Abuse - Definitions, Statistics, Barriers to Response

Definitions

“Older Adult”

For the purposes of this manual an older adults is defined as anyone 60 years of age or older.

That being said, it is recognized that issues of power and control underlie all abuse situations and the more someone is vulnerable in some fashion the greater the chances that they could be taken advantage of in some way. Therefore, anyone who has become vulnerable due to some aspect of the aging process, and is being abused in some way, would be classified as an “abused older adult”.

“Vulnerable” is defined as: “capable of being physically, or emotionally wounded or hurt; exposed; open to attack, persuasion, etc.” [1]

A person may become vulnerable due to such things as: a lack of information, a lack of self-esteem, a physical condition that restricts him or her. Levels of “vulnerability” can vary from person-to-person and from time-to-time, and this variability must be taken into account when assessing the level to which an older adult is at risk of being abused.

This manual utilizes the term “older adult” as opposed to the more commonly utilized term “elder” because they have found that the term “elder”:

- conflicts with the aboriginal concept of elder
- conflicts with the title of elder often used in faith communities, and
- some older adults have expressed discomfort with the use of the term "elder" as this connotes "elderly"…as in "frail elderly"…lacking capacity or abilities…whereas many abused older adults are mentally capable, and are active participants in their communities

[1] *Canadian English Dictionary*; Harper Collins Publishers Ltd.; 1991

“Abuse”

Abuse as discussed in this manual and workshop is defined as any action, or deliberate inaction, by a person in a position of trust, which causes harm to an older adult.

"Trust" is defined as: "confidence, firm belief, reliance, responsibility … rely on, believe in, expect, hope consign for care."[2]

A person in a position of trust is someone with whom the older adult has built a relationship with and has come, over **time**, and because of past actions, to trust. The person in a position of trust could be a spouse, a family member, a paid caregiver, a staff member at a long-term care facility or care/retirement home, etc.

Relationships are abusive when a person uses various tactics to maintain power and control over another person. (See the Power and Control Wheel, and the Equality Wheel, contained in Section Four of this manual for a visual representation of what actions might be taken by a person who is exerting power over another person, and what actions would be taken if one was acting in an egalitarian fashion.)

This manual will not provide an in-depth discussion of self-neglect or financial exploitation due to telephone or door-to-door solicitation (for example) as forms of abuse of older adults.

“Self-neglect is a failure or inability to provide necessary care or attention to oneself that causes, or is likely to cause within a short period of time, serious physical, mental or emotional harm to oneself, or substantial damage to, or loss of, one’s assets. Like other forms of neglect [or abuse], self-neglect may be active (intentional) or passive (unintentional). Support and information about how to avoid harmful effects may, but do not necessarily, change the behaviour.” [3]

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[2] *Canadian English Dictionary;* Harper Collins Publishers Ltd; 1991

[3] *Developing Community Response Networks: A Guide for Communities*; Holland, Sylvia; North Shore Community Services, British Columbia; Revised for use in Ontario 1999

This manual does not specifically discuss the issue of self-neglect as the dynamics of self-neglect are different than the dynamics of abuse perpetrated by a trusted other.

When addressing the issue of abuse perpetrated by someone in a position of trust one must take into account the dynamics of power and control, and the imbalances of power in abusive relationships. When someone is neglecting him/herself, he/she may be choosing to neglect him/herself, and/or he/she may not have information regarding how to properly care for him/herself and/or where to find assistance to improve self-care. The provision of information and/or assistance to the self-neglecting older adult may end the self-neglect situation, or, it may not.

This is not to suggest that a community should ignore adults in this type of situation. It is **important** to recognize and respond to an older adult who may be at risk as a result of self-neglect. The process used and approach taken to assist a person who is neglecting him or herself is likely to be the same, in most circumstances, as when assisting a person who is being abused by another. For example, you would always talk to the person first. If he or she has the mental capacity to make decisions for him or herself, you would provide him or her with information, make suggestions to him or her, offer supports, hope that he or she will act on your suggestions, and follow-up with the person to see if the situation has improved or the person needs more, or different, assistance.

It is important to include agencies and/or individuals who can provide training on how to prevent, and respond to, situations of self-neglect (e.g., community nurses, physicians/geriatricians, agencies that provide nursing care, physiotherapists, occupational therapists, etc.) in any community response to the abuse of older adults. Education on these issues would be conducted along with education on the key issue of the abuse of an older adult that is perpetrated by someone who has gained a position of trust with the individual suspected of being abused.

The reasons for excluding an in-depth discussion of financial exploitation (due to such practices as telephone or door-to-door solicitation) in this manual, although some of these exploitations may be criminal acts, are that:

- although it is embarrassing for someone to admit that they have been “taken” in a financial exploitation scheme these types of abuses are more readily reported to authorities, such as the Police, than are abuses perpetrated by someone who the person suspected of being abused knows and has come to trust

- the Police, the Ministry of Consumer and Commercial Relations, etc. can be effective at warning community members when such financial exploitation

schemes are being perpetrated in a community (usually by notifying the media about such schemes)

- the Police (and others) offer public education programmes and materials about such schemes and teach individuals how to avoid being taken advantage of in such schemes, (Community Service Officers and/or Abuse Issues Co-ordinators on local Police services and/or the Ontario Provincial Police provide such educational programming. Please contact your local Police service to find out which officer(s) provide such a service in your area)

- the victims of this type of financial exploitation are far more likely to advocate for, and assist in, the prosecution of the perpetrators of this type of abuse than are individuals who are abused by someone whom they know, and have come to trust

As stated in the discussion of self-neglect, it is important to include agencies and/or individuals who can provide training on how to prevent, and respond to, these kinds of financial exploitation situations in any community response to the abuse of older adults. Education on these issues would be conducted by people such as the local Community Service Officer or Abuse Issues Co-ordinator along with education on the key issue of the abuse of an older adult that is perpetrated by someone who has gained a position of trust with the individual suspected of being abused.

Types of Abuse

The following definitions are not legal definitions. Rather, they are intended to help people in the community and professionals working with older clients to recognize abuse of seniors, which is a social phenomenon as well as, in many cases, a crime. Abuse of seniors may include:

Physical Abuse

Any act of violence or rough treatment causing injury or physical discomfort. This may include the inappropriate and/or unwarranted use of physical or chemical restraints.

Emotional or Psychological Abuse

Any act, including confinement, isolation, verbal assault, humiliation, intimidation, infantilization, or any other treatment which may diminish the sense of identity, dignity, and self-worth of the senior.

Financial Abuse of Exploitation

The misuse of a senior's funds and assets; obtaining property and/or funds

without that person's knowledge and full consent, or in the case of a senior who is not mentally capable, not in that person's best interests; the misuse of a Continuing Power of Attorney for Property.

Sexual Abuse

Any sexual behaviour directed toward a senior without that person's full knowledge and consent: e.g., sexual assault, sexual harassment.

Neglect

Intentional withholding of basic necessities or care (active neglect) or not providing basic necessities or care because of a lack of experience, information, or ability (passive neglect).

Medication Abuse

Misuse of a senior's medications and prescriptions, including withholding medication and overmedicating.

Medical Abuse **

Any medical procedure or treatment done without the informed consent of the senior or his or her legal substitute decision-maker as defined in the Ontario Health Care Consent Act.

Systemic Abuse **

When government or institutional policies and regulations create or facilitate harmful situations.

Violation of Civil/Human Rights

Denial of a senior's fundamental rights (as set out in legislation, the Charter of Human Rights and Freedoms, common law): e.g., withholding information, denial of privacy, denial of visitors, restriction of liberty, or mail censorship.

* These definitions have been adapted from: *Connecting: A Curriculum Guide on the Abuse of Seniors*; British Columbia Coalition to Eliminate the Abuse of Seniors; April, 1996, except ****** which are adapted from *Abuse Prevention in Long-Term Care*; Sisters of Charity of Ottawa Health Services Inc.; Ottawa, Ontario; 1997

Please Note: Some educators on abuse issues have found it useful to describe abuses as being on a continuum. Abuses can be perpetrated that have "lesser" effect on persons than others, so they can be seen to be on a continuum that

ranges from "lesser" harm to causing death . This is not to say that abuses that have “lesser” effect on individuals are not as serious as abuses that cause more harm. This also does not imply that your strategies for assisting an abused person would alter with the level of harm the abuse caused. This reference to

continuums is as a reminder that some actions that you may not consider to be abusive, in fact, **are** - and all types of abuse could ultimately lead to the death of the abused individual. (See the Continuums of Physical Abuse, Emotional Abuse, Sexual Abuse and Financial Abuse in Section Three, pp. 13 - 16, of this manual.)

For information on the **indicators of abuse** please see*: Information Sheet 2 - Module # 2 Indicators of Abuse* in Section Three, pp. 17 - 20 of this Manual.

Statistics on the Abuse of Older Adults

The National Clearinghouse on Family Violence, in ***Community Awareness and Response: Abuse and Neglect of Older Adults*** states that: “In 1991 there were approximately 3.2 million Canadians over the age of 65 (Statistics Canada, 1992). Projections indicate that by the year 2031, there will be approximately 7.5 million older adults. During the same time period, the percentage of older adults will rise from 11 percent of the total Canadian population to almost 23 percent. [4] In general, the increasing older population will [also] live longer.” [5]

More and more, studies into the abuse of older adults are been conducted.

In 1989, the Ryerson Study was conducted. Researchers telephoned 2000 adults living in private dwellings. Their survey found that approximately 4% (1 in 25) of competent older adults, living independently in their community, are neglected or abused.[6]

It should be noted that the Ryerson study is now 13 years old. The telephone survey was directed only to mentally capable older adults living in the community. The respondents were required to self-report about abuses that they may be experiencing.

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[4] *Canada's Aging Population*: McDaniel, Susan; Butterworths; Toronto; 1986.

[5] *Community Awareness and Response: Abuse and Neglect of Older Adults*: National Clearinghouse on Family Violence; 1993; p.6

[6] *National Survey on Abuse of the Elderly in Canada: The Ryerson Study*: Podnieks, Elizabeth; Karl Pillemer, Thomas Shillington & Alan Frizzel; Ryerson Polytechnical Institute; Toronto; 1990.

Individuals working in communities to address the issues of the abuse and neglect of older adults feel that the numbers of abused older adults living in the community may actually be higher than the 4% figure, but more study is required to determine whether or not this is true.

In 1997, the College of Nurses of Ontario conducted an abuse survey of RNs and RPNs working in Ontario. To publicize the statistics compiled in that survey, the College released a Fact Sheet entitled "Speak out to Stop Abuse...10 Facts about Client Abuse in Community Care".

This Fact Sheet does not describe abuses committed toward older adults in particular, but it does give us an idea what the RNs and RPNs have identified about abuse in the communities in which they performed their work.

"Speak out to Stop Abuse
10 Facts about Client Abuse in Community Care

Fact # 1	56% of nurses working in community care witnessed or heard about at least one incident of abuse by a nurse since 1993
Fact # 2	The type of abuse was 43% verbal, 25% physical, 21% neglect, and 2% sexual
Fact # 3	43% of nurses in community care reporting abuse reported more than three separate incidents
Fact # 4	Clients who are stressed, confused, elderly, or require assistance with movement are most at risk for being abused
Fact # 5	Most clients know their abusers moderately well
Fact # 6	Nurses awareness of abuse has increased in the past four years
Fact # 7	The number of nurses who intervened directly to stop an incident of client abuse doubled since 1993
Fact # 8	Only 47% of nurses in community care who witnessed abuse tried to stop it
Fact # 9	89% of nurses who try to stop abuse are successful

Fact # 10 Abuse prevention awareness decreases client abuse" [7]

In 1995 and 1996, under the auspices of the Sisters of Charity of Ottawa Health Services Inc., Jean Kozak and Teresa Lukawiecki directed a research project, (the *Abuse Prevention in Long-Term Care Project*) and developed an educational package for intervening and preventing abuse and neglect of residents in long-term care facilities. Materials produced in that project include *Policy and Procedures Guidelines for Responding to and Preventing Abuse and Neglect in Long-Term Care*. (These Guidelines can be found in the Training Manual *Abuse Prevention in Long-Term Care*.)

The Guidelines state that "Abuse and neglect in long-term care (LTC) is not a new phenomenon. It is a complex issue affecting residents, staff, families, volunteers, unions, and administrators, among others. Although the true prevalence of abuse and neglect in institutional settings is unknown in Canada, research since the late 1970's clearly indicates that it does exist." [8]

A study conducted by the Ontario College of Nurses in 1993 states:

> "In a recent study conducted on behalf of the Ontario College of Nurses, 804 registered nurses and 804 registered nursing assistants were asked about abusive incidents committed by nursing staff against clients of any age in institutional settings. Nearly one half of the respondents reported witnessing one or more incidents of abuse by nursing staff. However, as the College notes, the time period in which the incident occurred was not specified, so these events could have occurred anytime during a career.
>
> The incidents were reported in hospitals (85%), nursing homes (29%), and homes for the aged (7%). Although the Ontario study focused on abuse in institutional settings for all age groups, 63% of the reports were clustered among the older population (65 and older). In 83% of the cases, the staff member committing the abusive act was reported to have previously worked with the client and knew the client 'very well or moderately well'. ... Seventy-five percent of respondents indicated that the abuser was not rebuked by the client. ... Respondents also indicated that follow-up by nurse managers or other nurses only occurred in 42% of reported cases.

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[7] *Speak out to Stop Abuse*: College of Nurses of Ontario; 1997

[8] *Policy and Procedures Guidelines for Responding to and Preventing Abuse and Neglect; Abuse Prevention in Long-Term Care*; Sisters of Charity of Ottawa Health Services Inc.; Ottawa, Ontario; 1997

> … the most commonly mentioned type of abuse(s) witnessed by respondents were: “roughness (31%), yelling and swearing (28%), offensive/embarrassing comments (28%), hitting/shoving (10%)....and the study found that over 90% of these incidents were personally witnessed.” [9]

During the course of the "*Abuse Prevention in Long-Term Care Project*" focus groups were held with long-term care residents, staff (clinical and administrative), institutional volunteers, family members and advocates. Focus group participants identified the following "as major causes or contributing factors with regard to abuse and neglect within LTC:

- Attitude/Personality
- Lack of competence
- Systemic or institutional processes
- Cognitive and communication deficits" [10]

Obviously, any activities organized to prevent abuse in Long-Term Care will need to address these factors. A place to begin this work would be to look at the factors identified as being important to building a supportive and respectful environment in LTC in *Returning Home: Fostering a Supportive and Respectful Environment in the Long-Term Care Setting* (2001).

This booklet states that "It is important …to build a supportive and respectful environment that provides residents with every opportunity to maintain control over their own life by encouraging them to:

- make decisions
- express individuality
- speak for self
- care for self, and
- have a sense of purpose

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[9] *Abuse of Clients by RNs and RNAs: Report to the Council on Results of Canada Health Monitor Survey of Registrants*: College of Nurses of Ontario; Toronto; 1993

[10] *When Home is not a Home: Abuse and Neglect in Long-Term Care - A Resident's Perspective*: Kozak, Jean and Teresa Lukawiecki; Health Canada; 2001

…Residents…placed…emphasis on caring for themselves and having a sense of purpose…" [11]

The Haldimand-Norfolk Questionnaire on the Abuse of Older Adults

In July of 1999 the Steering Committee of the Haldimand-Norfolk Project sent to individuals and organizations in their area over 400 copies of a survey on abuse of older adults. Multiple copies of the survey were sent to each organization, so the 400+ surveys went to a total of one hundred and twenty-two (122) agencies/individuals. A total of 70 surveys were returned, including: 35 from community organizations; 7 from long-term care facilities and retirement homes; 12 from hospitals; 4 from medical offices; 4 from churches and 6 from pharmacists.

The predominant professional background of the respondents was nursing (55%), followed by pharmacists (8%), physicians (6%) and clergy (6%). Approximately 50% of the respondents were front line workers.

It is clear from the results of the survey that more than two-thirds of the respondents believe that abuse of older people is occurring in H-N.

Approximately one-half receive reports of abuse, and 40% receive requests for information on abuse. Thirty-seven of the responding organizations estimated that they had identified between 1 and 28 cases of abuse in the previous year. (The average number of cases per year was 5.4 for these organizations.)

Twenty-two respondents indicated that between 1 and 6 cases of abuse had been reported to them in the previous 3 months. In addition, seventy percent (70%) of the respondents indicated that most abuse is not being reported. Abuse of women was more frequently reported than abuse of men (21 respondents).

Emotional and financial abuse were most frequently reported, followed by neglect and physical abuse.

The survey results also suggested that there were a number of areas for further organizational and community development, as well as staff training, about the abuse of older people. Some key issues were identified.
These were:

[11] *Returning Home: Fostering a Supportive and Respectful Environment in the Long-Term Care Setting*: Kozak, Jean and Teresa Lukawiecki; Health Canada; 2001

- Only 13% of survey respondents believed that abused older people understand their rights

- Approximately 50% of respondents indicated that there are gaps in the system for responding to abuse

- Approximately 40% of respondents believed that the responses to abuse will be co-ordinated and effective

- Many respondents indicated that the organizations that they work for do not systematically collect information on the numbers of cases of abuse reported to them

Key issues at the staff level, as identified by respondents, were:

- Only 50% of agencies and staff have been adequately trained about abuse, how to document it, and to whom abuse should be reported

- Only 30% indicated that they understand the approaches that would be taken by organizations to whom they report abuse" [12]

It is interesting to note that the *Policy and Procedures Guidelines for Responding to and Preventing Abuse and Neglect in Long-Term Care* also documents some barriers to reporting and responding to abuse(s).

This document states that: "... research also demonstrates that our inability to detect abuse and neglect results from a variety of factors such as:

- a poor understanding of what constitutes abuse and neglect

- people's reluctance to report it due to fear of reprisal

- people not knowing to whom they should report the incident

- unclear Policies and Procedures for reporting or investigating incidents, and

- poor or inappropriate documentation" [13]

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[12] *Interim Evaluation Report: Haldimand-Norfolk Project on the Abuse of Older Adults*; Meredith Associates; September 30, 1999

[13] *Policy and Procedures Guidelines for Responding to and Preventing Abuse and Neglect; Abuse Prevention in Long-Term Care*; Sisters of Charity of Ottawa Health Services Inc.; Ottawa, Ontario; 1997

Although this statement refers to abuses that are not recognized, and therefore not reported, in long-term care facilities, one could project that the same types of barriers exist in the community.

Barriers to recognizing, documenting, and responding to abuse

When one combines the comments made in the *Policy and Procedures Guidelines for Responding to and Preventing Abuse and Neglect in Long-Term Care* with the findings of those of the Haldimand-Norfolk Questionnaire on the Abuse of Older Adults, a number of barriers to recognizing, documenting, and responding to abuse are identified. These include:

- A belief that older adults do not understand their rights (H-N Questionnaire)
- People have a poor understanding of what constitutes abuse and neglect (P& P Guidelines)
- People are reluctant to report abuse due to fear of reprisal (P & P Guidelines)
- Only 50% of agencies and staff felt that they had been adequately trained about abuse, how to document it, and to whom abuse should be reported (H-N Questionnaire)
- People do not know to whom they should report an abusive incident and there are unclear policies and procedures for reporting or investigating incidents (P & P Guidelines)
- There is poor or inappropriate documentation of abusive incidents (P & P Guidelines)
- Only 30% of respondents indicated that they understand the approaches that would be taken by organizations to whom they report abuse (H-N Questionnaire)
- People believe that there are gaps in the system for responding to abuse (H-N Questionnaire)
- Many respondents indicated that the organizations that they work for do not systematically collect information on the numbers of cases of abuse reported to them (H-N Questionnaire)

* The Community Issues" section of Community Worksheet # 2 - contained in Section Three of this Manual - may assist you in your work identifying barriers in your community. This Worksheet will also assist you in identifying strategies to overcome obstacles you will face.

These comments/findings are reinforced by the findings of the *Study of Shelter Needs of Abused Older Women* done in 1998 by the Kappel Ramji consulting Group for the Older Women's Network. This study found that:

- "abuse of older women is not well understood or acknowledged by society as a whole

- abused older women seek help in many different ways... [they may go to]...their families, friends and/or cultural or faith communities first for help, [or] they may seek help from mainstream services if they are concerned about confidentiality or stigma. ...

- sometimes when they access these services they encounter barriers. .... Many physicians, social workers, and community faith and cultural groups do not recognize the signs of abuse of older women or are not sure where to get help for women who do disclose abuse.

- a major gap in services is the lack of information, co-ordination and integration of the services that exist" [14]

Within each community, these, and any other barriers particular to that community, must be recognized, attention must be paid to them on an on-going basis, and techniques to overcoming barriers must be developed, if a community is to be successful in addressing the issue of abuse and neglect of older adults and/or in assisting abused individuals.

When you are gathering people together and building your community response network to the abuse of older adults the process that you will go through, and the work that you undertake, will inherently address a number of these barriers, in that you will be:

- educating yourselves, and others, about abuse, the fact that these barriers exist, and the fact that you need to constantly be aware of them

- reviewing what the needs of abused older adults in your community are, and what is being done, and what is not being done, in terms of meeting these

[14] *Study of Shelter Needs of Abused Older Women*: Older Women's Network; Kappel Ramji Consulting Group; April 29, 1998

needs (i.e., services will be reviewing their internal practices and revising them if need be, community members will be reviewing how they have been working together to address these needs and their practices)

- creating strategies to overcome identified barriers

- evaluating whether or not what you are doing, in terms of educating and assisting, is working, and making appropriate alterations to what you are doing based on your evaluations

and, you will be doing these things on an on-going basis.

Communities that utilize the Connecting Module Workshops to develop the framework for their community response network will participate in various exercises, the purpose of which is to help the group identify barriers and to assist the group in creating strategies to overcome them.

Basic beliefs underlying attempts to assist older adults who are abused *

1. It is a basic right for all individuals to live their lives free of abuse.

2. Older adults have the right to decide whether they wish to accept help and intervention.

3. Older adults should have access to help for all forms of abuse.

4. Ending the abuse of older adults is everyone's responsibility. Social change must occur through education and action.

5. The service network must address the issue of abuse of older adults at both the individual and systemic level.

6. Services need to be sensitive to address the following: cultural diversity, language, religious beliefs, lifestyle choices, poverty, disabilities and educational background.

7. Service providers, using a community based approach, must be committed to the development and delivery of services designed to meet a diverse range of needs.

8. Services for abused older adults must be accountable to the older adults who use the services in the community.

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* Adapted from: *An Elder Abuse Resource and Intervention Guide*; The Council on Aging, Ottawa -Carleton; 1995.

Assisting a person whom you suspect is being abused

Anyone whom you are attempting to assist must be treated with respect.

> "**Respect** is the act of (a) giving particular attention, (b) considering worthy of high regard, (c) refraining from interfering with. We use the concept of respect to identify what we need to *do*, not merely espouse, with [an abused person]. We require of ourselves that we respect other people's history, choices, and ability." [15]
>
> "**Effective service** is respectful service that achieves clearly communicated goals that flow from the stated needs of the people who use the service." [16]
>
> "**Regular practices** ...are the things that we have learned to keep *doing*. They are actions that we have found important to maintain as we work on improving our understanding of abuse, of [older adults], ourselves. We believe that, for people to get the kind of services they need for abuse to stop, we must make certain practices habitual, without letting these actions become reflexive. These are disciplines of practice that we follow with all [everyone], not just those who are victims of abuse or neglect:
>
> (1) When working with a [person] on a problem not identified as abuse, check for abusive situations by *asking* the [person] if anyone is harming or threatening them in any way. Ask the [person] if he fears anyone, or if anyone is interfering with his or her right to make and act on decisions.
>
> (2) Ask the [person] what he or she *wants and needs*, and what he or she hoped to get from her discussion with you.
>
> (3) Discuss choices with the [person]. *Offer* the [person] information about different courses of action, instead of waiting until the [person] asks about a particular option.
>
> (4) Ask the [person] what *he or she* wants to do to improve the situation.
>
> (5) Ask the [person] what he or she wants *you* to do. Offer information on the actions that you *can* take.

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[15] *Developing Community Response Networks: A Guide for Communities*; Holland, Sylvia; North Shore Community Services, British Columbia; April, 1994, p. 15

[16] *Ibid*: p. 16

(6) *Stop* long enough to ask yourself - “What is happening here?” - and stay still long enough to hear the answers. Allocate time and resources for reflection, as well as for action.

(7) As service providers, [and individuals], re-examine and *question* habits and policies that you discover aren’t helpful from the [person’s] perspective, even if what you have been doing is consistent with your own beliefs or those of you employer [or “group”, for example, a peer support program]. [17]

When you are providing information to/counselling an older adult it is sometimes easier to "deal only with the [person's] presenting question, and not to take the time to sense undercurrents, to probe for more information, to provide a resting place in which the client can pause long enough…to voice apprehensions. Taking the easy route can lend one the impression of great efficiency, but does it lead to an *effective* response to the victim of abuse?" [18]

Take **time** to get to know the person that you are attempting to assist, their circumstances, and their wishes.

Remember the barriers that are faced by yourself and by the person you suspect is being abused when you are discussing their situation with them and address barriers as they arise. For example, neither of you might have enough information about the person's rights and options; the person might be afraid to tell you about what has been happening for fear of reprisal by the abuser and/or because the disclosure could end their relationship with the abuser. Never be embarrassed to say "I don't know, but I will find that out for you". It is far better than giving someone incorrect information.

Have people who work with abused persons train you on interviewing techniques. For example, the staff members of your local Women's Shelter are usually very skilled at interviewing and assisting abused persons.

> "When practicing your interviewing techniques 'give yourself' (or a group of you) a fictitious abuse of an older adult situation/scenario to work with. Write down, in detail, how you believe that you would intervene in this case. When you have done this, review what you

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[17] *Developing Community Response Networks: A Guide for Communities*; Holland, Sylvia; North Shore Community Services, British Columbia; 1994; p. 21

[18] *Connecting: A Curriculum Guide on the Abuse of Seniors*: British Columbia Coalition to Eliminate the Abuse of Seniors; April; 1996

have said you would do and ask yourself/the group working on the exercise:

- In what way will the intervention empower the older adult?
- In what way will the intervention keep the older adult safe?
- In what way will the intervention disempower the older adult?
- In what way will the intervention make the older adult less safe or put the older adult in danger?

Review your answers and ask yourself/the group the following questions:

- What new insights do you have on the interventions you suggested?

- How can you see yourself using these questions in deciding what intervention is appropriate and effective for an older adult who is being abused? " [19]

For further information on interviewing and advocating on behalf of an abused person, please see:

- *Community Worksheet # 4* - Section Three, page 7 of this Manual, and
- *Information Sheet 6 - Interview Techniques 1" (*Section 3, pages 31 - 33) and *Information Sheet 2 - Advocacy* (Section Three, pages 25 - 27) in this Manual.

The booklets from the Advocacy Centre for the Elderly, Community Legal Education Ontario and the National Clearinghouse on Family Violence - listed in Section Six of this Manual - will also contain information on advocacy and interviewing that is helpful.

[19] *Connecting: A Curriculum Guide on the Abuse of Seniors*: British Columbia Coalition to Eliminate the Abuse of Seniors; April; 1996

The Issue of Confidentiality

Anyone who is going to talk to an older adult about the possibility that they are being abused should always start with **trust**. If you have not built a trusting relationship with the person whom you are attempting to assist they will not open up to you.

Developing trust can be hard to do if you have not known the person for very long and even more so if this is the first time that you have met them. "If this is the case, the goal of your [first] contact…may be simply reducing the anxiety and mistrust associated with your visit." [20]

The following is a list of suggestions regarding how you might build a trusting relationship with the older adult.

- Talk to the person when you can be alone with them. You especially do not want to start a conversation about possible abuse when there is a chance that the person they claim is being abusive toward them could overhear you.

- Eliminate, or reduce, distractions in the room in which you are talking (turn the TV off, etc.).

- Take your **time** while talking to the older person. Allow time for them to get their thoughts together and respond your questions before you speak again.

- 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. Don't just focus on the possible abuse - relate to the **person** as a person not as a victim**.**

- Check if the person can hear the conversation that you are having - some people are hard of hearing but don't like to say that up front. Or they may wear a hearing aid but don't have it with them or it may not be working properly. It's easier to communicate if you can hear each other!

  If the person is hard of hearing, whether or not they use a hearing aid, consider having available a device to assist your communication. Staff at the Advocacy Centre for the Elderly use a personal amplification device, a small amplifier that is about the size of a pocket dictation machine, when meeting with clients that are hard of hearing. This device has a head set that the person being interviewed wears. The other person talks into a small

[20] *Elder Abuse: What You Need To Know*; Elder Abuse Task Force of Niagara; Intervention Sub-Committee; Draft By Kathy Ryan; February, 1996

microphone attached to the device. Information about such equipment may be obtained from the Canadian Hearing Society (www.chs.ca)

Likewise, make sure that you make any accommodations needed if the person is visually impaired. If the person ordinarily wears glasses, he or she will likely be more at ease if wearing the glasses when you are meeting together. Be conscious of the person's physical comfort and take breaks from time to time if the meeting is lengthy or emotionally difficult.

If you feel that the older person is now comfortable with you asking more in-depth questions:

- reassure the person that you are there to help them

- Assure them that you will **not repeat anything they tell you without their permission/you will keep the information that they are giving you confidential.**

However there are some exceptions to confidentiality.

This is not a complete discussion on confidentiality. Some professionals may have duties about confidentiality that do not apply to other people and some agencies may decide to have more stringent rules about confidentality over and above any legal standard that they may be required to meet.

Examples of some exceptions to confidentiality include:

* **Immediate Emergency** - Most people, if not all, when faced by an emergency where someone is at immediate risk of serious harm to life or serious risk of injury would contact the appropriate authorities, e.g. Police, Ambulance services, Etc, even if the person was objecting or refusing assistance.

- **Legislated requirement to Report Harm to Residents in a Long-term Care Facility** - All persons **other** than residents in a long-term care facility (this would include staff, visitors, consultants, volunteers, and any other persons that may go into a facility) are required to report any suspicions that a resident has suffered or may suffer harm as a result of unlawful conduct, improper or incompetent treatment or care or neglect to the "Director" at the Ministry of Health and Long-term Care.

  "Director" is defined as the person appointed by the Minister of Health for this purpose. In practice, the reports are made to the Regional Directors in the Health Care Programmes Division of the Ministry. The Ministry is required to investigate any such reports on receipt.
  This requirement to report is contained in the *Nursing Homes Act* which

applies to all nursing homes in the province. There are two other types of long-term care facilities - Homes for the Aged and Charitable Homes for the Aged. This section about reporting is not in the legislation that applies to those types of facilities (the *Homes for the Aged and Rest Homes Act* and the *Charitable Institutions Act*). However, by Ministry policy and by the facility service agreements, this same requirement to report applies to those types of facilities as well.

Note that this reporting requirement does not apply to residents. Residents may choose to not report abuse. They may report the abuse to the Ministry of Health "Director" or to others at the Ministry of Health, such as the compliance adviser for the facility. They may choose to report the abuse to a staff person or to the administrator or to follow the protocol that the facility may have in respect to abuse response. They may also choose to contact someone outside the facility for assistance, such as an external advocate or lawyer. Some residents contact the staff at the Advocacy Centre for the Elderly to request assistance with abuse issues. ACE does provide this service to many seniors.

Residents are not required to report abuse in the manner directed by the legislation as they may need other assistance to have the abuse dealt with effectively, particularly if they are experiencing the abuse. The flexibility of residents to direct how they want to respond or to get assistance was retained in the legislation as an added protection for them.

The section in the *Nursing Homes Act* reads as follows:

Nursing Homes Act
Reporting of harm to resident
25. (1) A person other than a resident who has reasonable grounds to suspect that a resident has suffered or may suffer harm as a result of unlawful conduct, improper or incompetent treatment or care or neglect shall forthwith report the suspicion and the information upon which it is based to the Director.

Protection of persons reporting
(2) No person shall dismiss, discipline or penalize another person because,
(a) a report has been made to the Director under subsection (1);
(b) the Director has been advised of a breach of this Act or the regulations; or
(c) the Director has been advised of any other matter concerning the care of a resident or the operation of a nursing home that the person advising believes ought to be reported to the Director,unless the other person acts maliciously or without reasonable grounds.

Idem
(3) No person shall coerce, intimidate or attempt to coerce or intimidate another person because information described in clause (2) (a), (b) or (c) has been given to the Director.

Idem
(4) No person shall include in a report to the Director under subsection (1) information the person knows to be false. R.S.O. 1990, c. N.7, s. 25 (1-4).

Duty on practitioners
(5) Even if the information on which a report may be based is confidential or privileged, subsection (1) also applies to a legally qualified medical practitioner or any other person who is a member of a College as defined in subsection 1 (1) of the *Regulated Health Professions Act, 1991* and no action for making the report shall be commenced against a practitioner or person who acts in accordance with subsection (1) unless that person acts maliciously or without reasonable grounds for the suspicion. R.S.O. 1990, c. N.7, s. 25 (5); 1998, c. 18, Sched. G, s. 66 (10).

Privilege of solicitor
(6) Nothing in this section abrogates any privilege that may exist between a solicitor and the solicitor's client.

Director to investigate
(7) The Director shall cause any report made under subsection (1) to be investigated forthwith after receiving it. R.S.O. 1990, c. N.7, s. 25 (6, 7).

Licensee to forward complaints
26. (1) A licensee shall forward forthwith on receipt to the Director any written complaint the licensee receives concerning the care of a resident or the operation of the nursing home.

Statement of licensee
(2) The licensee shall include with a complaint forwarded under subsection (1) a statement of reply, setting out,
(a) what the licensee has done to remedy the complaint;
(b) what the licensee proposes to do to remedy the complaint and within what time the licensee proposes to do it; or
(c) that the licensee believes the complaint to be unfounded and the reasons for the belief.

Director to investigate
(3) The Director shall cause any complaint received under subsection (1) to be investigated forthwith after receiving it. R.S.O. 1990, c. N.7, s. 26.

Immediate investigation
27. Where the Director receives a report from any source that gives the Director reasonable grounds to believe that the health, safety or welfare of a resident may be at risk, the Director shall cause an investigation to be commenced and the nursing home in which that resident lives to be visited forthwith. R.S.O. 1990, c. N.7, s. 27.

See below at page 25 in this section for further discussion about the reporting of abuse.

- **Legislated requirement of Health Professionals to report other Health Professionals if there are reasonable grounds to believe that the health professional has sexually abused a patient** - All members of regulated health professions, such as nurses, physicians, psychologists, dentists etc. are required to report to the Registrar of the appropriate Health College (i.e., College of Physicians and Surgeons, College of Nurses and so forth) if he or

- she has reasonable grounds to believe that another regulated health professional has sexually abused a patient in the course of practicing his or her profession. This obligation is in s 85.1 of the Health Professions Code under the *Regulated Health Professions Act.* The name of the patient who has been abused is **not** included in the report unless the patient or, if the patient is incapable, the patient's representative, consents in writing to the inclusion of the patients name.

- **Report to the Ontario Public Guardian and Trustee of an allegation that a person is mentally incapable of managing property or mentally incapable of personal care and that serious adverse effects are occurring or may occur as a result** - If you believe that a person does not have the capacity to manage property or to make personal care decisions, and is at serious risk of losing a significant part of their property or is unable to provide necessities of life to him or herself, or is at risk of serious injury or illness, or at risk of being deprived of liberty or personal security, you can call the Ontario Public Guardian and Trustee (OPGT) to ask them to investigate.

  This risk of serious harm may be as a result of self-neglect but may also be as result of abuse by a third party. This report to the OPGT is not mandatory but is permissive and was included in the *Substitute Decisions Act* to facilitate assistance to persons **that are not mentally capable** and therefore unable to direct assistance or to take control over their own lives.

  Persons who work for or through Community Care Access Centres (either staff at the CCACs or service providers that provide services arranged by the CCAC) may make these reports to the OPGT and may disclose what is otherwise confidential information in order to make these reports without breaching confidentiality. This is permitted by section 32(5) of the *Long-term Care Act.*

  More information on the issues of capacity, the Substitute Decisions Act, and the Office of the Public Guardian and Trustee, is available in the papers included in Section 4 of this Manual.

There are other exceptions to confidentiality. These are only a few examples. As well, new provincial privacy legislation is expected to be released in Ontario in the spring of 2003. The Ontario government has attempted to reform this area of law for many years and several drafts of privacy legislation have been presented for consultation but without passage. It is difficult to draft a comprehensive bill that balances the need for privacy of personal information with appropriate disclosures. Any new legislation may change the existing law, including information contained in this manual.

The issue of confidentiality is often a "red herring". Many people who want to help persons who have been abused are anxious to help and want to help the person to a solution quickly. In their eagerness to help, they sometimes work at a pace that is too fast for the person, who then seems to reject their help. The helpers are left feeling that they cannot move forward as to do so would breach confidentiality. The helpers may be able to avoid this situation if they first gain the trust person that they are attempting to assist (as described in the earlier discussion in this section of the Manual Page 19). Those with experience in assisting older adults suspected of being abused have found that if they have taken the time with the person, and they have fully explained why they wish to speak to a third party (such as a lawyer, or a social worker, or the police) about the person's situation, the person will quite often agree to what they are suggesting.

In some instances, the options available to the person to address the abuse are ones that the person is reluctant to take because he or she may see the so-called solutions as worse, or as bad as, the abuse. Then the person refuses the help and refuses to give permission to disclose information about the abuse to anyone else. The frustrated helper then blames the fact that help can't be given on "confidentiality". However it may be possible to alleviate the fears of the older adult if time is taken to explain what the expected consequences of taking action/talking to others would be. It is important to ask the older adult why he or she seems to be rejecting the offers of assistance - to ask her whether she is frightened - so that you can either ease the person's fears or offer other ways of addressing the problems than were what were originally proposed.

For example, if the abuser is an adult child of the senior, and the senior has been financially victimized by the adult child. The adult child has used the senior's continuing power of attorney for property to deplete the senior's bank account for his or her own personal benefit. The senior may not want to report the adult child to the police for theft, or to take action through the court to recover the funds misappropriated, because the senior does not want the adult child to "get into trouble".

However, upon identifying these fears and talking further to the senior an alternative to taking legal action might be found. For example, the senior might want to revoke the Continuing Power of Attorney for Property to stop future financial mismanagement. In addition, the senior might try to negotiate with adult child, either directly or through a lawyer or advocate, to recover the funds that were taken.

There may be times when the senior does not wish to do anything to recover his or her funds as the senior does not want to jeopardize the relationship with the adult child. The senior may fear that even mentioning the problem to the adult child, let alone revoking the Continuing Power of Attorney for Property or trying to

get back what is rightfully his or hers would cause the adult child to stop visiting or stop assisting the senior with such things as transportation, deny the senior access to grandchildren, and so forth.

If this is the case the helper should attempt to find ways of helping the senior that maintain what is important to them him or her and yet help recover the misappropriated funds/stop the abuse. If it's the relationship that is key, will it actually be fractured by the senior just talking to the adult child about the return of the funds? If the real fear is not the loss of the relationship, but the fear of the loss of the assistance (driving, care, supports) that the adult child provides to the senior, are there alternative resources for these supports (transportation services for free or for a fee, home support services in the community, services through the Community Care Access Centre, other relatives or friends?). Can a remedy (such as a court application) be done in stages (a demand letter first, then negotiation, then the issue of the statement of claim etc.) so that the senior can see what will happen at each stage and be comfortable with moving through the stages?

What the senior chooses to do to address the abuse often depends on the degree to which he or she feels confident in the person assisting him or her.

If the person advising the senior on the options to address the abuse only advises on one an option, and that is not one that the senior wants to follow, then it's likely that senior will be reluctant to tell the full story to anyone again, and/or to give permission for the person assisting to tell anyone else about the incident.

Similarly, if the approach suggested by the person advising is one that is dependent on other people doing something, or following through with some actions, the senior may be reluctant to give permission to pass on information because he or she doesn't know the third party, doesn't know what that third party will do with the information, or doesn't know whether the third party can be trusted with the follow through.

You can increase the senior's confidence in you by gaining their trust - doing such things as letting them know that they are not alone and that you have dealt with similar situations, offering more than one remedy to potentially end the abuse, taking time to listen and respond to their concerns, assisting them in talking to the third party directly rather than making the referral yourself, explaining exactly what you would tell the third party you would like to pass information on to should they wish you to make the referral, relating what your experiences have been when you have shared information with that individual/agency in the past.

Often the senior will give permission to disclose information and/or to seek help from a third party if he or she:

- knows who the information will be passed on to
- is informed how that information will be used
- is aware of what steps will be taken as a result of the disclosure
- can trust that the persons involved in assisting will listen to him or her (the senior) and take direction from him or her
- can trust that the persons assisting him or her will actually follow through and do what they say they will do in providing assistance

Remember…

- If you are not under a legal obligation to disclose information about the abuse, and this is not an emergency situation, and the older adult does not live in a Long- Term Care facility - **do not report** what the mentally capable older adult has told you to **anyone** without their full knowledge and consent.

- If you are required to report the abuse insure that the person is always informed about what is happening regarding addressing the allegation of abuse - you are talking about their life!

Documentation

If an older adult has the capacity to give you instructions - (i.e., he or she understands what you are saying to them/asking of them and they appreciate what the consequences of acting on your suggestions will be) - and they give you permission to speak to another person or agency representative about their situation - then you can do so. The older adult's verbal consent for you to disclose information about them to an identified third party is enough for you to do so. Consent is not a piece of paper, it’s the communication of the assent.

Sometimes your employer, or the agency/organization you are representing, requires you to get documentation of the older adult's consent, i.e., a signed "release/disclosure of information form", before you proceed to share the older adult's information with another individual/agency. If this is the case, explain the form to the older adult, clearly write on the form "who" it is that the older adult has given you permission to speak to, and ask the older person to sign the form.
It is a good idea (as long as it is **safe**, for the older adult, for you to do so) to ask the older adult to sign two such "release/disclosure forms" so that you can leave one with them for their records/information.

Why is there no Duty to Report Abuse Against Older Adults like there is for Abuse of Children?

There is no general legislation in Ontario to require any person to report allegations of abuse of a mentally competent older person to a central agency or particular service to investigate the allegation. This type of legislation, often known as "adult protection legislation", is fairly common in the United States. Forms of it are also in Newfoundland, Nova Scotia, New Brunswick, and Prince Edward Island.

Whether the reporting is voluntary or mandatory, this type of reporting legislation has been extensively criticized as an ageist and inappropriate response to a difficult and complex issue.

It has been called ageist because it is based on childrens' legislation and does not reflect the rights of adults (such as the right to make informed choices) when made to apply to adult problems.

Seniors are NOT children, they are adults. As adults, all older adults have the right to liberty and the right to choose how to live. It is unlikely that anyone wants to live in an abusive situation, however, some adults choose to live in abusive situations even after their options, in terms of leaving/getting out of this situation, have been explained. Adults also have the ability to make choices to remove themselves from difficult situations that are harmful and to take steps to seek help to address the abuse. Adults may choose the form of help, and the degree of help, that they want.

Abuse results from an abuse of power therefore adults do need supports and services to address abuse as many cannot remove themselves from their situation on their own. However, the fact that they need help does not justify a service or system taking over the older adult's life and removing their right of choice - which the model of adult protection legislation usually does.

Adult protection legislation often focuses only on older adults, or adults with disabilities, and not on all abused adults. It would not apply to abused younger adult women. It may be asked then, if adult protection legislation is justifiable, why should it not also apply to these situations? The dynamic of wife assault/abuse is similar to that of abuse of older adults. However few people would find the interventions which occur in adult protection legislation as appropriate when applied to a mentally capable younger woman, even though she was a victim of abuse, as it would remove control of her life out of her hands and make others decision makers for her. So then why is it believed to be acceptable for older adults?

Adult protective legislation has also been called inappropriate because abuse of older adults is not a single issue or single problem and there is not one solution to all abuses. There are many different types of abuses, and the remedies and responses to assist an abused older adult are many and may come from a variety of sectors - adult protection services focus on **one** service responding.

But one service can't solve all the abuse problems. The assistance the older adult may need, may have to come from a lawyer if it's a legal problem (such as misappropriation of property) or a social worker if the abuse is rooted in family conflict and a history of abuse. Or some incidents of abuse are best responded to by police intervention. Or the abuser may need to get assistance through a drug or alcohol rehab programme There is a need to continue to develop a variety of responses and services to address abuse of older adults as it is impossible for a single service to meet all needs in this area.

Some people think that special legislation would increase resources to respond to abuse. But ironically, the creation of a special "abuse response" or adult protection service may reduce the response to an older adult rather than increase it. As soon as a service is specifically mandated to respond, the other services that don't have that particular mandate or specific funding, then drop out as a resource, referring the older adult to the special service. This may happen even if the older adult actually needs the help from that first contacted service. This just creates additional delay and steps that have to be taken before help is given.

It is more efficient and effective for all relevant services - whether labeled as abuse response services or not - whether a funded service, or volunteer group, or informal organization - to be aware of the network of services and response in a community so that when a senior makes contact with one service, he or she may be directly connected to other parts of that network without having to go through a specialized service and wait in line to just then be referred to the appropriate service. This networking and interconnection is one of the advantages of a community response network over an adult protection legislated service.

Reporting legislation does not create solutions to abuse problems - it is only a means of people referring to a particular service to investigate. It appears attractive to other service providers who know that assisting a person who has been affected by abuse will take time and resources and/or who may feel that they lack the expertise to assist the older adult. Service providers may therefore prefer to pass on the matter to another person to deal with rather than help the older person themselves.

However, passing on the problem to another person doesn't mean the older person will be helped. The specialized services are usually overloaded and many

times need to refer the older person back to the person who referred them as the help the older person needs is that available at the referring agency, not the specialized service. Also, in most cases, the specialized services focus on investigation and possibly the co-ordination of a response to the older adult, but do not directly provide service to the person.

Reporting legislation is a bandaid - its not a solution but a cover-up that makes it look like something is being done to help the older adult when in fact that's not the case. **Some help may be given but usually not the type to resolve the abuse.**

For an interesting discussion on the Nova Scotia Legislation read the report from the Dalhousie Health Law Institute - *Mistreating Elderly People: Questioning the Legal Response to Elder Abuse and Neglect* - Elder Abuse Legislation Research Team, Coughlan, Stephen et al, Halifax, Nova Scotia November 1995.