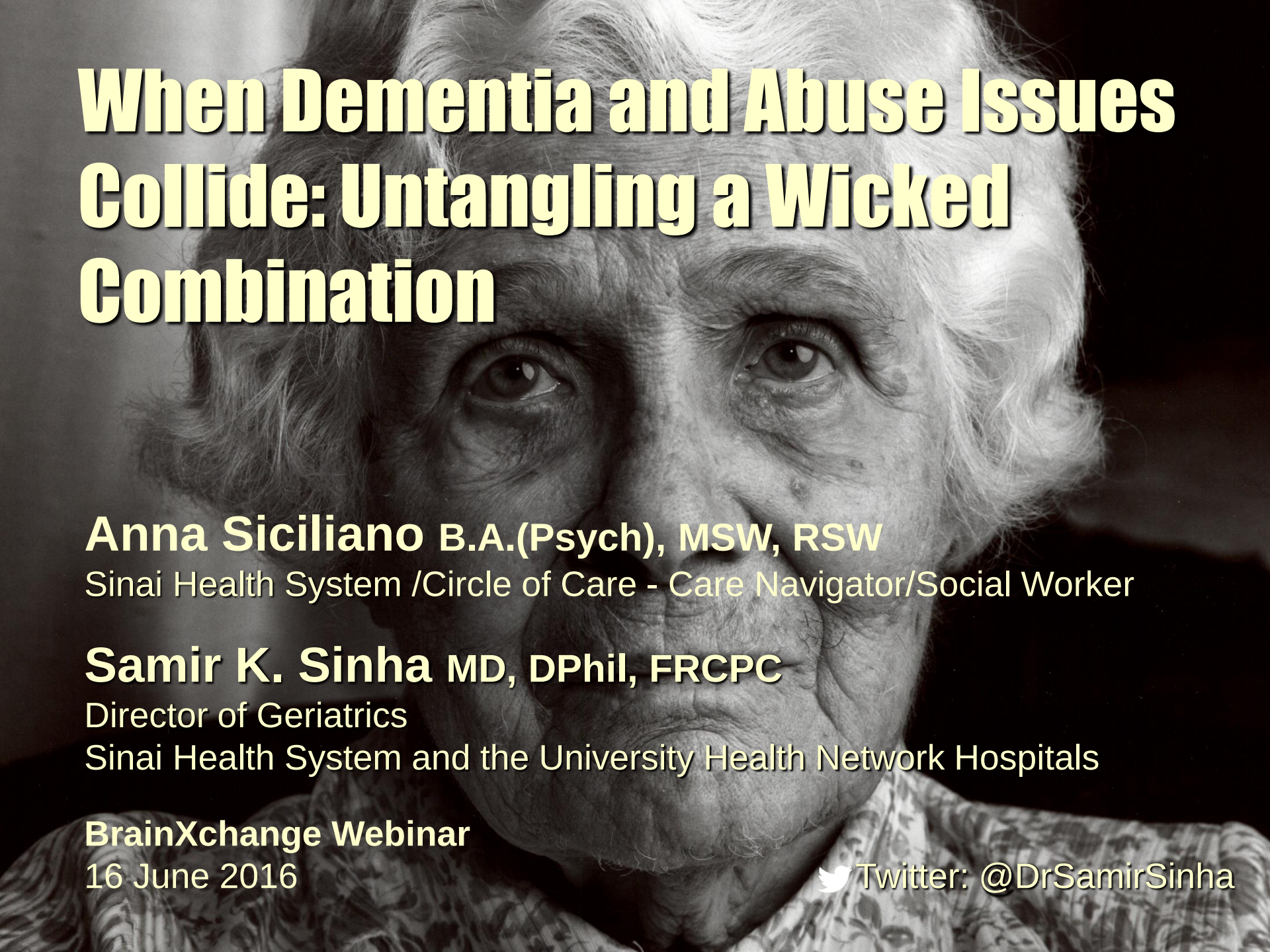

When Dementia and Abuse Issues Collide: Untangling a Wicked Combination

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Establishing our Context

- Canada and Ontario's older population is set to double over the next twenty years, while its 85 and older population is set to quadruple *(Sinha,* Healthcare*Papers 2011).*
- The number of Canadians expected to be living with Dementia is expected to at least double in the coming decades as well.

Ageism and Elder Abuse in Canada

- It is estimated that 4-10% of older adults in Canada will experience one or more forms of abuse at some point during their senior years. *(National Seniors Council, 2007)*
- In Ontario, approximately 4%, or 75,000 of Ontario's 2 million older adults, are reported to be living with elder abuse. *(OHRC, 2009)*
- Due to under-reporting of elder abuse, the real percentage is estimated to be close to 10%. *(OHRC, 2009)*

What is Elder Abuse?

Elder Abuse is defined as,

> "single or repeated acts, or lack of appropriate action, occurring within a relationship where there is an expectation of trust, which causes harm or distress to an older person."
>
> (WHO, 2012)

Defining Dementia

DIAGNOSTIC CRITERIA FOR DEMENTIA

1. Presence of acquired memory impairment associated with one or more cognitive domains
2. Cognitive impairment is severe enough to interfere with social/occupational function.

DIAGNOSTIC CRITERIA FOR MILD COGNITIVE IMPAIRMENT (MCI)

1. Presence of acquired memory impairment associated with one or more cognitive domains
2. Cognitive impairment does **NOT** interfere with social/occupational function.

Categorizing Dementias

DEMENTIA SEVERITY IS BASED ON FUNCTIONAL STATUS

1. **MILD** – Minor IADL Impairments / ADLs Usually Intact
2. **MODERATE** – Major IADL and Minor ADL Impairments
3. **SEVERE** – Major IADL and ADL Impairments

IADLS INCLUDE:

Housework; Medications Management; Managing Money; Shopping; Using Transportation, Telephones and Technology

ADLS INCLUDE SELF CARE TASKS:

Transferring; Ambulating; Toileting, Bathing, Personal Hygiene, Dressing and Eating

Essential Management of Dementias

Non-Pharmacologic

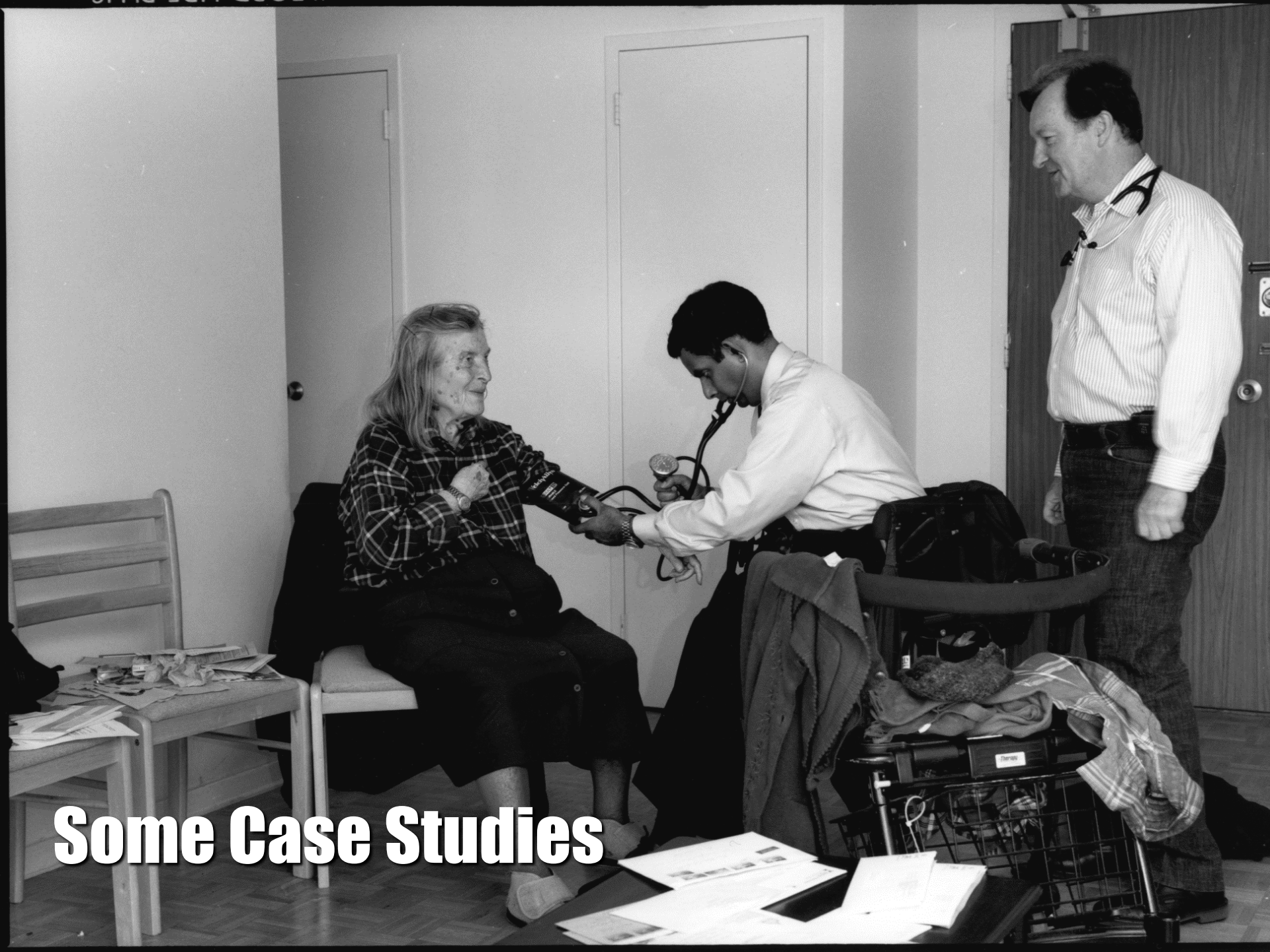
- State Diagnosis and Prognosis
- Alzheimer Society (First Link program)
- Caregiver Education and Support Program
- Home Supports (Home Care and MEDS Mx SUPPORT)
- Community Support (MOW, Adult Day Programs…)
- Update Will
- Assign Power of Attorney
- Advance Directives
- Should they be Driving?
- Start Goals of Care Discussions Early as well…a good offence is a great defense…

What are the Types of Abuse?

- Financial Abuse (Most Common)
- Psychological (Emotional) Abuse
- Physical Abuse
- Sexual Abuse
- Neglect (including Self-Neglect)
- Systemic Abuse

“With regards to elder abuse, many older adults suffer in silence and some do not know how and where to get help.”

- Ontario Seniors Strategy Survey Respondent


Some Case Studies

Case Study #1

- Mrs. T. is an 80-year-old woman who is residing with her husband in a downtown Toronto apartment.
- Mrs. T. has been diagnosed with Moderate to Severe Vascular Dementia and is supported through a Geriatric Medicine Clinic at Mount Sinai Hospital. Her declining dementia is now being characterized by visual and auditory hallucinations, wandering and reckless behaviours.
- A subsequent referral to the local Community Outreach Team (COT). Mrs. T.'s spouse reported to COT Social Worker Anna that Mrs. T. would often attend at the bank to withdraw large sums of money and that in the absence of a formal Power of Attorney document the bank had not been successful in limiting Mrs. T.'s access to funds but had attempted redirection of Mrs. T. on numerous occasions.
- In addition, Mrs. T. has exhibited responsive behaviors consisting of wandering in the community necessitating police accompanying her home.

Case Study #2

- Mrs. S. is an 82 year-old woman, diagnosed with dementia and was residing with an adult son who had assumed the role of caregiver to Mrs. S. with respect to her ADLs and some of her ADLs.
- Mrs S' son is the designated Power of Attorney (personal care and property).
- The Police were contacted following the client's attendance at her Adult Day Program for individuals with cognitive impairment and her subsequent report that her son had physically assaulted her and a pattern of abuse consisted of verbal, emotional and financial abuse.
- Mrs. S. is a recipient of government funded Personal Support Worker services, and Social Work services through a local Community Agency.

Case Study #3

- Mr. L. is an 88-year old-man who was residing with his son and his wife in the same house.
- Mr. L. had been sponsored by his son from Russia to immigrate to Canada.
- Mr. L. was diagnosed with dementia a few years ago and was provided with instructions from the client's son and wife not to interact with other family members at the residence and not to occupy certain rooms of the house.
- It has come to the attention of a local Personal Support Worker that comes to give him a bath twice a week that Mr. L is experiencing social isolation and symptoms related to depression and anxiety.

Who Is At Risk?

Individual Risk Factors

- Marginalization of individual elder or abuser
- Poverty
- Social Isolation
- Frailty or Impairment (including Cognitive)
- Gender
- History of previous abuse
- Dependence
- Substance abuse

Abuser Characteristics

- Social Isolation
- Emotional Issues
- Stress in other aspects of the abuser's life
- Financial dependence or stress
- Need for control
- Substance Abuse
- Lack of caregiving knowledge or experience
- Confusion of dementia of the abuser

Familial and Caregiving Elements

- Research studies and cases reported to the criminal justice system have found that family members are most often the abusers.
- Caregiver stresses, combined with external stressors such as lack of social supports for either person can lead to potentially abusive situations.
- Interdependency between elders and family/significant other abusers.
- Behaviour may vary according to one's family or cultural background.

Underlying Risks

- Power imbalances and societal stereotypical attitudes about older persons can have an often unrecognized effect on the views, actions and inactions of caregivers, family/significant other members and even on the elders living with abuse themselves.
- Imbalances such as ***ageist and sexiest*** values in the society and within an organization providing service, can create an environment in which elder abuse is "tolerated" by the society.

Identifying Signs of Abuse

Signs/Symptoms of Elder Abuse

Financial Abuse

- Sudden changes in banking practices, large, unexplained withdrawals by person accompanying elder
- Unauthorized withdrawal of funds using ATM card
- Abrupt changes in will or financial documents

Emotional Abuse

- Being emotionally upset or agitated
- Withdrawn or non-communicative
- Feeling depressed
- Feeling intimidated or afraid of caregiver

Signs/Symptoms of Elder Abuse

Physical Abuse

- Bruises, burns, welts
- Elder's report of being hit, or unexplained injuries
- Caregiver's refusal to let visitors see an elder alone

Sexual Abuse

- Bruises around the chest or genital area
- Torn, stained, bloody underclothes
- Elder's report of sexual assault

Signs/Symptoms of Elder Abuse

Neglect/ Self-Neglect

- Dehydration, poor nutrition
- Poor personal hygiene
- Unsanitary or unsafe living conditions

Systematic Abuse

- Prejudicial attitudes towards older people
- Elders are denied access to certain services due to institutional practices and policies


Assessment and Intervention

Addressing Ageism and Elder Abuse

- Ageism is a multi-faceted and manifests itself in multiple ways.
- While there has been work undertaken in Canada and internationally to address ageism, it still appears to be very much present in our health care system and is treated less seriously than other forms of discrimination.
- Elder abuse is also more complicated than child abuse.
- As Ontario's population ages, the potential exists that elder abuse will increase unless it is more comprehensively recognized and addressed.

Is Elder Abuse A Crime?

There is no specific crime of 'elder abuse'. However, forms of elder abuse may be a crime under the *Criminal Code.* Examples include:

Financial Abuse
- Theft (s. 322)
- Stopping mail with intent (s. 345)
- Extortion (s. 346)
- Forgery (s. 366)
- Fraud (s. 380)

Physical Abuse
- Assault (s. 265)
- Assault with a weapon or causing bodily harm (s. 267)
- Aggravated assault (s. 268)

Psychological (Emotional) Abuse
- Intimidation (s. 423)
- Uttering threats (s. 264.1)
- Harassing telephone calls (s. 372.3)

Active Neglect
- Criminal negligence causing bodily harm or death (ss. 220-221)
- Breach of duty to provide necessities (s. 215)

What You Can Do

- **R**ecognize the Signs of Elder Abuse
- **A**sk
- **R**eport or **R**efer

Abuse is Common and Can Be Stopped

- Clients who are stressed, confused, elderly, or require assistance with movement are most at risk for being abused.
- Most clients know their abusers moderately well
- Only 47% of nurses in community care who witnessed abuse tried to stop it
- 89% of staff who try to stop abuse are successful.
- Even if we can't stop abuse, we can improve things.

What You Can Do

- Listen to older adults and others who may tell you about suspicions of abuse
- Do not discount an older adult's claim simply because of a cognitive impairment
- Look for elder abuse indicators and behavior changes
- Ask questions even if you do not suspect abuse to encourage disclosures

How to Ask

- Interview should be conducted privately.
- Should take the form of dialogue when possible.
- Make questions a “routine” part of the interview.
- Document answers meticulously, using interviewees own words whenever possible.

Reporting Elder Abuse

- If the situation is an emergency and you believe that the person for whom you are concerned is at risk, call "911."
- In a growing number of organizations, there may be a key contact in place that can help you respond and refer.
- If the older adult does not have the capacity to understand their situation, phone the Office of the Public Guardian and Trustee (OPGT) at 416-327-6348 or Toll-free at 1-800-366 0335. The OPGT will conduct an investigation.
- Document answers meticulously, using interviewees own words whenever possible.

Essential Management of Dementias

Non-Pharmacologic

- State Diagnosis and Prognosis
- Alzheimer Society (First Link program)
- Caregiver Education and Support Program
- Driving Assessment
- Home Supports (Home Care and MEDS Mx SUPPORT)
- Community Support (MOW, Adult Day Programs…)
- Update Will
- Assign Power of Attorney
- Advance Directives
- Start Goals of Care Discussions Early as well…a good offence is a great defense…


Case Studies Revisited

Case Study #1

- Mrs. T. is an 80-year-old woman who is residing with her husband in a downtown Toronto apartment.
- Mrs. T. has been diagnosed with Moderate to Severe Vascular Dementia and is supported through a Geriatric Medicine Clinic at Mount Sinai Hospital. Her declining dementia is now being characterized by visual and auditory hallucinations, wandering and reckless behaviours.
- A subsequent referral to the local Community Outreach Team (COT). Mrs. T.'s spouse reported to COT Social Worker Anna that Mrs. T. would often attend at the bank to withdraw large sums of money and that in the absence of a formal Power of Attorney document the bank had not been successful in limiting Mrs. T.'s access to funds but had attempted redirection of Mrs. T. on numerous occasions.
- In addition, Mrs. T. has exhibited responsive behaviors consisting of wandering in the community necessitating police accompanying her home.

Case Study #1 – What We Did…

- Long Term Care application explored with family.
- Referral to local Behavioral Support Outreach Team (BSOT)
- Strategies and counseling provided to Mrs. T's spouse (Caregiver) to address Mrs. T.'s responsive behaviors
- Advocacy Centre for the Elderly (ACE) legal aid clinic was contacted by the Social Worker for the purposes of consultation (client's identifying information not provided to ensure confidentiality)
- Meeting coordinated with the bank manager and with Mrs. T's spouse and Social Worker to discuss options relating to client's excessive bank withdrawals.
- POA Documents Located
- Geriatrician supported in completing paperwork to help bank and spouse better support Mrs. T's finances.

Case Study #2

- Mrs. S. is an 82 year-old woman, diagnosed with dementia and was residing with an adult son who had assumed the role of caregiver to Mrs. S. with respect to her ADLs and some of her ADLs.
- Mrs S' son is the designated Power of Attorney (personal care and property).
- The Police were contacted following the client's attendance at her Adult Day Program for individuals with cognitive impairment and her subsequent report that her son had physically assaulted her and a pattern of abuse consisted of verbal, emotional and financial abuse.
- Mrs. S. is a recipient of government funded Personal Support Worker services, and Social Work services through a local Community Agency.

Case Study #2 – What We Did…

- The Social Worker engaged a Police Community Relations Officer which resulted in the client's son being criminally charged with assault and a 'No Contact Order' was issued for the client's son to leave the client's residence and reside elsewhere
- Client's attendance at the Adult Day Program was extended from a part-time basis to a full-time basis as a means to provide supervision and safety. Funding for participation in the Adult Day Program was found through a local community care fund.
- A Long Term Care application was completed.
- The Advocacy Centre for the Elderly (ACE), legal-aid, assisted the client in revoking the Power of Attorney
- The Office of the Public Guardian and Trustee, Special Investigations Unit assumed responsibility for managing the client's finances

Case Study #3

- Mr. L. is an 88-year old-man who was residing with his son and his wife in the same house.
- Mr. L. had been sponsored by his son from Russia to immigrate to Canada.
- Mr. L. was diagnosed with dementia a few years ago and was provided with instructions from the client's son and wife not to interact with other family members at the residence and not to occupy certain rooms of the house.
- It has come to the attention of a local Personal Support Worker that comes to give him a bath twice a week that Mr. L is experiencing social isolation and symptoms related to depression and anxiety.

Case Study #3 – What We Did…

- Communuity Social Worker got a Consultation with a local Elder Abuse Consultation Team at Family Services Toronto
- Pat's Place shelter for seniors, affiliated with Family Service Toronto was explored but client declined this option as preferred to live at home.
- Priority subsidized housing application (Housing Connections) was completed and Mr. L was approved for priority subsidized housing.
- An increase in Personal Support Worker services was provided by government home care agency to serve as a "check in" with client on a daily basis.


This is Our Time To Lead

What You Can Do

- **R**ecognize the Signs of Elder Abuse
- **A**sk the Person You Are Concerned about if they are being abused and Ask for Help if You Need Help to Help the person of concern
- **R**eport or **R**efer whenever possible to ensure help can be arranged to stop or at least reduce the abuse from occurring in future.

Questions?

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Financial Abuse

- The most common of elder abuse.
- Often refers to the theft or misuse of money or property like household goods, clothes or jewellery.
- It can also include withholding funds and/or fraud.
- Examples include: forgery, misuse or theft of money or possessions; use of coercion or deception to surrender finances or property; or improper use of guardianship or power of attorney.

Psychological (Emotional) Abuse

- The wilful infliction of mental anguish or the provocation of fear of violence or isolation.
- It diminishes the identity, dignity and self-worth of the seniors.
- Forms of psychological abuse include: name-calling, yelling, ignoring the person, scolding, shouting, insults, threats etc.

Physical Abuse

- Any physical pain or injury that is wilfully inflicted upon a person or unreasonable confinement or punishment, resulting in physical harm is abuse.
- Physical abuse includes: hitting, slapping, pinching, pushing etc.

Sexual Abuse

- Sexual abuse is understood as contact resulting from threats or force or the inability of a person to give consent.
- Behaviours includes: assault, rape, sexual harassment, intercourse without consent etc.

Neglect

- Neglect can be intentional (active) or unintentional (passive) and occurs when a person who has care or custody of a dependent senior fails to meet his/her needs.
- Older adults themselves may fail to provide adequate care for their own needs and this form of abuse of called self-neglect.
- Behaviours include: inadequate hygiene, overmedicating, inadequate provision to housing etc.

Systemic Abuse

- Our society, and the systems that develop within it, can generate, permit or perpetuate elder abuse.
- Also known as ageism, which is the discrimination against older adults due to their age and often combined with additional factors (i.e. gender, race, colour, language etc.)

Impacts of Abuse

Mortality: Elders who experienced abuse, even modest abuse, had a 300% higher risk of death when compared to those who had not been abuse. *(Lachs, et al, 1998; National Academies, 2010)*

Distress: victims of elder abuse have had significantly higher levels of psychological distress and lower perceived self-efficacy than older adults who have not been victimized (Comijs, et al, 1999; Dong 2005)

Impacts of Abuse

Health: older adults who are victims of violence have additional health care problems than other older adults, including increased bone or joint problems, digestive problems, depression or anxiety, chronic pain, high blood pressure, and heart problems. (Dyer, et al, 2000; Stein & Barret-Connor, 2000)

Fiscal: The direct medical costs associated with violent injuries to older adults are estimated to add close to $6 billion to the nation's annual health expenditures, and the annual financial loss by victims of elder financial exploitation were estimated to be $2.9 billion in 2009, a 12% increase from 2008.