Guidelines for Developing Elder Abuse Protocols

A South West Ontario Approach

Approved by South West Regional Elder Abuse Network

Revised: February 22, 2011
Dedicated to
vulnerable seniors
in our society
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PREFACE

Elder Abuse has many faces. It includes physical, financial, emotional and neglect, which can be the abandonment of the vulnerable by families and institution. Elder abuse does not just happen at the hands of uncaring individuals, it is also necessary to consider the pressures on caregivers and the outcomes of that pressure, and how those pressures can be lessened through various forms of support, thus strengthening and honouring both the caring relationship as well as the well being of our elders. Elder Abuse is a many faceted and complex social issue.

Until the introduction of recent initiatives to address child abuse and domestic violence in the last quarter of the 20th century, abuse of the elderly remained a private matter, well hidden from public view. Today, it is seen as a problem that is likely to grow as Canada experiences a rapidly aging population. Information on the extent of the abuse of our elders is not readily available, it is suggested that between 4 and 10% of the senior population are abused each year. For older people the consequences of elder abuse have wide system and personal impacts. Any injury to an older person runs the risk of further deterioration of health status and wellness. Even minor injuries can cause serious and permanent damage due to brittle bones and fragile health status.

Elder abuse is defined by the World Health Organization (2004) as: “any action or lack of action which causes harm to an older adult”. It is believed that 42% of the abuse is financial, 35% is physical, and the remaining split between neglect and psychological (emotional) abuse. Elder abuse is a complex issue. Someone who commits this type of abuse usually has control or influence over the older person, and usually the victim knows and trusts the abuser. Most victims depend on the people who hurt them, sometimes for food, shelter, personal care or companionship. When abuse is ongoing, the abused person may lose self esteem & confidence, become depressed, demoralized and sometimes experience confusion.

The time has come to do something about Elder Abuse. While our society has become increasingly aware of various forms of family violence, elder abuse has been slow to gain recognition as an equally serious social problem. The complexity of elder abuse with its multiple forms - physical, psychosocial, neglect and exploitation – requires a coordinated approach from all levels of our community.

All people who come into contact with older persons should know that a) abuse and neglect exist as problem for some, not all, seniors; b) concern for an older person’s safety and wellbeing is the starting point for identifying abuse and neglect; c) there are people to call for advice at all levels – no one person or agency has to handle a situation on their own; and d) Many other organizations are working to ensure that the right advice and services are available.

This publication offers general guidelines to various types of agencies or services interested in identifying and responding appropriately to cases of elder abuse and neglect. The characteristics of protocols in a number of different settings are described and some specific indicators of abuse or neglect are offered. Each agency is urged to use the relevant protocol descriptions and indicators to develop its own complex set of procedures and training programs.

The South West Regional Elder Abuse Network consists of multiple system partners in the South West Region of the SW Ontario LHIN. Specifically, but not limited to, this group brings together 6 local county elder abuse networks as well as regional partners from the Ministry of the Attorney General, Ministry of Health Promotion, Southwest Community Care Access Centre, Ontario Provincial Police, and Ontario...
Network for the Prevention of Elder Abuse (ONPEA). The six local elder abuse networks represented at this table are:

- **Grey and Bruce County** (SAAN) = Seniors Advocacy and Awareness Network;
- **Huron County** (REACH) = Response to Elder Abuse County of Huron;
- **Perth County** (PEACe) = Perth County Elder Abuse Committee;
- **London and Region** = Coalition to End Abuse of Older Adults (London and Region);
- **Elgin County** (EEARC) = Elgin Elder Abuse Resource Committee; and,
- **Oxford County** (OCEAN) = Oxford County Elder Abuse and Neglect Committee.

The SW Regional Elder Abuse Network recognizes and thanks the London and Middlesex Committee on Abuse and Neglect of the Elderly (CANE) for the work that they did on these protocols originally. CANE has graciously shared the work contained in this document, for the greater use by the SW region.

It is our hope, that this resulting document will assist you, in your own organization to develop Elder Abuse Protocols to help our vulnerable seniors.

“For so many to live to be old is one of the most remarkable achievements of the 20th century. To be old and live in dignity, free from all forms of abuse and violence, must be a common goal for all societies of the 21st century. It all starts with respect, as in the words of one older person, RESPECT IS BETTER THAN FOOD OR DRINK”

*World Health Organization, Missing Voices: Views of Older Persons on Elder Abuse*
INTRODUCTION

PURPOSE OF THESE GUIDELINES

- To establish a standardized interdisciplinary approach to managing elder abuse and neglect situations.
- To assist health, social services and other community groups in the development of comprehensive and coordinated protocols for the identification, assessment and management of elder abuse and neglect.

PHILOSOPHY AND VALUES (Ethical Considerations)

In dealing with the elderly, the following issues must always be considered.

- Abuse/Neglect must be considered as a possibility in all contacts with seniors. The areas to be considered should include physical, psychosocial, development and financial factors. Avoid premature labeling of abuse.
- Individuals’ values, beliefs, cultural heritage and race, language, immigration status, sexual orientation and ability must be considered. Each individual’s situation is unique.
- The dignity of all individuals must be respected. Focus should be on the individual’s/family’s strengths and abilities for positive action.
- Individuals must be informed of their options and rights; and encouraged to participate in making decisions about themselves in accordance with their ability to do so. Choices should be maximized.
- Individuals have a right to self-determination including the right to refuse assistance and intervention.
- Individuals have the right to express themselves in confidence and privacy. This confidentiality must be respected.
- Intervention should be the least intrusive or restrictive.
- Health care workers’/service workers’ own feeling, issues, and biases need to be recognized and addressed to avoid having their own (or agency’s) needs met at the expense of the elder.
- All professionals must be cognizant of their professional and ethical responsibilities in areas of recognizing and reporting abuse/neglect situations by fellow workers and work to ensure appropriate agency procedures are in place.

Elderly persons have the rights to:

- The basic requirements of life – food, shelter, clothing, health care and social contact. The right to receive is not equivalent to the obligation to receive;
- Self-determination – the right to live their lives as they wish and to make decisions about themselves provided that their actions are not contrary to the law or that they do not infringe upon the rights and safety of others;
- Protection – from physical, emotional, financial, and sexual abuse; from violation of their civil and legal rights; and from neglect;

1 Adapted from the Regional Niagara Senior Citizens Department (1996); source document Interdepartmental Working Group on Elder Abuse and Manitoba Seniors Directorate, (1993), p.4-5
• Rights of Refusal – to refuse assistance, intervention or medical treatment, to live at risk provided they are competent to choose and do no harm to others;

• Privacy – to share only that which they wish to share;

• Safe and adaptable environments – living conditions that are safe and appropriate to personal preference and changing abilities

• Formal supports- the right to access social, health, housing, legal services and any other services necessary to enhance capacity for autonomy and well-being. This includes the right to access services, at the same level provided for other age groups, when dealing with the implications of violence in later life.

• Confidentiality – whatever information they choose to share or whatever information becomes known about them will remain confidential to the extent that is possible, within the requirements of agency practices and the law.

In the case of apparent abuse, intervention should be guided by the choices of the elderly person and be:

• Aimed at maximizing the elderly person’s choices;

• Based on a skilled assessment of the person(s) involved and their environment (identifying the type and degree of risk posed to the person);

• The least intrusive or restrictive possible in the circumstances;

• Based on the elderly person’s strengths and abilities for positive action;

• Undertaken with voluntary and informed consent to the elderly person whenever and to whatever degree that is possible;

• Respectful of the elderly person’s family’s right to confidentiality.

Certain types of behaviour directed toward elderly persons are criminal activities. Sexual and physical abuse, uttering threats to cause harm or to kill, theft, fraud and neglect are all examples of situations where a criminal charge may be laid.

DEFINITION OF ELDER ABUSE

Elder Abuse is defined as any action, or deliberate inaction, by a person in a position of trust which causes harm to an older person (WHO 2002). Elder abuse can take the form of financial, physical, sexual, emotional and neglect.

CATEGORIES OF ABUSE

FINANCIAL ABUSE
Financial abuse is any improper conduct done with or without the informed consent of the older adult that results in a monetary or personal gain to the abuser and/or monetary or personal loss for the older adult.

**Behaviours may include but are not limited to:** Improper use of power of attorney, guardianship, theft of money or possessions, forging an older person’s signature, coercing changes in wills, withholding money.

**Indicators:** Withdrawals of money that are erratic or not typical of the older person; withdrawals of money that are inconsistent with the older person’s means; changing a will or property title to leave a house or assets to “new friends or relatives”; property is missing; older person “can’t find” jewelry or personal belongings; suspicious activity on credit card account; lack of amenities, when the older person could afford them; untreated medical or mental health problems; level of care is not commensurate with the older person’s income or assets; unrealistic burden of care for housing/support of children/grandchildren/great-grandchildren.

**PHYSICAL ABUSE**

Physical abuse is any act of violence or rough handling that may or may not result in physical injury but causes physical discomfort or pain.

**Behaviours may include but are not limited to:** Pushing, shoving, hitting, slapping, poking, pulling hair, biting, pinching, and confining or restraining a person.

**Indicators:** Says physically assaulted; unexplained falls and injuries; injuries inconsistent with explanation, burns and bruises in unusual place or of an unusual type; cuts, finger marks, or other evidence of physical restraint; excessive repeat prescriptions or under usage of medication; malnourishment or dehydration without an illness-related cause; person seeking medical attention from a variety of doctors or medical centres.

**SEXUAL ABUSE**

Sexual abuse is any sexual behaviour directed towards an older adult without that person’s full knowledge and consent.

**Behaviours may include but are not limited to:** Inappropriate sexual comments or jokes, fondling or sexual assault, forced to commit degrading acts, demanding or forcing sexual intercourse.

**Indicators:** Says has been sexually assaulted; unexplained changes in behaviour, such as, aggression, withdrawal or self-mutilation; frequent complaints of abdominal pain or unexplained vaginal or anal bleeding; recurrent genital infections, or bruises around the breasts or genital area; torn, stained or bloody underclothes; sexual behaviour that is out of keeping with the older person’s usual relationships and previous personality.

**PSYCHOLOGICAL/EMOTIONAL ABUSE**

Psychological/Emotional abuse is any act which diminishes an older person’s identity, dignity or self-worth.
Behaviours may include but are not limited to: Insults, threats, humiliation, bullying, treating an older person like a child, abandonment, withholding affection, expecting older person to look after grandchildren when beyond their wishes or ability, threatening to put older person in a ‘home’, removal of decision making.

Indicators: States has been emotionally abuse (belittled, ridiculed, bullying); change in eating pattern or sleep problems; may be isolated by others; fear, confusion, or air of resignation; passivity, withdrawal or increasing depression; helplessness, hopelessness or anxiety; contradictory statements or other ambivalence not resulting from mental confusion; reluctance to talk openly; avoidance of physical, eye or verbal contact with the suspected abuser.

NEGLECT
Neglect is the deliberate or thoughtless failure to meet the needs necessary for the older person’s physical and mental well being; may be passive neglect due to lack of experience, information or ability.

Behaviours may include but are not limited to: Failure to provide adequate food, clothing, shelter, health care, hygiene, and social stimulation, failure to prevent harm, being left in an unsafe or in isolated conditions. Note that an older person’s self-neglect is not considered to be elder abuse.

Indicators: Unkempt appearance, dirty or inappropriate clothing; malnourished, dehydrated; missing dentures, glasses, hearing aid/batteries; missed or cancelled appointments; unattended for long periods; hypothermia; untreated medical problems; confining to bed or chair, room or house; fridge or cupboards have little or no food.

DENIAL OF CIVIL RIGHTS
Denial of civil rights is denial of a person’s fundamental rights according to the Charter of Rights and Freedoms/Declaration of Human Rights.

Behaviours may include but are not limited to: Denial of privacy; withholding information; denial of visitors; denial of independent legal advice; mail censorship; restriction of liberty.

Indicators: Restricted access, difficulty visiting, calling or otherwise contacting older adult; older adult makes excuses for social isolation; inability to express opinions or vote; not allowed to attend faith or social gatherings; isolation.

ADDITIONAL FORMS OF ABUSE INCLUDE

SYSTEMIC ABUSE
Systemic abuse is institutional or government policies and regulations that create or facilitate harmful situations.

MEDICAL ABUSE
Medical abuse is medical procedures or treatments done without the informed consent of the older person or the recognized substitute.

INDICATORS RELATED TO THE ABUSER
In a family or close relationship, the abuser:

- Seems excessively concerned or unconcerned;
- Blames the older person for acts;
- Behaves aggressively;
- Treats the older person like a child or in a dehumanized way;
- Has a history of substance abuse;
- Has a history of abusing others;
- Does not want the older person to be interviewed alone; and,
- Responds defensively when questioned, may be hostile or evasive.

If married to the victim:

- Evidence of marital conflict or marital instability;
- Male dominance in the family;
- Economic stress; and,
- Poor family functioning;

If the abuser is a caregiver:

- Appears tired or stressed;
- Has been providing care to the older person for a long period of time;
- Poor pre-existing relationships;
- Refuses to permit hospitalization/diagnostic tests for the older person;
- Makes decisions without consulting the older person; and,
- Lacks understanding of the aging process/ageist attitude.

**LEVELS OF CONTACT FOR GENERAL PROTOCOL**

The community has been divided into four levels at which contact, intervention and management of abuse and neglect may occur. This division is recognized because the approach and intervention techniques will vary depending on the organization’s structure, mandate and services.

The four levels are:
• Level A – General Populations.
• Level B – Health Care and Social Services Agencies which are Community Based.
• Level C – Institutional Settings.
• Level D – Specialty Assessment and Treatment Facilities.

Each level’s role in the identification and response to elder abuse and neglect is defined and examined in the following areas:

- Identification;
- Assessment;
- Intervention; and,
- Follow-up.

**LEVEL A – GENERAL POPULATION**

This level includes establishments who have seniors as one segment of their service population. Examples would include the retail service sector such as banks, real estate agencies, grocery stores, service stations and so on. Also included would be churches, neighborhood groups, and service clubs and so on.

It is important to include this level to heighten awareness of everyone’s responsibility to do something about elder abuse and neglect. The establishment of a protocol assists individuals in taking action when abuse or neglect is suspected or observed; in knowing that they are not alone in this process; and in avoiding an “it’s none of my business” stance.

1. **Identification**
   Screenings at this level should be general and simple for all employees. Organizations should develop a list of risk indicators most relevant to their own setting. A comprehensive list of indicators of Elder Abuse (Physical, Psychosocial, and Exploitation) may be found in Appendix A. Often, concerns become evident after a pattern develops. Repeated observations of such behaviors may indicate that the person is at a higher risk of being abused.

2. **Assessment**
   A protocol needs to address how the concerns identified by the employee are discussed with someone within the organization who is able to evaluate the facts and make or suggest appropriate action. Actions on the part of the organizations may be:
   - Immediate referral to a community resource found in Appendix B because of the severity of concern.
   - Planned observation within the organization to determine whether there is a pattern of high risk behavior before making a referral; that is, monitor and document the situation for a time period.

3. **Intervention**
Possible referral sources need to be identified and a designated person empowered to make contact with the appropriate agency at the appropriate time. See Appendix B.

4. Follow-Up
If possible, a system of obtaining feedback should be established so that the action taken by the person suspecting abuse can be reinforced and affirmed.

LEVEL B – HEALTH CARE/SOCIAL SERVICE AGENCIES WHICH ARE COMMUNITY BASED
These settings include facilities providing physical and/or psychosocial health care to seniors such as Home care, family physicians, health care centers, and community nursing, support services, and social services organizations.

Referrals may be received from the individual involved, Level A facilities, and/or other community health professionals.

1. Identification
All staff employed in community based agencies should be familiar with the indicators of high risk as outlined in Appendix A. Protocol should include mechanisms for consultation and reporting of suspicions of elder abuse and neglect, as well as actual abuse and neglect, both within the agency and if appropriate to an external resource as listed in Appendix B.

2. Assessment
In completing an assessment at this level, the following issues should be considered:

- Legal and protection issues: Is there a criminal offence? Professionals must be aware of Ontario laws and dealing with the protection of adults, and their property, and what constitutes a criminal offence.
- Knowledge of physical, psychosocial and exploitation issues.

3. Intervention
If an abusive situation is strongly suspected or identified, a plan for intervention must be developed. Strategies must include both the person being abused as well as the person(s) doing the abusing.

Interventions can be divided into three steps:

a) Primary Intervention:
   - Advocate for legislative change to protect the elderly;
   - Establish an advocacy program for elders;
   - Promote research;
   - Promote public education; and,
   - Promote early education regarding management of family conflict and stress as well as attitudes about aging.

b) Secondary Intervention:
   - Having knowledge of normal aging process;
Establish and utilize screening tools;
- Establish intervention strategies for victim and abusers, dependent on their willingness and cooperativeness;
- Provide appropriate protection and legal services;
- Be aware of and coordinate community supports (see Appendix B);
- Provide services to decrease caregiver stress;
- Provide education for effective caregiver roles; and,
- Be aware of the possible need for an interdisciplinary conference.

c) Tertiary Intervention
- Address immediate safety issues and work with abused and abuser to facilitate change;
- Provide or arrange for rehabilitation for abused; and,
- Provide or arrange for rehabilitation for abuser.

4. Follow-Up
- A follow-up system must be established to determine if the intervention were appropriate and effective; and,
- A follow-up system must be established to see if the process is effective.

LEVEL C – INSTITUTIONAL SETTINGS
This level includes institutions where elderly persons live and are cared for, or are admitted on a time limited basis for specific treatment. Examples are general hospitals, long term care facilities, retirement homes, and so on. Sources of referral can be from other professional organizations, other residents/patients/clients and/or their families.

1. Identification
Staff working within institutions, residents/patients, family members, volunteers and visitors should be educated about the indicators for high risk as outlined in Appendix A.

Reporting mechanisms when elder abuse or neglect is suspected should be clearly identified. Ultimately, the attending physicians, nurse-in-charge and social worker should be informed to evaluate and intervene. If the suspected abuser is an employee, the Personnel Department of the institution will also be involved.

2. Assessment
Within an institution, a multidisciplinary team approach is recommended for the comprehensive evaluation and development of intervention strategies regarding elder abuse and neglect. The following points should be considered.

- If the suspected abuser is an employee of the institution, personnel protocol will need to be followed.
- The suspected victim should be separated from the suspected abuser for purposes of evaluation and safety.
- If the competency of the suspected victim is questionable, a psychiatric evaluation should be requested.
If the alleged abuse is a potentially criminal offence, an immediate police consultation should be made. Legal consultation may also be indicated.

A comprehensive bio-psychosocial assessment should be completed and documented with collaboration and communication among all disciplines.

An interdisciplinary conference should be considered to develop intervention strategies.

3. Intervention

Issues to be considered:

- Receptivity to intervention by individuals involved.
- Appropriate legal and protection issues, for example safety of the victim versus victim’s right to live at risk.
- Knowledge of family and support network.
- Knowledge of available institutional and community resources for ingoing intervention and counseling.

4. Follow-Up

An appropriate follow-up system must be established: to determine if the interventions were appropriate and effective; to establish an ongoing data base for future teaching and research; to evaluate the protocol established and revise as necessary.

By reviewing cases, other methods for prevention or elder abuse and neglect within the institution may be established.

**LEVEL D – SPECIALITY ASSESSMENT AND TREATMENT FACILITIES**

This level includes facilities which deal with issues of elder abuse after all other approaches/interventions have been attempted and the abuse continues and/or increases, placing the life and safety of the elder in jeopardy. Included are in or out-patient psycho geriatric units, in or out-patient psychiatric units, and so on.

Referrals might come to “Level D” facilities from any levels including other “Level D” facilities.

1. Identification

   The following are important points to consider:

   - Referring agencies have identified actual abuse or have string evidence on which to base their suspicions;
   - The referring agency or physician agrees that this level of intervention is necessary;
   - The abused elder, as well as the abuser, is often resistant to intervention;
   - The abused elder, as well as the abuser, may continue to deny that any problem exists.

2. Assessment

   At this level of suspected or proven abuse the following should be considered within a multidisciplinary team approach:

   - A detailed review of all previous medical history, with particular emphasis on neurological and psychiatric history;
➢ A detailed review of previous social history of the elder and his/her family with particular emphasis on a history of substance abuse or violence;
➢ A detailed examination of the elder’s current physical, psychiatric and social situation;
➢ An assessment of mental competence;
➢ Elucidation and evaluation of the elder’s actual and potential support system, both personal and professional.

3. Intervention
Following up the assessment and in consultation with the community agencies involved on the care of the elder, one or more of the following may be recommended.

➢ Further psychiatric assessment and treatment of the elder (either in or out-patient) caregiver intervention with community support, counseling and assistance;
➢ General hospital admission;
➢ Legal intervention;
➢ Relief bed placement of the elder;
➢ Long term placement of the elder.

4. Follow-up
Follow-up monitoring for both the abused and abuser is an essential component of the plan of intervention. Periodic community conferences may be necessary to ensure the safety and health of the elder at risk.
APPENDIX A – INDICATORS OF ABUSE

Indicators of Abuse may be found on the National Initiative for the Care of the Elderly (NICE) website as follows:

http://www.nicenet.ca/files/IOA.pdf
ELDER ABUSE PROTOCOL PHYSICAL INDICATORS

1. Unexplained loss of hair, abrasions, bruises, burns, bumps, contusions, falls, fractures, grip marks, hematomas, immobility, infections, internal injuries, lacerations, pain, restricted movement, rope marks, swelling, tenderness, ulcer, welts;

2. Pain, bruising, bleeding in genital area (indicators of sexual abuse);

3. Shivering, cyanosis, lowered body temperature;

4. Malnourishment, emaciation, no dentures;

5. Dehydration, mouth sores, confusion;

6. Bed sores, poor skin condition, poor hygiene, soiled linen, urine burns, unkempt appearance;

7. Clothes in poor repair, inappropriate for the season (indicator of neglect);

8. Over-sedation, reduces physical/mental activity, drug or alcohol abuse;

9. Depression (also indicator of medication abuse);

10. No glasses, lack of hearing aid (also indicator of neglect);

11. Dangerous/unsafe environment;

12. Unattended, tied to chair/bed (also indicator of neglect);

13. Not taken to doctor/dentist/therapist when necessary (also indicator of neglect);

14. Deserted;

15. Forced institutionalization; and,

16. Any injury for which explanation does not fit the evidence.

ELDER ABUSE PROTOCOL PSYCHOSOCIAL INDICATORS

1. Low self-esteem;

2. Withdrawn, passive;

3. Fearful, appears nervous around caregivers, “What are you going to do to me?”;

4. Inappropriate quilt;

5. Excluded from family gathering, not permitted to have friends, visitors, go to church;

7. Ribbons in hair, toys, “baby talk”;

8. Depressed, hopeless, helpless (affect);

9. Confused, forgetful; and,

10. Denied access to grandchildren.

ELDER ABUSE PROTOCOL

EXPLOITATION/FINANCIAL INDICATORS:

1. Illegal use of elder’s possessions/property/investments for profit/personal gain;

2. Forced to sign a document (will, property deed, power of attorney) without full understanding of choices;

3. Unwillingly used as a babysitter/housekeeper;

4. Insufficient money for food/clothes/social activities;

5. Inadequate living environment;

6. Unexplained discrepancy between know income and standard of living; and,

7. For financial institutions; elderly person surprised by overdrawn or reduce bank balance; unusual transactions conducted on behalf of an older person.
APPENDIX B – REGIONAL SUPPORT INFORMATION

General Information – This is a very general list of regional supports available to provide information and support about elder abuse. For specific contact information please use local directory or internet web access.

<table>
<thead>
<tr>
<th>REGIONAL SUPPORTS AVAILABLE</th>
<th>PHONE NUMBER/E-MAIL (please complete with your local information)</th>
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<tbody>
<tr>
<td><strong>Community Health and Social Services:</strong></td>
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<tr>
<td>Ontario Seniors Safety Line</td>
<td>1-866-299-1011</td>
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<tr>
<td>Local Public Health Department</td>
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<tr>
<td>Local CCAC</td>
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<tr>
<td>Family Physician</td>
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<tr>
<td>Local Community Health Centre</td>
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<tr>
<td>211 Information and Referral Network</td>
<td>Dial 211 or 1-866-743-7818</td>
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<tr>
<td>TTY: 1-888-435-6806</td>
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<tr>
<td><strong>Police:</strong></td>
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<tr>
<td>Emergency Service</td>
<td>911</td>
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<tr>
<td>Ontario Provincial Police</td>
<td>1-888-310-1122</td>
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<td>Local Police</td>
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<td><strong>Hospitals:</strong></td>
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<td>Local Hospital</td>
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<td>Family MD</td>
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<td><strong>Legal Services:</strong></td>
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<tr>
<td>Office of the Public Guardian and Trustee</td>
<td>1-800-366-0335 (Toronto)</td>
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<td></td>
<td>1-800-891-0504 (London)</td>
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<td>Lawyer Referral Service</td>
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<tr>
<td>Legal Aid (accepts collect calls)</td>
<td>1-800-668-8258</td>
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<tr>
<td>Family Lawyer</td>
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<td>ACE (Advocacy Centre for the Elderly)</td>
<td>416) 598-2656</td>
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<td><a href="http://www.advocacycentreelderly.org">www.advocacycentreelderly.org</a></td>
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<td><strong>Other:</strong></td>
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<td>Clergy</td>
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<td>Bank Manager</td>
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<td>Emergency Shelter</td>
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<td>Victims Assistance</td>
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<td><strong>Websites</strong></td>
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<td>Ontario Network for the Prevention of Elder Abuse</td>
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<td>The Heath Line</td>
<td><a href="http://www.thehealthline.ca/">http://www.thehealthline.ca/</a></td>
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APPENDIX C – NATIONAL INITIATIVE FOR THE CARE OF THE ELDERLY (NICE) WEBSITES

National Initiative for the Care of the Elderly (NICE) website includes:

Elder Abuse Suspicion Index:  http://www.nicenet.ca/files/EASI.pdf

Caregiver Abuse Screen: http://www.nicenet.ca/files/Case.pdf

EXAMPLES OF A RISK ASSESSMENT TOOL

There are six questions included in this screening questionnaire. They are formulated to enable a helping professional to quickly evaluate the extent to which elderly persons may be at risk for abuse. The questions themselves are based on known risk factors in the areas of dependency; effects of stress for the elderly person or for the caretaker: emotional or psychiatric problems for any family member; availability of effective support networks; and a history of violence in the family.

No attempt has been made to discriminate between the relative risks of each of these factors; however any of the top ratings must be taken very seriously. To quantify the risk, assign a mark of 1, 2 or 3 to each answer. 1 being least problematic and 3 being most problematic.

Total the Scores:

<table>
<thead>
<tr>
<th>Score</th>
<th>12-18</th>
<th>7-11</th>
<th>Less than 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relative Risk</td>
<td>High Risk</td>
<td>Some Risk</td>
<td>Low Risk</td>
</tr>
</tbody>
</table>

These questions are designed to be used by the health professionals in asking the caretaker and/or the elderly person. Any discrepancy in answers should be noted for follow-up.

This assessment tool can also be used to focus follow-up questions to assist with further data collection, planning, support teaching etc. It is also suggested that in addition to these six closed questions, you can use an open question like “Are there any other problems that you are having at this time?”

ASSESSMENT OF ELDER AT RISK FOR ABUSE - (“SCARED” TOOL)

1. **S – Stress Level**

<table>
<thead>
<tr>
<th>Do you sometimes wonder if your present living arrangements are good for you and your “family”?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Often</td>
</tr>
<tr>
<td>☐ Rarely</td>
</tr>
<tr>
<td>☐ Never</td>
</tr>
</tbody>
</table>

2. **C – Coping**

<table>
<thead>
<tr>
<th>Has anyone in your family had any difficulty with “nerves”, forgetfulness, or mental health problems?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Yes, it is a problem at this time.</td>
</tr>
<tr>
<td>☐ Yes, is not a problem at the time.</td>
</tr>
<tr>
<td>☐ No, have not had these problems.</td>
</tr>
</tbody>
</table>

3. **A-Arguments**

<table>
<thead>
<tr>
<th>How would you describe relationships within your family?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Much arguing, no cooperation</td>
</tr>
<tr>
<td>☐ Occasional arguments, little cooperation</td>
</tr>
<tr>
<td>☐ Few arguments, close cooperation</td>
</tr>
</tbody>
</table>

4. **R-Resources**

<table>
<thead>
<tr>
<th>Is there adequate support to help you care for yourself and your family?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ resources/supports are not adequate</td>
</tr>
<tr>
<td>☐ Resources/supports are at times not adequate</td>
</tr>
<tr>
<td>☐ Resources/Supports are adequate.</td>
</tr>
</tbody>
</table>
### 5. E- Events

<table>
<thead>
<tr>
<th>Have there been changes for you and your family in the last six months?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Yes, important changes</td>
</tr>
<tr>
<td>☐ Yes, some changes</td>
</tr>
<tr>
<td>☐ No changes of importance</td>
</tr>
</tbody>
</table>

### 6. D- Dependency

<table>
<thead>
<tr>
<th>How dependent is the older person on assistance?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Relatively dependent</td>
</tr>
<tr>
<td>☐ Dependent at times</td>
</tr>
<tr>
<td>☐ Relatively independent</td>
</tr>
</tbody>
</table>
REFERENCES


8. The Community Network for Prevention of Elder Abuse for the Eastern Counties and Akwesasne, Intervention Guidelines for Elder Abuse
DECISION TREE A and B – NON REGULATED WORKERS AND VOLUNTEERS

Decision Tree A – Non regulated Workers and Volunteers

(A) Evidence /Suspect Abuse

(B) Determine actual and potential risk

(C) Is it an emergency situation? Is the person in immediate danger?

YES

(D) Maintain personal safety
LTC Home: Activate Emergency System

NO

(E) LTC Homes: mandatory to report to supervisor
Community: report to supervisor and document

(F) Discuss with supervisor/Director of Care
Debrief with team
Follow-up as assigned.
Reflect and increase understanding of Elder Abuse.
**Decision Tree A**

**Box A: Evidence/Suspect Abuse**
- Refer to Chap 2 for types of abuse
- Record objective facts – what you see? What you hear?
- Determine the exact issues that are raising your suspicions

**Box B: Determine Risk**
- Refer to Chap 2 for risk factors.

**Box C: Emergency Situation**
- Determine if the senior is in immediate danger, i.e. life threatening situation or at risk of imminent harm.
- Call 911 and/or any special facility code.

**Box D: Maintain Personal Safety**
- Ensure personal safety.
- Ensure safety of other individuals exposed to the potential danger, such as roommates.

**Box E: Responsibilities**
- Reporting abuse to MOHLTC is mandatory within long-term care homes.
- As per facility policy, notify supervisor/Director of Care and document.
- Refer to Chapter 4 for more details on role responsibilities.

**Box F – Discuss with supervisor and debrief with team**
- Discuss the situation with your supervisor after witnessing abuse
- Discuss with supervisor your responsibilities in the follow up plans and appropriate ways to interact with senior.
- Discuss with supervisor and team what was learned from this case, e.g. red flags, preventative measures etc.

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**Decision Tree B**

1. **Evidence /Suspect Abuse**
   - 2. Determine actual and potential risk
     - YES 3. Is it an emergency situation? Is the person in immediate danger?
     - NO 11. Report as per agency protocol, standards of practice
     - YES 4. Maintain personal safety
     - NO 12. SDM determined?
     - YES 13. Consent & Capacity Board-P GT – Guardian Investigation
     - NO 5. Police and/or medical assessment
     - YES 15. Unsure? Ask... Peers
     - NO 16. SDM acting in best interest of person?
     - YES 17. Obtain consent from SDM
     - NO 8. Develop options with senior.
     - YES 9. Safety Plan Contact info Resources
     - NO 10. Follow-up & Evaluate
     - 18. Plan course of action with SDM and person
     - 14. Follow-up & Evaluate
**Decision Tree B**

**Box 1: Evidence /Suspect Abuse**
- Refer to Chap 2 for types of abuse.
- Note objective facts – what you see? What you hear?
- Determine the exact issue that is raising your suspicion.
- Determine how long you have had your suspicion?

**Box 2: Determine risk**
- Refer to Chap 2 for risk factors.

**Box 3: Emergency**
- Focus on risk of imminent harm — consider the immediate safety of the victim.
  Respond with immediate action if the senior is in an emergency situation. Call 911 when:
- It is an emergency situation, i.e. life threatening.
- The person is at immediate risk for physical injury.
- The person is at imminent risk for health or safety reasons.
  Assess the need for medical attention and other resources. Consider the following:
- Has the person sustained injuries?
- Does the person need transportation to a medical facility or shelter?
- Can the person contact the police or other emergency services on his or her own?

**Box 4: Maintain personal safety**
Assess immediate danger to the senior and worker:
- Where is the alleged abuser?
- Are there any weapons present?
- Does the alleged abuser have a weapon?
- Are their uncertainties such as the presence of mental health or addiction issues?
- Are others in the household?

**Box 5: Police and/or medical assessment**
Assess the need for safety, shelter and financial resources.
- Does the senior require transport to emergency housing?
  Does the person wish to go to a shelter, or have friends or other family who could provide temporary accommodation?
- Assess need for prescribed medication. Does senior need medical attention?
- Determine if any urgent mental health issues are present.
Guidelines for Developing Elder Abuse Protocols
### Interview Strategy

1. Develop trust and be sensitive to person's culture, religion, comfort level and timing in obtaining disclosure: Interview alone, listen, be patient, non-threatening and non-judgmental, validate feelings and offer emotional support, avoid premature assumptions and suggestions. Some cultures may require a family member to be present during the interview or it may be necessary to negotiate in order to interview someone alone.

2. Note suspicious histories: Explanation vague, bizarre or incongruent with type or degree of injury, denial of obvious injury, long delay between injury and treatment, history of "doctor shopping".

3. Be alert to person's wishes and assess ability to understand. Try to assess whether the person "understands" and "appreciates" what is happening and what their needs are.

4. Identify what information is missing: Frequency, duration, urgency, need for physical examination.

5. Be aware of interdependent relationships / power differences: Be cautious of involvement of third party who may be the abuser; note conflicting histories. Where appropriate, interview family members but remember it's key to TALK TO THE SENIOR even if family are available.

### Possible Interview Questions

- Is there something that you would like to share with me?
- Has there been a recent incident causing you concern?
- Has anyone ever pressured or forced you to do things you didn't want to do?
- Has anyone ever tried to take advantage of you?
- Has anyone ever failed to help you take care of yourself when you needed help?
- Have you ever signed any documents that you didn't understand or didn't want to sign?
- Do you make decisions for yourself or does someone else make decisions about your life, like how or where you should live?
- Are you afraid of anyone?
- Would you like some help with...?
- It must be hard for you to look after...

### Possible Interventions

Consider impact on the persons, their wishes, and their ability to recognize that they may be a victim of abuse. Note their understanding and appreciation of the consequences of their decisions. Understand that often before a person will seek or agree to accept help, they need to be able to trust you and know that you will follow through with the help you offer to give. Your role could be singular or part of a team of service providers that could support the person to be healthy and safe. Be aware of appropriate resources or know how to link with broader community. Follow your professional standards in obtaining client consent. If client does not consent maintain contact to initiate A and/or B. (See Below)

### A. Education

Provide information and support according to the interests expressed by the person. Be aware of services outside the healthcare system which are specific to the needs of any older adult or specific to the needs of the older persons who are being victimized or are at risk, including social services, legal services, financial assistance, housing options and the faith community.

### B. Safety Plan

The plan may include a change to an element of their environment or their relationship which could result in the elimination of the role of the abuser or context of the abuse. Consider:

- Home visits, telephone contact, contact with other family and friends, regular appointments.
- Secure assets e.g. Hide emergency money (coins for phone pay) somewhere outside home.
- Give copies of important documents and keys to trusted friends or family members.
- Plan escape by packing a bag of extra clothing, medicine and personal aids (e.g., glasses, hearing aids).
- Keep phone numbers of friends, relatives, shelters or other trusted individuals handy.

### C. Coordination and Consultation Help Humber

Some of these organizations will provide direct assistance and others will refer callers to local organizations to get information or assistance. This is not an exhaustive list. It is important to develop your own list of local contacts.

- Advocacy Centre for the Elderly: 1-416-596-2656
- Association of Local Public Health Agencies: 1-416-595-0000
- Alzheimer Society of Ontario: 1-416-967-5000
- Ministry of Government Services — Consumer Services Bureau: 1-800-889-8708
- Ministry of Health — Tele Health Line: 1-866-727-0000
- Ministry of Health and Long Term Care - Complaints Line: 1-866-434-0144
- Office of the Public Guardian and Trustee: 1-800-366-0335
- Ontario Association of Community Care Access Centres: 1-416-750-1720
- Ontario Rental Housing Tribunal: 1-888-332-3234
- Ontario Seniors’ Secretariat Info Line: 1-888-910-1999
- Ontario Retirement Communities Association: 1-800-361-7254
- Ontario Network for the Prevention of Elder Abuse: 1-844-846-8784
- PhoneBusters: 1-888-365-8501
- Senior Crime Stoppers: 1-800-222-8477
- Victim Support Line: 1-888-579-2888
Thank you for downloading this document. It is the sincere desire of the Southwestern Ontario Regional Elder Abuse Network that this work has been of assistance to you and your organization in the development of local policies and protocols.

If you have any questions or feedback about the guidelines, please e-mail the chair of the Southwestern Ontario Regional Elder Abuse Network at sworean@gmail.com.

Note: For emergency situations or specific elder abuse questions, please contact the Provincial Seniors Safety Line at 1-866-299-1011.