



# **Elder Abuse Network Training Manual**

**2005**

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## Acknowledgement

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# ONTARIO'S STRATEGY TO COMBAT ELDER ABUSE

## **Ontario's Strategy to Combat Elder Abuse**

Building on its longstanding commitment to seniors and community safety, the Ontario government launched its \$4.3 million Strategy to Combat Elder Abuse in March 2002. The strategy was developed with advice from the private and public sectors through the Round Table on Elder Abuse. It reflects the government's vision of an Ontario where all seniors can live with dignity and free from harm.

The Ontario Network for the Prevention of Elder Abuse (ONPEA) is partnering with the Ontario Seniors' Secretariat, the Ministry of Citizenship and Immigration and the Ministry of the Attorney General to implement the strategy. Key elements of the five-year plan include co-ordinated community services, training for front-line staff and public education to raise awareness of elder abuse.

## **Co-ordinated community services**

The newly hired regional elder abuse consultants will be key resources for communities across the province supporting their efforts to combat elder abuse. They will also support local elder abuse committees, strengthen partnerships between these committees and promote information sharing among professionals working with abused seniors. They will develop model protocols on issues such as information sharing among service providers working with abused seniors.

## **Training for front-line staff**

The training and public education developer will create training resources for front-line staff from various sectors, including banking, healthcare and retailing, who work directly with seniors so that they can recognize and respond to elder abuse. An annual conference will bring together seniors, service providers and criminal justice staff to focus on collaborative strategies to support abused seniors and those at risk of abuse. The first annual conference on elder abuse was held in November 2002 and was attended by more than 460 participants from 12 countries and eight provinces.

## **Public education campaign**

A province-wide multi-media public education campaign will promote awareness about elder abuse and provide information on how to access support services.

## **Facts about elder abuse**

A recent Statistics Canada study (Family Violence: A Statistical Profile 2000) reports that:

- 68% of seniors who reported they were physically abused reported that they were assaulted by a family member;
- When family members were reported as the abuser, it was most often adult children (42%) or spouses (31%);
- 38% of female seniors reported they had been abused versus 18% of male seniors;
- 9% of male seniors reported financial or emotional abuse versus 5% of female seniors.

For more information or to contact the Regional Elder Abuse Consultant in your area, please call ONPEA at (416) 978-1716.

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# THE TORONTO DECLARATION ON THE GLOBAL PREVENTION OF ELDER ABUSE

***“Elder Abuse is a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person”. It can be of various forms: physical, psychological/emotional, sexual, financial or simply reflect intentional or unintentional neglect.***

Abuse of older people has only recently been recognised as a global problem. NPEA’s advocacy work and the emphasis given to elder abuse prevention by the World Health Organization have contributed significantly to raising awareness worldwide. Academic institutions, around the world, have also substantially contributed to enhancing understanding and raising awareness and have developed methodological tools to study the problem. However, much is still to be done.

On one hand more research is needed – for instance, along the lines of the seminal joint project “Global Response to Elder Abuse” which resulted in the publication “Missing Voices – Views of Older Persons on Elder Abuse” and on the other hand practical action at local, regional and national levels.

Twenty or thirty years ago, societies throughout the world denied the existence of violence against women and child abuse. Then, through research, came the evidence. As a result the civil society exercised the appropriate pressure for action from governments. The parallel with elder abuse is clear.

This declaration is a Call for Action aimed at the Prevention of Elder Abuse.

Points to be considered:

- Legal frameworks are missing. Cases of elder abuse, when identified are often not addressed for lack of proper legal instruments to respond and deal with them.
- Prevention of elder abuse requires the involvement of multiple sectors of society.
- Primary health care workers have a particularly important role to play as they deal with cases of elder abuse regularly – although they often fail to recognise them as such.
- Education and dissemination of information are vital – both in the formal sector (professional education) and through the media (combating the stigma, tackling the taboos and helping to de-stereotype older people).
- Elder abuse is a universal problem. Research conducted so far shows that it is prevalent in both the developed and the developing world. In both, the abuser is more often than not well known to the victim, and it is in the context of the family and/or the care unit that most of the abuse happens.
- A cultural perspective is mandatory in order to fully understand the phenomenon of elder abuse – i.e. the cultural context of any particular community in which it occurs.
- Equally important is to consider a gender perspective as the complex social constructs related to it help to identify the form of abuse inflicted by whom.
- In any society some population sub-groups are particularly vulnerable to elder abuse – such as the very old, those with limited functional capacity, women and the poor.

- Ultimately elder abuse will only be successfully prevented if a culture that nurtures intergenerational solidarity and rejects violence is developed.
- It is not enough to identify cases of elder abuse. All countries should develop the structures that will allow the provision of services (health, social, legal protection, police referral, etc) to appropriately respond and eventually prevent the problem.

The United Nations International Plan of Action adopted by all countries in Madrid, April 2002, clearly recognises the importance of Elder Abuse and puts it in the framework of the Universal Human Rights. Preventing elder abuse in an ageing world is everybody's business.

This declaration was devised at an expert meeting, sponsored by the Ontario Government in Toronto, 17 November 2002

More information at the following websites:

[www.who.int/hpr/ageing](http://www.who.int/hpr/ageing), [www.inpea.net](http://www.inpea.net) and [www.onpea.org](http://www.onpea.org)

***"In Ontario elder abuse will not be tolerated. That is why we are launching our comprehensive provincial strategy to combat elder abuse".***

—Minister De Faria, Ontario's Minister Responsible for Seniors

***"Elder abuse is a violation of Human Rights and a significant cause of injury, illness, lost productivity, isolation and despair.***

***"Confronting and reducing elder abuse requires a multisectoral and multidisciplinary approach."***

—Active Aging, A Policy Framework, WHO, 2002



Aging and Life Course  
Noncommunicable Disease Prevention and Health Promotion  
Injuries and Violence Prevention  
World Health Organization  
E-mail: [activeageing@who.int](mailto:activeageing@who.int)  
Web site: [www.who.int/hpr/ageing](http://www.who.int/hpr/ageing)  
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# Introduction

## GOALS AND OBJECTIVES FOR AN ELDER ABUSE WORKSHOP

### **Overall goal**

To provide a learning environment which will promote dialogue and enhance skills of health care providers regarding the early detection and management of elder abuse.

### **Learning objectives**

At the end of the workshop the following outcomes are expected. Participants will be able to:

- Define various types of elder abuse
- Understand the precipitating factors for elder abuse (triggers)
- Describe a common profile of a “victim” and “abuser”
- Recognize elder abuse and apply intervention strategies to individual situations
- Appreciate the importance of working with a team (at least one other person) to problem solve issues related to possible elder abuse
- Access relevant community resources and information
- Gain confidence related to assessing and managing elder abuse cases



## WORKSHOP TIMELINES

### SUPPLIES NEEDED

#### PRE-WORKSHOP PREPARATION

Advertise workshop and register participants	6 – 8 weeks prior to workshop	<input type="checkbox"/> Pre-workshop packages
Photocopy learner materials	2 weeks prior to workshop	
Distribute pre-workshop package	1 week prior to workshop	
Request pre-workshop questionnaires to be completed for workshop	Collect questionnaires at beginning of workshop	

#### WORKSHOP CONTENT

INFORMATION SESSION	Overview of learning goals Definition of elder abuse Types of elder abuse Typical profile of abused/abuser Approach to assessment and treatment Strategies for intervention	50 minutes	<input type="checkbox"/> Overheads and projector OR <input type="checkbox"/> Laptop and LCD projector <input type="checkbox"/> Participant handouts
INTERACTIVE STRATEGIES	Video <i>or</i> Build-a-Case <i>or</i> Role Play <i>or</i> Case Study	30 minutes	<input type="checkbox"/> Video <input type="checkbox"/> TV / VCR <input type="checkbox"/> Flip chart <input type="checkbox"/> Markers <input type="checkbox"/> Copies of case study
DIALOGUE/DISCUSSION RELATED TO SELECTED INTERACTIVE STRATEGY	Use questions developed in manual to guide discussion	30 minutes	<input type="checkbox"/> Flip chart <input type="checkbox"/> Markers <input type="checkbox"/> Masking tape
WRAP-UP AND EVALUATION	Administer post-workshop questionnaire and collect completed questionnaires	10 minutes	<input type="checkbox"/> Post-workshop questionnaires

#### POST WORKSHOP

Program evaluation	Review questionnaires and collate results	30 minutes	<input type="checkbox"/> Completed questionnaires
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Please note time lines are estimated for a two-hour workshop based on the use of one of the teaching tools selected from above (eg video, build a case, role play or case study). If the facilitator wishes to use more than one teaching strategy then time will need to be adjusted accordingly. It is recommended that a 15-20 minute break be provided during the workshop. Therefore total time of the workshop will be 2–2 1/2 hours.

See back of this manual for pre- and post-workshop questionnaires.

## EQUIPMENT CHECKLIST

- ☐ Overhead projector
- ☐ LCD projector / laptop (if desired)
- ☐ Flip chart
- ☐ Markers
- ☐ Masking tape
- ☐ TV and VCR
- ☐ Video
- ☐ Pre- and Post-Workshop Questionnaires
- ☐ Pre- and Post-Workshop Information Packages
- ☐ Access to photocopy machine
- ☐ Power point presentation equipment



# **Speakers' Notes**









# WORKSHOP-AT-A-GLANCE

Collect the pre-workshop questionnaires from the participants and distribute workshop handouts

## I. INFORMATION SESSION

50 minutes





Overhead presentation using Speakers' Notes

<b>Elder Abuse Workshop</b>  Developed by the Regional Geriatric Program of Toronto 	<b>Learning goals</b> <ul style="list-style-type: none"> <li>■ <b>See</b> subtle signs of elder abuse</li> <li>■ <b>Hear</b> all perspectives</li> <li>■ <b>Understand</b> cultural issues</li> <li>■ <b>Feel</b> confident in approach</li> <li>■ <b>Act</b> with support of team</li> </ul> 	<b>Elder abuse is...</b>  any act of commission or omission that results in harm to an elderly person 	<b>Types of abuse</b> <ul style="list-style-type: none"> <li>■ Physical</li> <li>■ Financial</li> <li>■ Emotional</li> <li>■ Sexual</li> <li>■ Neglect</li> </ul> 														
<b>Typical elder abuse profile</b> <table border="0"> <tbody> <tr> <td><b>Victim</b></td> <td><b>Abuser</b></td> </tr> <tr> <td>■ Over 75 years</td> <td>■ Often under 30 or over 60 years</td> </tr> <tr> <td>■ Female/widow/single</td> <td>■ Close relative or caregiver</td> </tr> <tr> <td>■ Physical and/or cognitive impairment</td> <td>■ Living with abused elder</td> </tr> <tr> <td>■ Social isolation</td> <td>■ Psychologically stressed or depressed</td> </tr> <tr> <td>■ Dependent on caregiver</td> <td>■ Substance abuse history</td> </tr> <tr> <td>■ Low self-esteem</td> <td>■ Financial problems</td> </tr> </tbody> </table> 	<b>Victim</b>	<b>Abuser</b>	■ Over 75 years	■ Often under 30 or over 60 years	■ Female/widow/single	■ Close relative or caregiver	■ Physical and/or cognitive impairment	■ Living with abused elder	■ Social isolation	■ Psychologically stressed or depressed	■ Dependent on caregiver	■ Substance abuse history	■ Low self-esteem	■ Financial problems	<b>Approach to treatment</b> <ul style="list-style-type: none"> <li>■ Crisis intervention</li> <li>■ Short-term intervention</li> <li>■ Long-term intervention</li> <li>■ Follow-up</li> </ul> 	<b>Screen for abuse in all elderly individuals</b> <b>T</b> hink about risk factors <b>O</b> minous danger signs present <b>P</b> hysical findings <b>H</b> istory <b>A</b> ddress issue of elder mistreatment <b>R</b> eport issue of elder mistreatment <b>M</b> anage with prevention and risk factor modification 	<b>Strategies for intervention</b> <ul style="list-style-type: none"> <li>■ Awareness of own attitudes and values</li> <li>■ Interview</li> <li>■ Documentation</li> <li>■ Team approach</li> <li>■ Knowledge of community resources</li> <li>■ Education – proactive, prevention</li> </ul> 
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## II. INTERACTIVE STRATEGIES

30 minutes

Use one or more of the four different interactive teaching strategies shown.

Video:  <b>She's Happier There</b>  The Ontario Network for the Prevention of Elder Abuse (ONPEA) <a href="http://www.onpea.org">www.onpea.org</a> 	<b>BUILD-A-CASE</b> 	<b>ROLE PLAYING</b> 	<b>CASE STUDY</b> 
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## III. DISCUSSION OF INTERACTIVE STRATEGIES

30 minutes

## IV. WRAP-UP AND EVALUATION

10 minutes

Administer post-workshop questionnaire and collect completed questionnaires.

# Elder Abuse Workshop

Developed by the  
Regional Geriatric  
Program of Toronto



## Learning goals

- **See** subtle signs of elder abuse
- **Hear** all perspectives
- **Understand** cultural issues
- **Feel** confident in approach
- **Act** with support of team



### Explain that workshop has two general themes:

- Part I – Flagging and Detecting Elder Abuse
- Part II – Strategies and Interventions for Elder Abuse

### Quote for Bullet #3

*"Elder Abuse is an international problem found among all racial, ethnic, and socio-economic backgrounds, with an incidence and prevalence only slightly less than that of child abuse."*

– Anne Sclater, MD April 2000

### Main ideas to stress:

- Elder abuse is not uncommon
- Happens in a variety of circumstances for a variety of reasons – may involve strangers, but also many instances where the abuser is someone trusted by the elder
- Importance of health care provider' awareness of the issue and the need to look for signs or risks
- Importance of working as a team (CCAC agencies, healthcare providers)
- Idea that it is not about blame, but trying to assist the elder and well as the perpetrator
- Focus is on identification and prevention, as well as intervention (many forms) as necessary

## Elder abuse is...

any act of commission  
or omission that results in  
harm to an elderly person



**Commission** – intentional act of harm

**Omission** – failure to act on need(s)

### Definition:

1. Action on Elder Abuse in the U.K. developed a more detailed definition stating that elder abuse is a single or repeated act, or a lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person
2. Any action or inaction by a person in a position of trust (family, friend, neighbour, or paid caregiver which causes harm or threatens the health and welfare of an elderly person
  - includes both intentional and unintentional acts
  - can occur in all economic, social, and cultural groups
  - can occur in the home, community, and in health care or long-term care facilities
  - how we define or understand elder abuse will have a direct impact on our clinical interventions
  - our approach should not be about blame, judgement or punishment

Abuse can be a one time thing, happen occasionally, or on an on going/daily basis, regardless, they are all legitimate instances of abuse.

## Types of abuse

- Physical
- Financial
- Emotional
- Sexual
- Neglect



### **Physical:**

Any behaviour exhibited towards a person that may be perceived to inflict violence or physical harm. (Examples: slapping, pushing, striking with an object, cutting, burning, force feeding, holding hands down, improper restraint, incorrect positioning in bed or chair)

### **Financial:**

Inappropriate use of an elderly person's resources for personal or monetary profit or gain, or misuse of Power of Attorney. (Examples: theft, misuse of a person's funds and assets, coercion to deprive the elderly person of money or property)

### **Emotional:**

Behaviour which diminishes an elderly person's identity, dignity, or self-worth. (Examples: habitual verbal aggression, threats, insults, humiliating or infantilizing statements, name calling, intimidation, threats of institutionalization, social isolation, forced confinement, removal of decision-making power)

### **Sexual:**

Forced sexual activity with a competent or incompetent person. (Examples: suggestive talk, unwanted touching or fondling, rape)

### **Neglect:**

Intentional or unintentional failure of a designated caregiver to meet the needs necessary for the elderly person's physical and mental well being. (Examples: failure to provide adequate food, clothing, shelter, medical care including medication, hygiene, social stimulation)



**Statistics/prevalence:**

According to the 1990 National Survey on Abuse of the Elderly in Canada which conducted telephone interviews of a random sample of 2000 individuals over 65 years living in the private homes, the prevalence of abuse and neglect was 4% (Podneiks & Pillemer) – approx. 2.5% financial abuse, 1.4% chronic verbal aggression, 0.5% physical violence, 0.4% neglect.

A 1999 study of Family Violence in Canada found that:

- 7% of older persons had experienced some form of emotional or financial abuse
- 1% cent of financial abuse
- 1% of physical abuse at the hands of children, caregivers, or spouse during the past five years

According to the Canadian Incident-based Uniform Crime Reporting Survey, in 2001:

- the most frequently recorded family-related incident against seniors was common assault such as pushing, punching, slapping (56%), followed by uttering threats (20%)
- the most common offences committed by non-family members against older persons were common assault (34%), followed by robbery (29%)

In many cases, more than one type of abuse may be occurring.

Many cases go unreported due to lack of identification and underreporting – tip of the iceberg phenomenon. Victims may choose not to report abuse for many different reasons (e.g. shame, isolation, fear of retaliation, fear of institutionalization, etc.). However, the number of reported incidents of elder abuse is growing.

According to the Metro Toronto Police Statistics (2000), there were approximately 10 reported incidents per day.

In Ontario, mandatory reporting exists in long-term care facilities

*“Only one in six cases of elder abuse is reported compared to 1 in 3 for child abuse.*

*Rather than occurring as isolated incidents, abuse of the elderly is recurrent in up to 80% of cases.”*

(Anne Sclater, MD, 2000)

Typical elder abuse profile	
Victim	Abuser
<ul style="list-style-type: none"> <li>■ Over 75 years</li> <li>■ Female/widow/single</li> <li>■ Physical and/or cognitive impairment</li> <li>■ Social isolation</li> <li>■ Dependent on caregiver</li> <li>■ Low self-esteem</li> </ul>	<ul style="list-style-type: none"> <li>■ Often under 30 or over 60</li> <li>■ Close relative or caregiver</li> <li>■ Living with abused elder</li> <li>■ Psychologically stressed or depressed</li> <li>■ Substance abuse history</li> <li>■ Financial problems</li> </ul>



- Discuss – victim/abuser;
- Important to remember not to be judgmental
- Try to increase the caregiver's coping skills, provide them with support, and resources.  
Ongoing changes (e.g. dementia, cognitive changes, etc.), “sandwich generation”, sole caregiver, etc. may increase burden to caregiver
- Many risk indicators can and will overlap
- Need to look for and identify/red flag the risk factors and symptoms of abuse
- Discuss situations that may precipitate an abusive situation

Examples: history of family violence/abuse; marital conflict/discord; inadequate housing; cultural norms/beliefs; poor social network; ineffective coping patterns; finances

*“Most elderly people value autonomy above personal safety and comfort, and would rather have inadequate care with families than the best of institutional care” Anne Sclater, MD April 2000*

### Why does it happen?

- Social isolation:
  - is profound contributing factor which can lead to abuse.
  - More vulnerable than elders with large networks of friends and/or family
  - associated with abuse but not sole cause of abuse... provides environment for abuse to occur
- Conflicted family relationships
- Mental illness
- Substance abuse
- Caregiver stress
- Lack of community resources
- Lack of awareness of community awareness
- Ageism – pervasive negative attitudes and stereotypes which form prejudice;
- Co-dependency
  - Victims feel powerless to say no
  - Institutional settings may give elder feeling of powerlessness and vulnerability
  - Victims are already dealing with losses and are unable to cope with extra burdens i.e. finances
  - Stress alone cannot be singled out as a single cause but it could be a combination of several issues

## Approach to treatment

- Crisis intervention
- Short-term intervention
- Long-term intervention
- Follow-up



Stress that all intervention/action should be considered in consultation with a team if possible.

### **Crisis intervention:**

- Focuses on risk of imminent harm – consider the immediate safety of the victim
- Assessment of decision making capacity of victim is critical
  - (a) where victim is competent, facilitate choices and
  - (b) where victim is not competent, protective action must be taken

### **Short-term Intervention:**

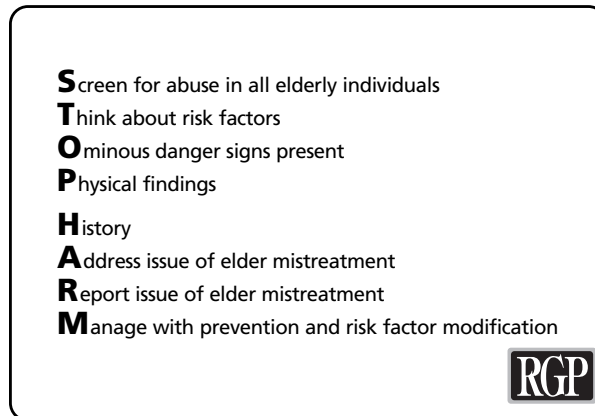
- Refers to areas that require problem solving, restoration and enhancement of the patient's functioning
- Usually these interventions last three to six months and involve medical treatment, counselling and education

### **Long-term intervention:**

- Involves evolution of client/practitioner relationship using risk reduction strategies and social services support. This phase often lasts two or more years

### **Follow-up:**

- Remaining involved until case manager is identified;



### **Risk factors and correlates associated with elder abuse and neglect**

- Stress – stressful life events experienced by a caregiver beyond care giving
- Alcoholism – and other substance abuse
- Violence – poor pre-morbid relationship and a history of violence
- Emotions – and the presence of mental illness can contribute to ineffective coping
- Dependence – for financial, emotional, physical needs
- Other correlates include:  
lack of community resources or lack of awareness of community resources, ageism, shared living arrangement.

### **Warning signs indicating the possible presence of abuse and/or neglect**

- Physical signs – multiple injuries, malnutrition, poor hygiene, inappropriate dress, bruises or skin lacerations, whiplash injury, burns, fractures, evidence of inappropriate medication
- Signs of neglect – lack of food, water, medications, eyeglasses or hearing aids, muscle wasting and atrophy
- Behavioural/physiological signs – withdrawal, arriving without caregiver, infantilizing of patient by caregiver, caregiver who insists on providing history, depressive symptoms, anxiety, fearfulness, agitation, cognitive impairment
- Signs of material abuse – loss of property, depletion of funds, inappropriate contracts or transactions, suspiciousness or fearfulness regarding safety of property, evidence of undue influence, failure to pay rent or bills, sudden changes in will.

Ref: Kruger MRM & moon CH. (1999). Can you spot the signs of elder mistreatment? Postgraduate Medicine, Vol. 106, No. 2, 177.  
STOP HARM – mnemonic was adapted from above reference

## Strategies for intervention

- Awareness of own attitudes and values
- Interview
- Documentation
- Team approach
- Knowledge of community resources
- Education – proactive, prevention



### **Awareness of own attitudes and values:**

Ask participants to reflect on their own attitudes and values regarding elder abuse

### **Interview:**

Provide overview of interview principles using handout “Important Interview Principles”

### **Documentation:**

Stress importance of always documenting all facts. When, what, who, source of information, (use direct quotes whenever possible), what action is/has been taken by whom, etc.

### **Team approach:**

*“Management of the abusive situation requires skill, diplomacy, and knowledge of a complicated health care and legal system.”* Ontario Medical Review, Jan. 1993

### **Knowledge of community resources:**

Providing resources – CCAC, Meals on Wheels, day programs, volunteers, financial aid, legal resources, victim services, counseling, etc.

### **Education – proactive, prevention:**

Public Education about aging, abuse, stress, resources

### **Important interview principles**

- Interview elder and caregiver separately
- Calm and relaxed interview environment
- Interview with concern not blame
- Questions should touch on all areas of abuse – physical, social, emotional, financial, neglect
- Purpose of interview is to gather information from each person’s perspective
- Start with soft approach and work up to uncomfortable issues – don’t avoid but don’t confront head on
- Validate where possible
- Point out consequences
- Limit and redirect
- Be encouraging
- If the person is unresponsive, summarize the discussion and offer help

### **Role of the health care professional in the management of abuse and neglect**

Documentation:

- Documentation of all assessment findings and actions taken is imperative
- It should be as reliable, accurate, complete and presentable as possible so that it is able to withstand legal scrutiny and challenge if necessary
- Should include all details involving allegations, accusations, observations as well as patient reports and expressed wishes
- Accurate quotation and dating of all documentation is critical

### **Management actions that might be undertaken by the health care team**

- Treatment of physical injuries, intoxication, unstable medical conditions, psychological trauma
- Highest priority should be to ensure safety while respecting patient's autonomy
- If in immediate danger, should be separated from abuser immediately
- Where abuse is related to caregiver stresses, actions can be taken to reduce these factors: respite/home care to reduce caregiver burden for high priority clients, supportive therapy or medical intervention for caregiver, education
- Wishes of a competent individual to remain in an abusive situation must be respected; role of health care team is to provide ongoing support and education
- For those who no longer retain decision-making capacity, team may need to involve Office of the Public Guardian and Trustee
- Other important interventions might include reducing isolation of older adults through community linking and, with the patients' permission, contacting other people who know the patient who may provide information or assistance in the situation

**Team approach**

- Sometimes staff/professionals see an abusive situation but pretend to not see it, because they think they have to deal with the situation themselves.
- Don't work alone, if you have a team or a group bring your concerns to them. Other team members can help brainstorm solutions or direction.
- Support from others help increase our confidence and security level when working in a difficult situation.
- If you don't have a team, you can try to create one with other professionals that may be involved with that person/family. These individuals may be the physician, police, religious figure (minister), CCAC, etc.

**Suggestions for debriefing elder abuse situations and planning action**

If at all possible:

- Involve a team or group of health professionals to debrief an elder abuse situation (conference calling may be used).
- Use other in-house and/or community resources for advice planning and education.
- Be aware of your own attitude, values and cultural influences regarding aging, family patterns and abuse issues. Deal with your own feelings.
- Become as knowledgeable as you can about the issues and your own area supports.  
For the victim and the family: Reduce stress on both parties wherever possible. If possible, educate both on contributing medical conditions, sources of help and support.
- Plan interventions, which involve as many other people as the system will tolerate. For example, even the daily Meals-on-Wheels volunteer is a contact/observer, which reduces the level of risk.
- Documentation, document, document the facts: when, what who, source of information. Where possible, use direct quotes. If it seems important to state your opinions, query assumptions and ask questions. Label these as such. For example, given the documentation weight loss of 25 lbs in three months and the lack of a medical reason at this time for this, I question if Mrs. B is given adequate food.
- Create a chronological history of recorded trips to the emergency incidences from the chart together with anecdotal information from other sources to clarify the picture.



### **Rationale**

The Build-a-Case Method is a variation of small group case-based learning. This method allows learners to reflect on actual clinical cases and allows health professionals to develop a composite case for discussion purposes. The method is consistent with three basic principles of adult learning:

- Learners control the learning process,
- Facilitators activate learners knowledge and encourage a process of analysis and synthesis,
- Facilitators provide a learning context that promotes the transfer of knowledge.

This method encourages a process of “inquiry” and promotes dialogue. The group leader is not “the expert” however is responsible for facilitating the process. For further understanding of this method please refer to the references listed below.

Materials needed:

- flip chart
- markers

### **Introduction/process of inquiry**

The group leader establishes the learning needs of the group and explains the Build-a-Case method. It should be stressed that the group is building a composite case and thereby capturing the collective experiences of the learners. The facilitator might ask the group to think about “a typical case”.

Once the group has had some time to reflect the facilitator begins the process by asking a question such as: “Let’s decide on a beginning for the case we are building “How did we first meet this client?”

The facilitator may need to prompt the group at this point to encourage participation with such questions as “Was the client referred to you?”, “Did someone call you about the client?”, “How did that case come to your attention?” etc.



**Develop the characteristics**

This step helps the group to describe the case scenario. The following questions may help promote the dialogue:

- How old is this client? Gender? Marital status? Living situation?
- Medical concerns? (brief)
- Psychosocial issues?
- Supports?
- Medications? (brief)
- Functional problems?
- Other concerns

The challenge here is to make case sufficiently complex so as to represent “reality” however not so complex that it is impossible to solve. Sometimes the facilitator might see that pieces are missing and might prompt with questions like “what about the client’s family?”

**Developing an intervention/plan for the client**

The group might want to consider what the key issues /concerns are for the client and might consider questions such as what issues are you concerned about as health professional? What are the client’s concerns? Families concerns? What are we going to do about it? In addition encourage the group to dialogue around a question such as how do know this is a case of elder abuse? Scribe significant discussion that relates to concerns and interventions. It is important to recognize the feelings of the learners as the discussion progresses. In any given situation the facilitator need to capture a variety of feelings and concerns. For example some participants may not feel that the situation is “abusive”; others may have strong feelings that elder abuse is a central concern. Recognize that there is more than one to approach a situation. The group may want to dialogue around interviewing strategies in an elder abuse situation. For example interviewing the client/victim separately from the abuser/perpetrator.

**Identify gaps between what we can do and what we would like to do**

Encourage the group to consider “next steps”. Encourage diversity of opinion as this lends itself richer discussion.

**Wrap up and reflection**

Here the facilitator can ask questions such as: What are key “learnings”? What are the take home messages? Please note it is not as important to solve the case as it is to promote dialogue and discussion.

**Strategies for a facilitator on how to “Build-a-Case”**

- Establish the learning needs
- Model of Elder Abuse – formulate guidelines in our minds.  
There is a difference between what we say we do and what we actually do
- Describe what they do – build a case
  - Get people to warm up
  - Make sure that people hold off from providing treatment

### **Build a case**

- We all know an incident where there are victims of abuse – Build-a-Case
- What things reflect the challenges of your work
- Question – think about the last case (picture) that you have been involved with where elder abuse occurred. How did that case come to your attention ?
- How did the case come to you ... CCAC referral etc. Afterwards ask people to provide more details
- Ask if the group is happy then move to what does the referral source say (while describing the case people start to connect)
- As the referral is being described the case is being built
- Ensure from the group that this is typical of the referrals
- Once the case is built, review

### **Review**

- What does the group need to know (who is involved, what professional, how recent, family involvement)
- Now get the group to answer the questions
- Have you decided to see the individual
- Let's give him/her a medical
- History – ask the group to list medications

### **What are you going to do?**

- Review the case – look for agreements
- Options are listed. How are you going to visit – will you go alone or with CCAC (find out why certain options are proposed – learning point – danger relationships
- Ask about feelings – comfort – what issues would you be concerned about

### **What are you going to do when you get there/**

- Have a meeting with your co-visitors prior to assessment to work on strategies
- Who will talk to who

During your case building – if time is running out

- Ensure that you find out from the group what are any key issues in the case
- Help the group establish strategy plans i.e. establish a relationship with the family and work on coming again to finish assessment
- Get all your information during the one visit
- Try to work with group in finding out what their learning points are: recognizing feelings, more than one way of doing things, how to work with other professionals, co-planning

Bring in interview guidelines. Let us see how we compare to interview guidelines – why did some things work – reflection – when did the group use one approach versus another

Video entitled:

## **She's Happier There**

The Ontario Network for the  
Prevention of Elder Abuse (ONPEA)  
[www.onpea.org](http://www.onpea.org)



### **Purpose**

The purpose of showing this video is to provide the audience with an opportunity to put a face to elder abuse, realizing that it can occur in situations that start out with the very best intentions but spiral downward when families cannot cope.

### **Goal**

The goal is to stimulate reflection and dialogue in this situation and to provide participants with the knowledge and resources needed to prevent and manage elder abuse in future.

### **Target Audience**

The target audience for showing this film would be health care professionals working in long-term care and/or community health care workers you feel would benefit from viewing the film. This is an intergenerational video (youth involved as change agent).

### **Time required**

The time required for showing the film and discussion after the film should be approximately one hour. The film itself is 32 minutes long and depending on the discussion thereafter you will need the full hour.

### **Equipment**

The only equipment needed is the video that can be purchased for \$25.00, a VCR and a TV. It is recommended that the facilitator view the film at least twice before showing it to participants thus ensuring a good grasp of the film content.

### **Introduction**

An introduction to the film would include opening remarks that this is a Canadian film made in Ontario that looks at the issue of elder abuse and the family dynamics that occur when grandmother Helen moves in with the family. The audience should be asked to watch the film closely and to decide for themselves if elder abuse is occurring and what they believe should be done to resolve this issue if they believe it exists.

**Examples of discussion questions re: Video Learning Tool**

- Reaction to video
- Why was this an abusive situation/not an abusive situation
- Why did the characters react the ways they did
- What were their beliefs at the time
- What stress is each person under
- What are their perceptions
- If you saw this situation in your practice what would you do
- Imagine you only know one perspective (a) grandmother/mom (b) mom/daughter (c) daughter/granddaughter
- End of discussion ask delegates if they have a different perspective on whether situation is abusive or not. If anyone changed, ask why.

## CASE STUDY



### Case Study 1

A 75 year old woman, Mrs. W. presented to a family practice clinic for treatment of hypertension and edema. She did not express any other concerns during the visit. The next day the daughter called the clinic saying that she thought her mother was incompetent and should be placed in a nursing home. Other information gained was that Mrs. W. lived in her home with the daughter, adult son and several grandchildren and that the son was a home health care worker and the daughter was receiving welfare. The family doctor decided to make a home visit. Although a request had been made that Mrs. W's children be present during the visit, the daughter was not there, the son was asleep and according to Mrs. W. could not be awakened. The house and its interior were once elegant but had now fallen into decay. Mrs. W's physical exam was unremarkable other than having extensive excoriation and evidence of a fungal infection to her perineal area as well as being cachectic. She also scored 20/30 on the Folstein Mini-Mental State Exam.

On questioning, Mrs. W. told the family doctor that both her children were living with her rent-free in exchange for providing her care, but they were seldom at home. She also mentioned that her daughter had a history of drug abuse and was currently under control. She mentioned that they sometimes forgot to leave her meals when they went out and her incontinence briefs were unchanged for long periods of times when the family was unavailable to assist her.

The primary care provider brought up the issue of moving to a nursing home or retirement home but Mrs. W. said "My daughter wants to get the house. That's why she wants me in a nursing home". Mrs. W. however also did say that she thought her children took care of her adequately "They just forget sometimes because they are so busy".

### **Case Study 2**

Mrs P. was brought into hospital for an assessment of her cognition. The daughter, Beth, provided most of the history. According to Beth, the mother's cognitive status has declined over the last 12 months and she has also become suspicious about family members regarding her finances. She has also experienced falls and some hallucinations at times.

Mrs. P. lives in a house with her daughter Beth and her teenage grandson. Beth moved into the family home a few years ago following her divorce. Mrs. P. also has another daughter Christina, whose involvement is limited due to conflict with her sister. The two siblings have had disputes over the Power of Attorney.

On examination it was found that Mrs. P. presented with possible Lewy Body type dementia. Her Folstein Mini-Mental Status Exam Score (MMSE) was 12/30. It was recommended that Mrs. P. be admitted to hospital for further assessment of her falls and cognitive impairment. The daughter was receptive to this admission and also requested that LTC papers be initiated.

Within a short period of time in hospital Mrs. P's cognitive status improved significantly. Her MMSE score improved to 23/30. She was started on Aricept. Mrs P. told the social worker that her daughter Beth often gives her wine to drink. She also requested that her other daughter Christina be contacted. Christina was surprised that her mother was in hospital and did not realize that she was having difficulties. According to Christina, when she attempted telephone contact, Beth would block the call stating that their mother was not well or resting. Mrs.P. made significant improvement in hospital and was found to be competent to make her own personal care decisions. Despite Beth's protest Mrs. P. returned home with support.

Beth continued her quest to persuade health professionals that her mother was incompetent by attempting to use other geriatric and medical consultations. Further assessments found Mrs. P. to be competent. At this time Beth threatened to sue her mother for half the house to cover the cost of renovations made on her behalf.

# ROLE PLAYING



## Facilitator's notes

Role play is an excellent way to get everyone involved and to help sensitize the learners to the different perspectives of persons involved in elder abuse cases

## Materials needed

- The room must be big enough to accommodate the number of small groups required to divide your audience by the numbers of roles you have decided to allocate.
- The furniture in the room should be movable to allow the formation of the groups.
- A case study. If you have used the "Build-a-Case" or the video, role play can be used to enhance the learning. All participants must be familiar with a case material.
- A flip chart and markers.

## Method

- The facilitator will introduce the role play and let the participants know that everyone will be asked to answer questions from the perspective of their role.
- The questions can be simple and should be available for everyone to refer to.
- Divide the audience into small groups and help direct the locations of the various groups.
- List to roles for the group, for example, victim, abuser, family member, interviewer, other healthcare professional. Allow time for the group to sort out roles and settle down.
- Give the groups a set time for the task.
- Monitor the progress of the groups. If a group seems to be "stuck" the facilitator can help by asking questions and drawing the group's attention to the question set out at the beginning of the exercise .
- Bring everyone back to the larger group at the end of the time stipulated.

### **Reflection and wrap up**

- Ask the participants of a role to answer the questions set out at the beginning of the exercise.  
Do not forget to ask participants for any additional comments or insights that they gained through the exercise.
- Make sure all the groups including that of the interviewer have time to respond.
- The point here is to facilitate the discussion.
- The facilitator can ask the group to what they found to be the most important thing learned from this exercise.

### **Sample questions for discussion**

The following questions are to be answered from the perspective of the role assigned to you.

- Is this a case of elder abuse?
- Who is being abused?
- What type of abuse is this?
- What factors contribute to the possible abuse?
- In your role, what action would you take? Would you do anything differently?
- Out of your role... as a member of a multidisciplinary team how would you handled this situation?  
What would be your recommendations? What information would you need in order to act?





# Resources

# **FACILITATING AN ADULT EDUCATION GROUP**

## **Adapted for the Elder Abuse Workshops**

Long gone are the days of didactic presentations to large groups aimed at improving clinical practice. It is now recognized that adults learn best by “doing” and by engaging in “dialogue”.

Dialogue: from the Greek “dia-logus” to inquire, discover, hear and understand multiple perspectives VS discussion- heaving ideas back and forth/debate.

This section of the manual will briefly highlight some key principles of adult learning and provide tips on how to facilitate learning in a group setting. Participants attending these sessions on elder abuse likely have considerable knowledge and skills in the area of geriatrics; however, may not be confident in assessing and intervening in abusive situations. By the end of the workshop, it is hoped that the participants will be more confident in “flagging” and “intervening” in abusive situations. Using active learning techniques including dialogue and reflection, the facilitator will assist the learners to discover a variety of strategies to address the issue of elder mistreatment/abuse.

### **Adult learning concepts**

1. Readiness to learn/ “need to know”
  - Adults learn when they have a need to learn
  - Participation in learning is voluntary
2. Prior experience of the learner
  - Adults bring a vast range of clinical and personal experience to each learning encounter.
  - Adults prefer to move from the familiar to the new and unfamiliar
  - The experiences of the learners provide a rich resource for the group
  - Prior experiences can create biases that can inhibit learning or shape new learning
3. Autonomy
  - Adults learn best when they have a sense of ownership over the process and feel respected in their opinion.
  - Adults like to participate and actively contribute to their own learning
4. Action
  - Adults want to be able to apply their learning to real life situation.
  - Adults have different learning styles
  - Reflection is an important step in action “Action with Reflection”

Learning through dialogue adapted from Jane Vella and others

- Don’t tell what you can ask; don’t ask if you know the answer – tell, in dialogue
- The more teaching; the less learning
- Build upon the experiences of the learner
- Draw upon the “collective wisdom” of the group
- Safety in the environment and the process

# GUIDELINES FOR DEVELOPING COMMUNITY RESOURCES FOR ELDER ABUSE

## Introduction

It is suggested that each geographic region or area develop a customized Elder Abuse Resource List that reflects local resources as well as more general resources. These resources may include agencies, clinics, support services including policing units, health professionals specific to elder abuse, books and web sites.

## Creating or updating an Elder Abuse Resource List

Check your own organization for elder abuse resources including an elder abuse policy. If this does not exist, then it will be important to talk to individuals who may be able to identify organizational or community resources.

Contact your own professional association (eg. RNAO) or other allied professional organizations to determine if they have any resources that could be incorporated into your list. The APSW (social work) has a booklet entitled Elder Abuse: A Practical Handbook for Service Providers. APSW 416-923-4848.

Contact local community information organizations such as the Chamber of Commerce or libraries for information that they may have regarding elder abuse resources.

Contact the local police department and determine who is the contact person for elder abuse concerns.

Talk to your local Community Care Access Centre, outpatient clinics or counseling services for seniors.

Check websites - see attached list.

Include provincial resources such as the Office of the Public Guardian and Trustee, the Advocacy Centre for the Elderly (ACE) 416-598-2656; and the Ontario Network for the Prevention of Elder Abuse 416-978-1716.

## Maintaining an up-to-date Elder Abuse Resource List

Assign one person or group to be responsible for updating the resource list and sharing changes with others. Phone numbers should be checked annually to ensure that information is current.

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## WEBSITES

### CANADA

#### **Abuse of Older Adults, National Clearinghouse on Family Violence (NCFV)**

Health Canada

[http://www.hc-sc.gc.ca/hppb/familyviolence/age\\_e.html](http://www.hc-sc.gc.ca/hppb/familyviolence/age_e.html)

#### **Brockville Police**

<http://www.brockvillepolice.com/SeniorsFraud.html>

#### **Competition Bureau of Industry Canada**

<http://competition.ic.gc.ca>

Provides information on legislation enacted in Canada.

#### **2002-olderadultvictims**

<http://www.hc-sc.gc.ca/hppb/familyviolence/pdfs/2002-olderadultvictims.pdf>

#### **Health Canada, Division of Aging and Seniors**

[http://www.hc-sc.gc.ca/seniors-aines/pubs/enhancing/chap5\\_e.htm](http://www.hc-sc.gc.ca/seniors-aines/pubs/enhancing/chap5_e.htm)

#### **Hot Peach Pages World-Wide List of Abuse Agencies**

<http://www.hotpeachpages.net/>

#### **Investor e-education Fund**

<http://www.investored.ca>

#### **Ontario Network for Prevention of Elder Abuse (ONPEA)**

<http://www.onpea.org>

#### **Ontario Seniors' Secretariat You Asked Us**

<http://www.gov.on.ca/MCZCR/seniors/english/elderabuse.htm>

#### **Ontario Securities Commission**

<http://www.osc.gov.on.ca>

#### **Ontario Seniors' Secretariat**

<http://www.gov.on.ca/citizenship/seniors/english/guide-consumerinfo.htm>

This information is also available in A Guide to Programs and Services for Seniors in Ontario, which is included in this package.

#### **OHRC– TIME FOR ACTION Advancing Human Rights For Older Ontarians**

[http://www.ohrc.on.ca/english/consultations/age-consultation-report\\_10.shtml](http://www.ohrc.on.ca/english/consultations/age-consultation-report_10.shtml)

#### **Phone Busters 1-888-495-8501**

<http://www.phonebusters.com>

A national telemarketing call centre, co-ordinated by the OPP.

You can order an educational video through this website.

#### **Regional Geriatric Program of Toronto**

<http://www.rgp.toronto.on.ca>

#### **Volunteer Centre of Toronto**

<http://www.e-volunteering.org/aboutfraud/>

Telephone: (416) 961-6888. A non-profit social service agency responsible for the national co-ordination of The Scotiabank Fraud Awareness Program: ABCs of Fraud.



## UNITED STATES

### **Flim Flam dot com**

<http://www.flimflam.com>

### **National Center on Elder Abuse (NCEA)**

<http://www.elderabusecenter.org>

### **National Consumers League**

<http://www.nclnet.org>

### **National Fraud Information Centre**

<http://www.fraud.org>

### **Spam Laws**

<http://www.spamlaws.com>

Contains information on legislation enacted in the U.S., Europe, and Canada.

### **United States Sentencing Commission**

<http://www.ussc.gov/reports.HTM>

Provides links to pdf reports on Corporate Crime and Fraud. Of particular interest might be a Report to the Congress: Adequacy of Penalties for Fraud Offenses Involving Elderly Victims and Report to the Congress: Telemarketing Fraud Offenses, Explanation of Recent Guideline Amendments.

## INTERNATIONAL

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

<http://www.inpea.net>





# Appendices

## HISTORY OF THE TRAINING PROGRAM

In 1999, an RGP Elder Abuse Network was formulated under the guidance of Gloria Lattanzio and Dr. Rory Fisher. A multidisciplinary group of social workers, nurses, occupational therapists, physiotherapists and recreationists from the five RGP sites in the Toronto area came together to discuss educational needs of professionals working in geriatrics particularly in the area of abuse. It was hypothesized that professionals in the field of geriatrics are often skilled and knowledgeable about general geriatrics, but their confidence level and ability to act on abusive situation was often low. The Elder Abuse Network focussed on identifying “flags” of abuse and strategies of intervention. A pilot project was launched in 2001 at three RGP sites. Revisions based on the evaluations and feedback from the participants was made. The workshops were condensed from four sessions to a two-part workshop that can be presented in a two to three hour period. Two years later, the educational workshop has been modified into a training model to accommodate the need and demand for this type of educational program. The present team of the Elder Abuse Network consists of Dr. Rory Fisher, Tracey Dion, Madeline D’Arpino, Lynn Zimmerman, Elizabeth O, Anne Stephens, Rola Moghabghab and Sherry Glazier.



## Regional Geriatric Programs of Ontario

# An Elder Abuse Workshop for Healthcare Providers

### *The Toronto Regional Geriatric Program (RGP) Elder Abuse Network*

Rory Fisher, MB, FRCP(Ed) (C) (Chair), Madeline D'Arpino, RN, Tracey Dion, RT, Sherry Glazier, MSW, RSW, Rola Moghabghab, RN, MN, Elizabeth O, BSc, OT, Anne Stephens, BScN, MEd, GNC(C), Lynn Zimmerman, MSW, RSW.

*The problem of elder abuse has been highlighted by the Ontario government's recent strategy. Considerable information is available about elder abuse but there is a lack of connection between this knowledge and the day-to-day activities of healthcare professionals. The Toronto Regional Geriatric Program therefore has developed an elder abuse workshop for frontline staff. In this workshop, elder abuse is defined, types of abuse are discussed, prevalence is addressed, victims and abusers are profiled and case discussions of an interactive nature take place. A post-workshop package is provided. The next step will be to develop a "train the trainer" model.*

**Key words:** elder abuse, workshop, Ontario government, Regional Geriatric Program.

The problem of elder abuse has been highlighted by the Ontario government's recent strategy to combat elder abuse. This strategy was developed with advisors from the private and public sector through a round table on elder abuse. An investment of \$4.33 million will be made in a five-year plan, in which the Ontario Network for Prevention of Elder Abuse will partner with the Ministry of the Attorney General and the Ministry of Citizenship. Key elements of the plan include coordinated community services, training for frontline staff and a public education campaign.<sup>1</sup> On a global level, the International Network for the Prevention of Elder Abuse, founded in 1997, is dedicated to the global dissemination of information as part of its commitment to the worldwide prevention of the abuse of older people.<sup>2</sup> The World Health Organization also has recently published a World Report on Violence and Health, which has a whole chapter devoted to an in-depth exploration of elder abuse. This document makes the case that violence is preventable, and it highlights the crucial role that public health has to play.<sup>3</sup> Very extensive information regarding elder abuse is also available from the National Center on Elder Abuse.<sup>4</sup>

### Development of an Elder Abuse Network

Despite these local and global attempts, a connection was lacking between the knowledge readily available and its translation into the day-to-day activities of healthcare professionals who interact with the frail elderly, since there is little training in the undergraduate and the post-graduate curricula related to this problem. To address this, the Toronto Regional Geriatric Program (RGP) formed an Elder Abuse Network in 1999. A multidisciplinary committee was set up with representatives from all the Toronto RGP services. The objective was to assist in the training of specialised geriatric service staff by increasing their awareness in the detection and management of elder abuse. The group undertook a comprehensive literature search, reviewing available materials and resources. A workshop was developed that was piloted at three hospital sites, then evaluated and revised. Though well received, it was felt that the program could be shortened with more flexibility and with a greater emphasis on interventions. A revised workshop has since been implemented, and is described here.

### The Elder Abuse Workshop

Participants are given a pre-workshop package. This consists of a questionnaire that allows participants to reflect on their experience with elder abuse, and their expertise, attitudes and confidence in dealing with the issue. Several review articles are provided, including ones by Wolfe,<sup>5</sup> Butler<sup>6</sup> and Curtin,<sup>7</sup> and a bibliography is added as well. The workshop consists of an introduction to elder abuse with discussion of a definition, types of abuse, statistics, identification, risk factors, profiles of abusers and victims, and "build-a-case"—an interactive group activity to develop an appropriate case of elder abuse for discussion. Strategies and interventions are then addressed and, finally, there is a summary. There is flexibility as to the length of the session and the use of such teaching tools as role play modules and videos.

### Definition of Elder Abuse

The workshop uses a simple definition of elder abuse; that is, any act of commission or omission that results in harm to an elderly person.<sup>8</sup> If the act is one of omission, it is usually described as neglect. The abuse may be intentional or unintentional, physical or psychological, or it may involve financial or other material maltreatment. It results in unnecessary suffering, injury or pain, the loss or violation of human rights and a decreased quality of life for the older person.<sup>9</sup> Action on Elder Abuse in the U.K. developed a more detailed definition stating that elder abuse is a single or repeated act, or a lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person.<sup>10</sup> It often occurs within a relationship of trust with family members, friends, neighbours or paid caregivers and it can occur in all economic, social and cultur-

## Elder Abuse Workshop

al groups. It includes abuse by individuals who prey on vulnerable seniors with fraudulent financial schemes. It takes place at home or in an institutional setting. This specific workshop deals with the home and community settings. It is planned to address the equally important issue of institutional abuse and the role of culture and cognition at a later stage.

### Types of Elder Abuse

Types of abuse are discussed under the following headings:

**Physical**, including the infliction of pain or injury, or physical- or drug-induced restraint;

**Psychological or emotional**, with the infliction of mental anguish;

**Financial or material**, with the illegal or improper exploitation or use of funds or resources of the older person;

**Sexual**, including non-consensual sexual contact of any kind with the older person, and;

**Neglect**, the refusal or failure to fulfill a caregiving obligation that may or may not be conscious or intentional.<sup>3</sup>

### Prevalence of Abuse

It has been noted that there are different interpretations of the definitions of abuse and there has been a call for more specific medical definitions, such as when malnutrition is a problem due to anorexia because of diseases rather than abuse or neglect. There also is a need for more objective ways to determine whether bruises and fractures are the result of abuse or the result of diseases.<sup>11</sup> Prevalence is discussed; a recent study of family violence in Canada found that 7% of older people had experienced some form of emotional abuse, 1% financial abuse and 1% physical abuse or sexual assault at the hands of children, caregivers or partners during the previous five years.<sup>12</sup> Surveys in five developed countries in the last decade have shown a rate of abuse of 4–6% among older people if physical, psychological and financial abuse and neglect are included.<sup>13–17</sup> In a U.S. incidence study in 1998 based on reports of elder abuse and neglect to the

Adult Protective Services (APS) agencies, the National Center on Elder Abuse concluded that unreported cases of abuse, neglect and self-neglect are four times greater than those reported to the APS agencies, and that reported cases are just the tip of the iceberg.<sup>11</sup>

### Victim and Abuser Profiles

The profile of the victim is discussed, including risk factors such as social isolation, functional disabilities, cognitive impairment or psychiatric problems, feelings of worthlessness or low self-esteem, and dependency on drugs or alcohol. Older men are at risk of abuse by spouses, older children and other relatives in about the same proportion as women.<sup>13,14</sup> A comparison of samples of patients with Alzheimer disease has shown that the degree of impairment was not a risk factor for being abused.<sup>18,19</sup>

Characteristics of abusers include being a close relative, neighbour or caregiver, being stressed from the caregiving role, substance abuse, mental illness, financial problems and dependency on the victim. The nature of the relationship between the caregiver and the care recipient before the abuse begins may be an important predictor of abuse.<sup>20</sup>

### Case Discussions

The participants of the workshop then take part in an interactive exercise to develop a case for discussion. This is based on their own experiences and the workshop leaders act as facilitators rather than experts.<sup>21</sup> Specific learning needs are identified and group discussions take place regarding possible management strategies. Principles of interviewing suspected abusers and victims are identified and sample questions and approaches are given. The involvement of colleagues and the importance of documentation are stressed. Practice gaps are identified and debated and interventions are suggested. An approach to treatment may be divided into three stages: crisis intervention; short-term intervention; and long-term treatment and follow-

up.<sup>22</sup> Crisis intervention should focus on the imminent harm and the immediate safety of the victim. In these cases, admission to hospital is often acceptable by both the victim and the caregiver if it is justified for treatment of specific health problems, rather than for protection from abuse. Short-term intervention requires immediate problem solving with restoration and enhancement of the patient's functioning. Specific goals are often achieved by referrals to particular agencies and groups. Long-term treatment involves resolving longstanding family conflicts with risk reduction strategies, including the introduction of social services such as home care, day care and financial aid.

With regard to legal action, all the Atlantic provinces have legislation for mandatory reporting of abuse of the elderly, while over 43 states in the U.S. require reporting of possible cases of elder abuse to state-designated agencies.<sup>23</sup>

### Post-workshop and Future Directions

A post-workshop package asks the participants to fill in the same questionnaire as that prior to the workshop, with an evaluation as well. Further readings by Sclater<sup>22</sup> and Patterson and Podnieks<sup>24</sup> are provided. Suggested questions for interviews and a list of resource services specific to the region are given with RISC: *A Protocol for Elder Abuse*. RISC is an acronym for recognition, interview, safety assessment, cognition and capacity.<sup>25</sup>

The workshop has been held on four occasions and the evaluations thus far have been positive. The next step is to develop a trainer model so that there will be a greater opportunity for more training for frontline staff. Interested staff will be invited to take part in this training program and will then be able to provide training and support in their work place. Anyone interested in participating should contact the Toronto RGP (rory.fisher@sw.ca). ♦

No competing financial interests declared.

## Elder Abuse Workshop

### References

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# Pre-Workshop Package

The following three pages are to be sent out ahead of the workshop.  
Copies can be printed from the PDF contained on the CD  
or photocopied from this manual.

Please note:

Participants will be asked to read the following three articles  
before attending the workshop:

Butler, R.N.(1999) Warning signs of elder abuse. *Geriatrics* 54(3), 3-4.

Curtin, K. (1995) Intervention in elder abuse: A swift blade,  
or a dull-edged saw? *Can Med Assoc J.* 152(7),1121-1123.

Wolfe, S. (Articles Ed.) (1998). Look for signs of abuse. In *RN*, 61(8), 48-51.  
Montvale, NJ: Medical Economics Publishing Company, Incorporated.  
([www.rnweb.com](http://www.rnweb.com))



## **OUTLINE OF THE WORKSHOP**

- An overview of elder abuse
- Flagging and detecting elder abuse
- Interactive group activity (“Build-a-Case”)
- Strategies and interventions for elder abuse
- Reflections and wrap-up



Dear Elder Abuse Workshop participants:

To assist you in preparing for the upcoming Elder Abuse Workshop please find attached the following materials:

- Outline of the workshop
- Pre-workshop questionnaire
- Pre-workshop readings

Butler, R.N.(1999) Warning signs of elder abuse. *Geriatrics* 54(3), 3-4.

Curtin, K. (1995) Intervention in elder abuse: A swift blade, or a dull-edged saw? *Can Med Assoc J.* 152(7),1121-1123.

Wolfe, S. (Articles Ed.) (1998). Look for signs of abuse. In *RN*, 61(8), 48-51. Montvale, NJ: Medical Economics Publishing Company, Incorporated. ([www.rnweb.com](http://www.rnweb.com))

Please come prepared with your questionnaire completed.  
We look forward to seeing you at the Workshop!

Yours sincerely,  
Elder Abuse Network

## RGP Elder Abuse Workshops

**PARTICIPANT PRE-WORKSHOP  
QUESTIONNAIRE**

Regional Geriatric  
Program of Toronto

**Purpose:** The purpose of this questionnaire is to provide an opportunity for you to reflect on your experience with elder abuse prior to participating in the workshops.

Please complete the pre-workshop questionnaire prior to reading the attached article.

**Relevant education and/or experience**

**AGREE    DISAGREE    UNSURE**

I have participated in a previous course or workshop on elder abuse.

☐      ☐      ☐

I have read articles and/or books on elder abuse/elder mistreatment.

☐      ☐      ☐

I have seen cases of elder abuse/mistreatment in my clinical practice.

☐      ☐      ☐

**Confidence Level**

Please rate your confidence level prior to participating in the workshop.

Pre-Workshop Self-Rating:

I feel \_\_\_\_\_% confident in dealing with elder abuse in my clinical practice.  
(1% – 100%)

**Attitudes and beliefs about elder abuse**

Please indicate if the following issues are barriers to your becoming involved in an “elder abuse” situation

**AGREE    DISAGREE    UNSURE**

Denial by the individual or caretakers of mistreatment

☐      ☐      ☐

Fear that the victim may suffer reprisals, loss of autonomy or relocation.

☐      ☐      ☐

The victim wants to avoid embarrassment or shame.

☐      ☐      ☐

The victim is reluctant to press charges against a close relative or caregiver in fear of isolation.

☐      ☐      ☐

Concern that minor injuries or subtle signs are not indications of abuse.

☐      ☐      ☐

Uncertainty regarding what your professional responsibility may be.

☐      ☐      ☐

Concern regarding confidentiality issues related to abuse.

☐      ☐      ☐

Other (please specify)

☐      ☐      ☐

*Thank you for completing this questionnaire. Please bring it with you to the Workshop.*



# Post-Workshop Package

The following two pages are to be completed at the end of the workshop.  
Copies can be printed from the PDF contained on the CD  
or photocopied from this manual.

Please note:

Participants are asked to read the following two articles:

Patterson, C., & Podnieks, E. (1993) A Guide to the Diagnosis and Treatment of Elder Abuse.  
Ontario Medical Review, January, 11-17.

Sclater, A. (2000) Elder Abuse: Recognition & Intervention for Health Care Providers.  
The Canadian Journal of CME, January, 185-193

## RGP Elder Abuse Workshops

**PARTICIPANT POST-WORKSHOP  
QUESTIONNAIRE**

Regional Geriatric  
Program of Toronto

**Purpose:** The purpose of this questionnaire is to provide an opportunity for you to reflect on your background and experience with elder abuse at the conclusion of the workshop.

Please complete the post-workshop questionnaire at the conclusion of the workshop.

**Confidence Level**

Please rate your confidence level prior to participating in the workshop.

Pre-Workshop Self-Rating:

I feel \_\_\_\_\_% confident in dealing with elder abuse in my clinical practice.  
(1% – 100%)

**Attitudes and Beliefs about Elder Abuse**

Please indicate if the following issues are barriers to your becoming involved in an “elder abuse” situation

	AGREE	DISAGREE	UNSURE
Denial by the individual or caretakers of mistreatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fear that the victim may suffer reprisals, loss of autonomy or relocation.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The victim wants to avoid embarrassment or shame.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The victim is reluctant to press charges against a close relative or caregiver in fear of isolation.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Concern that minor injuries or subtle signs are not indications of abuse.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Uncertainty regarding what your professional responsibility may be.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Concern regarding confidentiality issues related to abuse.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (please specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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*Thank you for completing this questionnaire.*

**RGP Elder Abuse Workshops****PARTICIPANTS' EVALUATION  
OF THE WORKSHOP**

Please circle one of the following options to indicate how this workshop will impact on your ability to handle "elder abuse" cases ?

☐ Definite Impact      ☐ Some Impact      ☐ No Impact

What is the most important "take home message" from this workshop ?

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Please rate the usefulness of the following teaching methods used in this workshop.

Lecture	<input type="checkbox"/> Helpful	<input type="checkbox"/> Not helpful
Overheads / slides	<input type="checkbox"/> Helpful	<input type="checkbox"/> Not helpful
Group discussion	<input type="checkbox"/> Helpful	<input type="checkbox"/> Not helpful
Build-A-Case	<input type="checkbox"/> Helpful	<input type="checkbox"/> Not helpful

The workshop:

☐ Exceeded my expectations      ☐ Meet my expectations      ☐ Below my expectations

Would you recommend this workshop to your colleagues?      ☐ Yes      ☐ No

Suggestions for improvement of this workshop:

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*Thank you for completing this questionnaire.*







# **Workshop Materials and Handouts**

The following two pages are to be completed at the end of the workshop.  
Copies can be printed from the PDF contained on the CD  
or photocopied from this manual.

## Learning goals

- **See** subtle signs of elder abuse
- **Hear** all perspectives
- **Understand** cultural issues
- **Feel** confident in approach
- **Act** with support of team




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## Elder abuse is...

any act of commission  
or omission that results in  
harm to an elderly person




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## Types of abuse

- Physical
- Financial
- Emotional
- Sexual
- Neglect




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## Typical elder abuse profile

### Victim

- Over 75 years
- Female/widow/single
- Physical and/or cognitive impairment
- Social isolation
- Dependent on caregiver
- Low self-esteem

### Abuser

- Often under 30 or over 60
- Close relative or caregiver
- Living with abused elder
- Psychologically stressed or depressed
- Substance abuse history
- Financial problems




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## Approach to treatment

- Crisis intervention
- Short-term intervention
- Long-term intervention
- Follow-up




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**S**creen for abuse in all elderly individuals  
**T**hink about risk factors  
**O**minous danger signs present  
**P**hysical findings  
**H**istory  
**A**ddress issue of elder mistreatment  
**R**eport issue of elder mistreatment  
**M**anage with prevention and risk factor modification




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## Strategies for intervention

- Awareness of own attitudes and values
- Interview
- Documentation
- Team approach
- Knowledge of community resources
- Education – proactive, prevention




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## **BUILD A CASE**



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Video entitled:

### **She's Happier There**

The Ontario Network for the  
Prevention of Elder Abuse (ONPEA)  
[www.onpea.org](http://www.onpea.org)



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## **CASE STUDY**



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## **ROLE PLAYING**



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## COMMUNITY RESOURCE LIST ON ELDER ABUSE

For further details, refer to the Blue Book Directory of Community Services in Toronto

### Protective and Legal Services

Community Policing Support Unit	416-808-7040	24 hours 7 days a week	Contact person: Constable Patricia Fleischmann voice mail
Victim Services Program of Toronto	416-808-7066	24/7	CTOVictimService@aol.com
Office of Public Guardian and Trustee Investigation Unit	416-314-2800 416-327-6348	0830–1630 hrs	leave voice mail message <a href="http://www.attorneygeneral.jus.gov.on.ca">www.attorneygeneral.jus.gov.on.ca</a>
Advocacy Centre for the Elderly (ACE)	416-598-2656	0900–1700 hrs Thursdays: 1300–1700 hrs	<a href="http://www.advocacycentreelderly.org">www.advocacycentreelderly.org</a>
Ontario Network for the Prevention of Elder Abuse	416-978-1716		<a href="http://www.onpea.org">www.onpea.org</a>

### Community Supports / Services

Community Information Toronto (Blue Book Information)	Dial "211"	24/7	<a href="http://211toronto.ca">211toronto.ca</a>
Client Services & Information Unit (Social Services/Welfare)	416-392-2956 After 1800 hrs: 416-392-8600	0830–1630 hrs	<a href="http://www.city.toronto.ca">www.city.toronto.ca</a> Click on Services
Mobile Crisis Unit	416-289-2434	24/7	
Red Door Women's Shelter (always keeps four spaces for elderly women – not wheelchair accessible)	416-469-3610	24/7	
Warden Woods Centre	416-694-1138	0900–1700 hrs	Contact: Dorothy Miller (ext. 36)
Circle of Care Support Group for Abused Women	416-635-2860	0830 – 1630 hrs	<a href="http://www.circleofcare.com">www.circleofcare.com</a>
Family Services Association – Elder Abuse Consultation Team	416-977-0559	0900–1700 hrs	<a href="http://www.fsatoronto.com">www.fsatoronto.com</a>
Sexual Assault & Domestic Violence Care Centre Sunnybrook & Women's (Women's College Campus)	416-323-6040		leave voice mail message <a href="http://sunnybrookandwomens.on.ca">sunnybrookandwomens.on.ca</a>

### Publications

Elder Abuse Manual – Toronto Police Service	416-808-7040		
Senior Abuse Manual – Nepean Police Service	613-836-4680		
Fraud Free Calendar (produced by Ministry of Consumer & Business Services)	416-326-8525		<a href="http://www.cbs.gov.on.ca">www.cbs.gov.on.ca</a>
A Guide to Advance Care Planning	1-888-910-1999 To order, call 1-888-910-1999		<a href="http://www.gov.on.ca/citizenship/seniors">www.gov.on.ca/citizenship/seniors</a>

### Other

Seniors Secretariat (OSS)	416-326-9886		Elder's Abuse Project
Office for Seniors Issues	416-327-4244		

## THE INTERVIEW – SUSPECTED ABUSER

It is more effective to start with a soft approach and work up to the uncomfortable issues.  
Do not avoid the difficult issues but do not confront head on.

These are some techniques to use when conducting your interview:

“I need your help to understand what happened.”

Validate where possible:

“I can understand your frustration.”

“Thank you for telling me what happened.”

Point out consequences:

“You could be charged. \_\_\_\_ (victim) could be seriously hurt.”

Limit and redirect:

“It is important to prevent this from happening again.”

“What would be helpful to you in preventing this?”

Be encouraging:

“We have helped others with similar problems.”

If the abuser is responsive, confirm you (the team, etc.) will do all you can to help.  
Then start to work on a plan.

If person is unresponsive, summarize the discussion and offer help:

“I know you don't want to talk any more about this right now and I respect that.”

“I need to stress how harmful this behaviour is.”

“I'm very concerned and you can reach me at \_\_\_\_ if you want to talk about this later.”

## THE INTERVIEW – VICTIM

The purpose of the interview is to gather information about the person's health, walk of life, ADL and IADL functioning where abuse is suspected, for example from the referent, collateral report, your own observation. You may want to be sure to include questions of the following sort:

1. Do you have any problems or concerns?
2. Are you alone a lot? (Social isolation)
3. Is there someone you can turn to with a problem or if you have trouble?
4. Are you concerned about anyone in your family?  
Does any member of your family drink or use drugs?
5. Do you need help to take care of yourself?  
Do you control your own medication? Make your own meals?
6. Do you manage your own money? Do you own banking, manage your cheque book?  
Do you help anyone financially?
7. Do you feel safe in your home?

## RISC: PROTOCOL FOR ELDER ABUSE

**R = Recognition**

**I = Interview**

**S = Safety assessment**

**C = Cognition and Capacity**

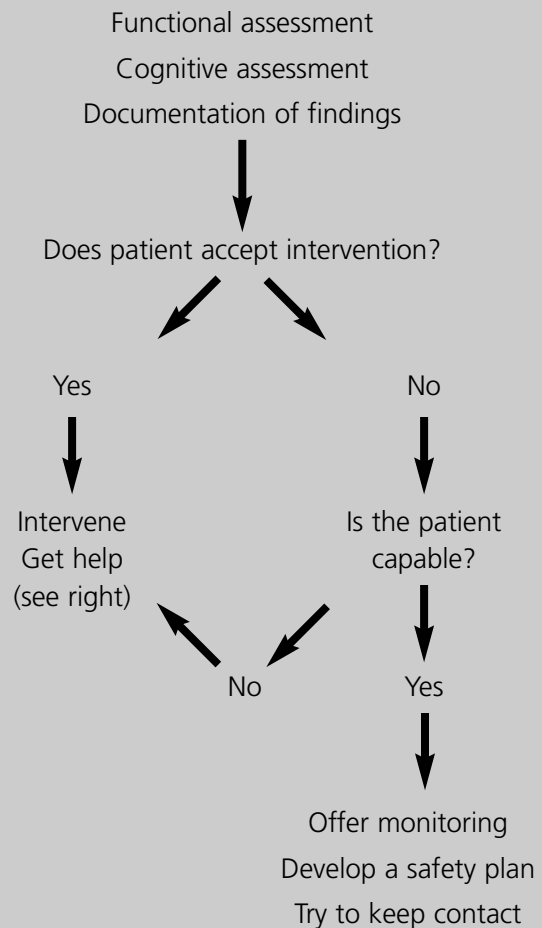
### Presentation

- Injuries are disproportionate with history
- Presentation without caregiver
- Vague or bizarre explanation for injury
- Delay in seeking medical attention
  - Caregiver stressed or has low tolerance for patient
  - Caregiver infantilizes the elder
  - Frequent visits to ER despite adequate resources

### Patient

- Withdrawn, fearful
- Poor hygiene, inappropriate dress
- Bruises in various stages of healing
- Malnutrition when appropriate resources present
- Unexplained fractures
- Unusual bruising or injuries
- Vaginal or rectal bleeding

### What do you do if you suspect abuse?



### Elder Abuse Resources for the Health Professional

Victim Services (Police):	(416) 808-7066
Mobile Crisis Unit (if mental health diagnosis is involved):	(416) 498-0043
Office of the Public Guardian and Trustee: (Investigation Unit)	(416) 327-6348
Advocacy Centre for the Elderly (ACE):	(416) 598-2656
Seniors Information and Referral Service, Toronto	(416) 392-0505
Women's College Campus Domestic Violence Program (24 hrs/day)	(416) 323-6040
Community Care Access Centre:	
North York	(416) 222-2241
Scarborough	(416) 750-2444
Toronto	(416) 506-9888
Regional Geriatric Program of Toronto	(416) 480-6026



## Elder Abuse Interview

(Note: Interview patient and caregiver separately)

### Patient Interview:

- Assess functional capacity and need for assistance in ADLs
- Ask about the role of the caregiver
- Ask if the patient has ever been verbally, physically or psychologically abused
- Ask if the patient would like intervention
- Assess risk to patient (safety)
- If appropriate, administer a Folstein Mini Mental Status Examination
- Should the patient decline intervention, determine their capacity to understand the associated risks
- Document physical findings of abuse or neglect

### Caregiver Interview:

- Ask about health needs of the patient
- Ask what role they play in providing care of patient
- Inquire about the caregiver's health
- Inquire about any history of alcohol, drug and mental health problems\*\*
- Inquire about current social support and outside contacts\*\*
- Is caregiver reliant on the patient for finances/housing\*\*
- It must be stressful looking after (relative). How do you manage his/her care?
- Where appropriate ask:
  - Caring for the elderly is sometimes difficult. Have you ever been so frustrated that you have (insert – pushed him/her, hit him/her, yelled at him/her)?
  - The patient has (describe injuries). Could you explain how he/she sustained these injuries? If appropriate, inquire as to why it has taken this long to seek out the proper care.
  - The patient appears to be malnourished. Do you have any idea how this happened?

\*\* Denotes high risk situation

Originally developed by Dr. Karen Fruetel.

## QUOTABLE QUOTES

"Only one in six cases of elder abuse is reported, compared to one in three for child abuse. Rather than occurring as isolated incidents, abuse of the elderly is recurrent in up to 80% of cases."

Anne Sclater, MSc, MD, FRCPC  
Presented at the 6th Annual Update, Internal Medicine for the Primary Case Physician,  
Edmonton, Alberta, April 2000

"Elder abuse is an international problem found among all racial, ethnic and socio-economic backgrounds, with an incidence and prevalence only slightly less than that of child abuse".

Anne Sclater, MSc, MD, FRCPC  
Presented at the 6th Annual Update, Internal Medicine for the Primary Case Physician,  
Edmonton, Alberta, April 2000

"Most elderly people value autonomy above personal safety and comfort, and would rather have inadequate care with families than the best of institutional care."

Anne Sclater, MSc, MD, FRCPC  
Presented at the 6th Annual Update, Internal Medicine for the Primary Case Physician,  
Edmonton, Alberta, April 2000

"Management of the abusive situation requires skill, diplomacy, and knowledge of a complicated health-care and legal system."

Ontario Medical Review January 1993

"The key to detection is proper assessment and documentation in the medical record."

Anne Sclater, MSc, MD, FRCPC  
Presented at the 6th Annual Update, Internal Medicine for the Primary Case Physician,  
Edmonton, Alberta, April 2000

"Behavioral observation may provide the only clue to verbal or emotional abuse. Careful observation of the patient may indicate a state of generalized fear and anxiety."

Anne Sclater, MSc, MD, FRCPC  
Presented at the 6th Annual Update, Internal Medicine for the Primary Case Physician,  
Edmonton, Alberta, April 2000

"Geriatric services, where available, are able to review the entire situation, perform the necessary assessments, and arrange for additional services."

Ontario Medical Review January 1993



# Overheads

The following pages are actual sized copies of the overheads.  
If you cannot access the Powerpoint presentation on the CD,  
overheads can be produced by copying these pages  
or printing them from the PDF on the CD.

# Elder Abuse Workshop

Developed by the  
Regional Geriatric  
Program of Toronto



# Learning goals

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- **See** subtle signs of elder abuse
- **Hear** all perspectives
- **Understand** cultural issues
- **Feel** confident in approach
- **Act** with support of team

# Elder abuse is...

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any act of commission  
or omission that results in  
harm to an elderly person

# Types of abuse

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- Physical
- Financial
- Emotional
- Sexual
- Neglect

# Typical elder abuse profile

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## **Victim**

- Over 75 years
- Female/widow/single
- Physical and/or cognitive impairment
- Social isolation
- Dependent on caregiver
- Low self-esteem

## **Abuser**

- Often under 30 or over 60
- Close relative or caregiver
- Living with abused elder
- Psychologically stressed or depressed
- Substance abuse history
- Financial problems



# Approach to treatment

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- Crisis intervention
- Short-term intervention
- Long-term intervention
- Follow-up

# Strategies for intervention

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- Awareness of own attitudes and values
- Interview
- Documentation
- Team approach
- Knowledge of community resources
- Education – proactive, prevention

**S**creen for abuse in all elderly individuals  
**T**hink about risk factors  
**O**minous danger signs present  
**P**hysical findings  
**H**istory  
**A**ddress issue of elder mistreatment  
**R**eport issue of elder mistreatment  
**M**anage with prevention and risk factor modification



**Video entitled:**

# **She's Happier There**

**The Ontario Network for the  
Prevention of Elder Abuse (ONPEA)**

**[www.onpea.org](http://www.onpea.org)**



# BUILD-A-CASE

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# ROLE PLAYING

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# CASE STUDY

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**REGIONAL GERIATRIC  
PROGRAM OF TORONTO**

Elder Abuse Network:  
Sunnybrook & Women's College  
Health Sciences Centre  
2075 Bayview Avenue, H4T8  
Toronto, ON M4N 3M5  
Tel: 416-480-6802  
Fax: 416-480-6068  
Website: [www.rgp.toronto.on.ca](http://www.rgp.toronto.on.ca)





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PROGRAM OF TORONTO**



## **Elder Abuse Network Training Manual**