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Abuse and Neglect of Older Adults:

A Discussion Paper

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Abuse and Neglect of Older Adults: A Discussion Paper was prepared by **L. McDonald** and **A. Collins** for the Family Violence Prevention Unit, Health Canada.

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Executive Summary

As the decade comes to a close, it has become increasingly clear that abuse and neglect of older adults has come to be recognized as a problem worthy of serious academic inquiry and coordinated social action on the part of all Canadians. The purpose of this paper is to provide an overview of the important developments that have occurred in the field since the publication of the first discussion paper in 1989. Existing problems in defining abuse and neglect, issues surrounding data on incidence and prevalence, the lack of progress on the theoretical front and the related problems of identifying risk factors are revisited. Changes in adult protection legislation, along with advances in the creation of protocols for detection, intervention, and programming are described. We conclude by surveying some of the preventive strategies that have been adopted across Canada in recent years and by offering suggestions for future directions.

Issues related to definitions have historically generated considerable controversy in discussions about abuse and neglect of older adults, and these still persist today. Consequently, there continues to be a multitude of definitions available in the literature. Most would agree, however, that there are three major categories (domestic abuse and neglect, institutional abuse and neglect, self abuse and neglect) and three major types of abuse (physical, psychological and financial). Unfortunately, beyond this, little agreement exists. Stakeholders appear to be growing tired of the continued debate around definitions, nevertheless, this issue should not be shelved. It remains important because definitions determine who will be counted as abused and who will not; what the legislation does and does not cover; and who is and is not eligible for service. Thus, as Canada approaches the next millennium, the challenge will be to sharpen the definitions; seek agreement among practitioners, academics, legislators, and policy-makers about definitions; incorporate perspectives on abuse and neglect articulated by our ethnic communities and ensure the participation of those most affected by the definitions—the seniors themselves.

To date, a substantial number of studies have documented the existence and nature of abuse and neglect of older adults. However, only a few have provided data on the prevalence and incidence of the problem among non-institutionalized seniors. Accurate data has been

difficult to obtain because of differences in definitions, methodologies and samples. Consequently, at this time, it is not possible, with any degree of confidence, to interpret the reported prevalence rates, which vary from 1 to 4% in Australia, Norway, the United States, and Canada to a high of 20% in France. Incidence rates are still unknown in most countries, including Canada. Therefore, there is no way of knowing whether abuse and neglect is getting better or worse. In Canada, we only have prevalence data from 1989 which, at best, offers a quick snapshot of the problem. From the standpoint of strategic planning, two priorities have emerged. The first is the need to know the actual dimensions of the problem so that interventions can be calibrated to meet them. This could be achieved through follow-up with the participants in the Ryerson study (1989). Additionally, an incidence study, comparable to the National Incidence Study on Child Abuse, is necessary to help plan for the future.

Canadians have been slow to investigate the abuse and neglect of older adults in institutions. Despite this, there is evidence to suggest that this is a widespread problem. In Canada, however, there are currently no real incidence or prevalence studies of abuse and neglect in institutions. Additionally, few theories have been offered to explain this phenomenon. North American scholars have articulated a number of hypotheses. These include: the lack of comprehensive policies with respect to infirm seniors; financial incentives that contribute to poor-quality care are built into the long-term care system; poor enforcement of institutional standards; poorly trained staff; and work related stress.

The last decade had seen increasing pressure placed on Canadian institutions to establish protocols for detection, intervention, and prevention of abuse and neglect. While these are long overdue, no information is available on how many facilities have incorporated these strategies and no information is available on whether they work. It is argued therefore, that at this time, prevalence studies are needed to quantify how many older adults are abused or neglected in institutions at any given point in time. This would document the extent of the current problem and, in turn, allow us to focus on where and how limited resources should be used. At the same time, incidence studies are needed to provide clues about the etiology of abuse. These would also provide us with the data to evaluate the efficacy of preventive programs. Finally, the *outcomes* of abuse need serious consideration because there appears to be some evidence that abuse is associated with increased mortality rates in institutions.

With respect to our current knowledge about the characteristics of victims and perpetrators, a decade and a half of research can be summarized in the following way: victims of psychological and physical abuse are often in good health but suffer from psychological problems, while their abusers often have a

history of psychiatric illness and/or substance abuse, often live with the victims, and are financially dependent; patients with dementia who exhibit disruptive behaviour and who live with family caregivers are more likely to suffer physical abuse, while their abusive caregivers may have low self-esteem and may be clinically depressed; a typical financial abuse victim may not exist; and victims of neglect tend to be very old, with cognitive and physical incapacities, which serves as a source of stress for their caregiver. Importantly, race and ethnicity have emerged in the literature as two new risk factors, but most of the discussion to date has been based on speculation.

A review of the abuse and neglect literature suggests that there have been few new developments on the theoretical front. Because there is such a paucity of incidence studies in the world, it is not surprising that little headway has been made in this regard. At present, most people still rely on the same old theories with the same old flaws. Importantly, there is still a strong tendency to blur the boundaries between theoretical explanations and the individual risk factors related to abuse. For example, specific risk factors, like stress, are often treated as full theoretical explanations even though stress is a factor that could be incorporated into many different theories. At present, at least four distinct theoretical perspectives are available in the literature. They are the situational model, social exchange theory, symbolic interactionism, and the feminist model. Recently, there has been some suggestion that there may not be one all inclusive explanation for abuse and neglect of older adults. If this is the case, it is suggested that theorists will have to cast their nets wider than the current gerontological and family violence literature.

Investigations into the specific factors hypothesized to be associated with abuse and neglect remains limited and those that do exist suffer from significant methodological problems. The principal factors that have been associated with abuse include the personality traits of the abuser, the intergenerational transmission of violence, dependency, stress, and social structural factors such as ageism—all of which can be subsumed under any of the previously mentioned theories. At present, because the field has made such little progress, it is unwise to assume that we can predict who will be abused and/or neglected regardless of how many protocols exist or how elaborate they are. At the direct service level, there are few formal response protocols, policies, and procedures; those that do exist range from unsystematic assessments that rely on professional judgement rather than objective data, to checklists of risk indicators. Many of the screening and assessment tools currently in use are based on assumptions found in the domestic violence literature and, thus, contain the same weaknesses found in the field. Currently, there is a clear content bias toward issues related to physical abuse and neglect. As such, the instruments available today most likely catch only a small percentage of the total abuse cases.

Four major kinds of programs have been developed to respond to abuse and neglect: the statutory adult protection service programs; programs based on the domestic violence model; advocacy programs for seniors; and an integrated model. All fifty states in the United States and four Canadian provinces have dealt with the problem of abuse and neglect by enacting special adult protection legislation. This approach is influenced by child welfare models and is characterized by legal powers of investigation, intervention, and mandatory reporting. There has been, and continues to be, considerable controversy over adult protection legislation and programming. Proponents argue that such intervention means that the rights of older adults are safeguarded, and that attempts can be made to improve their quality of life while protecting them from harm. Opponents vigorously challenge this position and suggest that this system of care infantalizes seniors and violates their independence.

The domestic violence approach has gained considerable momentum in North America because it is not seen as violating people's rights, or as discriminating on the basis of age. This response consists of a multi-pronged approach that includes a whole range of health, social, and legal resources. This model is not without critics who are quick to point out problems with police response and restraining orders, poorly managed shelters, and a shortage of follow-up services. This model also fails to apply in cases of neglect.

Like the domestic violence model, an advocacy approach acknowledges that the older adult is potentially vulnerable and may be in a dangerous situation. Advocacy programs believe that the least restrictive and intrusive interventions should be used. Advocacy undoubtedly plays a role in protecting and furthering the rights of victims. However, knowing one's rights is one thing—acting on them is another. Those who can assert themselves are more likely to gain attention. Unfortunately, many victims are in need of help but, because of disability or isolation, may not get the assistance they require.

An observable trend at the direct service level has been the development of multidisciplinary teams using an integrated model. Although little research has established the efficacy of this approach, many believe that it enhances the quality and quantity of care. The main drawback appears to be that teams spend more time per case than professionals acting alone.

A glaring lack of program evaluation still exists in the field. At present, even the most fundamental questions about what types of services work, for whom, and under what circumstances, remain unanswered. This is an area that requires immediate attention. Evaluation is important, and thus, it has been suggested that deliberation by clinicians, researchers, and seniors about how to measure the effectiveness of interventions would be useful at this critical juncture.

At present, there appears to be three major types of roadblocks to the provision of services to abuse seniors. Some are associated with client variables, some are attributed to front-line practitioners and others exist as a result of broader systems level issues. The most obvious barrier is related to the hesitancy of victims to engage with services. At the system level, barriers include: agency mandates that do not specifically address abuse and neglect; inadequate funding of appropriate resources; and an overall lack of coordination among existing services. What is needed at this time is a broad-based community response that includes services that are available, affordable, accessible, known, and perceived as appropriate by the seniors themselves. It also appears that mainstream services do not appropriately address the needs of seniors from diverse backgrounds. This alone presents many challenges at the service delivery level.

Education and public awareness are critical elements in any comprehensive approach to abuse and neglect of older adults. This includes the education of older adults themselves, professionals, caregivers and the public. A number of exciting and innovative programs have developed within Canada in this regard.

Thus, when one reflects on the developments in the field of abuse and neglect of older adults in the last decade, there is reason to be proud because considerable progress has been made. This is not to suggest that there is nothing more to be done. Most of our progress has been made in the areas of prevention and intervention, with only small gains in the area of research. It seems that the next logical step for Canada would be the formation of a national organization devoted to the abuse and neglect of older adults that could pull together the strands of practice, education, and research. From this, a national strategy for action can be developed through the participation of all stakeholders, the most important of which being Canadian seniors.

1 The Canadian Context

The purpose of this paper is to provide a general overview of the major developments that have occurred in the field of elder abuse and neglect since the publication of the first discussion paper in 1989. To this end, we revisit the problems of defining abuse and neglect; the issues about the incidence and prevalence of abuse; progress on the theoretical front; and related problems of identifying risk factors for abuse and neglect. Changes in adult protection legislation and related research are examined and advances in creating protocols for detection and intervention, as well as innovations in programming, are considered. The discussion concludes by surveying some of the preventive strategies adopted across Canada and setting out some ideas for future research.

The field of elder abuse[1] has expanded dramatically since the appearance of the first federal discussion paper in 1989 (Gnaedinger, 1989). At that time, elder abuse had just been recognized as another form of family violence, similar in status to child abuse, "discovered" in the 1960s, and wife abuse, identified in the 1970s. Although the first reference to elder abuse was made in Britain in the 1970s (Baker, 1975; Burston, 1975), the issue had far greater prominence in the United States at that time, with Canada following suit in the 1980s. The first prevalence studies[2]—by Bélanger (1981) and Grandmaison (1988) in Quebec, Shell (1982) and King (1984) in Manitoba, the G. A. Frecker Association on Gerontology (1983) in Newfoundland, Haley (1984) in Nova Scotia, Stevenson (1985) in Alberta, and the Ontario Advisory Council on Senior Citizens (1985) in Ontario—suggested that an appreciable proportion of Canadian seniors were being mistreated at the hands of their caregivers.

1 When the abuse of older adults was first addressed, it was labelled elder abuse and still is today in most countries (Kosberg & Garcia, 1995b). In Canada in the mid-1990s, several researchers and government officials decided to use different labels for the terms "elder abuse" and "neglect." They also consulted seniors themselves about the terms. New terms proposed were "abuse and neglect of older adults," terms that could not be confused with those used in other ethnic and religious communities. There was also the suggestion that, because the term "elder abuse" supposedly had the potential to be "stigmatizing" and to focus on the "oldest of the old," the proposed terms were more suitable (Spencer, 1995). In this discussion paper, we use the term "abuse and neglect of older adults" except when reporting the research of others who use the earlier terms.

2 Prevalence refers to the number of occurrences in a lifetime.

In the late 1980s, the first Canadian book on abuse, written by Schlesinger and Schlesinger (1988), served to formally alert the field to some of the more distressing issues practitioners and legislators had to face. The authors unearthed over 200 North American papers on the abuse and neglect of older adults, providing the first annotated bibliography for Canadians. During the 1980s, the need to respond to the problem prompted an examination of adult protection legislation and a consideration of the pros and cons of mandatory reporting of abuse. The initial debates, restricted to a small cadre of practitioners and academics, provided the impetus for reforms to adult guardianship and adult protection legislation—a process that had begun in 1973 in Newfoundland and 1976 in Alberta. At the same time, the federal and provincial governments of Canada began funding various research, educational, and intervention initiatives, all of which supported the drive to produce irrefutable evidence of the existence of abuse and neglect of older adults.

In 1989, the landmark national survey, by Elizabeth Podnieks, revealed that four percent of elderly Canadians living in private dwellings experienced some form of abuse and neglect (Podnieks, 1990). The publication of this study brought the first era of Canadian research on elder abuse to a favourable conclusion. A small but important group of enterprising practitioners, aided by an even smaller group of researchers, had succeeded in bringing the disturbing social problem of elder abuse and neglect to the attention of Canadians.

The 1990s saw a new era characterized by an ever-increasing commitment to research, education, and action on behalf of Canada's abused and neglected older adults. Today, numerous national, provincial, and local conferences directed toward professionals, the public, and seniors themselves, are offered to address the multitude of issues related to the abuse and neglect of older adults (e.g., *One Voice*, 1995; Health and Welfare Canada, 1997). A wealth of educational materials is regularly produced, from the local to the national level, and governments, despite fewer resources, continue to fund innovative responses to the problem (e.g., British Columbia Seniors Advisory Council, 1992; Health and Welfare Canada, 1992; Health and Welfare, 1993; Mackenzie & Senechal, 1991; Wasylkewycz, 1993; Wigdor, 1991).

The early 1990s saw the introduction of a whole new generation of researchers who, moving beyond proving that elder abuse was a social problem, began to conduct research designed to guide practice and the formulation of policy, and, to a lesser extent, the reform of legislation (e.g., Beaulieu, 1992; Pittaway & Westhues, 1993; Poirier, 1992; Reis & Nahmiash, 1995a; Stones & Pittman, 1995; Sweeney, 1995). As the decade comes to a close, abuse of older adults has been recognized as a critical problem worthy of serious academic inquiry and concerted social action on the part of all

Canadians. As Canada approaches the next millennium, we take stock of these developments, the new issues they raise, and their implications for the seniors of tomorrow.

2 Defining Elder Abuse and Neglect

2.1 Proposed Definitions

A leading researcher in the field of elder abuse observed that "[f]rom the very beginning of the scientific investigation into the nature and causes of elder abuse definitions have been a major issue" (Wolf, 1988, p. 758). The lack of a generally acceptable definition has spawned a wide variety of definitions of abuse and neglect, which, to this day, still generates controversy and debate (Bennett, 1990; Council of Europe, 1992; Decalmer & Glendenning, 1993; Kozma & Stones, 1995; Sanchez, 1996; Wallace, 1996). Nevertheless, most would agree on three basic categories of abuse and neglect: (1) domestic elder abuse; (2) institutional abuse; and (3) self-neglect or self-abuse. Most would also agree on the major types of abuse—physical, psychological, and financial abuse. Beyond this classification, however, there is little agreement (Decalmer & Glendenning, 1993; Hudson, 1994; Wolf, 1992;).

Choosing definitions is obviously risky. For the purposes of this paper, the definitions of abuse will be based on those set out by the National Centre on Elder Abuse (NCEA) in the United States, mainly because there is some consensus on their utility. "Domestic elder abuse" generally refers to any of several forms of maltreatment of an older person by someone who has a special relationship with the senior, such as a spouse, a sibling, a child, a friend, or a caregiver, in the older person's own home or in the caregiver's home (NCEA, 1998). The abuse is called "domestic abuse" because it occurs in the community, rather than in an institution such as a nursing home. The abusive behaviour can cause physical, psychological, and material injury to the older person, resulting in distress and suffering (Hudson, 1991; McDonald, 1996).

"Physical abuse" is defined as the use of physical force that may result in bodily injury, physical pain, or impairment. Physical abuse may include, but is not limited to, such acts of violence as striking (with or without an object), hitting, beating, pushing, shoving, shaking, slapping, kicking, pinching, and burning (National Centre on Elder Abuse (NCEA), 1998; Stones, 1995; Wolf & Pillemer, 1989). Such maltreatment as the inappropriate use of drugs, and physical restraints and force-feeding are also considered physical abuse (NCEA, 1998). The possible signs

and symptoms of physical abuse appear in Table 1.

"Sexual abuse," which is sometimes subsumed under physical abuse (McDonald, 1996), is defined as non-consensual sexual contact of any kind with an older adult. Sexual contact with any person incapable of giving consent is also considered sexual abuse. It includes, but is not limited to, unwanted touching and all types of sexual assault or battery, such as rape, sodomy, coerced nudity, and sexually explicit photographing (NCEA, 1998). The possible signs and symptoms of sexual abuse are outlined in Table 1.

"Psychological (or emotional) abuse" is defined as the infliction of anguish, pain, or distress through verbal or non-verbal acts. This type of abuse includes, but is not limited to, verbal assaults, insults, threats, intimidation, humiliation and harassment. Other examples of emotional abuse include treating an older person like an infant; isolating the person from his or her family, friends, or regular activities; giving the older person the "silent treatment"; and enforced social isolation. This type of abuse is difficult to assess, as can be seen from the signs and symptoms noted in Table 1.

"Material abuse," often referred to as "financial abuse," involves the illegal or improper exploitation of an older person's funds, property, or assets. Examples include, but are not limited to, cashing an elderly person's cheques without authorization, forging an older person's signature, misusing or stealing an older person's money or possessions, coercing or deceiving an older person into signing any document (e.g., a will), and the improper use of guardianship or power of attorney (Gordon, 1992; Health and Welfare Canada, 1993; McDonald, 1996; NCEA, 1998). The signs and symptoms of financial abuse are displayed in Table 1. Acts such as theft, physical assault, rape, and burglary by a person *outside* of a trusting relationship with the older person usually would not be classified as elder abuse but rather as crimes. Crimes against the elderly include some, but not all, forms of elder abuse (Health and Welfare Canada, 1993; McDonald, 1996).

"Neglect" is intentional or unintentional harmful behaviour on the part of an informal or formal caregiver in whom the older person has placed his or her trust. Unintentional neglect involves a failure to fulfil a caretaking responsibility, but the caregiver does not intend to harm the older person; intentional neglect occurs when the caregiver consciously and purposely fails to meet the needs of the older person, resulting in psychological, physical, or material injury to the older person (McDonald, 1996). "Neglect" typically refers to the refusal or failure to provide an older person with the necessities of life, such as water, food, clothing, shelter, personal hygiene, medicine, comfort, personal safety, and other essentials (NCEA, 1998). Neglect is also difficult to ascertain, because the symptoms can easily be confused

with illness (Filinson & Ingman, 1989). Some of the signs of neglect appear in Table 1.

"Self-neglect" is characterized as behaviour by an older adult that threatens his or her own health and safety. "Self-neglect" usually means that the older adult refuses or fails to provide himself or herself with the necessities of life noted above. This newer definition of self-neglect excludes situations in which a mentally competent older person knowingly makes a voluntary decision to engage in acts that threaten his or her safety (NCEA, 1998). The signs and symptoms are similar to neglect by a caregiver. There is some question as to whether self-neglect should be included in a consideration of neglect and abuse of older adults, because no abusive caregivers are involved.

Table 1: Signs and Symptoms of Abuse

Physical Abuse

- bruises, black eyes, welts, lacerations, rope marks
- bone fractures, broken bones, skull fractures
- open wounds, cuts, punctures, untreated injuries in various stages of healing
- sprains, dislocations, and internal injuries/bleeding
- broken eyeglasses, signs of being restrained
- laboratory findings of medication overdose or underutilization of prescribed drugs
- an older person's report of being hit, slapped, kicked, or mistreated
- an older person's sudden change in behaviour
- a caregiver's refusal to allow visitors to see an older adult

Financial/Material Abuse

- sudden changes in bank account or banking practices
- the inclusion of additional names on older person's bank signature card
- unauthorized withdrawal of the older person's funds using the person's ATM card
- abrupt change in will or other financial documents, unexplained disappearance of funds or valuable possessions
- unpaid bills despite adequate funds
- discovery of forgery of older person's signature
- unexplained sudden transfer of assets to someone in or outside the family
- an older adult's report of financial exploitation

Abandonment

- desertion of an older person at the hospital, nursing facility or institution
- desertion of the older person at a shopping centre or other public location
- an older person's report of being abandoned

Sexual Abuse

- bruises around the breasts or genital areas
- unexplained venereal disease or genital infections
- unexplained vaginal or anal bleeding
- torn, stained, or bloody underclothing
- an older person's report of being sexually assaulted or raped

Emotional/ Psychological Abuse

- being emotionally upset or agitated
- being extremely withdrawn, non-communicative, non-responsive
- unusual behaviour usually attributed to dementia (e.g., sucking, biting, rocking)
- an older person's report of being verbally or emotionally abused

Table 2: Signs and Symptoms of Neglect and Self-Neglect

Neglect	Self-Neglect
• dehydration, malnutrition, untreated bedsores, poor personal hygiene • unattended or untreated health problems • hazardous or unsafe living conditions (dirt, soiled bedding, smell)	• dehydration, malnutrition, untreated bedsores, poor personal hygiene • unattended or untreated health problems • hazardous or unsafe living conditions (e.g., improper wiring, no heat) • unsanitary or unclean living conditions (smell) • inappropriate and/or inadequate clothing, lack of medical aids (e.g., eye glasses, hearing aid) • grossly inadequate housing and homelessness

Note: Adapted from the National Centre on Elder Abuse, 1998

Most recently, abandonment has been added to the list of abuse. "Abandonment" is defined as the desertion of an older adult by an individual who has assumed responsibility for providing care for that person or by a person with physical custody of an older adult (NCEA, 1998). The most common signs and symptoms are listed in Table 1.

2.2 Definitional Disputes

Many elder abuse professionals are weary of the continuing search for definitions of elder abuse and neglect. However, the issue remains an important one: the definition determines who is counted as abused and who is not; the definition determines what the legislation does and does not cover; and it determines who is and is not eligible for service. The definition will also determine the type of treatment offered and, ultimately, the effectiveness of the treatment in stopping the abuse. Thus, accurate definitions of abuse and neglect ensure accuracy in screening, classification, and appropriate treatment.

In addition, the variations in the definitions of elder abuse make it impossible to pool or compare data collected from different provinces in Canada, or even social agencies in any given city. Without standardized definitions of abuse, cross-national comparisons are also out of the question. If Canada were to conduct another study to determine the prevalence of abuse as it did in 1989, we would have to retain the original definitions of abuse if we were to judge whether the problem had grown better or worse since that time (Podnieks, 1992).

The "definitional disarray" noted by Pillemer and Finkelhor (1988, p. 52) can be attributed to a number of factors. One clear difficulty is that the definitions have been developed from different perspectives—the abused older person, the caregiver, the health professional, the lawyer, the police, the social worker and the policy-maker. So, while the behaviour of a police officer is probably affected by definitions of elder abuse found in the *Criminal Code*, a community worker will follow agency policy, which, more than likely, will encourage a broader definition of abuse, in order to cover all contingencies in the community. The difference in perspective is easily illustrated: for example, a Canadian study revealed that there was considerable difference between the public's view of physical abuse and that of abuse professionals (Gebotys, O'Connor & Mair, 1992). The legal definitions of abuse and neglect also vary across jurisdictions in Canada. For example, in Newfoundland, the legislation applies only to "neglected" adults, and makes no provision for cases of abuse, whereas the legislation in British Columbia provides a specific definition of abuse (Robertson, 1995).

A review of the earlier literature on the abuse of older adults indicates the tendency of researchers and practitioners to develop taxonomies or typologies (lists of types) of elder abuse and neglect (Block & Sinnot, 1979; Chen et al., 1981; Hickey & Douglass, 1981; Lau & Kosberg, 1979; McDonald et al., 1991; Pillemer & Finkelhor, 1988; Rathbone-McCuan & Voyles, 1982; Sengstock & Hwalek, 1987; Sengstock & Liang, 1983; Steinmetz, 1988) or to try to develop broad, all-encompassing conceptual definitions that capture the multi-dimensional nature of abuse (Filinson, 1989; Fulmer & O'Malley, 1987; Hudson, 1988; Johnson, 1986, 1991; O'Malley et al., 1979, 1983; Podnieks, 1985; Rathbone-McCuan, 1980; Wolf, 1988).

The problem with descriptive lists of different types of abuses is that there is no uniformity among the categories used by the experts or within the categories themselves. Some researchers, for example, include violation of rights as a category, while other researchers omit this category (Lau & Kosberg, 1979; Sengstock & Hwalek, 1987). As well, the categories contain such a wide range of abuses that they tend to become ineffectual in application because every act becomes abusive or neglectful. The conceptual definitions also suffer from problems. Typical examples include the definitions by Fulmer and O'Malley (1987) "…actions of a caretaker that create unmet needs for the elder person" (p. 27) or the one by Johnson (1991) "…self- or other-imposed suffering unnecessary to the maintenance of the quality of life of the older person by means of abuse and neglect caused by being overwhelmed" (p. 4). The first definition focuses on the outcome of abuse, while the second refers to the causal factors, the means, and the outcome of abuse (Johnson, 1991; Stones, 1995). The unevenness of the conceptual definitions and their

imprecise nature cause confusion for researchers and workers alike.

2.3 The 1990s and Beyond

Even though the terminology of abuse remains in a state of flux, there has been a concerted effort in the 1990s to address the lack of consensus around definitions of abuse and neglect. Researchers have "researched" definitions themselves, with some interesting results. Canadian researcher Michael Stones (1995) finds three basic approaches to the meaning and definitions of abuse and neglect found in the professional literature. He shows that there are connotative definitions that emphasize the consequences of abuse, such as the two examples above from Johnson (1991) and Fulmer and O'Malley (1987). There are definitions based on structural criteria that highlight the criteria to be used to determine whether behaviour is abusive. Stones (1995) refers to his own definition as an example: "A misdemeanor against acknowledged standards by someone a senior has reason to trust" (p. 114). The third approach is to use denotative definitions, which are the same as the descriptive lists noted above and which appear in Table 2. The examples in Table 2 are a result of the compilation of an abuse inventory created through several rounds of agreement about different types of abuses on the part of seniors and practitioners (Stones, 1995).

The conceptual framework by Stones brings a new clarity to the issue of definitions. The continuing attempt to include seniors and caregivers in the definitional process is crucial if all Canadians are to identify abuse (Beaulieu, 1992; Hudson, 1994; Johnson, 1995; Nandlal & Wood, 1997).

Some Norwegian scholars use the science of meaning (semiology) to understand acts of abuse (Johns, Hydle & Aschjem, 1991) and have developed a model in which abuse of older adults is a social act, involving a witness with a clear understanding and a moral evaluation of the event. This reflects quite a different view from North American perspectives which, until very recently, did not emphasize the moral aspects of abuse.

Even as the weaknesses of existing definitions are being tackled, new issues are complicating the matter. The globalization of activities related to abuse and neglect of older adults brings new definitional challenges, as a result of the intellectual contributions made by various nations from around the world. This variety of perspectives has also helped to refocus our attention on the multicultural diversity of our own Canadian society. For example, in a recent review of cross-cultural perspectives on the abuse of older adults, the concept of abandonment was introduced into the definition of elder abuse in India (Shah, Veedon & Vasi, 1995) and in Hong Kong (Kwan, 1995). Abandonment has also now been included by the NCEA in the United States. In some countries, definitions of abuse do not include age, often because the lower life expectancy of the population

precludes most people from entering old age (Kosberg & Garcia, 1995a). Closer to home, Tindale (1994) rightfully laments the lack of research on ethnic differences in patterns of abuse and neglect of older adults in Canada. A few Canadian studies of ethnocultural communities by the Aboriginal Nurses Association of Canada (1992), Bergin (1995) and Spencer (1996), represent a step in the right direction, but they are only a beginning. The first national conference on understanding and combatting elder abuse in minority populations was held as recently as 1997 in the United States, indicating that our knowledge in this area is, at best, preliminary.

The 1990s has also seen the "discovery" of another group of Canadians who are at risk for abuse: disabled persons, who in some quarters are included with the population of abused older adults under the more inclusive phrase "vulnerable adults" (Mickish, 1993; Health and Welfare Canada, 1997; Roeher Institute, 1995; Sobsey, 1994). The rationale for this classification is that more disabled persons are living into old age, and they share many of the needs and interests of abused older adults. There is also an implication that amalgamating the groups will help to maximize the effect of scarce resources for combatting the problems of both groups (Health and Welfare Canada, 1997). While combining resources will undoubtedly benefit both groups, it remains to be seen how the merger will be viewed by the disabled and the elderly, and how they will respond to sharing the label "vulnerable adults"—another term that will require definition.

The challenge of the next century, then, will be to continue to hone the definitions of abuse and neglect; to continue to seek agreement among practitioners, academics, legislators and policy-makers about the definitions; to incorporate perspectives on abuse that represent Canada's ethnic communities and, perhaps, the disabled communities; and to ensure and enhance the participation of those most affected by the construction of definitions—the seniors in Canada (McDonald, Harnick, Robertson, & Wallace, 1991).

3 Abuse and Neglect of Older Adults in Domestic Settings

Many studies have documented the existence and nature of elder abuse and neglect, but only a few have collected data on the prevalence (number of occurrences in a lifetime) and the incidence (number of new occurrences within a specific time) of the problem among the non-institutionalized elderly. Accurate data have been difficult to obtain, not only because definitions of abuse and neglect vary, but also because methodologies used to deal with the highly sensitive topic differ and the samples studied do not fully or accurately represent older people (Decalmer & Glendenning, 1993; McDonald, 1996). Abuse is a hidden problem that older adults sometimes feel uncomfortable reporting (McDonald, et al., 1991), and the cases reported probably represent only "the tip of the iceberg." In light of these difficulties, it is not easy to interpret reported prevalence rates, which vary from as low as one to three percent in Australia, Norway, and the United States, four percent in Canada, and five percent in Finland, to as high as 17 percent in Sweden and a reported high of 20 percent in France (Compton, Flanagan & Gregg, 1997; Dunn, 1995; Hugonot, 1990; Johns & Hydle, 1995; Kivelä, 1995; Kurrle, Sadler & Cameron, 1992; Kurrle, et al., 1997; Pillemer & Finkelhor; 1988; Podnieks, 1992).

The most widely quoted study was carried out in 1985–86 in the United States (Pillemer & Finkelhor, 1988). The Greater Boston area study, based on a representative sample of 2020 persons, all 65 years of age or older, found that 3.2 percent had experienced some type of abuse. Approximately 2 percent of the sample were physically abused, 1.1 percent chronically verbally abused, and about 0.4 percent were neglected. Financial abuse was not considered in this investigation, resulting in a generally lower prevalence rate than reported in Canada and Britain. This investigation showed that spouse abuse was more prevalent (58 percent) than abuse by adult children (24 percent); it showed that equal numbers of men and women were victims, and that financial situation and age were not related to the risk of abuse (McDonald, 1996).

Modified versions of the American prevalence study were carried out in both Canada and Great Britain. The 1989 national telephone survey in Canada, sometimes called the Ryerson study, surveyed 2008 randomly selected older persons. The study found that about four percent of the sample reported some type of abuse (Podnieks et al., 1990). Approximately 2.5 percent of the

sample experienced financial abuse, 1.4 percent experienced chronic verbal aggression, and 0.5 percent suffered physical abuse. About 0.4 percent reported neglect. Both physical abuse and chronic verbal aggression were perpetrated by spouses, whereas financial abuse tended to be perpetrated by both relatives and non-relatives. As in the American study, men and women were equally represented as abused (Podnieks et al., 1990).

Although there have been no further national prevalence studies in Canada, a study in British Columbia, called the Notary Study, sheds further light on financial abuse, the most common form of abuse in this country (Spencer, 1996). In a random sample of 200 seniors selected from a provincial enumeration poll, it was found that approximately 1 in 12, or 8 percent, of the respondents had been financially abused since turning 60 years of age. Older men and women were equally likely to be abused, usually by family members, with daughters being the most likely abusers. The main types of abuse included abuse of power of attorney and real estate transactions, such as signing over title to a home. In this study, abused older people were no more likely to be physically dependent on the abuser than the non-abused, but if they were, the abuse tended to be more serious. Physical dependence was also associated with a high likelihood that other forms of abuse occurred concurrently (Spencer, 1996). Interestingly, the persons who were abused were no more financially inexperienced than those not abused (Spencer, 1996). Another form of abuse was involved in two thirds of the financial abuse situations (Spencer, 1996).

The British study was carried out as part of a regular survey that is conducted monthly by the Omnibus section of the Office of Population Census Surveys (Bennett & Kingston, 1993; Ogg & Bennett, 1992). Reports based on a sub-sample of 593 seniors, from a British national survey of 2130 people in 1992, indicated that 5 percent of the sample were verbally abused by a family member, 2 percent were physically abused, and 2 percent were financially abused. No overall abuse figure was given. More women than men were verbally abused, while a slightly higher proportion of men reported physical and financial abuse (Bennett & Kingston, 1993).

The results of these national prevalence studies cannot be directly compared because of differences in their methods and procedures; all three investigations indicate, however, that most older people are not victims of abuse and neglect. The prevalence rates of 5 percent or less are relatively low but they may also be misleading. Although these studies represent the best prevalence studies currently available, they all suffer from flaws in their design and implementation; they are subject to cultural and contextual differences and, more than likely, provide low estimates because the cognitively impaired have been excluded from the investigations (McDonald, 1996, p. 2).

Incidence rates for elder abuse are still virtually unknown in most countries, including Canada. In the United States, a national incidence study carried out between 1994 and 1997 has just concluded, but the data are not yet ready for release. The study, conducted by the NCEA, gathered data on domestic elder abuse from adult protection services and area offices on aging, and through "sentinels" (data collectors trained specifically for the study) located in agencies not exclusively focused on aging. This approach, which has been used for incidence and prevalence studies of child abuse, will provide information about reported and unreported cases of elder abuse (NCEA, 1998; Wolf, 1997).

In the meantime, the National Aging Resource Centre on Elder Abuse in the United States has attempted to estimate incidence rates on the basis of two surveys of state adult protective service agencies and state units on aging across the United States. In 1986, 117 000 substantiated reports of abuse in domestic settings were made, as compared to 128 000 in 1987, 140 000 in 1988, 211 000 in 1990, and 227 000 in 1991. There were 227 000 reports in 1993 and 241 000 in 1994 (NCEA, 1998). Neglect seems to be the most common form of mistreatment, rising from 47 percent in 1990 to 58.5 percent in 1994. Reports of physical violence dropped from 20.2 percent of all reports to 15.7 in 1994. In the four-year period, financial abuse decreased from 17.3 to 12.1 percent, as did emotional abuse, declining from 11.7 percent of all reports in 1990 to 8.1 percent in 1994. Reports of sexual abuse seemed to remain constant over the four years, representing approximately 0.5 percent of the cases (NCEA, 1998).

These nationwide figures have to be interpreted with some caution, because of the wide variation in the definitions of and criteria for reporting abuse, as well as the possibility of duplication in reporting. It is obvious that the incidence rate is rising, but this could be a function of increasing awareness of the problem and/or improvements in reporting procedures. Some experts, too, argue that only 1 out of 14 domestic abuse incidents (excluding self-neglect) comes to the attention of agencies (NCEA, 1998).

In Canada, we have no way of knowing whether the problem is getting better or worse, because we have only prevalence data—a quick snapshot in 1989—and no incidence data whatsoever. As we prepare for the future, it would be helpful to know the actual dimensions of the problem so that we can ensure that our intervention and educational strategies are calibrated to meet current needs. A follow-up of the respondents in the Ryerson study would help us achieve that goal relatively cheaply. Likewise, an incidence study, comparable to the National Incidence Study of Child Abuse (Health Canada), would help us plan for the future, as the baby boomers become older.

4 Abuse and Neglect of Older Adults in Institutional Settings

4.1 Definitions and Categories

Canadians have been relatively slow to investigate elder abuse and neglect in institutional settings, although Podnieks expressed concern about this type of abuse as early as 1983. The term "institution" typically refers to a wide range of settings, such as hospitals, and long-term care facilities, which include nursing homes and homes for the aged (McDonald, 1996). In 1994–95, the federal government, in partnership with a national advisory group of elder abuse professionals, produced three publications on the abuse and neglect of older adults in institutional settings (Beaulieu & Tremblay, 1995; Spencer & Beaulieu, 1994; Spencer & Beaulieu, 1994). Recognizing that institutional abuse is a "slippery concept,"[3] according to these reports, abuse and neglect in the institution "… refers to any act or omission directed at a resident of an institution that causes harm, or wrongfully deprives that person of his or her independence." (Spencer, 1994, p. 19). By expanding this definition, the author adds a new dimension not contained in most other definitions,[4] namely that an abuser in an institution could also be another person in a position of trust, such as a family member or a friend (Spencer, 1994).

Elder abuse and neglect in the institution fall into the same categories as those used to describe domestic abuse, but the victims are likely to be more vulnerable to abuse, because they require the protective environment of a facility (Beaulieu & Bélanger, 1995). Some researchers, including Spencer (1994), have added violations of civil or basic rights to the list of abuses that can occur in institutions, as well as a specific category of medical abuse

3 Wierucka and Goodridge (1996) note that institutional abuse is a slippery concept, especially when unintentional harm to the resident is involved. Their example of an arthritic patient being forced to have a painful bath because of institutional duty could be construed as abusive although there is no intention to harm the patient. Spencer & Beaulieu (1994) picks up this thread in her discussion of whether intent should be included in the definition of elder abuse and decides against its inclusion in favour of focusing on remedying the harm.

4 The definition used for institutional abuse by the NCEA is similar to the one for domestic abuse and neglect, except that the perpetrators of institutional abuse are usually persons who have a legal or contractual obligation to provide older adults with care and protection. This definition focuses on the legality of the caregiver relationship and puts less emphasis on the outcomes of the abuse when compared to the Canadian definition.

that includes "…any medical procedure or treatment that is done without the permission of the older person or his or her legally recognized proxy" (1994, p. 20). Abuse or neglect in institutional settings, then, can take several forms, such as "… a single act in complete opposition to society's sense of proper conduct (e.g., punching a resident)"; or "…a repeated pattern of any types of abuse or neglect" (Spencer, p. 20). Institutions may also be the scene of systemic abuse and neglect, which refers to harmful situations created, permitted, or facilitated by procedures within the institution that are ostensibly designed to provide care (Spencer, 1994). As is the case with domestic abuse, many acts of abuse or neglect in the institution are crimes, such as assault, sexual assault, theft, and forgery (Spencer, 1994). Other examples of abuse and neglect in institutional settings are provided in Table 3.

As might be expected, there is little agreement on the definitions of abuse and neglect in the institution, for many of the same reasons as in domestic abuse: differing professional perspectives; divergent personal values and beliefs; and differences of culture and perspective between the caregiver and the abused (Bennett & Kingston, 1993; Spencer, 1994).[5] Despite this lack of consensus, an increasingly comprehensive and complex grasp of institutional abuse seems to be developing. In one Canadian study, Beaulieu (1992) describes how the views of managers of public facilities have changed over time. The managers in her study stated that they had changed their understanding of abuse in the space of a few years, moving from a limited view of abuse as physical mistreatment, to include more subtle forms of elder mistreatment, such as the violation of persons' rights. They also seemed to recognize the possibility of systemic abuse (Beaulieu, 1992).

4.2 The Incidence and Prevalence of Institutional Abuse and Neglect

Institutional abuse has been researched much less than domestic abuse, possibly because so few older persons live in institutions (only about 7 percent of older persons live in nursing homes in Canada) (Beaulieu & Bélanger, 1995; Spencer, 1994). One researcher in Britain argues that institutional abuse has received short shrift because abuse has been identified as a form of family violence; this precludes studying abuse in the institutional setting (Phillipson, 1993).

There is enough anecdotal evidence, however, to suggest that abusive behaviour is a widespread, regular aspect of institutional life. There

5 The repercussions of the problems with definitions are highlighted by the experience of the Canadian Task Force on the Periodic Health Examination (1994). The task force examined the evidence on the detection, assessment, and management of abuse and concluded that detection is impossible because there is insufficient evidence to support or exclude case finding. Part of the problem is the risk factors are not specific or sensitive enough to be useful in case finding (Canadian Task Force, 1994).

have been reports of material abuse, including the theft of patient's funds, fraudulent therapy, and pharmaceutical charges; physical abuse, including such medical maltreatment as inappropriate chemical and physical restraint; and psychological abuse, including social isolation (Beaulieu & Tremblay, 1995; Gilleard, 1994; Halamandris, 1986; Meddaugh, 1993; Middleton & Forbes, 1993; Paton, Huber & Netting, 1994; Payne & Cikovic, 1995; Spencer, 1994).

The most accurate study of abuse in nursing homes was carried out in the United States (Pillemer & Moore, 1989; 1990). In a random survey of 577 nurses and nursing home aides conducted in 1989, staff were asked to report on abuse perpetrated by others and on their own abusive actions. Only physical and psychological abuse were considered. The researchers found that, overall, 36 percent of the sample had seen at least one incident of physical abuse in the preceding year. The most frequent type of physical abuse observed by the staff was the excessive restraint of patients. A total of 81 percent of the surveyed staff had witnessed at least one psychologically abusive incident in the preceding year. The most frequent type of psychological abuse observed by the staff was yelling at a patient in anger (70%). Ten percent of the nurses reported that *they themselves* had committed one or more physically abusive acts, the most common being the excessive use of restraints (6%). Forty percent of the nurses admitted to psychological abuse, the most common form being yelling at a patient (33%).

Table 3: Examples of Signs and Symptoms of Abuse and Neglect in Institutions

Neglect

- dehydrated, malnourished
- missing dentures, glasses, hearing aids
- poor hygiene, inappropriate clothing
- untreated medical problems
- poor skin conditions
- unattended or tied to a bed or chair
- failure to monitor restraints
- failure to allow outside services, no outside medical appointments

Physical Abuse

- unexplained injuries – fractures, bruises
- unexplained falls
- unauthorized or inappropriate use of restraints
- delay in seeking and receiving treatment

Sexual Abuse

- pain, swelling, bleeding in the genital area
- fear of specific persons or being alone with them
- sexually transmitted disease
- drawing back from touching

Table 3: Examples of Signs and Symptoms of Abuse and Neglect in Institutions (Continued)

Psychological/ Emotional Abuse

- feelings of fear, passivity, shame, guilt
- extreme passivity and withdrawal
- symptoms of depression
- exclusion from activity and family
- the use or talk of punishment
- decisions made for resident

Financial Abuse

- lack of necessities or comforts
- unauthorized use of resident's money or property by others
- disappearance of the resident's property
- unexplained changes in a deed or will
- inadequate facilities to protect resident's property
- resident constantly lacks money to buy small personal comforts
- lack of accounting for way finances have been spent

Medical Abuse

- reduced/absent therapeutic response
- poor documentation of medical records
- improper administration of drugs
- no reasons for treatment given

Violation of Rights

- difficulty visiting, calling, or contacting older person
- not permitted to manage their own financial affairs
- lack of choices in life
- lack of privacy
- resident not allowed to participate in decision making about their own affairs
- lack of confidentiality in use of health care records

Note: Adapted from Abuse and Neglect of Older Adults in Institutional Settings *(Spencer, 1994).*

One of the drawbacks to this study is the limitation of the instruments that were used to assess physical and psychological abuse. For a more detailed critique of this survey, see Kozma and Stones (1995) and Middleton and Forbes (1993).

In Canada, there have been no national prevalence or incidence studies of abuse and neglect in institutions. In fact, there is really only one study from Ontario, which provides a rudimentary picture of the nature and extent of institutional abuse. A random telephone survey of 804 registered nurses and 804 registered nursing assistants was carried out in Ontario to determine the extent, circumstances, and type of abuses they had witnessed or heard about in their work (College of Nurses of Ontario, 1993). Nearly one half of the respondents had witnessed one or more incidents of abuse, with verbal abuse being the most common type (37% of respondents), followed by physical abuse (32% of

respondents). Eighty-five percent of the nursing personnel identified hospitals as the setting of the abuse, while 36 percent identified nursing homes or homes for the aged. It is important to note that the respondents felt that the incidents tended to be isolated, and that nurses were no more likely to be abusive than were the registered nursing assistants. The majority of the identified abusers were female, and the abused elders were most likely to be cognitively impaired females in poor condition and confined to bed. Seven out of 10 of the respondents viewed the client as having been the primary cause of the abuse, usually because of their uncooperative behaviour. Less than half of the reported cases were followed up (College of Nurses of Ontario, 1993). While this study represents a first step in understanding the extent of abuse in institutions, it is important to note that the survey reports only alleged incidents of abuse and the incidents were not restricted to any specific time period.

4.3 Understanding Institutional Abuse and Neglect

Few theories have been proposed to explain the abuse of the older adult in institutions. As in the analysis of domestic abuse, several North American scholars have identified a number of factors they believe contribute to the abuse of elderly residents by institutional staff. These factors include the lack of comprehensive and consistent policies with respect to the infirm elderly; the fact that the long-term care system is characterized by built-in financial incentives that contribute to poor quality care; the poor enforcement of nursing home standards; the culture and organization of the institution; the lack of highly qualified and well-trained staff; work-related stress and professional burnout; the powerlessness and vulnerability of the elderly residents; the personality traits of the staff; and the tendency of staff to avenge patient aggression (Beaulieu & Tremblay, 1995; Braun et al., 1997; Brennan & Moos, 1990; Cassell, 1989; Chappell & Novack, 1992; Feldt & Ryden, 1992; Gilleard, 1994; Kingdom, 1992; Meddaugh, 1993; Pillemer & Bachman-Prehn, 1991; Spencer, 1994; Stilwell, 1991; Whall et al., 1992).

One American researcher has developed a model of the potential causes of elder abuse in nursing homes (Pillemer & Moore, 1989). This model includes factors related to the socio-economic environment of the institution, such as the supply of nursing home beds and local unemployment rate; and to the characteristics of the facility, such as ownership status, size, staff-patient ratios and staff turnover rates; staff characteristics, such as age, education, gender and degree of burnout; and resident characteristics, such as health of the patients, their degree of social isolation and their gender.

In a partial test of this model, the researchers found evidence that the maltreatment of nursing home patients appeared, to some extent, to be a response to highly stressful

working conditions, rather than a consequence of the characteristics of the nursing home, such as the size or ownership status of the institution. Staff who were burned out and who experienced aggression from patients were most at risk of becoming abusive toward their elderly patients (Pillemer & Bachman-Prehn, 1991).

4.4 Combatting Institutional Abuse and Neglect

In the 1990s, there has been a serious push in Canadian institutions to tackle abuse and neglect by establishing protocols for detection, intervention, and prevention through legislation,[6] through the education of staff, the residents and their families, and through changes to the policies and organizational structure of the institution (Beaulieu & Bélanger, 1995; Beaulieu & Tremblay, 1995; Spencer, 1994; Watson et al., 1995). While these initiatives are long overdue, we have no idea how many institutions in Canada have adopted any initiative at all, nor do we know how these developments are affected by diminishing health care resources. If there are initiatives in place, we have no idea if they work.

As was the case in the 1980s, we simply have no incidence or prevalence studies of abuse and neglect in institutions in Canada. As a result, policies, protocols, interventions and preventive measures are currently being formulated on the basis of anecdotal information, if on any basis at all. Some would argue that this does not matter. However, in times of far-reaching cutbacks to health care, strained resources must be deployed ever more carefully to have even a minimal impact on abuse and neglect (Braun et al., 1997; McDonald & Wigdor, 1995).

Prevalence studies, then, are needed to tell us how many older persons are abused or neglected in institutions at a given point in time or during a given period of time. Prevalence studies indicate the extent of the current problem of abuse and, in turn, allow us to target more accurately where and how limited resources should be used for education and intervention. Incidence studies would provide information about how many persons have been abused for the first time during a specified time period. This type of information helps determine the causes of institutional abuse and enhances our ability to evaluate the effectiveness of the prevention programs institutions have put into place. Because incidence studies can also be used to estimate how much institutional abuse and neglect we can anticipate in the future, they would also help Canada prepare intelligently for the aging of the baby boomers and their use of institutions in the next century.

6 For example, Ontario operators of nursing homes are required to report abuse and neglect under the *Act to Amend the Nursing Home,* while in British Columbia there is legislation under the *Community Care Facility Act* that requires licensed operators to report "serious incidents," which may or may not include abuse and neglect.

At the same time, more studies are required that address the concerns and feelings of older adults in institutions, their families' experiences and the views of the staff who provide the care. In considering institutional staff, it would be important to pursue the issue of who is actually abusing whom (examining the interactional nature of abuse) and to discover the "lived experiences" of staff in times of strained resources. Stories of families that are forced to purchase extra nursing services, which they often can barely afford, because institutional resources are inadequate, need to be investigated. The views of nursing home residents about abuse and neglect also need to be heard. Finally, the *outcomes* of abuse for older adults need serious consideration. The rates of depression for older persons living in institutions are reportedly high (Bland, Newman & Orn, 1988; Parmelee, Katz & Lawton, 1989) and there is emerging information that abuse may actually be related to mortality (Wolf, 1997).

5 Characteristics of Victims and Perpetrators

The first wave of research on elder abuse, which began in the late 1970s in the United States, concluded that the typical victim was over 75 years of age, a female with debilitating physical and psychological impairments, and dependent upon a family caregiver, usually a daughter (Douglass, Hickey & Noel, 1980; Hwalek, 1989; Kosberg, 1988; O'Malley et al., 1983; Rathbone-McCuan, 1980; Sengstock & Liang, 1983; Shell, 1982; Stevenson, 1985; Wolf, 1986). Research at the end of the 1980s, based on sounder methodologies and more clinical experience, cast some doubt on early observations and indicated that the situation was far more complicated than originally presumed (McDonald, 1996). The focal point shifted from classifications of the victims to classifications of the perpetrators, and to profiles of different combinations of victims, perpetrators, and types of abuse (Bendik, 1992; Hocking, 1994; Homer & Gilleard, 1990; Pillemer, 1993; Spencer, 1995; Wolf, Godkin & Pillemer, 1986). Today, more and more researchers are uncovering the *interactive* aspects of elder abuse, and distinctions between patient-directed, patient-generated, and mutual abuse (Coyne, Reichmann & Berbig, 1993; Grafstrom, Nordberg & Winblad, 1993; Homer & Gilleard, 1990; Nolan, 1993; Pillemer & Suitor, 1992).

A decade and a half of research can be distilled into four major observations:

(1) Victims of psychological and physical abuse usually have reasonably good physical health, but suffer from psychological problems. Their abusers have a history of psychiatric illness and/or substance abuse, live with the victim, and depend on them for financial resources (Anetzberger, Korbin & Austin, 1994; Bristowe & Collins, 1989; Cooney & Mortimer, 1995; Greenberg, McKibben & Raymond, 1990; Homer & Gilleard, 1990; Paveza et al., 1992).

(2) Patients with dementia, who exhibit disruptive behaviour and who live with family caregivers, are more likely to be victims of physical abuse. Their abusive caregivers may suffer from low self-esteem and clinical depression (Compton, Flanagan & Gregg, 1997; Coyne, 1991; Coyne et al., 1993; Homer & Gilleard, 1990; Paveza et al., 1992; Pillemer & Suitor, 1992).

(3) There may not be a "typical" victim of financial abuse; however, when the abused person is dependent on the abuser, the financial abuse may be more serious (Rowe et al., 1993; Spencer, 1996).

(4) Victims of neglect tend to be very old, with cognitive and physical incapacities. Their dependency on their caregivers serves as a source of stress (Bennett & Kingston, 1993; Wolf, 1992).

Race and ethnicity are two "new" risk factors considered in the elder abuse literature but most of the discussion is based on speculation (Bergin, 1995; Browne, 1989; Dunn, 1992; Grier, 1989; Griffin, 1994; Lachs et al., 1994; Longres, 1992; Maxwell & Maxwell, 1992; Moon & Williams, 1993; Spencer, 1996; Tomita, 1994). A study by Lachs et al. (1994) of 2800 men and women in Connecticut showed that adults with minority status were more likely to undergo official investigation for alleged mistreatment than adults with non-minority status. In smaller studies that examined cases of abused minority older adults and non-minority adults, the results are contradictory (Hall, 1987; Longres, 1992). The national exploratory study by the Canadian Association of Social Workers (Bergin, 1995) found no compelling differences in the circumstances associated with elder abuse in ethnocultural communities, except for the obvious difficulties related to language barrriers and the problems associated with adapting to life in Canada.

Although some ground has been gained in identifying the characteristics of victims of abuse, the emphasis in current research has shifted to an examination of the interactional aspects of abuse. This approach appears to hold some promise for accurately identifying abuse. Investigators now focusing on the abused older adult are also more interested in the consequences of abuse, a topic that is surprisingly absent in the research literature. Depression, mortality, learned helplessness and post-traumatic stress are some of the outcomes that are currently being investigated (Wolf, 1997).

6 Understanding Abuse and Neglect of Older Adults

6.1 Theories of Abuse and Neglect

A survey of the elder abuse literature suggests few new developments on the theoretical front (McDonald & Wigdor, 1995; McDonald, 1996). As noted above, an incidence study would be the most effective mechanism for examining the causes of abuse and neglect of older adults; and, because there are so few incidence studies anywhere in the world, it is no surprise that there has been little headway in theory building. Without fresh evidence, most professionals still rely on the same theories, with the same flaws. The very few theoretical advances are offshoots of a political economy approach (Biggs et al., 1995) and the growing influence of postmodernism on all aspects of gerontology (Katz, 1996).

At the outset, it is important to note that much of the literature on elder abuse does not make an essential distinction between theoretical explanations and the individual risk factors related to abuse (McDonald, 1996; McDonald et al., 1991). Typically, a theory provides a general, systematic explanation of how some part of the world works. In the elder abuse literature, a particular risk factor, such as stress, is often treated as *the* theoretical explanation even though stress is only one factor, and could be subsumed by a number of divergent theories. The relationships between the various risk factors and elder abuse should, in fact, form the crucial scaffolding upon which theories are built.

In the short history of elder abuse, different accounts of the relationships among the risk factors have led to at least four distinct theoretical perspectives, all of which have been "borrowed" from other disciplines and fields of study, usually, with few modifications being made in the transfer to the field of elder abuse.

6.2 The Situational Model

The first and most widely accepted perspective on the cause of elder abuse is the situational model, which has its roots in the mainstream perspectives on child abuse and family violence (McDonald et al., 1991; Phillips, 1986). A well-known premise of the situational model is that stressful situations cause the caregiver to abuse the older person, who is usually viewed as the source of the stress because of his or her physical or mental impairment. This approach implies that mistreatment is an irrational response to stressful

situations. The situational variables that this theory associates with abuse include factors related to the caregiver, to the older person, and to the social and economic conditions of both parties (McDonald, 1996). An unemployed caregiver who has an alcohol problem may abuse an older parent who is financially secure but mentally impaired. Interventions grounded in this perspective attempt to reduce the stress of the caregiver by providing more support services and support groups (Scogin et al., 1992).

One major flaw of this perspective is that it fails to account for the fact that some caregivers, who experience the same stresses as abusers, do not abuse their elderly. The perspective has also been criticized for being dangerously close to blaming the victim, because it identifies the older person as the source of the stress. This is not an idle criticism, if one remembers that in one study, 7 out of 10 nurses perceived the patient as the primary cause of the abuse (College of Nurses of Ontario, 1993). One might also wonder why general stress theory is not drawn upon to expand this model (Kahana & Young, 1990). More to the point, more rigorous case-comparison studies have produced little convincing evidence to support this model (see Pillemer, 1993, for reviews of these studies). The lack of evidence to support this model leads Pillemer (1993) to marvel at its persistence in the elder abuse literature. In Canada, Pittaway and Westhues (1993), in a secondary analysis of data from health and social service providers in London, Ontario, found modest support for this model as a means of predicting physical abuse. However, their study is hampered by the constraints of a secondary data analysis, which inevitably does not have all the required information.

6.3 Social Exchange Theory

Social exchange theory is founded on the assumptions "…that social interaction involves an exchange of rewards and punishments between at least two people, and that all people seek to maximize rewards and minimize punishments" (Glendenning, 1993, p. 25). In most relationships, people have different degrees of access to resources and different capabilities to provide services to others, which makes some people more powerful than others. In the social exchange perspective, it is argued that, as people age, they become more powerless, vulnerable and dependent on their caregivers; it is these characteristics that place them at risk for abuse (Phillips, 1986). In essence, older adults remain in the abusive relationship only as long as the satisfaction of their needs exceeds the costs of the maltreatment.

There are many difficulties with this perspective, not the least of which is its ageist assumption: people do not automatically become dependent and powerless as they age. Indeed, several researchers have argued, and subsequently shown, that the dependency may lie elsewhere (Pillemer & Wolf, 1986). A number of investigations have found the abuser to be dependent on the older

person; it is the abuser's sense of powerlessness that leads to maltreatment (Homer & Gilleard, 1990; Pillemer & Suitor, 1992; Pillemer & Wolf, 1986). Interventions prompted by a social exchange analysis would first have to identify the dependent person. If the older person were assessed to be dependent, then services aimed at increasing independence would be in order, whereas a dependent adult child might need help from mental health services, or require vocational training or job placement in order to become self-reliant (McDonald, 1996).

6.4 The Symbolic Interaction Approach

The Symbolic Interaction approach has been adopted from the family violence literature and focuses on the interactive processes between the older adult and the caregiver. This perspective emphasizes not only the behaviours of the elder and the caregiver, but also both persons' symbolic interpretations of such behaviour. Such an analysis of elder abuse centres on the different meanings people attribute to violence and on the consequences these meanings have in certain situations (McDonald, 1996). An example is the finding of Steinmetz (1988) that a subjective interpretation of stress by the caregiver is a better predictor of burden than the actual level of burden. The fact that many researchers have been unable to find an association between the *degree* of cognitive impairment of the abused person and the level of the abuse (Cooney & Mortimer, 1995) may simply be a matter of overlooking the caregivers' interpretation of the situation.

Social learning, or modelling, is part of this perspective: the theory posits that abusers learn how to be violent from witnessing or suffering from violence, and the victims, in suffering abuse, learn to be more accepting of it. Treatment based on this approach would focus on changing family values and norms regarding abuse and attempt to change the interpretations of the situation. The difficulty with this approach is that it does not consider the social or economic factors that might influence the abusive process, nor does it account for the fact that not all caregivers who were abused as children abuse their elders. In fact, recent research comparing child abusers and elder abusers finds that child-abusing parents are more likely than elder abusers to have experienced severe violence in their childhood (Korbin, Anetzberger, Thomason & Austin, 1991). The authors conclude that the intergenerational transmission of family violence may be more applicable in the context of child abuse.

6.5 Feminist Models

Current prevalence studies indicate that spouse abuse is a significant dimension of elder abuse (McDonald et al., 1997; Podnieks, 1992). Despite the research findings, elder abuse experts have clung to the situational model; as a result, only limited theoretical advances have been made

to explain this type of abuse (Aronson, Thornewell & Williams, 1995; McDonald & Wigdor, 1995). Most scholars have assumed that spouse abuse is a form of wife abuse "grown old." As a result, it has been explained by a handful of feminist scholars as one consequence of family patriarchy, which is identified as one of the main sources of violence against women in society (Jack, 1994; Pittaway & Gallagher, 1995a; Vinton, 1991). Some scholars have belatedly questioned whether spouse abuse is ever first-time abuse in old age (Eckley & Vilakazi, 1995; Knight, 1994; Neysmith, 1995).

A patriarchy is seen as having two basic elements: a structure in which men have more power than women, and an ideology that legitimizes this power (Miller, 1994). The family is considered to be the most fundamental unit of patriarchy in society, and traditional sex-role expectations for wives provide ideological support for the less powerful position of women in the household hierarchy. This power imbalance makes women vulnerable and open to abuse whether they are young or old. Feminist interventions generally include consciousness raising and mutual problem solving within a caring and equal relationship. The shortcoming of this approach is that, to date, there is little empirical evidence to support the claims of the theory. And, it is, at best, a partial account of elder abuse, because older men are just as likely as older women to be abused (Podnieks, 1992). Pittaway & Gallagher (1995a) in their study find that the feminist model is one of the stronger explanatory models explaining physical abuse and, interestingly enough, that the quality of the marital relationship is the most important risk factor in predicting physical abuse of older adults across all the models.

The application of feminist theories to all forms of spouse abuse is a hotly debated issue in the mainstream family violence literature (Miller, 1994; Renzetti, 1994). The small, but growing, body of research on gay and lesbian domestic violence has seriously thrown into question gender-based theories of partner violence (Coleman, 1994; Letellier, 1994) as has the growing evidence of women using violence against men (Gelles & Loseke, 1993). The real issue, it is argued, is the power imbalance between partners (Jack, 1994; Miller, 1994). Feminist theories, then, might be extended to explain both female and male spouse abuse, if the theme of power imbalances is developed. These measures may also have some potential to explain sexual abuse, which, according to a British study, is mainly perpetrated by sons, husbands, son-in-laws and grandsons on older women on whom the perpetrator is dependent (Holt, 1993). In a convenience sample in the United States, Ramsey-Klawsnik found similar results, except that the abused older women were dependent on their abusers (Ramsey-Klawsnik, 1991).

As the 1990s come to a close, most scholars have realized that there are many manifestations of abuse and neglect of older adults on many

levels and have come to question the search for a comprehensive, all-inclusive explanation of the phenomena (Pillemer, 1993). Most of the theorizing has been done at the individual level, not at the societal level, and most theories ignore the history of relationships across time, as would be found in a life-span view of elder abuse (Tindale, 1994).

In the future, new theories of abuse of older adults may continue to emphasize only *some* of the dimensions of elder abuse and neglect at any given time. Theoreticians may have to cast their theoretical nets wider than the current gerontological and family violence theories that have been the mainstay of the elder abuse literature. Some attempts have been made. For example, the political economy approaches to elder abuse describe abuse as a function of the forced dependency of older persons, which results from their exclusion from society through retirement, poverty, and institutionalization (Biggs et al., 1995; Phillipson, 1993). This perspective helps to locate abuse within the larger socio-political context, and urges a consideration of the role of the structural factors of race, gender, poverty, and ageism in abuse. Postmodernism, which has just made its debut on the gerontological stage, addresses elder abuse as a "problematization" (Katz, 1996, p. 134) that entails an examination of how the gerontological enterprise turned abuse into a crisis (Katz, 1996, p. 9). These and other theoretical initiatives are welcomed. With more theories, practitioners will have a wider array of interventions at their disposal, which will facilitate the provision of more effective care for mistreated older people (McDonald, 1996).

7 Risk Factors for Abuse

7.1 The Study of Risk Factors

The research carried out on the specific factors hypothesized to be associated with elder abuse and neglect continues to be limited to a handful of studies (Godkin et al., 1989; Pillemer & Suitor, 1992). The emphasis on risk factors undoubtedly follows from the demand for protocols required to screen those at risk, to assess the nature of the abuse and neglect, and to choose appropriate interventions (McDonald et al., 1991). Such risk factors have become the backbone of these protocols, many of which have been developed for both domestic and institutional abuse. Unfortunately, risk factors are difficult to study: they may have a delayed effect; they may be so rare or so frequent that they are hard to track; they may be common to other conditions; and they may be dependent on the presence of other factors. As a result, all of the research on risk factors suffers from methodological difficulties, and must be interpreted with some care.

The principal factors that have been associated with abuse include the personality traits of the abuser, the intergenerational transfer of violence, dependency, stress, and social structural factors such as ageism—all of which could be subsumed under any of the four theories described above.

7.2 Personality Traits of the Abuser

This factor, also referred to as intra-individual dynamics, or the psychopathology of the abuser, is based on observations from a number of studies that discovered an inordinately high proportion of abusers had histories of psychiatric illnesses and problems with drugs and alcohol (Anetzberger, Korbin & Austin, 1994; Bristowe & Collins, 1989; Cooney & Mortimer, 1995; Greenberg, McKibben & Raymond, 1990; Homer & Gilleard, 1990; Paveza et al., 1992; Wolf, Godkin & Pillemer, 1984, 1986).

As in the family violence literature, there is some controversy surrounding this hypothesis, mainly because psychopathology has not been directly and *causally* linked to abuse (Pillemer, 1993). In the field of aging, it is troublesome to regard caregivers as mentally unstable, given the burgeoning gerontological literature that portrays family members as willing, responsible and concerned (McDonald, 1996). Others have criticized this approach because it overlooks the role of structural

factors, such as poverty or ageism and because it rules out the use of resources to intervene at the societal level (Ogg & Munn-Giddings, 1993). The only conclusion that can be drawn at this time is that the role of perpetrator psychopathology in elder abuse and neglect is unresolved and requires further research.

7.3 The Intergenerational Transmission of Violence

There is some evidence to suggest that children sometimes learn, through observation and participation, that violence is an acceptable response to stress. Having learned violent behaviour, a significant number of children are violent toward their own children and their spouses in adulthood (Hotaling & Sugarman, 1986). This transmission of violent behaviour may be reinforced by a family subculture that accepts and condones violence. While this is a popular hypothesis in the literature on family violence, very few elder abuse studies have actually found evidence to support the idea that children who were mistreated by their parents went on to abuse their parents in later life. In fact, several studies have clearly found no basis for the proposition (Anetzberger, 1987; Anetzberger, Korbin & Austin, 1994; Ogg & Munn-Giddings, 1993). It appears, then, that further research is required to test this hypothesis.

7.4 Dependency

There are two contrasting views in the literature about dependency (Ogg & Munn-Giddings, 1993). One view is that, because of physical and/or cognitive incapacities, the older person becomes increasingly dependent upon the caregiver for psychological, physical, and material support. This dependency is a heavy burden for the caregiver and can result in resentment and caregiver stress. A lack of resources and inadequate support services for the caregiver may then exacerbate the situation to the point where abuse of the elderly can occur (Steinmetz, 1988; 1993). The alternative view is that abuse is not caused by the dependency of the older person, but is a consequence of the dependency of the abuser upon the older person (Pillemer, 1993). Pillemer (1993) could not locate one study that supported the notion that elder abuse results from the dependency of the older person.

Critics of the dependency hypothesis point out that not all dependent relationships among seniors and caregivers result in abuse and neglect, and that there must also be some triggering event or crisis that precipitates the abuse. In short, while dependency may be a significant factor in abuse, it is not clear how it operates to produce abuse (McDonald et al., 1991).

7.5 Stress

The most fruitful line of inquiry into stress examined people who cared for cognitively impaired older persons. Earlier studies of the stresses of caring for older, mentally impaired patients were descriptive in nature, and usually did not establish a diagnosis of dementia (Block & Sinnot, 1979; Lau & Kosberg, 1979; Wolf, Godkin & Pillemer, 1984). The most recent studies of patients with dementia, such as those suffering from Alzheimer's disease, have shown that the link between cognitive impairment and abuse is precipitated by the interactive, day-to-day problems that arise between the patient and the caregiver.

In patient-caregiver dyads, where the caregiver was assessed as being clinically depressed, the risk for severe physical violence was three times greater than for dyads in which the caregiver was not depressed (Paveza et al., 1992). In this study, Alzheimer's victims living with their families but without the presence of a spouse were three times more likely to be severely abused than patients in other living arrangements (Paveza et al., 1992). Coyne, Reichman & Berbig (1993) found similar results among community dwelling caregivers of dementia patients. The abusive caregivers, when compared to non-abusive caregivers, had been providing care for more years, were providing care for more hours per day, were caring for patients at lower levels of functioning and displayed higher levels of burden and depression (Coyne, Reichman & Berbig, 1993). Caregivers subjected to abusive behaviour were more likely to direct abusive behaviour back to the patient in their care. Another study, done in Britain, found that abusive caregivers showed more depression, and the abused adults were rated as more socially disturbed (Homer & Gilleard, 1990). Although these newer investigations suffer from methodological inadequacies and require more extensive confirmation, the interactional nature of the relationship between stress and abuse first noted by Steinmetz is supported by evidence, at least in the case of cognitively impaired elders (Steinmetz, 1988).

7.6 Structural Factors

Research has concentrated on the abused and the abuser at the expense of exploring the wider implications of age, gender, race, ethnicity, and class, all of which influence people's positions in the social structure and their opportunities in life (Ogg & Munn-Giddings, 1993). For example, older people can be subject to discriminatory attitudes and actions that are based on negative perceptions about their chronological age. Experts have proposed that such ageist attitudes toward older people may contribute to the development of elder abuse (Quinn & Tomita, 1986). Misconceptions and distortions about aging dehumanize older persons, making it easier for them to be victimized, and making it easier for the abusers to feel little or no remorse. At the same time, older people may even view their maltreatment as deserved, because they too, may have adopted society's negative attitudes. Feminist models

also supply an account of structural factors: gender determines a set of positions in society that facilitate, and even justify, the abuse of women (Aronson, Thornewell & Williams, 1995). Other crucial factors that are known to influence the aging process, such as race, ethnicity and socio-economic status, are only now attracting modest attention, mainly in Britain (Biggs, Phillipson & Kingston, 1995).

7.7 The Same Issues

It is unwise to assume that we can now predict who will be abused and who will be neglected, no matter how many, and how elaborate, our detection protocols. The field is bereft of theoretical progress, and the research on risk factors is limited. For example, we still are not clear about who is most at risk for financial abuse, although this is the most common form of abuse in Canada. Our understanding of how different types of abuse are linked (Mendonca, Velamoor & Sauve, 1996) or whether risk factors change according to ethnocultural community is still limited. An understanding of caregiver stress, the most commonly used predictor of risk for abuse, still eludes us—a serious matter, because our responses to the problem (i.e., health and social services) differ significantly from those in the United States, where most of the research has been conducted.

What is more, Canadians, faced with one of the largest baby-boom cohorts in the world, may face unexpected challenges. The aging of the baby boomers, the shrinking of health and social services, and the shift of care for the elderly from the institution to the community could be a recipe for trouble (McDaniel & Gee, 1993; McDonald, 1996; Rosenthal, 1994). Although the development of theories and the research of risk factors (usually through case-control or incidence studies) is treated with some impatience, it seems that we ignore these issues at our peril.

8 Protocols

8.1 Detection

The detection of abuse and neglect of older adults remains an extremely complex and notoriously difficult task, often complicated by denial on the part of the older person and his or her caregiver (Canadian Task Force on the Periodic Health Examination, 1994). Older adults who have been victimized often fail to report, because of feelings of shame and stigma, a fear of retaliation, or a fear of being placed in an institution (Fulmer, 1989; Mulligan, 1990). An exploratory study in the United States found that significantly more victims of male perpetrators refused service offers than victims of female perpetrators. The tendency not to report was more common in parent-child relationships than in spousal relationships (Vinton, 1991). In addition, older adults are less likely to attend community events regularly, making the abuse harder for others to detect.

During the past 10 to 15 years, tremendous energy has been invested in developing instruments to identify seniors at risk for abuse or neglect. The development of these screening techniques was apparently motivated by such factors as the acknowledgment that abuse was a significant social problem, the recognition that there was a basic lack of awareness of this "hidden" problem among front-line workers (Kosberg, 1988), and the desire to intervene early and defuse problems before serious harm occurred (Breckman & Adelman, 1988).

Emergency department personnel (Fulmer et al., 1992) and nurses in acute-care and community-based settings (Canadian Nurses Association, 1992; Havilland & O'Brien, 1989; Smelters, 1991; VanderMeer, 1992) have long taken the lead, understanding themselves to be in an ideal position to detect abuse and neglect. However, in recent years, other professional groups, including dentists (Galan & Mayer, 1992; Holtzman & Bromberg, 1991; Jorgensen, 1992; Kelly, Grace & Wisnom, 1992; McDowell, 1990; Vaughn, 1993), lawyers and notaries public (Blunt, 1991; McKenzie, 1993; Schmidt, 1993), occupational and physical therapists (Holland, Kasraian & Leonardelli, 1987), physicians (American Medical Association, 1992; Lachs, 1995; Noone, Decalmer & Glendenning, 1993), police (Goodwill, 1992), and social workers (Basu, 1992) have all made a concerted effort to educate themselves and join the force of clinicians working to combat abuse and neglect of older adults.

At present, many screening devices are available in the literature (Bloom, Ansell & Bloom, 1989; Fulmer & O'Malley, 1987; Johnson, 1991; Kosberg, 1988; Neale et al., 1991; Pillemer, 1986; Quinn & Tomita, 1986; Reis, Nahmiash & Schrier, 1993; Sengstock & Hwalek, 1986). Most include items that direct investigation toward the characteristics of the older person, the characteristics of the caregiver, and, depending on the theoretical stance of the author, the characteristics of the family system (McDonald et al., 1991). These instruments usually rely heavily on the subjective impressions of health and social service staff and/or verbal reports from informants and abused elders (Bloom, Ansell & Bloom, 1989; Reis, Nahmiash & Schrier, 1993; Kozma & Stones, 1995). Additionally, most fail to address issues related to the sensitivity and specificity of the measures.

Three of the better-known Canadian screening devices for risk are the QUALCARE scale (Bravo et al., 1995), the Brief Abuse Screen of the Elderly (BASE) and the Caregiver Abuse Screen (CASE) (Reis, Nahmiash & Schrier, 1993). The original version of the QUALCARE scale was developed by Phillips et al. (1990) to evaluate the quality of care given by a caregiver to an elderly person. The instrument was designed to quantify the extent to which the caregiver satisfies the needs of the recipient. The QUALCARE Scale is designed to be completed by a nurse after visiting the elderly person at home. Sources of information include personal observations, the data collected during a semi-structured interview with the older person and the caregiver, and any other available assessment information. In 1995, Bravo and colleagues attempted to further validate this scale by assessing its utility in identifying family-mediated elder mistreatment. The results of the study suggest that a measure of the quality of care is a valid indicator of the risk of mistreatment. However, the reproducibility of this scale proved to be insufficient. Thus, while this work represents an important step forward, the findings must be interpreted cautiously.

Both the BASE and the CASE were developed in Montreal in response to growing concern, expressed by local service providers, over a perceived increase in suspected abuse cases. The BASE consists of a one-page questionnaire that asks about the presence or absence of abuse by a caregiver. It also involves a three-stage screening process to confirm or refute the possibility of abuse. According to its authors, this approach also makes it less likely that more subtle forms of abuse or newly developing abuse cases will "slip through the cracks" (Reis & Nahmiash, 1995a).

The CASE serves as an effective complement to the screening provided by the BASE. The authors recommend the CASE as a useful "first alert" tool for direct practice. It consists of eight questions that screen for current physical, psychological, and/or financial abuse or neglect. It is intended for use with all clients who are caregivers of seniors, regardless

of whether abuse is suspected. In addition to "flagging" current abuse, the authors report that the responses of caregivers on the CASE may be indicative of tendencies and stresses that could lead to subsequent abuse (Reis & Nahmiash, 1995b). The CASE was found by the authors to distinguish between abusive and non-abusive groups, and higher scores coincided with higher scores on independent abuse and aggression measures (Reis & Nahmiash, 1995b).

At present, it appears that the BASE and the CASE are the only Canadian screening instruments that have been the subject of psychometric scrutiny. The initial findings regarding the reliability and validity of these devices look promising. If these results can be replicated on a sufficiently representative sample of abuse and neglect victims, then both the BASE and CASE will be welcome tools for practitioners (Kozma & Stones, 1995; McDonald, 1996).

One significant limitation of these screening tools is that the indicators the tools rely upon derive from existing research on risk factors which, as noted above, is less than satisfactory. Many of the protocols, as a result, still favour the stereotype that older adults are abused only by their adult children, and make up provision for spouse abuse, sexual abuse and, more often than not, financial abuse. Some screening instruments do not seem to reflect the interactional aspects of abuse, even when they do apply the situational model. Failure to assess interactional factors represents a significant oversight in the field. At present, then, those at risk can be easily missed by existing protocols, and the possibility of misidentifying people as abusers or as victims because they "fit the profile" remains very real (McDonald et al., 1991; Sprey & Matthews, 1989).

8.2 Assessment

Assessment tools substantiate whether or not mistreatment has occurred or is occurring (Johnson, 1991), and assessments in general are the basis upon which intervention strategies are developed. Two recent government-sponsored surveys of programs for abused older Canadians (Health & Welfare Canada, 1992; Pittaway & Gallagher,1995b) have noted a paucity of formal response protocols, policies, and procedures at the direct practice level. There are, however, a few notable exceptions. In the last decade, a number of primarily local initiatives, carried out by hospitals, social service agencies, institutions and community programs in Canada and the United States, have produced procedures for dealing with abuse and neglect of their older clients.

These independently developed protocols range from unsystematic assessments that rely on professional judgment rather than objective data (Rathbone-McQuan & Voyles, 1982) to checklists of risk indicators for abuse and/or neglect (Fulmer, 1989; Podnieks, 1988; Sengstock et al., 1986). Such checklists may or may not include reviews of the victim's physical, psychological, medical, and social support (Glendenning & Decalmer, 1993; Johnson, 1991;

Quinn & Tomita, 1986). The more detailed protocols, such as the Elder Abuse Diagnosis and Intervention Model (Quinn & Tomita, 1986), the Staircase Model developed by Breckman and Adelman (1988), the SEVNA model (Smelters, 1993), the Victoria Elder Abuse Project (1993) and the Project Care Model developed by Reis and Nahmiash (1995), also outline intervention strategies and case management procedures.

Many of the assessment protocols currently in use are based on assumptions found in domestic violence literature; therefore, they contain several weaknesses that originate in the inadequate definitions, theory development and research methodologies found in this field (McDonald et al., 1991; Phillips et al., 1990). Like the screening instruments, many of these assessment protocols use only one model, such as the situational model, and ignore other factors that have been associated with abuse. They also discount the interactional aspects of abuse, as noted above. Importantly, very few of these assessment instruments or protocols have been tested clinically; as a result, there is no evidence that they actually facilitate accurate identification or "case finding." A problem related to detection and screening for abuse and neglect of older adults is the issue of service provision. Callahan (1988) has argued, for example, that case finding and detection are ineffective unless there are sufficient services and personnel to deal with the cases (Watson et al., 1995).

Both screening and assessment instruments would also benefit from more attention to the different types of abuse and neglect. In the existing literature, there appears to be a clear content bias toward issues related to physical abuse and neglect. Item frequencies for the different types of abuse and neglect are far from equal (Kozma & Stones, 1995; Sengstock & Hwalek, 1987): those related to physical abuse and neglect are overrepresented, while those designed to explore issues related to psychological and financial abuse and the violation of personal rights remain underrepresented (McDonald et al., 1991; Sengstock & Hwalek, 1987). Consequently, the instruments that are used in clinical settings today are likely, at best, to capture only a small percentage of all abuse cases.

8.3 Intervention

Decisions about how and when to intervene for victims of abuse and neglect are among some of the most difficult faced by service providers (Canadian Task Force on the Periodic Health Examination, 1994). Conceptually, two types of intervention protocols have developed in North America: agency-specific and community-based. The former define a particular agency's mandate and its procedures for responding to abuse and neglect, while the latter focus on coordinating and consolidating the efforts of community and social service agencies (Health & Welfare Canada, 1997). In the 1990s, at the direct service level, protocols for intervention still receive less attention in the literature than

screening and assessment protocols. This imbalance may reflect the inability of experts in the field to define elder abuse adequately or to identify its causes. The intervention protocols that do exist represent a variety of approaches, and usually include legal, therapeutic, educational, and advocacy components (Breckman & Adelman, 1988; Fulmer & O'Malley, 1987; Quinn & Tomita, 1986; Reis & Nahmiash, 1995). Some protocols list the options for intervention (Podnieks, 1985; Quinn & Tomita, 1986), while others provide decision trees for front-line service providers (Braun et al., 1993; Fulmer & O'Malley, 1987; Basu, 1992).

In recent years, a number of interesting and important developments have occurred at the community level across the United States and Canada. Specifically, there has been a significant shift toward establishing community protocols in an attempt to improve service delivery (Wolf, 1992). The best example of this in the United States is the San Francisco Consortium for Elder Abuse Prevention, a network of 55 agencies established to improve the city's professional response to elder abuse (Wolf, 1992). This program, administered by the Mount Zion Institute on Aging, provides information, training and support to member agencies to help them deal effectively in their response to abuse and neglect (Njeri & Nerenberg, 1993).

Many Canadian provinces and communities also boast locally developed intervention protocols. These include, but are not limited to, the Centres locaux de services communautaires (CLSC), such as NDG/Montreal West and Rene Cassin CSLCs in Montreal, the Advocacy Centre for the Elderly in Toronto, the Elder Abuse Resource Centre in Winnipeg, the Kerby Centre in Calgary and the North Shore Community Services in North Vancouver (McKenzie et al., 1995). Most recently, the Haldimand-Norfolk Steering Committee on the Abuse of Older Adults in Ontario has been awarded a three-year grant to import and implement a community response network model developed in British Columbia (Chapman, 1994; Vancouver Elder Abuse Network, 1994; Zannatta & Sagi, 1995).

In the last decade, Canada has clearly taken considerable initiative in developing both local and community-based intervention protocols. Perhaps because the interventions are so recent, their efficacy has seldom been evaluated; instead, evaluations have relied on anecdotal reports offered by practitioners (Spencer, 1995). Thus, many of the limitations of current screening and assessment devices may also be discovered in the intervention strategies. McDonald et al. (1991) offer three critical observations about the existing protocols: they assume a caregiver/situational model of abuse, which persists despite contradictory evidence emerging in the literature; they fail to provide adequate definitions of the indicators of what strategies should be used, with whom, and under what circumstances; and they point to little

or no evidence of the efficacy of treatments/interventions.

8.4 Making the Hard Choices

The problems of developing valid and reliable protocols for screening, assessment and intervention continue (Kozma & Stones, 1995; McDonald & Wigdor, 1995). This was brought to the fore when the Canadian Task Force on the Periodic Health Examination (1994) concluded that there was insufficient evidence to support or exclude case finding. Their review and critique suggested that no combination of risk factors has been shown to be sufficiently sensitive or useful in case finding. Given the renewed flurry of research activity into the psychometric properties of a number of protocols, the report may have served as a wake-up call for both clinicians and researchers. In order for the psychometric work to continue, more research will have to be done—a hard choice when resources are scarce and there is a preference in the field for intervention over research.

The discussion of protocols takes on a whole new dimension when ethnicity is considered. Currently, a few studies offer documentation and description of abuse and neglect as it manifests itself in different ethnocultural groups. These include investigations in the Aboriginal community (Aboriginal Nurses Association of Canada, 1992; American Indian Law Centre Inc., 1990; Dunn, 1992; Maxwell & Maxwell, 1992; Spencer, 1996), the African-American community (Griffin, 1994; Griffin & Williams, 1992; Njeri & Nerenberg, 1993) and the Asian community (Moon & Williams, 1993; Tomita, 1994), as well as a range of ethnocultural communities (Bergin, 1995).

The most obvious conclusion emerging from this work is that knowledge in this area is still in its infancy. At present, a number of basic and fundamental questions need to be addressed. Are Western models of elder abuse assessment, diagnosis, and intervention applicable to other groups? If not, how are existing methods to be modified? Do ethnocultural differences affect definitions of what constitutes abuse and neglect? And, finally, are there any ethnocultural factors that contribute to abuse and neglect (Pittaway & Gallagher, 1995a; Tomita, 1994)? If research in these areas reveals major differences from the patterns of elder abuse in mainstream society, new protocols will have to be devised.

9 Programs and Services

9.1 General Considerations

A program provides a blueprint for service delivery, establishes resources, and coordinates the delivery of service through government and/or private and public agencies (McDonald et al., 1991). Four major kinds of programs have been developed to respond to elder abuse: the statutory adult protection service programs, programs based on the domestic violence model, advocacy programs for seniors and an integrated model.

9.2 Adult Protection Programs

9.2.1 Legislative Approaches

A number of legal remedies are available to Canadians in dealing with the problem of elder abuse and neglect. General legal safeguards found in the *Criminal Code* deal with physical abuse, assault and neglect. Powers of attorney deal with financial abuse, and guardianship laws in every province provide for the appointment of a guardian who will act on behalf of an individual who is mentally incapable of managing his or her own affairs or personal care. All of these laws have been soundly criticized for inadequacies in responding to elder abuse and neglect (Carbonell, 1992; Coughlan et al., 1995; Gordon, 1995; Gordon & Verdun-Jones, 1992; Harbison et al., 1995a, 1995b; Robertson, 1995; Spencer, 1996), but no legal provision has attracted as much critical attention as adult protection legislation.

All 50 United States and four Canadian provinces have reacted to the problem of elder abuse and neglect by enacting special adult protection legislation (Robertson, 1995; Wolf, 1992). The legislative approach, heavily influenced by child welfare models, is characterized by legal powers of investigation, intervention and mandatory reporting (Robertson, 1995). A review of these programs in the two countries suggests that actual responses vary widely across and between states and provinces. The variability appears to be related to the type of legislation and the financial commitment of the jurisdictions to community resources (Quinn & Tomita, 1986; Robertson, 1995; Wolf, 1992; Zborowsky, 1985).

Protective service programs usually combine legal, health and social services to allow for the widest array of interventions. They require considerable coordination and interdisciplinary team work. In Canada, with the passage of adult

protective legislation in the Atlantic provinces, protective services have been delivered by the provincial departments of social services.

9.2.2 Nova Scotia

Nova Scotia developed an Adult Protective Services Unit, within the provincial social services department, in 1986, following the enactment of its *Adult Protection Act*. The purpose of the unit is to "provide protection from physical abuse, sexual abuse, mental cruelty and neglect for persons aged 16 years and older who are incapable of adequately caring for themselves." Mandatory reporting is part of the legislation, and reports of abuse are investigated by adult protection workers located throughout the province. At present, the Adult Protective Services Unit appears to be concerned primarily with crisis intervention. Emphasis is placed on bringing services into the home (McDonald et al., 1991). Victims are referred to community resources on a voluntary basis. Court-mandated intervention is used as a last resort, and only when the victim is deemed incapable of making an informed decision (Health & Welfare Canada, 1992).

The Nova Scotia *Adult Protection Act* has recently been criticized as dealing not with abuse but with self-neglect, and as fundamentally failing to deal with the abused competent older adult. According to one review, the mandatory reporting requirement should be replaced by voluntary reporting (Harbison et al., 1995a; 1995b).

9.2.3 Prince Edward Island

The P.E.I *Adult Protection Act* (1988) ensures that people who are unable to guard themselves against abuse are given protection. This is to be done in the least intrusive manner available, and, if possible, in such a way as to respect people's wishes. Of the four provinces, P.E.I's legislation least resembles the child welfare model (Gordon, 1995). The legislation was modelled after the Nova Scotia *Act*, but it does not include mandatory reporting (Health & Welfare Canada, 1992). It contains a 68-step implementation plan that sets out a multidisciplinary response to reported situations of abuse. Currently, there are no specialized services for older adults who are victims of abuse. Instead, community support services for victims appear to deal with elder abuse as part of a broader approach to family violence (McDonald et al., 1991).

9.2.4 British Columbia

As a result of the enactment of the *Adult Guardianship Act,* S.B.C. 1993, British Columbia has undertaken a new initiative with respect to support and assistance for abused and neglected older adults (Robertson, 1995). The *Act* represents a complete revamping of the law regarding the protection of vulnerable adults. Gordon (1995) argues that the B.C. law represents a new trend in Canada to incorporate protection provisions into reconstructed omnibus adult guardianship statutes (Gordon, 1995). Including adult protection provisions in the larger body of adult guardianship law may result in the

routine use of court-ordered guardianship, rather than less intrusive measures (Gordon, 1995).

Similar to the legislation in the Atlantic Provinces, the *Act* gives extensive powers of investigation to specific agencies, including the authority to apply to the court for the provision of services to those found incapable (Robertson, 1995). At a programmatic level, a number of important developments have occurred. In an attempt to discover less restrictive and intrusive means to deal with abuse and neglect, the federal government's Seniors Independence Program (SIP) funded the development of Community Resource Networks (CRNs) in a number of B.C. communities. The CRNs consist of local health, social service and legal agencies, which pool their resources to respond to abuse and neglect in an integrated and cooperative manner. The goals of the networks are to provide a continuum of services to abused adults, act as a resource for service providers, and to offer reliable and consistent service to their consumers (Zannatta & Sagi, 1995).

9.2.5 Critiques

Considerable controversy remains over adult protection legislation and programs. Proponents suggest that such interventions mean that the rights of the older adult are ultimately safeguarded and that attempts can be made to improve a person's level of functioning while protecting him or her from harm (McDonald et al., 1991). Those who oppose the enforcement-oriented approach vigorously challenge these claims. They argue, for example, that any system of care that is modelled on protectionist child welfare legislation must inevitably infantilize older adults and fail to respect the right to independence (ARA Consulting Group Inc., 1991). On a practical level, it is often claimed that adult protection workers are "trigger happy" in petitioning for guardianship in order to place seniors in institutions (Quinn & Tomita, 1986)—a concern that grows with the use of the new omnibus legislation. Others have argued that the adult protection legislation is not useful because, in many instances, resources are insufficient to deal adequately with identified cases (Bond, Penner & Yellen, 1995; ARA Consulting Group Inc., 1991). Without adequate services in place to support abused older adults, an adult protection services system cannot respond effectively to cases of abuse and neglect (ARA Consulting Group Inc.,1991).

Several Canadian studies underscore some of the flaws of the adult protection legislation and its implementation. Bond, Penner and Yellen (1995) surveyed Canadian and American professionals about the effectiveness of adult protection legislation. Most thought it was effective—but they also expressed a concern that there were insufficient funds to administer the program and to provide services to abused older persons—and this was before governments started to slash budgets.

Poirier (1992) compared the application of adult protection legislation in Nova Scotia and New

Brunswick and found that, despite many similarities, the interpretation of the adult protection legislation in New Brunswick was heavily influenced by the norms of the social work profession. Consequently, in New Brunswick, less intrusive interventions were used, and fewer cases were brought before the courts. However, in Nova Scotia, Poirier found the court system is used to enforce legislation 6 to 12 times more often than in New Brunswick. In another study, Poirier (1992) examined the outcomes for clients subject to the adult protection legislation in New Brunswick. He found that the most important factor in determining whether or not protective measures were ordered was whether the person was represented by a lawyer. Clients with legal representation were better protected. He also found that the legal philosophy of the judge had a significant influence on the outcome—a danger, if the judge favoured the intrusive aspects of the legislation.

9.3 Domestic Violence Programs

The domestic violence response to elder abuse and neglect has gained considerable momentum in North America because it does not violate people's civil rights, or discriminate on the basis of age (Crystal, 1987; Finkelhor & Pillemer, 1984; McDonald et al., 1991). This response to elder abuse consists of a multi-pronged approach that includes crisis intervention services, such as telephone hotlines; a strengthened role for police in the laying of charges; court orders for protection; the use of legal clinics; emergency and secondary sheltering; support groups for both the abused and the abuser; individual and family therapy; and the use of a whole range of health, social, and legal services (McDonald et al., 1991). An integral component of domestic violence services is educating the public, and, especially, educating the abused about their rights.

At present, there are a number of individual and group programs for victims of elder abuse. In Canada, the Elder Abuse Resource Centre, a program of Age and Opportunity located in Winnipeg, and the Kerby Centre in Calgary loosely fit the domestic violence approach. The Elder Abuse Resource Centre, for example, responds to situations of suspected abuse of persons 60 years of age or older. The Centre was designed to coordinate community services for elder abuse and neglect, to provide education for, and consultation to, agencies, and to offer counselling to abused seniors (McKenzie et al., 1995). The Kerby Centre, on the other hand, combines a multidisciplinary team and a family systems approach. Clinicians treat cases of elder abuse as part of a continuum of family violence issues, and believe that efforts to address elder abuse should consider the entire family unit (ARA Consulting Group Inc.,1991). Several U.S. states also have shelters dedicated to older victims of abuse (Cabness, 1989), and many existing women's shelters now accommodate abused older women (Vinton, 1991). In Canada, Montreal opened the first shelter for older victims of abuse, and

some other communities are considering such facilities[7] or adapting existing shelters to accommodate some older women.

The domestic abuse model is not without its critics (McDonald et al., 1991; Phillips, 1986), who are quick to point out its flaws. Problems with police response and restraining orders, poorly managed shelters, and a shortage of follow-up services are but a few of the issues. Gerontologists have also cautioned against the singular use of crisis intervention, because problems experienced by older persons tend to be complex, multiple, and interrelated; they may take a long time to sort out and need to be monitored closely (Ledbetter Hancock, 1990). The model also fails to apply in cases of neglect as opposed to abuse.

9.4 Advocacy Programs

Advocacy refers to the actions performed on behalf of an individual or group to ensure that their needs are met and their rights are respected. Like the domestic violence model, an advocacy approach acknowledges that the older person is potentially vulnerable and may be in a dangerous situation. Advocacy programs for the abused believe that the least restrictive and intrusive interventions should be applied to an older person's situation.

There can be two types of advocates, informal and formal. Informal advocates are usually volunteers, such as friends or family, who do not take part in a structured program; formal advocates[8] are professionals, and are paid for their services within the context of a structured program. In practice, advocates advise clients of their rights and the alternative services available to them, and they can assist them in carrying out agreed-upon plans. The most important feature of advocacy is the advocate's independence of any formal delivery system; this distance allows the advocate to establish a positive relationship with the older person.

Three well-known advocacy programs illustrate this independence. The Senior Advocacy Volunteer Project, in Madison, Wisconsin trains volunteers to serve as advocates on a one-to-one basis with victims of elder abuse. The volunteers are given one-year assignments to provide a range of assistance, including weekly visiting, help with such tasks as negotiating the health and social service systems, financial resource management, assistance with relocation, and companionship (Wolf, 1992). The Advocacy Centre for the Elderly, in Toronto, Ontario is an example of a formal legal advocacy program. Established in 1984 as a specialized legal aid service for the residents of Toronto, its primary mandate is legal

7 One initiative resulting from the Synergy II Project in Calgary is a shelter for abused seniors that will open sometime in the next year.

8 Ontario had a formal advocacy program under the *Advocacy Act* which was recently repealed. Gordon (1995) argued that the problem with advocacy programs was that during times of fiscal restraint there was a strong likelihood for services to be cut. In the Ontario case, the *Act* was cut.

advocacy, including the provision of legal advice to the elderly, as well as representation before the courts and tribunals (Gordon et al., 1986). The North Shore Community Services, in North Vancouver, has also developed an advocacy model: it serves as a one-stop shopping centre for seniors requiring information and services. The philosophy of this service is based to some extent on both feminist ideology and legal advocacy. It locates people's personal experience within the larger context of society (McKenzie et al., 1995) and gives power and control to the senior by taking instruction from them.

Advocacy undoubtedly plays an important role in protecting and furthering the interests of vulnerable adults. An extensive review of such services in the United States provides evidence that when victims have advocates, they report less social isolation, are better linked to community services, achieve more goals and are less likely to suffer abuse (Filinson, 1993). However, two issues require further consideration. As McKenzie et al. (1995) correctly point out, knowing one's rights is one thing—acting on them is another. Those who can assert themselves are more likely to gain attention. Unfortunately, many older adults are in great need of help but, because of disability or isolation, do not get the assistance they deserve.

9.5 The Integrated Model

An observable trend at the community level has been the development of multidisciplinary teams, made up of workers from a broad array of agencies that represent all of the programs described above. These community-based teams or committees provide consultations on atypical and difficult cases of abuse, help to resolve agency disagreements, and provide services, such as legal and medical consultations, not readily available in the community (Wolf, 1992). In situations involving elder abuse, researchers and policy-makers frequently advocate coordinating health care and social services in the detection and intervention process (Decalmer & Marriott, 1993; Health & Welfare Canada, 1993; Pittaway & Gallagher, 1995a,b). Although little research has been conducted to assess the effectiveness of multidisciplinary teams, many believe that they enhance the quality and quantity of service (Health & Welfare Canada,1993; Watson et al., 1995).

In the United States, two programs are worth highlighting. Illinois has directed all agencies that provide elder abuse service to a population base greater than 7200 to establish multidisciplinary teams with representatives from mental health, medicine, law enforcement, religious,

legal, and financial services (Hwalek, Williamson & Stahl, 1991). Also noteworthy is the multidisciplinary case consultation team provided by the San Francisco Consortium for the Prevention of Elder Abuse. This team comprises nine representatives from a number of professions, including case management, family counselling, mental health, geriatric medicine, law enforcement, financial services, and adult protection services. The teams meet monthly to review cases and make detailed comprehensive assessment and intervention plans for multi-problem, multi-agency elder abuse cases.

In Canada, Project Care (Reis & Nahmiash, 1995) appears to be an extension of the integrated model; it incorporates several of the services that Wolf (1992) identified as best-practice approaches. Project Care, funded by the Family Violence Prevention Division, Health Programs and Services Branch, Health Canada, was designed to develop a global intervention program through which professionals and volunteers could effectively intervene in instances of abuse and neglect. The authors describe seven main elements of their intervention model: the Tool Package, to flag abuse cases; a Home Care Team, which is staffed by multidisciplinary agency professionals and paraprofessionals, who together provide front-line service; the Multidisciplinary Team, a smaller advisory group that monitors all abuse cases and counsels Home Care Team members on particular cases; the Expert Consultant Team, an additional advisory group assembled outside the intervening agency to provide specialized advice; the Volunteer Buddies, trained volunteers who meet regularly with the abused seniors on a regular basis; an Empowerment Group for the abuse victims and a Caregiver Support Group, which offers support and problem-solving strategies to those who have abused; and the Community Senior Advisory Committee, which focuses on prevention of abuse and raising community awareness.

Initial assessments of this approach to the provision of services have been very positive: service providers become familiar with one another, resources are organized and dispersed in a single initiative, and more comprehensive care plans are produced. The main drawback is that the teams spend more time per case than professionals acting alone (McDonald, 1996).

9.6 Issues in Practice

9.6.1 Evaluation of Practice

A few comments need to be made about the glaring lack of program evaluation in the field of elder abuse. As Spencer (1995) has noted, American research in this area has, until recently, been rudimentary, and Canadian work in this area is non-existent. To date, even the most fundamental questions about what types of services work, for whom, and under what circumstances remain unanswered (Stein, 1991). Program evaluation is important for a number of reasons: it provides front-line practitioners with feedback about what works; it allows agencies to

compare program goals and actual outcomes; it indicates which aspects of programs are obsolete and ineffective; and it offers evidence for the relevance of particular interventions, which in turn can be used to support applications for continued funding (Pittaway & Gallagher, 1995a,b; Spencer, 1995). It is heartening to see that many of the most prominent Canadian elder abuse intervention programs have risen to Stein's (1991) challenge to improve the way outcome research is designed and conducted. Projects like the Elder Abuse Resource Centre in Winnipeg, the Victoria Elder Abuse Project, Project Care and Synergy II have all incorporated a range of measures into their designs. Taken together, the results of these studies will provide invaluable information about the efficacy of these approaches; it is to be hoped that others will be encouraged to join the "outcome(s) revolution."

Program evaluation depends, of course, on how "effectiveness" is conceptualized. McDonald et al. (1991) were the first to note that whether or not an intervention is deemed useful is a matter of perspective. For example, to a clinician, "the removal of the senior from an abusive situation" may constitute success, while the victim may regard this as an unsuccessful approach (Kozak, 1994). Thus, deliberation by clinicians, researchers and seniors about how best to measure effectiveness would be a useful exercise at this juncture. Wolf and Pillemer (1989) and Spencer (1995) have started this discussion by suggesting the consideration of such questions as: Does the intervention stop the abuse or reduce its severity? Is there a change in how often abuse occurs following intervention? Does the victim feel that there has been an improvement in the situation?

9.6.2 Barriers to Services

Two recent government documents offer insights into existing roadblocks to the provision of services to seniors who are being abused (Health and Welfare Canada, 1993; ARA Consulting Group Inc., 1991). These barriers currently fall into three categories: some are associated with client variables, some are attributable to front-line practitioners, and others exist as a result of broader systems-level issues.

The most prominent barrier to effective intervention is related to the hesitancy of victims themselves to reach out and engage with services, as was noted above (Pittaway & Gallagher, 1995b). Direct service providers have also contributed to the problem. Service providers are sometimes unclear as to what constitutes abuse and neglect; they may lack knowledge about appropriate services and community resources available to help with the problem. Of greater concern is a general unwillingness to intervene. Taken together, the three government documents strongly suggest that priority should be given to increasing seniors' and practitioners' awareness of, and knowledge about, services (McDonald, Pittaway & Nahmiash, 1995).

At a systems level, a number of barriers have also been highlighted. These include agency mandates that do not specifically address elder abuse, inadequate funding of appropriate resources, and an overall lack of coordination among existing services. Podnieks et al. (1990), for example, identified gaps in Canadian services, pointing to a significant shortage of adequate and affordable respite care, caregiver support groups, self-help groups and emergency shelters. While some programs have attempted to respond to some of these identified deficiencies (e.g. Project Care, Kerby Centre), significant deficits in programs and services remain.

Finally, while coordination has been identified as an important component of service delivery, it is often easier said than done. Differences in leadership and decision-making styles, philosophies, principles and values are cited as routinely interfering with the development of a cooperative, seamless system of care (McDonald, Pittaway & Nahmiash, 1995; Pittaway & Gallagher, 1995b). Thus, what is needed is a broad-based community response to the problem of abuse and neglect. Services must be available, accessible, affordable, known and perceived as appropriate by those for whom they are intended (McDonald, Pittaway & Nahmiash, 1995).

9.6.3 Multicultural Issues

A recent report by the Research Study Group on Elder Abuse (Chappell, 1993), which focused on First Nations and Chinese communities, was among the first to issue a strong statement about the need to think about abuse and neglect from a more culturally relevant perspective. This sentiment was further echoed in reports generated by two Canadian projects that also explored services across a variety of communities (Canadian Association of Social Workers, 1995; Pittaway & Gallagher, 1995b).

Considerable evidence already exists to confirm that violence against older persons is a problem among many different ethnocultural groups. As such, two pressing questions regarding service delivery have emerged. First, do mainstream services appropriately address the needs of seniors from diverse backgrounds? And, if not, how should existing approaches be modified?

The answer to the first question appears to be a resounding no. In one study, for example, older people from different ethnocultural backgrounds reported experiencing problems with communication, transportation, and financial resources (Roche & Doumkou, 1990). Service provision to this population is closely linked to the existence of systemic racism. Some authors (McDonald, Pittaway & Nahmiash, 1995) have suggested that service providers need to critically examine their beliefs and attitudes to determine whether they are in some way undermining the response to abuse and neglect.

Both the CASW study and Pittaway & Gallagher (1995a,b) summarize the cultural issues that present

challenges in providing services in cases of elder abuse. These include the effect of cultural differences in defining what constitutes abuse, and perhaps influencing help-seeking behaviour; the need for unbiased interpreters; the unavailability of translated pamphlets and other materials; the need for creative service delivery models that are culturally acceptable; the need to train service providers to be more culturally sensitive; and the need for stronger links between the mainstream agencies that serve seniors and community leaders and the resources that are affiliated directly with different ethnocultural communities.

10 Prevention

10.1 Educational Initiatives

Education and public awareness are believed to be critical elements in any comprehensive approach to the abuse and neglect of older adults. Education is not just about learning new information: it is about changing attitudes, behaviours, and values. As such, education is a fundamental preventive strategy (Gallagher et al., 1993; Podnieks & Baillie, 1995; Podnieks et al., 1990; Greene & Anderson,1993).

10.2 Education of Older Adults

The importance of educating older adults about abuse and neglect, as well as providing information about where to turn for help, cannot be overstated (Podnieks & Baillie, 1995). Knowledge is power and can be used to help people help themselves. It allows victims (or potential victims) to protect themselves and their rights. This, in turn, contributes to feelings of increased control and self-efficacy (Reis & Nahmiash, 1995).

In Canada, the One Voice–Canadian Seniors Network has assumed a pivotal role in developing a coordinated plan of action to address the abuse suffered by seniors across Canada. An important, recent initiative by this group involves providing communities with the tools to develop a coordinated response to abuse of older adults. To this end, One Voice, using a community development approach, has developed a Community Action Resource Kit for seniors to use to create solutions for abuse. This kit contains all of the resource materials necessary to support the advocacy efforts of seniors who want to address the needs of older adults who are abused in their communities.

Within the United States, the American Association of Retired Persons (AARP) has taken a leadership role in developing a national effort to increase public awareness of elder abuse. Its emphasis has been on prevention and empowerment. Its unique program, called “Toward the Prevention of Abuse,” teaches older adults to anticipate risk and to prepare for aging in ways that minimize the likelihood of being victimized (Douglass, 1991).

Recently, practitioners have grown to realize that information, provided in isolation, is not enough. Consequently, there has been a move both in the United States and Canada to develop

support and problem-solving interventions, to serve as adjuncts to educational programs. The assumption has been that these additional services not only offer protection against abuse but also reduce isolation (British Columbia Seniors Advisory Council, 1992).

Within Canada, Project Care, in Montreal (Reis & Nahmiash, 1995), offers an excellent example of an intervention program that incorporates both individual and group support in an attempt to empower clients. As part of a broader network of care, Volunteer Buddies meet regularly with abused seniors on a one-to-one basis. They help reduce isolation and inform clients of their rights. Additionally, its Empowerment Group meets weekly to help victims discuss feelings and brainstorm ways of dealing with specific problems they are encountering. In the United States, one outstanding example of this approach is the Victim Support Group at the Mt. Sinai Centre for Elder Abuse (Wolf & Pillemer, 1994). This group provides ongoing support, encouragement, and guidance to abused elders and acts as a buffer against feelings of victimization.

A notable variation of these individual and group approaches is peer counselling, which brings victims together on a one-to-one basis. Peer counselling, like the other two approaches, exists in seniors' organizations and social service agencies across Canada and the United States (Podnieks & Baillie, 1995).

The active involvement of older Canadians in addressing the issue of abuse is a welcome movement in the field. Increasingly, health and social service agencies are realizing that care needs to be client-centred and client-driven. Many of the well-established elder abuse programs in Canada have made seniors active players in the development and day-to-day operation of their services (e.g., the Elder Abuse Resource Centre in Winnipeg, CRNs in British Columbia, Project Care in Montreal). However, considerable work still needs to be done in this area. There a number of ways to involve seniors in the fight to reduce abuse: professional recognition of seniors' contributions, collaboration between seniors and professionals, generating seniors' interest and commitment, ensuring a meaningful experience, brainstorming, using seniors as advisors and central coordination (ARA Consulting Group Inc., 1994).

10.3 Educating Professionals

It is especially important for professionals to be able to identify when seniors are abused and to intervene constructively and appropriately. Education of clinicians in this area is a critical component of knowledge and skill development, and it provides the necessary foundation upon which to offer service. An important first step lies in finding ways to teach clinicians to reflect on their own attitudes and beliefs about aging and violence in general (Johnson, 1995). Unfortunately, sources of bias and discrimination are often deeply

hidden (Pittaway & Gallagher, 1995a,b). It is imperative to provide opportunities for consciousness raising, so that individuals, agencies and communities can critically reflect on their belief systems and determine how these influence their responses to elder abuse. A noteworthy Canadian attempt to provide this kind of teaching has been made at the Deer Lodge Centre in Winnipeg. This long-term care facility has developed an innovative way of encouraging its staff to look at the impact of ageist attitudes and behaviours (Podnieks & Baillie, 1995). Through a program called the "Aging Game," staff are sensitized to the process of aging and the impact that inappropriate treatment of seniors has on everyone concerned. To supplement this program, Deer Lodge Centre also provides regular in-service training on the origins of abusive behaviour.

The elder abuse literature often describes the shame, guilt, and fear of retaliation that victims of abuse experience, and how these may result in denial of the abuse. What the literature fails to do in any substantive way, however, is to address workers' fears and denial (Baron & Welty, 1996). Working with victims of violence is challenging at the best of times. The strong feelings that victims and abusers arouse in clinicians need to be dealt with in training and supervision. British training specialist Annie Zlotnick summarizes this best when she states that "a purely didactic approach to the topic of elder abuse is inappropriate because of the intense nature of the issues where emotions play so central a role" and that the "cruelty of abuse could easily cloud the issues of even the most level-headed approach to best practice and decision making" (Zlotnick, 1993). A similar premise underlies the elder abuse training program conducted by the New York City Department for the Aging (DFTA). In addition to helping professionals detect, assess and intervene constructively, workers are taught to identify and accept their own negative feelings that arise when they work with elder abuse victims.

In the last decade, significant strides have been made in increasing professional awareness in the broader community through training sessions and seminars on abuse. Increasingly, elder abuse has been on the agendas of education and scientific meetings, conferences and workshops in gerontology (Podnieks & Baillie, 1995). As a result, the field has grown across Canada, and many impressive examples of training programs and resource kits are being developed (Hoff, 1994; McGregor, 1995; Pay, 1993). Education and training of professionals is a critical prevention effort. The combination of education and experience is invaluable in the fight against elder abuse.

10.4 Educating Caregivers

Caregiver stress has been implicated as a factor that increases the likelihood of abuse and neglect (McDonald et al., 1991; Zarit & Toseland, 1989). As such, education and training programs for caregivers play a vital role in prevention.

Caregiver support groups have a long and distinguished history as a resource to assist in the care of the elderly. Available in most communities across Canada and the United States, they typically offer mutual support, stress reduction and problem-solving strategies. The underlying assumption is that the combination of social support and education/training will work to reduce the likelihood that anger, aggression and conflict will emerge in the caregiving relationship (Podnieks & Baillier, 1995).

An innovative offshoot of this traditional approach is mentioned several times in the literature. In 1992, Scogin et al. described a training program developed to assist abusive caregivers. The participants were involved in a program of didactic presentations, group discussions, role playing and guided practice. Participants were compared with caregivers who did not receive training, according to four variables: general mental health, an anger inventory, self-esteem, and degree of burden. The results indicated that the training program had little impact on anger and self-esteem. Caregivers, however, did feel some reduction in the personal cost associated with caregiving. The most important finding was that the group that received no treatment experienced an increase in symptoms of distress, while the treatment group experienced a decrease.

Project Care (Reis & Nahmiash, 1995) also offers a caregiver support group for those who have already been abusive. This group meets weekly and offers support, resource information and problem solving to arrive at non-abusive ways of behaving. Scogin et al. (1992) and Project Care are two of only a very few systematic intervention programs that attempt to deal with the needs of the perpetrator. Given the relational dynamic between abusers and victims, no solution to the problem of elder abuse will suffice without a satisfactory disposition of the abuser (Baron & Welty, 1996).

10.5 Education of the Public

In addition to training professionals, it is essential to promote public awareness of elder abuse. It is everyone's responsibility to take action against this hidden crime and to offer support to victims in a manner that encourages them to get help. Public education campaigns should be geared toward abused seniors and those in a position to recognize abuse when it occurs (Podnieks & Baillie, 1995).

In both Canada and the United States, many excellent public education tools, programs and materials have been developed. These include, but are not limited to, a wide variety of pamphlets on the topic, advocacy for resources, lobbying activities, the public media and local/national conferences. In Canada, for example, the Council on Aging (1988) designed a monograph as part of a pilot project to raise awareness of elder abuse at both the community and institutional levels. Additionally, the Seniors' Education Centre, at the University of Regina,

developed a comprehensive training manual that offers instruction on how to run a workshop, information about the role of a facilitator, directions for group activities, and supporting overhead transparencies (Podnieks & Baillie, 1995). In the United States, the New York DFTA conducted an outreach campaign in the fall of 1993. Presentations took place at seniors' centres. Posters and help lines were set up. The response to this public education program was overwhelming; the DFTA reportedly received more than 200 new calls to report elder abuse in that month alone (Baron & Welty, 1996). Similar programs have also been set up elsewhere in the United States (e.g., Florida [Vinton, 1991], Ohio [Anetzberger, 1993] and Rhode Island [Filinson, 1993]).

Coalitions consisting of service providers have also been established to educate their communities about issues related to abuse and neglect. These coalitions, such as the New York City Coalition on Elder Abuse, meet regularly and offer conferences and seminars. Ideally, this model will be duplicated in other cities throughout the United States and Canada.

Also noteworthy are the recent attempts in many Canadian communities to develop preventive programs that teach children early in life to respect older adults and create opportunities for intergenerational relationships (Podnieks & Baillie, 1995).

Abuse and neglect of older adults is a community problem. It should not remain a secret shared by the victim and perpetrator. It cannot rely on a social agency for its resolution because it is only through community and general public education that we can ensure the safety and security of older adults. As such, this area must be given priority (McDonald et al., 1991).

11 Looking to the Future

In taking stock of Canadian developments on elder abuse and neglect, it is encouraging to see the progress that has been made over the last decade. This is not to say, however, that there is no more to be done, or that the challenges will be any less arduous in the next century. We are currently experiencing a climate of scarce resources: jobs continue to disappear, research dollars evaporate, programs are shut down and competition is the order of the day.

Within this context, Canadian researchers, practitioners, and governments face a daunting agenda. Over the last decade, most of the progress has been made in intervention and prevention, usually at a regional level, with only modest gains in the area of research. The next logical step for Canada would be the formation of a national organization devoted to combatting abuse and neglect of older adults, which could pull together the strands of practice, education, and research from across Canada and weave them into a comprehensive whole that would benefit all Canadians. Within this framework, national agendas for research and for coordinated action could be undertaken; through cooperation and strategic targeting, these programs would be effective across Canada.

The research waiting to be done will be expensive, but only in the short term. Research is necessary to help apportion the use of limited resources in interventions, services and prevention, by demonstrating their relative effectiveness. Thus, to make any headway at all, we need an incidence study of abuse, a prevalence study of abuse in institutions, case control studies to determine risk factors for abuse, continued testing of screening and assessment instruments, and, more than ever, evaluations of practice, the new omnibus legislation and our preventive programs. A critical consideration in all areas of research will be the need to attend to ethnic diversity.

A national strategy for action cannot be suggested here. Such a strategy must be determined by all the stakeholders, the most important being Canadian seniors. As in other issues of national concern, Canada's seniors can and should provide the leadership in eradicating the abuse and neglect of older adults.

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