

Age Concern New Zealand Incorporated

# Promoting the Rights and Well-Being of Older People and Those who Care for Them

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A Resource Kit about Elder Abuse and Neglect



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## Age Concern New Zealand Incorporated

September 1992

This resource kit is a result of the dedication and hard work of many people and on behalf of Age Concern New Zealand I would like to thank everyone who has contributed to this valuable resource.

A consultative approach has been used which involved a core working group and a wider reference group with members coming from many backgrounds and from all parts of New Zealand.

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Promoting and protecting the rights and well-being of older people and those who care for them is the responsibility of each and every one of us. This kit will help us in this mission.

Best wishes

Margaret Ferner  
National President  
Age Concern New Zealand



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## Age Concern New Zealand Incorporated

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PO Box 1930, Wellington, Telephone 04 471-2709*

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## INTRODUCTION AND AIMS

Age Concern New Zealand has developed this resource kit because it believes that elder abuse and neglect is preventable and that something can and should be done about it.

Our philosophy is the promotion of human rights and dignity for all older people and carers whatever their age, culture, sex, health status or living situation.

In this kit we look at what can be changed by developing positive strategies rather than just identifying problems. Our emphasis is on enhancing the partnership between older people, carers and service providers and promoting ways that this can be done.

There are social as well as individual factors that contribute to elder abuse and neglect, which can mean that anyone is capable of abusing and/or neglecting an older person. Each of us can play our part in preventing this problem by promoting positive attitudes towards older people, by working cooperatively to provide effective support networks and services and by acknowledging and valuing the work of those caring for older people.

This resource kit has been designed for use by older people, their formal and informal carers, service providers, policy makers and the general public. It can be adapted to meet specific group or individual needs.

The aims of this resource kit are to:

- promote the rights and well-being of older people;
- promote the rights and well-being of carers;
- promote awareness and understanding of the nature of elder abuse and neglect;
- minimise the incidence of elder abuse and neglect;
- encourage a coordinated approach between those who care for and those who work with older people;
- provide a structure that enables effective assessment, support and review services and strategies to be developed; and
- encourage ongoing research which will improve our understanding of elder abuse and neglect and how to prevent it.

We need your help. Only by working together on positive and *practical strategies will we achieve these aims.*

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## MODULE 1

### Rights and Responsibilities of Older People and Carers

#### Introduction

Each of us has rights which entitle us to independence and opportunities to participate in our community. We also have rights to care and freedom, self-fulfilment, self-determination, ongoing learning and dignity.

Along with these rights we have the responsibility to use our skills and learn new ones, contribute to our community, prepare for our future and be open and flexible to the changing needs of ourselves and others.

These rights and responsibilities do not change as we grow older.

These rights and responsibilities do not change when we require care or provide care.

These rights and responsibilities protect older people from abuse and neglect.

#### United Nations Principles for Older Persons

In December 1991 the United Nations General Assembly adopted a set of United Nations Principles for Older Persons.

The United Nations General Assembly has recommended that governments incorporate the Principles for Older Persons into their national programmes.

The Principles are based on a Declaration of Rights and Responsibilities of Older Persons developed by the International Federation on Ageing (IFA). The IFA declaration includes the responsibilities of older persons, which were not included in the United Nations Principles.

Part of the United Nations Principles are set out in Appendix 1. The IFA Declaration of Rights and Responsibilities of Older Persons is set out in Appendix 2.

#### Promoting the Rights of Older People

This resource kit is based on a commitment to upholding and promoting the rights and responsibilities of older persons, as outlined in the United Nations Principles and the IFA Declaration.

We can prevent elder abuse and neglect by keeping the rights and responsibilities of older people foremost in our minds; by using the Declaration as a basis for our attitudes, actions and services, and by providing older people with the opportunities to exercise those rights and responsibilities.

The Declaration of the Rights and Responsibilities of Older Persons should form the basis of all our work with older people.

Consider how the Rights and Responsibilities of Older Persons relates to you as an older person or to your involvement with older people.

- How can you share this information with others?
- Can you think of a situation where any of these rights were denied to an older person you know or work with?
- What would you do now if a similar situation arose?
- What other action could you take to promote the rights of older people in your day-to-day activities?

### Promoting the Rights of Carers

The rights and responsibilities of older people are also shared by other members of the community.

It is important to remember that people providing care for older people also have rights and responsibilities.

A failure to acknowledge and promote the rights and responsibilities of carers increases the potential risk of abuse and neglect.

Using the Declaration of Rights and Responsibilities for Older People, consider:

- How these same rights and responsibilities apply to people providing care.
- How you can also promote the rights and responsibilities of carers, eg by providing access to support, the opportunity for “time out”, access to training and information, the opportunity to have their personal needs met.

The Carers’ National Association in England has drawn up a 10 point Charter. It was published in a paper by Sara Tomlin for the British Geriatrics Society, in May 1989: *Abuse of Elderly People: an unnecessary and preventable problem*. Implementing this Charter will also help overcome the difficulties faced by carers.

### Carers’ Charter

- 1 **Recognition** of their contribution and of their own needs as individuals in their own right.
- 2 **Services** tailored to their individual circumstances, needs and views, through discussions at the time help is being planned.
- 3 **Services** which reflect an awareness of differing racial, cultural and religious backgrounds and values, equally accessible to carers of every race and ethnic origin.

- 4 **Opportunities** for a break, both for short spells (an afternoon) and for longer periods (a week or more), to relax and have time to themselves.
- 5 **Practical** help to lighten the tasks of caring, including domestic help, home adaptations, incontinence services and help with transport.
- 6 **Someone** to talk about their own emotional needs, at the outset of caring, while they are caring and when the caring task is over.
- 7 **Information** about available benefits and services as well as how to cope with the particular condition of the person cared for.
- 8 **An income** which covers the cost of caring which does not preclude carers taking employment or sharing care with other people.
- 9 **Opportunities** to explore alternatives to family care, both for their immediate and long-term future.
- 10 **Services** designed through consultation with carers at all levels of policy planning.

### Summary

The Declaration of the Rights and Responsibilities of Older Persons recognises and values the wisdom, experience and skills of older people. It fosters positive attitudes towards older people and helps overcome the myths and stereotypes of aging.

The United Nations General Assembly summarised the Declaration as follows:

“Add life to the years that have been added to life by assuring all older persons: independence, participation, care, self-fulfilment and dignity.”

We also need to promote the rights and responsibilities of persons caring for older people and the Carers’ Charter emphasises these rights. Using this dual perspective - the rights and responsibilities of older people and the rights and responsibilities of carers - we will be in a better position to prevent elder abuse and neglect.

### Action Planning

- 1 Read through the Declaration and think about how you can actively promote the rights and responsibilities of older people.
- 2 Read through the Declaration and the Carers’ Charter and think about how they apply to those caring for older people. What rights and responsibilities do carers have? How can you actively promote the rights and responsibilities of carers?
- 3 How can you let others know about the Declaration and Carers’ Charter?

**Remember to read through the Declaration and Carers’ Charter regularly and use them as a guide for your activities**

## Appendix 1

### United Nations Principles for Older Persons

To add life to the years that have been added to life **The General Assembly,**

**Appreciating** the contributions that older persons make to their society,

**Recognising** that, in the Charter of the United Nations, the peoples of the United Nations declare, inter alia, their determination to reaffirm their faith in fundamental human rights, in the dignity and worth of the human person, in the equal rights of men and women and of nations large and small and to promote social progress and better standards of life in larger freedom,

**Noting** the elaboration of these rights in the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights and the International Covenant on Civil and Political Rights and other declarations to ensure the application of universal standards to particular groups,

**In pursuance** of the International Plan on Action on Aging adopted by the World Assembly on Aging and endorsed by the General Assembly in its resolution 37/51 of 3 December 1982,

**Appreciating** the tremendous diversity in the situation of older persons, not only between countries but within countries and between individuals, which requires a variety of policy responses,

**Aware** that in all countries, individuals are reaching an advanced age in greater numbers and in better health than ever before,

**Aware** of the scientific research disproving many stereotypes about inevitable and irreversible declines with age,

**Convinced** that in a world characterised by an increasing number and proportion of older persons, opportunities must be provided for willing and capable older persons to participate in and contribute to the ongoing activities of society,

**Mindful** that the strains on family life in both developed and developing countries require support for those providing care to frail older persons,

**Bearing** in mind the standards already set by the International Plan of Action on Aging and the conventions, recommendations and resolutions of the International Labour Organisation, the World Health Organisation and other United Nations entities,

**Encourage** Governments to incorporate the following principles into their national programmes whenever possible.

The principles are based on the Declaration of Rights and Responsibilities of Older Persons developed by the International Federation of Aging as set out in Appendix 2.

## Appendix 2

### International Federation of Aging - Declaration on the Rights and Responsibilities of Older Persons

#### Rights of Older Persons

**Independence** - Older persons have the right:

- 1 to access to adequate food, water, shelter, clothing and health care through the provision of income, family and community support and self-help;
- 2 to work and to pursue other income-generating opportunities with no barriers based on age;
- 3 to retire and participate in determining when and at what pace withdrawal from the labour force takes place;
- 4 to access to educational and training programmes to enhance literacy, facilitate employment, and permit informed planning and decision-making;
- 5 to live in environments that are safe and adaptable to personal preferences and changing capacities;
- 6 to reside at home for as long as possible.

**Participation** - Older persons have the right:

- 7 to remain integrated and participate actively in society, including the process of development and the formulation and implementation of policies which directly affect their well-being;
- 8 to share their knowledge, skills, values and life experience with younger generations;
- 9 to seek and develop opportunities for service to the community and to serve as volunteers in positions appropriate to their interests and capabilities;
- 10 to form movements or associations of the elderly.

**Care** - Older persons have the right:

- 11 to benefit from family support and care consistent with the well-being of the family;
- 12 to access to health care to help them maintain or regain the optimum level of physical, mental and emotional well-being and to prevent or delay the onset of illness;
- 13 to access to social and legal services to enhance capacity for autonomy and provide protection and care;
- 14 to utilise appropriate levels of institutional care which provide protection, rehabilitation and social and mental stimulation in a humane and secure environment;

- 15 to exercise human rights and fundamental freedoms when residing in any shelter, care and treatment facility including full respect for their dignity, beliefs, needs and privacy and for the right to make decisions about their care and quality of life.

**Self-fulfilment** - Older persons have the right:

- 16 to pursue opportunities for the full development of their potential;
- 17 to access to the educational, cultural, spiritual and recreational resources of society.

**Dignity** - Older persons have the right:

- 18 to be treated fairly regardless of age, gender, racial or ethnic background, disability or other status, and to be valued independently of their economic contributions;
- 19 to live in dignity and security and to be free of exploitation and physical or mental abuse;
- 20 to exercise personal autonomy in health care decision-making, including the right to die with dignity by assenting to or rejecting treatments designed solely to prolong life.

### **Responsibilities of Older Persons**

Consistent with individual values and as long as health and personal circumstances permit, older persons should try:

- 1 to remain active, capable, self-reliant and useful;
- 2 to learn and apply sound principles of physical and mental health to their own lives;
- 3 to take advantage of literacy training;
- 4 to plan and prepare for old age and retirement;
- 5 to update their knowledge and skills, as needed, to enhance their employability if labour force participation is desired;
- 6 to be flexible, together with other family members, in adjusting to the demands of changing relationships;
- 7 to share knowledge, skills, experience and values with younger generations;
- 8 to participate in the civic life of their society;
- 9 to seek and develop potential avenues of service to the community;
- 10 to make informed decisions about their health care and to make decisions about terminal care known to their physician and family.

## MODULE 2

# An Overview of Family Violence and Its Links to Elder Abuse and Neglect

### Introduction

As we work towards more accurately defining elder abuse and neglect, it is necessary to consider it in terms of other forms of family violence.

This module is not intended to give indepth information about the theories of family violence, as there is already extensive literature available. The aim is to draw attention to the characteristics that elder abuse and neglect have in common with other forms of family violence and to examine those which are unique to this particular social problem.

### Elder Abuse - A Form of Family Violence

Research indicates that elder abuse shares several characteristics with other forms of family violence<sup>1</sup>, for example:

- Victims and families are often socially and geographically isolated.
- Victims are in a weakened, powerless and dependent position.
- Families often lack adequate support and/or resources, eg practical, social, psychological, financial.
- There is often a history of family conflict.
- There is often a history of alcohol/drug abuse, psychological problems, low self-esteem and/or unemployment.

Despite the similarities, there are many differences between elder abuse and neglect and other forms of family violence.<sup>2</sup>

It is important to identify these similarities and differences so that they are taken into account by people working in the area of family violence, and so that policies and practice reflect the special needs of older victims of family violence.

### Definition of Family Violence

The following definition was developed by the Family Violence Prevention Coordinating Committee (1987).<sup>3</sup>

This definition provides a starting point to compare the similarities and differences of family violence and elder abuse and neglect.

Family violence is:

- Violence that occurs between those persons connected by relationships (non-strangers), usually in a non-public place.
- Violence is part of a system of behaviour used to establish and maintain power and control over another person.
- It includes conduct that damages physically, emotionally, socially and/or mentally and can be of a physical, sexual and/or mental nature.
- It involves fear, intimidation, emotional deprivation, assault with or without weapons and sexual violation.
- Such violence is often called 'domestic violence', 'child abuse', 'non-stranger rape', and 'incest/child rape' and includes all of these actions.
- It occurs irrespective of age, social status or ethnic group and affects a significant number of people in the community.
- Males are most often the aggressor, with females and children the predominant targets of this aggression.
- It is perpetuated and supported by the abuse and inherent power that individuals, groups, institutions and racial groups have over others.

This definition is similar to the definition for elder abuse and neglect used in this kit (See Module 3) except that it does not include 'material abuse' which is discussed later.

### **Power and Control**

It is assumed that the imbalance of power stems from dependency can lead to abuse, which in most cases is correct. For example, children and older dependent people are vulnerable and less able to protect themselves from an abusive carer. This also applies to women in violent family situations.

Issues involving power and control, however, may not always be straightforward. For example, a child may be abused by a parent because the parent is emotionally dependent on the child.

Likewise in abusive situations involving older dependent people, research has found that in some cases the abusive carer is financially and/or emotionally dependent on the older person. The frustrations of continued power and control can contribute to elder abuse. (Anetzberger<sup>4</sup> Pillemer<sup>5</sup>)

Abusive situations can arise due to loss of control and power. For example, an older person may resent his/her loss of independence and become abusive towards the carer. This is less likely to occur in other age groups.

Issues of power, control and dependency are involved in most cases of family violence, but with elder abuse these issues may be even more complicated.

### **Prevalence of Family Violence**

Both family violence and elder abuse and neglect are largely 'hidden' and private, and the acts committed by a person who is known to the victim. As a result, family violence and elder abuse and neglect are widely under reported; it is difficult to know how prevalent either is.

In a paper written in 1992 regarding the qualitative and quantitative measures of family violence in New Zealand, Raewyn Good states:<sup>6</sup>

“What is known is that over half the murders are ‘domestic’; that the Police were called to over 20,000 ‘domestic disputes’ last year; that refuges provided shelter to over 12,000 women and their children last year and received over 200,000 calls for help; that the Department of Social Welfare attends to more than 20,000 notifications of child abuse and neglect; that thousands of incest survivors seek help (often as adults) from Rape Crisis/Help Centres and the Accident Compensation Corporation; that the Family Court and Marriage Guidance deal with many hands of cases.”

The lack of general awareness of elder abuse and neglect, the belief in the right to privacy, and the diminishing networks and physical and/or mental health of older people, can mean that elder abuse and neglect is easier to conceal and harder to detect than other forms of family violence. These factors may also mean that abuse of older people is overlooked by those who come into contact with the victim. And it means that prevalence is extremely difficult to gauge.

### **Attitudes towards Family Violence**

Studies of domestic violence, in Australia, the United States and the United Kingdom indicate that it is widespread and positively sanctioned by a significant proportion of the community (Mungford).<sup>7</sup>

In 1988, a study regarding attitudes to family violence was carried out in New Zealand which covered Pakeha, Maori and Pacific Island perspectives.<sup>8</sup> It was found that there is a range of often contradictory beliefs and attitudes about violence. For example, most respondents believed violence is never justified and is a serious problem in our society, but this was not backed up when they described their actual behaviour.

The study also found that culture influences attitudes towards family violence; which is accepted as normal behaviour in one culture may be considered abusive in another. For example, some Pacific Island men thought that hitting their wives is acceptable practice:

“... if I did not hit my wife, I would be seen by both her family and mine as weak and not able to control her. Other men would joke about my lack of disciplining my wife. It is seen as part of the marriage relationship.”

Not all families accept violence and the use of force in either the same manner or degree. However, through experiencing and/or witnessing violence in their family, attitudes about what is appropriate and legitimate behaviour towards family members may affect individual perceptions and acceptance of family violence.

The question that arises in respect of elder abuse is: “Do attitudes towards violence in the family change with age?”

### **Child Abuse**

The most significant differences in the relationship between a parent and child, and an adult child caring for a dependent parent are:

#### **LEGAL RESPONSIBILITIES**

In parent/child relationships, the parent is legally required to provide care for the child. Older people, on the other hand, are assumed in law to be competent, responsible adults unless proved otherwise, and their adult children have no legal responsibility to provide care.

#### **EXPECTATIONS OF IMPROVEMENT**

Difficult and troublesome behaviour is often present in normal child development. With good parenting skills, the behaviour will improve as the child gets older.

With older people, improvement is unlikely and in fact behaviour will probably deteriorate. For example, parents can look forward to the day when a child is toilet trained, but a carer of an older person can expect incontinence to continue. Parents can also expect a child to increasingly understand what is expected of them, but communicating with an older confused family member may become more and more difficult.

In the cases of both children and older people, isolated situations of difficult behaviour rarely lead to abuse, but continuing negative interactions may build into abuse as stress builds up.

### **Violence Against Women**

Parallels exist between the underlying causes of violence against young women and older women. This results from the patriarchal nature and structure of our society which upholds the dominance of males over females.

The difficulties facing older abused women may be even greater than those of younger women; older women may believe that it is too late to start a new life or have come to accept violence as ‘her lot in life’. As dependency increases, so does the risk of abuse; for women who are victims of lifelong violence, the risk may be even greater.

Some research promotes the view that much aged abuse is in fact spouse abuse that has been occurring over many years (Pillemer and Finkelhor).<sup>9</sup>

Research is needed to discover the incidence and prevalence of lifetime abuse and the effects of such experiences on the victims.

## Violence Against Men

Situations that involve a wife abusing her dependent husband are though, in most cases, to be a result of past family violence; the role is reversed with the growing physical incapacity of the husband.

Some American research indicates that wives report more serious injuries when abused than do husbands, even though the incidence of abuse of male spouses was higher than that of female spouses (Pillemer and Finkelhor).<sup>10</sup>

## Material Abuse

Material abuse is often linked with physical or emotional abuse of older people. For example:

- Being physically abused or threatened with physical abuse, abandonment or removal from the home if possessions or assets are not handed over.
- Being aware that a family member is taken and using money or other assets without consent, but this is not reported for fear of retaliation.

Material abuse is less likely to apply in situations of abuse against children, as they are unlikely to have an income, possessions or property that would warrant abuse or threat of abuse.

Money and other assets are often a contributing factor in situations involving violence in adult relationships. Older dependent people may be unable to leave the abusive situation or report the matter due to their physical or mental incapacities.

It is therefore important that material abuse is considered when researching and developing policies regarding elder abuse and neglect. Questions that may need to be researched are:

- How often is material gain a motivator for acts of violence against older family members in New Zealand?
- What predisposing factors are more likely to be present when family members commit acts of violence against older people for material gain?

## Cycles of Violence

This theory of family violence holds that a child learns to respond violently within the family from the experience of being abused, and in turn grows up to become a child abuser. Extensive research gives credence to this theory (Gelles, Straus).<sup>11</sup>

Gender role models may also influence the acceptance of violent behaviour. For example, a female child who witnesses violence may grow up and continue to accept violence in her relationships.

A previous history of family violence has been suggested in elder abuse and neglect literature (Pillemer, Suitor).<sup>12</sup> However, Wolf, Godkin and Pillemer<sup>13</sup> state that “such a connection seems likely, but it is important to note that a difference exists between elder abuse and child and spouse

abuse regarding the transmission of violent behaviour. Children who abuse elderly parents were not *themselves* abused as elderly *parents*; the cycle of violence must therefore take a different form.”

This is an important factor that needs to be considered and researched. When a former abused child abuses his or her abuser, this may have the added dimension of retaliation as well as learned behaviour.

### **Alcohol/Drug Problems**

It is known that alcohol and/or drug dependency can contribute to both child abuse and violence towards women.

An Australian domestic violence information kit states:

“Alcohol appears to be involved in about 50% of incidents of domestic violence. These same offenders have also often assaulted their partners when sober. Abuse of alcohol is a risk factor which contributes to vulnerability to spouse abuse by lowering inhibitions, but alcohol does not cause domestic violence.”<sup>14</sup>

Alcohol is sometimes a factor in situations involving elder abuse. For example, an adult child with a drug/alcohol problem who returns home to care for his/her parent may find that the demands of care accentuate this problem, and abuse occurs.

Long-standing alcohol or drug problems in an older dependent person may make the task of caring even harder. The carer may have been subjected to problems related to alcohol or drug abuse over the years, and retaliates as the person they care for becomes more physically dependent.

As alcohol problems are often associated with other problems such as low self-esteem, relationship difficulties, etc, it can be assumed that the added stress of the care role may compound these difficulties and increase the risk of elder abuse.

### **Discipline and Violence**

The study “Attitudes to family violence: A study across cultures”<sup>15</sup> highlights the difficulty of finding a clear distinction between acceptable discipline for children, and unacceptable violence. The study found that what is considered acceptable discipline varies depending on the culture.

The Pacific Island study found that motive, context and consequences of the action determined the difference between violence and discipline. Most Maori and Pakeha responders felt that physical punishment is an appropriate method of disciplining children.

This raises the issue of managing the sometimes difficult behaviour of an older dependent person. Parents are expected to discipline their children as part of a child’s learning process, but it is assumed an older person knows how to behave so the learning element is not present. Spanking a child for constantly answering back may not be viewed as serious violent behaviour out of the

ordinary, while similar behaviour towards an older person would be. It is often impossible to reason with a confused older person, whereas this may be possible with a child.

## **Stress**

Stress is common to all forms of family violence and may be particularly relevant in abuse of older people. Stressors affect people in different ways and are often a combination of external pressures and personal ability to cope.

### **PERSONAL STRESS**

Personal stress can arise through demands of parenting, relationship difficulties, and a host of other reasons. A carer may be looking after two generations, his or her own children and a dependent parent. This 'sandwich' effect can create extreme stress, which may lead to abuse.

### **EXTERNAL STRESS**

External stress is a result of changes and demands caused by events such as birth, children leaving home, separation, divorce, aging, retirement, death, unemployment, etc. Justice and Justice<sup>16</sup> reported that child-abusing families were subject to high levels of stress. Many of the families they interviewed had undergone a long series of stressful events: accidents, illness, financial mishaps, and so on.

External stress may well increase the likelihood of elder abuse, particularly in today's changing society. Redundancy, for example, may mean that a man undertakes the care of an aging parent while his wife works. The financial pressure, loss of self-esteem and unfamiliarity with caring can result in violence.

Refer to Module 6: *Caring and stress*, for more information.

## **Social Isolation and Care Commitment**

Social isolation has been found to be characteristic of families in which child abuse and violence towards women occurs.<sup>17</sup> Families that have no support from other family members, friends or other usual social networks may find that caring for an older dependent family member is stressful and burdensome.

In some cases, family and friends find it difficult visiting an older person who is dependent and/or confused, as it raises issues about their own aging.

Older people are sometimes housebound due to disabilities; this can also restrict the carer's ability to leave the home.

Both children and dependent older people require a commitment of time and energy. If caring is seen as a "burden", abuse is more likely. The investment required to care for an elder parent is often perceived as detrimental to an adult offspring's own health and happiness (Koopman-Boyden and Wells).<sup>18</sup>

Refer to Module 6: *Caring and stress*, for more details.

## Intervention

Intervention methods used in situations involving elder abuse and neglect differ from those used in other forms of family violence.<sup>19</sup> For example, a younger woman would be encouraged to use a refuge, find alternative living arrangements in the community, undergo counselling, take court action, etc. The aim of the intervention is to stop the violence and help the victim re-establish and to find a better way of life.

Communities are now able to assist younger women and have appropriate services established. For example, refuges are mainly used by younger women and their families. For older people, the options are limited; they may only include remaining in the current situation or admission to a rest home or hospital, often with no likelihood of returning to their previous home.

## Information about Family Violence

Older people are more likely to be unaware about what to do if violence occurs. Publicity giving information about family violence is usually aimed at younger women and often does not include information for older abused people.

### ***Family Violence Prevention Coordinating Committee (FVPCC)***

Major moves have been made in New Zealand to address the problem of family violence. FVPCC, an interagency coordinating body established by Government in 1986, is attempting to address the problems of family violence by developing intervention and prevention strategies, in a coordinated approach between government departments and community groups.

The aim of FVPCC is to:

Address the problem of violence in the family/community in an effective, holistic manner through attitude change, behaviour change, improved agency action, increased community participation and ownership of the issues, and through improved coordination between agencies.

This aim is being addressed by cooperation between services and agencies, research and publications about family violence.

More information can be obtained from FVPCC, or from a booklet published by them, "Reach Out/Toro Mai"<sup>20</sup>, which lists agencies that can be contacted for help and information about family violence.

## Summary

Although elder abuse has parallels with other forms of family violence, there are also factors that set it apart. Understanding the special needs of older people, and the needs of those that care for them, is vital.

Further research is needed to more accurately identify the similarities and differences between family violence and elder abuse to enable appropriate intervention methods to be developed and support services to be provided.

**The diminishing networks and physical and/or mental health of older people, can mean that elder abuse and neglect is easier to conceal and harder to detect than other forms of family violence.**

### **Action Planning**

- 1 Having read this module do you consider there are any other factors that may differentiate elder abuse and neglect from other forms of family violence?
- 2 List the agencies and/or groups in your community that provide information and/or assistance regarding family violence.
- 3 If you do not know all the agencies and/or groups, who can you contact who does know?
- 4 By what date will you have contacted this person/group/agency?
- 5 How can you let others know what information and assistance is available?

## References

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## MODULE 3

### Towards a Definition of Elder Abuse and Neglect

#### Introduction

Overseas research has highlighted that elder abuse and neglect is a complex problem which cannot be explained by any single factor or theory.

Three essential characteristics define elder abuse and neglect at the personal level:

- 1 The age of the person who is abused or neglected.
- 2 The person responsible for the abuse or neglect is known to the victim and they have a relationship implying trust.
- 3 The behaviour of the perpetrator results in harm to the victim.

#### Social and Political Context

This resource kit focuses mainly on elder abuse and neglect occurring at the personal level.

However, the wider social and political environment also affects the quality of life of older people and those caring for them.

Public attitudes, government policies and funding arrangements, organisational policies and practices may also contribute to the problem of elder abuse and neglect. It is important to keep this wider context in mind when developing strategies to prevent elder abuse and neglect.

#### How Elder Abuse Differs from Abuse by Strangers

Elder abuse and neglect is committed by a person known to the victim and with whom they have a relationship implying trust.

Older people may also be the victims of violence or behaviours causing harm which are committed by strangers. These behaviours relate to criminal or civil offences between citizens. As such, the causes, possible solutions and legal implications are likely to be quite different compared with elder abuse and neglect.

As elder abuse and neglect occurs within an existing relationship implying trust, it is more likely to occur in private; it therefore entails quite different legal and social implications than abuse committed by strangers.

This kit does not deal with the issues of abuse by strangers. However, recent research has been undertaken in New Zealand regarding abuse of older people by strangers and is contained in a document: Violence Against Seniors: A Literature Review, Planning and Research Unit, Christchurch CIB, 1992.

### Why We Need to Define Elder Abuse and Neglect

- To provide a basic framework for coordinated action to protect older people from abuse and neglect.
- To enable the extent of the problem to be identified in New Zealand.
- To improve awareness and understanding.
- To facilitate research into the areas of elder abuse, elder neglect and elder self-neglect.

### Working Definitions of Elder Abuse and Neglect

At present there is no commonly used definition of elder abuse and neglect in New Zealand.

The boundaries of elder abuse, elder neglect and elder self-neglect are not clear-cut in practice and all may be involved in some situations.

Separate definitions have been used in this kit so that each aspect is clearly understood and researched.

If necessary, the following working definitions will be revised as more information from research becomes available.

#### Definition 1: Elder Abuse

*Elder abuse occurs when a person aged 65 or more experiences harmful physical, psychological, sexual, material or social effects caused by the behaviour of another person with whom they have a relationship implying trust.*

#### ABUSIVE BEHAVIOURS

The following categories have been identified in overseas research. Specific examples and signs are outlined in Module 7: *Signs of Elder Abuse and Neglect*.

- **Physical Abuse** - infliction of physical pain, injury or force.
- **Psychological Abuse** - behaviour which causes mental or emotional anguish or fear.
- **Sexual Abuse** - sexually abusive and exploitative behaviours involving threats, force, or the inability of the person to give consent.
- **Material Abuse** - the illegal or improper exploitation and/or use of funds or other resources.

#### Definition 2: Elder Neglect

*Elder neglect occurs when a person aged 65 or more experiences harmful physical, psychological, material and/or social effects as a result of another person failing to perform behaviours which are a reasonable obligation of their relationship to the older person and are warranted by the older person's unmet needs.*

### TYPES OF NEGLECT

Neglect has been divided into two areas, active and passive, to more clearly show the types of neglect that can occur.

Specific examples and signs are outlined in Module 7: *Signs of Elder Abuse and Neglect*.

- **Active Neglect** - conscious and intentional deprivation by a carer of basic necessities resulting in harmful physical, psychological, material and/or social effects.
- **Passive Neglect** - refusal or failure by carer, because of inadequate knowledge, infirmity or disputing the value of the prescribed services, to provide basic necessities, resulting in harmful physical, psychological, material and/or social effects.

### Definition 3: Elder Self-Neglect

*Elder self-neglect occurs when a person aged 65 or more experiences harmful physical, psychological, material and/or social effects as a result of failing to provide him/herself well-being.*

As self-neglect is self-inflicted, it is a different kind of problem from elder abuse and neglect and is therefore not dealt with in this kit. It is referred to because it is important to recognise that self-neglect does occur. In some situations it will be necessary to assess whether a situation is one of neglect by others or self-neglect, or a combination.

- **Ethical Issue** - the problem of self-neglect highlights a very important ethical issue. The right of the older person to self-determination must be respected. While elder self-neglect may cause considerable anxiety among neighbours and others, it is important to remember that unless the older person is causing danger to others s/he has every right to choose how s/he lives.

This ethical issue is also an important consideration when dealing with elder abuse and elder neglect. In addressing this problem we must ensure that we do not infringe the right of older people to self-determination.

### The Age of the Person Abused or Neglected

The age of 65 years has been used in the definition as it is the age most commonly used in international research on elder abuse and neglect. Precision regarding age is needed primarily for research on incidence.

From a practical perspective, flexibility regarding the age of the victim is important. The main emphasis should be on providing protection and support. People aged 55 to 65 years face major life transitions such as retirement or redundancy which can mean a change in roles and lifestyle. Others in this age group may have a chronic illness or disability, or experience premature aging, resulting in dependency on the care of others. In such situations abuse and neglect may occur, the only difference being the age of the victim. In those cases, the use of 65 in the definition of elder abuse and neglect should not inhibit action.

### **Universal Problem**

Elder abuse and neglect is a universe problem - it is not limited to any one gender, religious, cultural, ethnic or income group.

It occurs in rural and urban areas.

It occurs in private homes, boarding situations, rest homes, hospitals and other settings.

It is not limited to any one age group - older people may also be abusers.

### **Key Issues in Defining Elder Abuse and Neglect**

Elder abuse and neglect may involve relatively minor or major infringements of an older person's rights. It is a complex problem and each situation will be unique.

In addition, our personal and professional values and beliefs and our social, cultural and family experiences influence our perception and views about what constitutes elder abuse and neglect.

### **JUDGEMENT**

Deciding whether a situation involves elder abuse, elder neglect or elder self-neglect (or a combination of these) will be based on the knowledge, skills and judgement of the person assessing the situation.

Persons making such judgements have a responsibility to ensure they have the knowledge, skills and access to the resources and networks needed to make the best assessment of the situation and to respond positively and appropriately.

### **EFFECTS**

When considering a definition of elder abuse and neglect it is important to keep in mind the effect upon the older person. The effects of elder neglect may be as serious as those of abuse; the difference is the manner in which harm is inflicted. The nature, intensity and degree of the abuse or neglect will influence the effect on the older person.

#### ***Frequency***

The frequency of abuse can range from a single incident to a daily occurrence. For some types of abuse, even a single incident is harmful; for others it may not be.

#### ***Duration***

This overlaps with frequency but the two can differ.

For example, there may be no harmful effect on the older person unless the behaviour is repeated over an extended period.

#### ***Severity***

The severity of an abusive act will influence the degree of harm experienced by the older person.

***Intention***

The intention of the person inflicting the abuse and/or neglect is an important issue in intervention. For example, the response to a situation in which a carer abuses an older person due to exhaustion and unrelieved stress is likely to be quite different to a situation in which a carer has planned the abuse. However, for the purposes of identifying and defining elder abuse and neglect, the focus should be on the effects on the older person rather than the intention of the abuser.

## MODULE 4

### The Nature and Extent of Elder Abuse and Neglect

#### Why Does Elder Abuse and Neglect Occur?

There is no simple explanation as to why elder abuse and neglect occurs. The picture continues to change and expand as the results of new research are published.<sup>1</sup>

#### DEPENDENCY

Older people who are abused and neglected are likely to be dependent on others for all or part of their day-to-day physical care and well-being.

The carer may be dependent on the older person in some way, for example, financially or emotionally.

Module 6: *Caring and Stress*, covers this topic.

#### STRESS

The responsibility and demands of caring for an older person can be extremely stressful, especially when that person is a family member.

The carer may also face stresses such as unemployment, financial difficulties, health problems.

Module 6: *Caring and Stress*, examines the stress of caring.

#### FAMILY CONFLICT

There may be a history of family conflict and tensions so that spouse abuse becomes elder abuse when the couple becomes older.

A child that was abused may now be in a caregiving role and repeats the cycle of abuse to a dependent parent.

Unresolved previous sexual abuse may resurface.

Module 2: *Family Violence*, examines the issues of cycles of violence.

#### SUBSTANCE ABUSE

Dependency on alcohol or drugs increases the risk of abusive behaviour. This factor is also closely associated with family conflict, stressful conditions and dependency on the older victim.

Module 2: *Family Violence*, covers this area.

**ISOLATION**

A lack of supportive social contacts and networks can result in isolation for both the elderly person and the carer. The absence of adequate support and relief for the carer and limited opportunities to seek help increase the risk of elder abuse and neglect.

The importance of supportive social networks is discussed more fully in Module 6: *Caring and Stress*

**Profile of Older People More Likely to be Abused or Neglected**

<sup>2</sup>, <sup>3</sup> and <sup>4</sup>

- Those who are dependent on one person for all or part of their care.
- Those who exhibit difficult and/or inappropriate behaviour, confusion or memory loss either as a result of previous mental or psychological disturbances or due to more recent conditions such as impairment through a stroke, dementia, etc.
- Those with whom communication is difficult or impossible.
- Those with long-standing negative personality traits that may have become more pronounced.
- Those who have feelings of low self-esteem.
- Those with a background of family conflict and tension.
- Those who have limited social contact and networks.

**Profile of People More Likely to Inflict Abuse and/or Neglect**

<sup>5</sup>, <sup>6</sup> and <sup>7</sup>

- Those experiencing stress as a result of their caring role due to inadequate support, supervision and/or training.
- Those experiencing stress in other areas such as unemployment, financial, health.
- Those who may be dependent on the victim for money, housing, emotional support.
- Those who have experienced previous family conflict and tension.
- Those who have a background of mental health problems.
- Those who have a background of alcohol or drug related problems.
- Those who have poor support and/or social networks.
- Those who have difficulty controlling feelings of anger, frustration.
- Those who have feelings of low self-esteem.

See Module 7: *Signs of Abuse and Neglect*, for further details.

## Carer Abuse

In some situations an older person may abuse the person providing care. Contributing factors may include: lack of understanding and recognition of the carer's rights; difficulty in accepting his/her reliance on the carer; psychiatric illness, dementia or other disorders that result in aggression or a loss of judgement or insight; continuation of past abusive behaviour.

The carer may be in a very difficult situation and may feel trapped by feelings of responsibility, duty or guilt and limited alternatives. Module 6: *Caring and Stress*, examines the difficulties involved in caring for a dependent older person.

## Case Study

*Ted, who lived with his dementing wife, Beth, suffered constant hidings from her because, he said, he could never retaliate towards someone who did not know what she was doing.*

*Beth was assessed for day care but considered unsuitable because of her aggression.*

*She was prescribed tranquilising medication but it made her slow, languid and difficult to handle. She was admitted to hospital for "rehabilitation" purposes but realistically it was on humanitarian grounds. Ted, who had severe angina, was covered in bruises, and physically exhausted.*

## How Widespread is the Problem Overseas?

The definition and parameters of elder abuse and neglect vary considerably among studies undertaken overseas so it is difficult to accurately gauge the incidence and range of the problem. The following information has been taken from literature and illustrates the growing concern.

- In Australia, McCallum, Matiasz and Graycar state: "reasonable good surveys around the world show a prevalence rate for elder abuse of about 3% after age 65 years".<sup>8</sup>
- 3.2% of American elders are estimated to suffer abuse or neglect.<sup>9</sup>
- Approximately 4% (98,000) elders in Canadian private dwellings have been abused.<sup>10</sup>
- There are 10 million people over the age of 65 in Britain and it has been estimated by Mervyn Eastman that some 5000,000 elderly people could possibly be at risk of being abused (5%).<sup>11</sup>
- In China there are increasing concerns about incidents of maltreatment of elderly people. Similar evidence of neglect and abuse has emerged in Hong Kong and in Africa.<sup>12</sup>
- Reports of elder abuse in Japan centred on the daughter-in-law/mother-in-law relationship.<sup>13</sup>

The above references clearly show that elder abuse and neglect is not an isolated problem but a global issue with serious social consequences. The aging population indicates that unless action is taken now elder abuse and neglect will increase further.

In America, most states now have abuse laws which relate specifically to the elderly. In Britain, research and education programmes are being established. Canada and Australia have also undertaken indepth research in recent years.

### **What is the Extent of Elder Abuse and Neglect in New Zealand?**

People who work with older people and their carers in this country are aware that elder abuse and neglect happens; but as there are no standard procedures and it is not necessary to report cases of elder abuse and neglect, it is impossible to ascertain the extent of the problem.

### **Summary**

Our task now is to find ways of ensuring that the rights of older people are observed and that they have the opportunity to live without being abused or neglected. We also need to understand the sometimes very difficult and complex nature of caring for an older person so that carers have access to choices, constructive support, resources and education.

### **Action Planning**

To be alert to the problems of elder abuse and neglect you will need to consider:

- *The definitions and key issues contained in Module 3: Towards a Definition of Elder Abuse and Neglect.*
- *The likely causes of elder abuse and neglect contained in this module - Module 4: The Nature of Elder Abuse and Neglect.*
- *The profile of older people more likely to be abused or neglected (Module 4).*
- *The profile of people more likely to abuse and/or neglect an older person (Module 4).*

You will then need to decide:

- 1 How to gather and record information that will assist in a better understanding of the nature and extent of elder abuse and neglect.
- 2 How you can use the information gathered, for example:
  - Share information with others to ensure services for older people in your area are planned appropriately.
  - Forward findings to Age Concern.
  - Network with other groups.
- 3 How you can ensure that confidentiality is maintained without contributing to the problem of secrecy and the resulting failure to find positive solutions which protect the older person and support the carer.

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## MODULE 5

### Cultural Differences

#### Introduction

In this module we focus on the importance of recognising and being sensitive to cultural differences which, if overlooked, can result in abuse or neglect.

Judgement is a crucial element in identifying and deciding whether a situation involves elder abuse or neglect. In exercising judgement, we need to ensure that the values and viewpoints used are culturally appropriate for that situation.

This resource kit is written mainly from one cultural perspective and, as such, it cannot provide all the information or answers about such an important and complex issue. The intention is to ensure that cultural differences and needs are acknowledged as an important one.

Each of us has a cultural perspective from which we view the world and which influences how we act and react to situations around us. Each of us also has an obligation to ensure that we do not impose our own cultural perspective on people of other cultures. We can avoid this by:

- recognising and accepting our own culture;
- networking with other cultural groups;
- responding to the needs of people of other cultures;
- respecting opinions and judging when not to challenge or question a point; and
- ensuring that people of other cultures have the opportunities and resources to exercise self-determination.

#### Cultural Diversity

There are many cultures and social groups in New Zealand which are usually organised or distinguished by common bonds, eg ethnic origin, gender, age, sexuality, class, religion, etc. Organisations and institutions also develop their own cultures. The diversity of these cultures and social groups means that there are many differences in customs, values, beliefs, attitudes, behaviours and decision-making processes in our society.

People may belong to more than one of these cultures or social groups; this will contribute to their own particular perspective, needs and uniqueness as an individual.

These cultural differences must be respected if we are to promote and uphold human rights and protect older people from abuse and neglect.

#### Case Study

*Mrs T, a Samoan woman in her seventies, was admitted to a continuing care hospital. Mrs T had previously been cared for at home by her extended family but they could no longer meet her increasing needs due to advanced dementia.*

*The hospital endeavoured, within the constraints of institutional life, to identify and meet Mrs T's cultural needs, and family members were encouraged to visit as often as they wished.*

*The family liked to provide food for Mrs T and help her with it. A large number of family members usually came to visit at meal times and sat on the floor around Mrs T often sharing the meal with her.*

*The hospital received complaints from other visitors to the hospital because it was felt to be "terrible" that a private hospital did not give Mrs T enough to eat - "after all, they are paying for her care". Complaints also centred on the way the visitors had to sit on the floor, and on occasions so did Mrs T.*

*The hospital was investigated by the Public Health Nursing Service and an official complaint was made over this matter.*

## **Pakeha Culture**

The British Pakeha culture is, at present, the dominant culture in New Zealand. Our political system, decision-making processes and most of our institutions and services are based on a British heritage. This means that people from other cultures who are uncomfortable or unfamiliar with the Pakeha way of doing things have less power and reduced access to resources.

It is important not to overlook cultural diversity among people who share some common cultural links. For instance, there may be distinctive family values and differences within cultures, or religious, generational or other differences which should be acknowledged when caring for an older person. Using first name terms, for example, may be appropriate among younger people but may seem offensive or disrespectful to an older person.

## **Case Study**

*Joan moved into a rest home due to poor health. She was a devout Catholic and before admission had been told that a priest visited the home to give mass.*

*Joan was dismayed to find the priest only came once a month. She asked the matron if she could receive mass each week but this was not followed up.*

*Joan spoke to a visitor to the home who understood how important this was. The visitor explained to the matron that for a Catholic not to receive mass regularly is a mortal sin, and this was weighing heavily on Joan's conscience. The matron had not realised the importance for Joan and immediately arranged for her to receive mass each week.*

The dominance and diversity, both within Pakeha culture and between Pakeha and others, mean that we need to recognise the importance of cultural difference.

Awareness of one's own particular cultural perspective is an important first step in working with people from other cultures.

**Using the Cultural Questionnaire - Appendix 1:**

- **Examine your understanding and awareness of your personal attitudes and that of your own culture and how older people are regarded.**
- **Discuss this with people from your own and other cultures in a sensitive manner.**

## **Working with People of Other Cultures**

We tend to expect people to adjust to the perspective and values of the dominant culture. This is insensitive to the needs and rights of people with other values and perspectives and can be abusive in certain situations.

### **Case Study**

*Mrs M was Maori and was admitted to hospital following a stroke. She had lived alone and hospital staff decided that she could no longer manage without help. Mrs M had no immediate family and arrangements were made for her to live in a rest home on discharge from hospital.*

*Mrs M became very depressed in the rest home and was eventually readmitted to hospital. Mrs M confided to a nurse on the ward that she did not like the rest home and wanted to be with her own people. The nurse decided to make some enquiries to see if she could trace any extended family (whanau). Through a local group she discovered that a niece of Mrs M lived further north. This connection then led to other members of the extended family, who made arrangements for Mrs M to be cared for.*

It is inevitable that you will meet with or care for older people from other cultures. Sometimes you will not know how to deal with the situation as their decision-making processes may differ. Also, they will have values that are unfamiliar to you, but which are of the utmost importance to the older person.

These situations highlight the importance of developing strong links with people from other cultures and social groups in your community.

**Consider how you can begin to establish these links**

- **Identify and list the different cultures that are part of your community and arrange to meet with key people.**
- **Discuss with them what should be done when you are unsure or concerned about the care needs of an older person from that culture.**
- **Establish who you can contact in these circumstances and how they can contact you.**

People from other cultures and groups will be invaluable sources of advice as well as providing links to the decision-making bodies and processes of a specific culture or group. You should never presume that you will be a full participant in these processes, as your role may be different.

Funds also need to be made available so that cultural groups are able to set up their own support services for older people.

### Summary

Acknowledging and respecting cultural differences will promote human rights and help to prevent elder abuse and neglect.

Each of us has a particular cultural perspective. We all need to ensure that we do not impose that perspective on people of other cultures or assume we always know best. We also need to remember that there may be distinctive family or other values and differences within cultures which need to be respected.

Understanding our own cultural values, norms, attitudes and decision-making processes, and the diversity within our own culture, should increase our awareness of the importance and sensitivity of cultural issues.

Establishing networks with other cultures and social groups will increase our awareness and understanding of the diversity within our communities. More importantly, linking into those networks will enable us to avoid imposing a particular viewpoint by allowing each to exercise self-determination and to express values and needs. We must remember, however, that it takes time to get to know other ways.

### Action Planning

- 1 Have you completed the Cultural Questionnaire (Appendix 1)?
- 2 If you are unsure of any of the points raised in this questionnaire, who can you talk to?
- 3 Have you discussed your findings with a colleague or friend?
- 4 Can you think of a current situation/s where you have not considered the cultural perspectives?
- 5 What do you need to do about this? Who can you talk to?
- 6 Have you made contact with people/groups from different cultures in your community who can assist you with language, protocol, support services, etc?
- 7 If not, make a list of people/groups and set a date to contact them.
- 8 How do you intend to keep in touch with these people/groups?
- 9 Set a date when you will review your progress.

### Suggested Reading

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## Appendix 1

### Cultural Questionnaire

**If you come from two or more cultural backgrounds, complete the questionnaire for each.**

What are some of the important values and norms in your culture?

*Examples: birth, death, puberty, marriage, food etc*

How are major decisions typically made in your culture?

*Examples: By individuals, with the immediate family, with the extended family, by those voted to positions of power, etc*

Identify the values within your culture which contribute to diversity of attitudes, laws, practices, etc

*Examples: Religion, sexuality, politics, etc*

How are older people viewed in your culture - their role, status, etc?

*Examples: Automatically held in high regards, hold positions that are respected, head of the family, etc*

How do older people participate in the typical decision-making processes in your culture?

*Examples: Opinions valued, hold decision making positions, belong to lobby groups, participate in family meetings etc*

What provision does your culture make for the care of older people?

*Examples: Expectation that family provide care, residential care, none, etc*

How do you think your culture differs in its attitudes towards, and treatment of, older people, compared to another culture you are familiar with?

What role does a daughter/son have in providing care for a parent in your culture?

What would it mean to you/others in your culture if your mother/father was cared for in a rest home?

What would it mean to you/others in your culture if personal care was provided for your mother by a male nurse?

What would it mean to you/others in your culture if other people (volunteers, service providers) were to help out by providing care, social contact, meals etc, for your mother/father at home?

- **Discuss your answers with colleagues and friends from your own and different cultures.**
- **Compare the similarities and differences.**
- **Now go through the questionnaire again and note any points you need to remember.**

## MODULE 6

### Caring and Stress

#### Introduction

Caring for an older dependent person is an extremely valuable yet often undervalued role. Many older people are able to remain in the community because of the dedication and hard work of the people who care for them. Caring, then, is a major social service.

For some people, caring is a rewarding responsibility; for others it is difficult and offers few rewards. For many, including those who want to care for a dependent older relative, it is a stressful activity.

This module examines the reasons why caring can be stressful. It looks at the special needs of carers and way of managing stress.

#### Dependency

We live in a society which places great emphasis and value on self-help and independence; this can hinder our ability to accept and adapt to the changes that may result from increasing dependency. For example:

- An older person may deny the need for help past the point where it is safe to do so, and having offers of help refused or rejected can leave carers feeling angry and resentful.
- Carers may blame the older person for not being more self-reliant or independent because they do not understand that dependency is increasing because of failing health.

Dependency can happen in many ways, for example: suddenly and dramatically as a result of a physical injury or disabling illness (eg sudden stroke), or more slowly as an illness or disability progresses (eg memory loss). As we age, the likelihood of dependency increases, particularly for those aged over 80 years.

Coming to terms with dependency means adjusting to the diminishing abilities of the older person and to the changes that this may bring to relationships, roles and the balance of power between the dependent person and the carer. For example:

- A former equal relationship between husband and wife may change as one becomes more dependent on the other.
- Roles are reversed when a parent is cared for by an adult child.

Carers may not have the opportunity to identify, acknowledge and deal with their feelings about the changed relationship, due to the demands of responding to the emotional and practical needs of the older person.

In some cases, the dependent older person is unaware of the amount of care he/she requires and the demands this places on the carer. This lack of insight can mean the carer receives no recognition for what they do, and in some situations nothing they do meets with the approval of the dependent person.

When the relationship between the dependent person and the carer is strained or has broken down, the differences in abilities, imbalance of power and change of roles mean that abusive situations are more likely to occur.

### Case Study

*Judith had been caring for her father for three and a half years without a break. Her sister lived close by and had offered to have him, but he refused to go because he felt embarrassed at others helping him with the toilet. Over the last four months he had become incontinent and required frequent changes of clothes. This generated a lot of washing. He had also, over the last 12 months, because anxious when Judith was absent and she felt increasingly unable to leave him. All her friends had stopped calling. She had no time to call them; even if she had, she felt she had nothing to talk about. They had no appreciation of the intensity of the demands on her, regarding her as having "time off" from work. She felt desperately lonely, increasingly socially incompetent and extremely worried about how much longer she was going to have to care for her father. She knew how difficult getting paid work was going to be because she had been out of the paid work force for so long. She also felt guilty at almost wishing her father dead or institutionalised.*

*Judith had almost no social service support. The District Nurse came once a week to bath her father but was so rushed because of staff shortages there was no time to talk. Having her say, as she dashed out of the door, "but you are coping fine, aren't you?" did not encourage Judith to admit she wasn't. The more depressed she became, the more difficult it was to keep going and the angrier she found herself getting with her father when he wet himself.*

Accepting and coming to terms with the dependency of another person requires considerable personal adjustment. It is therefore important for carers to have someone they trust to talk about their particular situation. It is also important for them to acknowledge the negative feelings and changes that occur as a result of dependency and to have an opportunity to work through them.

Ways of managing the stress of caring can be found in the second part of this module.

**Questions - If you are a Carer:**

- How has dependency changed the relationship between you and the person you care for?
- Have you been able to talk to someone about these changes?
- If not, consider who you can talk to, eg family, friend, doctor, nurse, social worker etc
- Have any other difficulties or problems arisen as a result of the dependency of the person you care for?

**Questions - If you work with Older People and/or Carers:**

- Do you discuss dependency and what this can mean with carers when they first undertake care?
- How do you encourage carers to talk about their feelings and the implications for them as the older person's level of dependency increases?

### **Society's View of Caring for a Dependent Older Person**

Our society (and this extends to current Government policy) tends to believe that families offer shelter, nurturing and love to their members, without acknowledging the negative aspects which may exist such as destructive relationships, or the differences in values, beliefs and lifestyles of family members. For example, the lifestyles of a parent and an adult child may be totally incompatible. The belief that families ought to be able to cope can make it difficult for people to acknowledge the problems they may be experiencing in caring for a dependent person.

The tendency is to assume that the responsibilities of care are shared between a number of family members. However, most older people are cared for at home by a single relative, often with very little support from other family members. This mistaken assumption can result in a lack of support for people caring alone.

Many women have been socialised to place others ahead of themselves and renounce their own needs. As women do most of the caring work this can make it much more difficult for them to ask others to assist with tasks or to maintain aspects of their own lives that help to reduce stress.

These factors often mean that the stress which can be a part of caring is denied or, if acknowledged, can be thought of as a failure on the part of the individual carer. It can also mean that carers feel unable to let go of the caring role and jeopardise their own health and well-being.

### **Caring**

Caring for an older dependent person, especially over an extended period, can be physically and emotionally exhausting and debilitating. It is hard work.

The tasks involved in caring are often unscheduled, irregular and unpredictable. For example, on day a task may be carried out easily and quickly and the next day the same task may be difficult and time consuming. This makes it very difficult for carers to organise their own lives, respond to their own needs and interests and, at times, carry out basic household tasks.

Carers are expected to know how to carry out difficult tasks and understand complicated illnesses or disabilities with little or no training. They need to know how to work alone and also as part of a team, for example, with service providers that come into the home. Providing care for an older dependent person requires many skills and an understanding of the complexities of dependency and aging.

The carer may undertake the responsibility of care because of his/her positive relationship with the older person or because of a sense of obligation; yet at the same time the carer may feel uncertain, resentful, angry or afraid about doing so. These more negative feelings are likely to be intensified in situations where the carer feels trapped in the caring role or if the relationship has been difficult and/or distant. If there is a history of family violence, these feelings may be extremely strong.

### **Case Study**

*Beverly was still in the paid work force when she realised that Alex, her husband, was beginning to lose his memory. At first it was possible for her to leave Alex notes reminding him to do things, such as go shopping or eat his lunch; later on, she made his lunch, and wrote him notes to remind him to look for it in the fridge; later on again, she had to ring to check he had remembered to read the note.*

*As his memory deteriorated further, she gave up work to care for him fulltime. He required constant attention lest he wandered off, and his short term memory had completely gone. Beverly, who had loved to go off on the spur of the moment for drives, realised that this was no longer possible; she began to feel trapped, increasingly lonely, and also resentful of the way her life seemed to be closing in on her. She found that she was shouting at Alex at lot more and at times only just restrained herself from shaking him.*

### **Lifestyle and Other Changes that may Occur for Carers**

As the above study illustrates, there are many factors that affect the life of a carer besides the practical realities and demands of caring.

It is difficult to predict exactly what demands and changes in lifestyle will occur when care is undertaken. Often the demands build up slowly and the carer is unaware of how much their life has changed until the stress becomes acute or a crisis occurs..

Before undertaking the care role, it is vital for carers to take stock of their own needs and the needs of those close to them, as well as the needs of the dependent person. It is also important to

regularly review and assess the situation to ensure that the demands on both time and energy have not become too much.

Each carer needs to consider the factors that may make caring stressful for him/her.

### **THE PRACTICAL REALITIES AND DEMANDS OF CARING**

These may include:

- Multiple responsibilities, for example, managing two households if the dependent person lives alone or holding down a job as well as providing care.
- Helping without undermining the competence, dignity and self-worth of the dependent person. This can be very frustrating when it involves waiting for someone to slowly complete a task that you could have done quickly.
- Financial difficulties due to the loss of income and extra costs associated with caring, for example, laundry, daycare, transport.

### **THE PERSONAL ADJUSTMENTS THAT MAY BE REQUIRED OF THE CARER**

These may include:

- Giving up paid work, turning down promotion or long term job prospects;
- Loss of freedom to pursue interests, maintain social contacts;
- Acknowledging and managing the emotional demands and responses to caring such as:
  - loss of confidence and self-esteem
  - sense of resentment/guilt
  - anxiety about the future;
- Learning new skills, for example, financial management, household and caring tasks; and
- Accepting the need for help and support.

### **CHANGES THAT MAY OCCUR IN THE RELATIONSHIP BETWEEN THE CARER AND THE DEPENDENT PERSON**

For example:

- Coming to terms with changes in the dependent person, for example: memory loss, personality changes, physical disabilities and the grief that may be associated with these changes;
- Sexual relationships can become less satisfying or cease; alternatively one partner may become much more demanding;
- Communication may be difficult or impossible and may result in loneliness and loss of supportive advice;
- Loss of reciprocity and support in the relationship; for example, the carer may be giving more to the relationship while receiving less from it than before;
- Acknowledging and accepting a reversal in previous roles, for example, child/parent, husband/wife.

### **CHANGES THAT MAY OCCUR IN THE RELATIONSHIP BETWEEN THE CARER AND OTHERS**

For example:

- Less time with other family members and/or friends;
- Torn between the relationship with the dependent person and the relationship with other immediate family members;
- Unable to participate in significant family events;
- Lack of understanding about the demands of care by other family members;
- Disagreement with other family members about caring for the dependent person and/or how this is managed;
- The withdrawal or rejection of friends or acquaintances because of their fears about old age or discomfort about the situation.

### **LACK OF RECOGNITION ABOUT THE NEEDS OF THE CARER**

For example:

- Little or no time for self;
- Little or no practical help and/or support;
- Lack of understanding and/or acknowledgement about the carer's feelings, for example:
  - guilt and failure which may prevent carers from seeking help;
  - frustration and resentment about the changes to their lifestyle.

### **LACK OF SUPPORT SERVICES**

For example:

- difficulty of access to information about available support services;
- difficult of access to support services, for example, in rural areas;
- shortage of home support services and the limited range of assistance available;
- shortage of relief care on a regular daily basis;
- cost of support services.

To carry on alone and ignore the effects of caring may result in a breakdown of the carer's physical and/or mental health or, in some cases, abuse and/or neglect of the person they care for.

Carers must be encouraged and know how to:

- access practical help for themselves and the dependent person;
- identify and manage the stress that may result from the physical and emotional demands of caring.

**Questions - If you are a Carer:**

- **What are the most significant changes that have occurred in your life since undertaking the care role?**
- **Have you been able to talk to someone about these changes?**
- **If not, consider who you can talk to, eg family, friend, doctor, nurse, social worker etc**

**Questions - If you work with Older People and/or Carers?**

- **Do you discuss with carers the changes that have occurred as a result of caring for a dependent person and the assistance and support they may need to minimise these changes?**
- **How do you encourage carers to talk about the feelings associated with these changes?**
- **Do you link carers with others in a similar situation? If so, who?**

### **Identifying Stress Symptoms**

People do not experience the same situation or event as identically stressful. Life history, personality, health, degree of support available, the severity of the dependent person's disability, the length of time they have been caring, the quality of the relationship with the dependent person and events in the immediate past and present are factors which affect how carers respond to the demands of caring.

Identifying and acknowledging stress is an important step in managing stressful situations. Many people are aware of the major ongoing stresses associated with caring for a dependent person but many people underestimate how many small stressful events occur every day, to which a carer is forced to adjust.

Stress often begins with small warning signs, for example, feelings of frustration, alienation, emotional outbursts, withdrawal, minor health problems. If unheeded, these symptoms can progress until a major health problem occurs such as a heart attack; or the carer may be unable to control his/her negative feelings towards the dependent person. In some cases, this may result in abuse and/or neglect.

The following are stress indicators:

***Physical Indicators can include:***

- chronic fatigue
- lethargy
- lack of energy
- loss of appetite
- weight loss/gain
- frequent colds/infections

- indigestion
- ulcers
- backache
- headaches
- muscular tension
- bowel problems
- high blood pressure

***Emotional Indicators can include:***

- tiredness
- difficulty in making decisions
- loss of interest
- anxiety
- loss of motivation
- weepiness
- sudden mood changes
- fear about the future
- feeling overwhelmed
- bewilderment
- anger at oneself as well as the dependent person
- resentment
- feelings of isolation
- sleeplessness
- loss of concentration
- low self-esteem
- feelings of loss of control

**Important:** It is important to have a medical check-up when any of the above indicators persist.

**Questions - If you are a carer:**

- **What areas of care are stressful for you?**
- **Have you been able to talk to someone about these things?**
- **What actions do you need to take to reduce the stress?**

**Questions - If you work with older people and/or carers:**

- **When do you usually discuss stress indicators with carers - when care is first undertaken, when the carer shows signs of stress or both?**
- **How do you help carers identify areas of possible stress?**
- **What information/advice about ways to reduce stress do you provide?**

## The Reduction of Stress

Because high levels of stress contribute to the development of abusive situations, it is important that carers take what steps they can to reduce their stress. This is not always easy to do, however, and carers may need help to reduce and/or manage their stress.

Many carers have few options and those options that would help may not be available. Carers are often dependent on the availability of social services; access to these may become increasingly means-tested or no longer available through the public health services.

Asking for help is never easy. Carers may well feel there are actual or imagined constraints to adopting any of the possible courses of action outlined below. Protecting oneself in order to better protect and care for someone else requires determination and courage. It is important to remember that:

**“Loving someone does not mean that you have to be solely responsible for their care”**

## Stress Management for Carers

The following actions can be taken by carers to help them look after themselves and the dependent person they care for.

It is important to remember that, just as the causes of stress are unique to each carer, so too may be the methods of managing stress.

### ACKNOWLEDGE THE STRESSFULNESS OF YOUR SITUATION

- This is a responsible act and it is OK to acknowledge the difficulties.
- Feeling stressed is not the result of personal failure or that you are “not coping properly” and have in some way failed the person for whom you are caring. Stress is the result of the demands of the caring role.

### TELL OTHERS WHOM YOU TRUST THAT YOU ARE FEELING STRESSED

- This in itself can reduce the stress of feeling that you have to carry the full burden unacknowledged and alone.
- Those you talk to may be able to help you carry through decisions about how you can reduce your stress.
- Others may not understand your situation unless you tell them. People often do not appreciate the full complexity of caring situations, or may feel unable to ask how you are managing.
- Once you have explained the situation, you may also feel that you can ask them for some help.

### TAKE TIME AWAY FROM CARING

- For example, take time alone in prayer, meditation or reflection, or talking to a friend

This is vital to:

- the quality of care you provide;
- continuing to feel positive about the person you care for;
- your own physical, emotional and spiritual survival.

#### **ACKNOWLEDGING YOUR NEEDS - NOT JUST THOSE OF THE PERSON YOU ARE CARING FOR**

- One of the results of caring is the loss of friendships and interests; this may contribute to an increasing sense of isolation and poor self-esteem and lead to stress.
- Using day care, for example, can allow you time to maintain social contacts and your own personal interests. Use this time for yourself, not household chores.

#### **FIND OUT WHAT SOCIAL SERVICE ASSISTANCE IS AVAILABLE**

- There are names of organisations in this resource kit that provide assistance, or can help you identify who to talk to. For example, if you are caring for someone who has had a stroke, a good place to start is by contacting the field officer of Stroke Foundation; if caring for someone with dementia, ADARDS offers support and advice.
- Your doctor, local medical centre or community health centre will be able to tell you about the health and social services available in your district.

#### **REGULARLY REVIEW THE DEMANDS CARING PLACES ON YOU**

For example:

- Have the day-to-day demands of caring increased?
- What help is available from health/social services?
- What situations in daily life do I find stressful to manage?
- What are the ones to which I can learn to turn a blind eye?
- What are the other demands on me? Have they changed?
- What is my state of health?
- Is it reasonable or sensible to continue caring?
- Is this the time to use respite care programmes?

(It is often very difficult to make this decision. Talking it through with a supportive family member, friend, field officer, social worker or doctor can be helpful)

#### **CONSIDER CAREFULLY HOW YOU CAN REDUCE THE STRESS OF CARING**

- Start with something that is achievable and be specific.
- Talking to someone or making a list might help you become clear about things that could help.
- Identify what may stop you from doing this. Talking the issues over with someone can help.
- Set yourself a goal that will contribute to your stress reduction and/or help others recognise your stress.
- Set a date when you will review your situation. It is important to keep a check on yourself to ensure you have actually taken the action you planned and whether or not this action has helped relieve the stress.

For example, in the case studies referred to earlier in this Module, the action open to those carers includes:

*Judith might decided to get in first and say to the nurse on her arrival that she is nearly at the end of her tether.*

*Beverley might decide to ask her old friend across the road, who knows Alex well, to come in and stay with him on a regular basis to allow her to go out for a drive.*

The first step is important, no matter how small. Experiment to find methods that work for you. Remember to regularly review your situation because the demands will change as dependency increases. What works today may not work in say three or six months time.

Last but not least, remember you have rights and one of these is to enjoy your life. Think about things that make you smile and things you really enjoy, then make a real effort to build these things into your life. You deserve them!!

Attached is a list of books which provide further information.

#### **Questions - If you are a carer:**

- Which of the above stress management actions would be helpful for you?
- What do you need to do to ensure you try these ideas? For example, what will help and who can help you?
- Do you know what practical help is available to assist you?
- If not, consider who you can ask, eg doctor, nurse, social worker, etc.

#### **Questions - If you work with older people and/or carers:**

- Do you help carers monitor stress?
- Do you help and support carers to try different ways of managing their situation? How do you do this?
- Has this module highlighted any points you need to consider when working with carers in the future?

### **Community Organisations - Helping Carers Manage Stress**

The role that community organisations can play in carer's stress reduction are many. What role you adopt will depend on the particular orientation of your organisation.

- Some may wish to adopt a political role, pressing for more adequate service provision.
- Others, such as churches, social clubs and service organisations may want to look at ways in which they can sensitively assist carers, for example home visits, or developing practical services such as sitting or gardening.

- Others may be involved in the actual provision of services.

In relation to the last two points, it is vital to remember that you are there to assist with the caring tasks. You are not there to insist that carers adopt a course of action which seems appropriate to you. Older carers tend to find asking for social service assistance difficult and are hesitant about accepting services such as respite care.

The responsibilities of those who are helping carers are to:

- remain aware of constraints on the carer in asking for help;
- enable carers to clarify their options and explore what services are available and acceptable to *the carer*;
- ensure that the services offered are appropriate to the individual situation.

### Summary

Caring for a dependent person can be stressful because of its physical and emotional demands. These demands affect individual carers in different ways and it is therefore important that each carer has access to the services and support that are relevant to their particular situation.

Both carers and service providers need to understand the causes and indicators of stress and to know the options available to deal with stressful situations as they arise. This will help minimise the risk of elder abuse and neglect and enhance the quality of life of those who care.

### Action Planning for Carers

- 1 Have you considered the questions in this module?
- 2 Have you set an achievable goal to help reduce the stress of caring?
- 3 Have you identified people, services etc, that can help you achieve your goal?
- 4 Set a date when you will review your situation.

### Action Planning for Service Providers

- 1 Have you considered the questions in this module?
- 2 Is each carer treated as an individual with differing needs and responses to the caring role?
- 3 What do you need to do to ensure carer's needs are considered and met?

**Asking for help is not asking someone to take full responsibility; nor is it an indication of failure.**

### Suggested Reading

- *Caring Alone: Looking after the confused elderly at home*, by Anne Opie, Daphne Brasell Associates Press, 1991.  
(This is a New Zealand book and contains case studies which illustrate the demands of caring)
- *There's Nobody There: Community care of confused older people*, by Anne Opie, Auckland Oxford University Press and Philadelphia University of Pennsylvania Press, 1992.
- *The Relaxation and Stress Management Workbook*, by Martha Davis, Elizabeth Eshelman and Matthew McKay, New Harbinger Publications, Oakland, California, February 1989.
- *Stressmap*, by C. Michele Haney and Edmond Boenisch, Impact Publishers, California, February 1987.
- *Relax and Come Alive*, by Iris Barrow and Helen Place, Heinemann Publishers, 1986
- *Living Successfully with Stress*, Consumer Institute of New Zealand, Whitcoulls.
- *Superhealth; Self-relaxation Programme*, by Joan Atkinson and Dr John Raeburn, Mental Health Foundation, Auckland, 1987.  
(This booklet and audio tape are available free from the Mental Health Foundation)
- *The woman's comfort book: A self-nurturing guide for restoring balance in your life*, by Jennifer Loudon, Harper-Collins Publishers, 1992.

### ADDITIONAL RESOURCES

If you know of any other suitable resources that can be used with this Module, please notify Age Concern New Zealand, PO Box 1930, Wellington.

## MODULE 7

### Signs of Elder Abuse and Neglect

#### Introduction

In this module we look at why the detection of elder abuse and neglect is difficult and what signs can alert you to the problem.

#### Difficulties of Detection

##### SECRECY

Detection of elder abuse and neglect is often hampered by the fact that it is secret, takes place behind closed doors and is typically suffered by older people who are isolated and unlikely or unable to get out and speak for themselves. Those who are in contact with other people are often ashamed or frightened and are inclined to cover up and deny the signs or symptoms.

##### PRIVACY

Society's belief in individual and family privacy, and that the family takes care of its loved ones, also hampers detection. Neighbours, friends and acquaintances as well as service providers are inclined to believe that it is not right to pry into another person's life. Some older people believe that becoming old entails a duty not to complain and to accept what life deals out to them.

##### AGEING

As many of the signs and symptoms of elder abuse and neglect can be attributed to changes brought about by ageing or illness, it is easy to assume that ageing is the cause of the older person's condition. For example:

- Bruises may be the result of hitting or they may be caused by falls or bumping into things due to poor balance or eyesight.
- A withdrawn attitude may be due to continual verbal threats and abuse or it may be due to clinical depression, grief or low self-esteem (not uncommon for older people), which may in turn be exacerbated by perceived abuse.
- Loss of material possessions may be a result of theft by a family member or carer or it may be due to the older person being confused and forgetful.

Service providers who visit older people at home are more likely to come into contact with a victim when the abuse and/or neglect is in its early stages and symptoms are much more subtle or easily concealed. Others, such as health professionals, may see the victim for an unrelated health problem after the maltreatment has progressed and symptoms are more visible.

Abuse and neglect often goes undetected, sometimes for year, and in some cases may never come to notice.

These difficulties, to some extent, can be overcome by raising public awareness and educating service providers about the signs and behaviours that may signal abuse and neglect.

## General Indicators

As with all human situations, there are no hard and fast rules that indicate an older person is being abused or may be abused or neglected. Each situation is different.

There may be more than one type of abuse present, for example, physical and material. It is therefore important to take into account the entire situation and not just what is presented or obvious - abuse is often well-hidden.

There are however some factors that are common in most cases.

Module 4: *The nature and extent of elder abuse and neglect*, explains these, factors, which include:

- dependency;
- stress;
- substance abuse;
- family conflict;
- isolation.

There are certain characteristics associated with those more likely to be abused and neglected - for example, they may be exhibiting difficult and/or inappropriate behaviour. Some common characteristics are also associated with those more likely to be responsible for the abuse and/or neglect. These can include intergenerational problems, low self-esteem, etc.

Profile are included in Module 4: *The nature of elder abuse and neglect*, which list these characteristics.

It is also important to remember that the presence of these characteristics do not necessarily mean that abuse or neglect is taking place.

## Behavioural Signs

Abuse and neglect can sometimes be detected from the behaviour of the people involved as well as the more obvious signs and symptoms. The effect of the behaviour should always be considered as this will indicate what action should be taken as shown in Module 12: *Assessment*.

As abuse and neglect is often difficult to identify, special attention should be given to the interaction between the victim and those who are regularly involved with him/her. For instance, does the older person appear unduly afraid or excessively compliant in the presence of the carer or some other person?

It is important to be aware of sudden and unusual or different behaviour patterns in the older person, not only at home, but in other situations or settings - for example, suddenly not attending church or a group after regular attendance.

Behaviours that the **older person** may exhibit:

- show signs of being afraid of a particular person/people;
- appears worried and/or anxious for no obvious reason;
- becomes irritable or easily upset;
- appears depressed, withdrawn;
- loses interest;
- has sleep disturbances;
- has changed eating habits;
- has suicidal wishes;
- has frequent shaking, trembling and/or crying attacks;
- has rigid posture;
- presents as helpless, hopeless, sad;
- uses contradictory statements not resulting from mental confusion;
- is reluctant or hesitant to talk openly; waiting for carer to answer;
- avoids physical, eye or verbal contact with carer or service provider.

It is more effective to observe these behaviours in the home. However, it is important to be aware of them in other situations as well.

It is also important to observe the behaviour of people with whom the older person has contact. Are they willing to touch, talk, look at or listen to the older person? Do they react strongly to suggestions regarding the older person's care? Do they use ageist remarks or put-down comments?

Behaviours that may be exhibited by a **person inflicting abuse**:

- blaming the older person for his/her behaviour, eg, wandering, incontinence;
- not wanting the older person interviewed alone;
- refusing treatment for the older person;
- seeking medical attention from a variety of doctors/medical centres;
- responding defensively, making excuses, being hostile or evasive;
- excessively concerned or unconcerned;
- minimal eye, physical or verbal contact;
- treating the older person like a child;
- using threats, insults, harassment;
- taking control of the older person's money or other resources;
- difficulty managing their own life.

### **Case Study**

*Mrs C moved in with her son and daughter-in-law following her husband's death. She was an outgoing woman who was well known in the community and regularly attended the local resource centre. The social worker at the centre noticed that Mrs C had become very quiet and not interested in joining in the activities she had previously enjoyed. She mentioned these changes to Mrs C's daughter-in-law and was surprised when she responded in a defensive manner and commented that the social worker should try and live with her.*

*Mrs C stopped attending the resource centre after this and the social worker decided to visit her at home. She was met by the daughter-in-law who said Mrs C was asleep and that she did not want to go to the resource centre anymore. She again seemed defensive and avoided eye contact.*

*The social worker visited the home again and found Mrs C on her own. She seemed reluctant to let her in but with gentle encouragement said that her daughter-in-law wanted her to go into a rest home because of the extra work she had made for her. She was trying to be less of a burden by staying at home so that her daughter-in-law did not have to run her around. She appeared depressed and fearful and begged the social worker not to tell her daughter-in-law what she had said.*

*Transport was arranged to take Mrs C to the resource centre. The social worker continued to visit Mrs C at home and gradually gained the trust of her daughter-in-law which enabled them to openly discuss the difficulties and explore how they could be resolved.*

**Caution: Avoid jumping to conclusions! The above characteristics and behaviours may not necessarily indicate that abuse or neglect is present.**

## Environmental Signs

Living arrangements, and standards will vary; what is acceptable for one person may not be for another. It is, therefore, important that personal standards do not influence our judgement. Consideration should be on the **effect** the living arrangements or standards have on the older person.

If the home is hazardous to the older person's health or safety due to disrepair, level of cleanliness, fire safety etc, this may be a sign that the carer is unable or unwilling to provide adequate care and may signal abuse or neglect.

Inadequate heating, inability to reach food or water, inadequate sleeping or sanitary facilities are other signs that may indicate abuse or neglect.

The presence of any of the above behavioural or environmental indicators does not necessarily imply that abuse or neglect is taking place, but it does mean that further investigation is warranted.

The types of abuse and neglect discussed in this kit are outlined in Module 3: *Towards a definition of elder abuse and neglect*. The following examples of signs and symptoms will help clarify these definitions.

## Physical Abuse

Physical abuse is the infliction of physical pain, injury or force on an older person.

The physical signs of abuse may not always be visible, or the abusive behaviour obvious, so the general appearance, attitude and behaviour of the older person should be taken into account. Unexplained or repeated injury is a sign that further investigation should be undertaken.

Signs of physical abuse may include:

- abrasions;
- bleeding;
- burns;
- dehydration;
- dislocations;
- grip marks;
- internal injuries;
- over-sedation;
- punctures;
- sprains;
- welts;
- bed sores;
- bruises;
- cuts/lacerations;
- direct beatings;
- fractures;
- hypothermia;
- malnutrition;
- poisoning;
- scalding;
- swelling;
- wounds.

Physical abuse can occur in many ways, for example:

- general rough handling;
- acts such as slapping, hitting, pinching, kicking, pushing, tripping, shaking, burning, etc;
- restricting freedom or movement such as, tying to a chair or bed, confining to a small space or over-medicating;
- withholding pain relief or appropriate medical treatment.

### Case Study

*Alice, who was dementing, lived with her elderly husband who appeared to look after her very well.*

*She attended the local day hospital, who reported bruising to her arms and back.*

*Her husband insisted that she kept falling down and he had to “haul her up”, hence the bruising. A thorough medical examination ascertained that she did not have the tendency to bruise easily and she was not prone to falling while in the hospital setting.*

*The only clue of abuse came when Alice was offered a cup of tea and she dropped the cup. As the nurse leaned forward to mop up the spilt liquid from her lap, she visibly flinched and cowered back, covering her face with her arm.*

*Her husband was invited to a meeting called to discuss his wife and gentle probing brought an emphatic denial that he had ever hit her.*

*Regular relief care was arranged and this eased the situation considerably. Unfortunately the rejection was too entrenched and Alice was found a place in a rest home. It was later discovered that their relationship had always been strained and her mental state had served to exacerbate this.*

## **Psychological Abuse**

Psychological abuse results from actions which cause the older person mental or emotional anguish or fear.

This type of abuse can be verbal or non-verbal. It can take many forms, including:

- threats;
- insults;
- harassment;
- ridicule;
- social or spiritual constraints;
- withholding of affection;
- talking to the older person like a child;
- lack of respect for privacy;
- cultural insensitivity;
- withholding opportunities for self-determination;
- exposure to environmental extremes such as noise or extreme light or darkness.

Psychological abuse can be difficult to detect, so the behaviour, attitude and appearance of the older person and how they relate to other people may be important indicators. Careful consideration of all factors is important and necessary - for example, in situations where the older person has memory loss, these signs may be a result of that condition and not abuse.

Psychological abuse is often present with other forms of abuse and neglect. Fear of being physically abused or of being abandoned may prevent the older person admitting psychological abuse.

Signs of psychological abuse may include:

- resignation;
- fear;
- shame;
- depression;
- mental confusion;
- marked passivity;
- anger;
- insomnia.

### Case Study

*Mrs S, an 82-year-old widow, happily living along in her own home, was absolutely shattered when her son, who lived in another town, suddenly decided that she should sell her house and move into a pensioner village in his town.*

*Mrs S became instantly confused, concerned and distressed about the idea. She did not want to leave her home nor the community she had lived in for so long but she did not want to quarrel with her son.*

*The son and daughter-in-law seemed to have no concept of the emotional upset they had inflicted on their mother with their seemingly 'good idea' for her future.*

*Mrs S was in reasonably good health and managing with the help of friends and neighbours to maintain her property. She was neither lonely nor afraid and never doubted her own capabilities until her family suggested she could no longer manage. She is now unable to sleep and is very upset and anxious.*

### Sexual Abuse

Sexual abuse can be very difficult to identify as shame or fear will often prevent this matter being raised or discussed. This type of abuse can include:

- sexual assault;
- rape;
- sexual harassment;
- lack of recognition of sexuality;
- inappropriate touching;
- lack of respect for privacy.

Sexual abuse can occur, for example, if an older person feels uncomfortable when intimate care is provided by a person from a different gender. Being aware of the effect on the older person and making alternative arrangements for the intimate aspects of care to be carried out by someone of their own gender can overcome these problems.

If the following signs are apparent further investigation is warranted.

Signs of sexual abuse may include:

- bruising or bleeding in the genital area;
- venereal disease;
- difficulty in walking or sitting;
- pain or itching in the genital area;
- recoiling from being touched;
- fear of bathing or toileting;

### Case Study

*An elderly widow was befriended by an acquaintance of her late husband. She lived alone with the support of family and neighbours who became increasingly concerned about the attitude and motives of this man. He avoided contact with the family and the woman appeared very anxious when his name was mentioned.*

*The woman became ill and the doctor who attended her found she became extremely agitated and upset when he tried to examine her. She was admitted to hospital for assessment and was found to have an infection and severe bruising in the vaginal area. She told staff she did not know the reason for this.*

*The man did not visit her in hospital nor when she went home to live with her daughter. The only time she mentioned him was to insist that if he called she did not want to see or talk to him.*

### Material Abuse

Material abuse is the illegal or improper exploitation and/or use of funds or other resources.

Money can be a very sensitive subject. Fear of not having enough money for future care or feeling beholden to others can leave an older person vulnerable. These feelings can be reinforced and used as a threat.

Signs of material abuse may include:

- failure to pay rent or other bills on behalf of the older person;
- sale of property by an older person who seems confused about the reasons for the sale;
- lack of money for necessities;
- lack of money for social activities;
- depletion of savings;
- disappearance of possessions;
- management of a seemingly competent older person's finances by another person;
- signatures on documents/cheques not resembling the older person's signature;
- reluctance to make a will or have budget advice.

### Case Study

*A community nurse was concerned about an older woman she was visiting as she often had no food or money. On investigation it was discovered that her son had signing authority on all her bank accounts and that he was collecting her National Superannuation and the rent on properties she owned.*

*The son was supposed to provide his mother with food but she sometimes went without eating for days. The woman was physically frail but mentally alert and had no telephone or way of communicating with the outside world except through the community nurse.*

*The son was approached to provide a telephone and adequate food and money but did not comply with these requests. A property manager has subsequently been appointed.*

### **Active Neglect/Passive Neglect**

The signs or symptoms can be the same for both active and passive neglect and are a result of non-provision of basic necessities resulting in harmful effects for the older person.

To differentiate between active and passive neglect will involve assessing whether the acts are conscious and intentional or are a result of inadequate knowledge, resources or infirmity.

Signs of neglect may include:

- malnourishment or dehydration;
- hypothermia;
- weight loss with no apparent medical cause;
- pallor, sunken eyes, cheeks;
- injuries that have not been properly cared for;
- poor personal hygiene;
- clothing in poor repair; inappropriate for season;
- lack of safety precautions, supervision;
- absence of appropriate dentures, glasses or hearing aids when these are needed;
- abandoned or left unattended for long periods;
- medicines not purchased or administered;
- no social, cultural, intellectual or physical stimulation.

### **Case Study**

*Mr K aged 90 lived with his daughter and was becoming increasingly frail. Neighbours were concerned about him and contacted Community Health Services. A district nurse found him sitting in a chair that was soaking wet, he was malnourished and had untreated ulcerated legs. His daughter said she was at the end of her tether and just could not bring herself to keep changing him. She was herself in poor health.*

### **Self-Neglect**

Self-neglect is often reported by neighbours because they are concerned for the safety of the older person or because they find the behaviour difficult to understand and cope with.

The dilemma that self-neglect raises is the effect this lifestyle has on the safety of others versus the older person's right to determine how he/she lives.

The following signs do not necessarily indicate self-neglect, and even when they do, careful consideration should be given to the consequences that may result from any intervention.

Signs of self-neglect may include:

- reclusive;
- frugal;
- shrewdness, fear, distrust;
- inappropriate eating habits;
- malnourished, dehydrated;
- filthy and unhealthy living environments;
- collecting and/or hoarding rubbish;
- absence of basic hygiene and personal care;
- inappropriate or unusual clothing;
- menagerie of pets;
- inability or refusal to pay bills;
- capacity to survive;
- fiercely guards independence and privacy.

### **Case Study**

*Mr W lived on his own and neighbours were concerned that he did not appear to care for himself or his home properly. Eventually meals-on-wheels were arranged and each day Mr W collected them from his door step and his neighbours felt relieved that at least he was getting one good meal a day.*

*Some months later Mr W collapsed and was taken to hospital seriously ill. A social worker went to his home to collect possessions he needed and found he had stockpiled his meals-on-wheels. They were rotten, maggot ridden and a major health hazard, and had probably been the cause of Mr W's illness.*

### **Judgement**

The presence of one or more of the signs included in this module does not necessarily imply that elder abuse or neglect is taking place. Careful assessment of the situation is essential and those responsible for carrying out the assessment must learn to be non-judgemental. Each situation is different, and comprehensive information is needed to correctly assess whether elder abuse or neglect is occurring.

Even when abuse or neglect is clearly indicated, deciding what to do can be very difficult as most cases are not clear cut. The older person may refuse assistance, or not be aware they are being abused or neglected. The possible situations may in fact make the matter worse.

It must always be remembered that the older person has the right to choose how and where they live. They also have the right to know about the options available to them including other living arrangements, support services, counselling etc, which may assist both them and the carer/s. The exception may be in cases of severe abuse or neglect when immediate action is necessary for the safety of the older person.

A careful approach to assessing abuse and neglect situations and in determining appropriate assistance must be a priority. Factors that need to be considered before action is taken are:

- the older person's right to know what options, services and support are available;
- the older person's right to self-determination and his/her ability to exercise that right;
- the effect, frequency, severity and duration of the abuse or neglect;
- the safety of the older person.

Module 11: *Responding to a request for assistance*, and Module 12: *Assessment*, cover these areas in more depth.

## Summary

Being aware of the signs of elder abuse and neglect is extremely important but is only the first step. Assessing what should be done is the next step.

The diversity of the types of elder abuse and neglect, the similarity of the signs and behaviours and the complexities of human relationships can make identification difficult. However, using the signs and behaviours as guidelines can be a useful way of checking for elder abuse or neglect.

## Action Planning

- 1 Are there any signs or behaviours associated with elder abuse and neglect that you have encountered and that are not covered in this module?
- 2 What do you need to do to ensure that you do not overlook the signs and behaviours of elder abuse and neglect?
- 3 Has this module raised any concerns for you?
- 4 If so, who can you share these concerns with?
- 5 Set a date to talk to this person/people.

**Most older people live in safe, caring homes. Be sure to check normal causes before assuming the signs or symptoms are a result of abuse or neglect.**

## Appendix 1

### Summary of Signs of Elder Abuse and Neglect

The following signs do not necessarily indicate that abuse and/or neglect is present. The entire situation must be taken into account.

#### COMMON FACTORS

- dependency
- family conflict
- stress
- isolation
- substance abuse

#### BEHAVIOURAL SIGNS

- shows signs of being afraid of a particular person/people
- appears worried and/or anxious for no obvious reason
- becomes irritable or easily upset
- appears depressed, withdrawn
- loses interest
- has sleep disturbances
- has changed eating habits
- has suicidal wishes
- has frequent shaking, trembling and/or crying attacks
- has rigid posture
- presents as helpless, hopeless, sad
- uses contradictory statements not resulting from mental confusion
- is reluctant or hesitant to talk openly; waiting for carer to answer
- avoids physical, eye or verbal contact with carer or service provider

#### PHYSICAL ABUSE

- |                     |                    |
|---------------------|--------------------|
| • abrasions         | • bed sores        |
| • bleeding          | • bruises          |
| • burns             | • cuts/lacerations |
| • dehydration       | • direct beatings  |
| • dislocations      | • fractures        |
| • grip marks        | • hypothermia      |
| • internal injuries | • malnutrition     |
| • over-sedation     | • poisoning        |
| • punctures         | • scalding         |
| • sprains           | • swelling         |
| • welts             | • wounds           |

### **PSYCHOLOGICAL ABUSE**

- resignation
- fear
- shame
- depression
- mental confusion
- marked passivity
- anger
- insomnia

### **SEXUAL ABUSE**

- bruising or bleeding in the genital area
- venereal disease
- difficulty in walking or sitting
- pain or itching in the genital area
- recoiling from being touched
- fear of bathing or toileting

### **MATERIAL ABUSE**

- failure to pay rent or other bills on behalf of the older person
- sale of property by an older person who seems confused about the reasons for the sale
- lack of money for necessities
- lack of money for social activities
- depletion of savings
- disappearance of possessions
- management of a seemingly competent older person's finances by another person
- signatures on documents/cheques not resembling the older person's signature
- reluctance to make a will or have budget advice

### **ACTIVE/PASSIVE NEGLECT**

- malnourishment or dehydration
- hypothermia
- weight loss with no apparent medical cause
- pallor, sunken eyes, cheeks
- injuries that have not been properly cared for
- poor personal hygiene
- clothing in poor repair; inappropriate for season
- lack of safety precautions, supervision
- absence of appropriate dentures, glasses or hearing aids when these are needed
- abandoned or left unattended for long periods
- medicines not purchased or administered
- no social, cultural, intellectual or physical stimulation

### SELF-NEGLECT

- reclusive
- frugal
- shrewdness, fear, distrust
- inappropriate eating habits
- malnourished, dehydrated
- filthy and unhealthy living environments
- collecting and/or hoarding rubbish
- absence of basic hygiene and personal care
- inappropriate or unusual clothing
- menagerie of pets
- inability or refusal to pay bills
- capacity to survive
- fiercely guards independence and privacy

 **Caution: Avoid jumping to conclusions! The above characteristics and behaviours may not necessarily indicate that abuse or neglect is present.**

## MODULE 8

### Preventing Elder Abuse and Neglect at Home

#### Introduction

Preventing elder abuse and neglect is one of the main aims of this resource kit. Prevention will require action in several areas:

- increasing awareness and understanding of normal ageing and the problem of elder abuse among older people, carers, service providers and the general public - through training, education and information initiatives;
- promoting the rights and responsibilities of older people in all areas: our attitudes, our behaviours, how we provide services and the policies determining the funding and provision of services for older people;
- promoting the rights and responsibilities of people caring for older people and ensuring carers have access to adequate support, training, supervision and the opportunity to have their own needs met;
- a co-ordinated approach among service providers and professionals so that effective information, protection and support services are provided;
- ensuring that services and policies are acceptable and appropriate to people from diverse cultures.

These strategies will need to be implemented at various levels and for a variety of different target groups:

- 1 **Personal:** older people, carers, whanau, volunteers, other individuals.
- 2 **Community:** hapu, iwi and other cultural groups, voluntary groups, service providers, professional groups, local authorities, schools and tertiary institutions, general public, etc.
- 3 **National:** politicians and other policy makers, service planners and funders, news media.

#### How can the Risk of Elder Abuse and Neglect be Minimised?

Over 90% of older people live in private households. Living arrangements vary, with approximately equal numbers living alone and living with their spouse. A small percentage share accommodation with other relatives or friends.

The majority of frail older people are cared for by close female relatives at home. A survey of older people in 1990<sup>1</sup> found that 10% of people aged 60+ cared for another person for at least 20 hours or more a week and 8.7% provided constant care. The survey also found that 27% of those providing constant care were themselves in fair or poor health (Table 39).

The care and support an older person requires may change suddenly through illness or accident, or may increase slowly over a number of years due to ageing or an illness where dependency

increases gradually. These changes may result in the carer becoming overloaded and stressed. This situation can be further exacerbated by the declining health of the person providing care.

An older person may not be aware that the treatment they are receiving is in fact abuse or neglect. Even if they are aware they may be afraid or not know who to tell. In some cases those caring for an older person may also be unaware that they are abusing or neglecting the person in their care. They, too, may not know who to turn to for help.

### Case Study

*Mrs S was 78 and a widow who lived alone. She had failing eyesight and was finding it increasingly difficult to manage her home and personal care. Her son, Peter, was unemployed and had a history of heavy drinking. He suggested that he and his wife, June, move in with Mrs S to care for her. She agreed as she felt it would benefit all of them; it would ease the financial pressure for her son and daughter-in-law and they would provide her with the assistance she required.*

*Some months after Peter and June had moved in with Mrs S a neighbour, who had known Mrs S for many years, noticed that Mrs S had become very quiet and withdrawn. She talked to Peter about it and he responded that unless she had something constructive to offer she should not visit his mother. Because of her concern the neighbour called to see Mrs S a few days later and arrived in the middle of a row between Peter and his wife. In the heat of the moment June told the neighbour to look at the bruises on Mrs S's arms. Mrs S became very upset and kept repeating that she was alright and could manage and did not need help or to go into a home.*

*The neighbour did not know what to do and felt she could not betray Mrs S by talking to anyone. A few months later Mrs S was admitted to hospital with a broken arm and severe bruising.*

*When the nursing staff gained Mrs S's confidence it became clear that Peter frequently shook her and demanded money when he had been drinking and threatened to put her in a home when she refused. This was confirmed by June who said Mrs S could be difficult at times which made Peter angry, especially when he had been drinking, and she had not known what to do. Peter was very remorseful and frightened and said he had not intended to hurt his mother but he had no money and felt resentful and trapped. He said he had got cross with her and had pushed her which resulted in the fall that had broken her arm.*

*Mrs S's neighbour, on hearing she was in hospital, went to visit and plucked up courage to tell a nurse about her concerns. She said that although she suspected Mrs S was being abused she was not absolutely sure and felt she may do more harm than good if she told anyone.*

This situation may have been prevented if those involved had been aware of the potential pitfalls, their rights and obligations and the resources that were available to assist them.

### **Strategies that can help Prevent Abuse and Neglect**

Strategies for preventing elder abuse and neglect must be developed and should include information and advice for:

- people who may in the future require or provide care;
- older people who are at present being cared for at home and the people who provide the care.

It is important to provide information and advice about how to prevent problems arising in the future. This will enable older people to find out about the options available should they require care and to consider the pros and cons. It also alerts the family to the potential difficulties and allows them to realistically consider the implications of caring for an older dependent person.

It is also important for those already being cared for at home and for those providing the care to know who to contact for information and advice and also how to access the support services that are available.

The following points should be included when developing prevention strategies:

#### **PLANNING AHEAD**

- Who older people can talk to about protecting interests if they become unable to make their own decisions. For example: lawyer, trust corporations who can advice about an Enduring Power of Attorney.
- Who the older person can talk to about future care options. For example: doctor, social worker.
- Encourage families to discuss the future care of an older family member. For example: their own needs, the physical and emotional demands and changes in lifestyle this may involve for them and the older person.

#### **INFORMATION**

- The range of options for care and support, such as: home support services, residential care, volunteer visiting schemes.
- Who to approach for advice on best care arrangement. For example: general practitioner, Area Health Board social worker, Age Concern, Citizens Advice Bureau etc.
- The support services available to assist with the care and to deal with any personal and relationship problems, such as: district nursing, marriage guidance, relief care, carer support groups, etc.
- The rights and responsibilities in a caring situation, such as: Declaration on the Rights and Responsibilities of Older Persons, Carer's Charter, Protection of Personal and Property Rights Act 1988.
- The causes of elder abuse and neglect and what to do when it occurs.

**ADVICE**

- Who to approach for advice about caring at home. This would enable both the older person and the carer/s to discuss the options and possible problems and examine how these can be avoided or overcome. Family meetings can be an effective method of talking about the issues and finding solutions which are acceptable to all parties. They can include advice about other care options, support, counselling, etc.
- Sources of advice include: general practitioners, community nurses, social workers, Age Concern, CAB, carer support groups, ADARDS.

**SUPPORT SERVICES**

- Practical support services such as special aids, home help, meals on wheels etc.
- Support services for the carer for example, support groups, budgeting services, counselling etc.
- Support and time out from the stress of caring such as sitter services, relief care, shared caring arrangements with formal services.

**Asking for Advice or Assistance**

It is not easy to ask for advice or assistance and it is therefore vital for agencies, groups, service providers and others who are able to provide advice and/or assistance to encourage older people and carers to speak out when they require help or information. The message must be:

“Do not be afraid to ask; help is available”

**Planning and Implementing Education and Awareness Programmes**

Below are ways of planning education and awareness programmes about elder abuse and neglect and some suggested programme outlines.

You will need to decide the prevention strategy you will use, who your target group is, and the method you will use to get the message across.

**Key Prevention Strategies**

- 1 Information and awareness programmes about the nature and causes of elder abuse and neglect.
- 2 Education through specific training programmes on elder abuse and neglect.
- 3 Providing practical support services, eg sitter, daycare and relief services, home support services; separately considering and meeting the needs of the carer as well as the older person.
- 4 Effective prevention and protection through needs assessment, service provision including specialised help, and ongoing review.

- 5 Legal protection, eg Protection of Personal and Property Rights Act 1988, Carer's Charter.
- 6 Access to independent advocates and help with conflict resolution, eg social workers, patient advocate, Age Concern, ADARDS.
- 7 Monitoring quality of services and care provided.

### **Target Groups**

Target groups may include all or some of the following:

- older people
- carers
- families/whanau
- neighbours
- cultural groups and networks
- volunteers
- service providers
- professionals (doctors, lawyers, accountants, etc)
- policy makers
- general public

Some prevention strategies (such as information programmes) may be suitable for all target groups; other strategies (such as 4 above) will need to be directed at particular groups.

### **Methods**

The way in which you choose to action each prevention strategy will depend on the particular target group and your interest and skills. These are some examples:

- leaflets
- public meetings
- seminars
- planning and providing services
- training/education programmes
- radio and other news media

#### **EXAMPLE I**

##### ***Strategy***

Information and awareness about the nature and causes of elder abuse and neglect.

##### ***Target Groups***

Older people, carers

##### ***Method***

Seminars/radio programme

**Aim**

The aim of these seminars/radio programmes is to inform people 55 years and over of the causes of elder abuse and neglect and to look at ways of overcoming some potentially difficult situations.

**Ideas for Content of Seminar/Radio Programme**

- The nature of elder abuse and neglect  
(Use Module 4: *The nature of elder abuse and neglect*)
- Definitions and signs of abuse and neglect  
(Use Module 3: *Towards a definition of elder abuse and neglect*, and Module 7: *Signs of elder abuse and neglect*).
- Stress and caring  
(Use Module 6: *Caring and stress*)
- Specific suggestions for preventing abuse and neglect  
(The suggestions shown in this module can be used as well as information contained in other modules in this resource kit, eg Module 1: *Rights and responsibilities of older persons and carers*, Module 2: *Family violence*, Module 5: *Cultural differences*)
- Guest speakers can be used to give specific information  
(particularly for financial, legal matters etc)
- Suggestions about local service/supports  
(Give a list of local people and places and/or invite guest speakers - nurses, doctors, social workers, church, local Age Concern or other services for older people)
- Encouragement to report abuse and neglect  
(suggestions about who to talk to - the message throughout the seminar should be: "Do not be afraid to ask; help is available")

**Some of those taking part or listening may be living in an abusive situation. Remember to have support and follow up arrangements in place - for radio programmes this may include a telephone "hot line".**

**EXAMPLE II**

**Strategy**

Providing practical support services

**Target Groups**

Community domiciliary nurses, social workers, general practitioners

**Method**

Workshops, seminars

**Aim**

The aim of these workshop seminars, is to assess current support services for older people and identify methods of informing older people and carers of the services available.

***Ideas for Content of Workshop/Seminar***

- Undertake an audit of all support services available in your local community  
(suggestions and ideas can be found in Module 10: *Developing policies and practice procedures*)
- Compare with a checklist of necessary services  
(a list of services is contained in Module 13: *c*, which can be used as a guideline)
- Identify gaps and areas of stress/shortage  
(Module 12: *Assessment* and Module 13: *Planning services and support*, may be helpful resources)
- Check methods of gaining access to services - eg, how are people informed/referred  
(Module 11: *Responding to a request for assistance*, Module 5: *Cultural differences*, can be used to generate ideas)
- Prepare brochure about services  
(be creative - brainstorm ideas)
- Identify other action needed and people to include:
  - policy makers
  - service managers
  - research
  - liaison/co-ordination with other providers
  - ensure information reaches those who need it

Other prevention programmes can be designed by identifying a strategy, target group and methods as shown in the two examples above. The content can be adapted from different parts of this resource kit to meet the particular needs of your target group.

**REMEMBER** - to use your own ideas as well as the information in this resource kit, don't forget to share your ideas with others!

**Summary**

The above are some methods we can use to raise awareness about the prevention of elder abuse and neglect.

Raising awareness and providing information enables older people and carers to consider the options that are available and to make informed decisions about present or future care needs.

Co-operatively assessing existing support services and finding ways of bridging the gaps will enable those working with older people to offer more comprehensive services and options for older people being cared for at home.

Ongoing assessment and research will be required to ensure support services are in line with needs and to enable policy makers and service managers to plan effective services.

Remember - we too may need care to be a carer one day.

## Action Planning

Planning and organising prevention strategies.

- 1 Identify your goals and the key prevention strategies you intend working on
- 2 Identify who you need to contact to discuss how to start - older people, carers, service providers, etc
- 3 Who do you need to liaise with to ensure co-operation and co-ordination?
- 4 By what date will you have contacted the above people?
- 5 What do you see as your role?
- 6 What resources do you need?
- 7 Where will they come from?
- 8 What is likely to prevent you from getting started?
- 9 How can you overcome these blocks - who can help? what will help?
- 10 How will you know when you have achieved your objectives?
- 11 Set a date when you will review your progress

 **Start small - it is better to do one thing than nothing at all.**

## References

- 
- 1 Colmar Brunton Research, Lifestyle and Wellbeing of New Zealand's Over 60s, Age Concern NZ, Wellington 1990, Table 39

## MODULE 9

### Preventing Elder Abuse and Neglect in Residential/Institutional Settings

#### Introduction

Rest homes, private hospitals and public hospitals provide invaluable services for older people. Their role not only involves the care of residents or patients, but also brings them into contact with elderly relatives and friends who visit residents or patients.

When an elderly person requires care in a rest home or in a private or public hospital, it is a major life change. This has usually been preceded by other major events such as loss of a partner, illness, injury or a deterioration in the ability to manage in their former living situation. This can mean that older people in these settings are more likely to be dependent on the care of others and less able to do or say anything if abuse and neglect occurs. Their relatives or friends can also feel vulnerable and unsure about what to do if difficulties arise.

While most rest homes, private hospitals and public hospitals provide an excellent standard of care, it is important to acknowledge that elder abuse and neglect does sometimes occur in these settings. Managers and staff, as well as other professionals associated with these services, should be encouraged to think through the issues and develop strategies to prevent and detect elder abuse and neglect. These strategies should include:

- providing adequate training, supervision and support for management and staff;
- implementing sound management practices;
- ensuring that appropriate standards of care are maintained;
- providing information for relatives and visitors about who to approach and what help is available if they are concerned about the older person or the care they are receiving.

In addition, management and staff should be aware that elderly visitors may need support or help, and know what steps to take if they detect signs of abuse or neglect in a visitor.

Managers of rest homes, private hospitals and public hospitals require many skills. They need to ensure that the environment and services they provide meet the needs of individual residents or patients as well as the collective needs of those living and working there.

Constant monitoring and evaluation is required, as well as education and awareness programmes for staff about the causes of elder abuse and neglect. This ensures that those they care for are protected. These programmes should be a compulsory part of training for everyone involved with the care of older people.

### Case Study

*Mr B had Alheimers disease and had been in a public hospital for nine months. Prior to that his wife, Betty, had cared for him at home but his wandering and angry outbursts became too difficult for her to cope with. Betty visited her husband twice a week but found these visits more and more difficult as Mr B became withdrawn and unresponsive. His head dropped forward and he dribbled constantly. She mentioned her concern to one of the staff and was told not to worry - he was alright.*

*Betty was a timid person and did not like to keep asking but one particular afternoon Mr B seemed worse than usual. As Betty said later to a friend "It seemed like he was drugged". This friend persuaded Betty to talk to the nurse manager as she was so worried.*

*The nurse manager told Betty that Mr B had to be kept quiet somehow and there was only so much they could do due to the demands on staff. Betty commented that it seemed terrible to keep him so sedated and was told the only alternative was for her to take him home. Betty knew she could not manage this so did nothing. She felt helpless and powerless and became more and more depressed. Eventually she was unable to visit her husband.*

This situation highlights the vulnerability of a person needing care and how sensitive and affected family members can be. The outcome of this situation was that Mr B was deprived of visits from his wife and Betty became ill.

### HOW COULD THE ABOVE SITUATION HAVE BEEN PREVENTED?

To see how this situation could have been prevented we need to ask the following questions:

#### **Betty**

- Was she given information when her husband was admitted about the hospital's policy for long-stay patients?
- If so, did she understand the information and was she given the opportunity to ask questions?
- Was she aware of her own rights?
- Did she understand about Alheimers disease?
- Did she know about ADARDS?
- Did she receive follow-up from the worker/s involved in arranging her husband's admission to hospital?
- Was she receiving support herself? If not, did she know who to contact?

#### **The Nurse Manager**

- Was the nurse manager aware of Betty's "timid" nature and uncertainty about her husband's condition?
- Did the nurse manager encourage staff to talk to Betty and discuss her concerns?

- Did the nurse manager or other staff notice when Betty stopped visiting her husband?
- Was the ward under-staffed so there was no time to give more than basic care?
- Had the nurse manager received any training about elder abuse and neglect and how to care for people with Alzheimers disease?

### ***The Hospital***

- Was it the most appropriate hospital for caring for people with Alzheimers disease?
- What were the policies on discussion of patient care with family members?
- Was Mr B's doctor aware of Betty's concerns?
- What procedures were in place to deal with concerns or complaints?
- Were patients and relatives given information about these procedures?
- Was there a written policy and aims about standards of care?
- Did staff receive regular ongoing training?
- Did hospital policy and guidelines address the issue of elder abuse and neglect?
- Was specific training on this issue available for staff?

Unclear policies and procedures, lack of information and poor communication may all have played a part in this case study.

These questions also illustrate the complexities involved when a person requires care either in a rest home or hospital. Many factors need to be considered to ensure older people are not abused or neglected. Less obvious forms of abuse or neglect can easily happen and be overlooked, as this case study shows.

- **Could a similar situation occur where you work or visit?**
- **What positive action could you take to prevent it from happening?**

### **WHAT NEEDS TO BE DONE?**

#### ***Reviewing Care Policies and Practices***

The successful avoidance and detection of abuse and neglect in rest homes and hospitals requires that appropriate policies and procedures are in place. Working openly and honestly together to examine current practices and policies and sharing ideas will help ensure that high quality safe care is provided for residents and patients.

This need not be an overwhelming task. Many rest homes and hospitals have already developed excellent policies, procedures and teaching modules which we can use and learn from.

The legislation governing the licensing of and standards of care in private hospitals and rest homes is currently under review. The Old People's Homes Regulations 1987 and the accompanying Standards of are outline the minimum standards required. The Hospitals Act 1957 Part V and the Private Hospitals Regulations 1964 are the licensing requirements for private hospitals. The

Private Hospitals' Association has published a code of practice that provides clear guidelines and standards. The New Zealand Council of Health Care Standards manages the accreditation programme, which has been developed to provide a means for residential facilities to demonstrate that they provide a professionally acceptable quality of service and care.

These provide an important reference point for providers and recipients of care. Make sure information about the Standards of Care is available to staff and residents or patients.

**Using the attached Care Policy and Practice Checklist Appendix 1:**

- **Think about the ways in which you manage and provide care and what extra steps you could take to prevent elder abuse and neglect.**
- **Identify areas that are not currently part of your policy and service practice.**
- **Develop an action plan to implement those extra steps and address any omissions.**

***Awareness and Education Programmes***

Just as older people are unique individuals from different cultures and backgrounds with varying standards, beliefs and values, so are the staff who work with the elderly. They bring with them attitudes, values and beliefs that are shaped by culture, family and personal experiences. This can mean that perception as to what constitutes elder abuse and neglect may vary significantly.

The following points are important and if overlooked can lead to abuse and neglect. Using these are brainstorming topics will stimulate ideas and ensure staff know how to prevent abuse and neglect. The ideas generated can form part of the care plan or be incorporated into the overall programme of the home or hospital.

- Ensuring there are sufficient staff for the number of residents cared for.
- Valuing each resident's opinions including spiritual, sexual, political and other views and beliefs.
- Ensuring residents and their families/whanau are consulted and have choices including being involved in care planning.
- Recognising that all people are different and valuing them for that.
- Providing for cultural differences including language, food, dress, customs, etc.
- Encouraging residents and patients to maintain and develop their skills.
- Providing opportunities for residents to be alone, and to maintain contacts outside the residence, with family/whanau and friends.
- Encouraging open communication with family/whanau, including involvement in care plans.
- Ensuring all residents or patients have access to recreation, leisure, exercise and religious activities.
- Preventing isolation by ensuring each resident has individual time with staff and visitors.
- Ensuring residents have access to personal funds and discretionary spending.
- Allowing residents to have personal possessions.
- Helping residents to look their best.
- Providing privacy when toileting, bathing, etc.

- Having flexible routines including times of getting up and going to bed so as to allow for differing needs.
- Encouraging a resident's committee to express ideas and take concerns to management.
- Finding creative ways of managing difficult residents so as to avoid the use of physical and chemical restraints.

Awareness and education programmes can provide a forum to discuss with staff situations and behaviours towards residents or patients that would be considered abusive or neglectful.

These programmes need not place an extra load on already busy people as topics can be used individually and can form part of staff and management meetings.

Using the Care Policies and Practice Checklist (Appendix 1) will help you to identify specific topics you could think about for staff training in addition to the modules included in this kit.

### **Helping Staff to Manage Stress**

Caring for highly dependent people can be extremely difficult and stressful - not all dependent people are pleasant or rewarding to be with, or grateful for the care they receive. Their demands can leave staff feeling angry, resentful or stressed.

It is important that staff and management openly discuss the issues of abuse and that staff understand the consequences of abusing a person they care for.

It is not easy for staff to acknowledge stress if the implication is that they are at fault. Management should be responsible for:

- emphasising the value of human beings, including those who are highly dependent;
- ensuring all staff and managers take regular holidays as overwork leads to stress;
- ensuring staff are aware of stress as a potential problem;
- ensuring staff have effective support and that effective supervisory systems are in place;
- awareness of pressures on individual staff;
- ensuring that staff are adequately trained for the work they are undertaking;
- ensuring procedures within the institution allow patients and staff to be treated as individuals.

Staff members should take responsibility for:

- identifying when he/she is stressed and discussing this with his/her manager;
- attending education and training programmes that are provided or suggested;
- identifying and discussing with management any additional training requirements they may need.

### **Summary**

This module can only, at this stage, raise the issues and provide guidelines for policy and service practice. However, acknowledging the gaps in services, and planning how to overcome them is the first step in creating an environment where honesty and cooperation exist. This will bring

rewards for staff in terms of job satisfaction and ensure that older people are not victims of abuse and neglect.

### **Action Planning**

Planning and organising policy, service practice procedures, education and awareness training programmes in your workplace:

- 1 Having completed the *Care Policies and Practice Checklist* (Appendix 1) identify what improvements you need to make in your workplace, for example, planning, organising and implementing policy/service practice procedures, and/or education and awareness training programmes, etc.
- 2 Who do you need to contact to discuss how to start the above? Remember to consider key groups: older people, carers, staff, other service providers, trainers, educators, etc.
- 3 What extra time will you need to allocate?
- 4 Will it help to work with other rest homes, hospitals or wards?
- 5 If so, who can you liaise with?
- 6 By what date will you have contacted the above people?
- 7 What do you see as your role?
- 8 How can you involve staff?
- 9 How can you involve family and friends?
- 10 What is likely to stop you involving these people?
- 11 How will you overcome these blocks - who can help? what will help?
- 12 How will you know when you have achieved your objective?
- 13 Set a date when you will review your progress.

 **Each small improvements counts!**

## Appendix 1

### Care Policies and Practice Checklist

**Think about what you are currently doing in these areas from the viewpoint of preventing elder abuse and neglect and what you could do better.**

- Services that are sensitive to cultural and individual differences
- Promotion of patients/residents rights, including displaying the United Nations Principles for Older Persons
- Providing information to residents, visitors and staff about Standards of Care
- Providing information to residents, visitors and staff about complaints procedures
- Providing information to residents, visitors and staff about staff rights and responsibilities
- Providing accurate job descriptions
- Identifying the strengths and weaknesses of staff and team building
- Performance, planning and appraisal procedures
- Ongoing professional training
- Elder abuse and neglect awareness programmes
- Patient/resident assessment procedures
- Patient/resident admission procedures
- Patient/resident familiarisation procedures
- Patient/resident care plans
- Patient/resident observation sheets
- Key worker/s assigned to patient/resident
- Liaison with resident/patient's family and promoting ongoing contact with the community
- Evaluation and review procedures - including reference to Standards of Care
- Involve family members (if they choose) in a team caring approach

#### Questions

- Are any of the above not current practice?
- If not, how can they be introduced and implemented?
- Do you need to review the content and frequency of staff training?

## MODULE 10

### Developing Policies and Practice Procedures

#### Introduction

Raising awareness of elder abuse and neglect must go hand-in-hand with examining current policies and practice procedures for responding to it and, where necessary, planning and implementing new policies and practice procedures.

This module contains ideas and suggestions to assist agencies and professional service providers to consider how support services can be managed and coordinated in situations involving elder abuse and neglect. The following key points are discussed:

- Multi-agency/disciplinary approaches:
  - Elder abuse and neglect team or network;
  - Elder abuse and neglect key service provider/case manager - role definition
  
- Support policies and practices
  - Mandatory reporting;
  - Elder abuse and neglect register;
  - Training and support;
  - Monitoring service standards.

Each community will vary in its approach and, in some cases, may already have systems in place.

#### Range of Services/Agencies/Service Providers

Many services are available to assist older people, provided by a range of different agencies. Often there are several services being provided to one household. Some of these may be required on a long-term basis (for example, nursing) while others, such as meals-on-wheels, are needed for only a limited period.

Carers may also require services to enable them to manage the demands of caring or to deal with personal issues that have developed from their caring role. These services are often crucial in preventing elder abuse and neglect or relieving the situation when abuse and/or neglect has occurred.

All service providers, including volunteers, perform a variety of tasks depending on their professional background and skills. In some cases, roles and boundaries are not clear and duplication of tasks may occur. This can result in frustration for the service providers and confusion for the older person and carer. Unclear boundaries and roles can mean that all service providers are unsure about what is expected of them and how their services fit into the overall plan.

It is therefore essential that services complement one another and that the older person, carer and service providers are clear about individual roles, tasks and aims. Services therefore need to be planned and coordinated so that:

- services can be easily accessed by older people, carers and service providers;
- older people and carers receive maximum benefit from the services provided;
- services can be regularly reviewed and evaluated to ensure they are appropriate to the needs of the older person and the carer;
- service providers are clear about their own role and the role of others; and
- services and resources are well coordinated to prevent gaps and duplication.

**Questions:**

- **How are services to older people planned and coordinated in your community?**
- **Are current methods effective?**
- **If not, what are the main difficulties?**

### **Multi-Agency/Multi-Disciplinary Approaches**

Adopting a multi-agency/multi-disciplinary approach to planning and service delivery means that resources are used efficiently and effectively. This approach also provides support for service providers and an opportunity to share knowledge, experience and skills which enable new approaches to be tried and tested.

In Canterbury, an Elder Abuse Intervention Team has been established. The concept does not involve increased resources but pools existing ones. The team has three components:

- **Intervention team** - across agencies, made up of suitably qualified professions from existing health services who are involved in the care of older people.
- **Advisory group** - includes some of the intervention team and other health professionals with an interest in, and experience of, elder abuse.
- **Consultants** - who represent a wider variety of professions including different cultural groups.

A summary of the above is included in the resource section at the back of this kit.

The following ideas and suggestions provide a starting point for considering how a multi-agency/multi-disciplinary approach will work in your community if this is not current practice. The roles of individual service providers and the skills required to carry out these roles are also discussed.

### **Elder Abuse and Neglect Team**

An elder abuse and neglect team can be formed by selecting and training team members from a range of agencies and professions including medical, nursing, social work, leg, etc. The team's primary function would be to assess situations involving elder abuse and neglect, develop case plans and monitor the situation. This can be done in several ways, for example:

- The team could be notified of suspected or actual situations of elder abuse and neglect and team member(s) appointed to carry out each assessment, develop a case plan, obtain the necessary services, arrange family meetings, monitor the delivery of services and provide ongoing evaluation; or
- The team could be notified of all situations of elder abuse and neglect and work closely with the service providers to help them develop a case plan, arrange family meetings, monitor the delivery of services, evaluate the effectiveness of the services and provide "expert" opinions and advice.

Teams that have a multi-disciplinary, multi-agency mix bring together a variety of perspectives, skills and approaches, which ensure a comprehensive assessment of the situation and consideration of all possible courses of action.

In a changing environment, where services and systems are constantly being restructured, a team approach goes some way to ensuring the older person's best interests are considered within the limits of available resources.

Elder abuse and neglect teams also provide a central point for collecting and recording data regarding the incidence, types and causes of abuse and neglect. This information would enable services to be adapted and developed in line with needs, and provide valuable insights into the nature and extent of elder abuse and neglect in New Zealand.

### **ELDER ABUSE AND NEGLECT NETWORK**

A network could be formed by identifying and training key people to provide advice about assessment, planning support services, legal and emergency procedures, etc, to agencies and service providers working with older people. These people could act as a resource and provide a common link or point of contact. A member of this network could be included in family meetings to provide an independent viewpoint.

The network would rely on individual "experts" rather than a team. However the people involved in the network could meet regularly to update information and review the effectiveness of services and methods used in situations of elder abuse and neglect.

### **KEY SERVICE PROVIDER/CASE MANAGER**

In each situation involving elder abuse and neglect, a critical task may be to appoint a professional service provider as key service provider/case manager, responsible for coordinating the assessment, service provision and review. This may also help reduce the duplication of tasks and the role confusion. If there is an existing key service provider/case manager this person should be involved.

In communities where there is an elder abuse and neglect team the key service provider/case manager may be a member of this team or a service provider appointed by this team.

The key service provider/case manager's role may include:

***Advocate Role***

- Ensuring the older person and carer are aware of and understand the options and choices available;
- Supporting and assisting the older person and carer to take steps on their own behalf whenever possible;
- Supporting the carer/family/whanau or significant others in caring for the older person; and
- Facilitating access to services, specialist advice (for example, legal, financial, etc) essential for the older person's and/or carer's wellbeing and quality of life.

***Broker Role***

- Helping the older person and the carer to clarify goals and set realistic objectives that will meet their needs;
- Matching these needs with the services available and arranging delivery;
- Working with the older person, carer and service providers to ensure roles and objectives are clearly stated and understood;
- Coordinating services; and
- Regularly reviewing, evaluation and updated services.

A key service provider/case manager may find he/she needs to assume both the advocacy and broker roles from time to time. This can be confusing and demanding as it may involve representing the older person's needs and obtaining services on his/her behalf while representing a system supplying services. It is therefore important for key service providers/case managers to be clear about his/her role and to have training, supervision and support.

In some situations it may be necessary for the older person and carer to have separate advocates to ensure their individual needs are met. In such cases it may not be appropriate for either of these advocates to act as key service provider/case manager.

It is important to remember the special skills are required to carry out the above roles and that specific training may be necessary.

**Other Possible Policies and Practices**

**MANDATORY REPORTING**

Mandatory reporting requires nominated professional groups by law to report cases of suspected elder abuse and neglect. At present there is no clear legal framework that makes it compulsory to report elder abuse and neglect in New Zealand. The issues of mandatory reporting have been widely discussed regarding child abuse with points in favour and against. These issues will need to be addressed in respect of elder abuse and neglect.

When considering the pros and cons of mandatory reporting, the primary consideration must be whether it will minimise the incidence of elder abuse and neglect, or if it will make it even more difficult to detect.

Points in favour of mandatory reporting include:

- It ensures all cases of abuse and neglect are brought to public attention
- It provides clear procedures
- It provides data that can be used to ensure funds are allocated to address the problem

Points against mandatory reporting include:

- It can prevent older people making their own decisions about reporting abuse which may endanger their autonomy, dignity and self-esteem
- The definition of elder abuse and neglect is not clear-cut and judgements about the situation may differ
- If there are not enough resources available to alleviate the situation inappropriate institutionalisation may occur
- Finding methods of preventing elder abuse and neglect is more important than reporting it

It is vital to encourage people to seek advice and help and not to be put off from asking for assistance by fear of punishment or recrimination. It is also important that older people keep the right to make decisions for themselves and are not forced by law to make decisions against their will. On the other hand, it is important that older people are protected and that laws uphold this.

Gathering and recording information, developing guidelines and procedures, undertaking research and evaluating the effectiveness of services will provide a clear picture about the value of mandatory reporting. Meanwhile, however, each of us has a moral responsibility to respond to situations involving elder abuse and neglect.

#### ***When an Older Person or Carer is considered 'At Risk'***

There may be instances when a service provider is concerned about the welfare of an older person and/or the carer, but does not feel that assistance is necessary or would be helpful or appropriate.

#### **Case Study**

*Mrs N had not seen her doctor for several years but made an appointment to see him because she felt tired and run down. During the consultation the doctor discovered that Mrs N was caring for her father, Mr P, aged 87, who had been living with her since the death of his wife two years previously. Mrs N said her father expected her to do everything for him but complained about everything she did. She could not go out, and when she went shopping had to lock her father in his bedroom because he tried to follow her. They had no other family and no-one else visited them. The doctor suggested that he visit Mr P at home but Mrs N said it would make matter worse. She reluctantly agreed to bring her father to see the doctor but did not keep the appointment. He telephoned Mrs N to check on the situation and when he suggested she may need some assistance or someone to stay with Mr P while she had a break occasionally, Mrs N stated it was her job to look after her father even if it killed her.*

In the above case study the doctor is in the difficult position of knowing that the situation will not improve and will probably get worse. Going on Mrs N's past record, she is unlikely to visit him again in the near future and no-one seems to visit them to provide relief. The doctor is likely to conclude that Mrs N is 'at risk' of a serious physical and/or emotional breakdown and Mr P could be 'at risk' of abuse or neglect if Mrs N finds she can only get relief by locking him in his room and uses this method more frequently.

**Questions:**

- **How can situations like these be responded to?**
- **Does anyone have the right or responsibility to follow-up and/or monitor the situation?**
- **If so who, and what would be their role?**

**AT RISK REGISTER**

The purpose of the register would be to alert people who may come into contact with those considered to be 'at risk' of abuse and/or neglect. It would also provide a mechanism for keeping in touch with those who have refused assistance and are considered to be 'at risk'. The register could be the responsibility of the elder abuse and neglect team or other specifically trained service providers.

There are, however, many aspects that must be considered before establishing an 'at risk' register, for example:

- Being clear about the purpose of the register
- What are the criteria for making referrals?
- How are the rights of the older person and carer protected?
- Will people be advised if they are on the register?
- Who will be able to make referrals?
- Who will receive referrals?
- Who will be responsible for follow-up?
- How will this be done?
- What is the role of this person?
- Who does this person report to?
- How will confidentiality be maintained?
- When are names withdrawn from the register?
- How will this system be monitored and evaluated?

Disadvantages of creating an 'at risk' register:

- People become labelled inappropriately
- The referring service provider assuming his/her task is completed after making a referral to the list may not take further responsibility or action for the wellbeing or safety of the older person and/or carer

The potential disadvantages would need to be addressed before implementing an 'at risk' register.

Advantages of creating an 'at risk' register:

- Ensure those 'at risk' do not get overlooked by busy service providers
- Enables appropriate action to be taken by those trained in the area of elder abuse and neglect
- Provides a central pool of information about the needs of older people and carers, which would enable appropriate services to be developed to minimise the incidence of elder abuse and neglect

It is essential to respect the rights of the older person and the carer, including their right to refuse assistance provided this does not result in harmful consequences. It is important that they feel supported and not threatened. Gaining their confidence and trust must be the first step, as this may allow a service provider to discuss their needs and 'seed' ideas about services and support that can assist. This takes time and skills.

#### **Questions:**

- **Are any of the above methods used in your community?**
- **If not, which would be the most effective and why?**
- **Can you think of any other methods?**
- **How can these be implemented?**

### **Training and Support**

The complex and sensitive nature of elder abuse and neglect requires special skills and techniques. Successful intervention may require the development of new techniques and skills rather than simply transferring those used in other areas of work.

Service providers working in the area of elder abuse and neglect must be provided with training and ongoing support. They should also have an opportunity to share ideas, skills and techniques so that a body of knowledge is built regarding practice procedures.

The practice guidelines outlined in Modules 11, 12, 13 and 14 provide a starting point for training.

### **Monitoring Service Standards**

Services for dependent older people are unique, as in many situations a wide range of services are provided in the home and not in the agency setting, as is the case for other age groups. Due to the number of agencies and service providers who may be involved, it is important that procedures are developed for monitoring service standards.

It is easy for an ad hoc approach to emerge, whereby each agency monitors and evaluates its own services and service delivery, but does not take into account how these affect and are affected by other services. For example, a situation might break down because one service provider or agency fails to provide an adequate service or support which negates the effectiveness of other services being provided.

Many of these difficulties can be overcome by working cooperatively with other agencies to develop procedures that take into account the total picture. For example:

- Roles
- Responsibilities
- Accountability
- Performance appraisals
- Training
- How complaints can be managed
- Gaps in services
- Resources required
- Legislation and policy changes

This approach will also prevent service overlap and will ensure that resources are used in the best possible way.

#### **Questions:**

- **How are service standards monitored at present?**
- **Do present methods need reviewing?**
- **If so, how can this be done?**
- **What procedures are in place for handling complaints?**

### **Summary**

It is no small task providing comprehensive and coordinated services to older people who are at risk or who have been abused or neglected. It takes commitment, time and a willingness to work together to understand roles and responsibilities and provide effective services.

The effort to develop and establish services will need to continue as more information is gathered so that the law, policies, services and service delivery meet the needs of older people and carers.

### **Action Planning**

Having considered the questions in this module:

- 1 List your ideas and suggestions for effective policies and practice procedures
- 2 What will be your role and objectives?
- 3 Who do you need to discuss these ideas with?
- 4 By what date will you have contacted these people?
- 5 Set a date when you will review your progress

**Remember procedures are only tools - not end results!**

## MODULE 11

### Responding to a Request for Assistance

#### Introduction

It is important that older people, service providers and the general public know who to contact about abuse or neglect. A list of contact people and/or agencies should always be included in awareness programmes and should be displayed on notice boards in surgeries, health centres, shopping centres and other prominent places in the community.

It is equally important for those who are likely to receive a request for assistance to know how to respond and what steps to take.

#### Receiving Requests

Requests for assistance may take many forms and can be quite subtle or indirect?????

The initial request for assistance may not always be made to an agency or service provider who is trained in the area of elder abuse and neglect and who is therefore able to respond. For example, requests may be made to:

- health or social service agencies or service providers who do not deal specifically with issues involving older people;
- people known to the person making the request, for example: minister, pharmacist, lawyer, accountant;
- voluntary agencies and service providers, for example: home-help, meals-on-wheels driver, home visiting services, gardening services;
- local resource centre or drop-in centre, day centre, rest home;
- support groups, for example: ADARDS, Counterstroke, Parkinsons;
- community groups or agencies such as Age Concern, Samaritans, Lifeline.

It may not always be obvious that elder abuse or neglect is the problem, as the request for assistance may be subtle or indirect calls for help. Understanding the nature of elder abuse and neglect, what to listen for and how to respond is extremely important for everybody who has contact with older people, particularly those more likely to receive requests for assistance.

Confidentiality must always be considered. It is vital that people asking for assistance are treated sensitively and that any information disclosed is immediately given to an appropriate agency or service provider.

It is therefore important to identify who is likely to receive requests for assistance and that these people know who to contact if they are approached with a direct or indirect request for assistance.

### Case Study

*A volunteer at the Citizens Advice Bureau noticed that Mrs R had called in several times to look at the pamphlets and other information about support groups. She knew Mrs R was caring for her father and asked if she could help. Mrs R looked embarrassed and said she was looking for information for a friend. The volunteer asked what sort of information would be helpful but Mrs R was not sure.*

*After talking for a while the volunteer gently asked Mrs R about her father and commented how difficult it must be for her. Mrs R broke down but quickly tried to pull herself together and left. The volunteer was concerned and telephoned Mrs R a little later. She suggested that Mrs R talk to her doctor or contact a social worker who may be able to offer assistance. Mrs R said she could not have anyone come to the home because she was in such a muddle.*

*The volunteer decided to contact the community social worker who called on Mrs R and found both Mrs R and her father in desperate need of assistance. Neither had been eating properly and Mrs R's father was dehydrated and extremely dirty.*

#### Questions:

- Are you likely to receive requests for assistance regarding elder abuse and neglect?
- Do you know who to refer the matter to?

### Requests to Service Providers who are Trained to Respond

In order to assess the urgency of the situation, it is important to consider the following:

#### REQUESTS FOR ASSISTANCE

When the request is from an *older person or carer*, either by telephone or in person, assure the caller help is available and work through the following checklist:

- Record the caller's name, telephone number and address
- Record details about what has happened or is likely to happen
- Check if anyone else is involved or aware of the situation, for example, family/ whanau, doctor, nurse, social worker
- If you cannot directly help, tell the caller you will contact someone who can help them
- Give the caller your name and a telephone number they can use if needed
- Immediate action must be taken to refer the matter to someone who can follow up and arrange an assessment

When a request is received from *family, neighbours, friends, other agencies, service providers or significant others* work through the following checklist:

- Record details of the caller, eg name, address, telephone number and relationship to the older person
- Record details of the person who has been or is likely to be abused and/or neglected and who may be responsible for this
- Record details of exactly what has been observed and when
- Check if the older person, or other significant person is aware of the concern and that a request for assistance is being made
- Check if the caller is able to provide help or support for the older person, carer or other person/s involved
- Check if anyone else is aware of the situation or has contact with the older person, eg doctor, nurse, social worker etc
- If you are unable to assist the caller, explain that you will contact someone who can help and then immediately action the matter

When a request is received to investigate a report of suspected abuse and/or neglect in a *rest home/hospital* work through the following checklist:

- Record details of the caller, eg name, address, telephone number and relationship to the older person. If it is a service provider, their role and agency.
- Record details of the person who has been abused/neglected
- Record details of exactly what has been observed and when
- Record details of the rest home/hospital, eg name, address and telephone number, name of the matron, nurse manager and/or other people in charge.
- Check if the older person or other significant person is aware of the concern and of the request for assistance
- Check if the matron, nurse manager or other people in the home/hospital are aware of the incident/s and what action, if any, has been taken.
- Check if anyone else is aware of the situation or has contact with the older person, eg doctor, social worker, rest home/hospital visitor etc
- Refer to elder abuse team/network or other person trained to respond.

A form for recording details of an initial request for assistance is contained in Appendix 1.

Some people seeing assistance may not be prepared to give their name and contact details, and deciding if the situation is genuine will sometimes be difficult. If in doubt, arrange for a suitably qualified person (eg, a member of an elder abuse and neglect team or network) to visit the older person.

**Questions:**

- Do you have a format for receiving and recording requests for assistance regarding elder abuse and neglect?
- If not, what format would be useful and how can this be introduced? (See Appendix 1 for ideas)

**Action After a Request for Assistance is Received**

- 1 Decide who should follow up, eg the elder abuse team or a person trained to undertake the assessment.
- 2 The trained person responding will need to decide the urgency of the situation and what action is required.

In most cases it will be necessary to make an appointment to visit the older person, their carer and/or others to gather more information and assess what action, if any, is required. This process is covered in Module 11: *Assessment interview*.

**EMERGENCY SITUATIONS**

Having a list of steps to follow and key people to contact such as nurses, doctors, hospitals, lawyers, police, etc will enable a service provider to respond quickly in an emergency.

It is important to find out the facts, for example:

- If the older person has been harmed
- If urgent treatment is necessary
- If the older person is at risk of serious harm or death
- Who is with the older person
- If anyone else has been notified about the situation, eg police, ambulance, doctor, etc.

If the older person is considered to be in imminent danger or has been harmed, the police and/or ambulance should be called immediately.

Sometimes what appears to be an emergency may not require crisis intervention after all. In any crisis, it is important to find out the facts and to discuss the options and course of action with a trained person (eg member of the elder abuse and neglect team/network).

Always remember the older person's rights. Quick solutions may have adverse affects in the long term. For example, removing the older person from their home may cause them enormous stress and other repercussions. When deciding on the action to take consider the following questions:

- Is it appropriate to offer the older person refuge?
- What is the least disruptive option for the older person?
- Will the action being considered cause further harm?
- Have the rights of the older person been considered?

The older person may refuse assistance. This can be extremely difficult for service providers if there is a fear for that person's safety, but ultimately the rights of the person must be respected. If there is evidence that the older person is making a reasoned choice, the benefit of doubt should be in his or her favour.

If the older person is not able to make his/her own decisions, or if this is in doubt, there are legal powers available for the Court to intervene and to provide protection, for example, the Protection of Personal and Property Rights Act 1988.

A flow-chart of the steps to take when responding to requests for assistance is shown in Appendix 2.

#### **Questions:**

- **Do you know what to do in emergency situations involving elder abuse and neglect?**
- **Do you have a list of people to contact for assistance in emergency situations?**

#### **Summary**

Providing information about how to request assistance for situations involving elder abuse and neglect must go hand-in-hand with knowing how to manage these requests. Establishing guidelines and working cooperatively with agencies and service providers in your community will ensure this happens.

#### **Action Planning**

- 1 Have you answered the questions posed in this module?
- 2 Have you identified any areas that need clarification?
- 3 If so, who can you discuss these with?
- 4 Set a date when you will review your progress?

**Always ensure that requests for assistance are handled sensitively**

## Appendix 1

### Responding to an Initial Request for Assistance

**IMPORTANT:**

*If you are not trained to deal with requests for assistance take the caller's name, address and telephone number and immediately contact someone who knows what to do*

Date: ..... Time: .....

**Details of the person making the request:**

Name: .....

Address: .....

Telephone Number: .....

Relationship to the older person (if the called is not the person needing assistance):

.....

**Details of the person requiring assistance if different from above:**

Name: .....

Address: .....

Telephone Number: .....

**Details of *what* has happened, *when* and *how* often:**

.....

.....

.....

.....

**EMERGENCY SITUATIONS:**

- *Explain what action will be taken, eg ambulance, doctor and/or police and assure the caller assistance is on the way*
- *If possible, keep the caller on the telephone while you alert these services and any other people that can assist the older person*
- *Record what you have done*

Assess whether urgent treatment is necessary .....

.....

Assess whether the person is in immediate danger.....

.....

Find out if there is anyone you can contact to assist, eg family/whanau or a neighbour

.....

.....

Find out if those involved are aware that a request for assistance is being made (this applies only when a person other than the older person or carer makes the request)

.....

Find out if anyone else is aware of the situation or has regular contact with the older person, eg family/whanau, doctor, nurse, social worker, etc

.....

.....

Find out if the older person has given permission to act .....

Ask for permission for the information given to be acted upon .....

Give the person making the request your name and a contact telephone number.

Check out anything you are not clear about.....

.....

.....

Decide what immediate action needs to be taken

.....

.....

.....

.....

.....

.....

Record who you have alerted, eg police, ambulance, elder abuse and neglect team

.....

.....

Name of person receiving the request .....

## Appendix 2

### Receiving a Request for Assistance

- *Record date and time of call*
- *Record name, address and telephone number of caller*
- *Record details of older person, carer, rest home/hospital etc*
- *Record details of what has occurred, when and who is involved*
- *Assess urgency of situation*

#### **Emergency**

Find out:

- If the person is in danger
- If urgent treatment is required
- Who is with him/her

Call emergency services if this has not been done and is required

Ask the caller to stay with the older person and give him/her your name and telephone number

Immediately inform the abuse team/network of the action taken and complete 'Request for Assistance' form

#### **Urgent**

Find out:

- If immediate help is required and if anyone can provide this
- Ask if the older person/ carer is aware of the situation

Give the caller your name and telephone number

Immediately contact abuse team/network.

Complete 'Request for Assistance form'

#### **Non-urgent**

Find out:

- If the older person carer are aware of the report
- Who else is aware of the situation

Complete the 'Request for Assistance' form and refer to the abuse team/network

## MODULE 12

### Assessment

#### Introduction

When a request for assistance is received regarding elder abuse and neglect, it is important that an assessment is carried out as soon as possible.

Most cases of elder abuse and neglect are not crisis situations. Often the problems are long standing and complex and will take time to work through. Cases rarely fall neatly into categories and each one will be different.

There are often no immediate solutions. Service providers should be aware that no one person is likely to be able to provide all the answers or help that is needed.

#### Skills/Training Required by those Undertaking Assessments

Assessing situations of elder abuse and neglect requires special skills and only those who are trained in this area should undertake assessments.

In most cases the service provider/s responsible for assessments will be members of the elder abuse team/network or will have been specially appointed and trained to respond to requests for assistance.

#### Confidentiality

Confidentiality must always be a major consideration and only people involved in the assessment, support and evaluation (eg the key service provider and abuse team/network members) should have access to personal information regarding the situation. It is necessary and important to explain to the older person and the carer who will be involved, permission should always be sought to use any of the information gathered.

It should be remembered that the safety, wellbeing and rights of the older person must be the primary consideration.

Confidentiality must not be used as an excuse to do nothing.

#### Purpose of the Assessment

The purpose of the assessment is to identify where help is needed and to lay foundations for working with the older person and the carer so that solutions can be found that will help reduce the risk of elder abuse and neglect.

Those carrying out the assessment must not focus on suggesting services and support for the older person and/or carer as a way of avoiding discussing the abuse and/or neglect.

The safety, wellbeing and rights of the older person must always be the main focus.

### **Gaining Access**

Gaining access can be difficult as sometimes the carer or others may block access to the older person. At other times the older person may not be cooperative for fear of reprisals, removal from the home or because of guilt, shame or a belief that little can be done to improve the situation. Sometimes the older person may be unaware that he/she is being abused or neglected. Finding out who else knows the people involved, for example, doctor, minister etc and working through them on a confidential basis may help establish trust.

If access is denied, those involved in the assessment should keep trying with the aim of gaining the trust of the older person, their carer/whanau and/or significant others.

### **Gathering Information**

Discovering the facts, as well as building a rapport with the older person, their carer/whanau and/or significant others can be extremely difficult and may take some time.

A step-by-step approach may be necessary to cover the following important points:

- What actually happened or is likely to happen that made a request for assistance necessary?
- Why this happened or is likely to happen
- The frequency, duration and severity of the behaviour or acts
- Whether the behaviour or acts were intentional or unintentional
- The effects on the older person
- Whether the older person is able to take care of and protect him or herself
- What support systems the older person or carer has, eg family, whanau, neighbours, friends
- What else is needed to alleviate the situation

It is important, whenever possible, to check with others who know the older person and/or carer, eg doctor, district nurse, social worker, etc before visiting the home as they may be able to provide useful information.

### **Planning the Assessment Interview**

The assessment interview will provide vital information about the dynamics of the situation, so must be planned carefully.

The assessment may be carried out by several people who have specific skills and who are members of the elder abuse team/network. Who is involved will depend on the nature of the reported abuse or neglect, for example: doctor, nurse, social worker, lawyer, accountant. The individual assessments would then be collated into a single report.

In most cases a 'key' service provider will be appointed to coordinate the assessment.

The following guidelines will assist with planning the assessment interview.

**POINTS TO CONSIDER PRIOR TO THE ASSESSMENT INTERVIEW/S**

- Who will carry out the assessment and who will be the 'key' service provider if there is more than one? This will depend on what type of abuse and/or neglect has been reported. For example, if physical abuse is suspected a doctor or nurse would need to be involved.
- Consider the number of service providers that will be involved in the assessment. Too many people may overwhelm the older person and/or the carer.
- Clarify the role of each service provider and the particular area of the assessment they are responsible for. This will avoid the older person and carer being asked the same questions by several people.
- Check if the older person has memory loss or a psychiatric disorder as this may mean taking a different approach.
- Set realistic expectations, eg putting the older person and carer at ease and assuring them of continued visits may be all that can be achieved from the first visit.
- Prepare a list of points to cover. As Assessment Record is shown in Appendix 1. Do not use this in the interview as a checklist or questionnaire, only as a reminder. This record can be completed after the interview. Remember - only some points may be covered in the first meeting.
- Decide who will take notes during the assessment. Note taking can be distracting, so any important points should be taken down unobtrusively. Facts as well as personal observations and reactions to those facts can be helpful. Listing possible action steps is also useful.
- Detailed notes should be written in full immediately after the interview and the Assessment Record completed so that nothing is forgotten. All records should be dated, signed and filed.
- Allow enough time for the interview.
- Arrange to talk to the older person on their own, in private.
- Arrange to talk to the carer/whanau and/or significant others on their own, in private if appropriate.
- Liaise with general practitioner and other service providers who know the older person and the carer.

**POINTS TO REMEMBER DURING THE ASSESSMENT INTERVIEW**

- Match the pace of the older person and carer.
- Remember that active listening is probably the most important skill service providers need to use/practice. This involves identifying the total message the other person conveys through tone of voice, facial expression, posture and emotions underlying his/her words.
- Clearly state the reason for the visit, eg concern about the situation.
- Use easy, open questions such as "How do you spend your day?" This will elicit more information than a direct or leading question such as "Do you stay in this room all day?"
- Be aware of and note any signs of physical or personal neglect.

- Observe any environmental signs of neglect or discrepancy between the person's assets and their standard of living.
- Answer questions honestly and discuss possible courses of action.
- Explain and provide written information to the older person and carer about the services and support that are available.
- Plan the follow-up by making a definite date and time for another meeting.

### **INTERVIEWING THE OLDER PERSON**

The older person may deny there is anything wrong, give conflicting messages or react with confusion, fear or anger. They may state that nothing can be done.

Gaining the older person's confidence and trust is vital during the first interview. The service provider/s must show he/she is there to assist, not to judge. Reassuring the older person that the aim is to help by offering any support may alleviate some fears.

For many older people, talking about the situation will be extremely difficult. Allowing time for the older person to express things in his or her own way will be more productive than hurrying the interview by asking too many questions. The service provider/s should not expect the older person to 'bare their soul' and should allow him/her to keep secrets.

**Caution: Always be sure that the action does not cause more harm than the abuse or neglect and does not undermine the rights of the older person or carer**

### **Interviewing the Carer/Whanau and Significant Others**

Interviewing the carer/whanau and/or significant others will involve similar methods to those described above, as it is equally important to gain their confidence.

The carer may be under stress and frightened about what will happen. Putting him/her at ease while trying to find out the facts is not easy but will be the most productive way of gauging the seriousness of the situation and assessing what needs to be done.

In most cases, asking the carer to describe what is involved in the day-to-day care of the older person will open up the discussion and enable the service provider/s to check for stress, financial difficulties, health and other problems as well as the carer's ability to manage the care.

Where it is clear that abuse or neglect has occurred, the person involved should be asked to describe the events from his/her perspective, including why it happened. This will help the service provider/s assess whether the abuse or neglect was intentional, for how long and how often it has happened and whether it is likely to continue. It will also be necessary to find out what support this person has and what he/she considers will assist.

At the end of the interview a time should be made for the next appointment and the carer/whanau and/or significant others told what is likely to be the next step.

**Questions:**

- **Consider how assessments are currently conducted in your agency**
- **Are there written guidelines?**
- **If so, do these guidelines need amending?**
- **If not, would guidelines be helpful and what needs to be included?**

### **After the Assessment Interviews**

When there is more than one person involved in the assessment, the information gathered will need to be collated and a full report written. In most cases the 'key' service provider would be responsible for preparing the full report. This will then be discussed with the elder abuse team/network and a decision made about the action to be taken. Module 13: *Planning, Services and Support* provides further information.

### **What about the Service Provider/s?**

Assessments can be very demanding as abuse and neglect of older people is highly complex and emotionally charged and can elicit powerful responses and defences for everyone involved. The dual role of gaining the confidence of the older person and the carer/whanau and/or significant others as well as finding out the facts is difficult.

Providing a debriefing mechanism for service providers involved in assessment is essential. The elder abuse team/network could be used for this purpose.

To ensure that service providers do not become overloaded, the role of the 'key' service provider could be rotated.

*Being aware of personal value judgements is critical* as service providers must not let these influence their actions. Assessing the situation from the older person's perspective is necessary. To do this the service provider/s will need support and input from colleagues before and after the interview so they can discuss the options and any concerns.

'You cannot please all of the people all of the time' may be a phrase for the service provider to keep in mind. Being constantly aware of the older person's needs is vital because, at times, there will be pressure from family, neighbours or other service providers about what should be done. The service provider/s will, in the end, need to make the final decisions in consultation with the older person, their manager/supervisor and/or the elder abuse "team" or "network".

### **Summary**

The assessment process is difficult for everyone. Being sensitive to the needs to the older person, the carer/whanau and/or significant others while endeavouring to provide relief and support, can only be achieved by agencies and service providers working closely and cooperatively together.

### Action Planning

- 1 Have you considered the questions posed in this module?
- 2 Have you identified any areas where guidelines need to be developed?
- 3 If so, have you listed your ideas and how they can be implemented?
- 4 With whom do you need to discuss these?
- 5 By what date will you have spoken to this person/people?
- 6 What date have you set to review your progress?

 **Always be sure that the action does not cause more harm than the abuse or neglect, and does not undermine the rights of the older person or carer**

## Appendix 1

### Elder Abuse and Neglect Assessment Record

Date: ..... Name of Service Provider: .....

Details of older person: Name: .....

Address: .....

..... Telephone Number: .....

Has the older person given his/her consent for the assessment: Yes / No

Details of carer: Name: .....

Address if different from above: .....

.....

Telephone Number: .....

Relationship to the older person: .....

Service providers already involved: .....

.....

Details of *what* happened, *when* it happened and *how often* (use extra sheets if required)

.....

.....

.....

.....

.....

.....

.....

.....

.....

**Evidence of abuse and/or neglect**

**Note:** In cases of physical abuse or when the older person's health is a factor, a medical practitioner or nurse should always be involved in the assessment.

**Type/s:** (physical, psychological, sexual, material, active/passive/self-neglect)

.....

.....

**Signs:** .....

.....

.....

<b>Older Person's Dependence on Carer:</b>	<b>Total</b>	<b>Partly</b>	<b>Independent</b>
• Personal care including medication	.....	.....	.....
• Emotional	.....	.....	.....
• Finances	.....	.....	.....
• Companionship	.....	.....	.....
• Domestic (cooking, cleaning, etc)	.....	.....	.....
• Transportation	.....	.....	.....
• Other - specify .....	.....	.....	.....

.....

<b>Physical Environment</b>	<b>Problem</b>	<b>No Problem</b>
• Repair	.....	.....
• Level of cleanliness	.....	.....
• Architectural barriers	.....	.....
• Usual facilities	.....	.....
• Living area used by older person	.....	.....
• Sleeping area used by older person	.....	.....
• Fire safety	.....	.....
• Other - specify .....	.....	.....

.....

Risk Factors	Older Person			Carer/other person		
	Present	Suspect	Nil	Present	Suspect	Nil
<i>Isolation</i>						
• Social	.....	.....	.....	.....	.....	.....
• Emotional	.....	.....	.....	.....	.....	.....
<i>Stress</i>						
• Unemployment	.....	.....	.....	.....	.....	.....
• Insufficient income	.....	.....	.....	.....	.....	.....
• Inadequate accommodation	.....	.....	.....	.....	.....	.....
• Illness (physical, emotional, psychiatric)	.....	.....	.....	.....	.....	.....
• Other - specify	.....					
.....						
<i>Family conflict</i>						
• History of violence	.....	.....	.....	.....	.....	.....
• Role change	.....	.....	.....	.....	.....	.....
• Other - specify	.....					
.....						
<i>Sexual</i>						
• Previous sexual problems	.....	.....	.....	.....	.....	.....
• Other - specify	.....					
.....						
<i>Substance abuse</i>						
• Alcohol	.....	.....	.....	.....	.....	.....
• Drugs	.....	.....	.....	.....	.....	.....
• Prescription drugs	.....	.....	.....	.....	.....	.....
<i>Vulnerability</i>						
• Unable to defend self	.....	.....	.....	.....	.....	.....
• Unable to care for self if left alone	.....	.....	.....	.....	.....	.....
<i>Lack of support services</i>						
• Family/whanau	.....	.....	.....	.....	.....	.....
• Friends	.....					

- Neighbours

**Assessment of Cause**

(for example carer stress, inadequate support/help for older person and/or carer, inadequate living arrangements, financial difficulties, lack of privacy/time out, etc)

- .....
- .....
- .....

**Assessment of Needs of Older Person**

(for example, hospital assessment, home nursing services, day care, respite care, alternative care, financial/legal advice, meals-on-wheels, visiting services, etc)

- .....
- .....
- .....
- .....
- .....

**Assessment of Needs of Carer**

(for example, home-help, time out from care, financial advice, education - regarding care needs of older person, counselling, contact with specific support groups, etc)

- .....
- .....
- .....
- .....

**Supports that can be activated**

- |                   | <b>Yes</b> | <b>No</b> |
|-------------------|------------|-----------|
| • Family          | .....      | .....     |
| • Friends         | .....      | .....     |
| • Neighbours      | .....      | .....     |
| • Other - specify | .....      |           |

.....  
.....  
**Recommended action:** .....

.....  
.....

Follow-up appointment date: .....

**Caution:** Always be sure that the action does not cause more harm than the abuse or neglect, and does not undermine the rights of the older person or carer.

## MODULE 13

### Planning Services and Support

#### Introduction

Assessment and planning are not always distinct stages. During the assessment service providers will begin to consider what can and what cannot be changed to alleviate the situation. This will take into account the older person's needs, right to self-determination and freedom of choice and the needs of the carer, family/whanau and significant others.

Service providers may be confronted by situations in which the perceptions of the abuse and/or neglect vary significantly. It is therefore important for service providers to be aware when such differences in perception exist so that ways can be found to bridge these differences and reach common ground on which a working relationship can be built.

When considering options and planning the course of action it is important to be guided by the older person and his/her family/whanau. This is central to the wellbeing of the older person and the effectiveness of any action taken.

#### Points to Consider Before Planning Services

After the assessment has been completed the key service provider will begin developing a comprehensive case plan. How this is done and who is involved with depend on the method and processes which have been adopted for responding to situations involving elder abuse and neglect in your community (see Module 10: *Developing Policies and Practice Procedures*). For example, if an elder abuse and neglect team/network has been formed, the key service provider will work or liaise with this team or network.

The plan will be to take into account the services available in the community so that these can be matched with the needs of the older person and the carer. This will involve assessing what will be effective and appropriate, taking into account what can and what cannot be changed through intervention. Ineffective services can lead to frustration and an even greater level of powerlessness on the part of the older person and the carer and may increase the risk of further abuse and/or neglect.

In all decisions the following must be kept in mind:

- What is the least restrictive alternative?
- What is the least disruptive option?
- Will the action being considered cause further harm?
- Have the rights of the older person and carer been considered?

The aim of the case plan will be to find the best possible solution for the older person and the carer. It is therefore necessary to consider a plan which assists the older person and the carer to overcome the causes of the abuse and/or neglect with minimal disruption to their lifestyle. This

includes exploring the support networks of the older person and the carer to see if adequate resources can be activated from this source before introducing outside assistance.

The complexities of planning the delivery of services is compounded by the need to substantiate, in some cases, the abuse and/or neglect while providing immediate services and building trust. The key service provider must invest energy and time helping the older person and the carer identify the course of action they wish to take.

### **Identifying Services**

The range of services and information that service providers need to know about is enormous. Knowing who to contact and how to ask for services is essential.

The following are some of the services that may be required to assist older people and their carers:

- Assessment and rehabilitation
- Befriending services
- Chaplaincy
- Carer support groups, eg ADARDS
- Counselling
- Day centres
- Dental
- Dietary
- Emergency services (shelter, ambulance, money, food, clothes etc)
- Family counselling
- Financial (budget advice, accountants, benefit entitlements)
- Home help
- Hospice
- Hospital
- Housing
- Laundry
- Legal (police, solicitors, court, etc)
- Meals-on-wheels
- Medical
- Nursing
- Occupational therapy
- Pharmaceutical
- Physiotherapy
- Podiatric
- Relief care - at home/rest home/hospital
- Rest home
- Social work
- Speech therapy
- Visiting
- Telephone support services
- Transport

It is important for the key service provider to be specific about what is required and to have prepared an interim plan before contacting agencies and other service providers. This will enable a clear request to be made about what is required and when.

As well as using existing services, it is important to consider and develop new ways of providing help and support. For example:

- “Peer counsellors” - recruiting and training older people as non-threatening counsellors or advocates to help the dependent older person gain access to resources.
- Establishing local sitter services, daycare centre
- Establishing education programmes about the aging process and caring for a dependent older person.

**Questions:**

- **Do you have a list of services and supports that you can contact in your community?**
- **Are there any other services and/or supports that would be helpful?**
- **Who can you talk to about developing these?**

**Case Study**

*A local minister asked for assistance. He reported the Mrs E appeared very frail and unkempt and he had noticed several bruises on her forearms. He also felt concerned about Valerie, Mrs E’s daughter, who appeared unwell and unable to look after her mother or the home.*

*The assessment revealed that the house was run-down and dirty and Mrs E spent all day on her own while her daughter was at work. She appeared lonely, dirty and malnourished. She said she was a burden on her daughter and was worried about her daughter’s health. She was also concerned that the bills were not paid and she could not get to the bank to draw any money. When asked about the bruises Mrs E said she did not know how she got them.*

*Valerie worked full time and was a solo parent with two children, both of whom were in trouble at school. She was obviously under stress, saying she had enough worries trying to cope with the children and her own heart condition and had not got the energy to do the housework and leave meals for her mother which she didn’t eat. When asked about the bruises, Valerie was unresponsive.*

*When the service provider suggested that she could arrange for help with Mrs E’s care Valerie seemed relieved. Mrs E, however, said she was alright and didn’t want to bother anyone. The service provider then asked if there was anyone Mrs E knew who could call in and have a chat with her and perhaps take her for a drive sometimes. Mrs E said there was no-one now who would*

want to visit her. The service provider then suggested that she would call again the next day with some ideas that they could talk through and both Mrs E and Valerie agreed to this.

## Developing a Case Plan

A case plan must be:

- Realistic
- Achievable
- Based on the facts gathered during the assessment
- Provide choices and options for the older person and the carer to consider

The service provider in the above case study for example will need to consider:

### 1 **Mrs E's needs**

#### *Immediate needs*

- A full medical examination to check her physical health and the bruising
- Assistance with personal cleanliness
- Assistance with nutrition
- Contact with other people

#### *Possible longer term needs*

- Counselling to improve communications with daughter
- Financial advice

### 2 **Valerie's needs**

#### *Immediate needs*

- Assistance with the care of Mrs E
- Assistance with the children's problems
- Medical check-up
- Assistance with nutritional needs of the family
- A break - holiday camp for the children

#### *Possible longer term needs*

- Budget advice
- Counselling - to improve communication with mother and children
- Stress management and self-esteem skills
- Ongoing support

### 3 **Services to meet immediate needs**

- Doctor to assess Mrs E's and Valerie's medical needs
- District nurse to assess Mrs E's personal care and nutritional needs and discuss with Mrs E and Valerie
- Meals-on-wheels for Mrs E
- Home visitor for Mrs E
- School guidance counsellor to discuss children's needs

A sample case plan is contained in Appendix 1.

### **INVOLVING THE OLDER PERSON AND CARER IN DEVELOPING THE CASE PLAN**

Once the initial case plan is developed the key service provider should meet with the older person, the carer and others who will provide services and support to discuss and involve them in the planning. All those who play a major role in the care of the older person should, if possible, be involved at this stage - for example family/whanau as well as other service providers.

This is a critical point in the relationship and it is important that the older person feels able to state his/her preferences and choices and plays an active part in the decisions.

In situations where the older person is confused or has memory loss the key service provider may need to assume an advocacy role on their behalf or involve the older person's welfare guardian if one has been appointed.

The plan should include objectives, activities and timeframes - including when the plan will be reviewed and evaluated - which are understood and accepted by the older person and the carer. All service providers and significant others should have a clear understanding of their roles. Once this has been agreed the services can begin.

Guidelines for family meetings are contained in Module 14: *Family Meetings*. The role of the key service providers is outlined in Module 10: *Developing Policies and Practice Procedures*, and Module 14.

In the case of Mrs E the following case plan was developed:

#### **Objectives:**

- 1 Provide necessary medical care for Mrs E and Valerie  
*Tasks:* Family doctor to provide a full medical examination for Mrs E and Valerie.  
  
Valerie and Mrs E to keep the appointments with the doctor and any follow up he recommends.  
  
*Timeframe:* 2pm next Monday
- 2 Improve Mrs E's personal care and nutritional needs  
*Tasks:* Mrs E to bathe Monday and Friday each week with assistance from district nurse.  
  
Mrs E and Valerie to work with district nurse regarding personal care and nutritional needs.  
  
Mrs E to eat meals supplied by meals-on-wheels; Valerie to cook one meal per week with guidance from volunteer visitor.  
  
*Timeframe:* To start as from tomorrow

3 Provide company for Mrs E

*Task:* Volunteer visitor to visit Mrs E twice a week for one hour.

*Timeframe:* First visit next Wednesday

4 To assess children's school needs

*Task:* Valerie to make an appointment with school guidance counsellor; key service provider to attend this meeting.

*Timeframe:* Appointment arranged by next Wednesday

**Review Date:** One month from today - all people involved to attend. At that point a plan for longer-term needs will be developed.

**Caution: Always be sure that the action does not cause more harm than the abuse or neglect, and does not undermine the rights of the older person or carer.**

#### **OTHER POINTS TO CONSIDER WHEN DEVELOPING A CASE PLAN**

##### ***Cultural Needs***

Service providers must always be careful of the personal values and beliefs and cultural needs of the older person and the carer. This may sometimes mean that decisions need to be made in different ways. It may also mean that services provided by health or social service agencies are inappropriate and therefore ineffective. The key service provider should talk to the older person and the carer family/whanau about how their needs can be met and also consult with others who do know and understand the approach to take. Module 5: *Cultural differences* covers this area.

##### ***Financial Needs***

The older person and carer may be faced with financial decisions due to the hidden costs of care such as cost of medicine or special food. The carer may not be able to work because of the demands of care or they may be unaware of their entitlement to special benefits or other financial assistance. Service providers should be aware of these pressures and ensure that the older person and carer are receiving all the benefits they are entitled to.

##### ***Care Arrangements***

Sometimes an older person will require care away from home, for example: day care, respite care, or full residential care. In all situations the key service provider must help the older person and the carer prepare for this change as it can cause extreme stress for everyone concerned.

In situations where full residential care is considered, it should be the result of positive choice from a range of options - not viewed or presented as a first or last resort. Options should be discussed with the older person and carer and a visit arranged to the places selected to meet with those who will provide the care and those receiving care. The older person should be informed about what to expect including the activities, food, etc.

In the case of day care, the days and times should be discussed and when respite care is necessary, the length of time that is planned.

The older person and carer should be encouraged to fully express their thoughts and feelings about any aspect of a proposed course of action. Questions should be answered with sensitivity and honesty.

Sometimes the needs of the carer must come first to give relief so that care can continue.

Trial periods should always be arranged and discussed with the older person, carer and those who will provide the care.

### ***Education about Aging***

In some situations, providing information about aging can help the carer understand the needs of the older person they care for and enable them to provide the required care.

### ***Legal Action***

When serious abuse or neglect has occurred and legal action is necessary, the older person must be supported and informed regularly about what is happening. Emergency situations are frightening for everyone and even more so for an older person who is dependent on others for care.

### ***Encouragement***

Giving words of encouragement to both the older person and the carer is often the most productive way of achieving results.

Carers may feel guilty about receiving assistance so permission to take up services must be given.

### **Monitoring the Situation**

The key service provider will be responsible for ensuring services are delivered in accordance with the case plan and will need to keep in regular contact with the older person and carer and provide a contact telephone number in case of an emergency.

This service provider will need to monitor whether the services are fulfilling the intended function and how the older person and carer feel about the service delivery. The main thing will be to check whether or not the abuse and/or neglect is still occurring and then to see if other areas have improved; for example, is the older person eating properly and the carer less stressed.

It is important to remember that problems are often not solved immediately. Sometimes the older person or carer may have difficulty relating to a service provider or having strangers in the home may cause more stress and makes the situation worse.

Services have to be changed or adjusted and often it is a matter of trial and effort before finding a solution that works. If a crisis develops, the key service provider will need to call a meeting reassess the situation and decide on a different approach.

### **REVIEWING CASE PLANS**

The key service provider should arrange for the older person, carer, family/whanau and all other service providers to attend the case plan review on the date set in the original plan.

The purpose of the review is to:

- assess the effectiveness of the services by exchanging information about progress; and
- determine if the situation has changed and whether new services are required.

An updated case plan should be prepared and the next review date set.

### **Closing Cases**

This can be extremely difficult in situations of elder abuse and neglect, as often the key service provider and other service providers will have established relationships which the older person has come to rely on.

Even when the objectives have been achieved and the risk of abuse and/or neglect has been overcome, service providers may find it difficult to close the case. The older person may still require assistance. Unlike clients in other age groups where the goal is to achieve independence, the older person may continue to become more dependent due to failing physical health and require ongoing assistance and services, and sometimes an advocate. Often the older person has outlived friends and relatives and the relationship with a service provider has become both professional and personal.

It is important, however, for the key service provider to set limits once services are established. Regular contact by the key service provider may no longer be necessary and an occasional telephone call or visit may be enough to reassure the older person and maintain the relationship.

### **Support for Service Providers**

Working in situations involving elder abuse and neglect requires commitment of time and energy. The work is stressful and demanding but can be extremely rewarding.

Working successfully in this area may require the development of new helping techniques rather than transferring skills used in other areas.

Service providers must have a forum to share ideas, concerns and successes. They must have ongoing training that provides the opportunity to learn new skills and techniques and regular effective supervision. They must also be valued for their dedication and work.

### **Summary**

It is important to have a framework which enables service providers to work with older people and carers to examine needs, plan objectives, monitor service delivery and review progress. Older people, service providers and carers should be partners in the provision of care.

### Action Planning

- 1 Does your agency use written case plans?
- 2 If so, is the current format effective or does it need to be updated?
- 3 If case plans are not currently used, how can they be introduced and what format should be adopted?
- 4 Do you need to take any immediate steps to improve your own case management? For example, check when you last reviewed current cases; check you understand the roles of other service providers involved.
- 5 Who can you talk to about improving case management practice?
- 6 By what date will you have arranged to discuss the above?

 **Keep objectives and tasks simple and set timeframes.**

## Appendix 1

### Case Plan

Date of meeting: .....

Name of 'key service provider': .....

Name of older person: .....

Address: .....

.....

Telephone number: .....

Name of carer: .....

Relationship to older person: .....

Address (if different from above): .....

.....

Telephone number (if different from above): .....

**Current Situation** (describe what action has been taken and the older person/carer's response, etc)

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**Family/whanau present at the meeting**

- 1 Name: .....
- Address: .....
- Telephone number: .....
- Relationship to older person: .....
- 2 Name: .....
- Address: .....
- Telephone number: .....
- Relationship to older person: .....
- 3 Name: .....
- Address: .....
- Telephone number: .....
- Relationship to older person: .....

**Service providers present at meeting**

- 1 Name: .....
- Agency: .....
- Telephone number: .....
- Role: .....
- 2 Name: .....
- Agency: .....
- Telephone number: .....
- Role: .....
- 3 Name: .....
- Agency: .....

Telephone number: .....

Role: .....

4 Name: .....

Agency: .....

Telephone number: .....

Role: .....

**Others present at the meeting (Welfare, guardian, friend etc)**

1 Name: .....

Agency (if applicable): .....

Telephone number: .....

Relationship/role: .....

2 Name: .....

Agency (if applicable): .....

Telephone number: .....

Relationship/role: .....

**Reason for family meeting:**

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**Objectives for the family meeting:**

(Objectives of the meeting must be realistic/achievable/measurable)

*Objective 1:* .....  
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*Tasks (including what the task is, who will carry it out and the timeframe)*

Task 1: .....  
.....

Name: .....

Dates: .....

Task 2: .....  
.....

Name: .....

Dates: .....

Task 3: .....  
.....

Name: .....

Dates: .....

Objective 2: .....

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Tasks (including what the task is, who will carry it out and the timeframe)

Task 1: .....

.....

Name: .....

Dates: .....

Task 2: .....

.....

Name: .....

Dates: .....

Task 3: .....

.....

Name: .....

Dates: .....

Objective 3: .....

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Tasks (including what the task is, who will carry it out and the timeframe)

Task 1: .....

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Name: .....

Dates: .....

Task 2: .....

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Name: .....

Dates: .....

Task 3: .....

.....

Name: .....

Dates: .....

**Contingency Plan** (in case of emergency)

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Contact person/s: .....

.....

Telephone number/s: .....

Additional comments:

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Review date: ..... Time: .....

 **Ensure that everyone understands and agrees with the plan.**

**Evaluation of Plan** (to be completed before a new plan is drawn up)

*Objective 1:* (comments)

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Task 1 - outcome: .....

Task 2 - outcome: .....

Task 3 - outcome: .....

*Objective 2: (comments)*

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Task 1 - outcome: .....

Task 2 - outcome: .....

Task 3 - outcome: .....

*Objective 3: (comments)*

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Task 1 - outcome: .....

Task 2 - outcome: .....

Task 3 - outcome: .....

Additional comments and/or suggestions:

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## MODULE 14

### Family Meetings

#### Introduction

Planning and holding family meetings takes time, and it is easy to overlook or downplay their importance. These meetings are often held when organising and coordinating services for older people; they are particularly important in situations involving elder abuse and neglect.

The ideas and suggestions contained in this module are intended as guidelines for service providers who may be required to organise or take part in family meetings after an assessment has been completed (Module 12 covers the assessment process). However, these guidelines can also be used for any meeting involving an older person, carer, family/whanau and service providers, for example, when a carer has asked for assistance or when an older person can no longer live alone.

#### What is a Family Meeting?

A family meeting is a gathering of people who are closely associated with the older person and carer. The purpose of a family meeting is to discuss and prepare a case plan and to ensure that everyone is clear about the action to be taken, including roles and tasks.

The initial family meeting is often uncomfortable for everyone, including the service providers. These meetings can also be extremely threatening for the older person, their carer and family/whanau. When arranging a meeting, it is therefore essential to ensure that it will be held in a culturally appropriate and sensitive manner.

There are four stages to consider when planning a family meeting:

- 1 Deciding when to hold a meeting
- 2 Preparing for the meeting
- 3 The meeting itself
- 4 After the meeting

#### Stage One: Deciding when a Family Meeting should be held

##### TIMING OF A FAMILY MEETING

The timing of family meetings will vary, and a meeting may not be appropriate until some initial work has been done with the older person and/or carer. When a decision is made to hold a meeting, it should be arranged as quickly as possible. Lengthy delays may be stressful for both the older person and the carer.

##### IS A FAMILY MEETING ALWAYS APPROPRIATE?

There may be situations when family meetings are not helpful, for example, if the relationship between the older person and the carer has deteriorated to such an extent that providing refuge

for the older person is the only option. Even then, a meeting to discuss this option may be appropriate, particularly if there are family/whanau or other people closely involved.

In cases where the older person has no family or significant others, a meeting with the service providers should be arranged so that the older person and carer are involved in the planning and know what to expect.

*Caution* - always ensure that a family meeting does not cause more harm to the older person.

### **WHO SHOULD ARRANGE THE FAMILY MEETING?**

In most cases the key service provider will arrange the family meeting (see Module 10: *Developing Policies and Practice Procedures*). However, in some situations, it may be appropriate for the family to take responsibility for this in consultation with the key service provider.

#### **KEY SERVICE PROVIDER**

The primary role of the key service provider is to ensure that the needs and rights of the older person are considered while ensuring that the rights and needs of the carer, family/whanau are also taken into account. This is important both in the planning stage of the meeting as well as during the meeting itself.

The key service provider will often facilitate the meeting unless it has been agreed that a member of the family/whanau will carry out this role. In these cases, the key service provider should liaise with this person to ensure that roles and expectations are clear. This is particularly important if the key service provider is from a different culture.

When the key service provider is also the representative for the older person it will be necessary to consider if the facilitation role will conflict with this. If so, another person should be appointed to facilitate the meeting.

The key service provider may also be responsible for arranging:

- who will take notes during the meeting;
- preparation of the case plan;
- ongoing coordination of services;
- liaison with the older person, carer, family/whanau and other service providers; and
- review meetings

### **WHO SHOULD BE INVOLVED IN THE MEETING?**

The older person should always have the opportunity of being included in the meeting, even if he/she is not able to take an active part. Being there for part of the meeting may be an option in some cases. The only reason for not including him/her would be when it *would cause harm or excessive distress*. In these circumstances a representative for the older person should be present. This person/s, wherever possible, should be from the same culture as the older person.

The carer/s, should also be present, together with significant family/whanau and any other people who are closely involved, for example, service providers who already work with the older person

or carer and those who will in future work with them, friends, volunteers, or others who provide service and/or support to the older person and carer.

Careful consideration must be given to the size of the meeting as large meetings may be intimidating and threatening for the older person and carer. Although it is important to include key people, it is equally important to keep the meeting as small as possible and to discuss who to include with the older person and the carer beforehand.

The older person and the carer may not be familiar with family meetings and may feel uncomfortable talking in a group. Gentle encouragement and careful preparation is therefore essential to help allay these feelings.

### **ENSURING THE RIGHTS AND NEEDS OF THE OLDER PERSON ARE HEARD**

Sometimes an older person may not be able to take an active part in the meeting due to confusion, memory loss or other debilitating illness. In such cases, it is important for the older person's rights and needs to be accurately presented by someone who is known and trusted by the older person, for example, a welfare guardian or friend.

This person would, as far as possible, be responsible for ensuring the older person understands and agrees with the plan.

### **MANAGING CONFLICT**

Family meetings are not intended to be therapy or counselling sessions, they are planning meetings. If there is major unresolved conflict, this will usually be obvious during the assessment and will need to be dealt with separately before a family meeting is held.

Minor disagreements are likely to happen at times; this can be useful if handled in a constructive way as it may reflect some of the issues which have caused the problems. For example, if the carer states that meals-on-wheels are not needed and the older person says that he/she is not fed properly, this may be an opening to explore some of the underlying problems.

## **Stage 2: Preparing for a Family Meeting**

### **BACKGROUND INFORMATION**

It is necessary for the key service provider to have as much background information as possible to enable him/her to properly prepare for the meeting.

The assessment report will provide important details about what has occurred, the attitudes of the people involved about the situation and what action has been taken or recommended.

Key points to remember:

- Decide what is hoped to be achieved in the meeting. It is important not to make decisions or assumption before the meeting. However, it is also important to be clear about the reason for the meeting.

- Contact the older person and carer to discuss who should be included and what will be covered in the meeting; also arrange a suitable date and time for the meeting. In most cases this is better done in person rather than by telephone, particularly for the first family meeting.
- Arrange where the meeting will be held. In most cases it will be in the home unless there are good reasons for holding it elsewhere.
- Ensure that the meeting will be held in a culturally accepted manner. If in doubt, ask the older person, carer or significant others. If this is not possible or appropriate, consult with others who do know.
- Consult with those who were involved with the assessment and/or service providers who know the older person, about what support and services they think may be helpful.
- Prepare an agenda for the meeting.
- Decide on the length of the meeting. This is often difficult to ascertain, but it is important that the meeting is not too long as it may be stressful for the older person and carer. It is also important to remember that this is extra work for already busy service providers and others.
- Contact the other people who will be involved to confirm the date and time of the meeting.

It is courteous to confirm the meeting with the older person and the carer the day before; this also serves as a reminder to them.

It is important to allow enough time, both before and after the meeting, so as not to be rushed. The key service provider should arrive ahead of other people to reassure the older person and carer about the meeting and to meet people as they arrive.

Preparation is very important, and attention to detail will mean that the meeting itself is more likely to have a positive outcome.

### **Stage 3: The Family Meeting**

#### **THE FOCUS OF THE MEETING**

Family meetings should be low key and as informal as possible, so that the older person, family/whanau are not intimidated and feel able to speak openly.

The meeting should be positive and focus on what can be done to improve the situation. It is important to address the issues in a constructive way and encourage the older person and carer to make suggestions. This often means finding a balance between allowing people to just talk, and covering the essential points. It is also important to utilise the strengths and support within the family.

Key points to remember:

- Seating - ensure that no-one is disadvantaged by the seating arrangements, particularly the older person and carer. For example, do not leave the older person sitting in a corner away from everyone else. If the older person always sits in a particular place arrange the seating to include him/her.

- Make sure everyone is introduced and their role explained. This is particularly important if the older person and carer are meeting people for the first time.
- Clearly outline the purpose of the meeting. A sensitive, clear approach will be more productive than avoiding the issues or being confrontational.
- Encourage everyone to participate and share ideas.
- Make sure both the older person and carer are able to contribute and that the meeting is not dominated by others.
- Present options and suggestions clearly. For example, use clear language and avoid jargon or abbreviations; explain what each option involves.
- Answer questions honestly. It is important for the older person, carer, family/whanau to understand the realities of the situation and what can and what cannot be done to assist them.
- Where appropriate, allow the older person, carer, family/whanau time alone to discuss and feed back comments about the proposed plan.
- Summarise and clarify roles, tasks and expectation when an agreement has been reached about the actions to be taken.
- Set a date for the next meeting.

#### **Stage 4: After the Family Meeting**

##### **CASE PLAN**

Writing up the case plan and forwarding a copy to all those involved in the family meeting ensures that everyone understands what has been agreed. This will probably be done by the key service provider and should be completed as soon as possible after the meeting.

It may be beneficial to personally give the older person and carer a copy of the case plan, as this provides an opportunity to check that they understand what has been arranged.

Modules 10, 11, 12 and 13 in this kit also contain information and suggestions which may be helpful when planning and conducting family meetings, for example, Module 13: *Planning Services and Support Includes*:

- Points to remember when developing a case plan;
- Sample case plan; Appendix 1;
- Reviewing case plans; and
- Closing cases

##### **Questions:**

- **How are the family meetings viewed in your agency?**
- **Does a different approach need to be taken? How can this be done?**
- **Do you prepare for family meetings as outlined in this module?**
- **Can you think of any other things that need to be included in family meetings?**

## **Summary**

Family meetings play an important part in minimising the risk of elder abuse and neglect as they provide a mechanism which ensures:

- the older person and the carer are fully involved in decision making;
- the strengths of the family are utilised;
- the assistance provided is helpful and appropriate;
- cultural needs and differences have been taken into account;
- services are not duplicated;
- services are coordinated and that a multi-agency/multidiscipline approach is used;
- the older person, carer, family/whanau and service providers are clear about roles and tasks; and
- service roles are reviewed, updated, adjusted and terminated when appropriate

## **Action Plan**

Having considered the questions in this module:

- 1 List ideas and suggestions that help in planning family meetings.
- 2 List your own ideas and suggestions about how family meetings are conducted/facilitated.
- 3 List your ideas and suggestions about case plans.
- 4 Who can you discuss these ideas with>
- 5 Set a date when you will review your progress.

### **Preparation ensures cooperation**