VSCW 2025

Collaborate for Change: Dementia-Aware Responses to Abuse in Later Life

SESSION 1 HIGHLIGHTS:

Complexity is the Clue - Coordinating Equity-Oriented Responses in Cases Where Dementia and IPV in Older Couples Co-Occur

KEY FACTS ABOUT POLICE-REPORTED FAMILY AND INTIMATE PARTNER VIOLENCE IN CANADA

- In 2021, family violence against seniors was 8% higher than in 2020 and 14% higher than in 2019.
- Women accounted for nearly 6 in 10 senior victims of family violence.
- Older perpetrators were most often male; depression noted in as many as 75% of them.
- Incidents involving older adults = 23% of all domestic homicide-suicides.

SERVICES WITHOUT AN IPV LENS CAN REINFORCE HARM

Dementia, disability, dependency, substance use, mental health, housing instability - **all of these look different when abuse is present.**

A refusal of service may not reflect informed consent, it may reflect fear, coercion, or survival logic.

If we don't centre IPV, we risk interpreting through the wrong lens and acting on the wrong conclusions.

Well-meaning interventions can reproduce control: (safety plans without consent, discharge planning that assumes caregiving, police responses that ignore coercive control).

Systems that rely on "capacity," "evidence," or "compliance" without IPV awareness, often penalize survivors and reward perpetrators who present well.

STRATEGIES: RELATIONAL LEADERSHIP

	TEACH	LEARN
GBV Services	• **Recognize power, control, and coercion** even when subtle, chronic, or normalized. • **Safety is subjective** & must be survivor-defined, not assumed. • Leaving isn't the only measure of success in IPV cases. • **Resist the urge to "fix"** or control survivors' choices.	• About **cognitive impairment**, caregiver dynamics, and medical language that can shape or obscure risk. • **How to sustain engagement** with people whose capacity is changing.
Dementia & Health Services	• **Knowledge of progressive illness,** capacity, and how dementia may affect memory, behaviour, and consent. • **Clinical skills** - assessing needs beyond immediate physical safety. • Confusion, aggression, or withdrawal can be **survival strategies**, not just symptoms.	• Ask about **trauma histories** and relationship dynamics, not just diagnoses. • **Not all caregiving relationships are safe** or healthy, and safety cannot be assumed based on functional needs.
Home care	• **Real-time knowledge** of the daily realities in the home. • Insight into how dependency, pride, and stigma affect help-seeking in older adults. • **How service eligibility** and funding structures constrain or enable care.	• **Behind some "refusals" / "non-compliance"** may be coercion, fear, or isolation. • **Caring roles are not always chosen or safe**, and shouldn't be morally assumed.

CANADIAN NETWORK for the PREVENTION of ELDER ABUSE
RÉSEAU CANADIEN pour la PRÉVENTION du MAUVAIS TRAITEMENT des AÎNÉS

in partnership with

Elder Abuse Prevention Ontario

Funded by: Department of Justice Canada / Ministère de la Justice Canada

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STRATEGIES: RELATIONAL LEADERSHIP

	TEACH	LEARN
Elder Abuse & Adult Protection	• **Familiarity with laws and policies** governing capacity, protection, and guardianship. • **Tools for investigating** complex harm, including neglect, isolation, and undue influence. • **Language** around self-neglect and capacity-based decision-making.	• **How gendered violence operates differently** than general abuse and why a GBV lens is necessary. • **Dependency is sometimes a result of abuse**, not just aging or illness.
Police	• **Legal mechanisms** available for protection, intervention, and accountability. • How to investigate with **evidence standards** that will stand up in court. • **The risk of system-induced harm** if action is taken without careful coordination.	• **How to identify coercive control** and power-based patterns that don't look like criminal code violations. • **How to work with survivors** who have memory loss or altered communication, without dismissing credibility. • **Trauma-and violence-informed interviewing** that avoids re-traumatization.

SHARED LEARNINGS ON AGEISM

- **Older adults are not a monolith:** resist narratives that flatten older people into stereotypes.
- **Aging does not erase gendered experiences of violence:** ageism and sexism intersect often making older women invisible to both seniors services & GBV services.
- **Risk and harm look different in later life:** Harm can be misread as inevitable; assumptions made that it's 'too late' for intervention.
- **Older adults' decisions are shaped by lifelong survival strategies:** what looks like passivity or confusion may be deep caution, loyalty, trauma response or learned distrust of systems – be curious before judging capacity, credibility or choice.
- **Caregiving roles can be coercive:** expectations of duty even when risk is present.
- **Capacity is not the same as consent:** over-reliance on visible cognition and under-recognition of control.
- **Older people deserve futures:** It's never too late to be safe or to be seen.

Shared accountability means not letting the system default to care for one person at the cost of another. It means designing responses that honour complexity without abandoning justice.

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SESSION 2 HIGHLIGHTS:

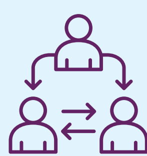
Caring Together: Enhancing CCR Models for Older Adults Living with Dementia and Experiencing Harm

KEY FACTS

- **Violence against older adults is rising, particularly financial abuse and coercive control.**
- **Older adults at greater risk due to memory loss, communication challenges, and dependency on others.**
- **Systems need to recognize the dignity, rights, and lived experiences of aging individuals.**

THE COORDINATED COMMUNITY RESPONSE (CCR) MODEL

CCRs brings together key partners and organizations to collaboratively address complex issues within the community.



Ensure a consistent, coordinated approach where different sectors work together to provide comprehensive support, services, and interventions.

Build strong community connections that creates trust and improve how we share information and respond to the unique needs of individuals.

CCRs succeed when relationships lead the way.

Acknowledge the importance of listening with empathy, responding with genuine kindness, collaborating with humility. Recognize that memory loss does not diminish a person's dignity.

KEY PURPOSES OF A CCR

Purpose	Description
Prevention	Education, awareness, protection
Response	Timely, coordinated care
Collaboration	Shared, cross-sector teamwork
Support	Holistic, heart-led services
Accountability	Reconciliation, responsibility, change
Systemic Improvement	Pathways, advocacy, inclusion
Community Safety	Relational, emotional, physical

CCRS SUPPORT CASE MANAGERS

- A well-supported CCR streamlines communication, improves access to resources, and reduces service gaps.
- Allows Case Managers to better navigate complex situations and ensures that individuals and families receive the most appropriate and timely support.
- Communities benefit from having a clear, shared vision of their CCR to ensure it is effective and grounded in local realities.

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INDIGENOUS HUBS (CCRS)

In Indigenous communities:

- Hubs reflect the strength of coming together as a whole.
- Are culturally grounded and focused on healing, balance, and accountability.
- HUBS & CCR teams partner with families, leadership, service providers, and cultural supports to prevent and respond to elder abuse.
- Connect health, justice, social support, and traditional practices.

Families and Nations serve as central hubs of care.

Create a circle of care that includes the whole community.

- Responses to elder abuse support the elder, the family, and often the person causing harm.
- Mistreatment is understood in the context of deeper issues like intergenerational trauma.
- Ensure safety for Elders, support for families, and healing opportunities for those who have caused harm.

DEMENTIA & CCRS

- Dementia can obscure disclosure or be misread as confusion.
- Abuse indicators can be missed or misunderstood in dementia.

- When services don't work together, older adults get left behind.
- CCRs support shared safety planning and community care.
- Capacity assessments, elder mediation, health & legal navigation.
- Services must be slow-paced, relational, trauma-and-dementia informed.

REMINDERS FOR PROFESSIONALS

Barriers rooted in ageism and ableism

Ensure cultural relevance and consent in communication

Caregiver support is important to prevent burnout-driven abuse.

Ensure autonomy: ***Just because someone forgets does not mean they forfeit their rights.***

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SESSION 3 HIGHLIGHTS:

Cross-Sectoral Solutions Supporting Survivors Of Gender-Based Violence-Related Traumatic Brain Injury Through A Survivor-Led Support Programme

KEY FACTS ABOUT IPV AND BRAIN INJURY

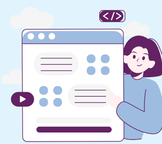
- IPV is one of the most common forms of violence against women.
- During COVID reports of IPV surged by 20% and severity of the violence escalated.
- Traumatic Brain injury (TBI) is acquired after birth through physical force.
- 75-92% of IPV survivors likely experience TBI from facial, head, and neck injuries.

IMPACTS OF TRAUMATIC BRAIN INJURY

Memory:
- Difficulty learning new ideas
- Forgetting information
- Losing or misplacing items
- Troubles scheduling

Mood and Emotions:
- Abrupt mood changes
- Emotions not aligned with the situation
- Escalation of anger or irritability with small triggers
- Symptoms of anxiety and/or depression

ABOUT THE PROGRAMME



5-Month, evidence-based, trauma- informed, multi-sectoral pilot programme for survivors of GBV-related TBI

8 services offered:
1 on 1 peer counselling, occupational therapy services, speech language pathology, music therapy, naturopathy, somatic therapy, psychotherapy, yoga

25 participants:
- 35% reported ~ 1-3 GBV-BIs
- 52% reported 4 or more GBV-BIs

PROGRAMME OUTCOMES

- **Positive sentiments and self-reported improvement of mental and physical health.**
- **Mental health had a more significant increase during the program (34%).**
- **Slight/ moderate decline in symptoms frequency during the program** (except blurred vision)
- **Improved knowledge & understanding of GBV (12%) and B.I. (46%) during the program**

PARTICIPANTS TAKEAWAYS

Strategies and tools to relieve symptoms of TBI
Skill-building and boundary-setting
Empowerment through self-esteem building, confidence and growth

PROGRAMME KEY LEARNINGS

Peer support and navigation help with stigma and isolation, especially for older adults.

Address GBV-BI specific challenges.

Language and cultural barriers present challenges, particularly for survivors from marginalized communities.

Need for joy-based healing spaces that celebrate and honour resilience, progress, and personal victories.

Survivor-Centred Preferences & Flexibility: Shape programme to the priorities, preferences and accessibility needs of survivors, including flexible timelines, individualized accommodations, and diverse outreach strategies.

Structured Closure for survivors and staff, as abrupt ending can exacerbate existing trauma.

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SESSION 4 HIGHLIGHTS:

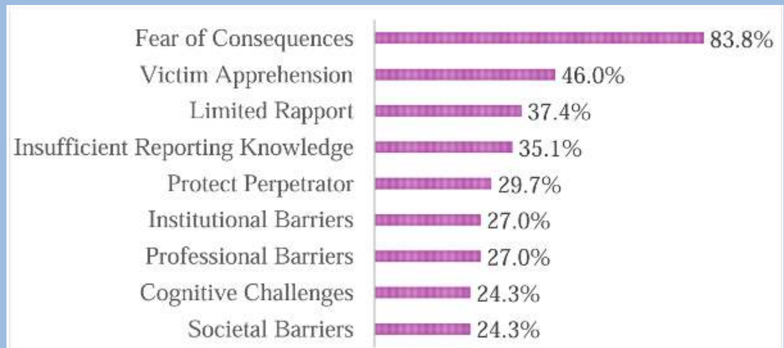
Best practices for interviewing older adults with diverse backgrounds and needs: Current research and future directions

KEY STATS

Out of 37 surveyed healthcare professionals in Ontario

64.9% reported observing older adult mistreatment on at least a monthly basis.

Barriers to Reporting Maltreatment



Out of 27 surveyed law enforcement professionals in Ontario

78% reported not feeling comfortable interviewing older adults with cognitive impairments.

Interviewing Challenges:

- **Health factors** (Memory, language, hearing, vision and mobility challenges): **88%**
- **Emotional factors** (shame, fear, denial etc.): **65%**
- **Socio-Cultural factors** (Generational differences in perception/report of mistreatment; family dynamic problems): **47%**
- **Awareness of mistreatment**: **24%**

Health and law enforcement professionals have expressed an important **need for improved training and resources for supporting older adults** most at risk for maltreatment.

AGE-RELATED DIFFERENCES IN EYEWITNESS PERFORMANCE

- Older adults can provide accurate, reliable and detailed rich eyewitness reports. Performance similar to younger adults on memory recognition tasks.
- All ages benefit from open-ended recall questions and follow-up prompts.
- Capacity can be static or it can fluctuate.
- For many adults, cognitive and psychological functioning remains relatively consistent day-to-day. Factors that can impact functioning:
  - Chronic fatigue, stress or pain
  - Exposure to trauma
  - Intoxication or substance use withdrawal.

OLDER ADULTS WITH DEMENTIA-RELATED DISEASES:

- Level of functioning progressively gets worse over time.
- Can fluctuate over the course of the day. (Sundowning: increased confusion that people living with dementia may experience from dusk through night-time)/
- Overly broad, complex and cognitively taxing questions are less effective with older adults 75+and those with lower cognitive scores.

IMPACTS OF AGEISM

On Interviewer:

- May forgo asking important open-ended interview questions and rely more on closed-ended practices.
- May "infantilize" older adult, which reduces level of trust, respect and rapport.

On Interviewee:

- May doubt or distrust their own memory capacity.
- Can increase risk for suggestibility and interviewer compliance.

On perceptions of older eyewitnesses:

Mock jurors with higher ageist attitudes:

- had more negative perception of older adult victim of neglect.
- were less likely to convict a perpetrator of elder financial abuse when the eyewitness report came from an older adult with a cognitive impairment.

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SESSION 4 HIGHLIGHTS:

Best practices for interviewing older adults with diverse backgrounds and needs: Current research and future directions

INTERVIEWING OLDER ADULTS

Effective Strategies

- Rapport building
- Cultural responsivity
- Supportive and empathetic demeanor
- Free-recall invitations
- Open-ended follow-up prompts.
- Wh-questions
- Closed-ended questions that build upon what the older adult previously discussed (such as clarification questions)

Practices to Avoid

- Leading and/or suggestive questions
- Multiple questions
- Overly broad questions
- Unsupportive demeanor
- Confrontation
- Blaming the victim
- Overly long interviews

OLDER ADULT INTERVIEWING ADAPTATIONS

- Interview at personal residence.
- Wearing plainclothes during interviews.
- Technological aids (Bluetooth receivers for hearing aid devices and voice amplifiers).
- Redirections.
- Timing of the interview - in the morning.
- Follow-up or additional interview opportunities.
- Follow-up communication and check-ins are encouraged.

INTERVIEWING OLDER ADULTS WITH COGNITIVE IMPAIRMENTS

- Plan in advance and allow more time for the interview.
- Consult with caregivers, family members and multidisciplinary professionals.
- Do not infantilize the person.
- If possible, have support person nearby or in the same building.
- Acquiring consent is an ongoing process.
- Speak slowly and clearly.
- Always face interviewee when communicating.
- Keep a low-pitch and reassuring tone.
- Avoid complex words and acronyms.
- Incorporate descriptive nonverbal gestures when communicating verbally.
- Explain your actions.
- Provide step-by-step instructions with pauses and clarification opportunities.
- Keep questions short and focused.
- Avoid cognitively taxing questions.
- Be prepared to repeat yourself or reintroduce yourself.
- Do not argue with person or try to orient them to reality. Older adult awareness of the situation, context of interview or sense of present reality may change over the course of the interview. Elevated stress increases likelihood of confusion.