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# World Health Organization (WHO) & International Network for the Prevention of Elder Abuse (INPEA)

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RYERSON  
SCHOOL OF NURSING

## GLOBAL RESPONSE AGAINST ELDER ABUSE REPORT FROM CANADA

*Prepared by: Elizabeth Podnieks*

### INTRODUCTION:

This report presents the findings from eight focus groups held in the province of Ontario, Canada as part of the WHO/INPEA Global Response Against Elder Abuse. It is hoped that the learnings which have emerged from this study will contribute to the knowledge generated from the other participating countries and together we can discuss and deliberate on the issue of elder abuse. The consultation meetings in October 2001 in Geneva will initiate this process.

International collaboration among seniors' advocates is an essential strategy in the fight against elder abuse. Not only does it forge the alliances needed to mobilize internationally, it also: strengthens the effectiveness of advocates' own local and regional work by exposing them to new models and strategies; promotes the notion of elder abuse as a violation of elders' human rights; and inspires and energizes advocates to continue the fight because they feel supported by a global community of activists striving to attain shared goals. Elder abuse challenges belief in the sanctity of the home and the inherent goodness of man. Also, it raises basic ethical and legal dilemmas regarding the elder's right to self-determination and society's desire to intervene. To arrive at a better understanding of this difficult problem, the experience of all countries is needed. These are precisely the reasons why Canada has welcomed the opportunity to join the WHO/INPEA Global Response Against Elder Abuse.

Please note that Community Care Access Centres are frequently referred to throughout the report. *Community Care Access Centres* (CCAC) are mandated by the Provincial Government to act as a single point of access for health and social services including: information; referral; special services for disabled, ill and children; specialty service areas in palliative care, pediatrics and community mental health services; and application and admission to long term care facilities. Anyone can call or visit a centre to speak with a staff member. Other community services offered by a CCAC include: Meals

on Wheels; Friendly Visiting; Supportive Housing; Attendant Services; Children's Treatment Centres; and Community Mental Health.

## **PROCESS:**

Eight focus groups took place between August 8, 2001 and September 12, 2001. Sessions were held at: two universities, one hospital, one senior's residential building, two community agencies and two community centres. Five groups were held in Toronto and three in smaller towns in Ontario. Participants were obtained by writing to fourteen agencies/organizations, outlining the project and requesting participation. These letters were followed with phone calls. Eight different groups were identified and the sessions began. One obstacle in the recruitment was the time of year – summer in Canada usually means that people are on holiday and those left to staff an agency are stretched to the limit. Many older adults also go on vacation and are not available to attend a focus group. This being said, we were able to attract a remarkable group of people to come to the sites listed above, and discuss their perceptions of elder abuse. We acknowledge with gratitude those older men, women and primary care providers for enriching our data and providing us with valuable insights into the issue of elder abuse.

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## **FOCUS GROUPS**

### **FOCUS GROUP: OLDER WOMEN**

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<b>Focus Group Location:</b>	The Institute for Human Development, Life Course and Aging, Toronto (Older Women's Network)
<b>Date:</b>	August 23, 2001
<b>Sex:</b>	Female (8)
<b>Location:</b>	High density
<b>Marital Status:</b>	Single (1), Married (6), Widowed (1)
<b>Access to Health Services:</b>	All felt that they had excellent to good access to health care services. Hospitals are also located nearby.
<b>Number of Participants:</b>	8
<b>Country:</b>	Canada (Ontario)
<b>Country of Origin:</b>	Canada (5), Great Britain (1), USA (1), India (1)

## **INTRODUCTIONS:**

Participants introduced themselves and provided brief background information. These older women have backgrounds in nursing, psychotherapy, early childhood education, business, working with women and volunteering for various organizations.

## **MOTIVATION FOR TAKING PART IN FOCUS GROUP:**

- interested in research regarding aging women
- frustration over lack of help when elder abuse incidents were witnessed by one participant (as a public health nurse) and people did not take report seriously

- older myself and can now see all kinds of problems that need to be addressed
- very encouraged when notified about this project
- older women perceived as invisible - not in a positive fashion
- interested in issues to do with women - especially abuse and violence
- concern for older people to learn more about elder abuse
- feel seniors are patronized
- concerned about adult children's neglect of elderly parents
- personal experience caring for Mother (dementia) sharing experience with Dad and brother and finally, the need to institutionalize

#### **CHALLENGES FACING OLDER PEOPLE TODAY:**

- isolation
- finances especially when husband dies and pension is reduced or non-existent
- neglect by adult children
- societal changes - e.g. grandfather babysitting, slapped child and was reported
- in different cultures, children only learn English and cannot communicate with their grandparents
- lack of respect by adult children and grandchildren
- not wanting to admit abuse is happening or to take action against family member
- systemic abuse - cutbacks to Public Health Departments, nurses used to visit all homes when new baby taken from hospital - had knowledge of the district and the people

#### **OVERVIEW OF ELDER ABUSE:**

##### **MEANING OF ELDER ABUSE TO PARTICIPANTS:**

- loss of freedom - e.g. in institution to choose the T.V. program they want to watch
- loss of control over own life - being forced to do something without consent
- hurting another person
- intimidation of seniors
- environmental/societal - street crossings - poorly lit and with insufficient time for seniors to cross
- lack of thought for older persons
- isolation and neglect - causes depression and possibly suicide or suicidal ideation
- financial difficulties causes low self-esteem - this issue needs to be addressed

##### **IS ELDER ABUSE ACCEPTABLE?**

- this question not specifically answered but implied consensus that elder abuse is unacceptable
- concern of participants indicated throughout discussion, supports this fact

##### **DIFFERENT KINDS OF ABUSE:**

- physical
- sexual
- psychological/emotional/mental – patronizing
- financial
- institutional abuse - especially issues around forced feeding
- verbal
- neglect

- systemic

#### **WHY ABUSE HAPPENS:**

- vulnerability - poor health, unable to care for themselves
- families do not have time or patience to look after senior
- controlling caregiver or family member
- isolation
- lack of communication
- neglect - by family and society
- financial problems - insufficient money for food, medical/dental needs, transportation
- caregiver stress, e.g. husband cannot cope with chronically ill wife and walks out
- increased elderly population
- cultural beliefs - especially around the issue of sexual abuse by husband, i.e. consent not seen as necessary
- changes in society - two parents working, grandparents have to babysit; grandchildren have no respect for seniors; adult children often do not have time to care for or visit parents

#### **SIGNS THAT CAUSE CONCERN:**

- abuse of alcohol
- controlling caregiver - taking away all responsibility from senior regardless of capacity - not listening to wishes of older person
- children never visiting – depression
- actions taken, e.g. moving person to an institution before they really need to be placed (for convenience of adult children sometimes?)
- neglect

#### **FACTORS PLACING AN OLDER PERSON AT RISK:**

- decreased independence due to frail health - loss of mobility and ability to care for self
- cultural issues - language barriers - dominance of men - lack of knowledge of available resources
- social isolation - need to keep track of vulnerable seniors
- alcoholism of senior or caregiver
- low self-esteem
- consequences of talking about abuse may place person more at risk especially if they have to continue to live in same environment, if other alternatives are unavailable
- lack of freedom to make decisions for themselves
- cutbacks to health care and community services
- shortage of physicians trained to recognize and deal with elder abuse

#### **IS IT DIFFERENT FOR MEN AND WOMEN AS THEY AGE?**

- generally women will care for chronically ill husband until he dies
- some men will walk out because they cannot cope
- women live longer
- women connect (communicate with) better with people than men
- will speak out more openly about abuse in some cases (at least to a friend)

## **IS ELDER ABUSE REALLY A PROBLEM IN ONTARIO?**

- implied throughout discussion that abuse is a problem in Ontario and general agreement that abuse is wrong

### **PERCEPTIONS: ABOUT OLDER PEOPLE:**

- seniors sometimes difficult to deal with and very demanding
- demand and expect too much from children and in-laws in some instances
- many are socially isolated
- some blame themselves for abuse by adult children - feel guilty for something they did or did not do

## **IS AGEISM A FACTOR IN ELDER ABUSE?**

- general consensus that a lot of elder abuse has to do with ageism and society's attitude towards seniors
- whole attitude of care (of seniors) has to be addressed - issue not first priority in Government's plans

## **CAN STRESSFUL OCCASIONS TRIGGER ELDER ABUSE?**

- not specifically dealt with

## **CAN ELDER ABUSE BE IDENTIFIED AS A HEALTH CARE ISSUE?**

- yes - shortage of doctors who are educated about elder abuse and know the right questions to ask elderly patients and can recognize signs other than obvious (physical)
- cutbacks in health care and community services - more services and more programs are needed, i.e. community visiting nurses

**Note:** Throughout participants also identified it as a legal (Powers of Attorney issue), societal and cultural concern

### **CONSEQUENCES OF ELDER ABUSE FOR ABUSED, FAMILY AND COMMUNITY:** (not specifically addressed but implied throughout)

- hurtful and demeaning to abused
- leads to struggles within family and broken relationships
- financial consequences

### **SOLUTIONS:**

#### **CAN YOU IDENTIFY EXISTING/NEEDED HEALTH AND SOCIAL SERVICES AND COMMUNITY SUPPORT IN RELATION TO ELDER ABUSE?**

##### ***Existing:***

##### ***Needed:***

- education - medical, geriatric, theology, intergenerational (elder abuse needs to be incorporated into curriculum)

- seniors awareness - so they know the resources available
- senior volunteers - specifically geared to elder abuse – peer support (this would require more funding for training seniors to support peers) more focus groups like this one and with all ages - to discuss and come up with some more local initiatives
- police involvement
- government recognition that front-line workers are important players - they know the seniors and observe the abuse - need funding to provide more services to prevent abuse, i.e. Public Health Nurses to visit and assess

#### **HOW CAN WE RESPOND TO ELDER ABUSE AND PREVENT IT?**

- raise awareness, especially of seniors, but also across the ages
- become more educated
- encourage respect and concern for older people
- ensure wider distribution of resource material, e.g. pamphlets, videos
- keep better track of isolated seniors - on a daily basis, e.g. telephone check ups
- lobby for funding
- go with "gut" feeling if you feel abuse is happening and take action, e.g. call another family member outside the home and voice your concerns, i.e. follow up
- acknowledge that abuse is happening in Ontario - be suspicious
- have better trained front-line workers who could spend time with the seniors
- listen to what is being said

#### **WILL THE QUALITY OF LIFE FOR THE OLDER PERSON, FAMILY AND COMMUNITY BE ENHANCED BY ADDRESSING THE ISSUE OF ELDER ABUSE?**

**Note:** This question not specifically dealt with, but throughout the discussion it is obvious that the older person, family and community will be enhanced by addressing the issue of elder abuse

#### **FOCUS GROUP: OLDER WOMEN**

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<b>Focus Group Location:</b>	Alzheimer Society of Haldimand-Norfolk
<b>Date:</b>	August 28, 2001
<b>Sex:</b>	Female (7)
<b>Location:</b>	Low density, Norfolk County, 60,000 total population in surrounding 1,500 square kilometers. All participants live in small towns.
<b>Marital Status:</b>	Single(0), Married (6), Widowed (1)
<b>Access to Health Services:</b>	Three live within thirty kilometers of Simcoe (small town) equipped with access to the Norfolk general Hospital, the Community Care Access Centre (CCAC), Victorian Order of Nurses (VON) and several doctors, dentists, a medical centre, and three nursing home facilities. Most health and social services are found in Simcoe.
<b>Number of Participants:</b>	7
<b>Country:</b>	Canada (Ontario)
<b>Country of Origin:</b>	Canada (6), Ukraine (1)

## **INTRODUCTIONS:**

Participants introduced themselves and provided brief background information. These older women had varied experience, three were Alzheimer Caregivers, others had experience in local nursing homes.

## **ISSUES DISCUSSED:**

### **MOTIVATION FOR TAKING PART IN FOCUS GROUP:**

- recently widowed and need some new experiences
- curious - never attended anything like this
- came with friend - I might have something to offer
- I have elderly parents
- my husband has Alzheimer Disease and is in a nursing home - I am concerned about abuse there
- I want to know about abuse
- it is something that needs to be addressed
- I know of one personal case of financial abuse

### **CHALLENGES FACING OLDER PEOPLE TODAY:**

- picking the right nursing home - some of them border on abusive (3 participants agreed)
- Government needs to fund more nursing homes - some are waiting up to three years to place a loved one
- Long Term Care facilities need guidelines, better pay for staff and better training - seniors are not getting proper care because staff are overworked and tired
- lobbying Government
- finding more in-home support so that loved ones can stay home longer
- getting more and better medications for behavioural problems – improper medication can lead to confrontations
- accessing the system to find resources
- having support staff properly trained to deal with dementia patients – this includes the problem of chemical and physical restraints, used to avoid confrontation and possible abuse - training is needed in nursing homes and for home care workers

## **OVERVIEW OF ELDER ABUSE:**

### **MEANING OF ELDER ABUSE TO PARTICIPANTS:**

**Note:** The group reviewed a prepared page with a definition and descriptions of the following forms of abuse: physical, emotional or psychological, financial, sexual, neglect, medication, medical, systemic, and human rights

### **IS ELDER ABUSE ACCEPTABLE?**

- there was general agreement that abuse of any sort was wrong - however: depriving someone of his/her rights may sometimes be necessary. That is, a caregiver may withhold information or deny visitors because he thinks it is for the good of the person. Group agreed this was a fine line - an incident was cited where a man in a nursing home was constantly falling out of bed and had put his teeth through his lip three times. His medication for sedation was doubled. Was this right? The choices were that he be over- medicated or keep on hurting himself. Doctor in nursing home sanctioned the medication without seeking the permission of the caregiver

- A brief discussion of restraints and the Alzheimer Society's position on restraints followed. It was agreed that the caregiver should be notified before any action is started. It is difficult to reach an objective decision about what is best for the family member.

### **DIFFERENT KINDS OF ABUSE:**

These types of abuse were reviewed by the group as part of the overview –

- physical
- emotional or psychological
- financial
- sexual
- neglect
- medication
- medical
- systemic
- human rights

### **WHY ABUSE HAPPENS?**

- frustration on the part of the caregiver
- caregiver having to bear the total responsibility, without relief, leading to an overburdening of one person
- day care not available for the person with Alzheimer Disease
- respite not available for the caregiver and she/he becomes stretched to the limit - when homemaker came, caregiver slept
- however, (one participant remarked) abuse should not be happening
- stress
- the caregiver commits himself/herself to doing everything, then reaches a breaking point
- having to move someone without the proper training may cause injuries (unintended abuse)
- victim denies he/she is being abused, making excuses for the abuser should this be perpetuating the abuse ("he must have needed the money")
- lack of energy - being on duty 24 hours a day, 7 days a week
- lack of family support
- Long Term Care facilities, Community Care Access Centres, etc. do not have sufficient staff

### **SIGNS THAT CAUSE CONCERN:**

- withdrawal or isolation
- bruising
- regression
- refusal to eat
- carelessness about hygiene

**Note:** other indicators taken from Elder Abuse, "The Hidden Crime" were also considered.

### **FACTORS PLACING AN OLDER PERSON AT RISK:**

- widowed women more apt to be abused - not used to managing finances
- women often have never been independent and are overwhelmed at being left with all the responsibilities
- women outlive men - therefore, many become vulnerable as they age



- women do not want to "air dirty linen" - internalize problems and complaints - thereby encouraging more abuse

#### **IS IT DIFFERENT FOR MEN AND WOMEN AS THEY AGE:**

- women live longer than men and are more often left alone
- men are used to being independent and managing money - not so vulnerable as women
- women are more apt to be abused (based on size and weight)

#### **IS ELDER ABUSE REALLY A PROBLEM IN ONTARIO:**

- Yes - as a result of the discussion the group began to realize that everyone knew of some instance of elder abuse (some close to home)

**Note:** The group received information about the potential for elder abuse in their own area based on Dr. Elizabeth Podnieks' 1989 study and that of Charmaine Spencer in British Columbia - i.e. 100,000 population projected 22,900 older adults - potential for abuse of 900 + based on the 4% figure

#### **PERCEPTIONS: ABOUT OLDER PEOPLE:**

- Great
- Spoiled
- on the move
- financially ok
- happy
- stable (these comments from Port Rowan - Long Point Seniors' Village)
- I see more people living alone in the country
- reasonably happy
- I see them in need of community living, possibly along ethnic lines. They would support each other and stay in their home longer. If they need services they are right there.
- I know a place like that - two people living alone put a "happy face" in the window at night and take it out in the morning so that their friend across the way knows that they are up and on the move

#### **IS AGEISM A FACTOR IN ELDER ABUSE?**

- yes, young kids think old people are stupid
- people talk down to elderly people, call them "sweetie" or "dearie"
- young people (often your own children) sometimes tell older people what to do because they think they know better or know more

**Note:** Two participants did not accept the idea of discrimination as a factor

#### **CAN STRESSFUL OCCASIONS TRIGGER ELDER ABUSE?**

- illness causes stress on the caregiver because of the worry and extra responsibility
- moving from one location to another or to a nursing home causes stress, especially if one of the elderly persons is balking at the move
- losing one's license and giving up the keys to the car \*

\* **Note:** This came up more than once as a very difficult time for the caregiver. Not only does he/she take the brunt of the anger from the ex-driver, but he/she now has added responsibilities - doing all the driving.

- the death of family and friends
- an accident, or any unexpected upheaval can cause turmoil and rash behaviour - overworked caregivers are often stretched to the limit, and like elastic bands, can snap under pressure
- stressful occasions can be alleviated a bit if couples take time to discuss the details connected with eventual death, discussing the wishes of the partner - death will still be a shock, but plans put in place will be helpful
- visiting a funeral home to make arrangements for a loved one is very stressful and an elderly widow/widower can be abused financially - there was some agreement that funeral directors take advantage of grieving partners - they use the natural emotions of grief to bump up the cost of the funeral. One participant called it "exploitation".
- another participant disagreed, citing the funeral home as great in helping the family to prepare for possible death

#### **CAN ELDER ABUSE BE IDENTIFIED AS A HEALTH CARE ISSUE:**

- medication is important in caring for the elderly
- doctors tend to over-prescribe, often giving the impression that they do not have time to deal with the elderly
- doctors are still revered as "gods" - what they say, or neglect to say, is very important - people seldom argue with or refute what the doctor says
- long waiting periods for MRI's and to get into nursing home puts pressure on everyone
- the health system is abusing the elderly by not providing access to services when needed
- people in the health system seem not to want to deal with elders – they don't ask the right questions and if they do, they do not listen to the answers - they often lack patience

#### **CONSEQUENCES OF ELDER ABUSE FOR ABUSED, FAMILY AND COMMUNITY:**

- general agreement that the pressures of caregiving could lead to abuse, through stress and frustration - affecting the abused person and the (family) caregiver

### **FOCUS GROUP – OLDER MEN**

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<b>Focus Group Location:</b>	Dixon Hall – Seniors' Residence
<b>Date:</b>	August 29, 2001
<b>Sex:</b>	Male (5)
<b>Location:</b>	High density
<b>Marital Status:</b>	Single (2), Married (3), Widowed (0)
<b>Access to Health Services:</b>	All felt that the residence they lived in provided excellent health care services. Also, hospitals are located nearby.
<b>Number of Participants:</b>	5
<b>Country:</b>	Canada (Ontario)
<b>Country of Origin:</b>	Canada (2), Guyana (1), Yugoslavia (1), The Netherlands (1)

## **INTRODUCTIONS**

Participants introduced themselves and provided brief background information. These older men, now retired, had varied career and work experience including military and banking. One man worked in a large hotel, one was a freelance illustrator and one worked for the Toronto Transportation Commission.

## **ISSUES DISCUSSED:**

### **MOTIVATION FOR TAKING PART IN FOCUS GROUP:**

- to learn more about elder abuse
- concern for seniors - in own homes and in institutions
- getting older myself - do not need services today - not so vulnerable yet

### **CHALLENGES FACING OLDER PEOPLE TODAY:**

- technological challenges - bank ATM machines - no personal contact
- seniors out of workforce are out of touch
- not enough professional advice or care for seniors
- need more accessibility to nurses in the community - to get advice
- safety and security in buildings, e.g. door closing too slowly - unauthorized people can get in behind you, or too fast, dangerous for people in wheelchairs or people who cannot move quickly
- some services not available in summer months
- concern for young people - job security and lack of pensions for their old age
- deteriorating health and strength - not so able to protect yourself attitude of young people who see elderly as drain on resources
- similar accommodation for seniors as this - excellent building - a model lack of family support
- being approached in the street and asked for money (panhandlers)
- poor attitude of some seniors - resent help

### **WHY ABUSE HAPPENS:**

- frustration - with seniors (by young people) - especially in grocery stores - impatience in line
- lack of knowledge
- addictions - alcohol, drugs
- vulnerability - especially those who are alone
- lack of transportation
- social isolation
- naivety - e.g. eggs stolen from line up in grocery store, don't believe abuse happens
- systemic abuse causes seniors problems, e.g. filling out Government forms for income tax or OHIP assistance - not telling people they are entitled to more financial benefits

### **SIGNS THAT CAUSE CONCERN:**

- talking down to older people
- abuse of Powers of Attorney
- neglect - blind lady unable to feed herself
- lady living alone, poor eyesight, potential to set clothes on fire

### **FACTORS PLACING AN OLDER PERSON AT RISK:**

- cutbacks in funding
- isolation
- deteriorating health and capabilities - e.g. eyesight, cognitive ability - think more slowly
- lack of support

### **IS IT DIFFERENT FOR MEN AND WOMEN AS THEY AGE:**

- more women abused than men - women seen as more vulnerable "people try things with women they wouldn't do with men"
- men can also be abused financially by children and others
- men more reluctant to talk about abuse (pride) - taught to be quiet
- women more open - talk more easily about problems
- both men and women ashamed to admit abuse by their children or to report it and seek help
- widows more vulnerable because often husband's pension is reduced or stopped

### **IS ELDER ABUSE REALLY A PROBLEM IN ONTARIO:**

- the discussion and examples given by the participants indicate abuse is really a problem in Ontario

### **PERCEPTIONS: ABOUT OLDER PEOPLE:**

- older people can be difficult at times, rude and ungracious – not accepting seat in bus when it is offered by a younger person
- sometimes isolate themselves and will not accept help
- can be abusive to other people - verbally and physically (old lady in subway train with umbrella with sharp point - uses it to jab people)

### **IS AGEISM A FACTOR IN ELDER ABUSE:**

- yes - general agreement
- not respected by younger people - give seniors the impression that they (young people) are supporting us
- seen as a liability to society once we are no longer in workforce
- societal attitude - prejudicial - nothing to do with worth or value of past experiences, has to do with the image society has of seniors - they are "over the hill"
- seniors resent the implication that they have not paid in for the benefits they receive - they have worked for these and paid into health, pension and unemployment
- people talk down to elderly people
- T.V. and commercials sometimes ridicule older people, especially women

### **CAN STRESSFUL OCCASIONS TRIGGER ELDER ABUSE:**

- deteriorating health - requiring surgery - senior draws up Power of Attorney - once recovered adult child continues to use P/A - many seniors do not know it can be revoked

### **CAN ELDER ABUSE BE IDENTIFIED AS A HEALTH CARE ISSUE:**

- general agreement – yes

- more education for family doctors
- more nurse practitioners needed

**Note:** implied during the discussion that it is also a legal and social issue

### **CONSEQUENCES OF ELDER ABUSE FOR ABUSED, FAMILY AND COMMUNITY**

- not specifically addressed but implied throughout that elder abuse affects the seniors, families and the community

### **SOLUTIONS:**

#### **CAN YOU IDENTIFY EXISTING/NEEDED HEALTH AND SOCIAL SERVICES AND COMMUNITY SUPPORT IN RELATION TO ELDER ABUSE:**

##### ***Existing:***

- seniors' residences

##### ***Needed:***

- more support needed for the elderly - both patient and caregiver
- better training and more staff, especially nurse practitioners in the community
- system needs to be far more accessible
- more publicity to raise awareness
- more education - for professionals and seniors and front-line workers - e.g. hydro and TTC
- police involvement (some disagreement over the role of the police - law versus social workers)
- more flexible health care services
- education prior to retirement
- more focus groups such as this

#### **HOW CAN WE RESPOND TO ELDER ABUSE AND PREVENT IT:**

- have better trained front-line workers who could spend time with the seniors
- recognize competent seniors have the right to make decisions and choose lifestyle
- continue to support seniors and be non-judgmental
- offer support if seniors involved in court system
- have trained people who can respond to elder abuse and deal with it in a quick, calm and firm way

#### **WILL THE QUALITY OF LIFE FOR THE OLDER PERSON, FAMILY AND COMMUNITY BE ENHANCED BY ADDRESSING THE ISSUE OF ELDER ABUSE:**

**Note:** This question not specifically dealt with, but throughout the discussion it is obvious that the older person, family and community will be enhanced by addressing the issue of elder abuse

## FOCUS GROUP – OLDER MEN

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<b>Focus Group Location:</b>	Bobcaygeon, Ontario
<b>Date:</b>	August 8, 2001
<b>Sex:</b>	Male (6)
<b>Location:</b>	Low density
<b>Marital Status:</b>	Single (1), Married (5), Widowed (0)
<b>Access to Health Services:</b>	All participants mentioned that they had access to hospitals and doctors. One participant mentioned that the access seemed limited, as there was a significant traveling distance to hospitals and that the area was under-serviced with doctors and medical specialists. There are two nursing homes, three medical clinics with some X-ray facilities, and two dentists.
<b>Number of Participants:</b>	6
<b>Country:</b>	Canada (Ontario)
<b>Country of Origin:</b>	Canada (5), Cheshire, England (1)

### INTRODUCTIONS:

Participants introduced themselves and provided brief background information. All are retired and involved in community volunteer work. They reside in different areas within the City of Kawartha Lakes, (Bobcaygeon, Fenelon Falls and Lindsay). The City of Kawartha Lakes has the second highest percentage of senior residents in the Province of Ontario and as more retirees relocate from Toronto (90 miles to the south), this number is increasing rapidly.

One member of the group had been involved in an Elder Abuse Committee now disbanded due to lack of funding and two others had some elementary knowledge of the issues.

### ISSUES DISCUSSED:

#### MOTIVATION FOR TAKING PART IN FOCUS GROUP:

- concern and respect for seniors
- group members now healthy and feel they can help peers - see themselves as caregivers for their peers
- giving something back to the community
- hobbies not enough after a busy working life - through volunteer work they get a sense of achievement and satisfaction and they now have time for volunteer work
- we are also getting there
- men were motivated to attend by their interest in the welfare of seniors and desire to learn about elder abuse

**Note:** One participant reported that when completing an income tax return for an elderly senior, she commented "I hope when you reach my age, there is someone to help you".

### CHALLENGES FACING OLDER PEOPLE TODAY:

- loneliness - often single - partner deceased
- isolation - geographic and social
- lack of family support - often because of geographic location, family members need to leave this area because of lack of employment opportunities

- loss of peer group friends through death
- finances
- decline in health and mobility
- physical limitations
- transportation
- frustration over changes in lifestyle necessary as they age - especially with regard to driving; (some seniors continue to drive when they are not fit to do so)
- concern over how they can stay in own home and a community that is familiar
- men - erectile dysfunction leading to depression - creates problems in family,
- cannot talk about it - too embarrassed
- Seasonal Affective Disorder – SAD (more of a problem now many seniors are unable to go south to escape the long Ontario winter - because of discounted dollar and expensive health care insurance, this option is no longer open to them)
- intergenerational accommodation - several generations under one roof - stress on primary caregiver (often daughter of senior and mother of children)
- there was extreme concern over the cutbacks in health care, especially issues such as short hospitals stays and returning the patient to the community without sufficient home care. The primary caregiver, as well as the patient, is often elderly and in need of support.

#### **OVERVIEW OF ELDER ABUSE:**

##### **WHAT DOES THE TERM ELDER ABUSE MEAN TO YOU?**

- vulnerability - especially susceptibility to scams from door-to-door or telephone salespeople
- mistreatment
- lack of respect
- impatience with older people by storekeepers and others - seniors move at slower pace and are out-of-step with today's faster moving lifestyle

##### **IS ELDER ABUSE ACCEPTABLE?**

- immediate initial consensus - No
- issue of restraints raised - although group do not like the idea of restraining older people, they realize that sometimes for safety of the senior, they are necessary
- cultural differences - what is acceptable in one culture is not in another
- self-neglect - group found this concept difficult - discussion followed regarding the freedom for competent adults to make (*unwise*) choices

##### **WHAT KINDS OF ABUSE OCCUR?**

- physical
- financial/scams
- mental/emotional
- spousal
- threats
- verbal
- neglect/self-neglect

**Note:** Self-neglect was an issue that was not understood and they had some difficulty with the need to maintain a non-judgmental approach in these cases.

## **WHAT ARE SOME OF THE FACTORS THAT PLACE AN ELDERLY PERSON AT RISK FOR ABUSE AND NEGLECT?**

- loneliness
- control over another
- lack of understanding of aging process
- impatience
- lack of mobility (due to stroke or other illness) leading to caregiver stress
- perception of incompetence, frailty and weakness, of older adults
- seniors grew up in an age where they could trust people - change in today's society
- naive and less worldly
- caregiver stress could result in elder abuse - this could include situations where the primary caregiver, as well as the patient, is often elderly and in need of support.
- living alone - isolation
- lack of regular visitors
- lack of family support
- health problems - mobility, eyesight, hearing, medication abuse or confusion
- home care and health services cutbacks
- unfamiliar surroundings
- lack of proper nutrition
- lack of public transportation
- pride - cannot afford drives to medical appointments, will not avail themselves of subsidized services

**Note:** The youngest member of the group (55) believes that his generation and those that follow, will be better prepared for old age and somewhat protected from abuse because, through necessity and mobility, they have been more independent and less reliant on the support of family and friends.

## **SIGNS THAT CAUSE CONCERN:**

- loss of weight
- change of mannerisms, tone of voice (e.g. whispering)
- lack of family visits
- living conditions - soiled clothing, poor hygiene
- bruises
- inability to pay bills and lack of money for necessities
- fearful attitude - reluctant to talk
- confusion over facts
- forgetfulness
- appears emotionally upset
- repetition of story

## **DO YOU SEE ANY DIFFERENCE BETWEEN RISK FACTORS FOR MEN AND WOMEN AS THEY AGE?**

- greater risk for women, (e.g. widows)
- women live longer and as surviving spouses often encounter financial problems due to reduced or cessation of pensions
- declining health of men may put them at risk - if a man has been difficult to live with over the years and has a stroke, wife might retaliate by abusing him (caregiver stress could also play



- a role here)
- men more vulnerable when they lose spouse - very dependent on wives and not as able to care for self (e.g. laundry, housekeeping)
- the men in the group admitted that even if they were aware of an elder abuse case that was happening, they would not know where to go to receive help

**Note:** One participant noted his experience with elderly friend whose wife died - he withdrew from all social activity, shut himself in the house and within two years he himself died. The participant felt that his friend died of loneliness.

Again, the youngest member of the group believes that as men and women from his and the following generations, age, they will be less vulnerable to abuse for reasons cited previously.

### **IS ELDER ABUSE REALLY A PROBLEM IN ONTARIO?**

- general consensus, although group noted their lack of personal experiences and knowledge about the issue, is that elder abuse happens in Ontario and in this area
- some skepticism by youngest man in group about the extent of the abuse and the perpetrators. All know it is there, but don't know how much. As a Bank Manager for some of his working life, he was well aware of financial abuse. He believes that the banks are quick to recognize incidents and do their best to help people avoid being abused. He perceives some cases of financial abuse as self-inflicted through greed which is why people get scammed. He also believes that many cases of financial abuse are family related and happen because seniors do not get sufficient professional advice before loaning money. Comment seniors don't recognize it is abuse. This participant also feels that elder abuse, especially financial, perpetrated by family members, may increase in cultural communities, as more older immigrants come to Canada.

### **PERCEPTIONS:**

#### **HOW DO YOU PERCEIVE OLDER PEOPLE?**

- need all the help we can get - I can help now, may need it myself in the future
- most pretty smart - others naive and susceptible to scams
- have stability, knowledge and life experiences (great babysitters for grandchildren)
- older people are survivors, particularly those in their 80's and 90's who survived the Depression and the Wars, yet many are very vulnerable
- seniors are packrats, save little bits of string - this is a throwback to Depression days
- seniors are more respectful and have more appreciation of what they have now and where they are today

### **IS AGEISM A FACTOR IN ELDER ABUSE?**

- attitude towards aging is changing - still some respect for seniors; gray power increasing
- seniors being hired again for employment - more reliable
- society has lack of knowledge about aging process although seniors have tried to pass on to younger people that they need to respect the older generation
- seniors suffer from lack of dignity in some situations, e.g. diapering of adults rather than attending to their needs - one member of the group recounted his experience when visiting an elderly friend (83) who had suffered a stroke - when he approached the nursing station and asked for help, he was told "Mr. C. has a diaper on - it is alright". The participant was extremely upset by this action, as was the patient, and he commented that there were five nurses sitting around at the nursing station, but they could not be bothered to unhook his

- friend and get him to the bathroom.
- the concept of ageism in our society does not appear to have been an issue that either concerned them, or to which they had given any thought

### **ARE THERE STRESSFUL OCCASIONS THAT CAN TRIGGER ELDER ABUSE?**

- yes
- financial problems - own and those of the family
- shared accommodation with several generations under one roof - big problem today
- lack of caregivers in institutions due to budgetary problems leading to reduction in staffing and patient to staff ratio becomes too high
- loss of spouse or significant other
- caregiver stress - looking after stroke victim, who is incontinent, slops food, etc. and caregiver is lacking knowledge of support available or unwilling to accept help
- seniors who are repetitive - actions (clicking nails, sucking teeth)

### **HOW DO YOU DEFINE ELDER ABUSE AS A HEALTH CARE ISSUE?**

- yes - physical abuse with need for hospitalization and medical care is a health care issue; other forms of abuse - e.g. psychological/verbal may become mental health issue
- lots of issues around medication - confusion over dosage, over-medication and withholding of medication by caregiver
- lack of government funding leads to cutbacks in health care service availability, more stress on caregivers and therefore more vulnerability for abuse
- it is not only health care issue, but also a societal concern

### **SOLUTIONS - INTERVENTIONS - CHALLENGES**

#### ***Solutions:***

- Haliburton, Northumberland and Victoria Community Care Access Centre based in Lindsay, Ontario (case managers have received training through the Ontario Association of Community Care Access Centre Elder Abuse Training Initiative)
- Home support agency - Community Care Victoria County with branches in Bobcaygeon, Fenelon Falls, Kirkfield, Lindsay and other small villages - offer friendly visiting, drivers, frozen meals, income tax preparation, daily telephone checks
- Meals on Wheels (separate organization from above)
- Service Clubs - e.g. Lions, Rotary, Knights of Columbus, Canadian Legion
- Churches
- Hospitals
- Nursing homes, retirement homes
- Doctors

#### ***Interventions:***

- by taking action against alleged abuse and getting involved
- by utilizing existing resources
- by intervening in cases of physical abuse where safety is a concern, but being cautious in other cases and investigating circumstances thoroughly
- by education to raise awareness through mall displays, seminars, presentations - of seniors, professionals and anyone involved with older people. Families would also benefit with increased awareness and knowledge.
- by developing a public relations program
- by working through local churches

- by investigating local sources for a call centre
- the men stated that listening to the discussion and the viewpoints of the other participants has been a valuable exercise

**Challenges:**

- more education to raise public awareness - for all age groups
- a telephone number to call for help - not just 9 a.m. to 5 p.m. but 24 hours, 7 days a week
- a publicity campaign to advertise support available

**Note:** The comment was made that local nursing homes are staffed 24 hours a day, 7 days a week and there is always an RN on duty. The question was asked "Why couldn't the nursing homes offer a telephone number to call?"

There was also concern because none of the participants knew where to go in the event that they became aware of an incident of alleged abuse or to find information for a client.

**WILL THE QUALITY OF LIFE FOR THE OLDER PERSON, FAMILY AND COMMUNITY BE ENHANCED BY ADDRESSING THE ISSUE OF ELDER ABUSE?**

It was a general consensus that if elder abuse is addressed, the quality of life for seniors would be enhanced. This would be done through education, allowing older people to be more aware of the potential for abuse and they would know where to go to seek help and information.

**Facilitator's Note:** We ran out of time and some participants had to leave. This question was not answered specifically, but I believe that the issues were dealt with throughout the discussion.

## **FOCUS GROUP – OLDER MEN AND WOMEN**

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<b>Focus Group Location:</b>	Ryerson University, L.I.F.E. Institute, Toronto, Ontario
<b>Date:</b>	August 8, 2001
<b>Sex:</b>	Female (7), Male (2)
<b>Location:</b>	High density
<b>Marital Status:</b>	Single (0), Married (2), Widowed (4), Anon. (3)
<b>Access to Health Services:</b>	All felt that they had excellent to good access to health care services and diagnostic facilities. Hospitals are also located nearby. It was also mentioned by one participant that they felt "blessed" to be in a country that works towards universal health care, and that they felt well looked after. Another participant agreed that while the services are available, there "sometimes can be a long waiting list" due to recent government health care cuts.
<b>Number of Participants:</b>	9
<b>Country:</b>	Canada (Ontario)
<b>Country of Origin:</b>	Canada (6), U.S.A. (2), Trinidad, W.I. (1)

**INTRODUCTIONS:**

Participants introduced themselves and provided brief background information. These senior men and women have varied life and career experiences. One is a retired lawyer, another a retired architectural draftsman. Another is a retired nurse and a wife of a Presbyterian Minister. All are

involved as volunteers.

#### **ISSUES DISCUSSED:**

##### **MOTIVATION FOR TAKING PART IN FOCUS GROUP:**

- to learn more about elder abuse
- hear and read about elder abuse but do not know the extent of the problem or what resource material is available (not familiar with elder abuse pamphlets)
- concern for older people and their future, especially those not so affluent or those without caring children/other family members to give emotional support
- getting older themselves - feel the need to "pave the road" to prevent own abuse when they are older
- concerned about lack of dignity for older people - feel seniors are patronized
- concerned about adult children's neglect of elderly parents
- systemic abuse - no consistency of care, in part because of cutbacks
- some concern expressed about ethical dilemmas

##### **CHALLENGES FACING OLDER PEOPLE TODAY:**

- societal change - lack of family values and respect for elders, fast pace of life, especially in large cities such as Toronto - better in small town communities
- lack of caring family and emotional support - perception by adult children that affluent parents in good care facility, are fine and that they "will call if they need us", do not recognize the importance of a "hug", telephone call
- isolation
- systemic abuse - no consistency of care, in part because of cutbacks and low rate of pay - even the affluent find it difficult to hire good trained people
- mobile families
- lack of knowledge about their rights and the law
- embarrassment and shame over abuse - feel foolish, do not want to admit it happened
- fear of cutting off relationships

#### **OVERVIEW OF ELDER ABUSE:**

##### **MEANING OF ELDER ABUSE TO PARTICIPANTS:**

- taking advantage of older person in some way that causes them to lose self-esteem
- controlling the older person to the point where they lose all sense of identity, i.e. loss of control over own life
- taking away independence of person
- patronizing attitude of some medical professionals who talk to patient as if they are unable to comprehend what is being said
- failing to listen to older person
- threats in case of non-compliant senior causing fear, i.e. if you don't want to go back (to a particular place or institution) you will do this....

##### **IS ELDER ABUSE ACCEPTABLE:**

- consensus implied throughout discussion - definite No
- one participant said he had an aversion to any form of violence against the weak and vulnerable (remainder of group in agreement)

## **DIFFERENT KINDS OF ABUSE:**

- physical
- psychological
- financial
- societal (neglect ?) - no food on table
- society's values - divorce lawyer worth many times more in dollars than MSW (Social Worker) working in hospital
- institutional abuse
- verbal

## **WHY ABUSE HAPPENS:**

- fear - of abandonment by adult children
- fear - of reprisal in some way - no access to grandchildren
- fear - loss of relationship - if I say anything, I won't even see them once a year!
- ignorance that it is abuse that is happening
- do not want to have family member prosecuted, therefore unwilling to report
- shame
- complexity of aging
- caregiver stress - e.g. Alzheimer patients
- desire to get even
- lack of ability to respond one-on-one to professionals - lack of trust or language difficulties, i.e. cultural issues

## **SIGNS THAT CAUSE CONCERN:**

- controlling caregiver - taking away all responsibility from senior regardless of capacity - not listening to wishes of older person
- children never visiting - depression "better off dead"
- actions taken "in the older person's best interests", e.g. moving person to an institution far away from friends where she/he is isolated and unhappy (for convenience of adult children sometimes?)
- neglect

## **FACTORS PLACING AN OLDER PERSON AT RISK:**

- decreased independence due to frail health - loss of mobility and ability to care for self
- cultural issues - language barriers - dominance of men - lack of knowledge of resources available
- perception that abuse is normal part of life - acceptable because of need to keep family together
- one participant felt that individuals who lack education, self-esteem and good communication skills probably are the ones who usually get "walked over" \*
- reduced ability to comprehend or respond to questions - leading to caregiver stress or impatience
- consequences of talking about abuse may place person more at risk especially if they have to continue to live in same environment

\*(**Note:** Some disagreement about this and others noted that well-educated financially secure men also abuse their wives). Participants in agreement about complexity of elder abuse.

### **IS IT DIFFERENT FOR MEN AND WOMEN AS THEY AGE:**

- general consensus – Yes
- men more used to fending off abuse throughout lifetime, so older men are probably better equipped to deal with abuse than older women
- as previously abusive man ages and becomes more dependent on wife - increased vulnerability and wife may become abusive (payback time)
- adult sons returning home after failed relationships and then abuse their mothers

**Note:** neither men nor women want to admit they are being abused.

**Note:** One participant noted situation is changing - younger women are more liberated - do not feel bound to stay in abusive marriage or one they no longer want - wife walks out, children left with husband as his responsibility - he has to ask family to help or hire help.

### **IS ELDER ABUSE REALLY A PROBLEM IN ONTARIO:**

- implied throughout discussion that abuse is a problem in Ontario and general agreement that abuse is wrong - aversion to violence against the weak, the vulnerable - analogy to other forms of abuse - child and spousal

### **PERCEPTIONS: ABOUT OLDER PEOPLE:**

- sometimes difficult to really know about an older person, e.g. Alzheimer patient may be aggressive one day and mild the next - have to recognize that reports of abusive caregiver may not be true - general agreement - false reports may cause damage to alleged abuser (i.e. perceived caregiver abuse reported by Home Care Worker to supervisor without accurate knowledge of facts)
- they are unaware of Family Law Act in Ontario that says if you have raised your children, children have obligation to look after you when you become old (even if seniors are aware of this clause, difficulties in acting on it - law gives them rights that are worthless because of repercussions, i.e. if I sue, I will never see son or grandchildren again)

### **IS AGEISM A FACTOR IN ELDER ABUSE:**

- general consensus that a lot of elder abuse has to do with ageism and the attitude towards seniors
- older seniors no longer in work force seen to be a drain on society
- many people find the thought of working with the elderly very depressing

### **CAN STRESSFUL OCCASIONS TRIGGER ELDER ABUSE:**

- yes
- especially holiday times - without supportive family - leads to depression and sometimes ideation of suicide or successful completion
- also stressful situations - i.e. adult child returning home to live with (usually) widowed mother

## **CAN ELDER ABUSE BE IDENTIFIED AS A HEALTH CARE ISSUE:**

- yes - shortage of doctors who are educated about elder abuse and know the right questions to ask elderly patients
- volunteers who come into contact with seniors and hear their stories can only listen, they need access to health professionals to be able to refer seniors
- cutbacks in health care and community services - more services and more programs are needed
- elder abuse programs need to be incorporated into medical/health care programs - e.g. geriatric

**Note:** Throughout participants also identified it as a legal, societal and cultural concern

## **CONSEQUENCES OF ELDER ABUSE FOR ABUSED, FAMILY AND COMMUNITY:**

(not specifically addressed but implied throughout)

- hurtful and demeaning to abused
- leads to struggles within family and broken relationships
- financial consequences

## **SOLUTIONS:**

### **CAN YOU IDENTIFY EXISTING/NEEDED HEALTH AND SOCIAL SERVICES AND COMMUNITY SUPPORT IN RELATION TO ELDER ABUSE:**

#### ***Existing:***

- day care centres, e.g. Baycrest
- Community Care Access Centre programs
- volunteer groups and organizations

#### ***Needed:***

education - medical, theology, intergenerational  
seniors awareness - so they know the resources available

- senior volunteers - specifically geared to elder abuse – peer support
- more day care centres that are accessible and affordable - to combat social isolation
- transportation to centres and subsidized programs for those seniors with low incomes
- public relations programs

## **HOW CAN WE RESPOND TO ELDER ABUSE AND PREVENT IT:**

- raise awareness especially of seniors, but also across the ages become more educated
- encourage respect and concern for older people
- ensure wider distribution of resource material, e.g. pamphlets
- encourage people to admit they are being abused
- listen to what is being said
- be prepared to intervene and taking action
- ensure confidentiality and anonymity

## **WILL THE QUALITY OF LIFE FOR THE OLDER PERSON, FAMILY AND COMMUNITY BE ENHANCED BY ADDRESSING THE ISSUE OF ELDER ABUSE:**

**Note:** This question not specifically dealt with, but throughout the discussion it is obvious that the older person, family and community will be enhanced by addressing the issue of elder abuse.

## FOCUS GROUP – OLDER MEN AND WOMEN

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<b>Focus Group Location:</b>	Bobcaygeon, Ontario.
<b>Date:</b>	August 9, 2001
<b>Sex:</b>	Female (4), Male (4)
<b>Location:</b>	High density
<b>Marital Status:</b>	Single (1), Married (4), Widowed (3)
<b>Access to Health Services:</b>	All participants live in or near Bobcaygeon or in Fenelon Falls, both of which are small towns. In Bobcaygeon there are two nursing homes, three medical clinics with some X-ray facilities, and two dentists. All participants mentioned that they had access to hospitals and doctors. However, the access seems limited, as there is a significant traveling distance to hospitals and medical professionals.
<b>Number of Participants:</b>	8
<b>Country:</b>	Canada (Ontario)
<b>Country of Origin:</b>	Canada (4), United Kingdom (3), Scotland (1)

### INTRODUCTION:

Participants introduced themselves and provided brief background information. All are retired and involved in community volunteer work. One member of the group had been involved in an Elder Abuse Committee now disbanded due to lack of funding and two others had some elementary knowledge of the issues.

### ISSUES DISCUSSED:

#### MOTIVATION FOR TAKING PART IN FOCUS GROUP:

- to learn more about elder abuse and increase their limited knowledge of the issue
- hear and read about elder abuse - don't know prevalence or what facilities or services there are available
- encouraged by issue being addressed at the global level and realize that global aspect is important - main concern is what is happening locally; hope that the Provincial Government will look at health care services *locally*
- concern for seniors generally and those they meet through volunteer work to find out how elder abuse is related to health

#### CHALLENGES FACING OLDER PEOPLE TODAY:

- lack of services, e.g. home care due to cut back in government funding
- short hospital stays, less and reduced home support (CCAC wait list for service)
- lack of family support due, in part, to mobility of families and younger members (few employment possibilities in this area)
- change in society - family system
- to get information on how to maintain independence - financial, good health and social interaction
- isolation and insulation - small towns, fewer services, lack of transportation
- difficulty in communication and getting information re services (technology, automated voice response)



- concern over lack of universal strategies and communication system - social services and support vary according to geographic location and circumstances
- difficulty experienced by older sibling members trying to get help in alleged family
- abuse situations (family dysfunction)
- attitude of seniors themselves
- abused seniors often do not have energy to seek help for themselves
- lack of local network to address issue - because so many community agencies have one paid staff member and must rely on volunteers for additional help, there is often no structured procedure leading to difficulties in communication and provision of information - where can we go for help in this area?
- medication - over-medication, improper dosage of prescription (not taking into account age, weight, etc. of senior) or misuse of drugs, through confusion or lack of knowledge;
- under-medication - due to inability to pay extra for drugs not on seniors' health plan

**Note:** one member said that a recent CARP (Canadian Association of Retired Persons) report suggested more elderly women are victims of over-medication than men; also that government keeps some control over drug usage by seniors.

#### **OVERVIEW OF ELDER ABUSE:**

##### **MEANING OF ELDER ABUSE TO PARTICIPANTS:**

- taking advantage of older persons financially, mentally/emotionally and physically (including scams)

##### **IS ELDER ABUSE ACCEPTABLE?**

- immediate initial and definite consensus - No
- issue of restraints raised - sometimes necessary for safety of senior, sometimes because too few staff in institutional settings due to cutbacks
- if restrained for staff or caregiver convenience, it is abuse; if restrained for safety, not abuse - very fine line between necessity for safety and use for convenience
- confinement to room and restriction of visitors is abusive

##### **DIFFERENT KINDS OF ABUSE:**

- financial
- scams
- "mental"/emotional/psychological
- physical
- confinement
- neglect - by family or caregiver
- self-neglect
- verbal - also present simultaneously in some of the other forms of abuse
- deprivation of necessities of life

##### **WHY ABUSE HAPPENS:**

- greed
- frustration
- vulnerability

- uncaring attitude by family members - family dysfunction and family dynamics - cyclical aspect of abuse - abuse of children in childhood, abuse by grown children as seniors age and become more frail
- caregiver stress
- lack of education
- lack of understanding of abuse and of the aging process
- generational issues - need for several generations to live under one roof - sandwich effect for main caregiver e.g. caregiver's mother and caregiver's daughter
- cultural differences

#### **SIGNS THAT CAUSE CONCERN:**

- physical appearance
- bruises
- withdrawal from interaction with visitors
- general attitude of senior - fearful, cowering, hesitant to talk or communicate
- living conditions - room or home
- poor personal hygiene
- lack of access to private phone
- controlling caregiver - lack of privacy during visits

**Note:** comment by one member - these signs apply to private home or institutions

#### **FACTORS PLACING AN OLDER PERSON AT RISK:**

- health problems - poor health in general, lack of mobility, failing eyesight/hearing trying to remain independent when they are no longer able to do so - e.g. insisting on cooking when eyesight poor (possibility of fire), poor balance
- scatter rugs
- stairs
- lack of financial resources and other support, e.g. family or friends or services
- location - isolation - due to both geographic location and circumstances - e.g. unable to continue to drive and unwilling to seek help leads to social isolation of senior
- person's own personality - pride - very independent or shy and with low self-esteem -
- unwilling to ask for assistance

#### **IS IT DIFFERENT FOR MEN AND WOMEN AS THEY AGE?**

- general consensus - greater risk for older women - they are more vulnerable because they live longer than men
- some men have more difficulty caring for themselves when the spouse dies - men in the generation of those in group did not do many of the chores that men today perform, e.g. child care, shopping, laundry, cooking
- men unwilling to ask for help
- yes, men are abused but we don't hear about it

**Note:** There was also discussion regarding the changes that are taking place in society today - men are living longer and presumably, will also become more vulnerable as their health deteriorates; younger women have become much more independent and have careers, they will be better prepared for old age than elderly women are today; men also getting more used to doing things for themselves, housework, cooking, etc.

## **IS ELDER ABUSE REALLY A PROBLEM IN ONTARIO?**

- general consensus, yes - with a great deal of verbal abuse that is not so evident as the physical or financial abuse, but very damaging
- group noted lack of personal knowledge, but have a sense that abuse happens in Ontario and in their own area
- seniors do not realize that what is happening is abuse
- issue of confidentiality raised as a barrier to identification of abuse
- fear of legal liability on part of people to get involved, especially professionals

**Note:** group questioned whether or not doctors and others had to report suspected abuse and the question of mandatory reporting was discussed

## **PERCEPTIONS: ABOUT OLDER PEOPLE:**

- some are nice, some aren't, some can be very testy and difficult interesting group
- good for economy because many have money to spend
- often seen as a major drain on health care system - "but over the years, seniors have provided the funds for these services"
- would rather work with seniors than with children
- valued for their life and work experiences - "they have spent whole lifetime getting this experience"; "great as volunteers" and save government money because of willingness to do this
- seniors are treated quite well and receive many perks - discounts in stores, travel, etc.
- seniors are secure in this area, not fearful as they might be in large city
- some seniors may tend to abuse system because of lack of family support

## **IS AGEISM A FACTOR IN ELDER ABUSE?**

- general consensus - no - society is concerned about seniors' well being. The aids that are in place for the disabled also help seniors, e.g. wheelchair ramps, automated door openers
- T.V. geared to young who have purchasing power because many are making high salaries and have more purchasing power

## **CAN STRESSFUL OCCASIONS TRIGGER ELDER ABUSE?**

- yes - arguments that get out of hand, especially in case of caregiver stress e.g. dealing with Alzheimer patients, senility, declining health)
- loss of job
- change of circumstances resulting in loss of home and need for senior to be relocated
- death of spouse
- retirement - change in routine can lead to spousal/marital difficulties
- intergenerational living

## **CAN ELDER ABUSE BE IDENTIFIED AS A HEALTH CARE ISSUE?**

- it is both a health and social issue for abused and abuser
- health issue for stressed caregiver
- can be root cause of serious depression in seniors and caregivers
- becomes health issue if someone suffers as a result of the abuse
- also a legal issue

- one member of the group felt that it is more of a social/societal issue than a health issue

#### **CONSEQUENCE OF ELDER ABUSE FOR ABUSED, FAMILY AND COMMUNITY:**

- decreased quality of life
- very hurtful
- demeans the abused and the abuser leading to poor self-esteem
- leads to struggles within the family for the abused, abuser and the sibling relations
- can break up the family
- depletion of finances

#### **SOLUTIONS – INTERVENTIONS - CHALLENGES**

#### **CAN YOU IDENTIFY EXISTING/NEEDED HEALTH AND SOCIAL SERVICES AND COMMUNITY SUPPORT IN RELATION TO ELDER ABUSE?**

##### ***Existing:***

- Haliburton, Northumberland and Victoria Community Care Access Centre (HNVCCAC)
- local doctors
- churches
- hospitals
- home support agencies

##### ***Needed:***

- more education to raise public awareness
- a resource to access when abuse is suspected - telephone number to call for information, coordinator and volunteers to answer telephone
- issues needs highlighting to stand alone, they gets hidden under other issues

#### **HOW CAN WE RESPOND TO ELDER ABUSE AND PREVENT IT?**

- utilize existing resources such as HNV CCAC, police
- education to raise awareness of elder abuse issues – raise awareness of elder abuse for all ages as well as the importance of a local resource
- launch a publicity campaign to identify elder abuse, raise awareness and prevent it from happening - this is of global, national and provincial importance, but should start “where we are” in this local area
- provide a 1-800 toll free telephone number for enquiries and advertising it as a resource for people to call for help
- take action against alleged abuse and getting involved
- tag day for Prevention of Elder Abuse, not just locally, but provincially and nationally

#### **WILL THE QUALITY OF LIFE FOR THE OLDER PERSON, FAMILY AND COMMUNITY BE ENHANCED BY ADDRESSING THE ISSUE OF ELDER ABUSE?**

- general consensus - yes, although we had too little time to discuss this question in detail, these issues were addressed throughout the meeting
- if elder abuse is addressed the quality of life will be enhanced – older people would be more aware of the potential for abuse and recognize their vulnerability

## FOCUS GROUP: PRIMARY CARE PROVIDERS

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<b>Focus Group Location:</b>	Family Service Association
<b>Date:</b>	September 7, 2001
<b>Sex:</b>	Female (9), Male (1)
<b>Location:</b>	High density
<b>Marital Status:</b>	Single (4), Married (6), Widowed (0)
<b>Access to Health Services:</b>	All work in the health care field, and therefore have excellent access.
<b>Number of Participants:</b>	10
<b>Country:</b>	Canada (Ontario)
<b>Country of Origin:</b>	Canada (8), U.S.A. (1), China (1)

### INTRODUCTIONS:

Participants introduced themselves and provided brief background information. All work in the health care field.

### ISSUES DISCUSSED:

#### MOTIVATION FOR TAKING PART IN FOCUS GROUP:

- a lack of protocol for elder abuse
- want to see guidelines for reporting of elder abuse
- believe this is an issue that is becoming more apparent in the field and must be addressed
- identification and discussion of elder abuse (with clients) is difficult - client often wants to remain passive and not change situation
- believe elder abuse is still a hidden issue - need more awareness and better legislative guidelines and strategies to cope with it
- reference made to mandatory reporting of child abuse and lack of this with elder abuse

#### CHALLENGES FACING OLDER PEOPLE TODAY:

- special needs of the client complicates their situation even further, especially in abuse situations
- vulnerability - cutbacks in funding make seniors vulnerable to poor health care and a lack of social assistance
- seniors suffer from a lack of choices and autonomy
- at risk of abuse, exploitation
- elderly is a population that is a bit unseen - invisible in the population as a whole
- abuse is not in the foreground
- cultural barriers and difficulties
- isolation, family often not available - breeds into different situations

**Note:** Isolation mentioned by three of the participants - seen as key issue.

#### WHAT ARE SOME OF THE CHALLENGES FACING THE SOCIAL SERVICE WORKER?

- lots of lip service - no funding available for elder abuse - we have to couch it under different service areas that are funded

- hospitals/institutions that have more money available and more methodical ways of coordinating effective care for elder abuse clients, don't - as a result clients fall into the lap of social services who don't have the money
- community is in need of more funding and resources to counter elder abuse
- respecting decisions of seniors is difficult, e.g. when a client makes an irrational decision based on guilt, e.g. elderly woman who was to be placed in alternate housing to get away from abusive son. Son jailed and she had accepted new housing so she would not be in the previous environment when he got out. Out of guilt for leaving her son alone, she refused to move and chose to stay in the abusive situation.
- we are dealing with a whole range of issues a client has - this can be overwhelming for the new worker
- lack of knowledge in the system, too - if person we turn to leads us astray, we have difficulty providing effective service
- we need adequate support for workers
- cultural issues - especially language, need services available in variety of languages
- need for comprehensive way of dealing with elder abuse - a protocol
- organizational support needed - more resources to respond in effective way
- issues of confidentiality - it gets thrown up as a red herring and conversation between workers, professionals, paraprofessionals, stops - becoming more and more of a barrier to providing adequate and appropriate service - how do we get around this when we need to address an issue
- confidentiality important but must do everything possible to help someone in imminent risk (It was suggested The Code of Ethics covers this point – confidentiality can be broken when risk to health and well-being is apparent.)
- must be recognition that money and time needs to be set aside for elder abuse work
- abuse is not the only issue in many cases and in the present system, one person deals with one issue and another deals with the other issue – need one person handling the case - to avoid duplication of assessment of client needs. The system creates the potential for discontinuity of service

#### **OVERVIEW OF ELDER ABUSE: WHAT DOES THE TERM ELDER ABUSE MEAN TO YOU?**

- an act perpetrated against an older person that harms them

#### **WHAT KINDS OF ABUSE OCCUR?**

- physical, neglect, psychological, financial
- domestic violence grows old in a relationship
- co-dependency - adult child dependent on senior for housing, money, food and senior is also dependent on adult child
- abuse of people for profit - especially with cognitively impaired
- retribution - abused child in a position to abuse - pay back
- grandchildren asking grandmother for money - she gives it because they are grandchildren
- abuse may be result of learned behavior - kids can get money from grandmother and then keep going back
- perception that parent can no longer make financial decisions although they may be quite competent
- abuse of Power of Attorney

### **WHY DO YOU THINK FINANCIAL ABUSE HAPPENS?**

- dependency relationship with individual
- fear of negative reaction if they don't give the money
- money will be mine when they die, why not take it now
- bank assumption that children are in a position to govern their parent's finances whether account is joint or not and whether child has financial P/A (Power of Attorney) or not values - senior thinks it is his/her obligation to provide for family for as long as possible
- society sees seniors as an easy target - others may not believe them if they say abuse has happened

### **WHAT WOULD YOU NOTICE ABOUT A PERSON WHO MAY BE BEING FINANCIALLY ABUSED?**

- rent cheques bounced and no money in bank
- struggling to buy food, etc. but have a good sized income
- unexplained withdrawals from bank account

### **WHY DO YOU THINK PHYSICAL ABUSE HAPPENS?**

- a pattern that is ongoing
- care giver stress
- relationships that were violent and have grown older
- control relationships since the beginning
- the perpetrator may be feeling a loss of control of themselves and need to compensate somehow

### **WHAT WOULD YOU NOTICE ABOUT A PERSON BEING PHYSICALLY ABUSED?**

- lots of trips to the hospital
- fear in the presence of the abuser
- withdrawal/depression

### **WHY DO YOU THINK PSYCHOLOGICAL/VERBAL ABUSE HAPPENS?**

- treating people in a demanding, threatening way
- access to phones is restricted (i.e. not allowing senior to access phone), call blocking
- threatening - loss of contact with family members

### **WHAT WOULD YOU NOTICE ABOUT A PERSON BEING PSYCHOLOGICALLY ABUSED?**

- a lot of excusing behavior of individual
- always having to verify actions with another person
- learned helplessness, powerlessness

### **WHY DO YOU THINK NEGLECT HAPPENS?**

- failing to provide the basics
- we often see issues of neglect, psychological and physical abuse all tied in together

### **WHAT WOULD YOU NOTICE ABOUT A PERSON WHO MAY BE BEING NEGLECTED?**

- missed doctor's appointments
- lack of food in the house, living in squalor
- no contact with other people, isolation
- malnutrition

### **WHAT ARE SOME OF THE FACTORS THAT PLACE AN ELDERLY PERSON AT RISK FOR ABUSE AND NEGLECT?**

- living alone
- physical disabilities
- cognitive disabilities
- financial restrictions
- loneliness and isolation
- mental health problems
- ageism
- societal attitudes - e.g. sexual abuse often missed because of perception older people are not looked on as sexual beings.

### **DO YOU SEE ANY DIFFERENCE BETWEEN RISK FACTORS FOR MEN AND WOMEN AS THEY AGE?**

- women tend to have lower incomes than men
- more women are abused by male partners than male by female partners
- with respect to financial abuse, mental capabilities apply to both sexes
- women are more likely to be widowed and living alone - increased chance for being preyed upon
- children are quicker to assume that mother cannot manage the finances
- mother is more of a "push-over"
- women live longer than men - this puts them at higher risk for all other risk facts such as cognitive impairment

### **IS ELDER ABUSE REALLY A PROBLEM IN ONTARIO:**

- ALL (EMPHATICALLY) YES!
- prevalence is currently 4% but this is suspected to be underreported
- unless more people go out and observe it, it will continue to go underreported
- iatrogenic abuse (neglect) is often unrecognized
- systemic abuse - government and other agencies may commit abuse simply through neglect

### **PERCEPTIONS: HOW DO YOU PERCEIVE OLDER PEOPLE?**

- wise and resourceful just the same as all of us, but with specific limitations (i.e. health, etc)
- as alert and aware as we are, have had more experiences
- we have stereotypical perceptions of older people and the more you work in the field, the more you see how inaccurate those stereotypes are.



### **IS AGEISM A FACTOR IN ELDER ABUSE:**

- stereotypes assuming that the person is older and can't handle finances
- an assumption of entitlement - it doesn't matter if we take her money now, we'll get it later
- elders are seen as less deserving, nonproductive
- older people seen as non-sexual and this leads to a decreased reporting of rape and domestic violence among elderly
- there is an assumption of mental incompetence

### **ARE THERE STRESSFUL OCCASIONS THAT CAN TRIGGER ELDER ABUSE:**

- holidays
- changes in funding to services (environmental influences) e.g. CCAC cannot provide services and then people go to other agencies and these agencies require a fee. Result, people discharged from hospital and people living in the community are getting no service and are forced on waiting lists
- living in poverty can contribute to stress which contributes to abuse
- systemic exploitation of seniors (environmental)
- telling seniors if they want to be bathed more than once a week, they must pay for it
- Community Care Access Centres (CCAC) in response to government cutbacks, have abandoned their clients - if a senior is getting service from CCAC, they cannot get service from Homemaking and Nursing Services Act (HMNS). Meanwhile, they could get more service from HMNS than they can get from a CCAC

### **HOW DO YOU DEFINE ELDER ABUSE AS A HEALTH CARE ISSUE:**

- psychological abuse, physical abuse, neglect and financial abuse all contribute to physical health status and mental health
- abuse and neglect will also impact the senior's ability to access care outside the home
- someone who is abused will need more health care services
- the principle of universality as it is written in the Canada Health Act holds that all persons are entitled to the same health care, regardless of socioeconomic status.- with government cutbacks, health care and health status is a function of how much money you have to pay for care in the home - the great majority of seniors cannot afford to pay for such care and therefore receive inadequate care
- this is essentially systemic abuse

### **WHAT ARE THE CONSEQUENCES OF ELDER ABUSE?**

- imminent risk clause calls for some sort of response - however, ANY concern about health and safety calls for a response
- it is important for elder abuse to be addressed in the assessment process, whether it is evident or not - we must bear in mind that it does happen and look for signs at assessment

### **CONSEQUENCES FOR OLDER PEOPLE:**

- lessening of quality of life
- premature death
- mistrust

## **CONSEQUENCES FOR THE FAMILY:**

- mistrust between family members

## **CONSEQUENCES FOR THE COMMUNITY:**

- segmenting a group of the population that has a lot to offer
- community is not as strong because the senior is not a part of it
- financial cost to society, e.g. welfare, etc.
- stress on emergency services, i.e. police, ambulance, crisis support

## **SOLUTIONS – INTERVENTIONS – CHALLENGES:**

- **FUNDING** – we need adequate funding to meet the needs of our clients
- Must address where the money should go and what priority we give to seniors, i.e. how do we establish seniors as a priority for funding in the first place? The Baby Boomers will help this happen, however, what do we do NOW?
- We must think about what kinds of supports for elder abuse are currently available and what needs to be developed
- Counseling/support for a variety of language groups – how will this impact the clientele and the community, i.e. any supports that are or can be put in place would help seniors, but also the community
- Volunteers – volunteers are taking up some of the slack because there is no funding to pay service providers – however, volunteers should not have to do this and a lot do not have the necessary training to effectively handle a variety of situations, in particular, abuse
- Define gaps that exist in:
  - housing – retirement homes are for profit, for those individuals with no money, where do they go?
  - time – not enough time to give adequate service since case loads are really high
  - legislation – there is no protocol, no mandatory reporting of elder abuse and no procedure to follow
  - not enough support for caregivers
  - services to the abuser, e.g. educational services for caregivers
  - Office of the Public Guardian – difficulty getting investigations going and getting the required parties involved
  - public education – society not aware of elder abuse – health promotion campaigns could be vital (publications, radio and TV)

**Note:** awareness and willingness to talk about elder abuse has increased somewhat, but passing information onto people is so important – however, while we can do the education, we may not have the resources to deal with the intake calls afterwards. This may be part of the government reluctance to promote and support educational initiatives because it then creates a greater need for resources that can respond to need. The issue of COST and FUNDING is an overarching theme.

## **THE FUTURE OF RESPONSE:**

**What would an effective response to elder abuse look like?**

- direct intervention
- consultation
- better/tighter legislation for police and the courts

- standard protocol of how different agencies/organizations should respond to reports of elder abuse
- seniors' groups getting together and organizing to change or improve the response mechanisms that currently exist
- supports/programs for the abusers
- for someone who is concerned about abuse occurring with someone they know or do not know, to be able to call somewhere, report it and know that there is going to be a response

**HOW WILL THE QUALITY OF LIFE FOR THE OLDER PERSON, FAMILY AND COMMUNITY BE ENHANCED BY ADDRESSING THE ISSUE OF ELDER ABUSE:**

- Person – improved health status (emotionally, physically and spiritually)
- Family – with knowledge they have, they can work together – greater family unity, more openness and communication between generations
- Community
  - caring community
  - improve perspective
  - less cost to social service providers and health care services
  - a good reflection on the community if the value of health care and service for the elderly is just as important as that of the other age segments of the population

## **FOCUS GROUP: PRIMARY CARE PROVIDERS**

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<b>Focus Group Location:</b>	Sunnybrook Hospital Health Sciences Centre, Toronto (Regional Geriatric Program)
<b>Date:</b>	September 12, 2001
<b>Sex:</b>	Female (9), Male (1)
<b>Location:</b>	High density
<b>Marital Status:</b>	Single (2), Married (4), Widowed (0)
<b>Access to Health Services:</b>	All work in the health care field, and therefore have excellent access.
<b>Number of Participants:</b>	10
<b>Country:</b>	Canada (Ontario)
<b>Country of Origin:</b>	Canada (4), Korea (1), Lebanon (1)

### **INTRODUCTIONS:**

Participants introduced themselves and provided brief background information. All work in the health care field, e.g. as Medical Doctor, Registered Nurses, Occupational Therapist, Social Worker (Geriatric Outreach) and Therapeutic Recreationist.

### **ISSUES DISCUSSED:**

#### **MOTIVATION FOR TAKING PART IN FOCUS GROUP:**

- **FRUSTRATION** - on inability to act and go forward, in part because of demands of their professional bodies to get consent, no mandate to interfere, no mandatory reporting as in child abuse

- need to heighten awareness of elder abuse
- concern for the elderly people they see on a day-to-day basis as well as for the families
- detection of elder abuse is an important issue, as is intervention
- cutbacks are affecting all services
- need for professional guidelines - what they need to do in elder abuse cases they see, what is within their scope, etc.

**Note:** The extreme frustration of these health care providers was very evident throughout the whole discussion - their concern and caring is evident, time to address the issue supported by funding for sufficient human resources and programs, is not available to them - reference made to having to "turn a blind eye sometimes".

### **CHALLENGES FACING OLDER PEOPLE TODAY:**

- vulnerability - cutbacks in funding make seniors more vulnerable – poor health care and a lack of social assistance seniors suffer from a lack of choices and autonomy in some instances – in other cases they will choose to stay in own home and be abused "put up" with emotional abuse and "shut up" about it - see abuse as their lot in life
- cognitive impairment
- seniors reluctant to go into hospital because they will lose their homecare and be put on a waiting list when they are discharged
- fear of the care they may receive in institutions, both acute and long-term care
- fear the use of restraints
- aging population, longer life expectancy will produce more people with dementia and require more care - caregivers will require more support
- cultural differences and traditions - resources are not there for many people who cannot speak English
- children of ethnic parents have grown up with different expectations and this adds to conflict within the families
- lack of family support - adult children who no longer see it as their duty to care for parents
- many cannot afford to buy extra services they need as caregivers and become over-burdened
- systemic abuse - long waits in emergency departments and then being sent home without proper assessment
- decreased quality of care for elderly, especially those who are alone - home help who do not carry out the duties as required in care plan - not bathing elderly person, just running taps
- society does not see them as a valuable segment of the population
- seniors own perception that after 65 they are useless

### **OVERVIEW OF ELDER ABUSE:**

#### **WHAT DOES THE TERM ELDER ABUSE MEAN TO YOU?**

- frustration at lack of funding to provide appropriate services
- any act that harms or threatens the health and welfare of an elderly person
- it can be an action or an inaction (including neglect)
- it can be intentional or unintentional - caregivers burnt out, stressed, who have really good intentions and are very caring and loving may reach a breaking point through not being aware they are being abusive, lack of knowledge or resources to help them
- it occurs within a relationship of trust, not just the stereotype of people on the street, i.e. a robber, but in all economic, social and cultural groups
- occurs across the spectrum - family, friends, neighbours and paid caregivers
- no group is sheltered from being exposed to this issue

- can occur at home, in the community and also in institutionalized settings
- any act of commission or omission against a senior that threatens their health and welfare

#### **WHAT KINDS OF ABUSE OCCUR?**

- physical
- neglect
- psychological/emotional
- financial
- sexual
- verbal

#### **WHAT ARE SOME OF THE FACTORS THAT PLACE AN ELDERLY PERSON AT RISK FOR ABUSE AND NEGLECT?**

- living alone
- physical disabilities
- cognitive disabilities
- financial restrictions
- loneliness and isolation
- mental health problems
- ageism
- societal attitudes - e.g. sexual abuse not seen as happening to the elderly
- stress through cutbacks impacting the ability of people to manage, e.g. in homecare
- fear of the care in the system and of the possibility of losing homecare help if they are hospitalized for a time, then have to go on waiting list

#### **DO YOU SEE ANY DIFFERENCE BETWEEN RISK FACTORS FOR MEN AND WOMEN AS THEY AGE?**

- men tend to be financially or emotionally abused
- if a man is physically abused, it is usually because he has been the abuser in the past - example given, husband always been master in own home, wife now demented and not accepting abuse - becomes abusive herself
- man sometimes older than woman when they marry, then becomes impaired and wife becomes caregiver - increased burden of care increases stress level abuse
- more women are abused than men - demographics of aging population and longer life expectancy of women - more widowed and become vulnerable
- men and women are reluctant to reveal abuse through embarrassment or shame
- women more accepting of abuse - "this is life and this is what marriage is and he's always been this way"
- women talk more easily about the frustration that causes them to abuse, when a trust relationship is established, they will talk and reveal "I get frustrated and I can't help it. I shout and I feel bad after" (reference made to video "Breaking Point" where the stressed caregiver finally asked "Why didn't anyone ask?")

#### **IS ELDER ABUSE REALLY A PROBLEM IN ONTARIO:**

- not specifically addressed but all dialogue focused around examples in day to day work as Primary Health Care Providers and the recognition that abuse of the elderly happens everywhere
- inability to provide appropriate and sufficient support services to prevent, intervene and respond to elder abuse causes immense frustration to health professionals, therefore elder abuse is a problem in Ontario

#### **PERCEPTIONS:**

##### **HOW DO YOU PERCEIVE OLDER PEOPLE?**

- entitled to have an holistic assessment of the situation including the help they get, the world in which they live, the culture in which they are a part and the support they need
- they are abused by the system - sent home without appropriate discharge planning
- the whole environment is hostile towards the elderly - physical abuse is one very obvious factor
- society is not responding well to the needs of the frail elderly - including informal caregivers, family members, health professionals, institutions and this will engender more abuse
- not listened to or being asked for opinion - some professionals, even with competent patients, will address questions to family member, rather than to elderly person many elderly feel they have lost control of their own lives – perception of others is that they are no longer capable of managing - e.g. finances, making decisions
- low self-esteem and perception that they do not have a right to say how they feel or make a decision about something (even in their own homes - daughter or son living with them - they defer to adult children's wishes)
- not willing to "rock the boat" - thus often preventing action from being taken
- when faced with obvious abuse, e.g. financial abuse by caregiver – elderly people usually do not want to take legal action - this again is extremely frustrating to the professional health providers - can only support them by listening, building up their self-esteem to the point where they can take control for themselves
- fearful about institutionalization
- health care providers work out care plan for elderly person on discharge from hospital, e.g. attend day care centres and help them have a sense of self – this disappears quickly when they return home to the same abusive environment

##### **IS AGEISM A FACTOR IN ELDER ABUSE:**

- yes
- perception that elderly people are not capable of making decisions for themselves results in loss of control for older persons
- some professionals also perceive elderly people as unable to answer questions and will talk to family rather than the older individual when gathering information
- frailty due to aging
- ageism as a factor is implied throughout discussion

##### **ARE THERE STRESSFUL OCCASIONS THAT CAN TRIGGER ELDER ABUSE:**

- holidays
- death of spouse or loved one leading to loneliness or isolation
- family visits by sibling(s) who live out of town - resentment towards the absent members - "they fly in and fly out and I do all the care"
- lack of family members at festive times - can lead to alcoholism, depression and possibly suicide

## **HOW DO YOU DEFINE ELDER ABUSE AS A HEALTH CARE ISSUE:**

- cutbacks in funding necessitate reduced service availability for seniors
- cutbacks are causing extreme frustration in health care providers who are unable to provide the services required for their clients
- early discharge from hospital requires increased community resources
- many elderly people are unable to pay for care privately and must be put on a waiting list for home care services
- doctors and other health care professionals require education about elder abuse - to aid in recognition of the problem, intervene and work to prevent it
- lack of education for health care providers about elder abuse

## **WHAT ARE THE CONSEQUENCES OF ELDER ABUSE?**

- physical abuse is obvious - in many cases the victim is taken to hospital and cared for
- some other instances of abuse are more subtle and require creativity to address, this takes time to build up trust
- it is important for people to be assessed for risk factors (whether abuse is evident or not) in order to put some interventions in place to prevent elder abuse reduced quality of life for older people
- mistrust
- isolation
- family conflicts
- more financial cost to society
- stress on emergency services, i.e. police, ambulance, crisis support and hospitals

## **SOLUTIONS - INTERVENTIONS - CHALLENGES**

### ***Solutions:***

- funding for increased services for the abused and the abuser to provide - more time available for clients
  - lighter case loads
  - training for professional health professionals
  - more support for the abused and the abuser - day care, support groups, etc.
- work to avoid duplication in services, e.g. no need for every agency to do complete assessment "analysis paralysis"
- keep updated on developments in elder abuse literature and other resources - education

### ***Interventions (Response):***

- coordinated team approach to respond to incidents
- need access to sites where trained people are available to help
- key to response is early detection, on-going surveillance and support and education - elder abuse more than just a medical diagnosis - look at whole picture
- professionals need to be willing to ask hard questions during assessment - "Do you ever lose your temper?" "Have you ever been abused by....?" Or of the caregiver "Have you ever done any action of which you are ashamed?"
- intervention must be client-directed for competent adults
- go with "gut" feeling and instincts - e.g. level of anxiety about particular case and potential for serious harm
- use community resources available

- keep contact with elderly person - don't accept first refusal of help, be there as a presence to support on an on-going basis make use of as many resources as possible when patient discharged, e.g. day care programs, friendly visitors, Meals on Wheels - the more contacts an elderly person has within or outside of home, the more likelihood of prevention of abuse

**Challenges:**

- raise awareness that elder abuse happens - in the home, in the community and in institutions
- to encourage elderly to talk about abuse
- to support the abuser, especially, the overburdened caregiver
- to remain non-judgmental - and not to place blame on anyone
- how to carry out interventions without sufficient funding
- how to avoid staff and caregiver burnout

**HOW WILL THE QUALITY OF LIFE FOR THE OLDER PERSON, FAMILY AND COMMUNITY BE ENHANCED BY ADDRESSING THE ISSUE OF ELDER ABUSE:**

- not specifically addressed but implied throughout that issue must be addressed on all levels
- reduction of frustration levels across the spectrum

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**SUMMARY OF FOCUS GROUPS:**

The participants in the eight groups were motivated to attend the sessions because of a strong desire to help seniors and to learn more about the issue of elder abuse. Most of the participants who attended (except for the primary health care providers) had little or no knowledge of elder abuse. Many were surprised at the initiatives and resources already developed to address the issue.

The length of the sessions was considered to be appropriate, but one group did feel they needed more time to adequately discuss the questions. Unfortunately time did not permit dialogue in the area of values and ethical differences which would have enriched the findings. There is a need to confront individual and group values and assumptions to answer such questions as "Who gets which services?" "Who makes decisions about services and resources for whom?" "Who should pay for services?"

Participants did verbalize the importance of looking at elder abuse in institutions and some had first or second hand knowledge of mistreatment in long-term care facilities. It was heartening to see the concern for youth – both as a group requiring our support and their roles in society as preventors of elder abuse. One participant stated that there should have been a focus group for youth. The participants also identified how vital volunteers are to any elder abuse strategy but the government must support their recruitment and training.

Lack of family and other support, geographic and social isolation (lack of transportation or inability to drive), changes in society and the family system, frailty, frustration when trying to get information regarding services (technology, automated voice response, etc.) the desire to stay independent and in their own homes, maintain good health and be



socially active, were all cited by groups as challenges for seniors. Over-medication and under-medication due to inability to pay extra for drugs not on the seniors' health plan were also mentioned. In addition, groups expressed concern over the lack of universal strategies to address elder abuse and of a local resource to provide assistance and information. Social services and support vary according to geographic location.

There was extreme concern over the cutbacks in health care, especially issues such as short hospital stays and returning the patient to the community without sufficient home care. The primary caregiver, as well as the patient, is often elderly and in need of support. Groups also concluded that caregiver stress could result in elder abuse. Participants expressed an interest in learning more about elder abuse and becoming involved in studies such as this and thus are not accessible to everyone.

***General Consensus from all Focus Groups:***

1. Adequate, available, and accessible long-term care services are essential.
2. Public awareness and professional education may have the greatest potential for preventing elder abuse. A public awareness campaign should include the voices of seniors allowing them to tell their own stories.
3. Information gathered from the experience and research of various cultures in characterizing and treating elder abuse is of immense value in advancing understanding and in stimulating ways to prevent the problem that will be applicable to all groups.
4. A closer partnership between the mental health system and the social service system is advocated given the high proportion of emotional problems and alcoholism/drug use in abusive families.
5. Building coalitions at the local and regional level is a powerful means for addressing the myriad of issues presented by elder abuse cases.
6. There is a need for a more positive view of aging to offset the negative bias that has been part of our social consciousness and the political agenda.

**ASSUMPTIONS:**

Following the eight focus groups, the following assumptions are presented:

- Competent older persons have the right to self-determination.
- No group is immune to elder abuse; the problem cuts across all social classes and all racial, ethnic, and religious groups.
- Most older people live independently, while others live happily and safely in the care of or in the homes of others; many Canadian families are heroic in the care they provide elderly relatives.
- Elder abuse is, in many instances, a result of the ageism prevalent in our society
- Elder abuse is part of the larger social problem of violence in contemporary Canadian life.

**CONCLUSIONS:**

## **RECCOMENDATIONS:**

### ***Education:***

- Health care providers, social service agencies, and criminal justice professionals should receive education and/or training in the detection, assessment, and treatment of elder abuse.
- Professional curriculum should include concepts of elder abuse and its prevention
- Education of children and youth
- Educational programs should be developed to increase public understanding of elder abuse.
- Community educational and outreach programs should be developed to help older people protect and take better care of themselves and to make use of community resources.
- Education programs should be developed to illustrate the potential for family violence throughout the life cycle and for the prevention of such violence.

### ***Research:***

- National studies should be carried out on the incidence, prevalence, dynamics and outcomes of elder abuse with both the community and institutions.
- Studies should be conducted to determine that effectiveness of programs to prevent, detect, treat, and control elder abuse.
- Items regarding elder abuse should be added to existing public health surveys.
- There should be a national elder abuse clearinghouse for coordinating research, training, and program development in the public and private sectors.

### ***Policy and Practice:***

- Services to elder abuse victims should include health care services, social services, legal, victim advocacy, emergency and long-term housing, and other services that help ensure the rights of older people to be independent and live free from abuse.
- Restorative justice is gaining as a strategy for resolving conflicts between family members as well as neighbors.

# APPENDIX A

## DEMOGRAPHICS:

Canada is the second largest national landmass in the world covering six time zones. It is a constitutional monarchy and a federal state with a democratic system of government. Canada has ten provinces and three territories, each with their own capital city. Canada's geography and climate are very diverse. It includes plains, mountains, lakes and rivers, wilderness, arctic tundra, and large urban areas.

Canada offers basic health care, with the exception of dental services, free at the point of delivery. It also has an extensive social security network, including an old age pension, a family allowance, unemployment insurance and welfare, which contribute greatly to a high quality of life for its citizens.

Canada currently has a population of 30.7 million with two thirds of that population residing in towns or cities. Over 3.8 million seniors are currently living in Canada, representing 12.5% of the total population. Canada is rich in culture with two official languages (English and French) and with 18% of the population being able to speak a language other than these as a result of a wide variety of ethnic origins. It also holds within it a wide variety of religious affiliations; although more than four-fifths of the country holds their faith in Christianity, other faith communities include Judaism, Islam, Hinduism, Sikhism and Buddhism. Families are, on average, 3.1 in size including 1.2 children.

Ontario, one of Canada's ten provinces, and is the most productive of these generating 40% of the country's entire gross domestic product. Ontario has several competitive edges including modern transportation services, natural resources, a large and well-educated labour force, reliable and inexpensive electrical power, and proximity to key U.S. markets. The northern climate is extreme, with transportation being limited to air and water. The southern portion of Ontario is composed of most of the population, industry, commerce and agricultural lands.

Ontario also contains Toronto, Ontario's capital and Canada's largest city with a regional population of more than 4.5 million. Toronto is Canada's leading producer of manufactured goods and is widely multicultural. Automobile manufacturing, mining, financial industries, and tourism are the province's largest industries. Within Ontario, more than 100 languages and dialects are spoken by a total of 11 million people. Moreover, Toronto, as cited by the UN, is one of the world's most multicultural cities with only one half of its residents being foreign born. Ontario also resides 141,000 people of Aboriginal, Métis, or Inuit origin. There is a total of 1.5 million older persons residing within Ontario.

The prevalence rate of elder abuse in Canada is 4% of older adults living in the community. This translates to one in twenty-five persons having experienced some form of abuse or neglect. Financial abuse is reported most frequently, followed by psychological abuse, physical abuse and neglect (Podnieks, 1990).

## ETHICS REVIEW:

### *Informed Consent:*

**Ryerson University was responsible for the data collection and analysis for this pilot project. This project was reviewed by the Ryerson University Research Board**

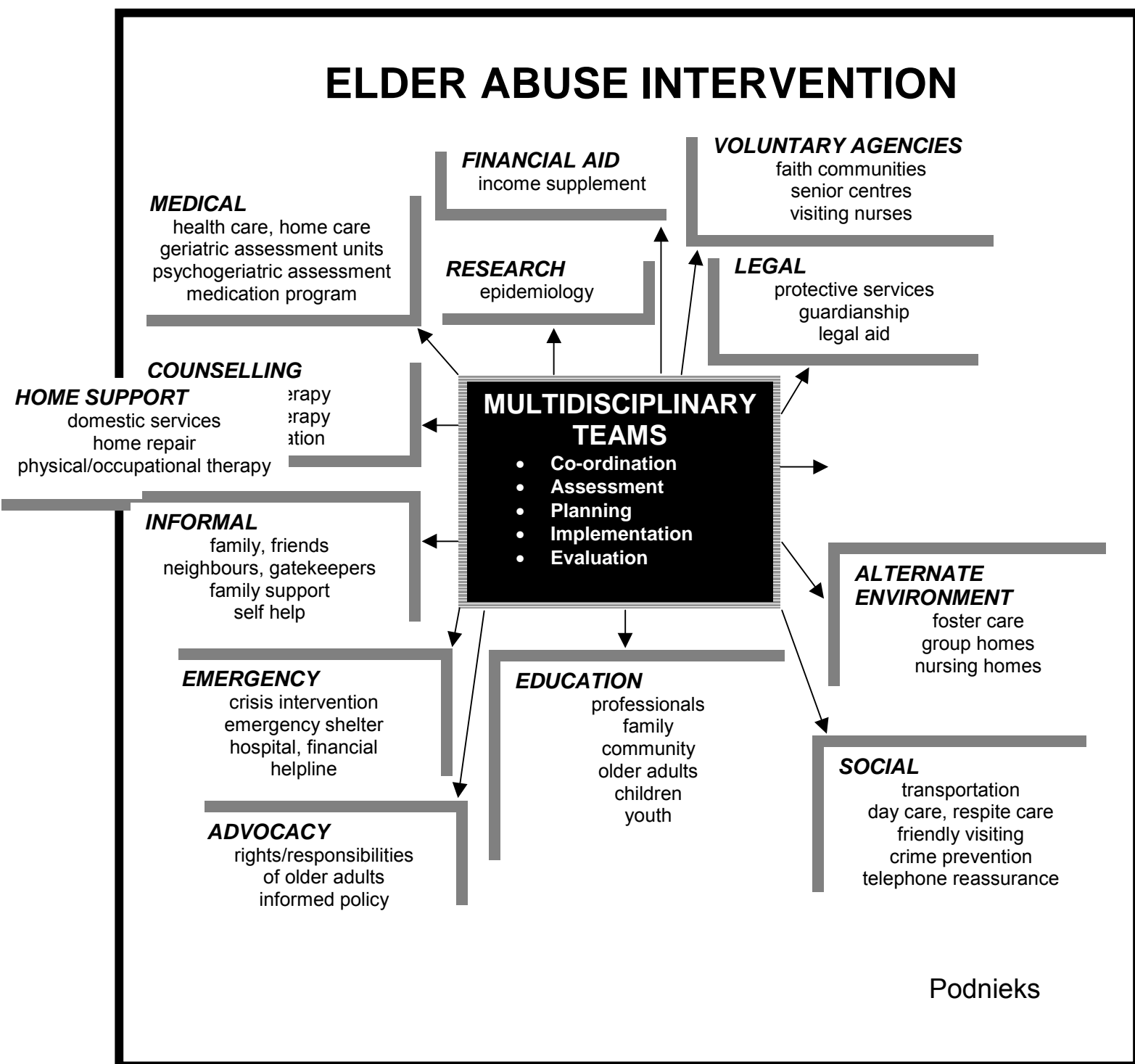
**of Ethics. Professionals referred all of the participants in this study. The initial introduction alerts the participants to the subject matter and lets them know clearly that they need not participate. Since no pressure was exerted on any person to participate, those who might fear the sensitive nature of the material could select themselves out of the group. The facilitators had special training that would help them to respond sensitively to any reaction on the part of the participants, and had available a list of resources and contact persons should the participants seek help. Written consent was obtained from the focus group members. The province of Ontario, Canada has no mandatory reporting legislation for elder abuse. This study strictly adhered to the “confidentiality of data” clause identified in the consent form. The legal policy regarding disclosure of past or potential illegal activities is that absolutely no information will be revealed under any circumstances throughout the duration of this study. Participants were advised that the focus group discussion would be tape recorded to assist in transcribing notes. (Please see copies of consent forms.)**

#### **SUNNYBROOK REGIONAL GERIATRIC PROGRAM:**

The Network is composed of health professionals working in the specialized geriatric services of the Regional Geriatric Program with an interest in elder abuse. The Director of the Regional Geriatric Program chairs this group.

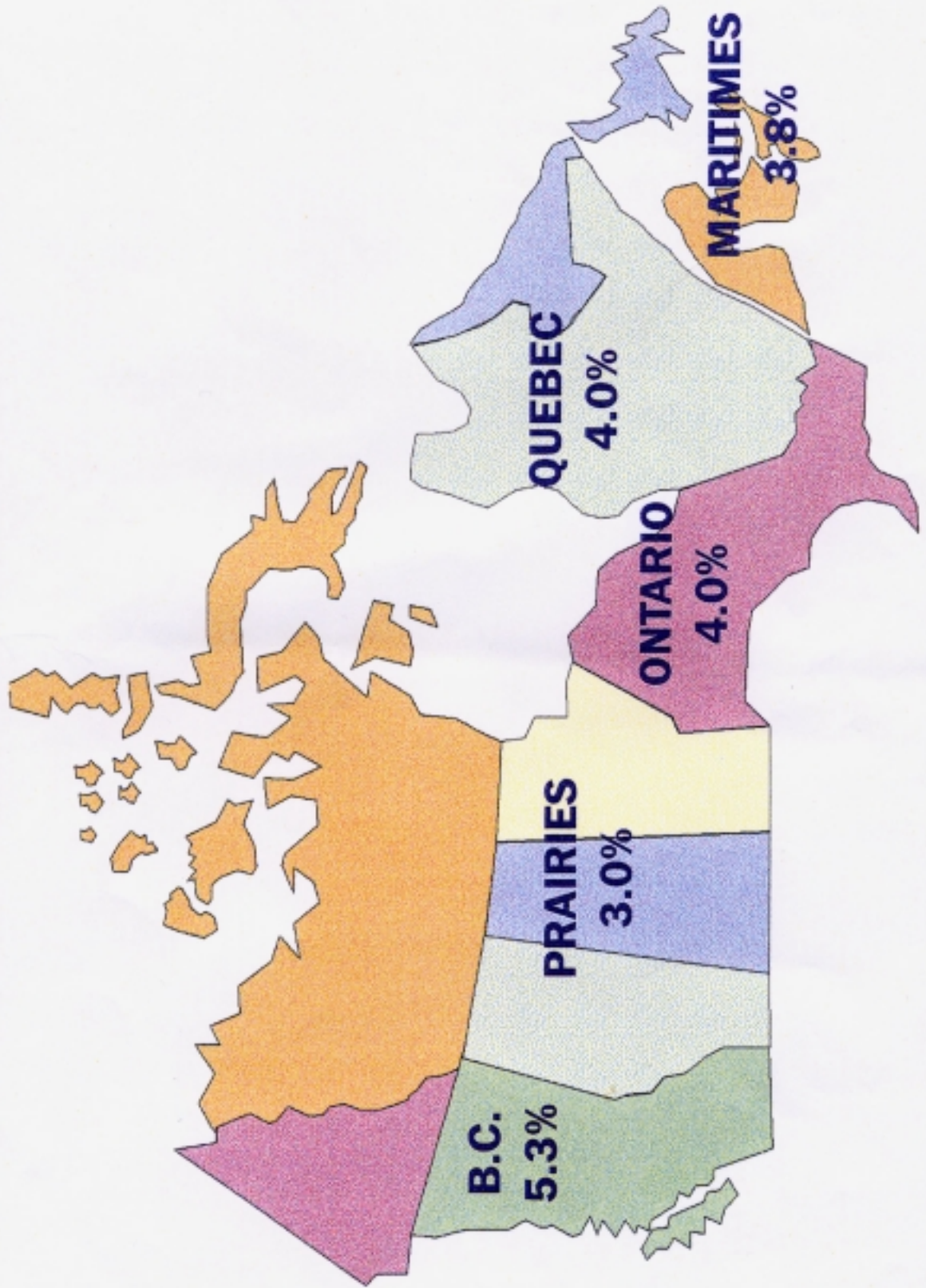
The objective of the Network is to ensure that all the clinicians working with the Specialized Geriatric Services, Regional Geriatric Program have the necessary knowledge and skills to detect and manage elder abuse. The group has reviewed the literature and existing protocols and tools related to elder abuse. A bibliography has been put together. A pilot project was designed with workshops for front line staff consisting of four modules. These modules addressed the definitions of abuse, types, prevalence and profiles of victims and abuses. Strategies for dealing with elder abuse were identified. The sessions were designed to be interactive and used both videos and case studies. The pilot project was tested at three geriatric services sites with four half day sessions at each. The results were evaluated and the intervention was very well received. Based on this experience the workshop will now be compressed to two sessions, and then offered to all the 21 participating organizations of the Regional Geriatric Program of Toronto. “A Build-A-Case” approach will be incorporated. The use of this concept allows the participants to build-a-case based on their own experience rather than being presented with a predetermined case. Plans will be made also for a videoconferencing format so that the workshops may be available to northern Ontario and other rural areas.

## ELDER ABUSE INTERVENTION MODEL:



MAP OF CANADA:

# Prevalence Rates of Elder Abuse in Canada



Podnieks, E. and Pillemmer K. National Survey on Abuse of the Elderly in Canada, (1990)



# Model for Education: Prevention of elder abuse

## OBJECTIVES

- to prevent elder abuse
- health promotion: wellness, quality of life
- to generate national attention to problem of elder abuse



## STRATEGIES

- curriculum development
- distance education
- workshops
- conferences
- training manuals
- teleconferences
- virtual network
- newsletters
- journal articles
- public awareness
- information referral
- culturally sensitive
- educational materials



## KEY PLAYERS

- ~primary, secondary & post-secondary schools
- ~universities/colleges
- ~seniors organizations
- ~voluntary sector
- ~gerontology network
- ~media
- ~churches/synagogues
- ~family violence prevention
- ~ethnic communities
- ~federal & provincial governments

**FOCUS GROUPS Facilitators:**

Location: Ryerson, L.I.F.E. Institute - Toronto  
Facilitator(s): Dr. Elizabeth Podnieks, Prof. Jane Mears  
Group: Older Men and Women

Location: 22 Rocky Road, Bobcaygeon, Ontario  
Facilitator(s): Stella Dean-Crisp, Alfred R. Crisp  
Group: Older Men

Location: 22 Rocky Road, Bobcaygeon, Ontario  
Facilitator(s): Stella Dean-Crisp, Alfred R. Crisp  
Group: Older Men and Women

Location: Ontario Network for the Prevention of Elder Abuse (Older Women's Network) - Toronto  
Facilitator(s): Dr. Elizabeth Podnieks, Prof. Jane Mears  
Group: Older Women

Location: Alzheimer Society of Haldimand-Norfolk  
Facilitator(s): Derek Bishop  
Group: Older Women

Location: Dixon Hall, Seniors' Residence - Toronto  
Facilitator(s): Dr. Elizabeth Podnieks  
Group: Older Men

Location: Family Services Association - Toronto  
Facilitator(s): Dr. Lisa Manuel  
Group: Primary Health Care Providers

Location: Sunnybrook Health Sciences Centre (Regional Geriatric Program) - Toronto  
Facilitator(s): Dr. Elizabeth Podnieks  
Group: Primary Health Care Providers

**ACKNOWLEDGEMENTS:*****Sincere appreciation is expressed to the following:*****Individuals:**

Derek Bishop, Chairman, Community Response Network of Haldimand-Norfolk, Simcoe, Ontario  
Alfred R. Crisp, Computer Consultant and Senior Elder Abuse Volunteer, Dean Crisp Associates, Bobcaygeon, Ontario  
Stella Dean-Crisp, Elder Abuse Consultant, Dean Crisp Associates, Bobcaygeon, Ontario  
Dr. Rory H. Fisher, Director of Regional Geriatric Program, Sunnybrook Hospital Health Sciences Centre, Toronto, Ontario  
Kit Julian, Executive Director, Alzheimer Society of Haldimand-Norfolk, Simcoe, Ontario  
Sandra Kerr, Continuing Education, Ryerson University, Toronto, Ontario  
Heather Lush, Research Assistant, Ryerson University Research Assistant, Toronto, Ontario  
Dr. Lisa Manuel, Social Worker, Family Services Association of Toronto, Toronto, Ontario  
Jeanne McLaws, Education Officer, Alzheimer Society of Haldimand-Norfolk, Simcoe, Ontario  
Jane Mears, Professor, University of Western Sydney, Australia  
Cara Mirabelli, Volunteer, Family Services Association of Toronto, Toronto, Ontario  
Linda Nightingale, Continuing Education, Ryerson University, Toronto, Ontario



Joanne Preston, Community Response Network of Haldimand-Norfolk, Simcoe, Ontario  
Leticia Ramirez-Arana, Dixon Hall Seniors' Residence, Toronto, Ontario  
Dorothy Rivers-Moore, Chair, Older Women's Network, Toronto, Ontario  
Roberta Scarlett, Senior Elder Abuse Volunteer, Dean Crisp Associates, Bobcaygeon, Ontario  
Beth Waldburger, Community Care Access Centre – Toronto, Toronto, Ontario

**Agencies:**

Alzheimer Society of Haldimand-Norfolk, Simcoe, Ontario, Canada  
Community Response Network of Haldimand-Norfolk, Simcoe, Ontario Canada  
Dixon Hall Seniors' Residence, Toronto, Ontario, Canada  
Elder Abuse Prevention and Education Association, Bobcaygeon, Ontario, Canada  
Family Services Association of Toronto, Toronto, Ontario, Canada  
L.I.F.E. Institute, Ryerson University, Toronto, Ontario, Canada  
Older Women's Network, Toronto, Ontario, Canada  
Ontario Network for the Prevention of Elder Abuse, Toronto, Ontario, Canada  
Sunnybrook Regional Geriatric Program, Toronto, Ontario, Canada

# APPENDIX B



## **INTERNATIONAL NETWORK for the PREVENTION OF ELDER ABUSE**

### CHAIR

Lia Daichman, MD  
Buenos Aires  
Argentina  
E: [lsdiachman@intramed.net.ar](mailto:lsdiachman@intramed.net.ar)

### VICE-CHAIR

Elizabeth Podnieks, EdD  
Toronto, Ontario  
Canada  
E: [onpea.info@utoronto.ca](mailto:onpea.info@utoronto.ca)

### SECRETARY

Gerry Bennett, MD  
London  
United Kingdom  
E: [gerry.bennett@thht.org](mailto:gerry.bennett@thht.org)

### TREASURER

Glenda G Callanen, MS  
Los Angeles, CA  
United States of America  
E: [gccallanen@aol.com](mailto:gccallanen@aol.com)

### SPECIAL OBSERVER

Alexandre Kalache, MD, PhD  
WHO, Geneva  
Switzerland  
E: [kalachea@who.ch](mailto:kalachea@who.ch)

### REPRESENTATIVES:

#### Europe

Bridget Penhale, MSW  
Hull  
United Kingdom  
E: [B.L.penhale@hull.ac.uk](mailto:B.L.penhale@hull.ac.uk)

#### North America

Susan Aziz, MA  
Santa Monica, CA  
United States of America  
E: [saziz@wiseseniorservices.org](mailto:saziz@wiseseniorservices.org)

#### Latin America

Laura Machado, MA  
Rio de Janeiro  
Brazil  
E: [lmachado@attglobal.net](mailto:lmachado@attglobal.net)

#### Oceania

Susan Kurrle, MD  
Hornsby, NSW  
Australia  
E: [kurrle@bigpond.com](mailto:kurrle@bigpond.com)

#### Africa

TBA

#### Asia

Toshio Tatara, PhD  
Chiba  
Japan  
E: [ttatara@med.tokai-u.ac.jp](mailto:ttatara@med.tokai-u.ac.jp)

July 31, 2001

Dear Health Care Provider,

I am writing to request your involvement in a WHO/INPEA study on elder abuse. WHO has added elder abuse to its mandate and we celebrate this plan of action.

The project is called "Global Response Against Elder Abuse." This research aims to raise the awareness among health professionals and the public at large on the extent of the elder abuse problem worldwide. It will also lead to the development of a strategy for the prevention of elder abuse within the context of primary health care. This study will identify and define indicators of abuse and neglect of older persons. This information will be used by primary health care workers in such a way as to ultimately enable them to prevent and/or act on it. Moreover, this study will devise a plan of action for 2002-2003 and beyond. The countries involved are Argentina, Brazil, Canada, India, Kenya, Lebanon, Austria and Sweden.

Partners for this research project include the World Health Organization (WHO) and the International Network for the Prevention of Elder Abuse (INPEA). Ryerson University is responsible for Canadian data collection.

**This research will prepare a background paper with current knowledge on the issue, highlighting the scope of the problem. Focus groups will be organized as a tool for assessing perceptions on elder abuse among older persons and primary health care workers. The intention is to gather opinions to better define what is elder abuse. We will explore people's knowledge, experience, and understanding of elder abuse.**

I would like to invite you to organize a focus group. There will be 8 focus groups in each country – 6 groups of older people and 2 groups of primary health care workers. This is broken down to: 2 groups of older women; 2 groups of older men; 2 groups of older men and women together; and 2 groups of health care workers (men and women). There should be 6-9 people in a group. The up to 2-hour session must be tape recorded and transcribed. The project needs to be completed by September 12, 2001. If you think there is any possibility of your organization being involved I will send you further details. Thank you for considering this request and I look forward to hearing from you.

Sincerely,

Elizabeth Podnieks  
Vice-Chair, INPEA  
Professor, Ryerson University

Dr. Lia Daichman, Arenales 1391 80 "B" (1061), Buenos Aires, Argentina  
Tel./Fax: (54-11) 4811-9590 Email: [lsdiachman@intramed.net.ar](mailto:lsdiachman@intramed.net.ar)

Dr. Gerry Bennett, INPEA Secretary, Academic Office, 1<sup>st</sup> Floor, Alderney Building,  
Mile End Hospital, Brompton Road, London E1 4DG, UK  
Tel: +44 (0) 20 7377 7894 Fax: +44 (0) 20 8981 5133 Email: [gerry.bennett@thht.org](mailto:gerry.bennett@thht.org)

WHO/INPEA GLOBAL RESPONSE AGAINST ELDER ABUSE  
REPORT FROM CANADA

Web site: <http://www.inpea.net>

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# World Health Organization (WHO) & International Network for the Prevention of Elder Abuse (INPEA)

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**RYERSON**  
SCHOOL OF NURSING

## **GLOBAL RESPONSE AGAINST ELDER ABUSE**

Dear Colleague,

**This is a letter of introduction to a study that is taking place now in the province of Ontario. We wish to inform you of the existence of the project and to keep you abreast of the developments and outcomes in order to facilitate a link between your organization and this global undertaking. It is our hope that this link will establish an opportunity to be of some assistance to you and to the older population in your community as you address the issue of elder abuse and neglect.**

**The research aims to raise the awareness among health professionals and the public at large on the extent of the elder abuse problem worldwide. It will also lead to the development of a strategy for the prevention of elder abuse within the context of primary health care. The study will identify and define indicators of abuse and neglect of older persons. This information will be used by primary health care workers in such a way as to ultimately enable them to prevent and/or act on it. Moreover, this study will devise a plan of action for 2002-2003 and beyond. A background paper with current knowledge on the issue, highlighting the scope of the problem will be prepared.**

**Partners for this research project include the World Health Organization (WHO) and the International Network for the Prevention of Elder Abuse (INPEA). Ryerson University is responsible for Canadian data collection.**

**Focus groups will be organized as a tool for assessing perceptions on elder abuse among older persons and primary health care workers. The intention is to gather opinions to better define what is elder abuse. We will explore people's knowledge, experience and understanding of the issue. A researcher from Ryerson University will be contacting you to ask if you would participate in this pilot study by conducting a focus group.**

Your participation is completely voluntary and you can withdraw from the study at any time. The researchers will do everything in their power to ensure that all information obtained from focus group interviews will be kept strictly confidential. However, the researchers cannot guarantee that all members of the group will keep information disclosed in the interviews confidential. All findings from the study will be reported in an aggregate form, such that no individual or organization can be identified. The focus groups will be tape-recorded. The tapes will be destroyed and the transcripts will be incorporated into the final report. This project has received ethics approval from Ryerson University. Your participation will benefit the goals and objectives of WHO and INPEA. Your organization will be acknowledged in the final report and you will receive a copy.

We wish to thank you in advance for considering this request. We feel it crucial that we all work together to help the victims of elder abuse and their families regionally, nationally and internationally

Thank you again.  
Please contact: Dr. Elizabeth Podnieks  
Vice-Chair, INPEA  
Professor, Ryerson University  
Phone/Fax: 416-925-7674 Email: [onpea.info@utoronto.ca](mailto:onpea.info@utoronto.ca)

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# World Health Organization (WHO) & International Network for the Prevention of Elder Abuse (INPEA)

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## **FOCUS GROUP GUIDELINES**

**A guideline for assessing perceptions on elder abuse  
among older people and primary health care workers**

Adapted from an article by Silvia Perel Levin  
WHO

### *WHY FOCUS GROUPS*

Focus groups are intended to gain insight into the views of older people and their primary care providers about elder abuse. The goal is to gather opinions about the problems of elder abuse in a context-specific manner. Previous understanding of the ethnic, cultural, religious, socio-economic background of the participants in the group will help to interpret the differences between countries. A major advantage of the focus group is that information is expressed in the participants' own words and context without having constrained categories.

Focus groups do not discriminate against people who cannot read or write and they can encourage participation from people reluctant to be interviewed on their own. Thus, instead of the researcher asking each person to respond to a question in turn, people are encouraged to talk to one another: asking questions, exchanging anecdotes and commenting on each others' experiences and points of view. People do not form opinions in isolation. They need to listen to others in order to adopt a personal viewpoint. Focus groups on elder abuse are especially relevant because it is an issue that is not largely recognized or openly discussed.

Participants can provide mutual support in expressing feelings that are common to their group but which they consider to deviate from mainstream culture (or the assumed culture of the researcher). This is particularly important when researching stigmatized or taboo experiences such as bereavement, sexual violence or abuse perpetrated by a family member or a person in a position of trust.

### *RUNNING THE GROUP*

Focus group sessions should not take more than 2 hours. Sessions will be tape recorded and transcribed. A recorder will note body language and other non-verbal communication. It may be useful to involve the group in writing key issues on a flip chart.

Although a number of questions have been prepared as a guideline for discussion, the facilitator will encourage the group to explore issues of concern to them. For this reason, it is likely that each group's discussion will develop in different ways, focusing on various issues and concerns. New information, or a question re-phrased within the group, allows the facilitator to observe when opinions shift and under what influences and circumstances.

Members of the focus group may share stories that illuminate their perceptions about the mistreatment of older adults within the home or community. The facilitator can then assist group members identify indicators and risk factors inherent in the situation and together they can explore intervention options.

### **PRINCIPLES OF GROUP INTERACTION**

1. Every participant in a group is responsible for the outcome of the group interaction.
2. Focus group facilitators promote equity and respect for differences by ensuring that all participants have an opportunity to speak.
3. Group solutions and insights profit from heterogeneity of input.
4. When people feel psychologically "safe" in a group, their participation will increase.
5. As trust levels increase, participation becomes more broadly distributed in the group. As personal knowledge and contact with each other increases, the trust level improves.
6. Attention to non-verbal cues is just as important as attention to verbal cues. People give each other feedback in a variety of ways.
7. People bring to any group their personalities, their previous experiences, their physical and emotional strengths and problems, and what happened to the group, etc. These affect interaction and participation levels.
8. All groups need a sense of closure at the end of their time together. Termination rituals are important for the continuity and satisfaction of the group.

*(Mancini Billson, J., 1995)*

### **BENCHMARKS OF AN EFFECTIVE GROUP**

An effective group ...

1. Has a clear understanding of its purpose and goals.
2. Is flexible in selecting its procedures and it works toward its goals.
3. Has achieved a high degree of communication and understanding among its members. Communication of personal feelings and attitudes, as well as ideas, occur in a direct and open fashion because they are considered important to the work of the group.
4. Has a high degree of cohesiveness (attractiveness to the members) but not to the point of stifling freedom.
5. Makes intelligent use of the different capabilities of its members.

6. Is not dominated by its leader or by any of its members.

*(Mancini Billson, J., 1995)*

#### IMPORTANT GUIDELINES!

The facilitator needs to analyze the outcomes from the focus group. The following framework is suggested:

- Themes – common points that reoccur
- stories – up to five case vignettes which exemplify a theme or issue
- soundbites/snapshots – words or phrases that give readers the “core” of the problem

There are many other aspects of qualitative analysis that groups may also include. When conducting the focus group sessions it is important not only to use the outlines included here, but to remember that after the warm-up period and the central time when the core of the work has been done to use the wrap-up period to prioritize the points being made.

**PLEASE RECORD THE FOLLOWING INFORMATION:**

1. Date: \_\_\_\_\_
2. Identification code for tape:  
\_\_\_\_\_
3. Sex: M / F
4. Location: High density / Low density
5. Marital status:        Married        Single        Widow
6. Type of group:        Primary Healthcare        Older People
7. Access to health services: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
8. Number of participants: \_\_\_\_\_
9. Country: Ontario – Canada \_\_\_\_\_
10. Country of Origin: \_\_\_\_\_

# CASE STUDIES

## CASE ONE: "Caregiver Stress"

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Mrs. W is a 67 year-old woman who attends a family support group sponsored by the Alzheimer Society. She and her husband have been married for 41 years. He was diagnosed with Alzheimer disease four years ago. At a recent meeting Mrs. W shook her fist in the air in frustration: "He's so stupid. He keeps repeating the same thing. I have diabetes and I have had four heart attacks – I can't take much more of this. He doesn't even know where the bathroom is. He makes me so angry that I yell at him and he hits me. If this continues, I'm going to hit him back." She acknowledges that this behaviour is not deliberate. However, she feels that she has reached the breaking point and could retaliate with abusive actions.

Mrs. W feels misunderstood by family and friends who don't appreciate the full extent of her husband's problems. She refuses respite services. When encouraged to take a break for the sake of her own health she says, "Where would I go? We played cards with our friends for 35 years, now I should go by myself?" Mrs. W's confrontative behaviour escalates her husband's aggression.

Discussion points:

1. What strategies would you use to intervene in this relationship problem?
2. What type of community resource would be most helpful to this couple?
3. What preventative approaches might have helped this situation earlier on?
4. What would give you cause for concern in this case?

## CASE TWO: "Investigating Financial Abuse"

---

Mrs. B is a year old widow. She lives on her pension and a small savings account in her own home. Shortly after her husband's death, Mrs. B's son has problems in his marriage which he told his mother were caused by his financial difficulties. To help him, Mrs. B lent him \$5,000 on several different occasions. The son never repaid these loans and he and his wife divorced. Subsequently his money problems got worse and he wanted to borrow again from his mother. Mrs. B could not give him any more but she agreed to co-sign a bank loan. She thought the loan was for \$10,000 but later found out it was for \$20,000. The son soon left town and stopped making loan payments. The bank came after Mrs. B because she was unable to keep up with the payments. The bank told her that her house would be repossessed to cover the loan.

Discussion points:

1. Should Mrs. B have loaned money to her son?
2. What can Mrs. B do now?
3. Comment on these statements:
  - "It was a gift"
  - "She owed me the money"



- “He told me I could borrow it”
- “I was going to give it back”
- “I am going to get it when she dies anyway”

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## World Health Organization (WHO) & International Network for the Prevention of Elder Abuse (INPEA)

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### FOCUS GROUP CONSENT FORM

**Research Project Title:** *Global Response against Elder Abuse*  
**Principle Investigator:** *Dr. Elizabeth Podnieks*

I understand that WHO/INPEA are conducting a study to examine the issue of elder abuse and how it may affect elderly individuals.

I further understand that I will attend and participate in a two-hour focus group with 6 to 9 other participants to discuss my perceptions about elder abuse. I understand that Ryerson University is responsible for gathering data from Canada and that this research has the approval of the Ryerson University Research Ethics Board. I understand that the focus group meetings will be tape-recorded. I understand that I can refuse to answer any questions I am asked and may leave the group at any time.

Any questions about the study have been answered to my satisfaction. I also understand the benefits of participating in the study, that is, my responses, will help WHO/INPEA to develop a strategy to enable them to detect, prevent and take action against elder abuse. I understand that I may now, or in the future, ask any questions that I have about the study. I have been assured that no information will be released or printed that would disclose my personal identity and that my responses will remain confidential. Tapes will be destroyed and transcripts will be incorporated into the final report. I also acknowledge that the researchers cannot guarantee that all involved participants will keep information disclosed in the group discussion confidential.

I understand that my participation in the study is completely voluntary. I further understand that I may withdraw my participation from this group at any time without explanation. If I have any questions about my rights as a research study participant, I will contact the Ryerson University Research Ethics Board.

I hereby consent to participate in the study.

\_\_\_\_\_  
Signature of Participant

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

For more information please contact  
*Dr. Elizabeth Podnieks (Ryerson University) at (416) 925-7674*  
Email: [onpea.info@utoronto.ca](mailto:onpea.info@utoronto.ca)

---

## World Health Organization (WHO) & International Network for the Prevention of Elder Abuse (INPEA)

---

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**SCHOOL OF NURSING**

### FOCUS GROUP OUTLINE

#### 1. INTRODUCTION:

- Welcome
- Why we are here – WHO/INPEA Project Goals:
  - I. To obtain a worldview understanding of elder abuse and neglect.
  - II. To develop materials and services to assist older people experiencing abuse.
- Who we are – individual introductions

#### 2. OVERVIEW OF ELDER ABUSE:

- DEFINITION of elder abuse
- CATEGORIES of elder abuse
- CAUSES of elder abuse
- INDICATORS of elder abuse
- RISK FACTORS for elder abuse
- PREVALENCE of elder abuse

#### 3. PERCEPTIONS/CONTEXT:

- When should you or others intervene?
- What are the consequences of elder abuse? (Older people, families, community)

#### 4. SOLUTIONS – INTERVENTIONS – CHALLENGES:

- Identify existing/needed health and social services and community support in relation to elder abuse.

*THANK YOU FOR COMING AND SHARING YOUR VALUABLE INSIGHTS!*

---

## World Health Organization (WHO) & International Network for the Prevention of Elder Abuse (INPEA)

---

**RYERSON**

**SCHOOL OF NURSING**

### **FOCUS GROUP AGENDA**

2 HOUR SESSION

<b>1. INTRODUCTION: 20 minutes</b>
------------------------------------

- Welcome
- Why we are here – WHO/INPEA Project Goals:
  - III. To obtain a worldview understanding of elder abuse and neglect.
  - IV. To develop materials and services to assist older people experiencing abuse.
- Who we are – individual introductions

<b>2. BREAK: 15 minutes</b>
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- Refreshments

<b>3. OVERVIEW OF ELDER ABUSE: 35 minutes</b>
---

- DEFINITION of elder abuse
- CATEGORIES of elder abuse
- CAUSES of elder abuse
- INDICATORS of elder abuse
- RISK FACTORS for elder abuse
- PREVALENCE of elder abuse

<b>4. PERCEPTIONS/CONTEXT: 30 minutes</b>
---

- When should you or others intervene?
- What are the consequences of elder abuse? (Older people, families, community)

## 5. SOLUTIONS – INTERVENTIONS – CHALLENGES: 20 minutes

- Identify existing/needed health and social services and community support in relation to elder abuse.

*THANK YOU FOR COMING AND SHARING YOUR VALUABLE INSIGHTS!*

**WORLD HEALTH ORGANIZATION (WHO)**

**& International Network for the  
Prevention of Elder Abuse (INPEA)**

**RYERSON**

**SCHOOL OF NURSING**

## **FOCUS GROUP QUESTIONS**

### **INTRODUCTION AND WARM-UP:**

- Welcome
- Why we are here – WHO/INPEA Project Goals:
  - V. To obtain a worldview understanding of elder abuse and neglect.
  - VI. To develop materials and services to assist older people experiencing abuse.
- Who we are – individual introductions
- What motivated you to come to the group (e.g.: concern for older people)
- Based on your knowledge and experiences, what are some of the challenges facing older people today?

### **OVERVIEW OF ELDER ABUSE:**

**Could use a vignette or short case study in this section – please see attached**

#### **DEFINITION:**

What does the term **elder abuse** mean to you?

Is it acceptable in some situations?

#### **CATEGORIES:**

What kinds of elder abuse occur?

#### **CAUSES:**

Why do you think it happens?

#### **INDICATORS:**

What would you notice about a person who may be being abused?

#### **RISK FACTORS:**

What are some of the factors that place an elderly person at risk for abuse and neglect?

Do you see any difference between risk factors for men and women as they age?

#### **PREVALENCE:**

Is elder abuse really a problem in Ontario?

### **PERCEPTIONS/CONTEXT:**

- How do you perceive older people?
- Is ageism a factor in elder abuse?
- Are there stressful occasions that can trigger elder abuse? e.g.: religious holidays
- How do you define elder abuse as a health care issue?
- When should you or others intervene?
- What are the consequences of elder abuse? (Older people, families, community)

<b>SOLUTIONS – INTERVENTIONS – CHALLENGES:</b>
--

- Identify existing/needed health and social services and community support in relation to elder abuse.
- Define the gaps, the needs and views for future response to abuse, care, and prevention.
- When the problem of elder abuse has been addressed, how will the quality of life for the older person, family and community be enhanced?

*THANK YOU FOR COMING AND SHARING YOUR VALUABLE INSIGHTS!*



## INTERNATIONAL NETWORK for the

Lia Daichman, MD  
Buenos Aires  
Argentina  
E: [lsdaichman@intramed.net.ar](mailto:lsdaichman@intramed.net.ar)

### VICE-CHAIR

Elizabeth Podnieks, EdD  
Toronto, Ontario  
Canada  
E: [onpea.info@utoronto.ca](mailto:onpea.info@utoronto.ca)

### SECRETARY

Gerry Bennett, MD  
London  
United Kingdom  
E: [gerry.bennett@thht.org](mailto:gerry.bennett@thht.org)

### TREASURER

Glenda G Callanen, MS  
Los Angeles, CA  
United States of America  
E: [gccallanen@aol.com](mailto:gccallanen@aol.com)

### SPECIAL OBSERVER

Alexandre Kalache, MD, PhD  
WHO, Geneva  
Switzerland  
E: [kalachea@who.ch](mailto:kalachea@who.ch)

### REPRESENTATIVES:

#### Europe

Bridget Penhale, MSW  
Hull  
United Kingdom  
E: [B.L.penhale@hull.ac.uk](mailto:B.L.penhale@hull.ac.uk)

#### North America

Susan Aziz, MA  
Santa Monica, CA  
United States of America  
E: [saziz@wiseseniorservices.org](mailto:saziz@wiseseniorservices.org)

#### Latin America

Laura Machado, MA  
Rio de Janeiro  
Brazil  
E: [lmachado@attglobal.net](mailto:lmachado@attglobal.net)

#### Oceania

Susan Kurrle, MD  
Hornsby, NSW  
Australia  
E: [kurrle@bigpond.com](mailto:kurrle@bigpond.com)

#### Africa

TBA

#### Asia

Toshio Tatara, PhD  
Chiba  
Japan  
E: [ttatara@biege.ocn.ne.jp](mailto:ttatara@biege.ocn.ne.jp)

September 27, 2001

Dear NAME,

I am writing this letter to thank and acknowledge yourself, the Alzheimer Society of Halimand-Norfolk, and your focus group participants for their generous involvement in the study "WHO/INPEA: A Global Response Against Elder Abuse." We are very excited about the impact that this data will have, which we are currently collecting for this collaborative project between the International Network for the Prevention of Elder Abuse (INPEA) and the World Health Organization (WHO). Your active involvement in the study has allowed us to gain insight into the perceptions that older adults have surrounding elder abuse.

The overall goals of this study are to raise awareness of, and respond to, elder abuse within a safe, supportive and intergenerational context across the world. The data collected by this project will inform the development of materials and resources for use by older adults, youth and primary health care workers, as well as offer direction to researchers and policy makers as to the impact that elder abuse has within our societies.

We anticipate that the needs of seniors will be positively impacted by the findings of this study. We will certainly update you on an ongoing basis as the study progresses and as materials/resources are developed.

Once again, thank you for your participation, enthusiasm and commitment to improving the quality of life for older adults.

Sincerely,

Elizabeth Podnieks  
Vice-Chair, INPEA  
Professor, Ryerson University

Dr. Lia Daichman, Arenales 1391 8<sup>o</sup> "B" (1061), Buenos Aires, Argentina  
Tel./Fax: (54-11) 4811-9590 Email: [lsdaichman@intramed.net.ar](mailto:lsdaichman@intramed.net.ar)

Dr. Gerry Bennett, INPEA Secretary, Academic Office, 1<sup>st</sup> Floor, Alderney Building,  
Mile End Hospital, Bancroft Road, London E1 4DG, UK  
Tel.: +44 (0) 20 7377 7894 Fax: +44 (0) 20 8981 5133 Email: [gerry.bennett@thht.org](mailto:gerry.bennett@thht.org)

Web site: <http://www.inpea.net>

