclose to someone that he or she is being abused. The senior may experience a strong emotional response or tremendous anxiety when disclosing. The service provider must be prepared, and skilled to deal with these emotions and have a plan to follow up with the senior or refer them for appropriate support to deal with these issues (Siegel, 2004).

Act According to Wishes and Follow-Up

1. The service provider must be very aware of his or her biases and avoid making valued judgments about what course of action the senior decides. A rights-based philosophy, as discussed is Chapter 2, acknowledges the older person's right to live at risk and to make decisions that may not match those of the service worker. Whatever the senior decides to do or not to do, it is important that he or she feel supported in this process.

2. In situations where the person does not want to address the abuse directly, a worker may be able to assist in a more general way. Often activities that help increase self-esteem and self-worth can have a positive impact on the person's life. Remember to ask what changes the person wishes to make and to support and assist the person in working towards these goals.

Listen carefully to the response. Making a change in a daily routine, leaving the house more frequently, getting reacquainted with friends, and strengtheningthe social network, may have a positive effect on an abusive situation.

3. The senior may decline any help; he or she has the right to do so. The service worker may ask if it is safe to leave the person with information in case the person may wish to follow-up later. The service worker must determine a safe way to leave the person with a phone number or follow-up information (i.e. left with a trusted neighbour or in a safe place). The worker can arrange follow-up for the person if the service relationship is ending. If service is continuing, a worker can check-in with the person every month or so to casually assess if the situation has altered or the senior has changed his or her mind about seeking assistance.

4. If the worker feels that the person is at imminent risk for serious harm to life or severe risk of injury, he or she should know to call 911 (for more information see Chapter 3).

5. Despite the numerous obstacles and barriers they face, the strength and resiliency of older survivors of abuse has been well-documented (Hightower et. al., 2001; Seaver, 1996; Podnieks, 1992b).

6. Seaver's work (1996) with older abused women suggested that "older women can free themselves from abuse or make major changes to cope with it" (p. 17) and that they would use resources such as support groups and shelters if they were available and adapted to meet their needs. Seaver (1996) concluded that the women had been eager to learn, had used resources well, and had responded "enthusiastically to the idea that they deserve more peaceful lives"(p.19).

Barriers to Disclosure

Why is elder abuse kept secret? Barriers to reporting abuse may exist for both the abused senior or perceived barriers for professionals, friends or family.

Disclosing the abuse experienced by the abused older adult can be difficult because he or she (Murphy, 1994; Seniors Resource Centre Association of Newfoundland and Labrador, 2006):

1. Fears more abuse

- The older person may be afraid that if he or she says something or complains, the abuser will find out and the abuse will get worse; particularly since the victim is often dependent on the abuser for care and socialization.

2. Feels humiliated or ashamed

- The abused older person may feel humiliated because he or she no longer has the power or means (control) to stop the abuse. He or she may feel ashamed that the abuser is a family member.

3. Blames themselves for the abuse

- The abused older person may feel that he or she deserves the abuse because the person chose the wrong spouse or perhaps didn't bring their children up properly.

4. Fears a loss of affection

- The senior may no longer have siblings, relatives or a spouse still alive. The abuser may be the only person who still has a connection to the abused older person or who connects the senior with the outside world. If the abuser were no longer present, the abused older person may have no one else in his or her life to who he or she feels connected.

5. Worries about what will happen to him or herself and/or the abuser

- The abused older person may worry about where he or she will receive care, if the abuser is not available to do so. The abused older person may also have fears about moving to a long-term care home.
- Often if the abuser is a loved-one, the abused older person may not want the abuser to be charged as a criminal and face prison.
- The abused older person is often isolated in the home with the abuser and is unable to get out; as a result the abused older person may fear that there is no other place to live.

6. Believes that family honour is at stake

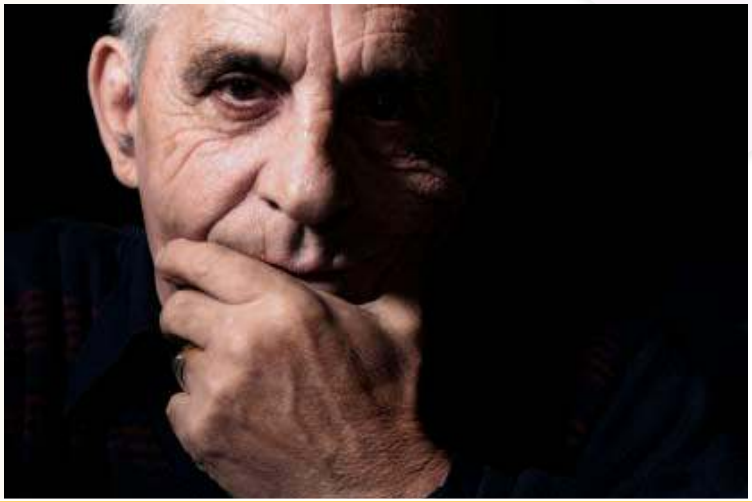
- The abused older person may believe that disclosing abuse will bring shame and dishonour to the entire family. In some cultures the family unit is considered more important than the individual and the abused older person may feel that it is his or her duty to suffer in silence rather than bring adversity or shame to the whole family.

7. Believes that privacy is at stake

- The abused older person may believe that he or she should be able to solve his or her own problems (e.g. should not "air dirty laundry").

8. Has a history of abuse

- The abused older person may have had a previous experience in disclosing an incident of abuse and had a poor or unpleasant outcome.



Complicating Issues

Other factors require consideration when interacting with the senior at risk and understanding barriers to disclosure:

1. Poverty

The lack of resources adds a complexity to the previous barriers to disclosing abuse. Understanding the term poverty is important. The Canadian Council on Social Development defines its opposite:

"Economic security refers to an assured and stable standard of living that provides individuals and families with a level of resources and benefits necessary to participate economically, politically, socially, culturally, and with dignity in their community's activities. Security goes beyond mere physical survival to encompass a level of resources that promotes social inclusion."

Personal Security Index, 2002

According to Williams (2004) 19% of Canadian seniors live below the Statistics Canada low income cut off, and this number rises to 30% for female, senior immigrants, and 53% of single senior women live in a low income situation.

Economic barriers can affect an older person's decision to deal with the abuse that he or she is experiencing:

- The senior might have less experience in handling financial matters.
- Lower income may lead to feelings of powerlessness. Limited income may lead to increased isolation due to the cost of transportation and mobility aids.
- Limited income creates a need to make difficult choices; for example, medication may be purchased at the expense of nutritious meals. Poor nutrition can lead to confusion and memory loss. Assumptions about the abused person's ability to understand a given situation may have an impact on the attention paid to it.
- Older women may find an even greater barrier due to the social expectations of their time (Hightower & Smith, 2004; ONPEA, 2004; Williams et. al, 2003).

2. Cultural and Language Considerations

(NACA, 2005)

Canada is a multicultural country with an increasing variety of cultures and languages present. Although the factors leading to abuse and the failure to disclose are found in these populations, there may be additional underlying cultural differences that complicate the issue, such as:

- A lack of knowledge about sponsorship rules and Canadian laws and rights and the fear of being deported back to their home country with no financial support.
- Financial dependence on the abuser and social dependency on family and/or sponsors which makes seeking support very difficult.
- Lack of family and friends close by, other than abuser.
- Language and cultural barriers may make seeking help very challenging; there may be limited access to objective translators, especially in smaller cultural communities. Acceptable service delivery systems may differ from culture to culture.
- The definition of abuse may look different from one culture to another; this may make it difficult and/or unlikely to seek out help.
- May come from war torn countries, experienced multiple traumas and may mistrust authorities, institutions.
- Lack of service provider understanding or sensitivity to the impact of one's culture on the way that the abuse is described.

The older abused person who experiences language and cultural barriers may be further isolated by a:

- Lack of adequate financial resources.
- Lack of connectedness to the service providers.
- Lack of understanding and fear of the legal system.
- Lack of ability and/or comfort to communicate the details of the abuse.

All of the above factors place him or her at higher risk for abuse.

Ethno-cultural considerations may also impact on the approach to be taken when intervening with the older person who discloses an incident of elder abuse. The factors that are barriers to disclosure, as previously discussed, may also interfere with a planned intervention. Social isolation and dependency due to cultural/language barriers may be compounded by feelings of powerlessness or a belief that one's fate and family status is predetermined and so abuse is to be accepted. Counselling may be a foreign concept, as sharing personal concerns may be seen as unacceptable. Therefore, working within the ethnic community, is critical in order to have an understanding of the best approach to take.

To respond in the most competent manner, the worker must be respectful of the beliefs, practices and linguistic needs of various populations. According to Eydt (2005), providing culturally competent services must involve understanding abuse as it might be seen by the older person who views it from his or her specific ethnic base.

Successful multi-cultural work also requires appropriate community resources to meet the support needs that abused or neglected older adults have, whose first language is neither English nor French.

3. Rural Community

The theme of isolation by geography, family or self-imposed could be a risk factor for abuse (Dimah, 2003).

- There may be large distances from neighbours, social supports and programs (which often heightensthe sense of isolation).
- Access to health care and service networks may be limited; this may put a greater strain on family to provide care. Familial and community expectations and feelings of obligation may add to caregiver stress.
- Younger generations may leave the rural community, leaving fewer family members upon whom to rely for assistance.
- There is often limited transportation to support services and programs.
- There may be a lack of viable options for housing, respite or shelter.
- In rural communities where "everyone knows everyone", the abused older person may not feel comfortable in relating private family issues.

Responsibilities of the Service Provider

Many individuals working with older adults may become aware of situations that do not appear to be healthy or safe for that individual. The instinct is often to protect that individual but they are unsure of how to do that without overstepping their 'authority' or interfering in 'family' affairs. A lack of concern is certainly not the reason that service providers appear to remain silent.

Barriers or perceived barriers for service providers to report abuse include:

- Fear of retribution from the abuser (fear violence to themselves or their family).
- Fear loss of job and loss of income.
- Fear lack of support from supervisor and/or management.
- Do not know that something can be done, who to call, what to do.
- Lack of knowledge about the law, fear litigation.
- Fear of getting someone (e.g. a co-worker) in trouble; may feel a loyalty to support their co-workers and not be labelled as a "tattle-tale".
- Fear getting involved, going to court, requiring time off and lost wages.
- Lack of knowledge or experience in dealing with issues around elder abuse, such as capacity, legislation, community supports, etc.
- Fear of increasing abuse to the older person, due to intervention.

Some service providers feel frustrated when they see abuse and feel that there is not much they can do to make it stop. They worry that if they bring attention to the abuse, the family may ask for that worker to be removed from providing care to the older adult. In a smaller community this can significantly reduce job opportunities for the service provider; this can result in removing the senior from someone who is concerned about their welfare. Often there is a lag between creating awareness of abuse and having the full array of resources available in the community.

Organizations delivering home care (through the CCAC) have an independent obligation to develop care plans that include ways to understand and support anyone suspected of dealing with a potentially abusive situation.

Remember, that we are still in the beginning stages of recognizing elder abuse as an issue that affects our community. Many believe that we are where domestic violence was 15 – 20 years ago. Back then many people were aware that wife assault was happening but no one really talked about it. By bringing the issue "out of the closet" society has made domestic violence unacceptable and has in place immediate and harsh deterrents. By continuing to advocate for our clients we will succeed in making sure that elder abuse is seen and labelled as unacceptable behaviour in our community.

Responsibilities of the Community

While some jurisdictions in Canada have Adult Protection legislation, no legislation exists requiring mandatory reporting of elder abuse cases in Ontario, other than in Long Term Care; nor is there evidence of the effectiveness of such legislation. The community therefore has a moral duty rather than legal one, ensuring that the older person is afforded the respect and feeling of safety that they deserve. This is made more possible by having policies in place dealing with abuse and by providing an atmosphere in which the older person can disclose abuse and have available resources to assist them when requested.

Communities are different in size and 'closeness' and will have diverse responses to abuse. Community members can reach out to the vulnerable friend or neighbour, seek out expertise in determining what resources are available to offer to the older person, and act as a link to potential referral agencies.

A community can assist in preventing elder abuse by shining light onto the subject: that:

- Provides information in 'neutral' locations (i.e. the individual may receive the information without bringing attention to it, if they so choose).
- Advocates for services/programs that encourage senior involvement.
- Raises awareness of the general public to issues of elder abuse.

Documentation

Accurate documentation is particularly important when working with abused older adults. Documentation assists in the monitoring of abuse and assists others who may become part of the support process for the senior (Seniors Resource Centre Association of Newfoundland and Labrador, 2006). Documentation may be used as evidence if the case goes to the criminal justice system.

Formal documentation may include use of specific assessment forms as prescribed by the protocols of the agency and/or professional college; it may include the recording of observations that alert the worker to potential abuse. Most regulated health professionals have standards of documentation practices. Non-regulated workers have specific agency policy and procedures to follow. All staff needs to become aware of the expected protocols that must be followed. Reporting concerns about what has been seen and heard is crucial. This may include noting details of incidents that may be indicators of potential abuse and sharing them with the supervisor so that appropriate action can take place.

Anyone working or volunteering in a Long Term Care Home is mandated to report any suspected incidence of elder abuse to the Ministry of Health and Long Term Care. Furthermore most, if not all, facilities have policies and procedures in place for zero tolerance of abuse. Staff and volunteers must familiarize themselves with the particular reporting requirements outlined in these policies and procedures.

McGregor (1995) and Daly (2004) provide the following tips for documenting abuse:

1. In situations of suspected abuse, clearly and accurately record the size, pattern, age, description, and location of all visible injuries on a body diagram.
2. Record all non -physical signs of abuse such as torn clothing, damaged jewellery, broken eyeglasses, or dentures, etc.
3. Record verbatim the client's explanation of injuries by prefacing each remark with "The client stated that…". Statements should be taken in the absence of the suspected abuser.

4. Avoid subjective data, lengthy descriptions, or client statements that are unrelated to the incident.
5. If the person denies being abused, document the person's exact explanation of the injuries as well as your own observation of the person's condition.
6. Determine whether any arrests were made or any charges were laid.
7. In all situations of suspected abuse or neglect, record the dates and times of all contacts, home visits and telephone calls.

Trends

Service providers are well placed to observe actual or potential cases of abuse. Often because of their close relationship with a senior they may hear disclosures of abuse. However as family, friends, and the community (i.e. bank tellers, pharmacists, postal workers) become more aware of the issues facing seniors, they are often in a position to also assist the senior in dealing with the abuse. Public education and awareness efforts are key in shedding light on the issue of elder abuse. Being aware of the signs and symptoms of abuse, services to which referrals may be made, and education and information resources are critical for the entire community, in order to provide a safer environment.

Chapter 5: Interacting with the Senior at Risk

The following chart provides the reader with action steps:

Item	Action
3As	Practice interactions using the 3As. Share/teach the 3As to others.
Barriers	Identify barriers that may exist with seniors you interact with. Work with team to strategize how to break through barriers.
Documentation	Review supporting policies and procedures. Review your responsibilities.

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Chapter 6

Interventions and Supportive Strategies

Understanding
The key issues of elder abuse which in-turn leads to the ability to recognize, interact and respond. Each situation is unique.

Recognize indicators of abuse
- Why is this situation causing me concern?
- What am I observing?

Interact with the senior at risk
- How do I feel about this situation/the alleged abuse?
- What are the values, wishes, goals of the person?
- Is the senior making the decisions?

Respond
- What resources are required?
- What are my responsibilities?
- What is my role on the team?

Reflection
Stop and think about the situation to promote a better understanding of the issues on an individual, team, organization, and systems level; this can contribute to better responses and the prevention of elder abuse.

Chapter Six: Interventions and Supportive Strategies

Introduction

Appropriate interventions and supportive strategies follow careful listening to the senior and most importantly follow the direction of the senior.

Understanding Intervention

Abuse left untreated can significantly shorten a senior's life. According to a study of older people, those who were mistreated were 3.1 times more likely to die during a 3 year period than those who did not experience abuse. After 13 years of follow-up, 9% of those who were mistreated were alive compared with 41 % who had not experienced abuse (Lachs & Pillemer, 2004). For this reason, intervention is critical.

As noted throughout the chapters, elder abuse is a complex issue; there is no simple solution for intervening in elder abuse situation. Each incident must be looked at with its own contributing factors and the unique individuals within each abusive situation, both for the senior and the abuser.

The chapter provides a generic guide for the service provider when working with the senior on intervention options. The service provider needs to understand the philosophical underpinnings of these models before intervening; he or she also needs to know what model of intervention the employer/agency supports.

Various Approaches to Intervention

A number of approaches exist to intervention. Often service providers use a combination of approaches.

1. Senior- Directed

- This approach is a rights-based model and advocates self determination for the senior. In a rights-based model the service worker offers information, options on how to improve safety, and support to the senior and follows the senior's direction for intervention. (Brandl and Raymond, 1997).
- The capable adult has the right to choose what, if any, intervention he or she wishes to pursue. The service provider is an advocate for the senior. (See Chapter 3 for more details on assessing capacity and SDM's.)
- Often abusers take power and control away from victims by isolating them from the people and information that can help them make thoughtful choices. Sometimes case managers and other service providers unintentionally control access to information and develop goals and expectations for clients. They may unwittingly become like the abuser as they attempt to manage the senior using influence, power, and control within their system. Service providers must be vigilant to ensure that they are not unduly influencing the senior to cooperate with their agenda.

- The capable senior has the right to choose or refuse intervention. Service providers must recognize the senior's right to choose and must work with the senior to facilitate this process. In cases where the older adult is capable and chooses to remain in the abusive relationship, the options for intervention need to be strategic and meaningful. Paramount in these situations is the preservation of the rights and choices of the senior.

2. Protectionist Approach

- This model focuses on protecting the victim (senior) from harm and ensuring his or her safety. The approach is generally modeled after child abuse interventions and includes mandatory reporting requirements.
- In ONPEA's experience, and those individuals within the sector such as Dr. Lisa Manual of Family Services Association in Toronto, "the more layers we wrap around the senior to protect them, the less effective is the intervention in the long-term".
- In many jurisdictions, particularly in the United States, the protective approach is the option chosen by policy makers.

3. Harm Reduction and Risk Management

The aim is to minimize or prevent future harm/risk to the senior in a manner that is least disruptive and intrusive to the senior's life style. At times there needs to be a balance between safety concerns and the level of risk to the senior. In a situation of imminent danger, an immediate emergency intervention is necessary to preserve the personal safety of the senior. However, where the risk is not life threatening or posing imminent danger to the senior, then the intervention should follow a model of managing risk and harm reduction.

4. Multidisciplinary Approach

Elder abuse is a complex, multifaceted issue. No one person has the necessary resources or expertise to deal with all the aspects of the situation. Working as part of a team can provide the abused senior with a more complete set of options. The following chart provides examples of potential team members and their possible functions. Team members are listed in alphabetical order.

KEY ROLES	FUNCTIONS
*** Banking Representative**	Detect financial abuse. Offer expert financial advise.
Community Care Access Centre Case Managers	Coordinate case elements. Provide referral. Facilitate access to services.
Community Support Groups	Provide direct service. Provide support and counselling. Provide expertise such as the Alzheimer Strategy. Provide case monitoring.
Law Enforcement	Detect abuse. Lay charges. Investigate criminal offences. Intervene with high risk volatile situation. Transport victim to safe housing. Remove others from household. Access psychiatric assessment. Intervene with abuser.
Lawyer	Offer advice. Provide options for criminal charges or civil action. Navigate legal system. Expertise with wills, powers of attorney. Act as advocate for senior in interactions with abuser and service providers.
***Pharmacist**	Detect health concerns, for example, over or under. medicating, neglect, safety. Offer expert advice with respect to medications, ***cont'd over.***

KEY ROLES, cont'd	FUNCTIONS, cont'd
Physician	Screen and diagnose. Contribute medical pathology. Determine capacity (Note physicians are not the only ones who do this, Refer to Chapter 3 for more information on capacity assessments and who can do them).
Regulated Health Professionals	Detect abuse. Determine capacity. (Note regulated health professionals are not the only ones who do this. Refer to Chapter 3 for more info on capacity assessments and who can do them) Bring specific expertise from professional background. Intervene.
Spiritual Leader	Provide guidance and support to victim and perpetrator.
Victim Services	Provide emotional support. Refer to community agencies for assistance. Support through legal system i.e. court process. Assist with Victim Impact Statements.

*** Please visit the ONPEA website for additional information.**

Effective Intervention

The next step after determining an approach(es) of intervention is to develop the components for an effective intervention plan. Uniqueness and diversity options and choices must be provided that take into account the senior's needs and life situation. Remember each senior
is unique. Refer to Chapter 5.

Five components to consider include:

1. Risk
2. Capacity
3. Consent
4. Support Systems
5. Community Resources

1. Risk

High risk where the senior is in immediate danger, i.e. life threatening situation or at risk of imminent harm, requires immediate action, which is generally 911 – police or medical.

2. Capacity

Need to determine if senior is capable, or who is acting as SDM for the incapable senior, while recognizing the senior's right to self-determination. If the senior is deemed incompetent, but has previously expressed wants or desires, every effort should be made to respect these wishes.The SDM has a legal obligation to decide and interpret the wishes of the incapable senior as well as to take into account the incapable wishes of the senior. The incapable wishes though aren't determinative of what the SDM has to decide. In addition, capacity can change over time, and therefore, the intervention must be revisited and evaluated on a regular basis to ensure the least intrusive options are adequately explored.

3. Consent:

Even in situations where the senior is deemed not capable, the service provider should solicit the cooperation and understanding of the senior for any intervention that is being implemented by the SDM. Critical to successful intervention is assessing how receptive the older adult victim is to accepting help (e.g. introducing safety measures, such as Lifeline or blocking the phone calls of an abuser).

4. Support Systems

Identify significant others in the seniors formal and informal network who can offer support for the senior, such as a neighbor, a faith leader, a relative, a friend etc.

It may be helpful to identify a support system for the abuser as well. Since the abuser is typically a family member, often the senior wishes to remain with them. Therefore it is necessary to work with the abuser to identify their issues and seek supportive programs for them in order to have a meaningful and effective outcome.

5. Community Resources

Workers need to be aware of emergency responses such as shelters, support services such as personal care and meals on wheels, rehabilitation services such as counselling and support groups, local community and police resources, their own agency resources, and the referral system for other team members.

Goal Development

When developing goals for intervention it is useful to think in terms of short and long term goals. In addition, it is also useful to think about the process that is used to achieve a particular outcome.

Short term intervention refers to areas that require more immediate problem solving, restoration, and enhancement of the person's functioning. These interventions can include:

- Medical treatment, counseling, education, and information about options.
- Coordination of community support systems to ensure safety and quality continuum of care.
- Home support services to increase independence.

Longer term interventions include using risk reduction strategies, follow-up, and evaluation of the effectiveness of the intervention plan.

Components of an Effective Intervention Plan

The focus of intervention is not the alleged mistreatment but, rather, the total situation. Assistance should be offered to both the alleged victim and the abuser if appropriate.

As the plan for intervention is developed with the senior, it is worthwhile to reflect on how well the following components have been integrated into the plan.

1. Customize the Plan

Interventions:

- Must be individualized, sensitive to senior/ family's culture, religion, race, sexual orientation, gender, socio-economic status.
- Maximize the seniors / family's strengths and abilities for positive action and are non-judgmental.

2. Take a Team Approach

- Identify available team supports and how to refer or access information about resources
- Organize a team consultation or who needs to be called to facilitate this
- Develop contacts within local police or criminal justice system
- Recognize that seniors may have competing health, cognitive, social or behavioural issues that may need to be dealt with in partnership by other professionals (See Chapter 2). Protocols are useful in establishing how this should take place and who should be the primary service worker.

3. Build Trust

- Helping the abused older adult is often slow work and the pace can be frustrating for the worker. However without taking the time to prepare the groundwork for change, chances of success are m inimal.
- Remember, the older capable person makes all final decisions about what steps to take; this helps to build self-esteem and to reduce feelings of victimization
- Trust is an essential element in this relationship; it takes time to develop that trust.
- Actively listen to what the senior is saying (See Chapter 5).

4. Include Other Relationships

Remember, the older person is embedded in a family and various relationships. There may well be conflicting views expressed by different family members over the same abuse. Some may express their views in a forceful way and request your assistance to resolve the situation.
These situations require much tact and diplomacy to resolve.

The abuser may require support and assistance in order to improve the situation for the senior who most often will choose to remain in the family setting. Untrained service workers should not confront the abuser as this may endanger the older adult. It needs to be done under the advisement and guidance of experts. This is where working with other team members is most helpful. Ideally someone else should work with the abuser or the abuser should be referred for help to a different agency so that the senior views you as their own advocate and trusts you. When this is not possible the service worker must make sure that the senior remains in charge and front and centre in the intervention plan. Speaking with a supervisor or colleague can be helpful in these cases.

Intervention Options

The following options provide an overview of options for developing a plan for intervention (ONPEA, 2006; Family Services of Toronto Best Practice Manual; 2005; Preston & Wahl, 2002; Groh, 2003).

Case Management

Case management is a model for providing services that was developed for persons with multiple and changing needs. This makes it quite effective for a senior because their needs and situations may vary over time. Ideally, case managers perform a comprehensive assessment. Following the assessment, the case manager works towards putting a plan in place that serves the senior as a whole person. Often this involves consulting with other professionals. As a result of this process, a multidisciplinary service plan can emerge, that matches the seniors needs with the available services. The case manager then arranges for and monitors the services, intervenes in problems and conducts routine reassessments to identify changes. This model is a good fit with elder abuse because it manages the situation in a non -intrusive way and works to circumvent crisis. Often this service is provided through the Community Care Access Centre although other service agencies who provide service to seniors may also utilize this model.

Safety Planning

Safety planning can be an important step for victims who have experienced violence. It is important to note that these plans in no way guarantee their victims safety, but may help to reduce specific risks. When working on a safety plan with an older adult, it is important for the front line worker to discuss what previous safety strategies the victim has tried. The service provider should try to access what has worked, what didn't work and why. This allows the service provider an opportunity to build trust, explore options and develop an action plan. See ONPEA website for sample safety plan.

Since many older adults do not leave the site of the abusive situation, a safety plan becomes an important tool in providing them with some sense of self-determination.

Counselling

Mental health professionals and counselling services can provide counselling for older adult victims to help them overcome feelings of denial, isolation, guilt and self-blame. They can also provide information or referral to emergency assistance, housing alternatives and financial services. In general elder abuse cases, counselling typically focuses on:

- Educating victims about resources and options.
- Breaking through denial and shame.
- Safety actions and safety planning.
- Building support networks.
- Addressing co-dependency issues between victim and abuser.
- Addressing traumatic or post-traumatic stress.

Support Groups

Support groups offer an opportunity for a senior to leave their house and meet with others. A peer support group helps victims of abuse to learn first-hand from other group members. It can help reduce their feelings of isolation and loneliness by learning that others are experiencing similar situations and he or she is not to blame for the abuse. Additionally a peer support group can be constructed around a common language and cultural values. This allows victims from a particular ethic-cultural group to communicate in the same language and to share experiences relevant to their community.

The building or strengthening of social support networks is a key community approach to address the abuse of older adults (ONPEA, 2006: Mears & Sargent, 2002; Hightower et. al., 2001). Support groups are also an effective way of breaking the pattern of isolation and restoring power and control to those who have survived abuse. (Hightower et al, 2001)

Peer support is also provided informally by friends and neighbours. Service providers can strengthen this by educating the public, including neighbours and friends, and people that older adults come into contact with in their daily lives such as bank tellers, store staff and apartment managers (ONPEA, 2006).

Support groups for abusers may also be an option if the abuser is willing to attend.

As the population ages and care giving becomes a fact of life for many families, a large number of new services have been developed to meet caregivers' need for support and assistance. Many of these new services have been designed to help caregivers and their families reduce their isolation, handle difficult behaviours and improve their coping skills.

Support groups that are organized by public and private agencies are also effective interventions. These groups provide support, information, and instruction in how to handle difficult behaviours, and assistance in working through the negative feelings that family caregivers may have towards their role. Some of these groups also help the caregiver understand their own stress "triggers" and develop techniques for reducing their stress.

Respite

Respite means rest or relief. There are a variety of approaches for providing relief. Some programs are available where volunteers or employees come to the seniors' home for a few hours at a time to allow the caregiver time to go out or attend to errands. This also allows the senior time to socialize with other people and to share their feelings safely. Other programs bring the senior to agencies or centres for several hours to participate in social, recreational or therapeutic programs. Specialty programs such as day programs for seniors with Alzheimer can also provide respite and support for the senior and caregiver.

Other programs offer placements in care facilities for several days at a time to allow caregivers an extended break from their care giving role.

Restorative Justice Model

This model focuses on a holistic approach to elder abuse where the victim and offender meet face to face to repair the harm. The focus is on healing for both the victim and offender, repairing the relationship between them and preventing future harm and reoccurrences. Restorative justice is an integral part of native community justice but also has its roots in many other cultures around the world. Trained mediators are required for the process.

For a detailed explanation please refer to: A Healing Approach to Elder Abuse and Mistreatment (Groh, 2003).

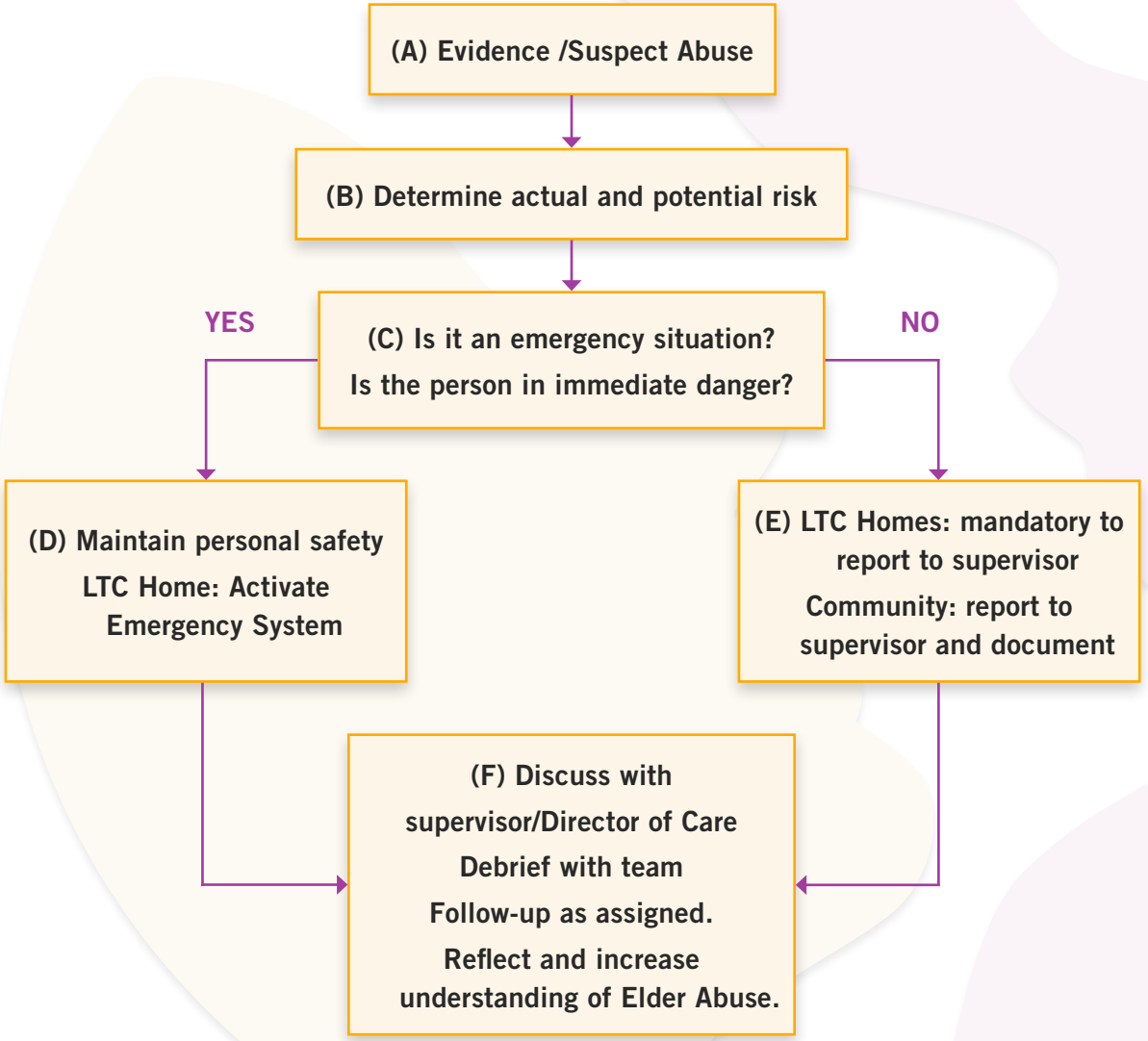
Decision Trees

The use of a decision tree is helpful in providing a quick guide along decision points to ensure that critical information is not overlooked or forgotten. The following decision trees are a guide to assist in developing an effective intervention plan. Many employers/agencies have developed their own decision trees to reflect their agency policies and procedures. These decision trees are not meant to replace those but offer more detailed information for various decision points.

Decision Tree A is intended for non-regulated workers and volunteers.

Decision Tree B can be used by regulated health professionals, law enforcement agencies and any other personnel who have the authority and responsibility to intervene. The boxes/decision points have been numbered for easy reference to the text. Detailed information and additional considerations are expanded upon in the text.

Decision Tree A – Non regulated Workers and Volunteers



Decision Tree A

Box A: Evidence/Suspect Abuse

- Refer to Chap 2 for types of abuse
- Record objective facts – what you see? What you hear?
- Determine the exact issues that are raising your suspicions

Box B: Determine Risk

- Refer to Chap 2 for risk factors.

Box C: Emergency Situation

- Determine if the senior is in immediate danger, i.e. life threatening situation or at risk of imminent harm.
- Call 911 and/or any special facility code.

Box D: Maintain Personal Safety

- Ensure personal safety.
- Ensure safety of other individuals exposed to the potential. danger, such as roommates.

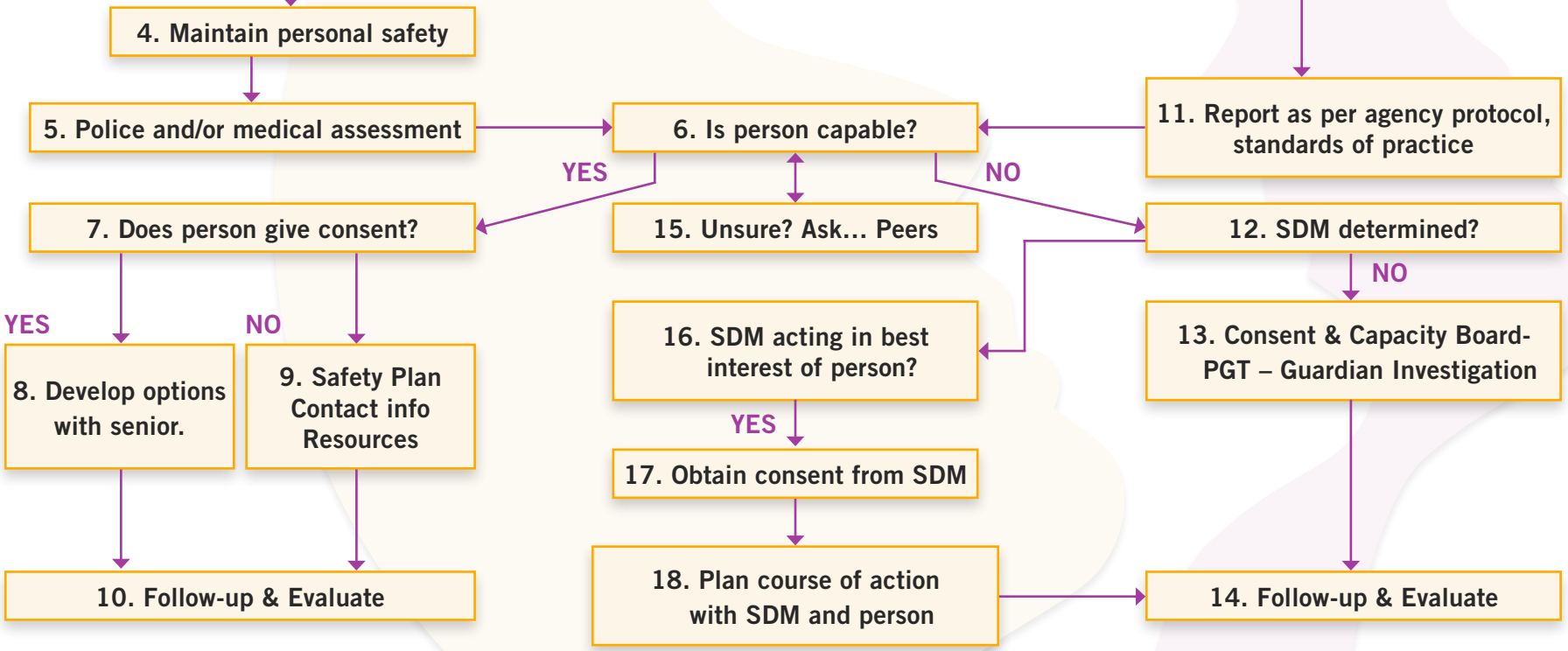
Box E: Responsibilities

- Reporting abuse to MOHLTC is mandatory within long-term care homes.
- As per facility policy, notify supervisor/Director of Care and document.
- Refer to Chap ter 4 for more details on role responsibilities.

Box F – Discuss with supervisor and debrief with team

- Discuss the situation with your supervisor after witnessing abuse
- Discuss with supervisor your responsibilities in the follow up plans and appropriate ways to interact with senior.
- Discuss with supervisor and team what was learned from this case, e.g. red flags, preventative measures etc.

Decision Tree B



Decision Tree B

Box 1: Evidence /Suspect Abuse

- Refer to Chap 2 for types of abuse.
- Note objective facts – what you see? What you hear?
- Determine the exact issue that is raising your suspicion.
- Determine how long you have had your suspicion?

Box 2: Determine risk

- Refer to Chap 2 for risk factors.

Box 3: Emergency

- Focus on risk of imminent harm — consider the immediate safety of the victim.

Respond with immediate action if the senior is in an emergency situation. Call 911 when:

- It is an emergency situation, i.e. life threatening.
- The person is at immediate risk for physical injury.
- The person is at imminent risk for health or safety reasons.

Assess the need for medical attention and other resources. Consider the following:

- Has the person sustained injuries?
- Does the person need transportation to a medical facility or shelter?
- Can the person contact the police or other emergency services on his or her own?

Box 4: Maintain personal safety

Assess immediate danger to the senior and worker:

- Where is the alleged abuser?
- Are there any weapons present?
- Does the alleged abuser have a weapon?
- Are their uncertainties such as the presence of mental health or addiction issues?
- Are others in the household?

Box 5: Police and/or medical assessment

Assess the need for safety, shelter and financial resources.

- Does the senior require transport to emergency housing?
  Does the person wish to go to a shelter, or have friends or other family who could provide temporary accommodation?
- Assess need for prescribed medication. Does senior need medical attention?
- Determine if any urgent mental health issues are present.

Box 6: Is senior capable?

- Consider a senior's mental capacity to understand his/her situation and ability to make decisions and understand the consequences of those decisions.
- Capacity is not a single skill or ability, but rather a series of abilities, some of which a person may or may not have e.g. cannot look after finances but can make decisions about medical treatment.
- Remember that capacity can change over time. Although a senior may be deemed incapable of understanding the consequences of certain actions and behaviors, all efforts should be made to continue to maintain the senior wishes and desires.
- Refer to Chap 3 for more details.

Box 7: Consent:

- Obtain voluntary and informed consent
- Do not assume that silence means consent. An explicitly stated yes means consent.
- Refer to Chap 3 for more details.

Box 8: Developing options for intervention

- The intervention plan has been divided into two parts: strategic components and intervention options. Discuss the intervention plan with the senior using the following:
- Strategic components include: customized plan, team approach, building trust, and including other relationships.
- Intervention options to consider: support groups, case management, safety planning, counselling, respite, restorative justice model.

Box 9: Consent not provided for intervention

- Provide the older person with information and options. Numbers and information about emergency shelters, criminal justice system and advocacy services are recommended.
- Stress the advantages of developing a safety/protection plan and review key elements.
- Stress to the senior that abusive behaviours tend to increase in frequency and intensity over time and rarely stop on their own.
- Negotiate a way of maintaining contact or providing follow up.

Box 10: Follow up and Evaluate

Follow up is important for several reasons:

- Provides ongoing contact and reassurance for the abused senior.

- Provides an opportunity to evaluate the effectiveness of the intervention plan and if any factors have changed, i.e. physical health, mental status, living arrangements.
- Provides an opportunity for the senior to reconsider options and change plans.
- Provides an opportunity to update resource materials.

Box 11: Not an emergency

- Ensure you are knowledgeable about your agencies policies and procedures on.
- Abuse and any legislation or college standards. Report and document as necessary.

Box 12: Abused senior not deemed capable.

- Check to see who would be the SDM.

Box 13: No SDM exists or SDM not acting in best interests of person

- Call police if there is criminal activity or if you suspect the Substitute Decision-Maker is criminally negligent.
- Report observations to immediate supervisors who can speak with the SDM.
- Call Ontario Public Guardian and Trustee if the older person is incapable to managing property or if you suspect the Substitute Decision-Maker is not acting in the best interest of the client. Refer to Chap 3 for more information.
- Consult with other team members who are providing service to that client.

Box 14: Follow up and evaluate

- See under box 10

Box 15: Unsure of senior's capacity

- Ask your immediate supervisor for assistance or draw upon the expertise of other team members who are involved with the senior. The senior's physician can be helpful in this situation or a number of other regulated health care professionals.

Box 16: SDM acting in best interests

- Assess to the best of your ability if SDM is acting in the best interests of the senior. Refer to Box 1 for more details.

Box 17: Obtain consent from SDM

- Obtain informed consent before proceeding. Work with the SDM to develop a plan of action, as you would with the senior.

Box 18: Plan with SDM

- See box 8 for details.

Developing a supportive environment to reduce potential elder abuse in Long Term Care Homes

1. How is respect shown to residents?

2. Is the work environment supportive?

- Are feelings supported and appreciated by management?
- Is there adequate supervision?
- Do you feel you have adequate knowledge and skills in dealing with residents and/or challenging behaviours? Is skill training available?
- Does feeling understaffed lead to burnout? Do you feel you are giving poorer care than you should? Are courses available to help (e.g. stress management)?
- Is conflict resolution among or between staff available? Is frequent staff turnover a concern?
- Are attitudes (for example, ageism) and understanding and sensitivity to working with older residents addressed in training?
- Are policies and procedures on dealing with abuse clear?

3. How are language barriers between staff and residents acknowledged? Are translators made available when needed?

4. How are the resident's culture and customs respected?

5. How well is the resident cared for? (e.g. unexplained bruises, bedsores).

6. How is the resident's mental state? (e.g. appears depressed, fearful of caregivers given attention and causes investigated).

7. How are resident's behaviours? (e.g. strikes out indiscriminately, crying noted and reviewed.) How are plans for response developed?

8. How are resident's possessions respected? (e.g. not moved around and/or missing).

9. How is the policy for zero tolerance of abuse interpreted? How does the organization build a climate of support for staff with the expectation that staff is expected to support each other? To consider also: Consistent approaches – clear definition of consequences with regards to physical/sexual abuse and emotional/ psychological abuse (there are different versions within some management teams) – protection mechanisms in place for staff who report.

There can be areas of grey when interpreting a zero tolerance policy. Things are not always as they appear.

Example #1:

Staff A goes by a resident's room and sees a co-worker, Staff B, heaving a resident onto the bed. Should this be reported as abusive behaviour?

- What should happen next? Staff A enters the room to first ensure the resident is all right, then, offers support to Staff B in order to break the abusive situation. A quick assessment is completed to be sure the resident is not in danger. The resident is asked if he or she is all right. Presuming the resident is all right, Staff A says to staff B, 'Can I help you?' or some other code phrase that the staff (with management as part of the development of the elder abuse prevention program) have designed to break an abusive situation. For example, 'Can I see you for just a minute?' Some abuse or apparent abuse may not be premeditated but is situational and not intended. Therefore the Staff B is supported by breaking the abusive situation and by Staff A offering assistance.
- Staff A reports what was observed and the subsequent interactions. The RN, or designate, investigates and finds out:

Staff B, who has cared for the resident for a long time, was transferring the resident when the resident's legs gave out. Rather than allow the resident to fall, Staff B heaved the resident onto the bed. The care plan showed a 1-person transfer. So what this abusive treatment? No.

As a result of the handling of this incident, the resident felt cared for and safeguarded. The resident's care plan was updated to designate a 2-person lift, thus enhancing the safety of both the resident and staff. As well Staff B felt supported by Staff A and an incident was fairly handled.

OR

Staff B did not possess the appropriate transferring skills.

This would be abuse. This finding would have to be reflected to Staff B with the clear direction that Staff B has a responsibility to be alert for care skills he or she does not feel competent with and to seek the necessary training. Also the staff responsible for training would be charged with training and supervising Staff B until his or her transferring skills are acceptable.

Example #2:

Staff A passes by the Administrator's office and hears her shouting at a resident. The intervention should be the same. Staff A would enter the office and ask the resident if he or she is all right and do a quick assessment to determine if the resident is in danger. Then Staff A would support the administrator with the code phrase.('Can I see you for just a minute?' for example). Having a code phrase serves the purpose of breaking the flow of what was going and alerting the administrator that the situation appears to be abusive.

There should still be an investigation and presumably it would be found that there was a reason for the yelling that was not abuse. This would be the ultimate test of how secure staff feel with regard to elder abuse and how committed they are to the protection of the residents.

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Appendix A: Resident Abuse Allegation Report

Part A (completed by Receiving Supervisor/RN)

Date of allegation: _____
Name/ Dept. of person making allegation: _____
Person (s) accused/ involved & dept: _____
Resident (s) involved: _____

Nature of abuse: _____
physical emotional/verbal financial sexual neglect

Summary of report: (include date/time & location).
_____
_____
_____
_____
_____
_____

Witnesses: (names and contact information).
_____
_____
_____

Summary of Scene Management:
(Description of immediate actions taken)
_____
_____
_____

Manager of accused staff contacted: __ yes __ no
Name of Manager contacted: _____

RN Contacted: __ yes __ no
Name of RN: _____
Further action: _____
_____
_____

Signature: _____ Date: _____

Form has been forwarded to_____

Date: _____

Part B – Completed by Senior Manager – Further investigation and Follow up:

Physical Injury involved: __ yes __ no

Medical followup if necessary: _____

_____

Photo evidence taken: (date) _____

Substitute Decision Maker contacted: __ yes __ no

Name: _____
By whom: _____
Details: _____

_____

_____

Manager(s) responsible for investigation: _____

_____

Managers' summary notes are enclosed summarizing investigation and other important details.
Date Investigation completed: _____

Summary of outcome: _____

_____

_____

_____

_____

_____

_____

_____

_____

All necessary documentation has been received and is filed in the Master File.

Administrators' signature: _____

Date: _____

Developed by Resident Task Form Team Regional Municipality of Durham, Services for Seniors and LTC Division Used with permission from Tammy Rankin. For more info they can contact Tammy at 905 - 579 - 3313 x. 5200.

Resident Abuse Allegation Report

Witness Report

Person completing Report: _____
Date / Time of incident: _____
Location of incident: _____

Incident details: Describe in detail what you witnessed or what was reported to you. Please be specific including details about what you saw and heard.	
Signature:	**Date:**

Developed by Resident Task Form Team. Regional Municipality of Durham, Services for Seniors and LTC Division Used with permission from Tammy Rankin. For more info they can contact Tammy at 905 - 579 - 3313 x. 5200.

Resident Abuse Allegation Accused Statement

Person completing Report: _____
Date / Time of incident: _____
Location of incident: _____
Name of Union Rep present at interview: _____

Incident details: Describe in detail what happened regarding this allegation in your own words.	
Signature:	**Date:**

Developed by Resident Task Form Team, Regional Municipality of Durham, Services for Seniors and LTC Division Used with permission from Tammy Rankin. For more info they can contact Tammy at 905 - 579 - 3313 x. 5200.

Staff to Resident Abuse Intervention Strategy

Resident abuse is witnessed or suspected.

An allegation of abuse is reported to a supervisor or manager immediately (hereafter designated as Receiving Supervisor).

High Risk Scene Management – if imminent risk of harm to resident(s).
- Remove staff member from facility or resident care area as necessary.
- Call 911 if necessary.

Receiving Supervisor (preliminary investigation)

1. Contacts RN on resident's unit to advise of situation involving resident. (**Note**: this might be the same person as the receiving supervisor)

2. Initiates preliminary investigation immediately.
- Completes Part A of **Resident Abuse Allegation Report** and delivers to Administrator/designate to begin Master File
- Contacts senior manager to advise

3. Contacts manager of accused staff member to initiate their investigation and contact appropriate union representative
- Provides **Resident Abuse Allegation Report** with Part A completed.
- Completes **Summary Report of Investigating Manager**
- (Note: this might be the same person as receiving supervisor)

Registered Nurse
- Assesses resident for physical injury or psychological upset.
- Documents assessment in Goldcare without notation of allegation.
- Provides necessary care and support.
- Contacts Physician as necessary.
- Documents verbal report from resident when possible using appropriate forms and forwards.
- Contacts DON/DOC immediately via phone for high risk or otherwise email.

Manager of the accused staff member
- Investigates incident, interviews accused and witnesses, documents findings.
- Forwards Resident Abuse Allegation Report and all documentation to DON/ DOC for Master File.
- Provide and/or arrange for support and counseling to all involved as needed.
- Initiate disciplinary process with staff as required (including reassigning as necessary pending investigation of incident with union president involvement).

Manager: (Usually the Director of Resident Care or delegate)
- Reviews and completes Master File – oversees management of case to resolution.
- Completes part B of allegation report form if not previously completed
- Complies with Ministry's reporting time frame including telephone call within 24 hours.
- Contacts Administrator, Director of Services for Seniors, Police (as necessary based on degree of risk associated with the incident).
- Contacts family members/substitute decision maker of involved resident.
- Creates plan of action arising from the findings (e.g. Education, policy revision).
- Ensure debriefing and support is made available to all involved.

Master File kept in administrators office indefinitely.

Note: Each allegation of abuse is unique so if you have questions or if you require further direction contact any manager.

Chapter 7

Taking Action: Working as a Team

Understanding
The key issues of elder abuse which in-turn leads to the ability to recognize, interact and respond. Each situation is unique.

Recognize indicators of abuse
- Why is this situation causing me concern?
- What am I observing?

Interact with the senior at risk
- How do I feel about this situation/the alleged abuse?
- What are the values, wishes, goals of the person?
- Is the senior making the decisions?

Respond
- What resources are required?
- What are my responsibilities?
- What is my role on the team?

Reflection
Stop and think about the situation to promote a better understanding of the issues on an individual, team, organization, and systems level; this can contribute to better responses and the prevention of elder abuse.

Chapter Seven: Working as a Team to Combat Elder Abuse

Introduction

Ending elder abuse is everyone's responsibility. Communities are challenged to create coordinated efforts that support the rights of older adults and create a culture that allows people to speak out about abuse and to get help. Change through awareness and education programs are other ways to enhance practices.

In Ontario, communities are working hard to develop adequate resources and services for elder abuse. Many communities find it beneficial to draw upon the expertise of a wide-range of sources including police, banks, businesses, community an d health services, faith communities, education services, and transportation services just to name a few.

Evaluation of services can identify how they may be better able to use existing services and adapt others to respond to the evolving aspirations and needs of older adults. Ensuring that culturally appropriate services and models of service delivery are integrated into community agencies presents another opportunity for communities to work together.

Many models and approaches are available to assist communities in their efforts. As mentioned in Chapter One, the Regional Elder Abuse Consultants also play a key role in:

- Supporting local elder abuse committees and networks and strengthen partnerships among them.
- Facilitating and undertaking education and training. initiatives for professionals, volunteers, and seniors.
- Promoting information-sharing among professionals and volunteers working with abused seniors.
- Developing model protocols on issues such as information sharing among service providers working with abused seniors.

Responding to Abuse as a Team

(ONPEA, 2006; Kinnon, 2002; McGregor, 1995)

Given the complex, multifaceted nature of elder abuse, a coordinated team approach will help the abused older adult get timely and effective help. Components of a team approach include:

1. Co-ordinated Support Services

- Working in a multi-disciplinary team provides opportunities to draw upon the expertise and resources of many. Coordination of teams and services facilitators is essential; however, this may provide some challenges if a co-ordinator function is not available. See Appendix A for a list of potential team members.

- Older adults have expressed a preference for a peer support model of intervention. If the senior is unable to get out of the house, another option is telephone support by a peer.
- Living arrangements can be a challenging barrier for many older adults. Most would prefer to stay in their own home rather than move to a retirement or long term care home (Macleans , 2007)
- Financial resources and support may limit their choices to move.

A co-ordinated system of support services includes:

- Peer support.
- Counselling and transitional supports.
- Activities to reduce isolation.
- Intergenerational programs.
- Transitional shelters and supportive housing.
- Support through family physicians and/or other health care workers.
- Community care system that provides nursing, therapies, and home supports.

An important component of the local co-ordination of services is a community coordinating committee and reaching out to those organizations working with seniors, justice, health and social services. Recruiting representat ives of older adults also strengthens the coordinated approach and solution-finding options.

2. Peer Support

Older adults often feel more comfortable talking with someone their own age, as they feel they will better understand and relate to their own life experiences. Through peer support programs, older adults can play an active and important role in a community's response to elder abuse. Peers can provide information, offer individual support, speak about services that are available to seniors, and advocate on behalf of seniors where services are not offered (Kinnon, 2001). Other options for the senior confined to home may include coordinated telephone support or friendly visitors. Peer support programs have been implemented in some communities across Canada such as the Seniors' Resource Centre in St. John's and the Guelph Wellington Senior Association in partnership with the Wellington Dufferin Steering Committee on Health and Long term Care Services for Older Adults.

Neighbourhood watch programs established for crime prevention are also an option for the detection of abuse and neglect (Kinnon, 2001). Neighbours can provide the older person with immediate assistance, check on his or her well-being, provide daily support, and monitor suspected abusive or neglectful situations. This is particularly helpful in rural and remote communities where few, if any, formal services exist.

3. Community Involvement and programs

Individuals who are in contact with older adults on a regular basis can play a key role in recognizing and assisting older adults who are being abused. On a daily basis, many seniors interact with people such as home care providers coming into the home, postal workers, cab drivers, apartment managers, utility meter readers, bank tellers, bus drivers, pharmacists, hair stylists and barbers. With education these individuals can offer support, companionship, information and referrals on the abuse and neglect of older adults (Kinnon, 2001).

One such program which exemplifies this model is the "Gatekeepers Program" implemented in the Niagara region.

4. Housing

In some communities affordable accessible housing for older adults may be limited. This can include non-profit apartment buildings or government-subsidized housing. Supportive housing provides some assistance with daily routines; a safe and secure environment; a decrease in social isolation and an increase in social activity. The National Advisory Council on Aging, in a 2002 brief, stated that safe housing is a factor in contributing to the quality of life of seniors.

Transitional housing or respite housing may be an option in the interim. This option gives the senior and the caregiver the much needed time and distance from the potentially abusive situation.

5. Reducing Isolation

Working with the victim to rebuild his or her social network includes maximizing the number of people who can be a support, provide encouragement and companionship. Home-based services such as Meals on Wheels, home support, friendly visitors, and professional clinical services can help strengthen a person's social support network.

Additionally, options such as adult day centres, community centres, and public events can provide a source of activity outside the home.

6. Professional Development

Service providers require professional education and training as a component of providing services for older adults. The curriculum should include information on the specific needs of older adults, the dynamics of abuse, and recognition of ageism, gender and culture. Learning strategies should be directed to many professional groups, including physicians and those working in the justice system.

Other Team Models

Consultation Team Model

Due to the complexity of elder abuse situations a multidisciplinary response is required to assist the senior. One approach that many communities have adopted is a "Community Consultation Team" model that is developed either within one agency or made up of representatives from different agencies to respond to abuse and neglect situations. These individuals and agencies work together collaboratively to address elder abuse through problem solving specific cases. This model provides an opportunity for cross-learning and for the exchange of information among service providers. Consultation Teams are implemented in difficult cases where conventional interventions have not been successful. They also address cases of abuse in the community not those occurring in long term care homes.

The main purpose of a consultation team is to make recommendations to the service provider(s) who are dealing with a situation of elder abuse which include intervention options and prevention strategies. The team assists the provider to develop the most effective plan possible to improve the situation for the older adult. Working in partnership with home care also improves each agency's response to elder abuse.

Reis and Nahmiash (1995) outlined the following goals of a multidisciplinary team:

- Provide a forum for detailed case presentation and the formulation of plans for intervention.
- Ensure that intervention protocols are followed.
- Assign responsibility to certain team members for certain tasks, and provide support and advice to them.
- Refer cases to other appropriate intervention teams if required.
- Evaluation the effectiveness of particular interventions and jointly decide on different course of action.

Team members are selected from various disciplines with the expertise to resolve situation such as police, lawyer, Community Care Access Centre, social worker, geriatrician, social service worker, mental health worker, nurse, and occupational therapist.

Consultation Teams operate formally with written policies and procedures that are agreed upon by all team members. These policies typically include a mission statement, definitions, goals, criteria for referrals and case selection, role and responsibilities of team members, including a Letter of Understanding and confidentiality form which are signed by each member. These policies also reflect the guiding principles for intervention such as inclusion, meaningful participation, power-sharing, assuming capability, etc. (See Chapters 5 and 6).

The functioning of the Team will vary based on the community's needs, service options, and availability of team members. The Teams usually have a chair person or lead agency who coordinates the case presentations prior to the Consultation Team meetings. Team may meet monthly or bi-monthly to discuss the case(s) with minutes and recorded outcomes documented. In some cases the Team members are also available for telephone consultations outside of meeting times.

Many provinces, such as British Columbia, Quebec, Manitoba, Alberta and Ontario already use a consultation model. In Ontario this includes such agencies as the Family Services Association of Toronto, Seniors and Caregivers Support Services; Wellington Dufferin Interagency Coordinating Committee- Network Against Abuse of Older Adults, and the Citizen Advocacy Windsor-Essex.

The benefits of using a Consultation Team model are as follows:

- Allows for better inter-agency communication and education on elder abuse issues.
- Resolves existing conflicts and/or misunderstandings between agencies.
- Supports, builds and enhances local coordination of services.
- Facilitates opportunities for members to learn about services and agency perspectives in their community.
- Helps to identify gaps in services.
- Assists with facilitating systemic change in the community.
- Develops improved competence in elder abuse detection and intervention.

Coordinated Community Response Networks

Another model to the response of elder abuse is through a Community Response Network (CRN). Lack of coordination and appropriate referrals, among service providing agencies can occur especially when agencies are unaware of the types of services provided by other agencies. To alleviate this problem, concerned community members join together to establish a committee/network of community agencies, businesses, and older adults whose mandate is to create a coordinated community response to elder abuse (Holland, 1994) and a comprehensive strategy to prevention. (Kinnon, 2001).

CRNs provide a foundation for the community, as a whole, to work together as a team on an equal playing field, sharing power and responsibility (Kinnon, 2001). Activities include:

- Developing ways to coordinate and support their activities.
- Facilitating and promoting an interdisciplinary approach to services and support.

- Keeping track of how well the response is working.
- Working on related activities such as community. development, education, prevention and advocacy.
- Developing community protocols.
- Supporting designated agencies in carrying out their responsibilities.

Each community identifies who may have a role in responding to the abuse of older adults such as legal systems, social services, shelters, respite care, counselling agencies, police, mental health services and seniors' organizations, social workers, nurses as well as those involved within the social service network such as volunteer programs, Royal Canadian Legion, VON, meals on wheels, banks, churches).

The Networks are inclusive in their membership. In most CRN's there is an 'open door policy' to anyone interested in the prevention of elder abuse. The Networks meet on a regular basis (i.e. monthly, quarterly) to develop plans and implement programs. Members of the CRN usually develop terms of reference, goals, and objectives. The Networks may function differently but have a common goal of education and prevention of elder abuse. Through these Networks there has been a significant amount of awareness raised about elder abuse, educational programs implemented and improvement in services for elder abuse at the community level.

These CRN's exist in British Columbia and Ontario, where there are over 50 elder abuse networks established to respond to elder abuse.

Prevention: The Role of ONPEA

ONPEA does not provide direct services for victims of elder abuse.

ONPEA is available as an expert resource for front line workers, organizations, the general public and anyone who interacts with older adults.

ONPEA can provide information and resources on elder abuse to a variety of sectors such as justice, health, long-term care, community volunteers, general public, as well as provide customized staff/volunteer training and education.

Through its regional consultants, ONPEA can also provide local referral information with respect to what service may best serve the client's needs as well as information about the community resources available for victims of elder abuse.

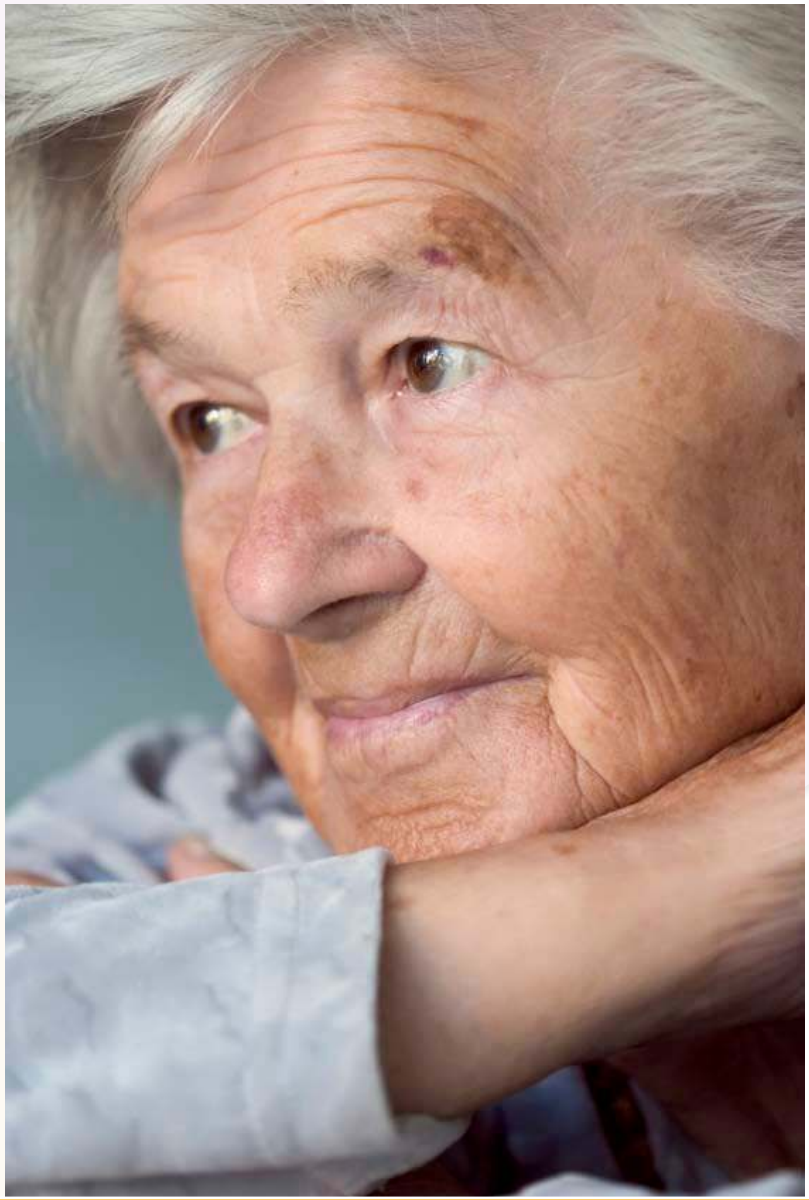
The regional consultants can also provide direct access to local regional networks, community response teams, local Council on Aging, etc.

The regional consultants will also help facilitate a performance improvement approach for enhancing the capacity of those that work directly with seniors to recognize and respond to elder abuse. A variety of learning methods and job aides are available to tailor the information for the needs of the learner including e-learning tools. ONPEA is dedicated to raising awareness of elder abuse and neglect through public education, professional training, advocacy, and service coordination. For more information about ONPEA refer to Chapter One or visit: www.onpea.org

Through its website, ONPEA provides up to date information about annual and regional conferences, training opportunities, upcoming educational events, local, provincial, federal and international community events, and contact information for regional resources, networks training materials, videos, etc.

ONPEA also has an extensive library of literature, videos, manuals, tools, etc. in the area of elder abuse.

Website: www.onpea.org
Telephone: (416) 640-7784
Fax: (416) 750-3624
Email: info@onpea.org



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Appendix A: Potential Interdisciplinary Team Members

Potential team members may include any of the following:

- Community Care Access Centre
- Hospital / Emergency Departments
- Elder Abuse Network / Council on Aging
- Community Service Agencies
- Family or Catholic Family Services
- Woman Against Violence Sector
- Police / OPP (These often have officers who specialize in elder abuse or senior's issues)
- Sexual Assault Centers
- Regional Health Departments
- Distress Centers
- Mental Health / Addiction Centers
- Settlement Agencies
- Victim Witness Assistant Programs
- Counselling
- Bank or Financial Institution
- Community Resource Center
- Senior's Center
- Deed Programs
- Family Doctor
- Clergy
- Ethnic-Cultural Community or Organization

Chapter 8

Enabling Changes in Practice; Senior Leadership Responsibilities

Understanding

The key issues of elder abuse which in-turn leads to the ability to recognize, interact and respond. Each situation is unique.

Recognize indicators of abuse
- Why is this situation causing me concern?
- What am I observing?

Interact with the senior at risk
- How do I feel about this situation/the alleged abuse?
- What are the values, wishes, goals of the person?
- Is the senior making the decisions?

Respond
- What resources are required?
- What are my responsibilities?
- What is my role on the team?

Reflection

Stop and think about the situation to promote a better understanding of the issues on an individual, team, organization, and systems level; this can contribute to better responses and the prevention of elder abuse.

Chapter Eight: Enabling Changes in Practice; Senior Leadership Responsibilities

Introduction

Elder abuse is a complex issue and requires the collective wisdom and collaborative work of many across systems. The good news is training can be a vehicle to promote large-scale system change!

Training is acknowledged as one part of a larger solution to improving practices and making positive change. ONPEA's training program plan is unique in that it is already supported and aligned with two other priorities within Ontario's Strategy to Combat Elder Abuse (see Chapter One):

- Coordination of community services.
- Public education to raise awareness.

ONPEA is also working with other provincial learning initiatives to integrate curriculums and enhance a learner's holistic approach to assessment and intervention.

The intent of this chapter is to:

1. Share thinking and research on knowledge transfer to practice.

2. Encourage leaders to think about elder abuse prevention, recognition, and response in performance improvement terms which includes understanding elder abuse and the link to:

- Organization's vision, mission, and goals.
- Current performance.
- Desired performance and best practices.
- The gap between current and desired performance.
- The causes of the gap.
- The range of interventions to target resources on closing the gap.
- Implementing interventions and managing the associated change.
- Monitoring and evaluating changes in performance.

3. Take a broader approach to developing and communicating an organization's policy and procedures on elder abuse prevention, recognition, and response to increase the likelihood of positive worker actions.

Learning and Development in the 21st Century

Most people think about the 'classroom' when they hear the word 'training'. However, long gone are the days of sitting in a classroom to learn! Now-a-days workers expect to be actively engaged in their learning experiences. With the increasing volume of information and rapidly evolving technologies, learners will continue to demand alternative ways to learn on-the- job and to learn just enough just-in-time!

To understand how practice can be better informed, it is helpful to remember:

- Human beings are designed to learn; learning is a natural process.
- Learning is not knowledge. Learning moves back and forth between what a person does (action) and reflection; this creates knowledge which resides within the person (Senge, 1989; Cross, 2007).
- Learning enhances capacity; it is always happening on the job. Cross (2007) suggests that into today's knowledge society, learning is the work and the work is learning.
- Learning means change; it helps to manage the change.
- The learner always learns what he or she wants to learn.

Paying Attention to How Adults Learn

Generally accepted principles of adult learning (Knowles, Holton, & Swanson, 2005) that apply to all adult learning situations and require consideration when creating strategies to help workers improve their work include:

1. An individual learner needs to know the why, what, and how.
2. The self-concept of the learner is autonomous, self-directing.
3. Prior experience of the learning includes mental models and resources.
4. Readiness to learn relates to life experiences and developmental tasks.
5. Orientation to learning is problem centered and contextual.
6. Motivation to learn com es from within the learner and relates to personal payoff.

Informal Learning in the Workplace

Cross (2007) and Benson (1997) suggest that 70-80% of learning in an organization is informal and organizations. Exploring and taking advantage of informal learning strategies can improve on the job performance.

Examples of informal learning in the workplace include:

- Team meetings and case conferences to share new information, ideas, or strategies related to real-time cases
- Performance coaching and reviews to encourage reflection on one's own practice and experiences, observation of other's practices, modeling practice after exemplary performers
- Working as a team to solve a common problem
- Sharing materials and resources with each other
- Encouraging experimenting with new ideas and techniques and learning from mistakes (trial and error)
- Gathering new information from outside the organization (e.g. internet, similar organizations, networks).

Goal of Learning Strategies

The goal of any learning strategy is transfer of knowledge into day-to-day practices. (Cross, 2007; Harris, 2001).

As previously mentioned, classroom training tends to be first choice for helping workers learn. Best practices in teaching these sessions include providing learners with ample opportunity to test out their ideas, problem-solve in a safe environment, dialogue on their most pressing issues, and take time to reflect on their learning experiences (Gagne, Wager, Golas & Keller, 2005; Konings, Brand-Grewel, & van Merrienboer, 2005; Rothwell, & Kazanas, 1998; Schon, 1987). However, even these interactive strategies with a goal of increasing knowledge have little impact on changing practices without proper attention to the factors that support performance (Clark, 2003; Bligh, 2000; Davis, 1992). The major factors supporting practice improvements include (Rummler & Brache, 1995; Broad, 2005):

- Clear performance expectations (standards, policy)
- Essential support (resources, responsibility, authority, time)
- Clear consequences (reinforcement, incentives, rewards)
- Prompt feedback (how well performance matches expectations)
- Individual capability (physical, mental, emotional capacity, experience)
- Necessary skills and knowledge (training, learning to perform)

Rummler & Brache (1995) indicate that factors 1-4 as noted above account for 80% of performance problems, that is, the need for a supportive environment for the learner/worker. Typically these four factors are outside the control of the individual learner; therefore, the role of senior leadership is to manage these factors and "clear the path for learners" who work with seniors.

Factor 5 (individual worker) accounts for 1% or less of performance problems. However, workers often get blamed for problems. Factor 6, receiving some form of training, can help with 15-20% of performance problems (Rummler & Brache, 1995); however, in the absence of support, the likelihood the learner will successfully transfer new skill and knowledge into practice is low. Research indicates that only about 10-30% of what people learn in training sessions transfers into their day-to-day work practices; this percentage decreases over time (Cross, 2007: Broad, 2005; Stolovitch & Keeps, 2002). Active worker participation in training does guarantee that performance will improve even with the most willing learners.

Obviously evidence is mounting to support the need for senior leadership direction in creating and nurturing learner-friendly and performance-focused environments.

The Role of Senior Leadership

Clark (2003), Newstrom & Broad (1992), and Stolovitch & Keeps (2002) identify a few major problems with transfer of knowledge to practice as failures to:

- Create a transfer culture with the organization.
- Shift general skills to a specific work situations.
- Identify situations that require some adaptation of a skill.
- Take a skill from one context to a very different context.
- Gain peer acceptance and support for change.
- Provide adequate time for practice and resources to support.

For these reasons, senior leaders in organizations need to pay attention to/further develop practical strategies to support learners and their efforts to change practice.

The following offers a range of ideas for supporting learners:

FACTORS that SUPPORT PERFORMANCE	SUGGESTIONS
1. Clear performance expectations (standards, policy).	• Policy and procedure on elder abuse exists, with clear role expectations for all levels of staff. • Process in place to review policy with staff and their understanding of the policy. • Clear statement of protecting employment and protection for staff who report abuse especially when the abuser is another staff member or management. • Keep in mind, improvement efforts means change. One of the barriers to transferring new skills and knowledge into practice is other staff resistance to change. The best way to enable change brought about by a performance improvement effort is to involve everyone affected by the change in the change process and to clearly articulate expectations.
2. Essential support (resources, responsibility, authority, time).	• Supervisory staff identified with contact information. • Support available in timely manner when staff concerned about potential case of elder abuse. • Supervisors trained in the elder abuse curriculum and promote positive culture of caring for staff and clients. • Case conferencing.
3. Clear consequences (reinforcement, incentives, rewards).	• Feedback from referral sources. • Reports of senior's safety. • Opportunity for promotion, opportunity for increased time off for undertaking continuing education or to attend more advanced training, opportunity for subsidized formal education leading to certificate, diploma or degree.
4. Prompt feedback (how well performance matches expectations)	• Debriefing following case—analysis of positive and negative; effectiveness of actions. • Timely review of cases, weekly communication about caseload to determine potential or actual risks for elder abuse. • Constructive input to improve performance rather than punitive. • Annual formal performance reviews with more frequent informal feedback.

FACTORS that SUPPORT PERFORMANCE, cont'd	SUGGESTIONS, cont'd
5. Individual capability (physical, mental, emotional capacity, experience)	• Understanding of issues. • Select the right person for the right job.
6. Necessary skills and knowledge (training, learning to perform)	• Awareness of and use of referral sources. • Recognition of potential abuse cases. • Case reviews and case studies of challenging cases where staff can brainstorm and learn from colleagues. • Promotion of team concept where staff ask others for assistance or provide assistance. • Structured orientation program with buddy system for new employees. • Role playing of abuse scenarios to prepare staff and provide them with appropriate tools for responding. Frequent check-ins during orientation period to review cases and to encourage questions. • Promotion of opportunities for team learning and for promotion of zero tolerance for abuse.

Proactively managing these factors requires working together with leaders in community organizations, agencies, and business; this will increase the likelihood of changes in practices related to the recognition and response to elder abuse.

When the intervention is a learning strategy

Increasingly evident is that the optimal way for adults already in the workplace to learn new knowledge and skills is through strategies most relevant to how they work and where they work (Harris & Keat, 2006). Learn from past successes and failures that the organization has had with education and training programs. What were the obstacles to changing practices? What worked well to help the worker improve performance?

Various methods ONPEA uses include:

1. Developing Capacity: In house resource teams.
2. Improving Memory: Job Aides.
   - A range of job aides are available at www.onpea.org.
3. Evolving Technology: ONPEA E-learning.
   - An interactive e-tool is available at www.onpea.org.
4. Learning Networks: Elder Abuse Networks
5. Self-directed learning.
6. Informal Strategies.
7. "On-the-job just-in-time" or "just –in-need" learning.
8. Formal coaching from Regional Consultant.

Support for workers learning about Elder Abuse begins prior to their involvement in a learning strategy. Additionally, after the worker completes his or her involvement in an elder abuse learning strategy, don't leave integration of his or her new skills and knowledge to chance!

The worker requires support pre and post involvement in an elder abuse learning strategy:

PRE	POST
• Review performance objectives with the worker. • Determine how achievement of the objectives will be measured. • Clarify expectations of the worker. What changes are expected following participation in an elder abuse learning program? • Discuss methods to support the worker following involvement in the learning strategy. • Articulate the link between what the worker is about to learn and how improved staff performance will impact on the quality of life for senior residents/ clients and advance.	• After completion of the learning program, gather his or her views on how the learning experience can enhance practice as on an individual, team, and organization level. • Follow-up on methods discussed prestrategy to support. • Think about the help needed to let go of old practices. From experience we know everyone likes progress but does not necessarily like change! When people are in difficult situations/ dealing with complex problems they tend to revert to old and comfortable practices under pressure.

Measuring Effectiveness of Learning Programs

The role of educators and trainers is evolving to that of performance improvement consultants; their evaluation of learning strategies requires close align to performance (Hale, 2002).

What is measured?	Examples
Level 1: What are learners' opinions about the learning program?	Reaction. Satisfaction with the course: • Content (meeting program objectives). • Methodology. Materials including job aides. • Learning environment. • Course administration. • Effectiveness of facilitation/ content delivery. • Confidence in ability to apply learning. • Intention to transfer: Action-planning. • Possible workplace barriers to transfer. • Link to pre-program preparation.
Level 2: What did he or she learn? (through the learning strategy).	Demonstration of learning that has been accomplished; competence in applying new knowledge and skills, such as: • Formal tests. • Demonstration of skills. • Case studies. • Role-playing. • Homework/practical assignment.
Level 3: Is the learner using it on the job? (learning transfer).	Evidence of use on the job, such as: • Surveys, questionnaires to learners and supervisors. • Observations on the job. • Evidence of workplace barriers. • Evidence that stakeholder strategies were used. • Accomplishment of action-plans.
Level 4: What are organizational results?	Evidence of impact such as: • Tasks completed. • Process time. Remember to take into account any other events besides learning programs that may have affected these results, to isolate the effects of the training itself (e.g. Regulation).
Level 5: Converting results to monetary values (return on investment, ROI). Intangibles: Results that are difficult to convert to monetary values.	Identifying the monetary value of the learning strategy. Other evidence of program's success, such as: • Teamwork, job satisfaction. • Customer satisfaction: complements and complaints. • Communication.

Chapter Eight References

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Chapter 9

Case Studies

Understanding
The key issues of elder abuse which in-turn leads to the ability to recognize, interact and respond. Each situation is unique.

Recognize indicators of abuse
- Why is this situation causing me concern?
- What am I observing?

Interact with the senior at risk
- How do I feel about this situation/the alleged abuse?
- What are the values, wishes, goals of the person?
- Is the senior making the decisions?

Respond
- What resources are required?
- What are my responsibilities?
- What is my role on the team?

Reflection
Stop and think about the situation to promote a better understanding of the issues on an individual, team, organization, and systems level; this can contribute to better responses and the prevention of elder abuse.

Chapter Nine: Case Studies

The purpose of this chapter is to provide case studies as a start point for dialogue across teams. Working through the various cases can assist teams in their use of the ONPEA 3 question template and also help them identify strengths and limitations in organization/agency supporting policy and procedures, expectations etc.

The cases are organized into the following categories:
LTC
Community
Pharmacy
Banking

Case Study Videos

Long Term Care Case Studies

Case Study # 1

Martha is 87 years old. She has been a resident of St. John's long term care home for approximately 10 months. Martha is a very quiet lady who mostly keeps to herself. When staff members try to interact with Martha, she is always very polite but never prolongs conversations. She rarely makes eye contact and avoids any interaction with staff or other residents.

Martha's husband Thomas visits her once a week. Thomas always stops at the nurse's station to inquire about his wife's condition. He often has a new joke for the staff and usually comments on how he misses having his Martha at home with him. Then, Thomas gets Martha from her room and brings her to the private family room so they can spend time together alone.

Staff members have noticed that when Thomas visits her, Martha appears very upset and even nervous. Yesterday, a staff member overheard Thomas calling Martha a "worthless old bitch". After Thomas left, staff also noticed that Martha had bruises on her cheek and on her arms. That evening as the nurse helped Martha prepare for bed, she noticed more bruises on Martha's thighs.

Case Study #2

Bernadette has worked as a Personal Support Worker at the long term care home for 6 years. Today, as she started her afternoon shift, she decided to begin by looking in on Mrs. Smith who has been experiencing a lot of pain in her legs and back due to a recent fall. Mrs. Smith asked Bernadette to look in the drawer next to her bed and take out $20.

"Bernadette, would you take that $20 and give it to Carole when she starts her night shift? I'm afraid I wasn't able to stay awake last night to give her the money. That way, I'll be sure she gets paid"

When Bernadette asked Mrs. Smith what the money was for, Mrs. Smith said that she owed this money to Carole for the 'extra care' that Carole has been providing her with since her fall.

When Bernadette explained to Mrs. Smith that Carole was not suppose to take her money as it was against policy, Mrs. Smith said: "Please don't say anything because Carole will be very angry with me, she made me promise to keep it a secret."

Case Study # 3

Nancy, a staff member at a Long Term Care home was helping Mrs. Jones get ready for bed.

Mrs. Jones, an 88 year old woman who loved to chit-chat had resided at the facility for two years and quickly earned the reputation of being the residence's "gossiper". While receiving care, Mrs. Jones always told staff about other resident's lives and business.

Tonight Mrs. Jones was unusually quiet and seemed troubled. When Nancy asked what was wrong, Mrs. Jones told her that Rebecca, who also worked the night shift at the Home, slapped her. Nancy, stunned at what she heard asked Mrs. Jones to give her more details.

Mrs. Jones said: "I had an upset stomach last night and rang the call bell for assistance to get to the washroom… I waited a long time but no one came to help me. I proceeded to go by myself because I knew I couldn't wait much longer. I didn't make it to the washroom and left a mess in my bed, the floor and the washroom. When Rebecca finally came, it was too late. Rebecca slapped my arm and started to yell at me. She told me that I would have to wear a diaper 'like a baby' because I obviously can't control myself."

Nancy finished helping Mrs. Jones with her blankets and reassured her that she would look into the matter and left the room.

Nancy's mother-in-law was a very close friend of Rebecca's (the night shift worker accused of hitting Mrs. Jones). Nancy knew that if she reported the incident, it would cause problems within her family.

Case Study #4

Janet was in the middle of a very busy shift at St. Clement's long term care home. She was behind in her work because of the extra time she had to spend with Mr. Johnson who had a terrible stomach flu. Janet had to change Mr. Johnson's bedding several times. To top it off, her co-worker had to go home early as she was feeling nauseated and sick to her stomach.

Janet only had a short time left in her shift and was feeling exhausted and hungry as she didn't even have a chance to go on a break. She still needed to sponge bathe two of the residents before the next shift came in.

She entered Mrs. Collins' room. Mrs. Collins was in a bad mood. She immediately began to complain to Janet about the fact that she had been waiting all day to have her bath and that her family members were going to arrive soon for a visit, so Janet better hurry up. Frustrated, Janet said: "You know Mrs. Collins you're not the only one I have to take care of and count yourself lucky that I'm here now." Janet continued with the sponge bath.

She was feeling terrible about how she snapped at Mrs. Collins. Janet had never spoken that way to a resident and felt a lump in her throat as she completed her task. After she finished, she sat down on the chair next to Mrs. Collins and began to sob. She apologized to Mrs. Collins, saying that she never should have spoken to her that way. She continued telling Mrs. Collins about her co-worker being sick and one of the residents too. Mrs. Collins took Janet's hand and said: I'm sorry too Janet I never should have rushed you and treated you as I did.

Community Case Studies

Case Study #5

Anne had been living on her own, but due to a fall she had asked her unemployed daughter to live with her. Anne had also been having difficulties with people trying to break into her home through her chimney, but when police were repeatedly called, no evidence was found. The family had determined it best for her daughter to move in for the time being. Her daughter's boyfriend touches and fondles her when her daughter is not home.

Anne has a nurse come in once a week. Anne is nervous to mention anything for fear she'll be "put away in a nursing home". Finally she asks the nurse if there is anyway to keep this man out of her house. After some more questions, she discloses to her nurse and is visibly upset when sharing.

Case Study #6

Harry is a 77-year and an elder in his community. He lives alone in the community with no means of transportation. His nearest neighbour comes by each month at cheque time to buy groceries. There is never any money left over.

Harry's living conditions have deteriorated.

Harry was concerned his neighbour would not be able to drive into his laneway, so he hired a local operator over the phone to plow the snow during the winter. When he got the bill in the mail, it was for $6 000, even though they only plowed three times. He mentioned this to his bank teller, who encouraged him to call police. Harry is now calling 911, although he is embarrassed.

Harry's son lives about an hour away and does not get down much.

Case Study #7

Son and daughter-in-law place their father in a respite bed at a long term care home while they go to Florida for a month. Upon return, son calls to say that his father will be staying at the nursing home permanently. This son is the Power of Attorney. His father does not meet the eligibility requirements for nursing homes on a permanent basis and is capable of making his own decisions.

The client is fairly independent and acts more like a volunteer than a resident at the nursing home. He does not feel he "fits in", and does not want to stay, he wants to return home to his apartment.

The son has given up his father's apartment and therefore client cannot return. The son agrees to meet with staff to discuss plan of action and becomes verbally abusive to both staff and family. At one point, son stands up and with his finger in the managers' face, he tells her "to shut up and listen, my dad is staying at the nursing home and that's final".

The son controls the rest of the discussion and hushes his wife on several occasions, reminding her that she should just keep her "mouth shut if she knows what is good for her".

The son states that his father has given away a large sum of money to various charities over the last 3 years and therefore can't be trusted alone at home. The son walks out.

The client has nowhere to go.

Case Study #8

Mrs. B, a 66-year old who lives in her own home with her 31-year old son presents in the Emergency Department with an exacerbation of C.O.P.D. Her previous medical history included back surgery secondary to trauma; nasal reconstruction secondary to multiple fractures; pinning of her left ankle; surgical removal of a bullet from her left foot. A chest X-ray done at the time of admission to Emergency showed several old rib fractures. Physical examination showed a very thin woman with old bruises evident on her arms and legs as well as several new contusions on her wrists and scalp. She admitted to being a 2 pkg/day smoker and said that she drank with her son "almost every day."

Upon questioning her further regarding her past injuries she volunteered that her son "gets a little rough sometimes." Further questioning revealed that her son had been hospitalized several times for treatment of schizophrenia.

The nurse asked: "Are you frightened at home?" Mrs. B. became tearful and said, "Yes, I would like him to live in a group home but he gets so angry when I try to talk to him about his drinking and taking drugs, that I'm scared to say anything. Besides, why would he want to leave? He takes my money and watches TV all night and then sleeps all day. He's just like his father and my father too for that matter."

At this point, Mrs. B's son arrived at the bedside cursing with a strong smell of alcohol on his breath. Mrs. B immediately became silent and withdrawn. The nurse requested that he wait in the family room until the examination was completed. He reluctantly and loudly left the cubicle and Mrs. B again began to cry. The nurse then said, "I will ask the Social Worker to talk with you about your situation."

After talking with the Social Worker about available alternatives Mrs B. chose to return home with her son.

Although the health care personnel in Emergency felt that Mrs. B was not making a good choice, they realized that she was informed and capable of making her own decision

Case Study #9

Mr. R, an 85 year old widower, is very frail and has progressive dementia (memory impairment, diminished judgment). He has become less able to manage his personal care and financial affairs over time. However, numerous community supports have enabled him to continue living in his own home. Home care has provided nursing and homemaking services. As well, the Meals-on-Wheels Program has been initiated, and he regularly attends an Alzheimer's Day Away Program. During the early stages of his illness, Mr. R. had granted his only daughter, Avery, power of attorney for property.

Staff of the Alzheimer's Day Away Program began to be concerned that he was being taken advantage of financially when he reported that he was no longer able to pay for transportation to and from the Program twice weekly. Upon further inquiry, it became apparent that he had been handing over half of his pension to his daughter each month to buy "groceries" but he could not tell anyone exactly what Avery bought for him. In fact, his homemaker reports that there is never any food in the apartment when she attends to help him. Over the course of a few months, Avery persuaded her father to transfer $5,000 into a joint bank account.

Case Study #10

Mrs. K. is a 76 year old Cambodian woman who has seen a physician twice since coming to Canada in 1978. She had tuberculosis in 1978 and was successfully treated for TB at the County Health Clinic. Mrs. K. has not seen a physician since 1979. She is brought in to see a male physician at the Health Clinics with complaints of severe headaches with dizziness, accompanied by her English speaking son who provides the English translation during the medical visit.

In the physical exam, the physician noted that Mrs. K. appears quiet and subservient in her son's presence. She appears malnourished, ill kept, and her hygiene is questionable. Her teeth are dark stained teeth and oral lesions are present in her mouth.

Mrs. K. is embarrassed to tell the male doctors, via her son, about some vaginal blood she noticed over the last 6 months. She stopped menstruating about 20 years ago. She has never had a well woman check up.

The physician's notes indicate that she talks about "thinking too much" about how many relatives she lost under Pol Pot and the Khmer Rouge. Her medical records are incomplete and include only a history of her TB treatment.

The son tells the doctor it is difficult to manage her at night. He states she yells out and if anyone goes into room, Mrs. K. goes under her bed to hide.

Case Study #11

Mary lives in a small, remote northern village. Her grandson has moved into the basement of her bungalow. He promised to supply the firewood she needs, in lieu of rent. Wood is the only source of heating or hot water in her community. All went well for the first few months but lately things have changed for the worse. Her grandson leaves her without firewood for days on end and Mary suffers from the cold. Some days she has had to stay in bed to keep warm. She has diabetes and severe arthritis and the cold conditions are very hard on her. Her grandson ignores her pleading for wood. He also has started to have parties and she's pretty sure drugs are involved so she's feeling very anxious and afraid. Her grandson is abusing Mary, yet she feels she cannot report him.

Case Study #12

Jim moved into town from the Reserve when his wife needed to go into a nursing home so he could be close to her. He lives in a tiny room in his daughter's house and visits his wife daily. First his daughter was happy to have him and would drop drive him to the nursing home, but now she says it's out of her way so he can take a bus. She also has started borrowing money from Jim which she doesn't pay back. Jim is running low on money for his prescriptions but doesn't want to make his daughter mad, he needs to live with her. She has begun to talk unkindly to him, makes fun of him and says if he's any bother she'll send him back to the village. She also says he eats too much, despite the fact that he pays rent. Jim is feeling very depressed over the way things are turning out, yet he feels helpless to stop it. He tells no one.

Case Study #13

Margaret lived in a remote, fly-in community until her health got so bad she was sent to a larger town; she now lives in a nursing home. Margaret cannot speak English so she is feeling very anxious and isolated. She finds the food and many of the customs strange; she often skips meals and sits quietly - feeling depressed and lonely. Most of the staff are kind but a couple of staff on the night shift have been quite rough with her and clearly resent having to care for her. They call her names and while she isn't sure what they are saying, she knows from their tone it isn't nice. She gets no visitors from her former home. Margaret feels helpless. She suffers in silence.

Case Study #14

Cathy has a small house which she is sharing with her son and daughter-in-law until they get full time jobs and can afford their own place. Often her son and his wife have wild parties and the drinking goes on all weekend. Cathy has spoken up and said she would prefer them not to have these parties - they ignore her. They also eat her groceries, which they don't replace, and make long distance calls which they never reimburse her for. When she asks them about the money they call her a mean old woman; her son says he suffered when he was growing up because all the drinking she used to do. He says she was a lousy mother. Cathy feels no joy in life, things are miserable for her.

Case Study #15

Mr. R is 80 years old and lives with his 75-year-old wife. Mr. R has a long history of diabetes and progressive onset of confusion. Mrs. R requests medication for Mr. R "to make him sleep at night" and "to control his kidneys." Mr. R appears disheveled, smells of urine, and has an unsteady gait. This represents a marked change from his usual neat demeanor and function. He complains of being left alone for long periods. Mrs. R interrupts him and claims that Mr. R is very demanding, doesn't sleep well at night, needs constant attention and personal care. She complains of no free time and an excessive burden in caring for Mr. R.

Separately, Mr. R complains that Mrs. R often leaves him alone and puts restraints on him so he can't get out of his chair or bed. He usually eats twice a day. He frequently receives his evening insulin dose late at night. He is disoriented to time, has trouble with abstract thinking, and remembers one of three items at 3 minutes. He seems to understand his situation. He worries about being placed in a nursing facility. He appears weak and needs assistance with transferring and undressing. His clothes are soiled. He smells of urine.

Mr. R's weight is 130 lb., a 30 lb. weight loss in the last 7 months. His mucous membranes are dry, and his tongue is red and smooth. He is unsteady standing. His skin shows bruising on the surfaces of his hands.

Case Study #16

Mrs. P, a senior and widowed, was sponsored from her homeland of Pakistan by her daughter twenty years ago. Mrs. P. liquidated her belongings, and was able to purchase a small home for her daughter's family. Mrs. P. provided much of the childcare and household responsibilities for the past fifteen years. Her limited social contacts were in the Pakistani community only, and she did not develop her English-language skills. Now, with Mrs. P's grandchildren in their teens, and with mobility challenges, her childrearing role is no longer needed. The daughter buys groceries and pays the bills out of Mrs. P's investment income. A home care worker visits daily to assist with some of the activities of daily living.

Over a period of time, the home care worker, who speaks the same dialect as Mrs. P, observes that often there is very little food in the fridge.

One day, after noticing an overdue statement from the gas company, the home care worker gently inquires if anything is wrong. Mrs. P breaks down and tells her that her daughter recently lost her job and her son-in-law spends all his time in the casino. She recounts that her daughter calls and a burden to the family because she cannot speak English. The grandchildren show little respect, conversing little, and playing their loud rock music constantly on the weekends.

Mrs. P knows her daughter is taking her money. Mrs. P feels guilty and ashamed for not being able to help her daughter and is afraid, because her daughter has threatened to deport her and keep her from her grandchildren by withdrawing sponsorship.

Pharmacy Case Studies

Case Study #17

Mr. Smith is an 82 year old man, who has had a heart attack several years ago and now suffers from angina. He is asthmatic and is on multiple medications, including blood thinners, and inhalers for his asthma. He has become forgetful and may be in the early stages of dementia, though he has not been found incapable or had his doctor make a diagnosis. He lives with his daughter and son-in-law. His daughter manages his care, and indicates that she administers his medication as he does not always remember to take his pills.

Mr. Smith's daughter comes to the pharmacy to fill her own prescriptions regularly, and will occasionally fill her father's at the same time. It seems to the pharmacist that Mr. Smith hasn't had his medications refilled regularly enough to be taking them as prescribed. Mr. Smith hasn't had a new inhaler in three years, though they do have an expiration date. The pharmacist has not seen Mr. Smith in quite some time, and is concerned about his health if he is not taking his medication as prescribed.

The pharmacist flagged both Mr. Smith and his daughter's files, so the next time either one came to the pharmacy she could speak to them. The next time Mr. Smith's daughter came into the pharmacy, the pharmacist asked her how Mr. Smith was, and how he was managing his medications. She indicated that he was difficult to manage, but that she administered his medication regularly. The pharmacist reviewed the list of his medications and the implications of not taking them regularly, and offered some suggestions on how to ensure he had them daily, as required.

Months passed, and Mr. Smith's prescriptions were still not being filled as regularly as necessary, indicating that he was not receiving his medications as prescribed. The pharmacist called Mr. Smith's doctor, and the doctor has scheduled an appointment with Mr. Smith and his daughter.

Case Study #18

Mrs. S is a 79 year old widow in the early- to mid-stages of dementia, though she has not been found incapable. She lives with her son, who does not work, and the son had agreed to monitor her medications and ensure she attended medical appointments. They live eight blocks from her doctor's office, down a busy street, with her pharmacy across the six-lane intersection.

Mrs. S has started walking alone to her doctors' office and to the pharmacy to pick up her medications. She regularly appears at the doctor's office and the pharmacy without an appointment, as she has difficulty remembering when her appointments are.

She does not discuss her son or his care of her. The pharmacist has given her a dosette of her regular weekly medications, only to discover that Mrs. S returns two days later, bringing her half-empty dosette. She has taken all her morning medications for the whole week, and none of her evening medications.

After being called, the son arrives at the pharmacy to escort his mother home, and promises to monitor her medication use more closely. The pharmacist calls the doctors office to express concern over the medication management, and the harmful effects of the over-medication and under-medication.

This pattern of behaviour continues for a few weeks. Mrs. S has now appeared alone at the doctors' office again, though she does not have an appointment. She is in her slippers, though it is raining out. The medical receptionist does not know what to do, and does not want to send her home again. Mrs. S believes she has an appointment, and complains of pain. The doctor gives her a physical exam, only to discover that she is wearing four undershirts.

The doctor sends Mrs. S to the hospital for a more thorough assessment, where she is held for several days on a social admission, as a plan is put in place with her.

Case Study #19

Mrs. Henry is a 79 year old woman who lives alone in her own home in the city. Mrs. Henry was recently widowed 6 months ago when her husband of 49 years of marriage passed away. In the past, Mr. and Mrs. Henry were very out going they attended social gatherings with friends, volunteered and were members of the local seniors' centre. After Mr. Henry's death, Mrs. Henry became lonely and depressed and was not attending many social functions. Marie, Mrs. Henry's neighbour and close friend would come over once a week for tea and talk. Mrs. Henry's daughter, Sarah (45 years old), who lives close by would also come and visit her on a regular basis, they had a close relationship but Sarah had always been known for bein g controlling and telling her mom what to do. Sarah would ask her parents for money constantly, without mentioning when, or if, she would pay it back. Mrs. Henry's son, Gerry (48 years), lives 4 hours away so has not able to be with his mom as much as he would like. When Mr. Henry's health problems began Mr. and Mrs. Henry wanted to ensure their financial affairs were in order so they saw a lawyer to get their Will and Power of Attorney completed. In doing so, they named each other as their Power of Attorney with no alternate attorney appointed.

Last week Mrs. Henry was outside putting out her laundry and fell breaking her hip. She was released from hospital after her hip surgery but now required help in her home for cooking, cleaning, and personal care until she was able to manage independently again. Her daughter Sarah said she would help her mom but indicated it would be easier to take care of her if she and her family were able to move in with her temporarily. Mrs. Henry agreed to this arrangement and they moved into the house right away. Over a period of time, Sarah started taking over her house, even moving in her adult children without the mother's permission. Sarah buys groceries for her mother and pays the bills with her mom's pension cheques. Mrs. Henry felt like her home was no longer her own, she didn't know how long Sarah would have to stay.

Sarah would come home from work and often yelled at her mother complaining the house was always a mess and that she was lazy and didn't help out around the house. Sarah would frequently go out to bars drinking heavily, and sometimes come home shouting obscenities, and threaten to put her mother in a 'home' if she didn't get better soon. Sarah took control of her mom's assets by convincing her that the signed Power of Attorney from a couple of years earlier meant nothing anymore and that she should be the 'new" attorney for her personal property and care because she has been making these decisions anyway and it would make it easier for her to do all the banking. Mrs. Henry felt threatened by Sarah's tone of voice and demeanor and granted her daughter, Sarah, power of attorney for property.

Sarah was now coming home with new clothing for herself and family, and told her mother she was going on a cruise two weeks and would have to find herself someone else to care for her while she was away. A few weeks later Mrs. Henry got a call from the bank who were concerned about the increased volume of withdraws from her account. The bank told her the most recent transaction was yesterday with $50,000 dollars withdrawn from her account. The bank asked if she had a Power of Attorney and she stated it was her daughter. The bank advised Mrs. Henry to talk with her daughter about this recent activity.

When Marie came for a visit and observed that there was very little food in the fridge and noticed an overdue statement from the gas company she gently inquired if anything was wrong. She began to be concerned that she was being taken advantage of financially by Sarah.

Mrs. Henry broke down and told her that her daughter has been yelling at her and telling her what to do all the time. She felt guilty and ashamed for having to rely on Sarah for help and is afraid if she confronts her daughter she will stop helping. She told Marie she wasn't sleeping well and was experiencing severe headaches. Mrs. Henry knew Sarah would never hit her but was afraid of her especially when she drinks and gets into a fury as she could explode. Mrs. Henry suspected her daughter was taking her money but did not know how to even approach her about the issue. Mrs. Henry is on a limited income and needs to address the Power of Attorney but does not know what to do or where to get help. She loves her daughter and wants the best for her, but she feels totally helpless.

Banking Case Studies

Case Study #20

Mrs. G is a 78-year-old widow who lives independently and handles her own finances. She has been banking at the same branch for many years and the staff knows her. Recently she came into the branch with a woman who identified herself as Mrs. G's niece. Mrs. G seemed somewhat flustered. The niece said she wanted to help Mrs. G with her banking and they wanted the account changed into a joint account with herself and Mrs. G. The banking representative wasn't sure Mrs. G really wanted the niece on her account. What should the bank do?

Case Study #21

A woman comes into the bank with a $5000 cheque signed by her husband for funds in an account, which was only in the husband's name. The signature on the cheque looked very shaky. When the banking representative mentioned the shaky signature the woman became very defensive and said the reason it was shaky was because her husband was very sick in hospital; she's had to hold his hand to write the cheque. What should the bank do?

Case Study #22

An 81-year-old pensioner came into the bank wanting to withdraw most of his savings. The amount was for $6000. When the amount was questioned by the banking representative the man happily said he'd won big on a U.S. lotto and needed the $6000 to cover the taxes and exchange fees involved with a foreign lottery, the man was very excited. What should the bank do?

Case Study #23

A young woman has been cashing cheques made out to her by her employer on a weekly basis for a set amount of $200. She says she is employed as a caregiver for a senior client who is ill. Just recently the cheques have been for larger amounts and sometimes there are 2 cheques in one week. The bank has become worried that things may not be right. What should they do?

Case Study #24

Two workmen come into the bank with an 80-year-old gentleman. The banking representative feels concerned when the men pressured the senior to get them $700 in cash. The senior doesn't look happy but goes ahead and asks for the money. When the teller asks what the money is for one of the men says it is none of her business. What should the bank do?

Case Study #25

Mrs. M has been banking with a downtown branch for many years. She always used to come in on Fridays and was dressed very well with neat hair and spoke warmly to staff. She was well liked at the branch. Lately she's been coming in any day of the week, seems confused and is looking somewhat untidy. This week she accused the banking representative of short changing her and was quite loud. What should the bank do?

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