DEFINING AND MEASURING ELDER ABUSE AND NEGLECT

Synthesis of Preparatory Work Required to Measure the Prevalence of Abuse and Neglect of Older Adults in Canada

NICE
National Initiative for the Care of the Elderly

Abstract

The goal of this two-year research program was to develop conceptual and operational definitions of physical, psychological, sexual and financial abuse and neglect of older adults who lived in the community and institutions that could be used in a national prevalence study in Canada. This research adopted a pilot study approach and used mixed-methods to achieve the goals. There were five related smaller research projects contained in the pilot research that were interlinked to create a whole. Each project had its own overarching goal and a varying number of objectives, how the objectives would be achieved and the coordination of each project. The pilot represented the entire study with all of its instruments and procedures to discover problems before the main research might be undertaken. Every project received ethical approval from the centres for the study, Universities of Toronto and Sherbrooke, prior to any fieldwork.

Conceptual and operational definitions were developed by the research team based on a review of existing definitions and input from community and institutional stakeholders. Several focus groups with older adults and care providers were carried out in French and English Canada to test the definitions. A bilingual questionnaire was created based on the definitions; the questionnaire underwent cognitive testing in French and English and was adjusted accordingly. Two hundred and sixty-two Canadians 55 years and over were interviewed in a non-random sample in both official languages by telephone to test the validity of the measurement instrument. Thirty-one residents or their proxies in institutions were interviewed using the same questionnaire modified for institutions.

The pilot study is unique for a number of reasons. The Canadian project is the first prevalence study to ever introduce a theoretical perspective that served as a framework for the study and which was tested in the study. Second, the study tested the validity of the measurements for the first time in the elder mistreatment field – measures that have been used extensively over the years with no previous validation. Third, the study examined, in a new way, the major issues of over and under estimation of the rates of elder mistreatment. Fourth, the methods included a community consensus approach that integrated the views of major stakeholders from across Canada at the inception of the project and finished with a knowledge transfer event for these stakeholders to share in the results and plan for the future. Lastly, an extensive ethics manual was developed that could be used by both practitioners and researchers in any aspect of intervention through practice or research that afforded the protection and resources older adults might require.

The preliminary analyses of the data indicate that with a few revisions, the questionnaire successfully identifies maltreatment and neglect. Unlike the existing 13 prevalence studies world wide, the Canadian research developed a more rigorous standard for determining abuse and neglect through the use of evaluative coding. Two consensus meetings of Canadian stakeholders at the beginning and end of the project provided input to the definition process and questionnaire. The conceptual definitions in the form of a 'pocket tool' are available through National Initiative for the Elderly (NICE).

Executive Summary

Description of the Research Program

- The overarching aim of this pilot research program was to examine the main problems associated with the conceptual definitions and measurement of mistreatment of older adults; the difficulties on the theoretical front, the current challenges associated with identifying risk factors for abuse and neglect and the issues surrounding the collection of reliable and valid data related to the prevalence of abuse and neglect.

- There were five related mini research projects contained in the pilot research that were interlinked to create a whole. Each project had its own overarching goal and a varying number of objectives, how the objectives would be achieved and the coordination of each project.

- The research was conducted by elder abuse experts from the *National Initiative for the Care of the Elderly* (NICE), a 1,800 member, not-for-profit, incorporated charitable organization sponsored by the National Centres of Excellence (NCE) and housed at the Institute for the Life course and Aging at the University of Toronto. An international team of researchers led the project and was advised by an international Advisory Committee.

- The Canadian study is unique because: it introduced a theoretical perspective that served as a framework for the study and which was tested in the study; it tested the validity of the measurements for the first time in the elder mistreatment field; the major issues of over and under estimation of the rates of elder mistreatment were examined and the methods included a community consensus approach that integrated the views of major stakeholders from across Canada at the inception of the project and finished with a knowledge transfer event for these stakeholders to share in the results and plan for the future. An extensive ethics manual was developed that could be used by both practitioners and researchers in any aspect of intervention through practice or research that afforded the protection and resources older adults might require.

Findings from the Literature Review

- To achieve the first goal, a review of both legal and social science literature was completed using specified inclusion factors that uncovered 13 community and 9 institutional studies.

- In order to meet the first objective of evaluating existing conceptual definitions, the literature on conceptual definitions and categories of mistreatment was subjected to an analytical assessment. For all of the relevant studies selected, each concept was assessed according to the type of concept used, the unit of analysis, the role of the concept as a cause, behaviour or outcome, the nature of the relationship as to whether it was one of trust, the underlying assumptions (e.g. caregiver stress), the variable used (e.g. physical abuse), the indicators used (e.g. Conflict Tactics Scale), the thresholds and the actual questions asked.

- The second objective was to review the measurement issues attendant on the conceptual definitions including levels of measurement, previously used scales and indices, and the issue of measuring cognitive impairment and thresholds of impairment. A summary table of the measures used in previous studies was developed according to functional status (e.g. Instrumental Activities, Lawton and Brody, 1969), cognition (e.g. Mini-mental Status Test, Folstein et al., 1975) and measures of violence, abuse and neglect (e.g. Indicators of Abuse Screen, Reis and Namiash, 1998). The various measures were analyzed according their validity for the target group, disadvantages and advantages and duration of assessment by the research team.

- The final conceptual definition used was: Mistreatment of older adults refers to actions and/or behaviours, or lack of actions and/or behaviours that cause harm or risk of harm within a trusting relationship. Mistreatment includes abuse and neglect of older adults.

- The research team, Westat consultants and the Advisory Committee developed operational definitions for the five main types of mistreatment (physical, psychological, financial, sexual, and neglect; both passive and active for the surveys); developed operational definitions for the chosen evidence-based risk factors for the community study (e.g. cognitive impairment, shared living situations, social isolation, depression, frailty of older adult, mental illness or alcohol or drug abuse by the perpetrator) and the existing risk factors outlined in the research for institutions (staff shortages, poor staff training, staff burnout, and resident aggression).

- The team developed operational definitions to classify perpetrators for the community and institutions and drafted preliminary questions for further testing and proxy interviews.

- Three focus groups were subsequently conducted for comprehension: one for older people in Ontario and one in Quebec with approximately ten people in each group and one focus group of formal and informal caregivers and proxy residents in Ontario. Two dyads of an older person and their caregiver were interviewed in an Ontario long-term care institution and one Quebec long-term institution. Two telephone interviews were tested in English in Ontario. All fieldwork was digitally recorded with permission and transcribed for analyses.

- An excel spreadsheet tracking the origins of each question and the sources in the literature and any revisions made to each question was created (DMEA Research Team, 2010c).

Findings from Cognitive Testing and Administration of the Survey Instrument

- Cognitive testing of the preliminary questionnaire (N=37) and subsequent refinements in French and English were completed; telephone interview of 267 participants recruited according to whether they were mistreated or not was carried out; and the administration of the intuitional questionnaire to older adults and a proxy in long-term care via face-to-face meetings was completed.

- The cognitive test included examined the instructions, wording, the definitions, items that asked for information to which the respondent did not have access; language issues; recall periods, question placement and flow, and confusing response options or response formats.

- Questions pertaining to the mental health and gambling of the perpetrator were added and a question was added asking whether the respondent relied on a wheelchair, walker, scooter or other mobility device.

- As many respondents struggled to provide a definitive number of times that they had experienced abuse or neglect in the previous 12 months, two questions were added to each abuse and neglect category. The first question referred to frequency of abuse, and the second question contained specific ranges to help respondents indicate a numerical range if they had difficulty listing a single number.

- Systemic abuse was not included as a separate category in the survey as items asking whether respondents were prevented from speaking their native language, or had experienced prejudice based on their age reflected the notion of "systemic abuse".

- Respondents from the French cognitive testing interviews emphasized the importance of using language and terminology that older adults readily understand.

- In the administration of the questionnaire with 54 mistreatment items, the survey instrument posed only a small respondent burden, especially for respondents who had not experienced abuse or neglect. On average, it took 32 minutes for respondents to answer all of the questions. Respondents who experienced abuse or neglect took only 8 minutes longer to complete the survey than those who did not.

Findings from the Data Analyses of the Survey

- The data analyses included 3 sets of analyses: profile of the respondents in the survey and the prevalence of the different types of abuse/neglect; the assessment of the validity of the community survey; and the assessment of the validity of the risk factors.

- Among community residents, most were younger than 75 years of age (86%), female (77%), White (92%), and had at least a high school diploma (92%). Fifty-eight percent of the respondents were married. Sixty-three percent lived with someone else. Twenty-eight percent reported feeling socially isolated and felt that they did not spend enough time with friends or others. Approximately 17 percent scored as possibly depressed on the modified Center for Epidemiological Studies Depression Scale (CES-D) instrument. Nearly 40 percent reported at least one limitation of the Activities of Daily Living or Instrumental Activities of Daily Living (ADL/IADL).

- Two-thirds of the older adults living in institutions were over 75 years of age (69%). Women comprised 59 percent of this group; 69 percent were White and 69 percent had at least a high school diploma. Only 12 percent of the respondents were married while 22 percent were widowed and 44 percent reported being divorced or separated. Thirty percent reported *feeling* socially isolated and thought that they did not spend enough time with friends or others. Most of the institutionalized respondents reported at least one ADL/IADL limitation (94%), while 12 percent scored as possibly depressed on the modified CES-D instrument.

- Five categories of mistreatment were examined: neglect, psychological abuse, physical abuse, sexual abuse, and financial abuse. Psychological abuse was the most common type of abuse. More than one-third (37.1%) of respondents indicated that

they had experienced one or more of the eight types of psychological abuse. The proportions of respondents experiencing other types of mistreatment were relatively small: 9.7 percent experienced financial abuse, 8.1 percent experienced physical abuse, 6.7 percent experienced sexual abuse, and 4.5 percent experienced neglect.

- Respondents were asked whether they felt they had been mistreated in the past 12 months, independently of whether they answered "yes" to any of the specific abuse or neglect items.

- The percentages of respondents who *felt* abused or neglected were lower than the percentages that experienced some form of mistreatment across four of the five categories (not neglect). Psychological abuse was still the most prevalent type of mistreatment. Twenty-five percent of respondents said that they *felt* they had been psychologically abused, although 37 percent answered yes to one or more items.

- Among respondents experiencing abuse or neglect, 31.3 percent lived with the abuser for at least one of the experiences of abuse.

- Only 13.7 percent of respondents who experienced abuse experienced it only once. One in five (19.7%) of abused individuals experienced the abuse every day.

- In an examination of the life course framework, abuse was reported more frequently for childhood (17 and under), than during any other life stages. Over half of the sample (54.6%) reported abuse during childhood; more than one-third (34.1%) reported abuse during young adulthood (ages 18 to 24), Forty-three percent said they were abused during mature adulthood (ages 25 to 54), and one-quarter (24.4%) said they were abused since age 55 but 12 months prior to the interview date.

- Known-groups validation was used for both the definitions and the risk factors for maltreatment. The responses of older adults who were believed prior to the study to have been abused were compared with those who had not been abused.

- Respondents in the known abuse group responded positively to 3.5 times more items than those in the known non-abuse group. Results of a multivariate discriminant analysis indicated that six items correctly classified 88.4 percent of respondents into the two groups.

- Discriminant function analyses with reduced lists of abuse items misclassified about half of known abuse group cases as not having experienced abuse or neglect. In

contrast, 35 of 39 (90%) "known abuse" group members said "yes" to one or several of the abuse items. All of the "known abuse" group members responded positively to items about abuse in the survey instrument. This result suggested that eliminating abuse items from the survey instrument would result in missing cases of abuse.

- Risk factors for abuse and neglect varied according to how abuse and neglect were measured. Some risk factors were related only to infrequent and isolated abuse experiences but not to frequent and widespread abuse.

- Non-white ethnic background was a significant risk factor for experiencing less frequent abuse and one type of abuse but not for more frequent abuse and multiple types of abuse.

- Respondents in the "known abuse" group answered yes to significantly more items on abuse or neglect than those in the "non-abuse" group regardless of gender, education level, or marital status. This result suggested that the questions in the survey instrument were able to differentiate been older adults who had been abused and those who had not equally well for older men and women, high school dropouts and graduates, and married and single people.

Ethics

- An extensive ethics manual was developed that could be used by both practitioners and researchers in any aspect of intervention through practice or research that afforded the protection and resources older adults might require.

- In the course of the study ten respondents requested and received assistance from a social worker.

Recommendations

- The survey instrument is highly suitable in predicting mistreatment in the community with some adjustments;

- Evaluative coding with decision rules should be used to reconcile the difference between what older adults experience and feel about mistreatment;

- The instrument when applied to those in institutions in face-to-face interviews distinguishes between those who are a mistreated and those who are not although more research is required;

- The ethical standards used in the pilot study followed the Tri Council policy statements for the Canadian Institutes of Health Research, the Natural Sciences and Engineering Research and Council of Canada, and the Social Sciences and Humanities Research Council of Canada and would be appropriate for further studies;

- The definitions and the measurement instruments (survey) will be made available when/if a national prevalence study is completed to those who request the instruments through the National Initiative for the Care of the Elderly, if deemed appropriate by the research team.

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Defining and Measuring Elder Abuse and Neglect – Synthesis of Preparatory Work Required to Measure the Prevalence of Abuse and Neglect of Older Adults in Canada

1.0 CONTEXT

Few systematic attempts have been made to understand the definitions and methods underpinning research on mistreatment worldwide.[1] A number of theories have been imported from other contexts such as family violence and child welfare, and from attempts to improve the quality of care for older adults. Their relevance and underlying assumptions, however, have rarely been examined. Existing definitions infrequently set out the events and behaviours meant by 'abuse' or 'neglect' and often do not fully reflect the experiences of older adults and others such as relatives or health care professionals. It is not surprising then, that globally there are few comparable prevalence and incidence studies of abuse and neglect in the community or in institutional settings.

One of the more prominent researchers in the field observed as early as 1988 that, "From the very beginning of the scientific investigation into the nature and causes of elder abuse, definitions have been a major issue" (Wolf, 1988, 758). As would is expected, how elder abuse is defined determines who is counted as mistreated and who isn't; who is at risk and who is not; the definition determines what the legislation covers and what it doesn't cover; and it determines who is eligible for service and who is not eligible for service. The definition will determine the type of treatment offered and ultimately, the effectiveness of the treatment in halting the mistreatment. Thus, accurate definitions of abuse and neglect insure accuracy in screening and classification and appropriate treatment, if not prevention (McDonald and Collins, 2006).

What is more, theoretical clarity and the development of consistent and reliable measures provide important conceptual tools for researchers, policy-makers and practitioners. Unambiguous and consistent definitions help to clarify policy focus and allow decision-makers to discriminate between courses of action and monitor change over time and context as to whether the mistreatment is better or worse. They allow policy makers and practitioners to compare and draw conclusions across settings and across jurisdictions to better understand the multiple forms of mistreatment and increase effectiveness of response. More generally, they facilitate better understanding of multi-causal problems and provide appropriate challenges to stereotyped thinking about abuse and neglect of older people (Biggs, Martin & Tinker, 2008). Without clear and consistent definitions none of this is possible. Furthermore, if the definitions are not comparable to international studies of

[1] In this project the terms used are as follows: *'mistreatment'* is used to refer to all forms of abuse (psychological, physical, sexual and financial) and neglect; '*abuse*' is used to refer to all forms of abuse, *excluding* neglect; 'interpersonal abuse' is used to collectively describe physical, psychological and sexual abuse (Biggs et al., 2009). For example, The General Social Survey, 1999, did not have an overall measure of mistreatment or even of abuse.

mistreatment and neglect no comparisons can be made as to how Canada is faring on the world stage of mistreatment.

Since the appearance of the first federal discussion paper on mistreatment of older adults (Gnaedinger, 1989) and the first commissioned literature review on institutional abuse (Ens, 1999), interest in understanding this disturbing phenomenon has grown among clinicians, policy makers and academics alike. The first studies of elder abuse suggested that a considerable proportion of older Canadian adults were mistreated by their caregivers (Bélanger, 1981; Grandmaison, 1988; Shell 1982; King 1984, the G.A. Frecker Association on Gerontology 1983; Haley, 1984; Stevenson, 1985; the Ministry of Community and Social Services, 1985). In 1989, the landmark national survey revealed that four percent of older Canadians living in private dwellings experienced some form of abuse and neglect (Podnieks, 1990). It was the publication of this study, which succeeded in putting the problem of elder abuse and neglect permanently onto the radar of Canadian policy makers, practitioners and academics.

The 1990s introduced a new generation of research studies in Canada which could be used to guide practice, formulate policy, and, to a lesser extent, reform legislation (*c.f.* Beaulieu, 1992, 1994; Beaulieu and Tremblay, 1995; Manitoba Seniors Directorate, 1993; McDonald et al., 1991; Pittaway and Westhues, 1993; Plamondon and Nahmiash, 2006; Poirier, 1992; Reis and Nahmiash, 1995; Stones and Pittman, 1995; Sweeney, 1995).

Beyond the 1990s, studies turned to institutions, albeit in a limited manner (Bigelow, 2007; Ens, 1999; Hirst, 2000, 2002; Kozak & Lukawiecki, 2001; McDonald et al., 2008). Studies focused on attempts to update estimates of prevalence (Pottie Bunge, 2000; Poole & Rietschlin, 2008), community development initiatives (Ontario Government, 2002; WHO, 2002), expanded abuse descriptions (Plamondon & Nahmiash, 2006), and legal issues (Canadian Centre for Elder Law, 2009; Watts & Sandhu, 2006).[2] Probably the most important driving force behind these developments was the commitment of governments to increased funding for education and small-scale studies (from both psychosocial and legal perspectives) that were designed to help raise awareness among Canadians about abuse and neglect (PHAC, 2010).

It is evident that the field of elder abuse and neglect in Canada has not, therefore, stood still in the past 20 years; indeed the field has been a hive of activity in its attempt to protect older adults from abuse and neglect. Nevertheless, much of the current work is recycling what is already known, sometimes cycling uncorroborated information or stretching what we do know such as inflating the prevalence of mistreatment. Part of the underlying problem is that a number of practitioners, policy makers and gerontologists do not consider the prevalence of abuse and neglect of older adults to be particularly useful other than for the purposes of advocacy. Understandably, the focus is to intervene to solve

[2] See Podnieks (2008) for a full version of the history of elder abuse in Canada.

the problem and all resources need to be marshaled to this end. Without doubt, mistreatment of the elderly can have potentially devastating effects on the lives of older adults. Injuries sustained by a frail older adult can have much more tragic consequences than similar injuries inflicted on a younger person. Physical abuse can result in nursing home placement, permanent disability or even death (Lachs, Williams, O'Brien, Pillemer, & Charlson, 1998).

The difficulty, however, is that even in the case of intervention, there is little, if any solid research data that supports any particular intervention and there is not likely to be much until we know the shape and scope of the problem.[3] To provide appropriate awareness, policies and interventions we have to know the nature of the problem, necessitating that the problem be defined in some way operationalized and then measured. For example, if financial abuse were the most common type of abuse in Canada compared to sexual abuse, funds would be better directed to uncovering the causes and interventions for this type of abuse rather than for sexual abuse. Not only would this be a cost effective approach to policy, practice and research, older adults would more likely be helped.

At the same time it is recognized that there is not likely to be "final and authoritative definitions" of the mistreatment of older adults worldwide (Dixon et al., 2009, p.418). The concept of mistreatment of older adults is "essentially contestable"[4] so, "it may be that definitions will need to be provisional, flexible and pragmatic, and particular to specific research and policy purposes." (Dixon et al., 2009, p. 418). It is within this context, that the elder mistreatment community in Canada set out to develop consistent definitions of elder mistreatment for Canada that could be utilized for policy and practice and for a possible new national prevalence study, not only relevant to Canada but internationally. The purpose of this paper is to provide a synthesis of the two-year project funded by Human and Resources and Skills Development Canada (HRSDC) to conduct the preparatory work to define the mistreatment of older adults in Canada. Final reports are available on all five phases of the project that include all process, details and decisions, all documents and the various iterations of the elder mistreatment questionnaires for the community and institutions.

The overarching aim of this pilot research was to examine the main problems associated with the conceptual definitions and measurement of mistreatment of older adults; the difficulties on the theoretical front, the current challenges associated with identifying risk factors for abuse and neglect and the issues surrounding the collection of reliable and valid data related to the prevalence of abuse and neglect. There were five related mini research projects contained in the pilot research that were interlinked to create a whole. Each project had its own overarching goal and a varying number of objectives, how the objectives would

[3] In 2009, Ploeg, Fear, Hutchison, MacMillan, and Bolan (2009) conducted a rigorous systematic review of 1,253 interventions for elder abuse, and sifted their findings down to eight studies that met their criteria for inclusion (Brownell & Heiser, 2006; Brownell & Wolden, 2002; Davis & Medina-Ariza, 2001; Davis, Medina, & Avitabile, 2001; Filinson, 1993; Jogerst & Ely, 1997; Richardson, Kitchen, & Livingston, 2002, 2004; Scogin et al., 1989). They found that in the majority of studies, methodological flaws limited the validity of the results.

[4] Essentially contested concepts involve widespread agreement on a concept (e.g., "fairness"), but not on the operationalization of the concept.

be achieved and the coordination of each project. The specific goals of the program of research were: (1) to develop definitions of abuse and neglect and of risk factors for both institutions and the community based on a review of robust and existing studies; (2) develop instruments to measure abuse and neglect in terms of prevalence and risk factors for abuse; (3) test the validity and reliability of the instruments; (4) examine the attendant ethical problems and lastly, (5) develop a preliminary consensus amongst key stakeholders. The research was conducted by elder abuse experts from the *National Initiative for the Care of the Elderly* (NICE), a 1,800-member, not-for-profit, incorporated charitable organization sponsored by the National Centres of Excellence (NCE) and housed at the Institute for the Life course and Aging at the University of Toronto. An international team of researchers led the project and was advised by an international Advisory Committee. [5]

2.0 THE LITERATURE

In this section of the report, the existing social and legal research relevant to a prevalence study in the community and institutions is critically examined. Thirteen community studies and nine institutional studies are reviewed, as are the risk factors for mistreatment in either setting. The problems with the definitions of mistreatment are highlighted with the conclusion that the majority of the prevalence studies suffer from some type of limitation that makes assessment difficult.

2.1 The Scope of the Problem

It is important to note that most researchers would agree on three basic categories of elder abuse: (a) abuse of the older adult in the community; (b) institutional abuse; and (c) neglect. Most would also agree on the major types of abuse – physical, psychological, financial, but beyond this classification, there is little agreement, especially about sexual abuse or neglect. For example, neglect can be intentional, non-intentional, and self-inflicted (Bonnie & Wallace, 2003). The increase in prevalence studies worldwide at the end of the 1980s is a welcomed development but clearly underscores the issues attendant on defining mistreatment and the problems inherent in developing a prevalence study either in the community or in an institution. Appendix A provides an overview of these studies drawn from a global review of the research prior to, and during the research project. The review of

[5] The Research Team included: Dr. Marie Beaulieu, University of Sherbrooke; Dr. Simon Biggs, King's College London; Dr. Thomas Göergen, German Police University; Dr. Barry Goldlist, University of Toronto; Dr. Sandi Hirst, University of Calgary; Dr. Anthony Lombardo, University of Toronto; Dr. Ariela Lowenstein, Haifa University; Dr. Shelley Raffin Bouchal, University of Calgary; Dr. Cynthia Thomas, Westat; Judith A. Wahl, Advocacy Centre for the Elderly; Dr. Christine Walsh, University of Calgary; Laura Watts, Canadian Centre for Elder Law; Dr. Kevin D. Willison, Lakehead University. The Advisory Committee included: Dr. Jane Barratt (Chair), International Federation on Ageing; Billie Allan, Native Women's Association of Canada; Elizabeth Esteves, Ontario Seniors' Secretariat; Dr. Michael Gordon, Baycrest; Detective Ed Lum, Hamilton Police Services; Lisa Manuel, Family Service Toronto; Thelma McGillivray, National Council of Women of Canada; Jean-Guy Saint Gelais, Canadian Network for the Prevention of Elder Abuse; Dr. Parminder Raina, McMaster University; Susan Somers, International Network for the Prevention of Elder Abuse.

prevalence studies provided the basis for the initial conceptual analyses of terms, their operationalization and questions asked, the inclusion criteria, prevalence period used and the theories used in international studies (DMEA Research Team., 2010a). Out of hundreds of articles, the inclusion criteria for the studies reviewed developed by the research team were four: (a) the target population was defined by clear inclusion and exclusion factors (e.g., age); (b) probability sampling was utilized; (c) the data collection methods were standardized (closed-ended survey questions administered face-to-face, by telephone, paper and pencil); and (d) the abuse measures were standardized and valid (e.g., Conflict Tactics Scale). The studies were analysed according to a conceptual grid that considered the conceptual definitions used, how they were used as a precursor to, a process or outcome of maltreatment, whether the definitions were based on theory, how they were operationalized and the actual questions asked in the various questionnaires.

Overall, 13 community prevalence studies in the research literature met the inclusion guidelines relevant to the research program. The community prevalence research included two studies from Canada (Podnieks, 1993; Pottie Bunge, 2000); four from the United States (Lifespan of Greater Rochester Inc.[6]; Acierno et al., 2010; Laumann, Leitsch, & Waite, 2008; Pillemer & Finkelhor, 1988); one from India (Chokkanathan & Lee, 2005); six from Europe (Naughton et al., 2010; Comijs, Smit, Pot, Bouter, & Jonker, 1998; Executive Agency for Health and Consumers, 2010; Garre-Olmo et al., 2009; Iborra, 2005; O'Keeffe et al., 2007); and one from Israel (Lowenstein, Eisikovits, Band-Winterstein, & Enosh, 2009).

The review clearly showed the prevalence rates varied widely between countries (2.6% in the UK versus 29.3% in Spain) and within countries, as is the case for the United States where Acierno et al. (2010) found an overall prevalence rate of 11.4 percent compared to 3.2% in Pillemer and Finkelhor, (Pillemer & Finkelhor, 1988). This comes as no surprise because the age for inclusion varied, as did the prevalence periods, the types of abuses addressed, the mechanisms for data collection, and the measures used. The most common factor among the studies was the absence of a theoretical model to guide the research except in one instance in which a family violence perspective was used (Pottie Bunge, 2000).[7]

The first prevalence study (number of cases in a given time frame) carried out in Canada was in 1989 (Podnieks et al., 1989). The researchers conducted a telephone survey of 2008 community-dwelling men and women 65 years of age and over. The study found that about 4 percent of the sample reported some type of abuse (Podnieks, Pillemer, Nicholson, Shillington, & Frizzell, 1990), with approximately 2.5 percent of the sample experiencing financial abuse, 1.4 percent experiencing chronic verbal aggression, and .5 percent suffering from physical abuse. Approximately .4 percent reported neglect. Spouses tended to perpetrate physical abuse and chronic verbal aggression, whereas financial abuse tended to

[6] A community prevalence study of the State of New York was released in May 2011 by the Lifespan of Greater Rochester, Inc., Weil Cornell Medicine Centre of Cornell University, and the New York City Department for the Aging. A random sample of 4,156 men and women aged 60 and over participated in the face-to-face interviews. In the last year, they reported rates of mistreatment per 1,000 for physical abuse 22.6; verbal abuse 35.4; major financial exploitation 41.6 and 14.9 for IADL assistance.

[7] The results of this systematic review are summarized in Appendix A.

be perpetrated by both relatives and non-relatives. Men and women were equally likely to be abused (Podnieks et al., 1990). The second Canadian prevalence study, the *1999 General Social Survey* on *Victimization* interviewed 4,324 randomly selected older adults 65 years of age and over, by telephone. Only one per cent of this population indicated physical or sexual abuse by a spouse, adult child, or caregiver in the five years prior to the survey (Pottie Bunge, 2000). According to Pottie Bunge (2000), seven per cent experienced psychological abuse and one per cent financial abuse. The two studies are not comparable because the prevalence periods are different (i.e., five years versus one year), the abuse categories are different (i.e., sexual abuse was not measured in the Podnieks study) and different measures of financial abuse were used. As a result, little can be said about an increase, decrease, or constancy in abuse rates from 1989 to 1999 because of the differences between the studies beginning with the definitions.[8] Without doubt, some headway has been made given the increasing number of prevalence studies, although there are still problems. Most of the prevalence studies suffer from some type of limitation such as (a) inadequate sample size (e.g., Chokkanathan & Lee, 2005), (b) limited descriptions of sample estimation procedures (e.g. Podnieks et al., 1989, (c) use of general surveys constructed for other reasons (e.g., Pottie Bunge, 2000), (d) inadequate information about response rates (e.g., Comijs et al., 1998), (e) the use of only retrospective studies with no etiology on the different types of abuse (e.g., Acierno et al., 2010), and (f) little information on the psychometric properties of the measurements, especially when they were modified to suit the survey (e.g., Laumann et al., 2008).

As seen Appendix A, the institutional abuse studies include three from the United States (Griffore et al., 2009; Pillemer & Moore, 1989; Ramsey-Klawsnik, Teaster, Mendiondo, Marcum, & Abner, 2008); two from Germany (Göergen, 2001, 2004); one from Norway (Malmedal, Ingebrigtsen, & Saveman, 2009); one from Finland (Nurminen, Puustinen, Kukola, & Kivela, 2009); one from Sweden (Saveman, Astrom, Bucht, & Norberg, 1999); and one from Italy (Ogioni et al., 2007). There was one reliable pilot study of institutional abuse carried out in the United Kingdom by Purdon et al. (2007), not reported because it was a feasibility study of how to study abuse in an institution. As is evident in Appendix A, the absence of a Canadian study is still the norm today. Generally, institution usually refers to those facilities such as nursing homes, resident care facilities or long-term care institutions that provide nursing care 24 hours a day, assistance with activities of daily living and mobility, psychosocial and personal care.

[8] Incidence rates (new cases in a given time frame) for elder abuse are still virtually unknown in most countries, including Canada. There is one incidence study of police-reported cases in 1999, from 164 police forces in 7 provinces that participated in this Incident-based Uniform Crime Reporting (UCR2) Survey, representing 46% of the national volume of reported crime. Adults 65 and over represented 2% of all victims of violent offences reported to a sample of police agencies in Canada. This incidence study identified that there were 802 cases of violence against older adults by family members. Among those who were mistreated by a family member, older adults were most likely to be abused by adult children (43%) and spouses (28%). Women were reportedly more likely to be victimized by both adult children (37%) and spouses (34%); men were more likely victimized by an adult child, (53%). Fifty-four percent of the older adults were the victims of common assault, 22% by uttering threats and 13% assault with a weapon or causing bodily harm, whether or not the victim was female or male (Pottie Bungie 2000, p. 30). This study only counts those cases that came to the attention of the police.

The increasing research on institutional mistreatment is at least informative for any future study in Canada. The recent growth of institutional studies has demonstrated how methodological issues are amplified when the research focus moves from the community to the institution. The institutional studies indicate that staff members were more likely to be asked about abuse than the older adults themselves, and if staff were unavailable, families served as proxies. The methodological problems are similar to those found in community studies of prevalence; however, there is the added complication of whom to interview: the older person, the staff and what level of staff, or family members and which family members. One of the studies in Germany indicated that 37 per cent of staff providing hands-on care self-reported psychologically abusing an older adult, but the number differed in a repeat German study by the same author who reported 53.7 per cent of staff self-reported psychological abuse during hands-on care (Göergen, 2001, 2004). In the United States, a random sample study of nursing homes found 40 per cent of nurses, representing three levels of staff, self-reported psychological abuse (Pillemer & Moore, 1989).

In contrast, 34.6 per cent of family members reported one to two incidents of psychological abuse of their relative in a nursing home (Griffore et al., 2009). In such instances, either the staff or the family member might be the abuser so an interview of the older adult, usually in person, is often preferable (Purdon et al., 2007). Nevertheless, the problem is challenging to researchers especially in cases where older adults have cognitive impairments: in those situations, interviews with staff and families, and perusal of medical records, are the alternatives to interviews of the older adults. Notably, none of the prevalence studies included persons with cognitive impairments. Marshal, Benton, and Brazier (2000) have argued that abuse is worse in the community than in institutions, but there are no grounds for this observation because the two cannot be compared on the basis of research design, especially since the respondents are different.

What is significant about institutions in Canada in 2010 is twofold. First, the proportion of people aged 65 or older living in institutions has remained stable at seven per cent since 1981 (Ramage-Morin, 2005); however, the actual number living in health care institutions rose from 173,000 to more than 263,000 residents in 2005 (Ramage-Morin, 2005). As a result, even though the latest government policies support "aging-in-place" (Szikita Clark, 2008), there will still be a substantial number of older adults who require institutional care (Kozak & Lukawiecki, 2001; Ramage-Morin, 2005). If the same level of institutionalization is maintained, it has been projected that over half a million (565,000) Canadians will require long-term care by 2031 (Trottier, Martel, & Houle, 2000), and the quality of care – including the prevention of abuse and neglect of residents – will become increasingly significant.

The second observation to be made about institutionalization in Canada is that those 85 years and older constitute the largest age group in long-term care settings and are frailer, have more complex needs, and are more likely to have some degree of cognitive impairment, such as dementia, or physical disabilities compared to their community-residing counterparts (Spector, Fleishman, Pezzin, & Spillman, 2001). Only about 12–13 per cent of residents are

married, and many others lack a close family member who lives within an hour of the facility (Hawes, 2002). Without an advocate, older adults in institutions are more dependent on others to provide care that heightens their vulnerability to abuse and neglect. Within this context, a study of institutional mistreatment in Canada would seem reasonable.

In light of the increase in national prevalence studies worldwide, there are lessons for Canada. Most of the prevalence studies suffer from some type of limitation that makes assessment difficult such as: (a) inadequate sample size (e.g., Chokkanathan & Lee, 2005), (b) limited descriptions of sample estimation procedures, (c) use of general surveys constructed for other reasons (e.g., Pottie Bunge, 2000), (d) inadequate information about response rates (e.g., Comijs et al., 1998), (e) the use of only retrospective studies with no etiology on the different types of abuse (e.g., Acierno et al., 2010), and (f) little information on the psychometric properties of the measurements, especially when they were modified to suit the survey (e.g., Laumann et al., 2008).

2.2 Definitional Disarray

Few researchers can discuss the abuse and neglect of older adults without first pausing to describe exactly what words will be used to explain the phenomenon. The discussion of definitions of mistreatment of older adults is both passionate and sometimes disagreeable: terms that are offensive to some are acceptable to others; ethnic and marginalized groups reportedly have their own definitions which do not match the conventional definitions (Bent, 2009; Moon, 2000); researchers and practitioners rarely see eye-to-eye (Payne, 2002); practitioners from different professions have difficulties communicating with each other, and older adults themselves are often ignored in the debate (Bennett, 1990; Bonnie & Wallace, 2003; Council of Europe, 1992; Decalmer & Glendenning, 1993; Kozma & Stones, 1995; Pillemer & Finkelhor, 1988; Sanchez, 1996; Wallace, 1996). In support of the difference in perspectives, a Canadian study found that there was considerable difference between the public's view of physical abuse and that of elder abuse professionals (Geobytes, O'Connor, & Mair, 1992).

As would be expected, the definitions of mistreatment reflect the differences in purpose and agendas of the various stakeholders. There is no uniformity of the categories used by the experts, coupled with a lack of uniformity within the categories themselves. Some researchers, for example, include sexual abuse as a category while other researchers omit this category (Lowenstein et al., 2009; O'Keeffe et al., 2007). The most common measurement used to evaluate physical and psychological abuse is the Conflict Tactic Scale (CTS), or its later version CTS2; however, in some studies the Conflict Tactics Scales is modified to suit each study (e.g., Lowenstein et al., 2009; Podnieks et al., 1990). As well, the categories can contain such a wide range of abuses that they tend to become ineffectual in application because every act (e.g., spiritual abuse) in effect becomes abusive or neglectful (Spencer & Gutman, 2008), which is unrealistic. In addition, some definitions focus on the outcome of abuse while others contain reference to the causal factors, the means, or the

outcomes of abuse (Johnson, 1991; Stones, 1995).

The legal definitions of abuse and neglect are no less challenging. An unpublished work by the Canadian Centre for Elder Law (Canadian Centre for Elder Law, 2009) indicates that definitions of elder abuse and neglect in Canada have evolved differently than in other prevalence study jurisdictions. Because of Canada's unique and forward definitions of breach of fiduciary duty, trust relationship breaches have their own more developed area of law, which is argued in addition to other "elder abuse" type torts. As such, definitions found in the common law in Canada are not limited to situations "in a relationship where there is an expectation of trust". Rather, the scope of what is considered "elder abuse" in Canadian common law is significantly broader and can include systemic issues, stranger-targeted elder abuse, and directed exploitative marketing and "grooming" of an elder victim.

According to Watts and Sandhu (2006), within the criminal context, Canada has no specific "elder abuse" code provision, such as those found within some other prevalence study comparator jurisdictions such as the United States. Generally, elder abuse and neglect cases are woven into criminal code charges such as assault and aggravated assault, unlawfully causing bodily harm, murder/manslaughter, forcible confinement, criminal negligence, fraud, extortion, forgery, theft, theft by person holding a power of attorney, unlawful conversion, and sexual assault. However, there is also a growing body of criminal case law which has been using key sections of the criminal code to prosecute "elder abuse and neglect" cases. In particular, there has been a recent expansion of Canada's *Criminal Code,* R.S., 1985, c. C-46, s. 215, on failure to provide the necessaries of life. Recent decisions of elder abuse and neglect have expanded understandings of failure to provide necessaries and have also broadly interpreted this section. In a recent case, financial abuse was formally connected with this section, paving the way for new elder abuse and neglect cases to more easily be located and prosecuted under this section. Again, the Canadian definition of elder abuse and neglect is different, in the legal context, and clearly does not require a "relationship where there is an expectation of trust" to exist.

Only one study has attempted to systematically analyze the variations in definitions and risk factors. In a secondary analysis of the data from the United Kingdom Study of Neglect and Abuse of Older People, researchers were able to expand the baseline definitions, the types of perpetrators, and reduced the number of times abuse or neglect occurred (Biggs et al., 2009). As an example from this analysis, a widening of the definition of mistreatment to include single incidents of neglect and psychological abuse (rather than only counting cases including 10 or more events) increased the prevalence of neglect, as did expanding the definition to include neighbours and acquaintances as well as family, friends, and care workers as perpetrators. The one-year prevalence of mistreatment, based on a sample of 2,111 people aged 66 and older in the United Kingdom, was 2.6 per cent for the baseline definition. This increased to 5.3 per cent when only one incident of psychological abuse and neglect was counted, and to 8.6 per cent when mistreatment by neighbours and acquaintances was included. In essence, the prevalence of mistreatment increased from 1 in 40 to almost 1 in 10 when the definitions were changed.

Regarding institutional abuse and neglect, the choices are compounded by the fact that elder abuse and neglect is multi-dimensional and multi-sectoral (McDonald and Collins, 2006; McDonald et al., 2008). For example, The Ontario Human Rights Commission states that, "Systemic or institutional discrimination consists of patterns of behaviour, policies or practices that are part of the social or administrative structures of an organization, and which create or perpetuate a position of relative disadvantage for persons identified by [a particular] status." These may appear neutral on the surface, but nevertheless have an exclusionary impact (McDonald et al., 2008). It is important to note that in many instances, abusive or neglectful staff members do not always *intend* to harm the residents but are simply ignorant of the severity of their conduct, or the administration of the facility may have failed to make it clear that the behaviour was totally unacceptable. An example of systematic abuse resulting from unquestioning regimentation would be the routine use of incontinence briefs instead of helping the person to the bathroom (Furness, 2006). Multi-sector can include the public/private divide in institutions where there is little evidence in Canada as to whether this makes a difference in care (McDonald 2007; Bravo et al., 2002).

The whole issue of neglect has generated considerable definitional turmoil in its own right. The primary issues around neglect are two-fold: the distinction between self-neglect and neglect by a trusted other and the measurement of neglect. In the first instance, self-neglect has been highly criticized as not a form of abuse because no trusted carer is involved. Self-neglect has been seen for years by social workers, police and lawyers as a typical problem, rightfully or wrongfully, as part of unsuccessful aging in the community, a situation that can be easily rectified with services (McDonald, 2007). In the second instance, in the early days of research, a common screening instrument was borrowed from practice to measure neglect, the OARS (Older American Resources and Services) which has been criticized since it purportedly measured unmet needs, not neglect (Comijis et al., 1998; Cooper et al., 2008).

Even as the weaknesses of existing definitions are being tackled, new issues are emerging which complicate this matter. For example, the globalization of activities related to abuse and neglect has resulted in important contributions from authors around the world. A recent review of cross-cultural issues reported that the concept of abandonment has been introduced into the definition of harms in India (Shah, Veedon and Vasi, 1995), Hong Kong (Kwan, 1995) and the US (NCEA, 1998) and what is labelled psychological neglect by adult children (Daskalopulos and Borelli, 2006; Konig and Leembruggen-Kallberg, 2006; but they have been given inconsistent attention in other communities. This globalization has also pushed local experts to begin to address issues related to diversity within Canada and the United States. Currently, the results of a few Canadian studies have described abuse and neglect in different ethnocultural contexts (Aboriginal Nurses Association of Canada, 1992; Bergin, 1995; Spencer, 1996; Bearpaw, 2011). However, our knowledge about this important issue is at best rudimentary.

A review of the literature from a conceptual perspective has identified the following issues pertinent to creating definitions of mistreatment: (1) there appear to be no

standardized conceptual definitions of mistreatment and neglect of older adults in the more rigorous studies conducted world-wide; (2) the expansion or contraction of conceptual definitions (thresholds) produces different estimates of mistreatment and neglect; (3) there is no agreement on prevalence periods with some attempts to provide two measures in a single study; (4) the lack of uniformity in the categories of mistreatment and neglect is exacerbated by an attempt to include as many forms of mistreatment as possible which no one can agree upon; (5) lack of uniformity within the categories so that a category may include one or all factors (e.g. casual factors, means and outcomes of mistreatment) such that comparisons are not possible and confusion may reign through overlap; (6) legal definitions are actually much broader in Canada then in comparable jurisdictions and do not always include the trust relationship (Dixon et al., 2010); (7) abuse and neglect among the community dwelling and institutional residents may differ at least on systematic factors that may lead to abuse or neglect.

2.3 Risk Factors

Risk factors are factors found to be associated with mistreatment in some way. Bonnie and Wallace (2003) following Timmreck (1998), note that risk factors are defined as experiences, behaviors, aspects of lifestyle or environment, or personal characteristics that increase the chances that elder mistreatment will occur." (2003, p. 89). Collecting data pertaining to possible mistreatment risk factors is essential for the development of comprehensive and efficient survey instruments in investigating abuse and neglect of older adults. The research in this area shows that some studies have focused on the elder's characteristics, some have examined the caregiver's characteristics, and others have assessed the living and social situation. More recently, researchers have emphasized that the duration of the situation of caregiving and the abuser-victim interactions and family history may also play a role in mistreatment, if they are not risk factors themselves (Erlingsson, Carlson & Saveman, 2003). Indeed, Erlingsson, Carlson and Saveman (2003) using an expert panel of 17 came up with 263 risk factors for abuse on their first round of a modified Delphi technique signifying the confusion in the field. Most recently, a qualitative investigation in New Zealand (Peri et al., 2008) added protective factors to the mistreatment equation which include personality factors, supportive families and social connectedness (Brozowski and Hall, 2003). These factors have been found to be related to superior health of older adults in non-abusive situations (McDonald, 2011).

There have been at least two frameworks offered for assessing risk factors. The more recent scheme by the National Research Council (Bonnie & Wallace, 2003) refines previous frameworks according to the supporting evidence for each risk factor. A distinction is made between risk factors (factors that increase the probability that a problem will occur) and protective factors (factors that decrease the probability of occurrence). The way in which risk factors affect the likelihood of mistreatment is complex, and the impact of risk factors may be altered by the presence of other factors. Following the National Research Council

framework that has been extensively used in the research (Biggs et al., 2009), the distinction between risk factors/ risk indicators, are divided into three categories based on available evidence, namely risk factors validated by substantial evidence, for which there is unanimous or near-unanimous support from a number of studies; possible risk factors, for which the evidence is mixed or limited and contested risk factors, for which potential for increased risk has been hypothesized, but for which there is a lack of evidence.

The research shows that the factors clearly indicating risk included: shared living situation (Naughton et al., 2010; Lachs et al. 1997; Paveza et al.1992; Pillemer and Finkelhor, 1988; Pillemer and Suitor (1992); social isolation and poor social networks (Compton et al. 1997; Grafstrom et al. 1993; Lachs et al. 1994; Phillips 1983; Wolf and Pillemer 1989); the presence of dementia for physical abuse (Coyne et al. 1993; Homer and Gilleard 1990; Paveza et al. 1992; Pillemer and Suitor 1992; Tatara and Thomas, 1998); mental illness of the perpetrator, mainly depression (Fulmer and Gurland 1996; Homer and Gilleard 1990; Pillemer and Finkelhor 1989; Reay and Browne 2001; Reis and Nahmiash,1998; Williamson and Shaffer 2001); hostility of the perpetrator (Quayhagen et al., 1997); alcohol abuse by the perpetrator (Anetzberger et al. 1994; Bristowe and Collins; 1989; Greenberg et al., 1990; Homer and Gilleard, 1990; Reay and Browne 2001;Wolf and Pillemer, 1989;) and lastly perpetrator dependency on the mistreated older adult (Anetzberger, 1987; Dyer, Pavlik et al, 2002;Greenberg et al., 1990; Pillemer and Finkelhor, 1989; Wolf et al., 1982)

The "possible" indicators included gender (Tatara and Thomas 1998; Wolf and Pillemer 1989; Wolf, 1997); personality of the victim (Comijs et al. 1998) and race (Lachs et al. 1994, 1997; Yan and Tang, 2004). The relationship between the victim and the perpetrator appears to be that the victims are more often abused by a spouse, rather than by a child or any other family member (Pillemer and Finkelhor 1988 and 1989, Bristowe and Collins1989, Pillemer and Suitor 1992).

The "contested" indicators included: physical impairment where Pillemer and Finkelhor (1988) found that those in poor health were three to four times more likely to be neglected. Similarly, Coyne et al. (1993) found a positive relationship between level of patient functioning and occurrence of abuse. Lachs et al. (1997) found that a few functional impairments, such as needing assistance with eating or grooming, were associated with a higher probability for ombudsman investigation. Naughton et al. (2010) found similar results to Lachs. They also report that older adults in poor health were three times more likely to self-report abuse (Naughton et al., 2010). However, Wolf and Pillemer (1989) did not find that physically abused elders were more impaired or in poorer health than members of a control group. Other studies have not found that physical impairment is a risk factor for elder abuse (Phillips, 1983; Bristowe and Collins, 1989; Homer and Gilleard, 1990; Paveza et al., 1992; Reis and Nahmiash, 1998).

A relationship has been found between chronic disease in the patient and elder abuse and neglect, but not in the expected direction: the prevalence of chronic disease was higher in the control group than in the abuse group (Lachs et al. 1997); victim dependency and care

induced stress (for Davidson, 1979; Hickey and Douglass, 1981; Steinmetz, 1988; and against Bristowe and Collins, 1989; Homer and Gilleard 1990; Phillips 1983; Pillemer 1985; Wolf and Pillemer 1989; Pillemer and Finkelhor 1989; Pillemer and Suitor 1992; Reis and Nahmiash 1995); and intergenerational transmission of abuse or social learning theory has found no support (Anetzberger et al., 1994; Wolf and Pillemer, 1989).

No such helpful distinctions have been made for risk factors for mistreatment in an institution, possibly because the evidence is thin. Several North American scholars have identified a number of factors that they believe contribute to the abuse of older residents by staff in nursing homes. 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 lack of highly qualified and well-trained staff; the powerlessness and vulnerability of the elderly residents, especially those with some type of dementia or memory loss; and the tendency of staff to avenge patient aggression (Beaulieu and Tremblay, 1995; Braun, Suzuki, Cusik, Howard-Carhart, 1997; Brennan and Moos, 1990; Cassel, 1989; Chappell and Novack, 1992; Feldt and Ryden, 1992; Kingdom, 1992; Gilleard, 1994; Meddaugh, 1993; Pillemer and Bachman-Prehn, 1991; Stilwell, 1991;Spencer, 1994; Whall, Gillis, Yankou, Booth and Beel-Bates, 1992).

Allen et al (2003) conducted a retrospective case record review complaints registered with the Connecticut long-term care Ombudsman Office. They found that larger nursing homes were associated with higher rates of abuse complaints; facilities with unionized staff were more likely to have abuse and care complaints; and the semi-private room rate was positively associated with abuse complaints. Similarly, Göergen (2001), in his studies on employees in nursing homes in Germany, found subtypes of elder abuse and neglect show differential correlation patterns with measures of work stress for nursing home staff. These stressors may be related to staff shortages or work overload and staffing patterns (Göergen, 2001; 2004).

Burgess and Philips (2006), in their retrospective record review of 284 cases of elder sexual abuse that were brought to the attention of professionals who investigated, examined or consulted on the cases, found older adults with dementia were abused by person known to them such as family members and caregivers. In Göergen's (2004) study of elder abuse and neglect in nursing homes in Germany, it was found that self-reported abuse and neglect correlated significantly with ratios of residents with special impairments (e.g., dementia) to nursing staff. In terms of financial risk factors, a significantly strong negative association was found between adults aged 60 and older and financial exploitation (Jogerst et al., 2005).

To summarize, there are a number of problems with the definitions of risk factors that need to be considered in planning elder mistreatment research. Risk factors are subject to all the same problems as the definitions of abuse and more: (1) there are few empirically-based risk factors; (2) the risk factor is dependent upon the unit of analysis (e.g. care provider or victim or their inter-relationship); (3) the lack of uniformity in the categories described and (4) lack of uniformity within the categories;

At its most fundamental level, a risk factor could have a causal influence, be the result of mistreatment, or simply vary with the mistreatment influenced by some common factor. For example, depression is one of the risk factors associated with mistreatment regardless of definition used. Although depression may increase the likelihood that older people perceive and report mistreatment, it may also be a consequence of experiencing mistreatment or a response to some common factor, such as a health problem. At the same time, an important variable unknown or unmeasured may have been omitted. Therefore, the multiple roles of risk factors have caused considerable confusion when it comes to comparisons of studies. Finally, risk factors for abuse in an institution may not be the same risk factors as in the community, an issue not researched in the extant literature.

There is new evidence from a number of multivariate analyses that changing definitions of mistreatment results in different risk factors (Biggs et al., 2009). Marital status, depression, quality of life and use of medication were found to be significant risk factors for mistreatment in the UK community prevalence study, regardless of the definition used. Increasing the scope of the mistreatment definition, however, appeared to reduce the overall number of risk factors. For example, sex was a risk factor in mistreatment by family perpetrators, but when neighbours and acquaintances were added to the definition, sex differences ceased to be significant.

3.0 THEORIES

The common theories used to explain the mistreatment of older adults in domestic settings are evaluated here as to their utility in guiding a prevalence study. The usual theories that include the situational, social exchange, and symbolic interaction models are found wanting on a number of fronts. The life course perspective from gerontology as an integrating framework is argued to be a reasonable choice for the study because it allows for the integration of almost any theory the researcher, practitioner or policy maker may want to use and it links both micro and macro theories for a more complete understanding of mistreatment. There are few, if any, explanations of abuse and neglect in the institution other than a consideration of organizational factors that are reviewed here.

Some researchers have contended that establishing an explanation for abuse and neglect in the community or institutions could be more valuable than determining prevalence because understanding reasons for abuse and neglect would make it easier to develop preventative programs (Hawes, 2002). Theory provides the basis for causation, the scope and reach of a study and how terms are conceptualized and operationalized, at least in a quantitative approach that would be a major aspect of a prevalence study (McDonald, 2007; Chappell, McDonald and Stones, 2008).[9] While many definitions have underlying assumptions, a step back from the assumptions usually ends up in some type of theoretical

[9] It is clearly recognized that qualitative studies can generate theory through a grounded theory approach which is desperately needed in Canada, if not in most countries (Denzin and Lincoln 2000; Glaser and Strauss, 1967).

explanation as to what is behind the research (Slife and William, 1995). For example, the adult protection legislation in PEI, New Brunswick and Nova Scotia assumes a negative view of aging such as that found in activity theory which sees the older adult on a permanent and inevitable downward slide into incompetence if they don't "keep busy" (Chappell, McDonald and Stones, 2008)

Unfortunately, there has been very little theorizing about abuse and neglect in the community or institutions (Ansello, 1996; Bonnie and Wallace, 2003; Harbison, et al., 2008; Phillips, 1983; Schiamberg and Gans, 1999; Wolf and Pillemer, 1989) for a whole host of reasons (*c.f.* Harbsion, 2008; McDonald, 2007, 2008 GSA). Much of the literature on elder abuse does not make an important distinction between theoretical explanations and the individual factors related to mistreatment. A theory provides a general, systematic explanation for observed facts; in the elder mistreatment literature, particular factors, such as stress or dependency, are often treated as complete theoretical explanations even though they are only factors and could be incorporated in any of a number of theories (McDonald, 2007, p. 14). The specific relationships between the various factors and elder mistreatment are meant to form propositions upon which theories are built. Over the course of the brief history of older adult mistreatment, different accounts of the relationships among the factors have led to at least three distinct theoretical perspectives. Their variations are of particular import, since each theory determines the definitions of abuse and neglect. We add one other perspective borrowed from gerontology that may have application to understanding mistreatment and neglect.

3.1 The Situational Model

Probably the most widely accepted perspective is the situational model, which has its roots in the mainstream perspectives on child abuse and family violence (Phillips, 1986, McDonald et al., 1991). The basic 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. This approach suggests that mistreatment is an irrational response to stressful situations. The situational variables that this theory links to mistreatment include factors related to the caregiver and the older adult as well as social and economic conditions. Interventions grounded in this perspective attend to reducing the stress of the caregiver. One major flaw of this perspective is that it fails to account for the fact that many caregivers, who experience the same stresses as abusers, do not mistreat their older family member. The perspective has also been criticized for being dangerously close to blaming the victim, since it identifies the older person as the source of the stress (Ryan, 1976) and it is too narrow a definition since it does not include those who are not family members. To date, there is no empirical support for this theory.

3.2 Social Exchange Theory

Social exchange theory is based on, "… the assumptions that social interaction involves an exchange of rewards and punishments between 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; and it is these characteristics that place them at risk for abuse (Chappell, Stones and McDonald, 2008). There are many problems with this perspective, not the least of which, is its basic ageist assumption: people do not automatically become dependent and vulnerable as they age. As noted above, it is the abuser's sense of powerlessness that leads to maltreatment. There is no empirical evidence to support this theory.

3.3 Symbolic Interactionism

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 (McDonald, 1995; 2007). It can be considered one of the first social constructivist theories following the qualitative tradition as used by Steinmetz in 1988 (Creswell, 1994; Schwandt, 1997; Steinmetz, 1988). This perspective emphasizes not only the behaviours of the older person and the caregiver, but also both persons' symbolic interpretations of such behaviour. This analysis of elder abuse centres on the different meanings that people attribute to violence and the consequences these meanings have in certain situations (McDonald, 1995). 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. The difficulty with this approach is that it does not consider the social or economic factors that might influence the abusive process and does not explain the finding that not all caregivers who were abused as children abuse older adults. Again there is no solid support for this set of theories.

3.4 The Life Course Perspective[10]

Strangely enough, the life course perspective has never been applied to the mistreatment of older adults although this is the most popular and promising theory in the field of aging, especially since it links the individual and the social structure and is accumulative of advantage/disadvantage. The main architect of the life course approach, Glen Elder, developed five paradigmatic principles that provide a concise, conceptual map of the life course: development and aging as life-long processes; lives in historical time and place, social timing, linked lives and human agency (Elder, 2006). One of the most basic premises relating to the life course perspective is that it is a framework that can 'house' other theories at the micro, meso or macro levels and link them, leaving policy makers, researchers and practitioners free to choose what approach they want at each level depending on the question of interest. For these reasons this approach is used to guide the formulation of the study.

3.5 Theories and Institutional Abuse

Whether community abuse and institutional abuse have different explanations has never been demonstrated but different theoretical perspectives have been proffered. Several American researchers have developed a model of the potential causes of elder abuse in nursing homes (Pillemer and Bachman-Pren, 1991). This model includes factors related to the socioeconomic environment of the institution such as the supply of nursing home beds and local unemployment rates; the characteristics of the facility, like 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 status, degree of social isolation, and gender. The researchers' test of this model suggested that the maltreatment of nursing home patients is likely a response to highly stressful working conditions, rather than a consequence of the facility's characteristics such as its size or ownership status. As confirmed in more recent studies (Goergen, 2004; Hawes, 2002), the

[10] It is useful to distinguish the life course, life cycle, life span and life history. The life cycle refers to the stages of parenthood, from the birth of the first child to the departure of all children. The cycle is repeated from one generation to the next, although occasionally some people will not have children and will not be part of an intergenerational life cycle. The life cycle comprises a set of ordered stages with the major transition points being marriage, the births of the first and last children and the departure of the last child. The lifespan, drawn from developmental psychology refers to age-related biological and behavioural changes from birth to death, with emphasis on the adult years. The generalizability of behaviour patterns of a normative nature is key to this perspective (Baltes & Reese, 1984). There is not as much emphasis on historical effects Life history usually refers to a set of methods for collecting information about human lives over time. The focus of life course theory is on trajectories and transitions that constitute an individual's life or the lives of similarly situated people. The life cycle is more about reproductive cycle from one generation to the next and the life span focuses more on age-related development (Chappell et al., 2008).

researchers found that staff who were suffering burn-out and who experienced aggression from patients were more at risk of becoming abusive towards their elderly patients (Pillemer and Bachman-Pren, 1991).

Overall, the problems with explanations about older adult mistreatment are scarce for a number of reasons: (1) there is a paucity of theories that explain mistreatment of older adults and what is available is out-of date, is borrowed from elsewhere (child welfare and family violence) and is not necessarily applicable to older adults; (2) the theories have little empirical support; (3) none of the most common theories link structural and individual factors for a more complete understanding of mistreatment although the life course perspective may afford this opportunity; (4) some scholars have realized that there is a broad diversity in the manifestations of mistreatment and neglect and that new theories of elder abuse may be required to explain different dimensions of elder abuse and neglect; (5) There may be different theoretical frameworks required for institutional and domestic mistreatment.

4.0 METHODS

This section describes the methods of the five projects that make up the whole of the study and highlights what makes the Canadian study somewhat different form existing studies. In light of the goals and objectives of the overall project, the level of funding available and the time lines for the study, the research team opted for a multi-method pilot approach that closely followed the five smaller projects that made up the requirements for HRSDC. The research tasks were undertaken in conjunction with the research consultants Westat[11] who have experience in the field of gerontology generally, and in the mistreatment of older adults specifically. In this pilot, the entire study with all of its instruments and procedures was conducted in miniature to discover problems before the main research might be undertaken. Every project received ethical approval from the centres for the study, Universities of Toronto and Sherbrooke, prior to any fieldwork. It is important to note that HRSDC called for a telephone interview in the community in light of past government successes with this approach. In essence, the methods for collecting data in the community were already specified for the study. Similarly, random sampling as part of a prevalence design was not part of the proposal as would be consistent with a pilot study. As a result, this study does not report the prevalence of mistreatment in Canada but rather the viability of the measurement tools.

[11] Westat, demonstrating technical and managerial excellence since 1963, is recognized as one of the foremost research and statistical survey organizations in the United States. The over two thousand consultants provide services to agencies of the U.S. Government, as well as businesses, foundations, and state and local governments. Westat did the first and only incidence study on elder abuse in North America.

Overall, the study improved existing surveys and instruments to make them "state of the art" with the participation of policy makers, practitioners and researchers in Canada who had a major stake in elder mistreatment. The Canadian experts worked with top researchers in the world who had previously completed prevalence studies in their own countries. The methodology and the outcomes of this study moved forward the global research on elder abuse in a number of important ways. The Canadian project is the first prevalence study to ever introduce a theoretical perspective that served as a framework for the study and which was tested in the study. Second, the study tested the validity of the measurements for the first time in the elder mistreatment field – measures that have been used extensively over the years with no previous validation. Third, the study examined, in a new way, the major issues of over and under estimation of the rates of elder mistreatment. Fourth, the methods included a community consensus approach that integrated the views of major stakeholders from across Canada at the inception of the project and finished with a knowledge transfer event for these stakeholders to share in the results and plan for the future. Lastly, an extensive ethics manual was developed that could be used by both practitioners and researchers in any aspect of intervention through practice or research that afforded the protection and resources older adults might require.

4.1 Project One

The information from the research reviews was used to evaluate mistreatment concepts, measurement instruments and possible theoretical frameworks. This process involved face-to-face meetings, teleconferences and emailing with the whole team and on-going consultation with the Advisory Committee. In project one the team established several basic criteria for the selection of definitions that could be used in a purposive telephone prevalence study in Canada, in a national prevalence survey, and in smaller projects that were either qualitative or quantitative in nature, or both. The main criteria chosen included cross-national comparability so Canada could determine where it rated on the world stage; national comparability to earlier studies in Canada (Podnieks, Pottie Bunge) to establish if there were any changes over time; the need to be future-oriented in terms of newer issues like cyber bullying; adaptability if used in longitudinal studies; and, what could be realistically achieved in a half-hour interview module of specific content on abuse and neglect, after other identifying data has been collected (e.g. an hour long interview). Because the research was to be a precursor to a possible prevalence study, it was agreed that subjective terms should be avoided such as *expectation* of trust (since what two people expect may differ), and that decisions would be determined by whether or not the concept under consideration could be turned into a direct act or behaviour. The group also concluded that the definitions must reflect the theoretical framework of the project and be suitable for application in English and French.

The first goal was to develop clear conceptual definitions of mistreatment by meeting five objectives. In order to meet the first objective of evaluating existing conceptual

definitions, the literature on conceptual definitions and categories of mistreatment was subjected to an analytical assessment. For all of the relevant studies selected, each concept was assessed according to the type of concept used[12], the unit of analysis, the role of the concept as a cause, behaviour or outcome, the nature of the relationship as to whether it was one of trust, the underlying assumptions (e.g. caregiver stress), the variable used (e.g. physical abuse), the indicators used (e.g. Conflict Tactics Scale), the thresholds and the actual questions asked. The second objective was to review the measurement issues attendant on the conceptual definitions including levels of measurement, previously used scales and indices, and the issue of measuring cognitive impairment and thresholds of impairment. A summary table of the measures used in previous studies was developed according to functional status (e.g. Instrumental Activities, Lawton and Brody, 1969), cognition (e.g. Mini-mental Status Test, Folstein et al., 1975) and measures of violence, abuse and neglect (e.g. Indicators of Abuse Screen, Reis and Namiash, 1998). The various measures were analyzed according their validity for the target group, disadvantages and advantages and duration of assessment by the research team.

The third objective was to review the pros and cons of what age and ethnic or marginalized groups to target, the languages to be used and the value of different prevalence periods. The decision rules used involved the necessity of including subgroups with a low life expectancy (e.g. Aboriginals) and the need to be able to expand or contract the age to correspond to previous and future studies. Prevalence issues were decided on the basis of a compromise between achieving accurate recall and the capacity to match previous Canadian and international studies. The team decided that the only financially feasible approach was to use French and English and that cognitive screening was required to ensure comprehension. According to recent reports, the most prevalent older minority groups in Canada include South Asians, Chinese and Blacks (Caribbean and Africa). While representative results could not be obtained for small groups without very large sample sizes the team decided that the study would attempt to include the largest ethnic subgroups in the study. [13]

The fourth objective was to examine the function of theory in the definitions research and what different roles it might play based in the current research. Two rules lay behind the choice of theory: first that the theory was acceptable to a wide audience, and second that it advanced the research on mistreatment (DMEA Research Team, 2010a). The last objective was to hold a *Definition Consensus Workshop* with international and national experts and stakeholders in Canada, to review the decisions to date, give input and achieve a

[12] Michael Stones (1995) usefully distinguishes three types of abuse and neglect definitions - connotative, structural and denotative (Connotative definitions attempt to provide a comprehensive meaning for elder mistreatment such as that of the World Health Organization (WHO) that is quite broad. Structural definitions indicate the contravention of acknowledged standards such as those specified in law or in ethical codes or what are believed to be community standard. Denotative definitions, the most commonly used, define mistreatment by providing descriptive examples of what is considered abusive behaviour.

[13] To include these groups in a nationally representative survey would require over-sampling and translation and back translation, which was not financially feasible.

preliminary consensus on the conceptual and operationalized definitions. The workshop with forty participants was held June 25, 2010, University of Toronto (DMEA Research Team, 2010b).

4.2 Project Two

The goal of project two was to develop community and institutional instruments for measuring elder abuse and neglect. This project developed specific modules of questions for the purposive telephone questionnaires for older adults in the community and in institutions. Following objectives one through five, the research team, Westat consultants and the Advisory Committee developed operational definitions for the five main types of mistreatment (physical, psychological, financial, sexual, and neglect; both passive and active for the surveys); developed operational definitions for the chosen evidence-based risk factors for the community study (e.g. cognitive impairment, shared living situations, social isolation, depression, frailty of older adult, mental illness or alcohol or drug abuse by the perpetrator) and the existing risk factors outlined in the research for institutions (staff shortages, poor staff training, staff burnout, and resident aggression). The team developed operational definitions to classify perpetrators for the community and institutions and finally, drafted preliminary questions for further testing and proxy interviews. The instruments were developed in modules for each specific type of abuse and could be skipped if the first question in the model was not relevant.

With the conceptual definitions and their operationalization tentatively agreed upon, the Advisory Committee helped recruit participants for three focus groups: one for older people in Ontario and one in Quebec with approximately ten people in each group and one focus group of formal and informal caregivers and proxy residents in Ontario. Two dyads of an older person and their caregiver were interviewed in an Ontario long-term care institution and one Quebec long-term institution. Participants were paid $25 to $30 for their participation. Two telephone interviews were tested in English in Ontario. All field work was digitally recorded with permission and transcribed for analyses. The purpose of the focus groups and face-to-face and telephone interviews (outlined in a moderator's guide) were to (a explore issues of abuse and neglect for general understanding; (b) comfort levels for talking on the telephone and face-to-face; (c) preferred characteristics of interviewers; (prevalence periods from participants perspective), and (d) participants understandings and recommendations about the conceptual and operationalized definitions.

The research team considered all feedback and revisions were made to the draft questionnaires. The sources of these changes included the focus group participants, dyad interview participants, research team members, advisory committee members, an expert consultant, and colleagues from HRSDC. Changes took place in the form of rewording questions, adding new questions, removing questions that were viewed to be redundant, strategic reorganization of certain questions and/or sections, and clarification of terms that were viewed to be ambiguous or difficult to understand. All of the feedback submitted was

reviewed extensively and final changes made. An excel spreadsheet tracking the origins of each question and the sources in the literature and any revisions made to each question was created (DMEA Research Team, 2010c).

4.3 Project 3

The goal of this phase of the program of research was the validation of the measurement instruments. Four objectives were identified: cognitive testing of the preliminary questionnaire and subsequent refinements; a telephone interview of 267 participants already recruited according to whether they were mistreated or not; and the administration of the intuitional questionnaire to older adults and a proxy in long-term care via face-to-face meetings.

The recruitment of 27 English speaking and 10 French speaking older adults for cognitive testing was done by project staff from already involved social services agencies and was implemented by the research team wherever the older person felt comfortable. The recruitment team stratified the sample according to age, Aboriginal status and gender where possible. The cognitive testing took place between February and April 2011. Specific elements of the questionnaire were covered in the cognitive test that included such factors as the instructions, wording, the definitions, items that asked for information to which the respondent did not have access; language issues; recall periods, question placement and flow, and confusing response options or response formats. Changes were subsequently made to the questionnaires on the basis of the research team's assessment of the feedback from the cognitive testing.

The telephone survey, carried out between June and July 2011, was the chosen methodology since this approach was requested by HRSDC. Participants were part of a purposive sample from the general population, including both known victims of abuse and others known or believed to be non-victims. Sample members included men, women, and Canadians of Aboriginal, Chinese, South Asian, and African/Caribbean descent. Ten percent of these interviews were conducted with French-speaking Canadians and the rest were done in English. The inclusion factors of age 55 and over, French or English speaking, cognitively intact and mistreated or not mistreated were the sample inclusion factors decided upon earlier by the research team.

The purposive sampling was challenging mainly because the topic was somewhat threatening and because people had to make their own decisions to call. Recruitment included fliers, emails using Constant Contact software and a Canada toll-free number. Potential participants could enrol in the study electronically or call the recruitment coordinator. Either way of enrolment resulted in an arranged time for the telephone interview and a time for a back-up interview if there were problems. Due to cost considerations and the small size of the sample, data was collected using paper questionnaires instead of by electronic capture. Westat conducted the interviews and

forwarded 10 requests for social work follow-up to the DMEA social worker who contacted respondents and provided support and resource recommendations.

Between August 23 and September 21 of 2011, three clinically trained social workers and a Westat-trained interviewer conducted thirty-two interviews (31 in English and 1 in French) at five Long-Term Care facilities in the Greater Toronto Area (GTA) in Ontario. Of the fifteen institutions that refused to participate or could not participate, the reasons given covered ethical issues, being overburdened with projects, accreditation issues, shortages of staff and administrators and language issues.

The data analyses were carried out by Westat and reviewed by the team. There were 3 major sets of analyses: profile of the respondents in the survey and the prevalence of the different types of abuse/neglect; the assessment of the validity of the community survey; and the assessment of the validity of the risk factors.

4.3.1 Descriptive Statistics

First, descriptive statistics were used to describe the characteristics of respondents that included, demographic, social, and health characteristics. Second, descriptive statistics on abuse/neglect were used, including data on the prevalence, number of different types of mistreatment, frequency of mistreatment, context, and patterns over the life course.[14] Third, the survey also asked respondents whether they felt they had been mistreated in the past 12 months independently of whether they answered "yes" or "no" to any of the specific abuse/neglect items. These questions were asked for each of the five types of abuse/neglect and the percentages reported. Fourth, descriptive statistics on the frequency of mistreatment and each type of mistreatment were conducted.

4.3.2 Validity of the Community Survey

With the descriptive statistics in hand, the next set of analyses was devoted to the validity of the community survey. First, item non-response, time to complete the questionnaire was analysed and predicting the time of completion, using multiple regression. Second, because there is no "gold standard" measure of elder mistreatment, this study used a known-groups methodology to assess the construct validity of the community survey. Older adults were asked at the time of recruitment to the survey whether they had experienced abuse or neglect. The first group consisted of 39 respondents who indicated at recruitment that they had been abused or neglected. The specific type of abuse or neglect (e.g., psychological, physical, financial, sexual or neglect) was not ascertained. The second group

[14] It is important to note that the results from this analysis do not represent a national estimate of the prevalence of elder abuse/neglect among older adults in Canada. Results are not representative because the sample was chosen by convenience to validate measures of mistreatment and risk factors for abuse and neglect and is not a national probability sample.

consisted of 228 respondents who did not indicate that they were abused or neglected when they were recruited. These two groups constituted the "known" groups because whether they were mistreated was known, at least according to self-report prior to the study. Four different analyses were conducted. The first analysis evaluated whether the two groups responded differently to particular items in the instrument using cross-tabulations and chi-squared tests. Secondly, the items on which the two groups differed were summed to create a score and the two groups were compared using t-tests on the mean number of abuse items to which they responded positively. In the third analysis, Cronbach's alpha was computed for the abuse and neglect items to determine if they constituted a single construct of a particular type of elder abuse. In the fourth analysis, a multivariate discriminant function analysis was conducted to determine which items resulted in the most efficient prediction of group membership.[15] The final analysis attempted to validate the instrument for subgroups of respondents defined on the basis of gender, age, and ethnicity.

The next analyses examined the risk factors for abuse using the known-groups validation approach. Frequency distributions and chi-squared tests were used to compare the two groups on 10 risk factors for elder abuse and neglect identified by prior studies. Next, the items that were significant in the bivariate analysis were summed to create a score for each respondent representing the number of risk factors. The mean scores between the two groups were compared using t-tests. Respondents were only included if they had non-missing data on all of the risk factors used to calculate the score. Last, discriminant function analysis was used to determine which combination of abuse or neglect items significantly predicted group membership. A stepwise discriminant function analysis was conducted to see if the number of risk factors could be reduced. The 7 risk factors on which the groups differed in the bivariate analysis were entered in the model and three risk factors significantly predicted group membership.

The final set of analyses explored the perceptions of mistreatment. Some experiences of mistreatment were not necessarily perceived by older adults as mistreatment. Conversely, not all respondents who felt they were abused/neglected had indicated that they experienced one or more of the specific types of abuse/neglect. The former would indicate that the items overestimate the prevalence of abuse; the latter would suggest that the instrument omits important experiences that older adults consider to be mistreatment. To explore these possibilities, we calculated the percentage of respondents who felt they experienced abuse separately for those who experienced abuse once or a few times and those who experienced abuse many times or every day/almost every day. We did this for each type of abuse separately.

The questionnaire also included questions on whether a respondent experienced mistreatment at earlier points in the life course, including childhood (age 17 and younger), young adulthood (ages 18 to 24), mature adulthood (ages 25 to 54), and older adulthood (age

[15] Discriminant function analysis is a technique that discriminates or determines members of groups using a regression equation with group membership as the dependent variable. This is useful for determine which items should be kept or dropped from the instrument.

55 to 12 months prior to the interview date). The percentages for these timelines were also calculated.

4.3.3 Validity of the Risk Factors

The relationship of risk factors to three different dependent variables was examined in this analysis. The first measure indicated whether a respondent experienced any abuse or neglect in the past 12 months. A respondent was considered to have experienced abuse or neglect if they responded positively to one or more of the 66 abuse and neglect items included in the survey. This variable was coded 1 for abused respondents and 0 for non-abused respondents. The second dependent variable captured the frequency of abuse. When a respondent reported abuse, he or she was asked how many times this happened to them in the past year. Response categories included: once, a few times, many times, and almost every day. The frequency of abuse was the highest category that a respondent indicated for any abuse experience. This variable had three possible categories: (1) not abused, (2) abused once or a few times, and (3) abused many times or almost every day. The third dependent variable indicated the number of different types of abuse and neglect that a respondent experienced. The type of abuse referred to the five broad categories of neglect, psychological abuse, physical abuse, sexual abuse, and financial abuse considered in this study. Respondents could experience from zero to five different types of abuse and neglect. The variable was collapsed into three categories: (1) not abused, (2) experienced only one type of abuse, and (3) experienced two or more types of abuse.

The first set of risk factors captured respondents' socio-demographic characteristics (age, ethnicity, educational attainment, marital status, living situation, social isolation, ADL/IADL and depression) and were coded as dummy variables. Additional variables captured and controlled for potential variations in the study population, including the region of the country in which the respondent lived, whether or not the interview was conducted in French and prior experience with abuse (See Appendix D for coding). Two different logistic regression models were used to evaluate the influence of the various risk factors, model one with the single risk factor and model 2 with all the risk factors. Because the other outcome variables (e.g., frequency of abuse, number of different types of abuse, and perception of abuse) were polytomous, multinomial logistic regression analysis[16] was used to examine the influence of each risk factor. The reference category was always 'no abuse' in all of the multinomial logistic regressions.

[16] An alternative model is the ordered logit model. The ordered logit model is appropriate when the dependent variable has three or more categories that are ordered. While frequency of abuse and number of different types of abuse are ordered, these variables do not meet the proportional odds assumptions of ordered logistic regression. The ordered logistic regression model assumes that the effect of each risk factor is the same for each pair of categories. In other words, the effect of each risk factor on moving from no abuse to once/a few times is the same as the effect on moving from once/a few times to many times/everyday. This assumption does not seem tenable for the frequency of abuse and number of different types of abuse.

4.4 Project 4

The overarching goal for this project was to identify ethical issues in conducting a study of mistreatment and to ascertain possible solutions. This project ran simultaneously beginning with the first project because many of the ethical issues had to be addressed prior to fieldwork (e.g. ethics approval). At the outset of the project, the research team acquired the approval for all fieldwork from the Research Ethics Boards (REBs) at the two universities and the participating agencies. The five objectives dedicated to ethics included compiling a resource manual for interviewers (see Appendix E), choosing a cognitive screening instrument to insure that participants were lucid, developing proxy interviews if the older adult was cognitively impaired and training the interviewers for the telephone interviews. A social work expert in elder mistreatment was hired to be on call to support anyone experiencing difficulty during the time of the interview.

The *Training and Resource Manual* was designed based on manuals that had already been developed, a literature review of ethical considerations for telephone surveys and mistreatment studies, mandatory reporting requirements for Canadian jurisdictions, as well as national and regional resources (through government and private agencies). Feedback from the research team and advisory committee guided development of this manual. The final manual included the following sections: 1) Interview guidelines; 2) Interviewer self-care; 3) Responding to participant distress; 4) Responding to imminent danger; 5) Mandatory reporting; 6) Questions & Answers; and 7) Provincial and territorial abuse helplines. Cultural sensitivity training received special attention in the manual and in the actual training through the participation of a recognized expert in anti-racism/ anti-oppression cultural competency training. The interviewers and students involved in the project were trained in English and French using this manual over four sessions.

The research team and the advisory committee had decided that that all respondents would undergo a cognitive screen at the beginning of the telephone and face-to-face surveys to ensure that they had the cognitive capacity to understand what was expected of them in order to give informed consent to participate in the survey, and to assure high data quality. After a number of refinements with contribution from the REBS a format was chosen and embedded into the interview schedule that was developed by Westat.

Because of the characteristics of older adults in long-term care facilities (i.e. a high percentage of residents have cognitive impairments), there was a high probability that many residents would not be capable of fully understanding the study or the questionnaire. It was essential to include this population because they are very vulnerable to abuse plus this enhanced the quality of the data. Thus, a proxy questionnaire based on the general questionnaire for older adults in institutions was adapted with special consideration of what a proxy respondent would likely know with respect to an older adult's experiences.

4.5 Project 5

During Project 1, the research team and funding officers agreed that two consensus events would occur; a Definition Consensus held in June 2010, with 40 attendees; and Pathways to Knowledge Transfer held in October 2011, with 60 attendees. This second event used a NICE tool "Defining and Measuring Elder Abuse" to stimulate discussion on how to use the definitions for policy, practice and research. Both knowledge transfer events provided an opportunity for the research team to present an overview of the Defining and Measuring Elder Abuse (DMEA) project, share findings and solicit feedback from stakeholders for a broad-based knowledge-transfer strategy. The events encouraged academics, policy-makers, practitioners, and government representatives to collaboratively develop next steps for dissemination and use of the definitions and measurement instruments of elder abuse and neglect on a national level.

5.0 FINDINGS

5.1 Theory

The research team decided upon a life course perspective because it seemed the most comprehensive from the point of view of most stakeholders.[17] The five principles of life course theory capture most of the salient aspects of the mistreatment of older adults. The appropriateness of the five principles of the framework for this study comprised the following ideas: 1) mistreatment can be treated as a major turning point in a person's life thus confirming its significance; 2) the theory allows for the inclusion of systematic factors in abuse such as those found in institutions or the law; 3) the theory recognizes that the mistreated person is embedded in relationships with others that include both professional and informal caregivers and strangers; 4) period and cohort effects mean that the mistreatment is influenced by the historical times and the group with whom the person has travelled through life, and most importantly, 5) older persons are considered to be adults who are knowledgeable and capable of making their own decisions which helps dispel infantilization of older adults. This framework was the main blueprint for the research in terms of the concepts to be considered, the interaction between societal, structural and individual factors, and changes over time. For this reason questions about abuse/neglect across the life course were included in the survey. Finally, the research recognized that other theories could be contained within a life course perspective and integrated vertically at the macro level, through linking theories to the micro level (Marshall, 1996).

[17] None of the community or intuitional prevalence studies used a theoretical framework in the literature review (Appendix A). However, it is evident that some drew on a family violence framework without an explicit description of the theory (e.g. Pottie-Bunge, 2000).

5.2 Conceptual and Operational Definitions

Based on the analysis of the social, legal and Quebec literatures and the decision rules adopted by the research team, the conceptual definitions and how they would be operationalized were chosen by the team and modified by the Advisory Committee, and by information from the dyad interviews and the focus groups. The end results were modules of questions in institutional and community formats to cognitively test. The definitions were further developed at the Definition Consensus Workshop and, as would be expected, not all team members and stakeholders agreed on all issues (see Report 1 for details: DMEA Research Team, 2010a).

The selected conceptual definitions used in both the community and institutions appear in Appendix B. The definitions and types of mistreatments were closely aligned with the current literature and the various types of mistreatments but were nuanced to fit the Canadian context and meet the expectations of stakeholders. In essence, the conceptual definitions mirrored the World Health Organization and the American National Research Council definitions which are the most commonly used conceptualizations. The inclusion factor for age was 55 years and over to insure the inclusion of those with lower life expectancies, French and English were the required languages because of cost factors and the minority groups to purposely sample included the South Asians, Chinese and Blacks. The prevalence period was established at one year as being suitable for recall. Recognizing that approximately 5 to 10 percent of those aged 65 and over in the community suffer from dementia and thirty percent of those over age 85 (Evans et al., 1989; Hendrie, 1998; Federal Interagency Forum on Aging-Related Statistics, 2004), the team chose to use a competency screen developed by Westat to insure that respondents were competent to answer the survey questions.[18] The operationalization of the measurement instruments used in the survey appear in Appendix C, Sources Consulted In Developing the Questionnaire, where the proposed domain, item and response set, source and question number, comments, revised question and more comments were tracked.

The administration of the survey instrument for the purposes of cognitive testing (N=37), 10 in French, and 27 in English, resulted in several changes. Questions pertaining to the mental health and gambling of the perpetrator were added and a question was added asking whether the respondent relied on a wheelchair, walker, scooter or other mobility device. As many respondents struggled to provide a definitive number of times that they had experienced abuse or neglect in the previous 12 months, two questions were added to each abuse and neglect category. The first question referred to frequency of abuse, and the second question contained specific ranges to help respondents indicate a numerical range if

[18] The objective of the screen was not to identify and diagnose whether someone had dementia, but to assess whether he/she was competent to answer the interview questions in the survey. Westat evaluated this instrument by comparing responses to the questions in this instrument with IQ and other neurological data for a sample of 30 respondents. It was found that the people who "failed" had an IQ of 65 or lower.

they had difficulty listing a single number. Systemic abuse was not included as a separate category in the survey as items asking whether respondents were prevented from speaking their native language, or had experienced prejudice based on their age reflected the notion of "systemic abuse". Respondents from the French cognitive testing interviews emphasized the importance of using language and terminology that older adults readily understand. Examples of problematic language in the survey included; the terms "sévice émotionnels", and "prejudices émotionnels", and "soignant professionnel", which translates in English to "professional carer."

5.3 The Survey

5.3.1 Survey Administration

Interviews were administered by telephone to 267 older adults living in the community across Canada between June 1 and July 30, 2011. Respondents were asked to volunteer for the community survey. Recruiters attempted to locate equal numbers of volunteers who claimed to have experienced abuse as those who had not. Of the 267 interviews, 236 were conducted in English and 31 in French. Twelve people signed up to participate but did not complete an interview. Two respondents had become ill and were unable to participate, 4 decided they were not after all interested in participating, and 6 were not reachable at the time they had chosen for the interview. The actual refusal rate was only 1 percent, if one assumes that the 6 people who were unavailable might have been reachable with a longer field period. Ten respondents requested and received assistance from a social worker.

As part of the survey of institutionalized older adults, 32 respondents living in institutions were interviewed in August 2011 (31 in English and one in French). The interviews were conducted in person rather than by telephone. The purpose of the institutional interviews was to determine whether the residents or their proxies would be able to answer the questions, and not to validate the instrument.

5.3.2 Characteristics of Study Population

5.3.2.1 Characteristics of the Older Adults Living in the Community

Among community residents, most were younger than 75 years of age (86%), female (77%), White (92%), and had at least a high school diploma (92%). Fifty-eight percent of the respondents were married. Sixty-three percent lived with someone else. Respondents typically spent time socializing with friends or relatives and used the telephone or the computer to stay in touch with people. Twenty-eight percent reported feeling socially isolated and felt that they did not spend enough time with friends or others. Approximately

17 percent of older adults living in the community scored as possibly depressed on the modified Center for Epidemiological Studies Depression Scale (CES-D) instrument.[19] Nearly 40 percent reported at least one limitation of the Activities of Daily Living or Instrumental Activities of Daily Living (ADL/IADL).

5.3.2.2. Characteristics of the Older Adults Living in Institutions

Two-thirds of the older adults living in institutions were over 75 years of age (69%). Women comprised 59 percent of this group; 69 percent were White and 69 percent had at least a high school diploma. Only 12 percent of the respondents were married while 22 percent were widowed and 44 percent reported being divorced or separated. Forty-one percent indicated that they shared a room with someone else. Thirty-eight percent did not spend time socializing with friends or relatives or use the telephone or computer to stay in touch with people, although only 30 percent reported *feeling* socially isolated and thought that they did not spend enough time with friends or others. Most of the institutionalized respondents reported at least one ADL/IADL limitation (94%), but only 12 percent scored as possibly depressed on the modified CES-D instrument. (See tables 5.1-5.3)

5.3.3 Prevalence of Abuse and Neglect

Most of the questions in the survey on elder mistreatment focused on the past 12 months. For purposes of this analysis, respondents were considered to have experienced abuse or neglect if they answered "yes" to one or more of the 100 questions on this topic in the survey. Using this definition, just under half of respondents (46%) experienced abuse or neglect. It is important to note again that this proportion should not be taken as an estimate of the prevalence of abuse or neglect in Canada.

The survey interviewers asked respondents about mistreatment in five categories: neglect, psychological abuse, physical abuse, sexual abuse, and financial abuse. Psychological abuse was the most common type of abuse. More than one-third (37.1%) of respondents indicated that they had experienced one or more of the eight types of psychological abuse. The proportions of respondents experiencing other types of mistreatment were relatively small: 9.7 percent experienced financial abuse, 8.1 percent experienced physical abuse, 6.7 percent experienced sexual abuse, and 4.5 percent experienced neglect.

[19] The CES-D scale is a short, self-report scale designed to measure depressive symptomatology in the general population. The scale is generalizable across different subgroups such as age, sex, race and education (Radloff, 1977).

Table 5.1 Socio-demographic and clinical characteristics of respondents

Characteristic	N	%
Socio-demographics		
Age ≤ 75	229	89.1%
Age > 75	37	13.9%
Male	62	23.2%
Female	205	76.8%
Race		
White	246	92.1%
Non-white	21	7.9%
Education		
Less than high school	22	8.2%
Marital status		
Never married	34	12.7%
Married	156	58.4%
Divorced or separated	47	17.6%
Widowed	30	11.2%
Living situation		
Lives alone	98	36.7%
Lives with others	169	63.3%
Social isolation		
Socially isolated	31	11.9%
Feels socially isolated	75	28.3%
ADL/IADL needs		
No ADL/IADL needs	164	61.4%
ADL/IADL needs	103	38.6%
Center for Epidemiological Studies Depression Scale score		
≥ 10	44	17.0%
< 9	215	83.0%
Prior experience with abuse		
Abused in childhood	143	54.6%
Abused in young adulthood	91	34.1%
Abused in adulthood	114	42.9%
Region		
Eastern Canada	199	74.5%
Western or Northern Canada	68	25.5%
English language interview	236	88.4%
French language interview	31	11.6%

As seen in Table 5.1, the number of positive responses to items in specific categories of abuse or neglect varied. There were small numbers of positive responses to the various types of neglect. Only a few individuals reported that they had been neglected. Among the psychological abuse items, having been repeatedly criticized was the most frequently reported type of psychological abuse (21.7%). At the other extreme, only 2.2 percent of respondents said that someone had forced them to do something against their will. The prevalence of physical abuse was low regardless of the specific item. However, there were two physical abuse items to which no one responded positively: having been burned or scalded and having been choked. Only one respondent indicated that someone had

administered drugs that were not necessary. The prevalence of sexual abuse was low for all items. The most prevalent form of sexual abuse was someone trying to touch the respondent in a sexual way (4.9%). No respondents indicated that someone made them watch pornography against their will, and only one respondent said that someone *tried* to make him or her watch pornography. Few or no respondents reported that someone had unwanted sexual intercourse with them or tried to do so. Under financial abuse, two items stood out as having a low prevalence: someone forced a change in a document (one respondent or .4%), or someone tried to take or keep power of attorney (0%).

Table 5.2 Prevalence of abuse or neglect in the past 12 months, by type of abuse

Type of abuse/neglect	Number	Percent
Neglect		
Not neglected	249	93.3
Neglected	18	6.7
Psychological abuse		
Not psychologically abused	168	62.9
Psychologically abused	99	37.1
Physical abuse		
Not physically abused	243	91.4
Physically abused	23	8.7
Sexual abuse		
Not sexually abused	248	93.2
Sexually abused	18	6.8
Financial abuse		
Not financially abused	240	90.2
Financially abused	26	9.8

5.3.4 Perception of Abuse and Neglect

The survey interviewers asked respondents whether they felt they had been mistreated in the past 12 months, independently of whether they answered "yes" to any of the specific abuse or neglect items. These questions were asked for each of the five types of abuse or neglect. Seventy-eight respondents or 29.2 percent of the sample said they felt they had been mistreated in response to at least one set of summary questions at the end of each section on a type of abuse or neglect. Note that this percentage is less than the 46.0 percent who experienced one or more specific incidents of abuse or neglect. Apparently, not everyone who experienced a specific incident felt that the experience actually constituted mistreatment.

The percentages of respondents who *felt* abused or neglected were lower than the percentages that experienced some form of mistreatment across four of the five categories. When respondents who had reported specific incidents were asked if they *felt* mistreated, a smaller proportion answered yes, except for cases of neglect. Psychological abuse was still the most prevalent type of mistreatment. Twenty-five percent of respondents said that they

felt they had been psychologically abused, although 37 percent answered yes to one or more items. Similarly, the prevalence of "feeling" other types of abuse was lower than the percentage that responded positively to one or more specific items: 4.5 percent *felt* financially abused versus 9.7 percent who experienced some form of it, 3.0 percent felt physically abused (versus 8.1 percent), and 1.2 percent felt sexually abused, versus 6.7 percent with a specific experience. However, the proportions were virtually the same for neglect: 4.9 percent *felt* neglected and 4.5 percent said they experienced an incident of neglect. (See Table 5.3.) Although the current version of the questionnaire did not solicit explanations from those who said yes to specific events but no to feeling abused, it would be useful to ask for explanations of these discrepancies so that the events can be evaluated and reclassified if appropriate. (The revised questionnaire includes such a suggested item.)

Table 5.3 Prevalence of perceived abuse and neglect in the past 12 months, by type of abuse

Type of abuse/neglect	Number	Percent
Neglect		
Did not feel neglected	254	95.1
Felt neglected	13	4.9
Psychological abuse		
Did not feel psychologically abused	200	74.9
Felt psychologically abused	67	25.1
Physical abuse		
Did not feel physically abused	259	97.0
Felt physically abused	8	3.0
Sexual abuse		
Did not feel sexually abused	264	98.9
Felt sexually abused	3	1.1
Financial abuse		
Did not feel financially abused	255	95.5
Felt financially abused	12	4.5

5.3.5 Frequency of Abuse and Neglect

Respondents who experienced mistreatment were asked to estimate the number of times they experienced mistreatment in each category. Respondents were asked to choose from four frequency categories: once, a few times, many times, and every day/almost every day. Among respondents who reported experiencing any abuse, the modal frequency was a few times (37.6%). Since respondents could report a frequency for more than one abuse experience, the overall frequency of abuse in a particular category was taken to be the highest frequency of any individual abusive experience. The second most commonly reported frequency was many times (29.1%). Only 13.7 percent of respondents who experienced abuse experienced it only once. One in five (19.7%) of abused individuals experienced the abuse every day.

Table 5.4 Frequency of abuse in the past 12 months, by type of abuse, respondents who experienced abuse

Frequency of abuse/neglect	Number	Percent
Neglect		
Once	2	16.7
A few times	6	50.0
Many times	2	16.7
Everyday/almost everyday	2	16.7
Psychological		
Once	8	8.3
A few times	39	40.2
Many times	31	32.0
Every day/almost everyday	19	19.6
Physical		
Once	8	38.1
A few times	11	52.4
Many times	2	9.5
Everyday/almost everyday	0	0.0
Sexual		
Once	8	44.4
A few times	9	50.0
Many times	1	5.6
Everyday/almost everyday	0	0.0
Financial		
Once	7	26.9
A few times	8	30.8
Many times	9	34.6
Everyday/almost everyday	2	7.7

Responses to the questions about experiences regarding the number of categories of abuse, the number of items in each category, and the frequency of occurrences of abuse in a category, as well as the specific types of abusive incidents, can be used to evaluate the severity or seriousness of the events experienced by each individual. Since many respondents only report one type of incident in a category of abuse or neglect, it is important to ask about a broad range of incident types, as in this instrument, in order not to miss any potentially abusive situations.

5.3.6 The Context of Abuse and Neglect

For respondents who reported abuse, the survey instrument included questions regarding whether an alleged abuser lived with them, and whether the abuser had an alcohol or drug problem or a mental health problem at the time the incidents occurred. Because someone might have experienced abuse several times, and each time by a different person, the characteristics of the abuser could be different for each specific incident.

Among respondents experiencing abuse or neglect, 31.3 percent lived with the abuser for at least one of the experiences of abuse. Abusers were more likely to live with

respondents who were victims of psychological and physical abuse than with those who experienced sexual and financial abuse. Among those who were psychologically or physically abused, an abuser lived with them for at least one experience for 34.0 and 29.2 percent of respondents, respectively. Among those who were sexually or financially mistreated, the abuser lived with 11.8 and 16.1 percent of them for at least one experience.

Table 5.5 Abuser lived with respondent at least one time, for respondents who experienced abuse/neglect

Abuser lived with respondent?	Number	Percent
Did not live with respondent	79	68.7
Lived with respondent	36	31.3

An alcohol or drug problem was present for about one-quarter of respondents who experienced mistreatment. Among respondents who experienced abuse or neglect, 24.6 percent said that the abuser had a drug or alcohol problem on at least one occasion. Whether the abuser had an alcohol or drug problem varied across the different types of mistreatment, according to the three-fourths of respondents who were able to answer these questions. Drug or alcohol problems were most prevalent in cases of financial abuse, where 34.6 percent of financially abused respondents reported drug or alcohol misuse on the part of the abuser on at least on occasion. However, approximately one-fourth of respondents did not know whether the abuser had a drug or alcohol problem. This item might be a candidate for deletion if the instrument is too long, given the high rate of non-response.

Table 5.6 Abuser had a drug or alcohol problem at least one time, according to individuals who were abused

Abuser had alcohol or drug problem	Number	Percent
Did not have alcohol or drug problem	63	51.6
Had alcohol or drug problem	30	24.6
Unknown	29	23.8

A mental health problem on the part of the abuser was present according to 39.3 percent of respondents who experienced mistreatment. The other 33.6 percent did not think that the abuser had a mental health problem. However, more than one-fourth of respondents did not know whether the abuser had a mental health problem. (See Table 5.7.)

Table 5.7 Abuser had a mental health problem at least one time, according to individuals abused

Abuser had mental health problem	Number	Percent
Did not have a mental health problem	48	39.3
Had mental health problem	41	33.6
Unknown	33	27.0

Respondents who were neglected were less likely to believe the person who abused them had a mental health problem than for all other types of abuse; 11.1 percent said that the abuser had a mental health problem on at least one occasion. However, in 27 percent of instances, respondents did not know if the abuser had a mental health problem. The percentage of respondents abused by someone whom they believed to have a mental problem was highest for physical abuse. Forty-three percent of respondents who were physically abused reported that the abuser had a mental health problem.

5.3.7 Patterns of Abuse and Neglect across the Life Course

The survey instrument included questions on whether a respondent had experienced mistreatment at earlier points in the life course, including childhood (age 17 and younger), young adulthood (ages 18 to 24), mature adulthood (ages 25 to 54), and older adulthood (age 55 to 12 months prior to the interview date). The forms of mistreatment asked about included psychological, physical and sexual abuse during childhood, and in addition, financial abuse during the other three time periods. Respondents were not asked about experiences of financial abuse during childhood since this form of abuse usually is not relevant for children. Neglect was not included as a form of abuse in the life course questions, since the nature of what constitutes neglect varies considerably across the life span, and often depends on one's physical or mental condition.

A history of mistreatment was common among the study participations. Abuse was reported more frequently for childhood than during any other life stage. Over half of the sample (54.6%) reported abuse during childhood; more than one-third (34.1%) reported abuse during young adulthood. Forty-three percent said they were abused during mature adulthood, and one-quarter (24.4%) said they were abused since age 55 but prior to the interview date. (See Table 5.8.)

Table 5.8 Prevalence of Abuse and Neglect, by Type of Abuse

Life Stage	Number	Percent
Childhood (age 17 and younger)	143	54.6
Young adulthood (ages 18 to 24)	91	34.1
Mature adulthood (ages 25 to 54)	114	42.9
Older adulthood (age 55 to 12 months prior to survey)	64	24.4

Three types of abuse were more common during childhood than during any other time period. Psychological abuse was the most common type of abuse at each life stage. (See Table 5.9.)

Table 5.9 Prevalence of Perception of Abuse and Neglect at Each Life Stage, by Type of Abuse

Characteristic	Number	Percent
Childhood		
Psychological	113	42.3
Physical	71	26.6
Sexual	86	32.2
Young adulthood		
Psychological	76	28.5
Physical	30	11.2
Sexual	35	13.1
Financial	21	7.9
Mature adulthood		
Psychological	102	38.2
Physical	26	9.7
Sexual	35	13.1
Financial	33	12.4
Older adulthood		
Psychological	55	20.6
Physical	6	2.3
Sexual	5	1.9
Financial	17	6.4

There is considerable continuity of abuse across the life course. Respondents were divided into four distinct groups based on whether and when they first experienced abuse: (1) those who never experienced abuse, (2) those who experienced abuse prior to older adulthood but not in the last 12 months, (3) those who did not experience abuse earlier in their lives but experienced it for the first time in the last 12 months, and (4) those who experienced abuse both earlier in life and in the last 12 months. Only 18.4 percent of the sample never experienced abuse over the entire life course. The largest group experienced abuse both earlier and in the last 12 months (38.7%). Slightly fewer respondents experienced early abuse only (35.6%). Few respondents experienced abuse for the first time in the last 12 months (7.3%). In short, there appears to be two major life course patterns with respect to abuse: those who experienced abuse early in life but not in the last 12 months, and those who have experienced abuse throughout their lives. For those who experienced elder abuse, there appears to be a continuity of a pattern of mistreatment that began earlier in life. Because the data are retrospective, however, it is possible that experiences of abuse later in life could influence someone's perception of whether earlier experiences constituted mistreatment. (See Table 5.10.)

Table 5.10 Prevalence of Perception of Abuse and Neglect, Life Course Patterns

Life Stage	Number	Percent
Never abused	48	18.4
Early abuse only	93	35.6
Abuse in the last 12 months only	19	7.3
Early abuse and abuse in the last 12 months	101	38.7

5.4 Validation of the Community Survey

The main objectives of the analysis were to validate the measures and to determine the extent to which the questions could be answered easily. This section begins with discussions of non-response to the abuse and neglect items and the time to complete the survey, both of which may provide information about difficulties with the instrument. Next, the validity of the questionnaire was assessed using a "known groups" validation method. The responses of two groups of study participants are compared: those who indicated when they were recruited for the study that they had experienced mistreatment at some time in the past, and those who said that they had never experienced abuse. Finally, positive and negative responses to experiences of specific incidents of abuse or neglect were examined together with respondents' perceptions of whether they *felt* they had been abused or neglected. Reports of experiences of abuse were not verified from independent sources.

5.4.1 Item Non-Response

Given the sensitive nature of the issue of elder abuse and neglect, it was important to examine the extent to which respondents did not answer items related to this topic. For each question about the prevalence of abuse or neglect in the past 12 months, respondents were allowed to select "refused" or "don't know." We considered both of these responses to be a "non answer."

Only 4 respondents (1.5 percent) did not answer one or more of the abuse and neglect items. This low rate of item non-response to these sensitive items may be due to the fact that many respondents volunteered to participate in the study. On the other hand, they would have been completely unaware of the detailed nature of the questions ahead of time, and virtually all of them chose to answer all the questions. Respondents in a national telephone survey who are not volunteers might be more likely to decline to answer sensitive elder abuse or neglect items. However, the favourable response to the questionnaire bodes well for a national study. Because of the small proportion of study participants who did not answer some of the questions, differences in the propensity for item non-response according to gender, age, or ethnicity could not be examined as originally proposed.

5.4.2 Time to Complete the Survey

Respondents took an average of 32.2 minutes to complete the community survey. The median at 30.0 minutes was somewhat lower than the mean, indicating that a few respondents took a very long time to complete the survey, driving up the mean. The majority of respondents (63.1%) completed in the survey in 15 to 30 minutes. Another 24.3 percent took between 31 and 45 minutes; only 7.1 percent took between 46 and 60 minutes; and 5.1 percent took more than 60 minutes. Times to complete the survey ranged from 13 minutes to 175 minutes. (See Table 5.11.)

Table 5.11 Time to Complete the Community Survey

Interview Length (Minutes)	Percent
Less than 15	0.4%
15-30	63.1%
31-45	24.3%
46-60	7.1%
More than 60	5.1%
Mean	32.2
Median	30.0
Minimum	13
Maximum	175

We examined whether different types of study participants took longer to complete the survey. Respondents who reported abuse were required to answer more questions than those who did not, so one would expect them to take longer to complete the survey. For this reason, the analysis controlled for whether a respondent experienced abuse in order to assess the multivariate relationship between survey completion times and other characteristics.

The results of a linear regression model predicting time to complete the survey are presented in Table 5.12. The coefficients can be interpreted as the average difference in minutes to complete the survey for each group. As expected, mistreatment was related to time to complete the survey. Respondents who reported mistreatment took 8 minutes longer to complete the survey than those who did not report mistreatment. Several other factors were significantly related to time to complete the survey. Depressed respondents took 13 minutes more to answer the questions than those who were not depressed. Respondents with one or more ADL limitations took 4.5 minutes longer to respond than those with no limitations. Finally, individuals who completed the instrument in French took 6.5 minutes longer to complete than those who answered in English. These coefficients could be used to estimate the likely completion times in a national survey, based on the proportions of people in each category, and thereby contribute to estimates of the costs of data collection for such a study.

Table 5.12 Linear Regression Predicting Time to Complete the Community Survey

Characteristic	Coefficient	Significance
Experienced abuse	8.098	***
Male	0.992	
Age > 75	-0.128	
High school dropout	-0.837	
Visible Minority	-0.223	
Married	-3.963	
Divorced	-3.533	
Widowed	-4.671	
Lives alone	1.145	
Depressed (CES-D > 10)	13.343	***
ADL limitation	4.502	*
Socially isolated	4.499	
Feels socially isolated	0.559	
Not Eastern Canada	-2.402	
French interview	6.439	+
Constant	26.044	***

+p<.10 *p<.05, **p<.01

5.4.3 Known Groups Validity

Construct validity is assessed by correlating responses to items in an instrument with external "gold standard" measures of the items. Because no gold standard exists for measuring elder abuse or its components, this study used a known-groups methodology to assess the construct validity of the items in the community survey. Known-groups validation involves comparing the responses of two groups known to be different according to the underlying traits of interest. The responses of older adults who were believed prior to the study to have been abused were compared with those who are thought not to have been abused. The validity of various risk factors was also examined by comparing the two groups.

5.4.3.1 Item Comparisons

Frequency distributions and chi-squared tests were used to compare the two groups on each of the 54 abuse or neglect items in the community survey. One would not expect a perfect result – that is, that the known abuse group would always answer yes to a particular item, and that the known non-abuse group would always answer no. Table 5.13 presents the results of these analyses. As the table shows, the two groups differed significantly on 20 items. In all instances, the known abuse group was more likely to respond positively to an item than the known non-abuse group. The items included two neglect items ("Someone did not provide help doing housework," "Felt experienced neglect"); eight of the nine psychological abuse items (only a positive response to "Other psychological abuse" did not

differ significantly between the groups); one physical abuse item ("Threatened with a weapon"); and seven out of ten financial abuse items ("Made give money, possessions, or property," "Tried to make give money, possessions, or property," "Taken money, possessions, or property," "Attempted to take money, possessions, or property," "Deliberately prevented access to money, possessions, or property," "Any other financial abuse, Felt experience financial abuse"). For several items, no members of either group had a positive response. The abuse items that were not significantly different between the two groups were those to which too few respondents said "yes" to detect a difference. However, in most cases, the known abuse groups responded more positively to the item even if the difference was not significant.

Table 5.13 Percent of respondents responding positively to each abuse/ neglect item, by group

Abused or Neglect Item	Known "Abused" Group (N=39)	Known "Not Abused" Group (N=228)	Chi-Square Test
Neglect			
Someone not provided help using the telephone	0.0%	0.4%	
Someone not provided help preparing meals	0.0%	0.9%	
Someone not provided help doing housework	15.4%	3.9%	*
Someone not provided help taking medication	2.6%	0.0%	
Someone not provided help eating	0.0%	0.0%	
Someone not provided help bathing or showering	0.0%	0.0%	
Someone not provided help dressing and undressing	0.0%	0.0%	
Someone not provided help taking care of appearance	2.6%	0.0%	
Someone not provided help using the toilet	0.0%	0.0%	
Someone not provided help getting in or out of bed	0.0%	0.4%	
Any other neglect	0.0%	0.9%	
Felt experienced neglect	23.1%	1.8%	***
Psychological abuse			
Repeatedly criticize	56.4%	15.8%	***
Repeatedly yelled or shouted	33.3%	11.0%	***
Repeatedly insulted	51.3%	9.6%	***
Called names or obscenities	25.6%	5.7%	***
Threatened or intimated	35.9%	6.1%	***
Repeatedly forced to do something against will	10.3%	0.9%	**
Repeatedly excluded or ignored you	48.7%	7.5%	***
Any other psychological abuse	15.4%	5.7%	*
Felt experienced psychological abuse	61.5%	18.9%	***
Physical abuse			
Restrained	2.6%	0.9%	
Handled roughly	2.6%	1.3%	
Pushed, shoved or grabbed	5.1%	2.6%	
Thrown something at	7.7%	2.2%	+
Hit or slapped	2.6%	2.6%	

Abused or Neglect Item	Known "Abused" Group (N=39)	Known "Not Abused" Group (N=228)	Chi-Square Test
Burned or scalded	0.0%	0.0%	
Pinched , scratched, or pulled hair	2.6%	1.3%	
Tried to choke you	0.0%	0.0%	
Kicked, bit, or punched	2.6%	2.6%	
Tried to hit with something	5.1%	2.2%	
Threatened with a weapon	5.1%	0.4%	+
Administered drugs that were not necessary	2.6%	0.0%	
Any other physical abuse	2.6%	0.0%	
Felt experienced physical abuse	5.1%	2.6%	
Sexual abuse			
Talked to in a sexual way against will	10.3%	3.9%	
Touched in a sexual way	2.6%	1.3%	
Tried to touch in a sexual way	2.6%	0.9%	
Made watch pornography	0.0%	0.0%	
Tried to make watch pornography	0.0%	0.4%	
Sexual intercourse against will	0.0%	0.0%	
Tried to have sexual intercourse against will	2.6%	0.4%	
Any other sexual abuse	2.6%	0.0%	
Felt experienced sexual abuse	2.6%	0.9%	
Financial abuse			
Made give money, possessions, or property	10.3%	0.4%	**
Tried to make give money, possessions, or property	12.8%	2.6%	*
Taken money, possessions, or property	15.8%	2.2%	*
Attempted to take money, possessions, or property	12.8%	3.1%	*
Taken or kept power of attorney	0.0%	0.4%	
Tried to take or keep power of attorney	0.0%	0.0%	
Deliberately prevented access to money, possessions, or property	7.7%	0.0%	**
Forced or misled to change your will or other financial document	2.6%	0.0%	
Any other financial abuse	7.7%	1.3%	*
Felt experienced financial abuse	20.5%	1.8%	***

*** p < .001 ** p < .01 * p < .05 + p <.10

5.4.3.2 Importance of Significant Abuse and Neglect Items

The 20 items that were significant in the bivariate analysis were summed to create a score for each respondent. This score represented the number of abuse or neglect items with a positive response. The mean scores between the two groups were compared using t-tests. Respondents were included only if they had non-missing data on all 20 items used to calculate the score. Complete data were available for 97.2 percent of the known abuse group (38 respondents) and 99.6 percent of the known non-abuse group (226 respondents.) Table

5.14 shows that the known abuse group responded positively to an average of 4.5 items, whereas the known non-abuse group responded positively on average to only one item. This difference was statistically significant ($p < .0001$). The differences in the responses suggest that the 20 most important items clearly distinguish between the two groups.

Table 5.14 Mean Number of Abuse or Neglect Items, by Group

Score	Known "Abused" Group (N=39)	Known "Not Abused" Group (N=228)	t-test
Mean number of items	4.6	1.0	***

*** p < .001 ** p < .01 * p < .05 + p <.10

5.4.3.3 Internal Consistency

Internal consistency is the extent to which several items measure the same construct (e.g., "psychological abuse"). If internal consistency is low, this indicates that the items measure several different constructs (e.g., psychological abuse versus physical abuse). Internal consistency of the community survey was assessed using the 20 items that differed significantly between the two groups. The analysis was performed only for psychological and financial abuse, since for these two categories three or more items differed significantly between the groups. The high Cronbach's alpha of .85 for psychological abuse suggests that the items do measure a homogenous construct of psychological abuse. A similarly high Cronbach's alpha of .80 for financial abuse also suggests high internal consistency for the financial abuse items.

5.4.3.4 Discriminant Function Analysis of Abuse and Neglect Items

We sought to determine whether the number of abuse items in the survey instrument could be reduced to make it more efficient. A stepwise discriminant function analysis was used to determine whether a smaller set of abuse or neglect items could efficiently predict group membership (abused persons versus not abused). If two or more items contribute overlapping information, then one could be deleted from the survey instrument. The 20 items on which the groups differed significantly in the bivariate analysis were entered into the model. Five items emerged as the most important predictors of group membership. These items included one from the neglect category; two from the psychological abuse category; and two from the questions on financial abuse. The items are: "Felt experienced neglect," "Repeatedly insulted," "Threatened or intimidated," "Deliberately prevented access

to money, possessions, or property," and "Attempted to take money, possessions, or property.

The discriminant function analysis also revealed information about the weight of each item in determining group membership. The standardized discriminant function coefficients for each item may be interpreted as standardized regression coefficients. The lower panel of Table 5.15 shows the discriminant function coefficients for each of the five significant items. Four of the five items discriminated equally strongly between the two groups. The only item that was weak was "Attempted to take money, possessions, or property." This is not surprising given that the model already included "Deliberately prevented access to money, possessions, or property." However, as explained below, reliance on these five items alone misses many cases of abuse. Given that elder abuse is relatively rare and that most victims experience only one indicator of abuse, it is necessary to include a comprehensive set of abuse items in the survey instrument.

Table 5.15 Discriminant Function Analysis

	Known "Abused" Group v. Known "Not Abused" Group
Cannonical Correlation	.558
Wilks' Lambda	.688
F	23.6
DF	5
p-value	p < .0001
Standardized Discriminant Function Coefficients	
Felt experienced neglect	.550
Repeatedly insulted	.535
Deliberately prevented access to money, possessions, or property	.522
Threatened or intimated	.430
Attempted to take money, possessions, or property	-.115

The discriminant function analysis classified 85.0 percent of respondents correctly. This percentage included 43.6 percent of those known to have been abused (17 respondents) and 96.5 percent (220) of those known not to have been abused (220). Only 8 (3.5 percent) of respondents were incorrectly classified as having experienced abuse or neglect when they had not. Of the 39 people reportedly experiencing abuse or neglect, 22 (56.4 percent) were misclassified as not having experienced abuse or neglect. These results suggest that false negatives were more likely to occur than false positives. That is, based on the five items, one would be more likely to miss cases of abuse or neglect than to falsely classify respondents who were not abused as having been abused or neglected. (See Table 5.16.)

Table 5.16 Classification Results for Five Variable Discriminant Function Model

Actual Group Membership	Total	Predicted Group Membership			
		Not abused		Abused	
		Number	Percent	Number	Percent
Known "not abuse" group	228	220	96.5	8	3.5
Known "abused" group	39	22	46.4	17	43.6

In a second discriminant function analysis not reported here, included all 20 of the items that were significant in the bivariate comparison. The discriminant function analysis classified 89.7 percent of cases correctly, only slightly higher than the five-variable model. Moreover, the percentage of known abuse cases misclassified as not abused was similar to that in the five-variable model. The addition of 15 additional items does not seem to reduce the rate of false negatives.

One possible explanation for this failure to correctly classify persons who claimed during recruitment to have experienced abuse may be related to the reference period for the mistreatment items in the survey. Whereas questions about abuse focused on the past 12 months, the question about mistreatment asked at the time of recruitment did not specify a time frame because of a life course approach. *Among the 24 respondents in the known abuse group who were misclassified as not abused, all but one (95.8%) reported in the survey that they were abused at some point prior to the past 12 months.* The reason that the abuse items do not capture more cases of abuse appears to be that some study participants were abused earlier in life, but not in the last 12 months. We expect that if known group status was ascertained for only the past 12 months, the rate of false negatives would be reduced.

5.4.3.5 Subgroup Analysis

We also examined whether the instrument was valid for subgroups of respondents defined on the basis of gender, ethnicity, level of education, and marital status. We compared the mean scores (number of items with positive responses) between the two groups separately for males and females, White and visible minorities, high school dropouts and graduates, and married and not married persons. Table 5.17 shows that respondents in the known abuse group responded positively to more items on average than those not abused across the three comparisons. These included gender, education level, and marital status. There were too few French respondents in the known abuse group to conduct this analysis for French and non-French speakers. Visible minorities were excluded from this analysis because there were two few of them in any one category. [20]

[20] Visible minorities included 4 First Nations, 4 Blacks, 4 "other," 3 Metis, 2 South Asians, 1 Chinese, 1 Southeast Asian, 1 Japanese, and 1 Arab.

Table 5.17 Mean Number of Abuse or Neglect Items, by Group and Subgroup

Subgroup	Known "Abused" Group (N=39)	Known "Not Abused" Group (N=228)	t-test
Gender			
Male	4.4	1.1	+
Female	4.7	1.0	***
Education			
High school dropout	5.6	0.4	***
High school diploma or higher	4.2	1.0	**
Marital Status			
Married	4.1	0.9	**
Not married	5.0	1.1	***

*** p < .001 ** p < .01 * p < .05 + p <.10

5.4.3.6 Summary of Known Groups Validation

The results provide evidence of the construct validity of the community survey. Taken individually, 20 of the 54 abuse or neglect items were significantly associated with group membership. For these items, respondents in the known abuse group were more likely to respond positively than those in the known non-abuse group. Moreover, there was a significant difference in the number of items to which each of the two groups responded positively. Respondents in the known abuse group responded positively to 3.5 times more items than those in the known non-abuse group. Results of a multivariate discriminant analysis indicated that six items correctly classify 88.4 percent of respondents into the two groups. Use of only these six items resulted in missing a modest percentage of abuse or neglect cases. All of these respondents except one, however, had experienced abuse or neglect at an earlier life stage as opposed to the last twelve months and were consequently misclassified as not having experienced abuse.

The items on which the two groups differed and those that most efficiently predicted group membership included items on neglect, psychological abuse, and financial abuse. There were two few instances of many items of physical abuse and sexual abuse to be able to reliably analyze the differences in responses to these two categories of abuse. The small frequency of responses to many of these individual items does not necessarily imply that these items should be deleted from the community survey. Rather, it suggests that these items are less common among the participants in this study but could elicit more responses in a larger sample of participants.

One limitation to this analysis is that the type of abuse experienced by the known abuse group was not ascertained a priori. Cases of abuse and neglect reported to and verified by social service agencies would be a better indicator of group membership.

5.5 Perceptions of Abuse

It is possible to gain some insight into over and under estimation by comparing respondents' answers to questions about whether they experienced specific categories of abuse with their answers to the questions about whether they felt they were abused.

Respondents who experienced one or more forms of abuse did not always feel that they were abused. The extent to which abusive incidents were perceived as abusive varied according to the category of abuse. Respondents who were psychologically abused were more likely than those who experienced any other type of abuse or neglect to feel that they had been abused. Among the 99 individuals who experienced specific items of psychological abuse, nearly two-thirds (64%) also felt that they had been abused; 36 percent did not feel that they experienced psychological abuse. For all other types of abuse or neglect, less than 50 percent of respondents who experienced abuse also felt that they had been abused. The percentages of individuals who experienced abuse and felt they were abused were 42 percent for financial abuse, 34 percent for physical abuse, 22 percent for neglect, and 11 percent for sexual abuse. Individuals who experienced sexual abuse were least likely than any other type of abuse to feel that they had experienced abuse.

This discrepancy points to the necessity of understanding why respondents did not feel abused when their answers suggested that they had been abused. The instrument asked for descriptions of what happened when respondents stated that they had been abused, but did not ask for explanations when respondents said yes to an individual item but did not consider it to be an instance of abuse. We are recommending that such an item be included in any national study. In contrast, for each type of abuse, few respondents who felt abused failed to check one or more of the individual experiences. This suggests that the survey instrument is fairly comprehensive in capturing experiences that could be viewed as abusive or neglectful.

A similar set of analyses not reported here for each specific abuse and neglect item experienced together with whether a respondent felt mistreated followed similar patterns (see report 3: DMEA Research Team, 2011a). Within each broad category of abuse or neglect, some items or experiences were more likely to be perceived as abusive or neglectful than others. In the category of psychological abuse, for example, all respondents who said that they were forced to do something against their will felt that they were abused.

5.5.1 Perception of Abuse by the Number of Different Types and Frequency of Abuse

In the previous section, we showed that respondents who experienced some form of mistreatment did not always feel that they had been abused or neglected. In the sections that follow, we considered several possible explanations for this finding.

One possible explanation is that mistreatment was more likely to be perceived as such if it occurred in the context of a variety of other types of abuse. To explore this

possibility, we calculated the percentage of respondents who felt they experienced abuse separately for those who experienced only one example in a category of abuse and for those who experienced two or more examples of abuse. The number of examples of abuse or neglect in a particular category was correlated with feeling abused for each type of mistreatment. Among respondents who experienced one type of neglect, 16.7 percent felt they had been neglected; among those who experienced two or more types of neglect, 33.3 percent felt neglected. Among respondents who experienced one type of psychological abuse, 35.7 percent said they had been psychologically abused compared to 86.0 percent of those who had experienced two or more types of psychological abuse. For physical abuse, the effect of the number of different types of abuse was less strong: among those who experienced one type of physical abuse, 30 percent said they felt abused compared to 40 percent of those who experienced two or more types. The percentages for sexual abuse were 7.1 and 25, respectively and 26 and 63 for financial abuse. In sum, respondents were more likely to feel abused/neglected when they experienced a greater variety of types of mistreatment.

Another possible potential explanation why respondents who experienced abuse/neglect did not always feel mistreated is that mistreatment was more likely to be perceived as such if it occurred frequently than if it occurred infrequently. That is, respondents who experienced abuse but who did not feel mistreated may have experienced abuse infrequently. To explore this possibility, we calculated the percentage of respondents who felt they experienced abuse separately for those who experienced abuse once or a few times and those who experienced abuse many times or every day/almost every day. We did this for each type of abuse separately.

For each type of mistreatment except sexual abuse, the percentage of respondents who said they felt they had been abused was higher among those who experienced abuse many times or every day/almost every day than among those who experienced abuse once or a few times. Among respondents who experienced neglect one time or a few times, the percentage saying they felt they had been neglected was 10.0 percent; among those who experienced neglect many times or everyday/almost every day, 37.5 percent said they felt neglected.

A similar pattern was observed for psychological abuse. Among respondents who experienced psychological abuse one time or a few times, the percentage saying they felt they had been psychologically abused was 44.7 percent; among those who experienced psychological abuse many times or everyday/almost every day, 82.0 percent said they felt psychologically abused.

Among respondents who experienced physical abuse one time or a few times, the percentage saying they felt they had been physically abused was 36.8 percent; among those who experienced physical abuse many times or every day/almost every day, 50.0 percent said they felt physically abused. Among respondents who experienced sexual abuse once or a few times, 11.8 percent felt sexually abused; the other 88.2 percent did not feel sexually

abused. The one individual who experienced sexual abuse many times or every day did not feel sexually abused. These numbers, however, are too small for conclusions.

Among respondents who experienced financial abuse one time or a few times, the percentage saying they felt they had been financially abused was 20.0 percent; among those who experienced financial abuse many times or everyday/almost every day, 81.8 percent said they felt financially abused. In sum, the results of this analysis suggest that the frequency of mistreatment is an important dimension of mistreatment. Estimates of abuse/neglect that do not take into account the frequency are likely to overestimate the prevalence of mistreatment.

5.6 Validation of Risk Factors for Elder Abuse and Neglect

The risk factors for elder abuse and neglect were tested for validity using data from the survey of older adults in the community. Risk factors were identified from previous research on elder abuse and neglect. Surprisingly, a life course perspective had not been applied to the study of elder abuse and neglect. This analysis also considered the role played by experiences of mistreatment earlier in life in the aetiology of abuse and neglect in older adulthood.

Several alternative definitions and measures of abuse and neglect and their relationship to risk factors were considered. This was important because prior research suggested that risk factors for abuse and neglect varied according to how mistreatment was measured. These included: (1) whether a respondent experienced any abuse or neglect, (2) the frequency of abuse, and (3) the number of different types of abuse. Where possible, risk factors for different types of abuse were considered separately. Appendix D provides the coding of the definitions for risk factors for all variables used in the analysis.

Due to the dichotomous nature of the primary dependent variable of experienced abuse in the past 12 months, logistic regression analysis was used. The odds ratios from the logistic regression models give the odds of experiencing abuse/neglect for respondents who had a specific risk factor relative to those who did not. Two different logistic regression models were used to evaluate the influence of the various risk factors. The first logistic regression model, referred to as Model 1, included each risk factor individually (i.e., no other risk factors were included). The odds ratios from this model give the bivariate relationship between each risk factor and experiencing abuse or neglect in the past 12 months. The second model, Model 2, included all of the risk factors simultaneously. The odds ratios from Model 2 give the relationship between each risk factor and abuse controlling for all of the other risk factors. In other words, the odds ratios represent the net or independent effect of each risk factor on abuse.

Because the other outcome variables (e.g., frequency of abuse, number of different types of abuse, and perception of abuse) were polytomous, multinomial logistic regression analysis was used to examine the influence of each risk factor. Multinomial logistic regression is

appropriate when the dependent variable has more than two unordered categories.[21] In multinomial logistic regression, one category of the dependent variable is chosen as the "reference category." The odds ratios differ for each response paired with the reference category. The odds ratio for each risk factor represents the odds of that response relative to the reference category. In all of the multinomial logistic regressions presented in this chapter, the refer category is always no abuse. For example, in the multinomial logistic model predicting the frequency of abuse, odds ratios are produced for two contrasts: once or a few times compared to no abuse and many times or every day compared to no abuse. The odds ratio for the first contrast gives the odds of being in the once/a few times category relative to no abuse; for the second contrast it represents the odds of being in the many times/everyday category relative to no abuse.

5.6.1 Predicting the Risk of Abuse

Table 5.18 gives the odds ratios, 95 percent confidence intervals for the odds ratios, and p-values for the models predicting abuse. Model 1 includes each potential risk factor individually. Several of the variables were significantly related to experiencing abuse. Non-white individuals were more likely to experience abuse than are White individuals (OR=4.24, p=.006). Being non-white was associated with a nearly five-fold increase in the odds of experiencing abuse. Having one or more ADL or IADL limitations was also related to abuse (OR=2.31, p=.001). Specifically, individuals with one or more ADL or IADL limitations were more than twice as likely to experience abuse compared to those with no such limitations. Depression was also strongly associated with abuse (OR=5.72, p=.000). The odds of abuse for individuals who were depressed (a score of 10 or greater on the CES-D) were more than four times higher than for those who were not depressed. Having experienced abuse in all three life stages (childhood, young adulthood, and adulthood) was associated with a heightened risk of abuse as an older adult. For each life stage, abuse increased the odds of abuse in older adulthood by a factor of 2 to 3.

Model 2 included all of the potential risk factors simultaneously. As can be seen, the results were largely unchanged. Non-white respondents were still more likely to be abused (OR=4.66, p=.011). The odds ratios for having one or more ADL or IADL limitation was still significant (OR=2.19, p=.012). Depression was still a strong risk factor for abuse (OR=3.55, p=.006). However, when abuse during all three life stages was considered simultaneously, only a history of abuse during childhood retained its importance (OR=1.81, p=.046).

Table 5.18 Odds Ratios, 95 percent confidence intervals, and p-values from logistic regression models predicting abuse

	Model 1 (Unadjusted)				Model 2 (Adjusted)			
Characteristic	OR	95% CI		p	OR	95% CI		p
Age > 75	.73	0.36	1.50		.88	0.38	2.05	
Female (v. male)	.99	0.56	1.75		.65	0.32	1.30	
Non-white (v. white)	4.24	1.50	11.93	**	4.66	1.43	15.21	*
Less than high school	1.48	0.61	3.55		1.04	0.33	3.23	
Married	.65	0.40	1.07		.93	0.26	3.29	
Divorced or separated	1.30	0.69	2.45		.70	0.23	2.14	
Widowed	1.54	0.71	3.33		1.71	0.53	5.53	
Lives alone (v. lives with others)	1.45	0.88	2.40		1.06	0.39	2.90	
Socially isolated	2.03	0.94	4.37		.89	0.32	2.45	
Feels socially isolated	1.66	0.97	2.85		1.05	0.52	2.10	
ADL/IADL needs	2.31	1.39	3.83	**	2.19	1.19	4.04	*
Depressed (CES-D ≥ 10)	5.72	2.63	12.46	**	3.55	1.44	8.72	**
Abused in childhood	2.94	1.76	4.89	**	1.81	1.01	3.26	*
Abused in young adulthood	2.79	1.65	4.71	**	1.92	0.97	3.81	
Abused in adulthood	2.30	1.40	3.78	**	1.39	0.71	2.73	
Other region	1.26	0.73	2.20		1.08	0.56	2.08	
French language interview	.31	0.13	0.74	**	.24	0.08	0.68	**

*p<.05, **p<.01

Table 5.19 presents the results from the multinomial logistic regression models predicting the frequency of abuse. The odds ratios for the first model represent the odds of experiencing abuse once or a few times relative to not experiencing abuse. The odds ratios for the second model give the odds of experiencing abuse many times or every day/almost every day compared to no abuse. Only results from a full model (including all potential risk factors simultaneously) are presented. Non-white race is strongly associated with being abused once or a few times but not with being abused many times or every day/almost every day. Having at least one ADL/IADL limitation was unrelated to being abused once or a few times but significantly associated with being abused many times or every day/almost every day. Depression was significantly related to both being abused once or a few times as well as many times or every day/almost every day. The odds ratio for many times/everyday was twice as large as the odds ratio for once or a few times. Finally, abuse during childhood significantly increased the odds of abuse in older adulthood but not the frequency.

Table 5.19 Odds Ratios, 95 percent confidence intervals, and p-values from multinomial logistic regression models predicting the frequency of abuse

	One or a few times (v. not abused)				Many times or everyday (v. not abused)			
Characteristic	OR	95% CI		p	OR	95% CI		p
Age > 75	1.08	.405	2.887		0.52	0.14	1.87	
Female (v. male)	0.73	.319	1.671		0.57	0.22	1.46	
Non-white (v. white)	5.56	1.535	20.111	**	2.83	0.64	12.58	
Less than high school	0.98	.261	3.717		1.03	0.26	4.10	
Married	1.05	.231	4.757		0.46	0.10	2.18	
Divorced or separated	0.64	.168	2.436		0.54	0.14	2.17	
Widowed	1.86	.475	7.258		1.45	0.33	6.35	
Lives alone (v. lives with others)	1.15	.335	3.964		0.65	0.19	2.22	
Socially isolated	0.59	.167	2.091		0.92	0.28	2.99	
Feels socially isolated	0.93	.403	2.123		1.03	0.44	2.42	
ADL/IADL needs	1.33	.642	2.771		4.36**	1.98	9.61	**
Depressed (CES-D ≥ 10)	2.90	1.013	8.310	*	4.86**	1.74	13.63	**
Abused in childhood	2.18	1.083	4.371	*	1.61	0.72	3.63	
Abused in young adulthood	1.52	.665	3.462		2.35	0.97	5.71	
Abused in adulthood	1.28	.572	2.869		1.81	0.75	4.36	
Other region	0.99	.456	2.155		1.40	0.60	3.24	
French language interview	0.23	.058	.889	*	0.29	0.07	1.11	

*p<.05, **p<.01

Table 5.20 presents the results from the multinomial logistic regression models predicting the number of different types of abuse. The odds ratios for the first model represent the odds of experiencing only one type of abuse relative to not experiencing abuse. The odds ratios for the second model give the odds of experiencing two or more types of abuse compared to no abuse. Only results from a full model (including all potential risk factors simultaneously) are presented.

Non-white ethnic background increased the risk of experiencing one type of abuse relative to no abuse but was unrelated to experiencing two or more types of abuse compared to no abuse. Having one or more ADL/AIDL needs was unrelated to experiencing one type of abuse but significantly predicted two or more types of abuse. A similar pattern was observed for depression. Depression was unrelated to experiencing one type of abuse but significantly predicted two or more types of abuse.

Table 5.20 Odds Ratios, 95 percent confidence intervals, and p-values from multinomial logistic regression models predicting the number of different types of abuse

	One type of abuse (v. not abused)				Two or more types of abuse (v. not abused)			
Characteristic	**OR**	**95% CI**		**p**	**OR**	**95% CI**		**p**
Age > 75	1.07	0.45	2.54		0.23	0.02	2.09	
Female (v. male)	0.73	0.35	1.52		0.76	0.25	2.33	
Non-white (v. white)	5.29	1.63	17.24	**	2.88	0.52	16.07	
Less than high school	0.97	0.29	3.22		1.33	0.30	5.98	
Married	0.90	0.24	3.35		0.99	0.15	6.43	
Divorced or separated	0.80	0.25	2.55		0.46	0.09	2.46	
Widowed	1.69	0.51	5.61		1.12	0.16	7.63	
Lives alone (v. lives with others)	1.03	0.36	2.94		1.28	0.29	5.67	
Socially isolated	0.85	0.29	2.48		1.37	0.38	5.00	
Feels socially isolated	1.04	0.50	2.16		1.38	0.52	3.68	
ADL/IADL needs	1.63	0.86	3.11		3.64	1.41	9.36	**
Depressed (CES-D ≥ 10)	2.24	0.87	5.74		5.81	1.92	17.62	**
Abused in childhood	1.57	0.85	2.90		2.98	0.97	9.20	
Abused in young adulthood	1.94	0.94	4.00		1.40	0.48	4.10	
Abused in adulthood	1.19	0.58	2.43		2.09	0.71	6.19	
Other region	1.18	0.59	2.34		1.06	0.38	2.98	
French language interview	0.38	0.14	1.06		--	--	--	--

*p<.05, **p<.01

Note: Odds ratio for French language interview could not be estimated because no French respondent experienced two or more types of abuse.

One important question was whether risk factors identified for abuse and neglect differed according to the type of abuse. The sample size/number of respondents who experienced abuse or neglect was too small to model the relationship between risk factors and specific types of abuse in a multivariate fashion. Such an analysis would risk overfitting the models. Instead, the bivariate relationship between each risk factor and each type of abuse and neglect were examined using chi-square tests. Respondents who experienced each type of abuse were compared to those who did not experience any abuse. For example, individuals who did not experience neglect but who experienced psychological abuse are not included in the comparison group for neglect. Only individuals who did not experience any abuse were included in the comparison group. Including abused individuals in the comparison group could wash out the relationship between risk factors and abuse. As seen in Table 5.21, only a few potential risk factors were unrelated to any categories of abuse and neglect, namely, education, and divorced, separated or widowed.

Table 5.21 Relationship between risk factors and each of five types of abuse and neglect

Characteristic	Not abused	Neglect	Psychological	Physical	Sexual	Financial
Age > 75	15.8%	9.1%	12.1%	0.0%*	5.6%	3.8%
Female (v. male)	76.7%	91.7%	78.8%	52.2%*	83.3%	73.1%
Non-white (v. white)	3.4%	16.7%	13.1%**	8.7%	22.2%**	7.7%
Less than high school	6.9%	8.3%	9.2%	13.0%	11.1%	19.2%
Married	63.0%	83.3%	53.5%	52.2%	27.8%**	34.6%**
Divorced or separated	15.8%	8.3%	23.2%	26.1%	22.2%	26.9%
Widowed	9.6%	0.0%	13.1%	4.3%	11.1%	19.2%
Lives alone (v. lives with others)	32.9%	16.7%	39.4%	34.8%	55.6%	57.7%*
Socially isolated	8.5%	33.3%*	15.5%*	17.4%	38.9%**	26.9%*
Feels socially isolated	23.4%	41.7%	37.8%*	45.5%*	58.8%**	40.0%
ADL/IADL needs	30.1%	100.0%**	51.5%**	52.2%*	50.0%	65.4%**
Depressed (CES-D ≥ 10)	7.1%	33.3%*	30.6%**	39.1%**	38.9%**	52.0%**
Abused in childhood	43.1%	91.7%**	68.0%**	90.0%*	83.3%**	76.0%**
Abused in young adulthood	24.0%	33.3%	44.4%**	69.6%*	77.8%**	53.8%**
Abused in adulthood	33.8%	66.7%*	58.6%**	69.6%*	61.1%*	65.4%**
Other region	23.3%	25.0%	31.3%	21.7%	27.8%	23.1%
French language interview	16.4%	8.3%	5.1%**	0.0%*	0.0%	3.8%

*p<.05, **p<.01

Note: Chi-square test is used except were cell sizes are less than 5. In these cases, Fisher's exact test was used.

To summarize, risk factors for abuse and neglect varied according to how abuse and neglect were measured. Some risk factors were related only to infrequent and isolated abuse experiences but not to frequent and widespread abuse. The findings with regard to ethnicity are noteworthy. Non-white ethnic background was a significant risk factor for experiencing less frequent abuse and one type of abuse but not for more frequent abuse and multiple types of abuse. Other risk factors were related to frequent and multiple abuse but not to less frequent abuse. For example, while it emerged as important in the pooled models, having an ADL/IADL limitation was unrelated to experiencing abuse infrequently or to experiencing only one type of abuse. However, limitations were strongly associated with frequent abuse and abuse in multiple domains. Depression predicted both infrequent and frequent abuse but did not predict experiencing only one type of abuse. Depression was only a risk factor for experiencing multiple types of abuse.

These findings suggested that different findings of prior studies with regard to the importance of specific risk factors may be due to differing ways of measuring abuse. It also underscores the importance of considering varying dimensions of abuse and neglect, such as the frequency and seriousness. In sum, several factors emerged as potentially important for

abuse and neglect in this study of older adults in Canada: non-white ethnicity, having one or more ADL/IADL limitations, depression, and experiencing abuse in childhood were all significant risk factors for abuse and neglect.

Nevertheless, it is important to note that the conclusions have to be interpreted with some care because of limitations such as questions about casual ordering, the use of a small sample size and the fact that elder mistreatment is a rare event and, finally, that the sample was not representative of the population.

6.0 SUMMARY AND CONCLUSIONS

This study examined the validity of items in two survey instruments designed to measure the prevalence of elder abuse and neglect among Canadians living in the community and in institutions, and related risk factors for abuse. The community survey was administered over the telephone; the institutional survey was conducted in person. The instrument was drafted and reviewed in a series of steps that included a thorough review of the literature, a consensus panel to develop definitions, focus groups, cognitive interviews, dyadic interviews, and, finally large-scale pretesting. A thorough analysis of the instrument was conducted to examine its suitability for use in a national study. This section summarizes the results and recommends several small changes to the instruments.

6.1 Validation of the Survey Instrument

Of the 267 respondents living in the community who responded to the telephone interview, 122 or 46 percent indicated that they experienced abuse or neglect in the past 12 months. Among respondents who indicated that they had been abused or neglected, the majority (85 or 69%) had experienced only one type of mistreatment. Of the 54 abuse or neglect items, 30 items elicited fewer than 5 positive responses, including 8 items with no positive responses. The dispersion of responses across the items implies that it is important to include a comprehensive list of mistreatment items in the survey instrument to measure prevalence. Since many older adults responded positively to only one abuse or neglect item, dropping too many items could result in missing cases of abuse or neglect. Few older adults among the 32 institutional interviews had experienced abuse, so a similar item analysis could not be conducted.

6.2 Response Differences between the two "Known" Groups

This research used a "known groups" validation design, comparing responses of older adults in the community who alleged during recruitment that they had experienced abuse to others who claimed no history of abuse. If the instrument measured abuse accurately, the "known abuse" group should respond more positively than the others to

questions regarding experiences of abuse or neglect. Respondents in the "known abuse" group were more likely to respond positively to 20 out of the 25 specific types of abuse that respondents mentioned most frequently than were members of the "known non-abuse" group. Thus, the questions in the survey instrument were able to differentiate between the two groups. Moreover, respondents in the "known abuse" group responded positively to 3.5 times more items than those in the known "non-abuse' group (4.6 items versus 1 item, respectively). These results provide strong evidence that the items in the survey instrument were able to differentiate between older adults who had been abused and those who had not been abused.

6.3 Length of the Instrument

We examined whether it was necessary to include all of the abuse items in the survey instrument or whether the number of items could be reduced. A stepwise discriminant function analysis was used to determine whether a reduced list of abuse items could differentiate the abuse group from the non-abuse group. The results suggested that the various abuse items contributed unique information and should be kept in the survey instrument. Discriminant function analyses that included reduced lists of abuse items misclassified about half of known abuse group cases as not having experienced abuse or neglect. In contrast, 35 of 39 (90%) "known abuse" group members said "yes" to one or several of the abuse items. The other four said that they had not experienced abuse in the past 12 months but had at some point earlier in life. In other words, all of the "known abuse" group members responded positively to items about abuse in the survey instrument. This result suggested that eliminating abuse items from the survey instrument would result in missing cases of abuse. Since elder abuse is relatively rare, and elderly victims may experience only a few indicators of abuse or neglect, it is indicated that a comprehensive list of items is necessary to measure prevalence.

6.4 Respondent Burden

Even with 54 mistreatment items, the survey instrument posed only a small respondent burden, especially for respondents who had not experienced abuse or neglect. On average, it took 32 minutes for respondents to answer all of the questions. Respondents who experienced abuse or neglect took only 8 minutes longer to complete the survey than those who did not. The time difference was due to skip patterns that asked abused respondents to answer additional questions about their experiences. The results suggest that the survey instrument is manageable for a national survey designed to estimate the prevalence of elder abuse and neglect.

The results of the analysis of the time to complete the survey can be used to obtain a more accurate estimate of the likely respondent burden in a national prevalence study. Respondents who were depressed and had one or more ADL limitations took more time to complete the survey (13 and 5 minutes more, respectively). A more accurate estimate of the respondent burden in a national prevalence study could be determined by looking at the distribution of these characteristics in the population of older adults.

6.5 Subgroups

The survey instrument worked well for important subgroups that we were able to include in the analysis. We examined the validity of the instrument for respondent subgroups using the "known groups" methodology. We explored whether the finding that the "known abuse" group responded more positively to the abuse and neglect items held for several subgroups. Respondents in the "known abuse" group answered yes to significantly more items on abuse or neglect than those in the "non-abuse" group regardless of gender, education level, or marital status. This result suggested that the questions in the survey instrument were able to differentiate been older adults who had been abused and those who had not equally well for older men and women, high school dropouts and graduates, and married and single people.

6.6 Experiencing Abuse and Feeling Abused

During cognitive testing of the survey instrument, some respondents noted that although they said "yes" to one or several items of abuse, they did not *feel* they experienced abuse. Because of this finding, we included a summary question that addressed this issue in the telephone interviews. Respondents were given a definition for each type of abuse. If respondents said "yes" to any abuse item, they were asked if they *felt* they had experienced that particular type of abuse (e.g. physical abuse). To further understand how they felt, we asked them to describe their experiences. While 122 (46 %) of respondents said "yes" to one or several abuse items, only two-thirds of them (78) felt they had been "abused." In classifying a series of events as abuse, it is important and relevant to take account of respondents' own perceptions and descriptions of the situation. Whether such individuals should be counted as abused is beyond the scope of this study. By including objective items as well as respondents' interpretations of events, there can be more sensitive and accurate estimates of prevalence. It may be necessary to make qualitative judgments about whether a specific case constitutes abuse. This is an important and unique contribution to the measurement of elder abuse prevalence. Given the relatively small proportion number of older adults who generally responded positively to one or more abuse items, a qualitative assessment would be a manageable task, even in the context of a national prevalence study.

6.7 Evaluating Risk Factors

This study also sought to validate risk factors for elder abuse and neglect. Potential risk factors were identified from prior studies. Logistic regression analysis was used to determine which risk factors were associated with abuse and neglect. Four risk factors emerged from the analysis: visible minority status, having one or more ADL/IADL impairments, depression (defined as having a modified CES-D score of 10 or higher), and having experienced abuse during childhood. In contrast to earlier studies, we found no relationship to abuse for those advanced in age (75 and older) or women. This study did not include a measure of mental status, such as dementia, which prior studies suggest may be a risk factor for abuse and neglect. At a minimum, questions tapping these four risk factors should be included in studies of elder abuse and neglect if risk factors are important to the study.

Results suggest that a life course perspective provides a useful framework for understanding elder abuse and neglect. Results suggested that a childhood history of abuse had a deciding influence on later mistreatment, over and above what happens later in life. For many older adults, abuse and neglect may be part of a continuing pattern of mistreatment that begins very early in life. However, early experiences with abuse are by no means deterministic of subsequent mistreatment; risk factors measured later in life, such as ADL/IADL impairments and depression, also predict abuse and neglect and may serve as potential points for intervention. Such preliminary findings could be confirmed in a national study.

6.8 Recommendations for the Survey Instruments

The results of this analysis provided strong evidence of the suitability of the survey instrument for measuring elder abuse and neglect among people living in the community. A few recommendations for changes to the survey instrument emerged from the analysis. If the instrument needs to be shortened, two physical abuse items—someone tried to choke you and someone burned or scalded you— could be dropped from the instrument since no one responded positively to these items. Although the survey instrument included several other items to which no one responded positively, these two items were less central to the construct of physical abuse.

Some questions about the characteristics of the alleged abuser could be omitted from the survey instrument. Respondents who indicated abuse were asked whether the abuser had lived with them at the time, had a drug or alcohol problem, or had a mental health problem. Respondents who replied positively to items of financial abuse were asked whether the abuser had a gambling problem. Rates of item non-response ("don't know") were very high (on the order of 25 percent) for all of these questions. For this reason, we feel that that the

items that ask about drug/alcohol problems, mental health problems, and gambling problems are candidates for omission if the survey needs to be shortened.

Respondents who said "yes" to one or several abuse items should be asked to expand on what happened. During the telephone interviews, respondents who felt they had experienced abuse were asked to describe the circumstances that led to their feelings, but those who answered yes to individual items but said no to feeling abused were not asked the explanatory follow-up questions. This discrepancy leaves a puzzling contrast between experiences and feelings. Therefore, we recommend that these respondents be asked to expand on what happened to help in the qualitative assessments of their experiences. With these modifications, the survey instrument can be incorporated into a national prevalence study of elder abuse and neglect in Canada.

6.9 Overall Recommendations

The team, according to its mandate and based on the pilot project recommends the following:

(1) That the survey instrument is accurate in predicting mistreatment in the community with some adjustments as noted above;
(2) That evaluative coding with decision rules be used to reconcile the difference between what older adults experience and feel about mistreatment;
(3) That the instrument when applied to those in institutions in face-to-face interviews distinguishes between those who are a mistreated and those who are not although more research is required;
(4) The ethical standards used in the pilot study followed the Tri Council policy statements for the Canadian Institutes of Health Research, the Natural Sciences and Engineering Research and Council of Canada, and the Social Sciences and Humanities Research Council of Canada and would be appropriate for further studies;
(5) The definitions and the measurement instruments (survey) will be made available when/if a national prevalence study is completed to those who request the instruments through the National Initiative for the Care of the Elderly, if deemed appropriate by the research team.

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APPENDIX A

National Estimates of Prevalence of Mistreatment in the Community, Selected Countries

Characteristic	Canada 1989 [Podnieks et al., 1989]	Canada 1999 [Pottie-Bunge, 2000]	Germany, Greece, Italy, Lithuania, Portugal, Spain, and Sweden. 2008/09 Soares et al., 2010	India (Chennai) 2001 [Chokkanathan & Lee, 2005]	Israel 2003/04 [Lowenstein et al. 2009]	Netherlands (Amsterdam) (1994/95) [Comijs et al., 1998]
Unit of Analysis	Individual men and women	Individual men and women	Individual men and women	Individual men and women	Individual men and women	Individual men and women
N	(2,008)	(4,324)	(4,451)	(400)	(1,045)	(1,797)
Age	65 and older	65 and older	60–84	65 and older	65 and older	5-year strata, age 65 and older
Prevalence Period	Past year	5 years (respondents were asked about the past 5 years)	12 months	12 months	12 months (abuse), 3 months (neglect)	12 months
Data Collection	Telephone interviews	Telephone survey	Face-to-face interviews and self response or both	Face-to-face interviews	Face-to-face interviews	Face-to-face interviews
Overall Mistreatment	4%	**Not collected**	**Not collected**	14%	18.4% (no neglect)	5.6%

Type of Mistreatment						
Physical	.5%	1%	2.7%	4.3%	2%	1.2%
Sexual	–	**Not collected**	.7%	–	–	–
Psychological/ emotional	1.4%	7%	19.4%	10.8%	14.2%	3.2%
Financial	2.5%	1%	3.8%	5%	6.4%	1.4%
Neglect	.4%	–Not collected	Not collected	4.3%	18%	.2%
Measures	CTS, OARS, own	Own (e.g., violence by current and previous spouses is measured by a module of 10 questions that describe specific actions rather than asking a single question)	CTS2, UK study definitions of abuse used	CTS, own	CTS2, OARS, own	CTS, own
Theory Noted	None	Family violence	None	None	None	None

	Spain 2006 [Iborra; 2008]	**Spain (Girona) 2006/07 [Garre-Olmo et al., 2009]**	**United Kingdom England, Scotland, Wales, N. Ireland 2006 [O'Keeffe et al., 2007)**	**United States 2005/06 [Laumann et al. 2008]**	**United States 2008 [Acierno et al. 2010]**	**United States 1988 [Pillemer &Finkellhor; 1988]**
Characteristic						
Unit of Analysis (*N*)	Individual men and women (3,190)	Individual men and women (676)	Individual men and women (2,111)	Individual men and women (3,005)	Individual men and women (5,672)	Abused men and women (2,020)
Age	65 and older	75 and older	66 and older	57–85	60 and older	65 and older
Prevalence Period	12 months	12 months	–12 months –since age 65	12 months	12 months	12 months
Data Collection	Face-to-face interviews	Face-to-face interviews	Face-to-face interviews	Face-to-face interviews and mail-in questionnaires	Telephone interviews	Face-to-face and telephone
Overall Mistreatment	.8%	29.3%	2.6%	–	11.4%	3.2%
Type of Mistreatment						
Physical	.1%	0.1%	.4%	0.2%	1.6%	2%
Sexual	.1%	–	.2%	–	0.6%	–
Psychological/ emotional	.3%	15.2%	.4%	9%	4.6%	1.1%

Financial	.2%	4.7%	.7%	3.5%	5.2%	_
Neglect	.3%	16%	1.1%	–	5.1%	.4%
Measures	Own	AMA Screen for Various Types of Abuse or Neglect	Own	Hwalek-Sengstock Elder Abuse Screening Test; Vulnerability to Abuse Screening Scale	Own	CTS, OARS
Theory Noted	None	None	None	Several theories noted	None	None

NOTE: An Irish community prevalence study was released in November 2010 by the national Centre for the Protection of Older People in Ireland, The random sample for this study consisted of 2,021 individual men and women, aged 65 and older who participated in face-to-face interviews. In the last 12 months the sample experienced 2.2% overall abuse, 1.3% financial abuse, 1.2% psychological abuse, .5 % physical abuse, .05 sexual abuse and .3% neglect. Retrieved June 2011, from http://www.ncpop.ie/index.php?uniqueID=1

ADLs: Activities of Daily Living

CTS: Conflict Tactics Scale

OARS: Older Americans Resources and Services Program .

Own: New measure developed by researcher

Table 2: National Estimates of Prevalence of Mistreatment in the Institution, Selected Countries

Characteristic	Finland 2009 [Nurminen et al., 2009]	Germany 1999-2001 [Göergen, 2004]	Germany 2001/2002 [Göergen, 2001]	Italy 2007 [Ogioni et al., 2007]	Norway 2009 [Malmedal, Ingebrigtsen, & Saveman, 2009]	Sweden 1999 [Saveman et al., 1999]	United States (one state) 1987 [Pillemer and Moore, 1989]	United States (five states) 2008 [Ramsey-Klawsnik et al., 2008]	United States (one state) 2009 [Griffore et al., 2009]
Unit of Analysis	Patients born in 1939 or earlier in five long-term care wards in Finland N = 154)	Staff regularly doing hands-on nursing work in residential care (*n* = 81)	Staff regularly doing hands-on nursing work in residential care (*N* = 361)	Patients aged 65 or older admitted to home care programs in Italian home health agencies (*n* = 4630)	Nursing staff (*n* = 616) in 16 nursing homes in the central part of Norway	3 levels of nursing staff who saw others commit abuse; those who committed abuse themselves	3 levels of nursing staff who saw and committed abuse (*N* = 577)	Vulnerable adults ages 18 and older living in care facilities (N= 429 cases of alleged sexual abuse)	The reported abuse and neglect as perceived and reported by relatives of elderly nursing home residents (*N* = 1,002) in Michigan
Age (years)	71 and older (mean age: 84.2)	16–60; (mean age: 38)	18–64; (mean age: 41)	65 and older (mean age: 80.5)	16–74 (mean age: 40)	–	–	60–101 (mean age: 79)	65 and older
Prevalence Period	Data collected from December 20, 2004, and January 9, 2005	Past 12 months	Past 12 months	1998–2002	Past two months	Past year	Past year	Past six months	Past 12 months
Type of Interview	Data about age, drugs, and diagnoses were collected from the medical	Semi-structured face-to-face interview	Self-completed questionnaire	Face-to-face All patients in the sample were assessed by a trained staff (nurses	Self-administered questionnaire distributed by coordinator	Self-administered questionnaire distributed by manager	Telephone interview	Face-to-face investigative interviewing of alleged elder abusers; follow-up telephone	Telephone interview

	records			and/or medical doctor) used by home health agencies who recorded all the information on the MDS-HC				interviews conducted
Overall Mistreatment	**Not collected**	70.4% self-reported 76.5% witnessed	71.5% self-reported 71.2% witnessed	One or more signs of potential abuse were identified in 462 subjects (10%)	91% nursing staff witnessed at least one act of inadequate care; 87% self-reported they had committed at least one act of inadequate care	11% witnessed one incident; 2% committed abuse	–	27% substantiation rate of alleged sexual abuse of elderly residents in care facilities
Type of Mistreatment	One psychotropic medication was regularly given to 79% of the patients, and three or more psychotropics were regularly given to one in three patients and regularly or irregularly to one in two patients.	**Not collected**	**Not collected**	Signs of potential abuse were identified in 336 (9%) of 3,869 participants without behavioral symptoms and 126 (17%) of 761 with behavioral symptoms; wandering was negatively associated with potential abuse, whereas other symptoms were positively associated with this outcome (verbally	91% of the nursing staff reported that they had observed at least one act of inadequate care; inadequate care of a negligent and emotional character was most frequently reported	**Not collected**	**Not collected**	

abusive behavior, physically abusive behavior, socially inappropriate behavior, active resistance of care)

MDS-HC: Minimum Data Set for Home Care

Table 2 Con

	Finland 2009 [Nurminen et al., 2009]	**Germany 1999-2001 [Göergen, 2004]**	**Germany 2001/2002 [Göergen, 2001]**	**Italy 2007 [Ogioni et al., 2007]**	**Norway 2009 [Malmedal, Ingebrigtsen, & Saveman, 2009]**	**Sweden 1999 [Saveman et al., 1999]**	**United States (One state) 1987 [Pillemer & Moore, 1989]**	**United States (Five states) 2008 Ramsey-Klawsnik et al., 2008**	**United States (One state) 2009 Griffore et al., 2009**
Characteristic									
Unit of Analysis	Patients born in 1939 or earlier in five long-term care wards in Finland (*N* = 154)	Staff regularly doing hands-on nursing work in residential care (*N* = 81)	Staff regularly doing hands-on nursing work in residential care (*N*=361)	Patients aged 65 or older admitted to home care programs in Italian home health agencies (*N* = 4,630)	Nursing staff (*n* = 616) in 16 nursing homes in the central part of Norway	3 levels of nursing staff who saw others commit abuse; those who committed abuse themselves	3 levels of nursing staff who saw and committed abuse (*N*= 577)	Vulnerable adults ages 18 and older living in care facilities (*N*+ = 429 cases of alleged sexual abuse)	The reported abuse and neglect as perceived and reported by relatives of elderly nursing home residents (*N* = 1,002) in Michigan
Age (years)	71 and older (mean age: 84.2)	16–60 (mean age: 38)	18–64 (mean age: 41)	65 and older (mean age: 80.5)	16–74 (mean age: 40)	–	–	60–101 (mean age: 79)	65 and older
Prevalence Period	Data collected from December 20, 2004, and January 9, 2005	Past 12 months	Past 12 months	1998–2002	Past two months	Past year	Past year	Past six months	Past 12 months
Type of interview	Data about age, drugs, and diagnoses were collected	Semi-structured face-to-face interview	Self-completed questionnaire	Face-to-face All patients in the sample were assessed by a trained	Self-administered questionnaire distributed by coordinator	Self-administered questionnaire distributed by manager	Telephone interview	Face-to-face investigative interviewing of alleged elder abusers; follow-up	Telephone interview

	from the medical records			staff (nurses and/or medical doctor) used by home health agencies who recorded all the information on the MDS-HC				telephone interviews conducted
Overall Mistreatment		70.4% self-reported 76.5% witnessed	71.5% self-reported 71.2% witnessed	One or more signs of potential abuse were identified in 462 subjects (10%)	91% nursing staff witnessed at least one act of inadequate care; 87% self-reported they had committed at least one act of inadequate care	11% witnessed one incident; 2 percent committed abuse	-	27% substantiation rate of alleged sexual abuse of elderly residents in care facilities
Type of Mistreatment	One psychotropic medication was regularly given to 79% of the patients, and three or more psychotropics were regularly given to one in three patients and regularly or irregularly to one in two patients			Signs of potential abuse were identified in 336 (9%) of 3,869 participants without behavioral symptoms and 126 (17%) of 761 with behavioral symptoms; wandering was negatively associated with potential abuse, whereas other symptoms were positively associated with this outcome	91% of the nursing staff reported that they had observed at least one act of inadequate care; inadequate care of a negligent and emotional character was most frequently reported			

	(verbally abusive behavior, physically abusive behavior, socially inappropriate behavior, active resistance of care)	

Table 2 Cont.

	Finland 2009 [Nurminen et al., 2009]	Germany 1999-2001 [Göergen, 2004]	Germany 2001/2002 [Göergen, 2001]	Italy 2007 [Ogioni et al., 2007]	Norway 2009 [Malmedal, Ingebrigtsen, & Saveman, 2009]	Sweden 1999 [Saveman et al., 1999]	United States (one state) 1987 [Pillemer & Moore, 1989]	United States (five states) 2008 [Ramsey-Klawsnik et al., 2008]	United States (one state) 2009 [Griffore et al., 2009]
Physical	Psychotropics were used as chemical restraints to control the behavior of the patients. For example, two or more benzodiazepine derivatives or related drugs were regularly given to 24% of the patients and regularly or irregularly to 46% of the patients.	19.8% self-reported 21.0% witnessed	23.5% self-reported 34.9% witnessed	Use of physical restraints was the sign of potential abuse most frequently observed (6.6%); presenting unexplained injuries, broken bones, or burns (0.2%)	Witnessed: restrained/held back a resident: (44%) and held a resident hard (36%) The two least frequently observed acts of physical character were pressing the nose in order to force the resident to open his or her mouth (2%), and 15% observed a colleague who tied down a resident. Committed: 33% of the nursing staff reported that they themselves had restrained/held back a resident, 5% reported that they had done this more than once a month, and 22% had held a resident hard.	74%	36% saw abuse 10% themselves committed abuse		58.1% reported 1 or 2 incidents of physical mistreatment; 43.8% reported 1 or 2 incidents of caretaking mistreatment

Sexual	–	–	0.0% self-reported 1.1% witnessed	–	2%	–	20 of the victims had been molested. Other violations experienced by the elders included inappropriate interest in the victim's body (*n* = 12) and sexualized kissing (*n* = 4). Two were exposed to exhibitionism, two had their breasts or buttocks exposed to others for the purpose of being humiliated, two were subjected to sexualized jokes and comments, two were sexually exploited, and two were forced to view pornography. One elder was anally raped, one was vaginally raped, and one experienced attempted vaginal rape. One elder was subjected to harmful genital practices; one elder suffered sadistic sexual behavior.	40.0% reported 1 or 2 incidents of sexual misconduct

Table 2 Cont.

	Finland **2009** **[Nurminen et al., 2009]**	**Germany** **1999-2001** **[Göergen, 2004]**	**Germany** **2001/2002** **[Göergen, 2001]**	**Italy** **2007** **[Ogioni et al., 2007]**	**Norway** **2009** **[Malmedal, Ingebrigtsen, & Saveman, 2009]**	**Sweden** **1999** **[Saveman et al., 1999]**	**United States** **(one state)** **1987** **[Pillemer & Moore, 1989]**	**United States (five states)** **2008** **[Ramsey-Klawsnik et al., 2008]**	**United States** **(one state)** **2009** **[Griffore et al., 2009]**
Psychological/emotional	**Not collected**	37.0% self-reported 56.8% witnessed	53.7% self-reported 61.8% witnessed	Verbally abuse = 8.1%	Witnessed: 38% = verbal disrespect; 40% = emotional or psychological mistreatment Committed: 69% emotional	71%	81% saw abuse 40% themselves committed abuse	**Not collected**	34.6% reported 1 or 2 incidents of emotional or psychological mistreatment; 56.7% reported 1 or 2 incidents of verbal mistreatment
Financial	–	–	–	**Not collected**	Witnessed: 1% had observed that a colleague had taken money or valuables from a resident	25%	–	**Not collected**	46.9% reported 1 or 2 incidents of material exploitation
Neglect	**Not collected**	27.2% self-reported 39.5% witnessed	53.7% self-reported 59.6% witnessed	Poor hygiene (2.6%); being fearful (0.7%); being neglected or mistreated (0.3%)	Witnessed: neglected oral care (68%), ignoring a resident (67%) and delayed care longer than necessary (67% omitting to give a resident enough food, and about 20% of the staff had observed a	56%	–	Neglect by the care facilities (in the form of either failure to prevent the sexual abuse or to respond appropriately to it) was alleged in 49/124 cases	99% 30.3% reported 1 or 2 incidents of neglect

					colleague commit such act, with 16% reporting that it occurred once a month or less. Giving inadequate treatment of wounds or injuries was also seldom observed (22%). Committed: neglecting oral care (64%) and delaying required care longer than necessary (55%)				
Type of Facility	Five long-term care wards in Pori City Hospital, Finland	8 nursing homes in the German federal state of Hesse	27 nursing homes in one metropolitan area in Germany	Home care programs in Italian home health agencies	16 nursing homes in the county of Sør-Trøndelag in central Norway	Yes	Intermediate & skilled nursing facilities	Abuse and regulatory agencies in five states contributed case data: New Hampshire, Oregon, Tennessee, Texas, and Wisconsin. Adult Protective Services in all of these states contributed to the study in addition to the Division of Aging and Disability Services (DADS) in Texas and the Bureau of Quality Assurance (BQA) in Wisconsin.	Michigan nursing homes

Table 2 Cont.

	Finland **2009** **[Nurminen et al., 2009]**	**Germany** **1999-2001** **[Göergen, 2004]**	**Germany** **2001/2002** **[Göergen, 2001]**	**Italy** **2007** **[Ogioni et al., 2007]**	**Norway** **2009** **[Malmedal, Ingebrigtsen, & Saveman, 2009]**	**Sweden** **1999** **[Saveman et al., 1999]**	**United States** **(one state)** **1987** **[Pillemer & Moore, 1989]**	**United States (five states)** **2008** **[Ramsey-Klawsnik et al., 2008]**	**United States** **(one state)** **2009** **[Griffore et al., 2009]**
Measures	One study author collected data (e.g., medical and nursing records); the Mini Mental State Examination (MMSE) test was used in assessing cognitive abilities	Interview schedule specifically developed for study	Building on CTS, but adapted to residential context and elder abuse components	Collected data using Minimum Data Set for Home Care (MDS-HC) on each patient judged eligible for the home care programs (the MDS-HC is a multidimensional assessment instrument designed in the United States to be the community analog to the nationally mandated MDS for nursing home)	Self-report survey questionnaire specifically developed for study	Four types of residence including older person's own home if receiving home care	CTS and own	Data in those five states came from personnel responsible for receiving and responding to regulatory abuse reports concerning vulnerable adults in facilities using the Sexual Abuse Survey (SASU)	Michigan Survey of Households with Family Members Receiving Long-Term Care Services (MLTCS) and a telephone survey of the noninstitutionalized civilian population of adults living in Michigan who have a relative who is receiving long-term care services
Theory Noted	None	None	None	None	None	Not clear; none	None – developed later	None	None

APPENDIX B

DMEA Definitions of Mistreatment, Abuse, and Neglect

Mistreatment of older adults refers to actions and/or behaviours, or lack of actions and/or behaviours that cause harm or risk of harm within a trusting relationship. Mistreatment includes abuse and neglect of older adults.

La maltraitance envers les personnes aînées fait référence aux actes ou comportements, ouà l'absence d'actes ou de comportements, à l'intérieur d'une relation basée sur la confiance, causant du tort ou un risque de tort.

- **Physical Abuse** – Actions or behaviours that result in bodily injury, pain, impairment or psychological distress.

Maltraitance de type physique - Actes ou comportements causant des blessures corporelles, de la douleur, un affaiblissement ou de la détresse psychologique.

- **Emotional/Psychological Abuse** – Severe or persistent verbal or non-verbal behaviour that results in emotional or psychological harm.

Maltraitance de type psychologique/émotionnelle - Une parole ou un comportement non-verbal, sévère ou persistant, causant des atteintes de nature psychologique ou émotionnelle.

- **Financial/Material Abuse** – An action or lack of action with respect to material possessions, funds, assets, property, or legal documents, that is unauthorized, or coerced, or a misuse of legal authority.

Abus financier - Acte ou absence d'acte non-autorisé, coercitif ou usage abusif d'une autorisation légale, eu égard à un bien matériel, un fonds, du capital, une propriété, ou un document légal.

- **Sexual Abuse** – Direct or indirect involvement in sexual activity without consent.

Maltraitance de type sexuelle - Activité sexuelle directe ou indirecte contre votre gré.

- **Neglect** – Repeated deprivation of assistance needed by the older person for activities of daily living.

Négligence - Privations répétitives dans l'assistance à une personne aînée qui en a besoin pour réaliser ses activités de la vie quotidienne.

APPENDIX C

Sources Consulted in Developing the Questionnaire

Study/Author	Social Interaction	Depression	Neglect	Psychological Abuse	Physical Abuse	Sexual abuse	Financial Abuse	Demographic Information
ABUEL (2009-2010)	X		X	X	X	X	X	
Acierno et al., 2010	X		X	X	X	X	X	
Atlanta Legal Aid Society			X					
First Canadian Longitudinal Study on Aging	X							X
Canadian Research team			X	X	X	X	X	
Center for Epidemiological Studies Depression Scale (CES-D), Radloff 1977		X						
Comijs et al., 1998			X					
Goergen, T., & Nagele, B. 2005				X			X	
Hawlick & Sengstock 1986	X							
Laumann, E. O., Leitsch, S. A., & Waite, L. J. 2008				X	X	X	X	
Lowenstein, A., et al., 2009 [Israel]	X		X					
Naughton C. et al., 2010 [Ireland]	X		X	X	X		X	
O'Keeffe, M., et.al., 2007 [U.K.]	X			X	X	X	X	
Podnieks, E., 1990: 1993			X					
Pottie Bunge, V. (2000)	X					X		
Ramsey-Klawsnik, H., et al., 2008						X		
Straus, et. al. 1996 [Revised Conflict Tactics Scale (CTS2)]				X				
Suggested by Focus Groups, Dyadic Interviews and Cognitive Interviews	X	X	X	X	X	X	X	X
Wiener, J., et al., 1990			X					

APPENDIX D

Descriptions of variables included in the logistic regression analyses

Variable	Definition
Socio-demographics	
Age > 75	=1 if older than 75 years
Female	=1 if female
Non-white race	=1 if race is non-white
Less than high school education	=1 if did not graduate from high school
Marital status	
Never married	=1 if single, never married
Married	=1 if married
Divorced or separated	=1 if divorced or separated
Widowed	=1 if widowed
Living situation	
Lives alone	=1 if lives alone
Social isolation	
Socially isolated	=1 if socializes with friends or relatives a few times a month, once a month or less, or never
Feels socially isolated	=1 if feels spend not enough time with friends or relatives
ADL/IADL needs	
ADL/IADL needs	=1 if needs help all of the time or some of the time with at least 1 out of 11 ADL/IADL needs including using the telephone, eating, bathing or showering, etc.
Depressed	=1 if score of 10 or higher on Center for Epidemiological Studies Depression Scale score
Prior experience with abuse	
Abused in childhood	=1 if felt experienced abuse before 18 years old
Abused in young adulthood	=1 if felt experienced abuse between 18 and 24 years old
Abused in adulthood	=1 if felt experienced abuse between ages 25 and 54
Region	
Eastern Canada	=1 if province is Ontario, Quebec, New Brunswick, Prince Edward Island, Nova Scotia, or Newfoundland and Labrador
Western or Northern Canada	=1 if provide is British Columbia, Alberta, Saskatchewan, Manitoba, Yukon, Northwest Territories, or Nunavut
French language interview	=1 if interview was conducted in French

APPENDIX E

Interview Training & Resource Manual

Table of Contents

Introduction

Due to the personal and sensitive nature of the mistreatment questionnaire, interviewers must be prepared to respond to the possible emotional responses of participants and react in an appropriate manner. It is important to recognize and be aware that the older adults you will be speaking with on the telephone will have come from various backgrounds and diverse experiences. Interpersonal awareness, sensitivity and professionalism are crucial to the success of these interviews. Not all participants will have experienced mistreatment; however it is important that you be prepared for participant distress and/or the possibility of a participant being exposed to danger, should these situations arise during the interview.

Interview Guidelines

1) Ensure the Participant is in a Safe Setting

- A comfortable private setting is important for participant safety (particularly if there is the risk of a perpetrator walking in and overhearing the participant's conversation with the interviewer).
- A quiet conversation space where the participant can sit comfortably for a period of time is also important to maximize the physical and emotional comfort of the participant as this questionnaire involves sensitive content matter and will take more than a few minutes to complete. It is estimated that the survey is about 45 minutes long.
- To ensure the participant is in a private setting and can speak openly, ask, "During the next 45 minutes, do you think that someone might enter the room you are in and interrupt the interview?" If the participant answers "yes" or "maybe" the interviewer should respond: "If you are interrupted by someone, we will need to confirm that you will have privacy to continue the interview, or whether we should reschedule. If we need to reschedule, what is a good time and date for you?" (Write down participant's response.) Then ask, "Is there anyone present in your household who you would feel uncomfortable asking to leave if they entered the room during the interview? If so, it would help if you could use a code word or phrase to indicate that this person is present. Can you think of a good discreet word or phrase that you could use with me? (If the participant cannot think of a word or phrase, made a suggestion, e.g. "Who's calling?" or "How is the weather?" Write down the suggested code word). Then tell the participant, "If you use the word/phrase: [insert participant code word(s) here], before ending our conversation, I will need to make sure that you are okay. I will ask you if you need any help. All you have to do is answer yes or no."

- If the interview is interrupted and the participant indicates to you that they do NOT need help, ask them if they would like you to call back at the agreed upon time. You should also ask them if they would like a follow-up call from the social worker for debriefing/support/community referrals. Please consult Decision Tree B: Imminent Danger, p. 8, for specific steps to follow should a seemingly dangerous situation arise during the course of an interview.

2) Maintain a Non-Judgmental Approach

- It is imperative that interviewers interact with participants in a professional, non-judgmental manner. Be friendly and courteous and try to establish rapport with the participant.
- Avoid negative language – specifically any words that could suggest anger, disgust, or disapproval.
- Be sure that the participant understands that you are an interviewer and not a professional counselor, i.e. you are not authorized to give advice. Tell the participant, "Just to let you know, I am an interviewer, not a counselor. If at any time during the interview you want to speak to the social worker, you can. The social worker can call you or I can give you her phone number and you can call her." However, if the participant asks you directly for help or signals that he or she is currently in danger, or experiencing mistreatment (abuse or neglect), give them the appropriate telephone crisis number for their region (see Table 1) and ask them if they would like to receive a follow-up call from the project social worker. You may also offer to give them the social worker's phone number if he or she would prefer to make the call themselves.

3) Be Sensitive to Hearing Impairment and Be Patient

- The recruitment process for interview participants will likely screen out individuals who for one reason or another are unable to fully participate in a telephone interview. It is possible, however, that a mild hearing impairment may only become evident during the in-depth interview. For this reason, during the cognitive screen and consent process at the beginning of the interview, interviewers should be particularly attuned to behaviour that could indicate participant hearing difficulties and adjust tone and volume accordingly.
- It is a good idea to ask at the beginning of the interview, "Can you hear me at this volume?" Allow time for the participant to gather his or her thoughts. Only move on to the next question when you are sure the participant has finished answering and is ready to move on.

4) Demonstrate Cultural Sensitivity

Canada's population is rich in cultural diversity, thus, cultural sensitivity is an essential skill for interviewers to possess. The National Association of Social Work (2001) defines cultural sensitivity/competence as:

> *The process by which individuals and systems respond respectfully and effectively to people of all cultures, languages, classes, races, ethnic backgrounds, religions, and other diversity factors in a manner that recognizes, affirms, and values the worth of individuals, families, and communities and protects and preserves the dignity of each.*
> (National Association of Social Workers, 2001, p. 10)

Some important cultural considerations are:

- Participants may have very different value systems than you. For example, some cultures value pride and self-reliance while others value submission and stoicism. For some, displays of emotion are encouraged, for others, concealing emotions is the norm.
- Certain cultural groups, notably Aboriginal peoples, may have been treated poorly in research studies in the past.
- Some new immigrants may be fearful of authority figures, as they may have come from countries where government officials and police cannot be trusted.
- Be aware that while a telephone interview allows for a degree of anonymity between the participant and the interviewer, it restricts non-verbal communication**.**
- Foster awareness by considering the origin of your personal worldview and how that may affect the power differential between yourself and the interview participant. Consider your cultural background, gender, sexual orientation, socio-economic status, personal and professional biases, etc. (Struthers & Neufeld, 2010)
- Consider your own understanding and experiences with mistreatment and how these may affect your approach to an interview with an older adult on this topic. Think about the best way to keep these biases in check (Struthers & Neufeld, 2010).
- Remember, while participants in this study are volunteers, they may not have previous experience participating in a research interview. As a result, participants may not know what to expect, and may find themselves surprised, upset, or confused by the questions being asked of them.

Compassion Fatigue

As an interviewer conducting interviews about mistreatment you may hear some traumatic accounts. These stories may be upsetting to you and you might even begin to feel traumatized as a result – this is often referred to as "compassion fatigue". Compassion fatigue is a common by-product for those who conduct research/work with victims of trauma or abuse and neglect.

Some common symptoms include:

- Feeling emotionally exhausted
- Apathy
- Low energy
- Feeling sad/uncharacteristically emotional
- Irritability
- Avoidance
- Anxiety
- Depression

(Canadian Training Institute, 2004; Pross, 2006)

Some strategies for preventing/minimizing compassion fatigue include:

- Engaging in self care (e.g. making time for hobbies and leisure, spending time with friends and family, exercising, maintaining a healthy diet, meditating)
- Fostering a strong sense of self-awareness (e.g. keep a reflective journal but be careful not to break confidentiality; take some time to reflect on your feelings, etc.)
- Debriefing with a trusted colleague or mental health professional (e.g. for this project, the team social worker)
- Striving to maintain professional boundaries – specifically a balance between professionalism and empathy without over-identifying with participants.

(Canadian Training Institute, 2004; Pross, 2006)

Responding to Participant Distress

(See Decision Tree A, p. 7)

It is important for an interviewer to be able to recognize participant distress during the interview and that the interviewer handle this appropriately and professionally.

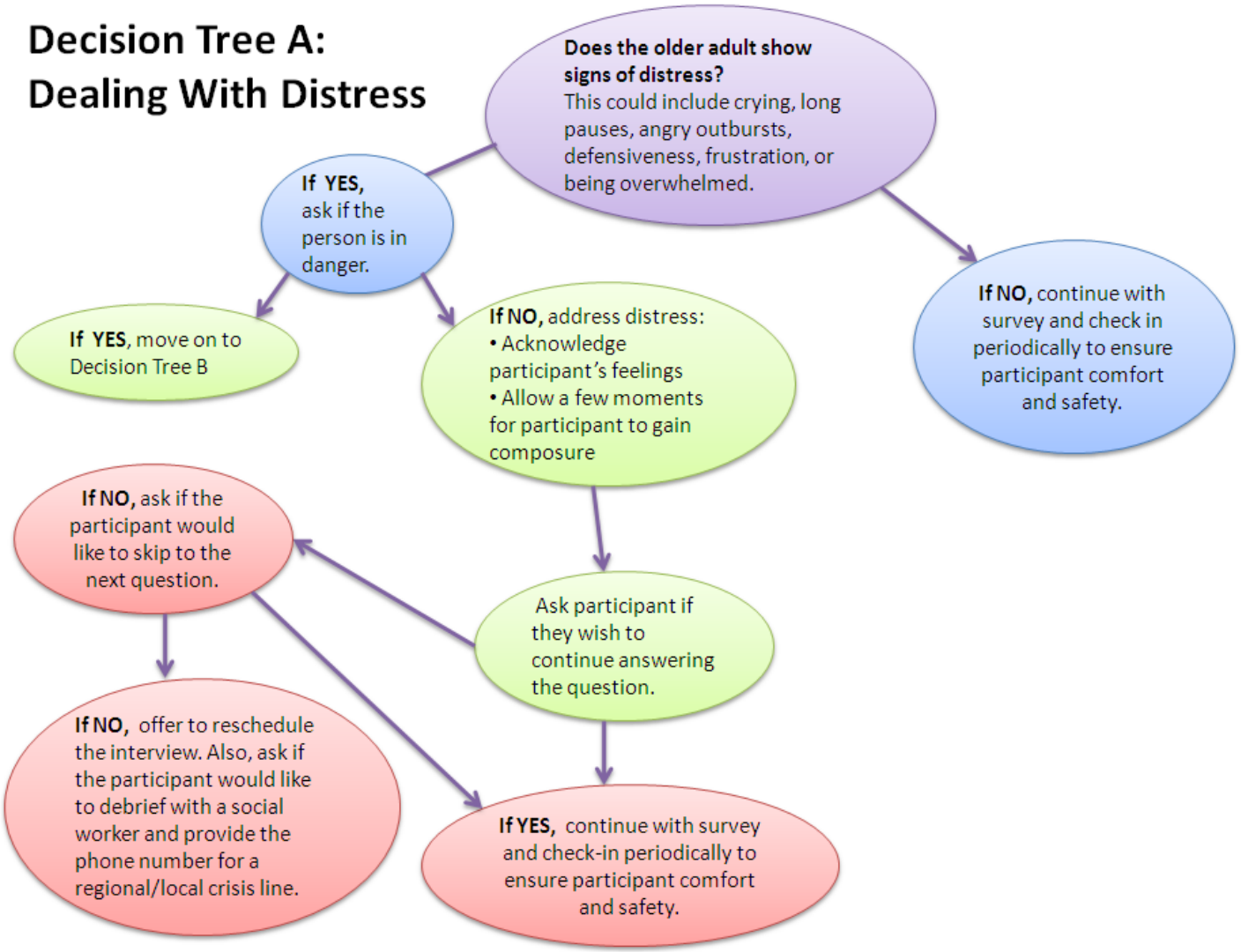
Signs of distress:

- Crying
- Long pauses
- Angry outbursts
- Defensiveness
- Expressing feeling overwhelmed
- Frustration

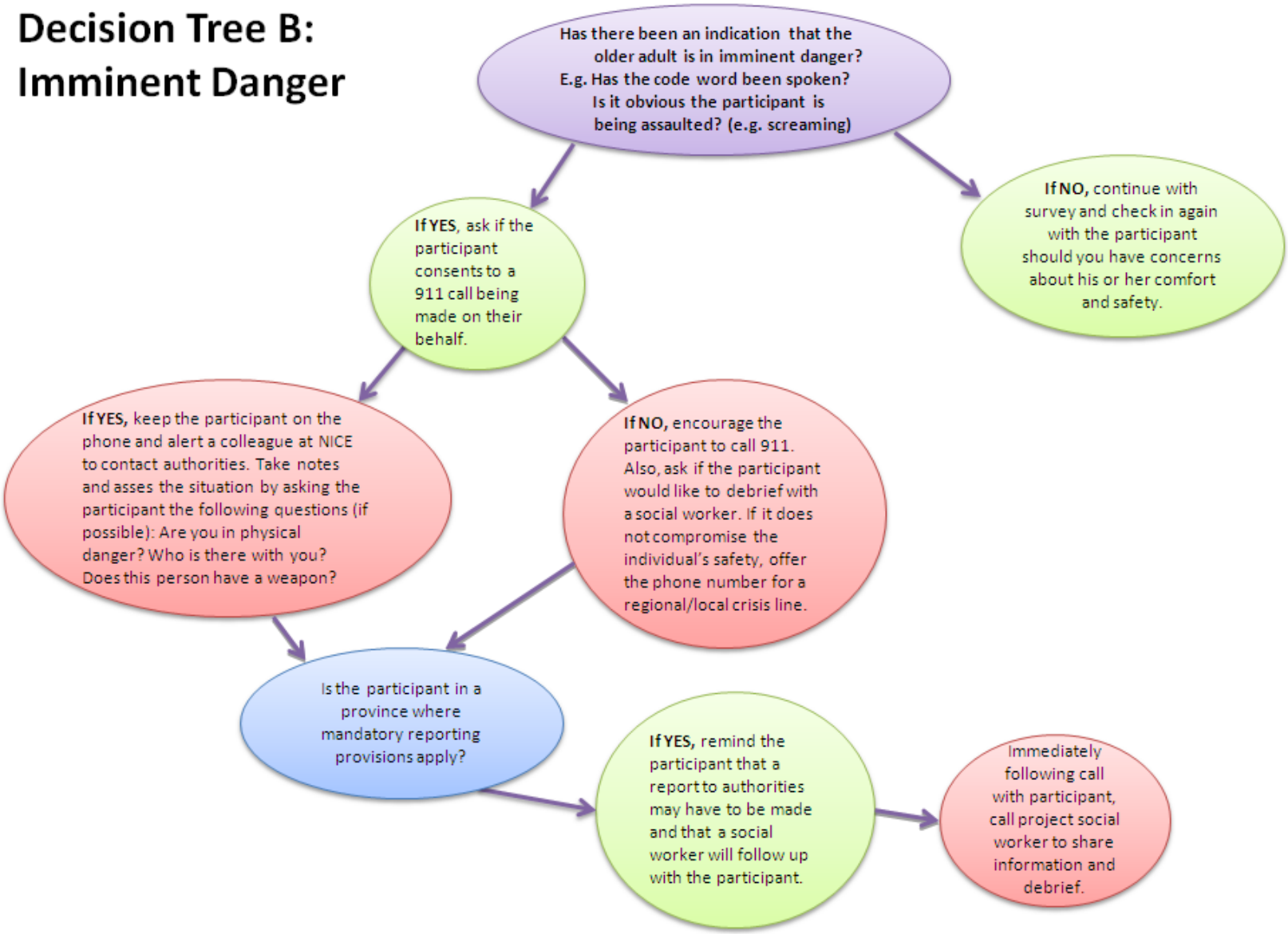
How to respond:

- Acknowledge the participant's emotion and be patient. For example, you could say, "I understand it must be difficult for you to talk about this subject. I really appreciate your openness. Please take your time."
- Allow the participant a few moments to compose him/herself.
- Ask if the participant is comfortable continuing with the questions. He or she may not want to answer certain questions. If this should occur, complete as much of the interview as possible, but remember, we do not want to further upset the participant. Sometimes the participant refuses questions early in the interview but seems more comfortable and willing to respond as the interview progresses. If this seems to be the case, at the end of the interview, ask when you've finished if he or she would like to reconsider the refused question(s). After the interview, list any refused questions (and why they were refused).
- If a participant chooses to end the interview for any reason, ask if he /she would like to reschedule.
- Participants who have experienced mistreatment should especially be given the option of follow-up from the team social worker. This is of particular importance for those who are distressed and/or choose to end the interview prematurely.

(Adapted From: Statistics Canada, 2007).


Decision Tree A:
Dealing With Distress
Does the older adult show signs of distress?
This could include crying, long pauses, angry outbursts, defensiveness, frustration, or being overwhelmed.
If YES, ask if the person is in danger.
If NO, continue with survey and check in periodically to ensure participant comfort and safety.
If YES, move on to Decision Tree B
If NO, address distress:
• Acknowledge participant's feelings
• Allow a few moments for participant to gain composure
If NO, ask if the participant would like to skip to the next question.
Ask participant if they wish to continue answering the question.
If NO, offer to reschedule the interview. Also, ask if the participant would like to debrief with a social worker and provide the phone number for a regional/local crisis line.
If YES, continue with survey and check-in periodically to ensure participant comfort and safety.

Decision Tree B: Imminent Danger



Responding to Imminent Danger

(See Decision Tree B, p. 8)

While probability is fairly low, it is possible that at some point during telephone interviews, a participant could find him or herself in imminent danger. Listen for the code word or another obvious indication that the participant may be exposed to harm. If a perpetrator enters the room and is abusive with the participant, the interviewer must attempt to quickly assess the situation. In such a situation, the interviewer should attempt to determine what is happening and offer assistance to the extent possible.

Some questions the interviewer might ask are:

- Are you in danger?
- What is your location/address?
- Where is _____ (the perpetrator)?
- Are there any weapons present?
- Are you being physically hurt?
- If it is obvious that the participant is being assaulted and is unable to call the police on his or her own, interviewers should keep the participant on the phone while alerting a colleague to make a call to the local police department.

(Adapted from: Family Service Association of Toronto, 2004)

All participants should be asked if they would like to receive a follow-up phone call from the project team social worker. If a meeting with the social worker is requested, the social worker will contact the participant as soon as possible to provide brief counseling and local treatment referrals as necessary. Participants who have experienced mistreatment will be provided with comprehensive resources that will include a list of local social services.

Mandatory Reporting

As the telephone questionnaire will be administered to older adults across Canada, regional reporting requirements must be followed. Nova Scotia and Newfoundland have mandatory reporting requirements for anyone who suspects abuse or neglect, thus, interviewers must be aware of this fact (see Table 1, p. 13, for specifics). If there *are* mandatory reporting requirements where the participant lives (e.g. Nova Scotia or Newfoundland), you will review this fact with the participant during the verbal consent process. Should the person reveal that he or she is experiencing some form of mistreatment during the interview, you must let the participant know that a professional connected with the study will contact them in the near future. Before hanging up with the participant, provide them with the telephone number to a helpline in the province / territory and have them repeat the phone number back to you (see Table 1 for phone numbers). All other provinces either have no mandatory reporting requirements, or legislation which outlines voluntary reporting (see Table 1).

If mistreatment is reported by participants in Nova Scotia or Newfoundland, the interviewer should contact the project social worker and alert her to the situation. The social worker will follow-up with the participant as soon as possible to assess the situation. She will then call the appropriate authority to report for the city or region that the participant lives in. She will describe the situation without using names or identifying information in order to determine whether the situation indeed must be reported. By taking this step, the social worker will avoid reporting a situation that does not, by law, constitute abuse under the province's legislation. Thus, by anonymously reporting the situation first to the adult protection worker in the participant's jurisdiction, a decision will be made by that worker as to how to proceed. In short, each situation will be reviewed on an individual, case-by-case basis.

Questions & Answers

Below are possible questions that participants may ask of interviewers, and suggested responses.

Q. Who is HRSDC? / Who is responsible for this study?
A. *Human Resources and Skills Development Canada (HRSDC) is a federal department of the government of Canada that is responsible for developing and researching various social programming and services that affect Canadians. They are funding this research. However, it is researchers from the University of Toronto and experts from across Canada and abroad that make up the research team for this study.*

Q. Who will see my answers?
A. Your responses will be recorded anonymously; however, all responses will be grouped together in a final report to HRSDC.

Q. Will you tell my family/ friends / employer what I say?
A. No we will not.

Q. If I report abuse, will this affect my sponsorship agreement with my family?
A. Yes, it may change your sponsorship agreement and you will be referred to the project social worker who will assist you.

Q. Will I have to go to a nursing home if I report?
A. No, you will not.

Q. Have *you* been abused? (to the interviewer)
A. I'm sorry, I can't answer that question.

Q. How do I know you are legitimate?
A. You will have spoken with Sydney Blum or a recruitment assistant in advance about participating in this project. If you would like to verify that I am calling about the same study before we proceed, you can call Sydney at: 416-xxx-xxxx or _____ at: 416-xxx-xxxx to verify my identity and involvement with the project.

Q. What is your background?
A. I am a trained research interviewer.

Q. Why the %&$# do you care anyway? / What will you do with what I tell you?
A. We are talking to older adults across Canada. The information that is shared with us will help us to understand the scope of the problem of the mistreatment of older adults in Canada. Once we know approximately how many people experience mistreatment, we can plan better services.

Q. How/why did you choose me?
A. You or someone you know suggested you would be interested or you indicated interest in the study to a service provider.

Q. Can you leave me your phone number?
A. I'm sorry but I'm not able to give you my direct line. I can provide you with the Principal Investigator's contact information (Dr. Lynn McDonald: 416-xxx-xxxx) or the project coordinator's phone number if you'd like more information about the study [Sydney Blum: 416-xxx-xxxx]. You may also call the project social worker, [_____: 416-xxx-xxxx] if you'd like to debrief with someone or want to know about local resources.

TABLE 1: Mistreatment, Abuse & Neglect, Reporting Requirements in Canada

Province	Reporting Requirements in the Community	Reporting requirements in institutions (e.g. hospital/LTC)	Crisis/Helpline Numbers for Victims of Mistreatment
Alberta	**No specific mandatory reporting requirements.**	**Mandatory reporting.** Any individual or service provider who has reasonable grounds to suspect any type of abuse has taken place must report the abuse to the Minister or a police service or committee (Protection for Persons in Care Act, R.S.A. 2000 c. P-29).	Family Violence Info Line 403-310-1818 (toll-free, 24/7)
British Columbia	**Voluntary reporting.** i.e. If you have concerns that an adult is being abused, neglected or self-neglected and is refusing support and assistance, and appears to be mentally incapable or physically unable to get help on their own, then the situation **can** be reported to the regional health authority or Community Living BC (for adults with a developmental disability). Under Part 3 of the *Adult Guardianship Act*, these agencies have a mandate to look into reports of abuse, neglect and self-neglect of adults who can't get help on their own http://www.trustee.bc.ca. Presumably, this applies to the community and institutions.		Phone Victim LINK 1-800-563-0808 (toll-free), 24 hour-a-day, seven day-a-week support and referral service.
Manitoba	**No specific mandatory reporting requirements for capable adults.** However, the *Vulnerable Persons Living with a Mental Disability Act,* C.C.S.M., c.V90, is intended for those with developmental disabilities. (Mentally incapable seniors would be excluded unless the person has grown old with a developmental disability).	**Mandatory reporting by service providers.** The *Protection for Persons in Care Act,* C.C.S.M., c. P144, requires service providers or any other person who has reason to believe that a patient at a hospital, personal care home or other health facility is experiencing abuse or is likely to experience abuse, to report the abuse to the minister.	Seniors abuse line: 1-888-896-7183 Protection for persons in care office: 1-866-440-6366
New Brunswick	**Voluntary reporting.** Under the *Family Services Act,* S.N.B. 1980, c. F-2.2. voluntary reporting by a professional person[22] to the Minister is recommended: **34**(2) Where an adult is a disabled person or an elderly person, or is within a group	**Mandatory reporting.** Under the New Brunswick *Nursing Home Act,* s.19, the operator has a duty to report "major incident or accident affecting health or safety of residents or staff."	Chimo crisis helpline: 1-800-667-5005

[22] A "professional person" means a worker in any adult day care center or residential or institutional facility, a vocational counselor or trainer, an educator, a physician, a nurse, dentist or other health or mental health professional, a hospital administrator, a social work administrator, social worker or other social service professional, a police or law enforcement officer, a psychologist, a guidance counselor or a recreational services administrator or worker and includes any other person who by virtue of his employment or occupation has a responsibility to discharge a duty of care towards an elderly person or a disabled adult.
1990, c.25, s.3; 1998, c.40, s.3.

New Brunswick Cont.	prescribed by regulation, and is a victim of or is in danger of being a victim of *(a)*physical abuse; *(b)*sexual abuse; *(c)*mental cruelty; or *(d)*any combination thereof, **35.1**(1) A professional person may disclose information to the Minister respecting a person whom the professional person has reason to believe is a neglected adult or an abused adult, including information that has been acquired through the discharge of the professional person's duties or within a professional relationship.		
Newfoundland and Labrador	**Mandatory reporting.** Under the *Neglected Adults Welfare Act,* S. 4(1) A person who has information which leads him or her to believe that an adult is a neglected adult[23], shall give the information, together with the name and address of the adult, to the director or to a social worker who shall report the matter to the director. (2) Subsection (1) applies notwithstanding that the information is confidential or privileged, and an action does not lie against the informant unless the giving of the information is done maliciously or without unreasonable cause. Reports should be made to the local regional health authority.	Nothing specifically mentioned in the *Homes for Special Care Act* or the *Private Homes for Special Care Act.*	Senior's Resource Centre of Newfoundland and Labrador (General information and referrals). Toll-free: 1-800-563-5599

[23] "neglected adult" means an adult: (i) who is incapable of caring properly for himself or herself because of physical or mental infirmity; (ii) who is not suitable to be in a treatment facility under the *Mental Health Care and Treatment Act;* (iii) who is not receiving proper care and attention, and; (iv) who refuses, delays or is unable to make provision for proper care and attention for himself or herself.

North West Territories	N/A	N/A	Family Violence Crisis Line Toll-free: 1-866-223-7775
Nova Scotia	**Mandatory reporting.** According to the *Adult Protection Act* R.S.N.S. 1989, c.2., S. 3: In this Act, (a) "adult" means a person who is or is apparently sixteen years of age or older; (b) c, (i) is a victim of physical abuse, sexual abuse, mental cruelty or a combination thereof[24], is incapable of protecting himself therefrom by reason of physical disability or mental infirmity, and refuses, delays or is unable to make provision for his protection therefrom, or (ii) is not receiving adequate care and attention, is incapable of caring adequately for himself by reason of physical disability or mental infirmity, and refuses, delays or is unable to make provision for his adequate care and attention; S. 5(1) Every person who has information, whether or not it is confidential or privileged, indicating that an adult is in need of protection shall report that information to the Minister.	**Mandatory reporting.** According to the *Protection for Persons in Care Act*, S.N.S. 2004, c. 33, 4 (2) The administrator of a health facility shall report to the Minister[25] all allegations of abuse against a patient or resident that come to the knowledge of the administrator. *2004, c. 33, s. 4.* **Duty of service provider** 5 (1) A service provider who has a reasonable basis to believe that a patient or resident is, or is likely to be, abused shall promptly report the belief, and the information on which it is based, to the Minister or the Minister's delegate. (2) The duty to report applies even if the information on which the person's belief is based is confidential and its disclosure is restricted by legislation or otherwise, but it does not apply to information that is privileged because of a solicitor-client relationship. *2004, c. 33, s. 5.* **Duty to report abuse or likely abuse** 6 (1) Any person who has a reasonable basis to believe that a patient or resident is or likely to be, abused may report the belief, and the information on which it is based, to the Minister or the Minister's delegate. (2) A person may report under subsection (1) even if the information on which the person's belief is based is confidential and its disclosure is restricted by legislation or otherwise, but it does not apply to information that is privileged because of a solicitor-client relationship. *2004, c. 33, s. 6.* 7 A patient or resident may report abuse against himself or herself to the Minister or the Minister's delegate. *2004, c. 33, s. 7.*	Senior Abuse Line: (Information, referrals and support). Toll-free: 1-877-833-3377 Out of Province: 902-424-3163 Adult Protection Services and Protection for Persons in Care (To report abuse of vulnerable adults or to report abuse in a designated health facility). Toll-free: 1-800-225-7225 Out of Province: 902-424-4288

[24] Note that financial abuse is not covered by this legislation.

[25] "Minister" means the member of the Executive Council assigned responsibility for the administration of this Act by the Governor in Council.

Nunavut	N/A	N/A	Crime Stoppers: 1-800-222-TIPS (8477) RCMP: 1-867-979-0123
Ontario	**No specific mandatory reporting requirements.**	**Mandatory reporting.** According to the *Long-Term Care Homes Act,* 2007, S. 24, any person that has reasonable grounds to suspect any of the following has occurred or may occur, is required to immediately report the suspicions and the information on which it is based to the Ministry of Health and Long Term Care: 1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 4. Misuse or misappropriation of a resident's money. 5. Misuse or misappropriation of funding provided to a licensee under this Act. Abuse should be reported to the CEO of the Long-Term Care Home, and to the Ministry of Health and Long Term Care.	Seniors Safety Line (For seniors at risk of abuse) Toll-free: 1-866-299-1011 Seniors Info line (General information and referrals) Toll-free: 1-888-910-1999 Long-Term Care ACTION Line (For complaints about LTC homes) Toll-free: 1-866-434-0144
Prince Edward Island	**Voluntary Reporting.** According to the *Adult Protection Act,* R.S.P.E.I. 1988, c. A-5, **4.** (1) Any person who has reasonable grounds	**No mandatory reporting to authorities.** However, under the *Nursing Home Regulation,* P.E.I. Reg. EC10/88, the operator of a nursing home is	Adult Protection Services (Provides assistance or protection to vulnerable adults).

	for believing that a person is, or is at serious risk of being, in need of assistance or protection[26] may report the circumstances in such manner and to such authority or person as may be designated by the Minister. Presumably this act also applies to adults in long-term care facilities.	required to *record injury, medication or treatment error* immediately on an incident report. In addition, under the *PEI Community Care Facilities and Nursing Home Act* the nursing home operator is required to inform next of kin, guardian or friend if resident "suffers an injury, a serious change in his condition, or dies" (s. 35 of Nursing Home Regulations). **Voluntary reporting** under the *Adult Protection Act,* R.S.P.E.I. 1988, c. A-5 may also be a possibility.	Charlottetown: 902-368-4790 Montague: 902-838-0786 O'Leary: 902-859-8730 Souris: 902-687-7096 Summerside: 902-888-8440 Seniors Secretariat – Office of Seniors (General information and referrals) Toll-free: 1-866-770-0588
Quebec	**No specific mandatory reporting requirements.** However, a complaint can be made to the Quebec Human Rights Commission, who may then investigate and attempt to resolve the situation. (REF – CNPEA reporting).	**No specific mandatory reporting requirements.** However, Abuse can be reporting to the institution's resident/users committee or to the . "commmissaire à la qualité" of the institution (*Loi sur les services des santé et les services sociaux*) or to the Commission des droits et libertés de la personne (Charte québécoise des droits et libertés de la personne).	Ligne Info-Abus: 1-888-489-2287
Saskatchewan	**No specific mandatory reporting requirements.**	**Mandatory reporting.** According to the *Personal Care Homes Regulations,* 1996, R.R.S. C. P-6.01 Reg 2, the operator of a care home must report all "serious incidents" to the resident's supporter and the health authority.	

[26] "In need of protection" in relation to a person, means requiring legally authorized protective intervention in order to preserve essential security and well-being, the necessity for which arises because, owing to physical or mental infirmity or disability or other incapacity to remedy the situation himself, the person in need, being an adult, continually or repeatedly (i) is a victim of abuse or neglect by, or otherwise put in danger by the behaviour or way of life of, someone having recognized supervisory responsibility for the person's well-being, (ii) is incapable of fending for himself and is unable to make provision for necessary care, aid or attention, or (iii) refuses, delays or fails to arrange for or comply with necessary care, aid or attention.

Yukon	**Voluntary Reporting.** Under the *Adult Protection and Decision Making Act,* S.Y. 2003, c. 21, Sch. A, 61(1) Anyone may make a report to a designated agency[27] where they have information indicating that an adult (a) is abused[28] or neglected[29]; and (b) is unable to seek support and assistance for any of the reasons mentioned in paragraph 59(b)[30].	**No known mandatory reporting requirements.**	**Victim Services/Family Violence Prevention Unit** Call 1-867-667-8500 Toll-free: 1-800-661-0408 (ext. 8500) **Victim Link** (24-hour crisis line) Toll-free: 1-800-563-0808

(Sources: Canadian Legal Information Institute, 2010; Canadian Network for the Prevention of Elder Abuse, 2009a, 2009b)

[27] "designated agency" means an agency designated by the regulations to have the authority of a designated agency under this Part, and includes the Minister.

[28] "abuse" means the deliberate mistreatment of an adult that (a) causes the adult physical, mental, or emotional harm, or (b) causes financial damage or loss to the adult, and includes intimidation, humiliation, physical assault, sexual assault, overmedication, withholding needed medication, censoring mail, invasion or denial of privacy, denial of access to visitors, or denial of use or possession of personal property.

[29] "Neglect" means any failure to provide necessary care, assistance, guidance, or attention to an adult that causes, or is reasonably likely to cause, within a short period of time, the adult serious physical, mental, or emotional harm, or substantial financial damages or loss to the adult, and includes self neglect.

[30] (i) physical or chemical restraint; (ii) a physical or intellectual disability that limits their ability to seek help; iii) an illness, disease, injury, or other condition that affects their ability to seek help; (iv) any similar reason.

Provincial & Territorial Helplines

ALBERTA:

Family Violence Info Line

(Available 24 hours a day for information, advice and referrals; the service is not bilingual; service can be provided in over 170 languages via tele-interpreter service, including French.)
Toll-free in Alberta: 403-310-1818

BRITISH COLUMBIA:

Victim Link

(Help line for victims of family violence; translation services available in over 130 languages, including French.)
Toll-free: 1-800-563-0808

Health and Seniors Information Line

(General information and referrals to crisis lines or provincial/national information lines; translation services available in over 130 languages, including French; line open Monday to Friday from 8:30am to 4:30pm.)
Victoria: 250-952-1742
Toll-free: 1-800-465-4911

BC Centre for Elder Advocacy and Support

(Speak with someone and get a referral to a legal advocate; 9am to 1pm, from Monday to Friday; you may get a voicemail.)
Toll-free: 1-866-437-1940 and local: 604-437-1940
Office line: 604-688-1927 (Vancouver)

MANITOBA:

Seniors Abuse Line

Toll-free: 1-888-896-7183

Seniors and Healthy Aging Secretariat

Toll-free: 1-888-896-7183

NEW BRUNSWICK:
Chimo Helpline
(Help line for victims of family violence.)
Toll-free: 1-800-667-5005

Department of Social Development
(General information and referrals; English and French, touch tone assistance, #1 if reporting abuse or seeking a referral, #2 to sign up for home care; Monday to Friday 8:15to 4:30 with a 24-hour on call social worker 7 days a week; older adults who call will be directly connected to a social worker, police may become involved in an investigation as well.)
1-866-444-8838

NEWFOUNDLAND AND LABRADOR:
Regional Health Authorities
(General information, referral and intervention.)
Eastern Health (Rural Avalon): 709-786-5245
Eastern Health (St. John's): 709-752-4885
Eastern Health: (Bonavista/Clarenville/Burin Peninsula): 709-466-5707
Central Health: 709-651-6340
Western Health: 709-634-5551 (ext. 226)
Labrador-Grenfell Health: 709-454-0372

Seniors Resource Centre of Newfoundland and Labrador
(General information and referrals.)
Toll-free: 1-800-563-5599

NOVA SCOTIA:
Senior Abuse Line
(Information, referrals and support)
Toll-free: 1-877-833-3377
Out of Province: 902-424-3163

Seniors Information Line
(General line if Senior Abuse Line is not answered, basic referrals.)
Toll-free: 1-800-670-0065
Out of Province: 902-424-0065

Adult Protection Services and Protection for Persons in Care
(Call to report abuse of vulnerable adults or to report abuse in a designated health facility; it is a central intake line which can also direct people to caregiving or other services.)
Toll-free: 1-800-225-7225
Out of Province: 902-424-4288

NUNAVUT:
Crime Stoppers: 1-800-222-TIPS (8477)
(Central Crime Stoppers number)

RCMP:
Emergency Line 24 service: 1-869-979/975 - 1111
Office line: 867-979-0123
Criminal operations: 869-975-4452
Sergeant for community: 869- 975-4409

NORTHWEST TERRITORIES:
Family Violence Crisis Line
Toll-free: 1-866-223-7775
Seniors Information Line
(General information on programs and services.)
Toll-free: 1-800-661-0878

ONTARIO:

Seniors Safety Line
(Crisis line for seniors experiencing abuse or people working with seniors; 24 hours, 7 days a week; counseling over the phone and referrals.)
Toll-free: 1-866-299-1011

Seniors Infoline
(General information and referrals.)
Toll-free: 1-888-910-1999

Long-Term Care ACTION Line
(For complaints about LTC homes)
Toll-free: 1-866-434-0144

PRINCE EDWARD ISLAND:

Adult Protection Services
(Provides assistance or protection to vulnerable adults; 8 to 4, Monday to Friday; you may reach a voicemail.)
Charlottetown: 902-368-4790
Montague: 902-838-0786
O'Leary: 902-859-8730
Souris: 902-687-7096
Summerside: 902-888-8440

Seniors Secretariat – Office of Seniors
(General information and referrals.)
Toll-free: 1-866-770-0588

QUEBEC:
Ligne Info-Abus: 1-888-489-2287

Sureté du Quebec:
Toll-free: 514-598-4141
Quebec: 418-310-4141
Montreal: 450 or 514-310-4141
Estrie: 819-310-4141
Nunavik: Corps de police régional Kativik: 1-800-964-2644

SASKATCHEWAN:
24-hour Abuse Line
Toll-free: 1-800-214-7083

Crime Stoppers
Toll-free: 1-800-222-TIPS (8477)(Central Crime Stoppers number)

YUKON:
Seniors' Services – Adult Protection Unit
Toll-free: 1-800-661-0408 (ext. 3946)

Victim Services/Family Violence Prevention Unit
Call 867-667-8500
Toll-free: 1-800-661-0408 (ext. 8500)

Victim Link
(24-hour crisis line)
Toll-free: 1-800-563-0808

(Source: Government of Canada, 2010)

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