Abstract

Elder abuse interventions need a multidisciplinary approach to address the complex dynamics of the abusive situation. The introduction of the Abuse Against Older Adults (AAOA) unit provides a unique opportunity to address the psychosocial, criminal and legal dimensions related to elder abuse. This thesis focuses on the evaluation of the AAOA unit in its first year of operation in Vancouver, B.C. A qualitative research study was conducted, utilizing focus groups to gather data. The findings show that a police-social worker partnership model is critical in meeting service gaps in this area of practice. The data also explored the interaction between the AAOA unit and the external health care agencies that refer cases to this team. The results encourage future research to continue studying collaboration across multidisciplinary service providers, and further study on the social work role in law enforcement culture.
Preface

This research was conducted with the approval from the University of British Columbia, Office of Research Services, Behavioral Ethics Research Board, UBC BREB number H08-00382.
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Dedication

To my parents, Francisco and Remy – I am blessed and grateful for your endless support and encouragement.

To James and Jess – thank you for keeping the faith from start to finish.

And finally, to Sheila J. and my cheerleaders at the “PAH” – thank you for helping me find power and courage at the final stages of the journey.
1 Introduction

Elder abuse was first acknowledged in the mid-1970s, citing the social issue as “granny-battering” (Burston, 1975) and “granny-bashing” (Baker, 1975). The use of this terminology reflected a limited knowledge base as to what constituted the mistreatment against older persons. Nonetheless, these early writings stirred a movement to uncover a broader and systemic perspective of violence against older adults.

Fast-forward almost 30 years later, when, in my first year practicing as a hospital social worker, I encountered my first case of elder abuse. To begin with, the victim was no “granny” – if fact, he was an elderly Asian man who spoke little English. He had been brought to the Emergency room by his wife, who anxiously glanced at the physician as the multiple bruises on his legs were examined. The fear on her face spoke louder than the few words of English she was able to speak. With the help of a friend who acted as an interpreter, the victim and spouse told their story of an abusive relationship with an adult child.

The emergency room team expressed concern over this couple’s home situation: the visible injuries on the man, along with the fear expressed through the couple’s story, lead the care team to determine that the police needed to be contacted. Through the interpretation of the friend, the couple was informed of the care team’s concerns and that the police would be contacted to investigate their situation. The man and his wife did not express objection to this plan.

The police were contacted to investigate, and within minutes, officers arrived to take statements for the victim, his spouse and the health care team. A pair of police officers (including an Asian officer who spoke the man’s first language) obtained victim impact
statements and photographs of the injuries. While this investigation was occurring at the hospital, the adult son of the couple was arrested and removed from the family home.

The police officers eventually left the emergency room, the patient was admitted into hospital, and his case was passed to a unit social worker. I do not know the outcome of his situation, or whether he returned home to his wife (and son.) Although I was no longer the responsible social worker for this man, I found myself asking more questions about how the Emergency Room staff and I had handled the case. How would the police continue to be involved in this situation? Was the son successfully charged, and was there ongoing support from the community to re-instill a sense of safety for the patient and his wife? Or did this intervention create a more dangerous situation where the man was placed at greater risk for future abuse?

I also questioned whether we fulfilled our role to advocate for the man and his wife. Ethically, the Emergency department staff felt responsible to follow through on this suspected case of abuse. The physical injuries we observed, in combination with the reports from the patient and his wife indicated to us that they were afraid to go home and that their safety was compromised. These observations generated concern that a criminal act may have occurred, and that the police needed to become involved.

As I reflect on this case some years later, I continue to re-evaluate how this case was approached. With the experience I have gained since then I believe that the health care staff acted appropriately in contacting the police. This case occurred during the time when adult guardianship legislation had been passed in British Columbia. Under this law, the staff responded appropriately by reporting any criminal act to the police.
I reflect on whether the man and his wife truly gave informed consent for police involvement: did he feel obliged to comply with the care team’s suggestions, or did he genuinely consent to reporting the abuse to the police? There was no official, unbiased interpreter who liaised between the care team and the patient, as their friend took on this role. How could we ensure that the messages and explanations that we were providing were being conveyed with the same intent to the patient?

Were this man’s wishes fully explored? One area I would have explored further would be a focus on the impact of the patient’s cultural background on this case. i.e. what was the impact of him reporting his son’s behavior to the authorities? As a father, “handing over” his son, what were his feelings around doing this? Furthermore, what did the police officers do with the information that they initially gathered? Did the police investigation continue, and how did they continue to support the family through their criminal investigation? Was further abuse ultimately reduced or even prevented by this timely intervention?

This case impacted me on several layers. In the days immediately following this case, I continued to ask myself questions like: “how would other social workers respond in this situation?” What policies and procedures were in place to guide social workers in elder abuse situations? I was uncertain whether my response and interventions in this case were made in the best interest of this patient.

I also felt that I needed more education around the area of elder abuse. What workshops or education were available to me and other social workers in this area? I was not completely aware of the adult guardianship laws, and in the crisis of this situation, I had only
a brief time to review a policy manual in the office. In hindsight, I believe that the responsibility would fall on the social worker to take a leadership role in educating staff about the legislation around abuse. However, I did not feel equipped to take on this role.

I discovered that at the time of this case, adult abuse workshops were not offered to social workers. At a more informal level, I also had access to debriefing with my professional practice chief about how I managed this situation, and how I could intervene in future situations.

These questions lead to perhaps the most important impact of this case – I did not want other social workers in my position to feel lost, or less equipped to manage a case of elder abuse, the way that I had felt. I felt that I did not have access to enough information in this area, and I wanted to learn about the resources that were out there. It also engaged my curiosity about the available research on elder abuse and ultimately inspired me to complete my graduate degree. In the years since my initial experience with the elderly man in the Emergency room, there has been an increase in the education and resources available to health care professionals. Workshops targeting the roles and responsibilities of social workers in adult abuse cases are conducted in various health care settings. The health care authorities have developed specific programs to assist health care professionals. For example, in the Vancouver Coastal Health Authority, the Re:Act program serves as a resource for the public and health care providers.

More specific and unique programs are also emerging. Within the city of Vancouver, a new pilot project has emerged where a highly-specialized team that provides unique assistance to health care and community professionals who work with abused older adults.
One of these pilot programs is the Abuse Against Older Adults Unit (AAOA). It presents a unique intervention that supports the older adult, family unit and the service providers that assist them. This pilot project offers a bridge to advocate for the older adult through the justice system, whether it is laying charges on an alleged abuser, or providing education and support on the legal processes that warrant the older adult’s involvement.

When I first learned about this pilot project, I was immediately drawn to the opportunity to work on evaluating this program. The AAOA Unit symbolized for me, the ideal resource that could have helped me with my first case of elder abuse. With a team like the AAOA Unit, there is the opportunity to bridge that gap in knowledge as to what the police role is, and how they are involved in cases of elder abuse.

My investment in the evaluation of this team allowed me to develop my own curiosity about how this team functions, but on a formal level it provided me the opportunity to participate in a qualitative evaluation by gathering data about how other service providers perceive the work of this team. Not only would these results contribute to the overall evaluation of the program and fulfill my graduate degree requirements, but I would also be contributing new knowledge to my profession.

This pilot project offers assistance in a way that has not been available before and attempts to address a gap in service. In order to better understand how the Abuse Against Older Adults Unit is a useful and effective service, the Family Services of Greater Vancouver initiated a program evaluation. Part of this evaluation sought to elicit feedback from the service providers who interacted with the AAOA team.
This thesis is a qualitative study that focuses specifically on the responses of the service providers who participated in this evaluation. It addresses the research question, “What are the experiences of the community service providers in working with the Abuse Against Older Adults Unit?” It is part of a larger evaluation study being conducted under the supervision of Dr. Deborah O’Connor.

To provide more depth to this research question, and the influences of a program like the AAOA unit, a literature review is presented in the next section. The discussion of relevant literature will include research from British Columbian and Canadian resources. The framework of methods used in this study will be reviewed, as well as an analysis of the findings. To further highlight the findings of the study, a discussion on the implications from the findings, as well as implications for social work practice will be presented.
2 Framing our Understanding of Elder Abuse

The purpose of this chapter is to compile information that can help us best understand what constitutes elder abuse. First, the literature informs us that there is no single definition for the term “elder abuse” and how the current state of research has studied how to respond to it. To add to this complexity, there is no one theoretical framework that can fully explain how and why elder abuse occurs.

Consequently, a multi-faceted, multi-disciplinary approach is consistently recommended in the literature as a response to elder abuse. The concept of multidisciplinary teams will be explored and a critique of the types of partnership programs that have emerged will be discussed. This will provide a background of the emergence of the Abuse Against Older Adults Unit and how it is poised to operate with the current framework of elder abuse intervention in British Columbia.

It is also important to explore the emergence of elder abuse as a social problem in a Canadian context. With a focus on British Columbia’s research and legislation in this area, the Adult Guardianship Act will be reviewed in relation to this paper. In providing a theoretical basis for this research, the impact of ageist and feminist frameworks will also be discussed.

2.1 Challenges in Defining Elder Abuse

Defining elder abuse starts with acknowledging that there is no single definition that describes this term. Researchers and professionals from national and international levels provide varying definitions.
Elder abuse is a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person. (Action on Elder Abuse, 1995)

Elder abuse is harmful or hurtful conduct that is willfully inflicted upon an older person. (Nerenberg, 2000)

There is validity to each of these definitions, but the components of these can be debated (Nerenberg, 2000). In attempting to develop an all-encompassing and unified definition, the literature raises several challenges as to what elements should or should not be considered. Some of these considerations relate to the concepts of neglect and self-neglect (Lachs and Pillemer, 1995).

- **Commission or omission.** When defining abuse against an older person, are we also considering the failure to provide care by a caregiver?

- **Intentional or unintentional Abuse.** In other words, in cases where an older adult is neglected, an alleged abuser may or may not willfully withhold care, or may lack the resources or support to provide the appropriate care. Furthermore, does it matter whether the act is intended to harm or not?

- **Presence of a perpetrator.** Should we specify that abuse is inflicted by one person to another? When considering cases of self-neglect, how do we incorporate those situations where an individual places their own selves at risk for harm?
Another factor to consider is degree of harm. The “degree” could incorporate such factors as the type of abuse inflicted, e.g. physical or emotional abuse, as well as the severity in which the abuse is experienced. Having said this, despite what degree of abuse is inflicted, it does not demean or belittle the experience. Abuse in whatever shape, form, or degree remains an unacceptable and inexcusable act. For this reason it is important that a unified definition of elder abuse be developed.

Nerenberg (2000) acknowledges that this is a challenge that all researchers face, and consequently impacts future research.

Virtually every researcher who has explored elder abuse to date has lamented the lack of consensus and consistency with respect to the definition of elder abuse - a problem that has made it practically impossible to compare results and to build upon the work of others. (Nerenberg, 2000, p. 87)

Definitions of elder abuse vary within literature, and across North American jurisdictions. State and provincial governments utilize different terminology to define elder abuse, which in turn shape prevalence rates and the development of interventions and services within those legal jurisdictions. For example, higher prevalence rates would be expected when intent to harm does not need to be proven. Moreover, although it may serve specific purposes for a certain piece of legislation, different ways of defining abuse create difficulties for researchers to generalize the effectiveness of legislative-specific interventions.

The literature presents additional considerations to defining abuse. For example, there is recognition that the cultural context of ‘abuse’ should also be considered. Wolf (2000) states that despite the variability in definitions, “the older person’s perception of the action and the cultural context in which the action occurs are salient factors in identification
and intervention” (p. 2). Thus, the process of seeking clarity around defining “abuse” will continue to be debated by researchers and practitioners alike. This ongoing process serves as a reminder that there is no one way to view this complex social problem.

The value in continuing to address a unified definition of abuse comes down to the fact that abuse is unacceptable in any form, whether overt or subtle in its presentation. The varied definitions of abuse present a concern when certain actions do not “fit” a definition. In the event that certain actions or behaviors do not fit a definition does that mean that abuse did not occur? Without a unified definition, there remain gaps in describing how and when an abusive act or situation occurs. It leaves room to “excuse” an act or behavior as being abusive.

Despite the lack of consensus in creating a unified definition of elder abuse, there is a general consensus on the types of abuse: physical, psychological, financial and neglect. The National Clearinghouse on Family Violence (1998) defines these categories of abuse in the following ways:

- **Physical abuse** involves inflicting physical discomfort, pain or injury. It includes behaviors such as slapping, hitting, punching, beating, burning, sexual assault and rough handling.

- **Psychological abuse** diminishes the identity, dignity and self-worth of the older person. Examples are name-calling, yelling, insulting, threatening, imitating, swearing, ignoring, isolating, excluding from meaningful events and deprivation of rights.
- **Financial abuse**, also known as material or property abuse, involves the misuse of money, property or material goods. Examples include stealing money or possessions, forging a signature on pension cheques or legal documents, misusing a power of attorney, and forcing or tricking an older adult into selling or giving away his or her property.

- **Neglect** is the failure of someone presumed to be in a care-giving role, to meet the needs of an older adult who is unable to meet those needs alone. It includes behaviors such as denial of food, water, medication, medical treatment, therapy, nursing services, health aids, clothing and visitors.

### 2.2 Scope of Elder Abuse as a Social Problem in Canada

The National Survey on Abuse of the Elderly (sometimes cited in literature as the Ryerson Study) was conducted in 1990 to begin to track the prevalence of elder abuse in Canada (Podnieks, 1992). Modeled after a study conducted in Boston, Massachusetts (Pillemer & Finkelhor, 1988), the results from this Canadian research were the first to capture a picture about the abuse of Canadian elderly.

Based on the findings of this study, it was estimated that approximately 98,000 older adults in Canada may be experiencing one or more forms of abuse or neglect. It suggested that approximately 40 out of every 1000 elderly persons in Canada will experience some form of abuse (Podnieks, 1992, p. 41). The prevalence rates of all forms of abuse varied across the provinces, with British Columbia having the highest estimate, 53 per 1,000 of older British Columbians. In comparison, the combined prevalence rates of Alberta, Saskatchewan and Manitoba was calculated at 30 per 1,000 older persons. Of the types of
abuse that were studied, material abuse (i.e. financial abuse) was the most prevalent in the study’s sample (2.5%), followed by chronic verbal aggression, physical violence and neglect (Podnieks, 1992).

The Podnieks study acknowledged a need for further education about elder abuse to permeate both professional and public levels of awareness. Law enforcement officials were specifically targeted as needing education about elder abuse. In this study, participants reported low rates in contacting police. Furthermore, the rate of reporting differed depending on the type of abuse. Providing front-line police officers with information on the various types of abuse may assist them when they are called out to investigate an abusive situation.

For older persons who are victims or could be at risk for abuse, the study made recommendations for prevention strategies, e.g. how can older persons protect themselves from material abuse? Since participants were more likely to report abuse if action was taken against the abuser, then information related to the criminal aspects behind material abuse need to be brought to public attention. In turn, older persons may be more inclined to contact the police.

The National Survey on Elder Abuse provided a Canadian framework to begin identifying how elder abuse was being reported across the country. It also inspired research to continue on a smaller and local level.

2.3 British Columbia’s Research on Elder Abuse

Following the publication of Podnieks’ national survey on elder abuse, research in British Columbia (B.C.) continued to develop knowledge on this topic. Expanding on the initial results from the national survey, Spencer (1996) provided more detail into the
experiences of older adults in the province. The report, “Diminishing Returns,” involved interviews with 200 older British Columbians to begin to define what was deemed an appropriate financial relationship between older adults and their family members, in comparison to an abusive financial relationship. Despite the fact that the study was not formally peer-reviewed, its findings suggest that financial abuse may be more serious than initially identified in the 1989 national survey. Based on the results reported in “Diminishing Returns”, 8% of the older adults who participated in the study reported some form of financial abuse (Spencer, 1996, p. 26).

A more comprehensive review on elder abuse in B.C. was provided in a 2003 report, “Profile of Later Life Abuse in British Columbia” (Spencer, 2003). It highlighted the diversity in older adult populations, by identifying “aging communities” in the province, as well as acknowledging the ethnic diversity among older adults. At the time of the report, 11% of the province’s population over age 65 represented a visible minority (Spencer, 2003, p. 8). This is valuable information to report as it shows that older adults of different ethnic groups may have differing cultural values and norms that can affect their risk and experience of abuse.

Spencer (2003) stressed that at the time of the report, there was limited Canadian research in this area, and not enough literature existed to provide comparisons of elder abuse with other Canadian provinces. However, the report highlighted the community responses to elder abuse, such as the B.C. Coalition to Eliminate the Abuse of Seniors (BCCEAS), which focused on community education and advocacy. It also stressed the need for legislative reform that specifically targets older adults in abusive situations (i.e. the Adult Guardianship Act and laws to protect older adults in care facilities).
The experience of abused older women was published from a British Columbian perspective. Hightower, Smith, Ward-Hall & Hightower (1999) conducted a survey to investigate the response of transition homes to meet the needs of older women who were in an abusive relationship. This study found that at the time, there were very few transition homes that were specifically geared for older women 60 years and over, and less than 10% of all the transition houses surveyed provided a specific program for abused older women. This was followed by a qualitative study in 2006, which provided data from older women themselves, as they told their stories about how abuse had impacted their lives (Hightower, Smith & Hightower, 2006). The researchers were able to gather data that described the unique needs of older women who are leaving an abusive relationship in later life and the influence of health on their experiences with abuse.

More recently, policy development in elder abuse practice is addressed in the “Provincial Strategy Document: Vulnerability and Capability Issues in British Columbia.” This report integrates current research in the area of vulnerability and capability of older adults with the legal frameworks and interventions that are available in B.C. to address the protection for older adults with limited capability. It provides a guide and clarification for front line practice workers, for situations where an older adult’s ability to make her own health care decisions is questioned.

Understanding the literature that shapes the climate of elder abuse research in B.C. also impacts policy development and service delivery. It can reflect those areas that are valued by researchers and identify gaps in knowledge. As B.C prepares to implement updated changes to its Adult Guardianship Act, it also presents the opportunity for research to study and evaluate how these changes are being carried out in direct practice.
2.4 Legislative Responses to Elder Abuse: B.C.’s Adult Guardianship Act

In terms of legislative reform, B.C. has been in the process of reviewing and implementing the legislation that reflects societal recognition of the needs and rights of vulnerable older adults in an abusive situation.

The Adult Guardianship Act (AGA) is one of four laws that comprise Adult Guardianship Legislation in BC. Part 3 of the AGA was proclaimed into effect in February 2000 by the British Columbia government to protect the rights of vulnerable adults. This legislation provides a guide for service providers who intervene with adults who experience or who are at risk of abuse, neglect and self-neglect.

The AGA is guided by three main principles.

- All adults are entitled to live in the manner they wish and to accept or refuse support assistance or protection as long as they do not harm others and they are capable of making decisions about these matters.

- All adults should receive the most effective but the least intrusive and restrictive form of support, assistance or protection when they are unable to care for themselves or their assets.

- The court should not be asked to appoint, and should not appoint decision-makers or guardians unless alternatives such as the provision of support and assistance have been tried or carefully considered.

(Public Guardian and Trustee of B.C., 2002)

Part 3 of the AGA specifically addresses the Support and Assistance of Adults (defined as individuals 19 years and older) who are Abused and Neglected. In part one section one of this legislation, abuse and neglect are defined as follows:
• *Abuse* is the deliberate mistreatment of an adult that causes the adult, physical, mental or emotional harm, or damage to or loss of assets, and includes intimidation, humiliation, physical assault, sexual assault, overmedication, with-holding needed medication, censoring mail, invasion or denial of privacy or denial of access to visitors (Adult Guardianship Act, 1996).

• *Neglect* is defined by the lack or inaccessibility of care provided to an adult, where “any failure to provide necessary care, assistance, guidance or attention to an adults that causes, or is reasonably likely to cause within a short period of time, the adult serious physical, mental or emotional harm or substantial damage to or loss of assets and includes self neglect” (Adult Guardianship Act, 1996).

In maintaining the goal to provide the least restrictive and intrusive interventions in elder abuse cases, the Adult Guardianship Act does not mandate the reporting of suspected abuse – section 46 states that individuals who have information in relation to the abuse of an adult “may report the circumstances to a designated agency” (Adult Guardianship Act, 1996).

Voluntary reporting is a unique feature of this legislation, in comparison with some other provincial adult guardianship laws, where the reporting abuse is mandated. The advantages to voluntary reporting is that the individuals have the choice to volunteer information regarding the abuse of an adult, which respects an older adult’s self-determination and right to reside in an abusive situation. It also recognizes the legal rights of an older adult to be presumed capable until proven otherwise.

Part 3 of the Adult Guardianship Act identifies specific service providers who are responsible to follow up when allegations of elder abuse are reported. These “designated
agencies” include health professionals who work within the provincial health authorities. They are comprised of service providers who work in various aspects of acute and community health care settings. Hospital social workers and community case managers in adult and mental health centres are examples of the specific professionals who are required to fulfill this role.

The designated agencies were identified as an alternative to creating a new, specialized adult protection agency. The Adult Guardianship Act gives formalized authority to the health and social service agencies that were already used to addressing adult protection issues (Gordon, 2000). Utilizing existing resources has its financial benefits; however, this also meant that that the staff in these designated agencies would require additional training to assist them to formally conduct these assessments. Also it would impact their current caseloads, as there appeared to be an expectation to assume this new role and add it to their existing work.

Designated agencies are mandated to investigate any reports of abuse. Upon completion of this investigation, there are several outcomes that could result. The designated responder may decide that no further action is needed, or that referrals to other community agencies may be needed to assist the adult (e.g. Public Guardian and Trustee.) If necessary, in situations where the person being abused is refusing assistance, the designated responders can also apply to the courts for the legal authority to implement a support and assistance plan. This plan would mandate the abused adult to comply to receive certain treatments or attend programs that would promote their safety. This is only done when the older adult is deemed incapable of turning down a support and assistance plan.
Although the initial disclosure of elder abuse is reported voluntarily, a designated agency is mandated to contact police if there is evidence of criminal activity. Section 50 states that,

If a designated agency has reason to believe that a criminal offence has been committed against an adult about whom a report is made under section 46, the designated agency must report the facts to the police. (Adult Guardianship Act, 1996)

After conducting their initial investigation, the designated responders are expected to identify when it is appropriate for police to become involved in an elder abuse investigation. It requires them to explore the details regarding the situation, and sorting out information that may be deemed as criminal evidence. Part 3, though, does not specify how the police will decide when to intervene and on what grounds they are mandated to follow up.

The Adult Guardianship Act represents B.C.’s interpretation of responding to adults at risk of abuse and neglect. When it was implemented, it included different components not seen in previously enforced provincial legislation. For example, the AGA did not include the creation of a separate adult protection service agency. Conceptually, this was seen as a cost-effective measure and could allow the tenets of the AGA to be implemented efficiently. Training and education would be provided to the designated responders on the practical application of the AGA.

Legislative responses to elder abuse, like the creation of laws such as the AGA assist in providing a framework for guiding the front-line practice of the professionals who work with older adults. However, before we can examine the environment in which elder abuse interventions are practiced, we need to explore the broader societal views that define the context in which elder abuse occurs.
3 Critically Understanding and Analyzing the Context of Elder Abuse

To better grasp the dynamics of elder abuse, it needs to be contextualized in the frameworks of societal attitudes and understandings. Using the feminist lens and the influence of ageist stereotypes, we can also begin to understand how older adults in our society can be placed in a position of vulnerability, and in turn most susceptible to abuse.

A few theories have been utilized to understand the causes of abuse. One theory explores elder abuse as a result of intergenerational violence (Brandl et. al, 2007). A child may be abused by their parent, learning patterns of violence in the process. As the family gets older, the scenario may become reversed, and the once-abusive parent has become the dependent receiver of care. In retaliation of the abuse inflicted earlier in life, the adult child may become the abuser towards their now older parent. Marital violence that continues into old age may be another cause of elder abuse. The abusive scenario could portray the long time abusive partner continuing the abuse into old age, or if the abused victim comes into the role of a caregiver, she may become abusive to her partner.

Caregiver stress has been theorized as another possible cause of elder abuse. In attempting to meet the physical and emotional demands of caring for an elder person, the care giver can become overwhelmed with their responsibilities. This stress could lead to the situation where the care-receiver may be at risk of harm, whether it be abuse by neglect or a combination of physical and psychological abuse.

Still, elder abuse can occur as an isolated incident, without involving a familial relationship of care. Strangers becoming “friends” and establishing new relationships with older persons can result in situations of abuse. Examples of financial abuse, in the form of
fraudulent phone scams, show that there may not need to be a long term history or pre-established relationship in order for abuse to occur.

In this review of the possible causes of elder abuse, it becomes apparent that an older adult is placed in a position of vulnerability. The use of ageist attitudes and beliefs, as well as the feminist lens can be useful in understanding the physical, social and cultural barriers that can contribute to the vulnerable position of adults.

Ageism is a form of discrimination that isolates the experiences of older adults based on their age. This section will first provide a brief discussion on how ageist attitudes can result in the unfair treatment of older adults, and make them vulnerable to other forms of abuse. Second, key components of the feminist perspective will be presented and its influence on our understanding of elder abuse will provide a broader analysis of the systemic issues that affect older adults.

3.1 Ageism

… the number of years a person has lived plays a significant and ambivalent role in Western cultural perception, significant in that age is tied to multiple structures of regulation (economic, legal, political and social), ambivalent because the passing of time associated with ageing is constructed simultaneously as a cause for celebration and a cause for mourning. (Aitken & Griffen, 1996, p. 55)

Society’s views on growing old play a significant role in our understanding of elder abuse. As we add years to our lives, Western society shifts its value on our ability to contribute economically and physiologically. The ability to participate and contribute to the workforce correlates with success and independence. Western society rewards such
achievements with a higher status given to the more financially-secure. Physiologically, the ability to bear and rear children is another role that is highly valued in our society. Growing older, however, is seen as a loss of these roles, and has created the perception that the numbers of years lived equates to an increase in dependency, and a burden to the community.

The societal role of being a “provider” or contributor to the economy shifts in value as we age. Policies such as mandatory retirement send the message that a person’s age is equated with their ability to perform in the workplace. This perpetuates the belief that we can no longer contribute economically into society once we have reached a certain physical age, and fosters a perception of becoming needy as we grow older.

Furthermore, physiological changes that accompany aging lend to views that older adults cannot manage their own care and thus require the state to step in and assume that care-giving role. Cognitive and mental health changes appear to justify the “frailty” of the elderly, giving society further reason to embrace the concept that aging equates with increased dependency.

Societal attitudes that respond to individuals based on their age can affect how older adults are treated in our communities. It can be reflected in our laws, or in how services and service providers respond to their older adult clients. Acknowledging that ageist stereotypes exists assist us in identifying the negative consequences of this type of thinking, but it also presents the challenge of generalizing such beliefs to an entire population of older adults.

Ultimately, an ageist framework suggests that aging adults may be more vulnerable in our society related to loss of power and status. As will be seen in the discussion of a feminist
lens for understanding abuse, this has important implications for understanding and responding to situations of abuse against older adults.

3.2 Contributions of a Feminist Lens

Feminist theory analyzes the impact of gender and social location on the construction of men and women’s roles and status in our society. It highlights the imbalance between the sexes, and the subordination of women as a result of this (Goldner, 1993, as cited in Crichton, Bond, Harvey & Ristock, 1999). Feminist theory also identifies how to bring change to the social structures that have created this gender inequity, including political, and economic institutions.

Though not the only theoretical perspective that can be used to explain the abuse of older persons, feminist theory can be seen as a good fit for this study because it emphasizes the need to share one’s lived experiences in order to highlight the differences between women and all individuals (Crichton et al., 1999, Harbison 1999, Harbison & Morrow, 1998). The feminist perspective can be used not only to understand the discrimination between the genders, but also to highlight the differences within groups of men and women.

“Feminist theories offer an analysis of systems of power in society and indicate how the unequal distribution of this power shapes the lives of men and women” (Mandell, 2005, p. 2). Violence in relationships is viewed as a manifestation of this unequal distribution of power (Crichton et al., 1999). These inequalities impact women by increasing their vulnerability to abuse, and furthermore, place them at a disadvantage to obtain the resources to stop the abuse (Nerenberg, 2002).
The experiences of older women highlight inequalities on social and economic levels. Mandell (2005) considers the demographic factor that not only is our population getting older (as a result of increased life expectancy), but women tend to outlive men (p. 102). For those older women who lose a spouse, they may experience various degrees of losses, including the loss of a source of social support, and the financial impact she experiences with the loss of an income source (from her partner). Older persons may also isolate themselves in their choices to seek outside assistance. For example, older adults may retain the value to refrain from seeking helping outside of the immediate family unit (Harbison & Morrow, 1998, p. 695). This can not only affect their ability to seek outside help from health and social services, but it can also prevent them from seeking information about what services even exist, and what they could potentially access at a future date.

Feminist research has also explored the relationship between gender and elder abuse. Crichton et. al (1999) studied the relationship between gender and the characteristics of victims and perpetrators of elder abuse. These authors’ hypothesized that there would no relationship between gender and victim/perpetrator characteristics, due to conflicting results found in the literature review they had performed. Upon analyzing data within the case files of a single Elder Abuse Resource Centre, the study found that victims were more likely to be female and perpetrators were more likely to be male. Having said this, the study focused on a small sample size, and does not qualify to be generalized across a larger population. This study does fit with feminist frameworks on understanding violence within the context of intimate relationships (Crichton et al., 1999), but it also addresses the need for future research to pursue the relationship between gender and elder abuse further. These authors recommended that future research focus on men who are victims of abuse, and the factors
and implications surrounding the experiences of male victims. Also, future studies could review female-perpetrated abuse. For example, what are the dynamics around female caregivers who withdraw or neglect the care of an older adult?

The need for continued feminist analysis in the area of elder abuse has been addressed in the literature. Traditional views of men and women’s roles in society cannot account for all explanations of abuse, and a more systematic, gender-based analysis is needed (Nerenberg, 2002). Without exploring the impact of gender further, then the focus of older women’s experiences will rest solely on age, which Hightower (2002) argues will portray elder abuse as a “sexless” phenomenon (p. 1).

Finally, it is important to acknowledge that age and gender are not the only factors to consider in elder abuse. The feminist lens can be used to extend our understanding of power of control beyond gender issues. Feelings of inferiority can be expressed across cultural and other social boundaries. Issues around ethnicity, for example, can be used to demonstrate this. In returning to the initial case example of the elderly Asian man, language barriers can prevent a non-English speaking elderly person from accessing services from English-speaking services providers. Furthermore, a lack of understanding of ethnic values around family status and roles could prevent understanding about the pride and shame about reporting or not reporting abuse against another family member. In essence, disclosing abuse may be seen as a loss of power in status from the older adult. Rather, ‘saving face’ in the ethnic community may be of more value than having a family member who is an alleged abuser removed from the home. Though not specifically addressed in this study, social barriers that affect culture, religion and sexual orientation may also present additional challenges to older adults as they experience abuse in their lives.
3.3 Service Delivery Approaches

The application of broader societal views of elder abuse can help inform the practice of systems of service delivery and agencies that work with older adults at risk of abuse (Brandl et al., 2007, p. 79). These models are roughly equated with the health care system’s approach, the Adult Protection model, domestic violence program model and criminal justice system approaches. The following description of these models is adapted from the work of Brandl et al., (2007).

The health care system includes professionals such as physicians, nurses and social workers, who provide various physical and psychosocial assessments of the individuals that they encounter in hospital and community settings. Lead by the physicians, the primary role of these health care teams is pathological in nature, i.e. diagnosing and classifying patients on the basis of their illness of disease. Health care professionals have a duty to advocate for the individual needs of the patient (Brandl et. al, 2007).

Elder abuse, as studied from a health care perspective, has identified medical professionals as being key contacts who are uniquely positioned to identify abuse. For example, there is a the body of literature that focuses on identifying elder abuse within the Emergency room department (Hogstel & Curry, 1999, Lachs et al., 1997, Marshall, Benton & Brazier, 2000). This particular body of research provides physicians with information on how to assess for potential abusers and victims, education on the common types of abuse, and the need to report abuse to the authorities (depending on local legislation that may or may not mandate reporting of abuse).
Despite the increased awareness for health care professionals to be involved in elder abuse assessment, this is not the only perspective from which to interpret the abuse of older adults. Hightower (2002) cautions that historically, elder abuse has been viewed from a medical model, which “emphasizes pathology, and a focus on the characteristics of the perpetrator and the victim” (p. 2). This can influence how service providers approach their work with older adults, and ultimately results in how professionals may perceive the older clients they work with, e.g. looking for a specific “type” of perpetrator/victim, and overlooking alternate forms of abuse.

A second approach to service delivery, the Adult Protection Model, has been modeled after child protection intervention models (Harbison, 1999, Nerenberg, 2002, Brandl et. al, 2007). The assumption underpinning this approach is that older adults are vulnerable and in need of protection. Staff who work in Adult Protection Services (APS) conduct intake assessments in response to reports of abuse against adults over 18 years of age. They are also responsible for assessing individuals’ ability to consent to services. (Brandl et. al, 2007, Nerenberg, 2002). The reports are provided from the community, particularly from those professionals who potentially encounter abuse (Nerenberg, 2002).

Harbison & Morrow (1998) caution that this “adults in need of protection” approach harbors a paternalistic approach, and perpetuates ageist values (pp. 687-8). The APS model of service delivery threatens the privacy and confidentiality of seniors, as their rights may be infringed by APS staff and assumptions of competence may be inadvertently discounted. For those older adults who may be reluctant to report abuse to outside services, these types of interventions may encourage their fears and embarrassment of exposing their private family matters and experience of abuse.
Guided by the feminist lens, the domestic violence approach uses the critical analysis of violence in intimate relationship to develop interventions that assist victims of abuse. It acknowledges the role of power and control that abusers exhibit over their victims, and addresses how victims can reclaim control through actions that promote empowerment (Brandl et. al, 2007, Nerenberg, 2000).

Nerenberg (2000) defines domestic violence as “a pattern of escalating violence against women by men, which is perpetrated for the purpose of exercising power and control” (p. 89). The abuse of women reinforces the patriarchal belief that women are subordinate in status to men, and are placed in a position of helplessness.

Although the domestic violence approach has not traditionally studied abused older women, the interventions used with younger women can be utilized in elder abuse situations. Using a crisis intervention model, domestic violence workers provide support to victims during and following a crisis situation to ensure their safety. Interventions focus on educating victims on the various community resources, and encouraging them to initiate contact with these resources when the woman feels ready (Brandl et. al, 2007, 93).

Developing a safety plan and discussing risk reduction strategies are some examples that demonstrate how a domestic violence approach can be incorporated in elder abuse intervention programs. Having said this, not all domestic violence interventions can be used with older women. This raises the call for further research to be conducted, to help determine how this approach can be best used to support older women who are subjected to abuse.
Finally, the fourth approach that has been used to understand service delivery is based within the criminal justice system. When elder abuse is viewed as a crime, it is an attempt by the criminal justice system to protect the victim by punishing the offender. By “criminalizing” elder abuse, the legal system sends a message that elder abuse is not tolerated in this society, and perpetrators are not excused for their actions. Any potential penalties that are determined against the perpetrator attempt to ensure accountability for the crime committed.

The professionals who work within the criminal justice system include law enforcement officers (police) and prosecutors, who uphold a duty to protect the public and enforce laws (Brandl et. al, 2007). In comparison with other models of service delivery, the focus is on welfare of the community and society at large, versus a specific focus on individual needs.

Bringing elder abuse to the attention of the criminal justice system acknowledges the issue as a societal problem and can ensure that perpetrators are held accountable for their actions (Nerenberg, 2002, p. 92). However, in the context of elder abuse, not all alleged abusers may be tried in this setting. Heisler (2003) reiterates that the courts will not necessarily see stressed caregivers “who are unable to balance the competing demands of home, family, job and ailing relative” (p. 53). Furthermore, the participation of older adults who are abused within the legal system may be limited by the fear of retribution from family and one’s personal values about seeking outside help (Harbison & Morrow, 2005). Finally, only some aspects of elder abuse are considered ‘crimes’ under the Canadian criminal code: physical abuse for example is but emotional abuse is not.
The four approaches to elder abuse practice discussed here brings a different outlook on how to approach elder abuse, which involves interventions to the victim, perpetrator and the community at large. It is not surprising then, that collaboration between the various disciplines has emerged in elder abuse research to exploit the strengths and fill the gaps in practice.

3.4 From Theory to Practice: Multi-Disciplinary Team Responses to Elder Abuse

Translating theory into practice impacts the creation of policies and programs that seek to address the abuse of older persons. “The diversity and complexity of abuse cases makes it unlikely that any single agency has all the resources, services or expertise needed to handle all types” (Nerenberg, 2006).

Building on a multi-faceted approach to defining elder abuse, the concept of a multidisciplinary approach to responding to elder abuse has been explored in the literature. Teaster, Nerenberg & Stainsbury (2003) describe one type of multi-disciplinary team (MDT) created with the purpose of reviewing complex cases of elder abuse faced by service providers in the community. The MDTs, as defined by these authors, work towards the goal of elder abuse prevention, and their primary functions include case consultation from a diverse group of community experts, service provider training and public education presentations.

Whereas the MDT model as defined by Teaster et al. (2003) is comprised of several professionals ranging from public, non-profit and for-profit agencies, another multidisciplinary approach that has had attention in the literature are programs that partner
law enforcement officers with social work professionals. These collaborative models are based on interventions used in the fields of child protection and domestic violence, and provide alternatives to working with victims and abusers. Though there is limited research available, the elder abuse literature is beginning to explore the use of police and social work partnerships as an effective form of intervention in elder abuse.

Exploring the effectiveness of police officers and social workers working together is not a new discussion in the literature. Holdaway (1982) examined the feasibility of social workers and police officers working together, in his analysis of a British report entitled, “Social Workers: Their Role and Tasks”. In his discussion, Holdaway cautions that the joint partnerships between police and social workers are influenced by the perceptions of the police of the social work role. Furthermore, social workers will need to work within the occupational culture of the police as part of their working relationship.

While there are different professional values and cultures that shape and govern these professions, Holdaway (1982) reviews the possibilities for a joint working relationship to exist. He recognizes that there are overlaps in the police and social work roles, but also addresses the need for these professions to have a dialogue around the “shared uncertainties” in fulfilling their roles to the greater community. Furthermore, if such a partnership is to function effectively, it is necessary for these professionals to understand the differing perspectives that each profession works from:

(S)tuff from the public services who seek to collaborate should inform themselves accurately about the scope and limits of each others’ work and develop greater awareness of the factors that influence the interactions between them. (p. 153)
Examining the perceptions of police and social work professions was part of the focus of Dolon & Hendricks’ (1989) exploratory research. The study compared police and social service providers’ attitudes and practices in response to cases of elder abuse and neglect. Respondents, which included police officers, visiting nurses and social workers, were asked to rank which services they would refer to in responding to an elder abuse case, the effectiveness of those same service providers, and an additional ranking of social factors that can impact elder abuse. A notable finding from the study’s questionnaires found that social service providers rated police officers as a helpful resource to refer to: in contrast, the police officers in this study seldom referred to social service groups and were inclined to find physicians and Emergency room staff more helpful. Despite these initial differences, the study recognized the need for education about the roles of both the police and social service providers. Training these professionals may increase the type of referrals made to each other when elder abuse cases arise. The bottom line was that despite any differences in attitudes, the “police and social service providers share a common concern: finding a safe and secure environment for victims of elder abuse and neglect” (p. 88). Using this shared goal is a step towards increased cooperation between the two professions.

The work by Holdaway and Dolon & Hendricks reiterates that joint partnership begins with an understanding of each profession’s roles, acknowledging the responsibilities that these professions uniquely identify with, and the perceptions that each profession may have of one another. In spite of the differences between police officers and social workers, the joint partnership model has been utilized as a form of intervention in abuse cases. Research on how a police-social work partnership works in the context of an abuse
intervention has been studied in the field of child protection, domestic violence and to a lesser extent, elder abuse.

Police and social work partnerships have been evaluated in the field of child protection. In a study from the United Kingdom, Garrett (2004) looked at perceptions of staff roles within a child protection unit in three local child protection districts. This qualitative study interviewed police officers and social workers who practiced in this particular unit, and asked how they viewed their responsibilities. One significant finding from this study was a “blurring of the social work identity” within these partnerships, although the social workers who participated in the interviews had mixed responses as to whether or not they agreed that such a loss in their professional identity occurred. Another finding showed that some of the police officers and social workers in this study had differing opinions when interviewing young victims. If a child was “lying” during their interview, police officers had a harder time accepting this fact as it impeded their investigation to gather evidence, whereas social workers sought to find out the reasoning behind the child making a false statement (Garrett, 2004, 86). The study’s finding placed a focus on the tensions in the working relationship between the police officers and social workers involved in the study. There were perceived overlaps in the roles of the partnering professions, as social workers took on a “social policing” role, and some police officers indicated that “they could undertake a ‘social work’ role” (p. 91).

However, this study did highlight the challenges of social workers working within a police department climate, and how this can impact their role. To address these challenges, Garrett suggests that social work training can emphasize the importance of being confident in
one’s professional identity, and that social workers be more prepared and educated about working within multidisciplinary teams.

In the field of domestic violence, police and social work collaborations have been studied in different forms. Corcoran, Stephenson, Perryman & Allen (2001) conducted a survey of police officers who utilized the services of a domestic violence response team (DVRT). As these police officers were called to an abusive situation, they would make a referral to the DVRT and a DVRT team member would follow up with the victim and family. This study found that 79% of the patrol officers surveyed found the team helpful (p. 396) and participants associated the DVRT’s role as primarily explaining the criminal justice system to victims, and providing victim counselling. In comparison to the Garrett (2004) study, the DVRT team consisted of professionals with human service backgrounds, but there was no specific police officer assigned to the team. However, despite the use of a “partnership model”, the study’s results appears to show that patrol officers responded positively in working with social service agencies in domestic violence cases.

Similarly Hovell, Seid & Liles (2006) evaluated a Family Violence Response team (FVRT) that responded to police officers’ request for domestic violence intervention. Team members would make follow up calls to the study’s participants at 6 and twelve month intervals. The results showed that of the 56 participants who received the intervention, 70% had reported repeated physical violence at follow up visits. It is not clear in the study, however, how the program is staffed, and if there are police officers are assigned to the team, or if FVRT members work directly with the police officers that made the original request. The professional backgrounds of the FVRT members (i.e. whether or not they are social workers) were not clarified in the study.
Davis & Taylor (1997) conducted a randomized controlled experiment on a specialized police and social work partnership used within the Domestic Violence Intervention Education Project (DVIEP) in New York. In the DVIEP, a police officer and social worker team are assigned to follow up on the initial police response to domestic violence complaints (Davis & Taylor, 1997, 309). What makes this study unique is that it one of the few controlled experiments in this area is a peer-reviewed study (Hovell et. al, 2006, p. 139).

This study was conducted in two parts: first, public education sessions were randomly assigned to public housing units. Half of the sixty-four housing units that were included in this study received public education. Secondly, when there was a domestic violence call to police, the DVIEP was randomly assigned to make a follow up home visit to participants. These home visits were attended by both the police officer and social worker.

A significant finding from the study is that participants who received both the public education and the home visit intervention were more likely to contact police more frequently (Davis & Taylor, 1997, 309). Participants within this group who had previous contact with police prior to the study were likely to contact police with repeat incidents. While the study did not report findings of decreased incidents of violence among participants, the increased reporting can be used to validate one the objectives of the DVIEP, which is “to increase confidence of victims of family violence in the police so that they will call the police more readily when violence occurs” (p. 310).

In terms of the use of police-social work partnerships used in elder abuse cases, the research is limited. When specifically searching for research on police-social work
interventions, one study did emerge. The model of the Davis & Taylor study was utilized in Davis and Medina-Ariza’s (2001) “elder abuse prevention experiment” in New York City. The purpose of this study was to determine if this intervention model would reduce incidents of elder abuse. It also looked at whether subsequent calls to police would increase as a result of receiving this intervention.

Like the 1997 study, the experiment had two parts – first, 30 of the targeted 60 public housing units were randomly assigned public education in the form of brochures, posters and community presentations. Following this, 403 residents out of all 60 housing units reported elder abuse within 10 months of the completion of the public education phase. Those residents were randomly assigned a home visit by the police/domestic violence team, or regular police follow up by a patrol officer, accompanied with a letter that offered further assistance (Davis & Medina-Ariza, 2001, p. 4).

The results had similarities with its 1997 domestic violence counterpart study - if a subject received both a home visit and attended a public education meeting, they were more likely to report new incidents to police. However, based on the results reported in the 2001 study, participants who received both interventions were more likely to report increased incidents of psychological abuse at the 12 month follow up point. Of particular note, participants who received a home visit and the public education sessions reported more incidents of psychological abuse than the participants who received only regular police follow up and no other intervention.

A running theme across the all studies of police-social work partnership models, was the focus on program evaluation, or the impacts of the partnership model. Does this
partnership work? What are the strengths/benefits? Can we measure the program effects by the number of reports received by police? How do members within the program evaluate their own and each other’s roles and responsibilities?

Given that elder abuse interventions are encouraged from a multi-disciplinary perspective, one type of evaluation that can benefit police-social work partnerships is gathering the impressions of other community professionals who work with the police-social work partnerships. Thus far, this literature review has looked at the studies of the perceptions of police officers who utilize the service and/or who work within the police-social work partnership. The other community services that the police-social work programs work with can lend further insight into program effectiveness. (It is also of value to incorporate feedback from the victims who utilize the service; however this is not the focus of this study).

Research into the evaluation of community services that work in elder abuse provides some discussion on the benefits of program evaluation by community professionals. Blakely & Dolon (2000) studied Adult Protective Services (APS) workers in 43 states to gather data on their perceptions of criminal justice professionals in elder abuse cases. The questionnaires used in the study included rating scales to assess helpfulness and open-ended questions about the forms of assistance received from criminal justice professionals. Results provided some insight into the expectations of APS workers as to how criminal justice professionals and victim assistants will respond, and consequently how these perceptions can be addressed by future training and program development.
Dauenhauer, Mayer & Mason (2007) conducted a quantitative study that evaluated Adult Protection Services in Monroe County, New York by the community professionals that interacted with the program. The results provided the researchers with information about what areas of improvement can be made to the APS role, i.e. the participants were more satisfied with intake process of the APS workers, but wanted more information about outcomes of the investigation (p. 54).

Program evaluation by external community service providers can be an important resource in developing and improving current practice in elder abuse interventions. When client satisfaction and feedback can be challenging to obtain (Dauenhauer et. al, 2007), gathering the opinions of other professionals can be a beneficial alternative.

The summary of this literature on police-social work partnerships highlights the potential for this model of collaboration to be utilized in an elder abuse setting. Additional research, however, needs to support the need for this type of specialized service, and how it can uniquely meet the needs of older adults.
4 Methodology

4.1 Statement of Research Problem

The literature review provided in this paper identifies key themes that relate to the implementation of a police-social work partnership model. First, the police-social work partnership model needs to be studied further as a potentially effective form of intervention in abuse situations. The literature review focused more on the use of this partnership in a domestic violence setting, although a study of how it is applied in child protection was reviewed. The application of the Davis & Taylor (1997) study in the context of elder abuse produced a positive response from the participants in that study, but also called for the need for further research in this area.

Overall, the literature on police-social work partnerships demonstrated the importance of evaluating the roles and responsibilities between the members of the partnership. Police perceptions about working in collaboration with social workers have been indicated as important to the evaluation of a partnership model. However, evaluation by external agencies may provide information from a different perspective. While there is some evidence in elder abuse literature that community partners evaluate the work of other agencies, there appears to be a lack of peer-reviewed research that evaluates the police-social work relationship by the external agencies that interact with them.

From a Canadian, and more specifically, a provincial perspective, utilizing a police-social work partnership model is an intervention that is new to elder abuse practice in B.C. The opportunity to formally evaluate this type of partnership program can produce promising
data to inform current practice, assist with program development and identify gaps in knowledge and services that have not been previously addressed.

My research question asks, what are the experiences of the community service providers in working with the Abuse Against Older Adults Unit?

To further inform the research question, the following sub-questions will be addressed:

- How do service providers perceive the roles and responsibilities/duties of the social worker and police constable?
- How are the roles and responsibilities of service providers and the social worker/police constable the same? How are they different?
- How does this service influence beliefs/values about the involvement of the criminal justice system in situations of abuse against older persons?

The evaluation will not only benefit this specific program, but it can generate knowledge about what makes a specialized police-social work partnership unique from working with regular police patrol officers, i.e., does having a specifically assigned police officer make a difference?

The Abuse Against Older Adults Unit introduces a new type of elder abuse intervention that has not previously existed in B.C. It presents a challenge to service providers to evaluate their previous practices involving police in elder abuse cases. Also, in documenting and sharing this information with researchers and professionals who have a vested interest in this field, we work towards improving this type of intervention so that it can be utilized and implemented in other B.C. communities.
4.2 Selecting the Case

The Abuse Against Older Adults Unit (AAOA) presents a unique intervention that supports the older adult, family unit and the service providers that assist them. It began as pilot project in late 2007, and is operated jointly by the Vancouver Police Department and Family Services of Greater Vancouver. The AAOA was created in joint partnership by these operating agencies, as well as the British Columbia Centre for Elder Advocacy and Support (BCCEAS). It is modeled after pre-existing Domestic Violence teams that are also operated between the Vancouver Police and Family Services. The program mandate is as follows:

Our mandate is to open files with older vulnerable adults that have been abused by someone with whom they have a relationship, after patrol has done an initial investigation. We will work in partnership with health agencies and any other agencies involved to create the most empowering and safe intervention possible to the people we work with. It is our goal to help remove barriers that older people face in accessing justice.

Description of services. The AAOA Unit is comprised of a family services outreach worker and a Vancouver Police Department detective. (The family services outreach worker has a professional and educational background in social work, and will be referenced as the “social worker” throughout the rest of this paper.) The role of the social worker on this Unit is to provide information, support, counseling, accompaniment and consultation to victims and family members. The police detective performs follow up investigations that were initiated by the patrol officers who did the initial investigation. Together the team conducts education sessions for health care staff about the program and their role in investigating cases of elder abuse.
This pilot project also works as a bridge, to advocate for the older adult through the justice system, whether it is laying charges against an alleged abuser, or whatever legal processes that warrant the older adult’s involvement. At the same time, the AAOA Unit offers continuity in case planning with other community and health care agencies. In particular, it educates service providers about the role of law enforcement officials, and how the criminal justice system operates in situations where older adults are mistreated.

**Referral process.** To ensure that the program’s mandate is being met, a police report needs to be filed with the Vancouver Police department before the AAOA Unit can become involved. Based on that data provided in this study, the members of this team are available to provide a consultative role to the service providers, determining whether the AAOA Unit needs to be involved, and providing direction to community and health care professionals in terms of additional resource counseling.

As part of its initial launch as a pilot project, the AAOA Unit incorporated an evaluative component to its program. This thesis research is drawn from a portion of that larger evaluative study to focus on the responses of service providers who were involved with the AAOA Unit. An evaluation of the Abuse Against Older Adults Unit presents an opportunity to address gaps in the current literature while contributing data that can be used for ongoing program planning and sustainability.

### 4.3 Rationale

Looking at the creation and telling of experience provided the impetus for choosing a qualitative research approach. More important, utilizing qualitative research methods guides
me in ensuring that the experiences shared in this research are, real, genuine and remain in the hands of the participants.

**Participant as expert.** Qualitative research positions the participant as the expert of her life, acknowledging that she is playing an active role in how she views the world around her. The interpretation of “experience” is key to this study. Grasping how service providers interpret their experiences, and ascribe meaning to them is how I hope the research question will be best answered.

**Design flexibility.** Having a rigid, linear methodology is not conducive to appropriately answering this research question. Qualitative methods allow for flexibility in the design to account for the subjective nature of the research topic. For example, a semi-structured format was used because I am looking at a specific experience(s) from my sample, but at the same time, I do not want my questions to define the boundaries of the participants’ stories.

**Empathic neutrality.** In reference to empathic neutrality, Patton (1990) states:

Complete objectivity is impossible … the researcher includes personal experience and empathic insight as part of the relevant data, while taking a neutral nonjudgmental stance towards whatever content may emerge. (p. 41)

Qualitative research views the researcher as the instrument to collect and analyze the data. It can be challenging for any researcher to complete this task without some bias. As personal experiences have guided me to conduct this study, it is important for me to be aware of how my own personal biases may influence the design and reporting of the study’s results. Qualitative approaches consider checks and balances to address issues of biases, e.g. validity
and reliability checks. Analyzing the participants’ experiences will uncover the meanings behind their experience, and also formulate an evaluative component that can be applied to service delivery.

4.4 Sampling

A purposeful sampling strategy was used to recruit potential participants. As defined by Maxwell (1996), purposeful sampling “is a strategy in which particular settings, persons, or events are selected deliberately in order to provide important information that can’t be gotten as well from other choices” (p. 70). In consultation with the social worker and the manager of the AAOA unit, a list was generated of service providers who had previously or were currently involved with the AAOA Unit. This list included service providers who made referrals to the AAOA Unit, or other professionals who had worked with the team or consulted them in their work thus far.

Snowball sampling was also used in the initial recruitment process. When service providers from the initial prospective participant list were contacted, they were encouraged to send the information to other service providers who may have worked or currently work with the AAOA unit and may be interested in participating in the study.

In this study, the main criteria guiding the selection of the sample came in two forms:

- Service providers who had provided assistance to an older adult that has experienced an incident of elder abuse where criminal charges may be involved. This criteria fits with section 50 of the Adult Guardianship Act, “If a designated agency has reason to believe that a criminal offence has been committed against an adult whom a report is made under section 46, the
designated agency must report the facts to the police” as the AAOA is a specialized unit within the Vancouver Police Department. This criterion also fits with the mandate of the AAOA.

- Service providers who have had direct contact with the service. To participate in the study, service providers needed to have been in contact with either one or both members of the AAOA Unit. The contact with the AAOA unit may have been brief, for example, to consult about the appropriateness of making a referral, or the involvement may have been for a longer period of time.

The study called for service providers who were investigating a suspected case of elder abuse. The definition of “service provider” included those health care professionals defined by the Part 3 of the Adult Guardianship Act as a Designated Agency, and any other professionals that worked in community and government agencies.

**Health care professionals.** The Abuse Against Older Adults Unit (AAOA) specifically worked with cases within the Vancouver Coastal Health Authority. This health authority is divided into four areas: North Shore/Coastal, Richmond, Providence Health Care, Vancouver Acute and Vancouver Community. The AAOA received referrals from cases that geographically cover the city of Vancouver, and hence the sample was specifically selected from the Providence, Vancouver Acute and Vancouver Community areas. The final selection of participants worked within the Vancouver Acute and Vancouver Community areas.

The health care professionals who participated held titles such as hospital social worker, older adult counselor, case manager, family and social support practitioner, program
director and managers, social workers in care facility settings, and mental health workers.

Information on the educational background of the participants was not gathered as part of this study, although in one focus group, participants stated their professional backgrounds were in nursing and social work.

**Other professionals that worked in community and government agencies.**

During the initial data generation process, invitations were sent to police officers, and Crown Counsel that were identified by the AAOA Unit as potential participants. Staff from the Office of the Public Guardian and Trustee were invited to attend. However the final sample did not include service providers from these agencies.

### 4.5 Recruitment

Out of a total of 39 service providers contacted, 21 chose to participate in the study. Twelve individuals participated in three focus groups; three service providers consented to a face-to-face interview and six submitted surveys via electronic mail.

Participants were recruited in cooperation with the social worker and police constable from the AAOA Unit. The AAOA social worker was asked to compile an initial distribution list of email addresses of service providers that they had previously and/or currently were involved with. Of the 21 participants, eight service providers were informed of the study through the snowball sampling process. Invitations to participate in a focus group were sent via electronic mail. Attached to the email was a letter of invitation explaining the details of the study, e.g. purpose of study, voluntary participation, time commitment.

Two follow up email invitations were sent – from these invitations one focus group emerged. Five individuals were unable to participate in the focus group due to scheduling
difficulties. These individuals were offered the opportunity to participate in an interview or complete a survey. One individual consented to an interview and four submitted a survey.

A second email was sent again to the initial distribution list compiled by with a brief survey attached. Two follow up emails were sent and resulted in an additional two responses were received.

Out of this email-based recruitment process, a focus group of four individuals was organized. These participants all worked in a community health care setting.

Hospital social workers who worked in Vancouver Coastal Health Authority hospitals were sent separate recruitment invitations. These invitations were electronically mailed to the Social Work Professional Practice Chiefs, and were then forwarded via electronic mail (e-mail) to the entire social work staff. As a result of these emails, a second focus group was organized with two people in attendance. A third individual was originally interested in participating in this group; however, due to location challenges, this individual declined to attend, and submitted a survey instead.

A third focus group consisted of community case manager consultants – they consented to a focus group interview as an extension of their regularly scheduled monthly meeting. There were 6 individuals who consented to participate in this focus group. In addition to these three focus groups, the AAOA Unit also identified two key informants to be interviewed as part of this evaluation study. Both of these informants consented and participated in individual interviews.
4.6 **Data Generation**

As the AAOA Unit is a pilot project, it was expected that the sample pool and response rate might be limited as it was just beginning to establish itself as a program. With this expectation in mind, a variety of data generation methods were utilized in ensure the data’s validity. As noted above, data was specifically generated in the form of focus groups, individual interviews and surveys sent by electronic mail.

**Focus groups.** Focus groups were the primary source of data generation. There was a total of three focus groups: one focus group had two participants, another had four participants, and the largest group had six participants. Two of the groups were conducted at a workplace setting and one at the UBC School of Social Work. A semi-structured questionnaire was formulated to collect the data. (Please refer to Appendix A for a copy of the focus group interview guide.) Participants were asked about how they initial came to learn about the AAOA Unit, and discuss their experiences with working with the social worker and police detective constable. As part of the questionnaire, participants had the opportunity to make suggestions on how the strengths of this program, as well as identifying areas of improvement. The focus groups varied in length – from 45 minutes to 90 minutes. The timing was, in part, influenced by the number of participants in each group.

**Individual interviews.** Individual interviews were presented as an option for service providers who expressed an interest in attending a focus group, but were unable to attend any of the available dates. One participant consented to this option, and two key informants were previously identified by the AAOA Unit and had initially agreed to an interview. The interviews lasted approximately 60 minutes in length and were conducted at the participant’s
workplace. The interview guide utilized was identical to the guide used for the focus group participants. (Please refer to Appendix B for a copy of the interview guide.)

**Surveys.** Surveys were given to participants via electronic mail, and were returned to me in the same method. The survey consisted of five open-ended questions that about the service provider’s experience with the team (See Appendix C). The survey was a summarized version of the questionnaire provided in the individual interviews and focus groups. A smaller number of questions were provided in order to encourage participation in the survey, and make it easy for participants to respond. These questions invited respondents to share specific experiences with the AAOA team.

### 4.7 Ethical Considerations

In compliance with university regulations regarding research ethics, an application was approved by the UBC Office of Research Services, Behavioural Research Ethics Board (UBC BRB Number H08-00382.)

All participants in this study were made aware that their consent was voluntary, and that they could withdraw from the study at any time. Survey participants were instructed to answer only those questions that they felt comfortable with.

Focus group and interview participants were given a consent form prior to the date of the focus group or interview. This ensured that consent to participate was informed, and allowed participants to withdraw from the study at any time.
Once the transcripts were completed, participants were contacted to review the transcript. Two participants responded to this invitation: when co-investigator contacted them for follow up, there were no requests for changes to the original transcripts.

Pseudonyms were utilized in the final transcripts and in the reporting of the findings to maintain the anonymity of the participants. Any computer documents pertaining to this study were password-protected.

All focus groups and interviews were audio-taped and transcribed verbatim – transcription was conducted by either me or a contracted transcriptionist. In addition to the written transcripts, field notes were created by myself after the focus groups and interviews. This study was part of a larger evaluation project of the AAOA Unit – the results of the focus groups, interviews and surveys were incorporated with statistical data, interview data with clients and with the members of the Abuse Against Older Adult Unit. The information was used to generate an evaluation report which was submitted in February 2009.

4.8 Strengths and Limitations in Methodology

In conducting this qualitative evaluation study, there were some notable strengths and limitations to the methodological process.

Sample and recruitment. The primary concerns regarding the methodology centre around the sample of participants and the recruitment process. Although initially included in the recruitment, none of the participants represented service providers from law enforcement: police officers and Crown Counsel were invited to participate in this study. The lack of input from this population reduces the variation in experiences added to the data collection. Similarly, there were no participants who represented the Office of the Public Guardian and
Trustee. Participants from this agency may have provided an alternate perspective outside of
law enforcement and health care professional perspectives.

**Maintaining interest.** There was interest expressed by two individuals who were unable to attend a focus group. Despite invitations sent to complete a survey, these service providers ended up not involved in the study. There is a window of opportunity when raising interest in participating in a study. It was a challenge to maintain the interest from potential participants as I waited to confirm details about a focus group. In hindsight, offering the interview and survey options should have been done sooner – doing so may have prevented the waning interest.

**Initial consent to receive information about this study.** The initial email distribution list was provided by the AAOA Unit, and consent to contact the individuals on this list cannot be presumed. The email invitation that I initially sent did indicate how the contact information was provided. However, would the sample size in the study have been influenced if the AAOA Unit had contacted the potential individuals first, outlining the benefits participating in this study?

**Two-member focus group.** One focus group had only two participants – these service providers worked in an acute hospital setting. In my own experience as a hospital social worker, I recognize that time constraints prevent service providers in this area the luxury of attending a focus group. Attempts were made to schedule the focus group either during or at the end of the working day in order to encourage as many participants as possible. This focus group went ahead as scheduled, despite the low attendance – it
acknowledged the two participants’ willingness to contribute to this research, and share their experiences with this program.

4.9 Data Analysis

A content analysis was used to analyze the data for this study. First, because this is an evaluative study, I did a descriptive analysis of the data. Basically I broke down each of transcripts and categorized them by the interview questions, and how each of the focus groups, interviews and surveys addressed the question. Doing so provided a comparative framework to view similarities and differences with how the question was answered.

Other categories were developed from re-reading the transcripts – for example, separate codes organized data into how the police detective constable and social worker were described. “Safety” and “communication” are examples of other codes that emerged from the data analysis as common themes that arose.

Memos were also developed as each transcript was reviewed. Combined with the field notes taken immediately after the focus groups, these memos provided impressions on the “character” of each focus group and interview. The memos provided a contextual analysis of the data: what made each transcript “unique”? What were the themes that emerged from each transcript? How are these themes influenced by the composition/background of the group members? What is the relationship of the participant to the theme – e.g. how frequently/closely do they interact with the team?

One unexpected category that coded the data was a single case study that was mentioned in three separate transcripts. The description of the case study was comparative
across the three transcripts and is discussed in detail in the section, Single Case Study Analysis.
5 Findings

Service providers were first asked to identify how they initially became aware of the Abuse Against Older Adults Unit (AAOA). Generating awareness about the AAOA Unit and educating health care professionals about this pilot project was communicated in a variety of methods. Participants’ responses included receiving electronic mail announcing the program, being informed by co-workers, management staff or the local police department. One participant was contacted directly by the AAOA to enquire about a client the team was following – prior to this call the participant did not know the program was available in the community.

The most common, and perhaps the most helpful method named by the participants, was that the AAOA team conducted presentations for health care staff in the community. For one hospital social worker, meeting the team made a difference,

And I have to say I wasn’t very clear about their role until we had their presentation, where they actually came and appeared in person and we met them, and could discuss actual cases. Because up until then, we’d known of their existence, maybe had made the odd phone call but really didn’t have a lot of clarity it is they actually did. (Sally, Social Worker, Focus Group 1)

Another case manager commented on her observations from a presentation she attended,

(T)he fact you went to the presentation and saw how many people were in the room and jammed … because how many case managers… sit there and keep their files on their desk -because you know they’re worried sick about some of these clients, but we have no support, no education - like there’s a real deprivation in this area. (Laurie, Case Manager, Focus Group 3)
This case manager’s response suggests the level of initial interest in the AAOA Unit, and the health care community’s curiosity as to how this program could potentially fill the gaps in service.

“We’ve been doing this work for years without any specialized training or supports …” How were health care professionals managing cases of Elder Abuse prior to this program? This team provided a welcome addition to service providers. Prior to the start-up of the program, health care professionals like community health case managers and hospital social workers were faced with the task of monitoring these cases on their own. To the best of their ability, health care professionals had long term cases sitting at the side of the desk as they waited for the next event to unfold in the alleged abusive situation. This was seen as highly problematic.

What everybody has to know is we’ve been doing this work for years without any specialized training or supports or counselors and, you know, we’re pretty burned out from doing it. We’ve got a lot of staff that don’t feel that this should be a part of what their role is and we’ve been there. We’ve been doing it. (Carol, Manager)

Part 3 of the Adult Guardian Act legislation came into force in 2000, with the intent to provide front line health care professionals in British Columbia with the guidance on how to intervene in cases of adult abuse and neglect. In addition to managing their regular responsibilities, these health care professionals were given an additional role to conduct specific investigations in alleged elder abuse cases. Part of this role involved contacting police when criminal activity may be involved. This did not work particularly well, prior to the development of the team. One participant recounts his previous experience with contacting the police:
(W)e had for a number of years a police liaison of sorts, and it was a number of different people who were doing it essentially off the side of their desk. And … they were constantly changing –and they were often very hard to get a hold of, so it was just wasn’t working very effectively at all. (O)n paper it looked like we had more than we really did…in my view. (Doug, Case Manager, Focus Group 2)

Although attempts were made to connect with the police, this case manager found there were challenges in establishing communication, and availability of police resources.

I agree it was sort of hit and miss. We ended up just calling 911 or something and just trying to talk to somebody and then you had to explain who you were and what is the health department doing in there and … that was pretty cumbersome. People would say, “well can’t you call the liaison?” I say, well… I can I can try, you know? (Matt, Case Manager, Focus Group 2)

Another social worker highlighted the lack of specialized training among regular police officers: “I think too [that the police are] not trained. They’re not specifically trained to understand what elder abuse is” (Sheila, Social Worker).

“And now I actually feel like there is a team…” Prior to the hiring of the current members of the Abuse Against Older Adults Unit, there was a sole police detective constable: when the pilot program introduced an elder abuse team with a police constable and a social worker, there was a shift in perceiving how this team could be helpful.

And now I actually feel like there is a team. That, you know, the response that I call the police constable on the Unit and say, ‘What’s happening with the son?’ ‘He’s phoning and saying he can visit and we’re talking and he’s not…’ and [the police
constable] is on it - it’s the same language because we know the same cases. (Erica, Manager)

The introduction of the team also ensured consistency in communication,

To have the same two people, who you can talk to through a case, instead of having a bunch of different people that might get pulled in … (Mary, Case Manager, Focus Group 2)

Having a police officer and a social worker impacted the accessibility of the AAOA Unit, because service providers have to consider what kind of assistance they are looking for, and who on the team is in the most appropriate position to address the issue. How, then, did the research participants describe the duties and responsibilities of the team members?

What makes this team different? What significance and value did this team have? Where did the differences lie in having a team versus working an individual police officer? What merit did having a social worker have on this program?

Based on their experiences in working with the AAOA Unit, participants were asked to describe the role and responsibilities of the team members. These service providers provided positive feedback that highlights the unique contributions that each member brought to the team.

“She is the police presence - people get the right message and she delivers it in the right way.” In describing the role of the police detective constable, the most common response revolved around her knowledge and skill working within the criminal system.

I see her as somebody who will be brought in after a report has been made and it’s identified as a crime against an older adult. Now I don’t know if she takes over the investigation completely herself or if she works with the primary [police officer] who
is doing the investigation. But she will get involved with doing the investigation for criminal activity. (Erica, Manager)

She is an excellent resource for in-servicing staff, regarding setting limits, knowing the law, knowing appropriate emergency procedures and generally providing a safety net. (Carol, Manager)

The [constable] has been helpful in explaining the Criminal Code and action that police can and cannot take. She also assists us in identifying risky situation, provides us with collateral regarding suspects and has attended with us on home visits as back up when there is a suspected risky situation. (Alice, Case Manager)

Participants also commented on her authority as a law enforcement officer, and her ability to communicate that authority to clients, family members and health care professionals.

(M)y experience in having [the police constable] come - she’s also very skilled in the way she speaks with clients and family members. (H)er presence … she is the police presence - people get the right message and she delivers it in the right way. (Wendy, Case Manager, Focus Group 2)

But that’s where having the constable…gives you the power in a way …and so that you know if you’re just walking in … to diffuse the situation you need to have the law there, I think. (A)nd also she carries the gun …and she can pull out her handcuffs . (Sheila, Social Worker)

She doesn’t come in heavy-handed but she comes in with the authority…and she explains her authority very clearly. (Wendy, Case Manager, Focus Group 2)
“To be a connection between health and social services systems and the police…”

The social worker was described in terms of a supportive counseling role, with a focus on assisting with family dynamics of a situation:

[The social worker is] someone who is there to support and respond to the victim of the crime, the older adult, to liaise with the healthcare system as well as the broader based community supports and to be a connection between, health and social services systems and the police. (Erica, Manager)

Particular attention was given to her role in working with the alleged perpetrator of the abuse. This skill was a key form of support for the service providers.

You know, she’s kind of like that bridging person? And can help explain the process, can come and do interviews, can, you know, provide assistance to the staff working with the victim of the crime, the adult who has been exploited or harmed as well as the perpetrator. And that’s the part I think is most distinct from the role that our staff will do. (Erica, Manager)

We’re not perpetrator focused unless that person happens to be one of our clients, which sometimes is the case. But [the social worker] can help with that end of things, help have some of those conversations, get the perpetrator of the crime involved in hopefully other places or set limits and do that kind of containment. And that’s not something that our health staff have the skill set for. (Erica, Manager)

The participants not only acknowledged the social worker’s role in having previous experience in the domestic violence field, but valued her previous experience in having worked with the police.
[The social worker] is so well versed. First of all she’s very skilled counselor and … her knowledge base is quite thorough in terms of the criminal justice system … what’s the difference between peace bond … what’s the appropriate intervention through that system. (Wendy, Case Manager, Focus Group 2)

She seems like a trusted person over there. She seems like she’s walked the fine line. She can talk about the police reports … which is something that is hard to get. (Matt, Case Manager, Focus Group 2)

Service providers also commented on the social worker’s interpretation of authority and working in the criminal justice environment.

She can also put in a human side too, sometimes. If you get sort of, caught up in the law, the law says, but you know what, this is also the human side of this. (Sheila, Social Worker)

[The Social Worker’s] role has often been to work with the adult children around some of those issues and put a slightly softer initial face on what is authority coming in. (Bev, Case Manager, Focus Group 2)

“Often I’ll phone both – if I can’t get one, I’ll try the other …” While some respondents indicated specific instances when they would contact either the social worker or the police constable, participants expressed a comfort in contacting either team member for a consultation. One case manager, commented, “Often I’ll phone both – if I can’t get one, I’ll try the other” (Jessica, Case Manager, Focus Group 3). Other feedback was similar:

(W)hat have the police done or what can the police do that’s what I would call [the police constable] about. But it is pretty flexible – [the social worker] has worked
with the police so long I think that she can speak pretty well to that.) Elaine, Case Manager, Focus Group 3)

This is a reflection of the social worker’s previous experience in working with the police in a domestic violence program. Responders also looked to both team members to gain access to police reports, and perform background checks on alleged abusers.

(T)he safety checks … we can call and just get a check on the history of police visits and any arrests, and that kind of thing. (T)hat can be huge in the end … vital [case manager, focus group] (Elaine, Case Manager, Focus Group 3)

[The social worker] was involved in doing background checks in terms of, was there information already about this fellow. (Wendy, Case Manager, Focus Group 2)

As the service providers who participated in this study described their experiences in working with the Abuse Against Older Adults Unit, four themes emerged in relation to the interaction and collaboration of the community health service providers and the AAOA Unit: confronting the challenge of role clarification, bridging parallel systems, and increasing feelings of support, and the need to expand services.

5.1 The Rules about Roles: Confronting the Challenge of Role Clarification

Role clarification was referenced in the two different contexts: (a) what is the initial role of the Abuse Against Older Adults Unit (in other words, when do service providers make referrals to AAOA) and (b) where do the roles of services providers and the members of the AAOA Unit overlap.
“They’ll always consult with us, but I think it’s less clear when we can call them.” Although the AAOA team could contact the service providers, there was some lack of clarity as to when the team itself could be contacted. For one service provider, it appeared that the process was unclear, “Well I think they’ll always consult with us, but I think it’s less clear when we can call them to actually be a support to the client” (Elaine, Case Manager, Focus Group 3).

Service providers expressed confusion, and needed clarity on when it was appropriate to contact the Unit.

(T)he first time we contacted the Elder Abuse Unit directly. The next time, it was – “you need to file a police report first” and then they get involved. So they make the referral. So it was kind of different two times … (Sheila, Social Worker)

This same participant later commented on the change in the referral procedure: “ I think when I found out that you had, you know go through (to) file a report… it was like a bit of a barrier rather than just going direct to the unit” (Sheila, Social Worker).

Another issue raised by a participant was identifying when roles and responsibilities overlapped. Under what circumstances is it appropriate to accept an overlap in responsibilities (between front-line workers and the Abuse Against Older Adults Unit) and how do we define such circumstances?

[The social worker’s] position is going to be a lot harder because she does a lot of what our staff do. She’s got more chance of stepping on people’s toes by doing “social worky”, “case managey” kinds of things, when our staff are going, “You know, why is she doing that? I’m doing that.” (Erica, Manager)
So there has to be some understanding of which cases [the social worker] will do primary case management role, and which cases she doesn’t. And how is that decided? Because that’s going to add a lot of confusion to all of this and she’ll start feeling like we’re dumping more on her and we’re going to start feeling that she’s there for a purpose that she’s not there for. (Erica, Manager)

How is this overlap addressed? From a managerial perspective, it was important for this participant to delineate the roles of the social worker on the AAOA Unit from those of the case managers. Although there may have been overlap in responsibilities, it could be resolved by working with the AAOA team.

It’s also being able to be there and knowing how to kind of access supports for the person and put them in touch. And also a little bit to coordinate some of those [services.] We also sometimes see that as our role so there was a little bit of a rub sometimes, although we managed to work it through by working together. (Carol, Manager)

However, there was no indication from the participants in this study that indicate that health professionals were feeling their “toes” were being “stepped on.” Instead, there was a general appreciation for the support that the social worker gave the service providers.

[The social worker] came in to support me in helping make a decision with the client … I actually approached [the social worker] and said, ‘What do I do about this, I’m really worried,’ and [the social worker] offered to come in … (Angela, Case Manager, Focus Group 3)
5.2 Building Bridges: The Interface of Parallel Systems

The interaction of the Abuse Against Older Adults Unit and the community health care providers marked the beginning of change in a coordinated community response to adult abuse and neglect. Historically, the law enforcement and health care systems operated in parallel to one another, gathering information using distinct interventions. As the service providers in this study described their experiences with the Abuse Against Older Adults Unit, they named three outcomes to the convergence of these two systems: recognizing differences, debriefing cases to review interventions, and information sharing.

Two main differences were identified by the service providers in this study. The first was recognizing differences in the approaches to interventions and second, acknowledging differences in professional values, which ultimately affect professional practice.

“We had these parallel systems coming up with the same answers, so it supported each other.” One case manager compared the police and the health care professionals’ approach to client interviewing. She identified the benefit of having different interview methods:

We had these parallel systems coming up with the same answers, so it supported each other – and [the police’s] interview system was really different, than the health one. (T)hey used different interpreter resources. And the other piece was their ability to follow up, and investigate, on the possible concerns about another [potential abuser]. So… way beyond what we would able easily be able to get at. (Bev, Case Manager, Focus Group 2)

This case manager identified a common goal that was reached despite the different interview methods that are conducted.
Another case manager recognized the sensitivity of information-gathering from a law enforcement perspective:

(I)t’s also very important legally … that in some way that we’re not getting in there because we’re not influencing the case or … if it does go forward and charges are laid, that somehow we haven’t said the wrong thing or acted in the wrong way or manipulated information, whereas they know what they’re doing. (Jessica, Case Manager, Focus Group 3)

“(W)e come at it from different angles … it’s very difficult for each of us to explain what the limits are, what we can and cannot do …” Professional values guide intervention and practice. One participant elaborated how the values of law enforcement officials and health care professionals can engage each other.

Police in the justice system will say, ‘Well you guys take them and protect them and give them care and put a cocoon around them so that the bad guys can’t get at them.’

And we go ‘Independence, economy, respecting the person’s right to live at risk. Can’t you guys do something to stop the abusers from hurting them? (Erica, Manager)

You know, we come at it from different angles. And it’s very difficult for each of us to explain what the limits are, what we can and cannot do and why sometimes we’re not doing what they think we should be doing. (Erica, Manager)

Acknowledging different practices and identifying the values that guide them lead to a reflection on one’s own profession. Furthermore, it can encourage dialogue as to how the strengths of these differing professions can best work together.
(I) it takes a lot of communication and walking through the situation and looking at the long term consequences of this before we can actually say, ‘This is why we’re not going to go that way.’ And we’re going to have to recognize each of our limitations.

(Erica, Manager)

Participants found that communicating with the team with the different cases helped to generate further understanding about how these parallel systems can work better together. This was specifically addressed in how cases were debriefed.

“We had a great big follow-up meeting of what we could have done differently…” A case manager described a scenario where the AAOA Unit was called in, but could not get involved in the case:

I came across a case where there was a daughter, who reported that her father said he was going to kill the wife. This father had [a] long history of [being] quite abusive with his wife, who now was quite significantly cognitively compromised. I did get hold of [the social worker and police constable] … but… because the daughter … did not want to lay any charge and so because there was no charge laid, then they couldn’t technically get involved. (Jessica, Case Manager, Focus Group 3)

The AAOA Unit ended up not becoming involved, but given the intensity of the situation, there was an identified need to review the case, and this case manager acknowledged this,

We had a great big follow-up meeting of what we could have done differently and [the police constable] and [the social worker] were quite involved in this …” (Jessica, Case Manager, Focus Group 3).
In engaging in a debriefing session, both the AAOA Unit and the health care professionals involved were able to evaluate their practices in that situation, and discuss alternative interventions that could have been used.

In another scenario, where the AAOA Unit was involved, the participant alluded to the debriefing process as being a beneficial component.

In one case where [the police] wanted the client swooped out. There were apparent indications of abuse and the officer who was doing the onsite follow up that health should… not take her home, [and] should facilitate her um what’s that term? Removal. We did debrief on it afterwards. [The police’s] information didn’t have the same history that we did. We had heard these allegations before. So they were hearing it for the first time and had an emotional impact… It felt really uncomfortable, but the debriefing piece was really constructive. (Bev, Case Manager, Focus Group 2)

“We need to know that that information is absolutely being kept private and safe…” In line with maintaining a bridge between law enforcement and health care professionals, there were strong concerns from the service providers as to how much information was appropriate to share, and how this information was being recorded.

I would also like to see …clear protocols between our organizations around things like confidentiality, management of evidence and information… (I)f we’re going outside of our normal patient confidentiality limits to report to police, we need to know that that information is absolutely being kept private and safe. (Erica, Manager)
I worry quite a bit about privacy of information because we’re clear that it’s a partnership and we need to share information for continuity of care. We’re clear on that. But sometimes I’m not so sure we’re clear on how much information we need to share. (Carol, Manager)

One case manager expressed concern about the process of documenting calls to the police officer. Furthermore, questions were raised regarding how information from those calls reach the Abuse Against Older Adults Unit:

I was wondering is when we call them… do they document our phone calls somewhere to say that, cause if I pass on the information, where does the information go? Does it go to some central place where there is a documentation at least that the case manager called regarding the situation? Like if they get the phone call, do they just goes into Neverland? Or does you know does it go to some reporting mechanism… (Laurie, Case Manager, Focus Group 3)

A participant recounted a scenario where documentation was assumed to have been communicated from the AAOA Unit to the local police officers. Unfortunately this resulted in a miscommunication.

We got into a situation where we assumed the community police had the information from the [AAOA Unit] [about this case and it was just a really, it was really weird disconnect. (T)he community police that we called didn’t think that we should have the information, and at one point I wasn’t sure that they even had information which is another issue so, anyway. (Wendy, Case Manager, Focus Group 2)
Participants wanted to ensure that there was a clear and appropriate process to have a “paper trail” when health care staff contacted the police. This also encourages discussion for health care staff to develop their own protocols in this area.

5.3 **Increased Feelings of Safety**

There was a consistent acknowledgement that service providers were feeling safer as a result of their interaction with the team. These feelings of safety were an expression of how these participants felt supported by the Abuse Against Older Adults Unit. Participants defined what safety meant to them, and gave examples of how the AAOA Unit evoked feelings of safety.

“**It really does come back to the client’s safety…**” Service providers defined safety in terms of client safety and staff safety. Client safety included identifying dangers to the client’s living situation:

It really does come back to the client’s safety and some really tangible outcomes in terms of them having helped to get peace bonds or get sons that are dangerous out of the home to have charges laid in financial theft ... (Elaine, Case Manager Focus Group 3)

This same case manager later identifies a specific task of the AAOA Unit to provide specific information that health care professionals do not usually have access to,

I also I think that … the safety checks - that we can call and just get a check on the history of police visits and any arrests, and that kind of thing that can be huge in the end … vital. (Elaine, Case Manager Focus Group 3)
Second, community health case managers felt a strong responsibility to ensure a safe environment for home support workers, who are contracted to provide hands-on personal care for elderly clients. If a home situation was identified as being unsafe, the case managers felt a duty to protect other care providers from entering a situation where their safety was at risk.

I refuse to put in home support if I don’t know the situation’s safe – I just say no - I don’t care what my manager says, let’s just go up the chain of command, because it’s not safe for people (Laurie, Case Manager, Focus Group 3)

“Just having them there, communicates a level of authority and seriousness that enables access without confrontation…” Participants expressed their feelings of safety by giving examples of how the AAOA Unit provided protection. Having the police presence instilled a sense of safety for one participant – and by providing a non-confrontation approach, clients and staff felt more protected.

(T)he keep the peace role, that they so access without escalation…that’s been successful. (S)ometimes just having them there, communicates a level of authority and seriousness that enables access without confrontation. (Bev, Case Manager, Focus Group 2)

Another example of how participants felt protected was in knowing the options of how the AAOA Unit could assist.

The option of police accompaniment if we’re really are getting that fragile in the road is really helpful that if we need police to go to the house with us for some reason. (Elaine, Case Manager, Focus Group 3)
5.4 Need to Expand Services

“\textit{I don’t know what they’re telling you, but I think they could probably use many more people working on that unit.}” There was a resounding consensus from the service providers in the study that reiterated the need for this service to continue and expand its resources. It was stated that the team operated from Monday to Thursday, but would benefit if the hours extended to include Friday. However, most of the service providers’ comments centered around hiring more than one team to the program:

\begin{quote}
(T)hey’re busy – they’re so busy – there needs to be more. I don’t know what they’re telling you, but I think they could probably use many more people working on that unit. There’s a lot more abuse out there than people want to acknowledge. (Sheila, Social Worker)
\end{quote}

It was also mentioned by participants that increasing the service could help alleviate the challenge of a timely follow up by the AAOA unit team members. For one manager, follow up was important, as “[they are] not always available when needed and communication at times was lost, although I know they tried very hard…” (Donna, Manager).

Furthermore, participants also felt that there needed to be AAOA units assigned to specific areas of the city:

\begin{quote}
I actually would love to see this expanded like this unit per community health centre catchment area. (Wendy, Case Manager, Focus Group 2)
\end{quote}

There’s a characteristic to each of [the health units] and then they could link better up with those health units and the community. (Jessica, Case Manager, Focus Group 3)
One case manager acknowledged the need for this service in surrounding communities.

And absolutely it should extend beyond Vancouver because I’m sure every
community could use this. (Elaine, Case Manager, Focus Group 3)

5.5 Summary of Findings

Overall, feelings of support by the Elder Abuse Unit resonated from the service
providers. Participants defined the service as helpful, and recognized its value to their work
with elderly clients.

In this case where I worked with [the police constable,] she was extremely helpful
and responsive. I was very impressed. There’s never been a case where I’ve sought
out their help and not been provided with it. (Sally, Social Worker, Focus Group 1)

A sense of support was felt from both members of the team, and their expertise in the law
enforcement area was a reassuring presence:

But again looking beyond and outside the box, I think it was good for them to be
involved because I had more reassurance that someone else is looking at that aspect
which happens enough times where … you want it to be brought to the forefront.
(Michael, Social Worker, Focus Group 1)

Both [the social worker] and [the police constable] – I find both of them very very
supportive and very helpful just in terms of … I’m not feeling I’m not feeling like a
complete idiot and their dealings with it. (A)nd I may not have all these … the
correct term that the police [use], but that they quickly grasp what I’m trying to say,
which is really good and helpful. (Jessica, Case Manager, Focus Group 2)
The presence of both members of the team was deemed necessary, and participants acknowledged the value of each of the team members. As the data suggests, there was an eagerness and willingness to see the program expand.

5.6 The Case of Mrs. A

Mrs. A is an elderly woman living with her adult son. She has a case file open with the local community health unit, and receives visits from community health workers to assist with her personal care. Mrs. A’s cognitive status causes concern for the care team at the health unit and they assess her at a level of being incapable to make her own health care decisions. Her son has a history of being verbally aggressive towards the nurses and community health workers who visit Mrs. A: now, it has come to a point where all visits to their home require accompaniment by a police officer.

Mrs. A’s health status changes, and she requires hospitalization. Her son’s aggressive behavior continues to be seen as he is physically violent towards a hospital staff member. It is eventually decided that Mrs. A requires care in a residential care facility. Unfortunately, her son continues to create a threatening presence when he visits her in the care facility, affecting the safety of the staff and residents there. In the end, Mrs. A is transferred to another residential care facility and “supervised” visits are required so that Mrs. A could continue to see her son.

The Abuse Against Older Adults Unit was involved from the time when Mrs. A lived at home, and supported Mrs. A through her hospitalization and subsequent move into a care facility. The police detective constable and social worker were instrumental in identifying when health care staff needed to make reports to the police about threats.
to their safety. The AAOA Unit also provided assistance to both Mrs. A and her son throughout the entire process of her move from home to residential care.

The case study of Mrs. A presented itself as a unique situation. It ultimately self-selected itself: through the data analysis, Mrs. A’s story was told by four different individuals in separate accounts. The details used to describe this case study were similar across all four participants. One interesting feature about Mrs. A’s case is that it was used three out of the four times as an example of how the Abuse Against Older Adults Unit was particularly helpful to the participant. In the fourth instance, Mrs. A’s case was used to describe how the participant was first introduced to the program.

Mrs. A’s story is also an example that integrates several of the findings from the service provider data. Staff safety, negotiating roles between the AAOA and the service providers and staff education and awareness were identified as outcomes in Mrs. A’s case by the four participants. How these themes emerged are also of note, as each participant chose to highlight certain aspects of the case in their individual descriptions.

**Staff safety and valuing the police presence.** For participant – Carol, one of the prominent themes in her discussion of this case study was the role of the police detective constable. Carol reports that the police detective constable was able to identify when verbal threats to the care staff needed to be reported to the police:

So what we wouldn’t have had without [the police detective constable] was … we would have absolutely misread that situation to think the [son] was a jerk. Well he’s probably never hurt anybody. But what [the police detective constable] knew was that he really did have the ability to follow through.
Having the police detective constable to consult with during the process was invaluable for a staff person like Carol, who would have otherwise overlooked the son’s behavior. The police detective was able to provide guidance about the criminal justice process, and assisted Carol in filing a police report. This documentation could also be used to reinforce the seriousness of his behavior and used as further evidence in protecting the staff. Staff safety was also mentioned in by participant - Sheila and she also received advice from the police detective constable to file a report about the son’s behavior.

**Negotiating roles between health care providers and the AAOA Unit.** Given the number of transfers to different health care environments (i.e. hospital and nursing homes) that Mrs. A had to experience since leaving her home, she would have come in contact with different and new health care staff who would assume responsibility for her health care. Fortunately, the AAOA Unit was involved in Mrs. A’s case early on and the AAOA social worker was able to build a therapeutic relationship with Mrs. A. For participant – Sheila, having the continuity of a familiar face for Mrs. A to turn to was important. Sheila’s concerns highlighted what Mrs. A’s expressed wished to see her son, despite his behavior towards staff.

> How do we keep her safe, because it’s her only child. She wanted to see him, ‘I forgive him, why don’t you?’

Similar to Sheila’s comments, Erica commented on impact of this transition from home to care facility on Mrs. A’s relationship with her son:
And the whole question for all of the people involved is, ‘Is this woman going to die and never lay eyes on her son again?’ and ‘Have we done the right thing by getting it to this point and could it have been handled differently?’

Despite his negative behavior, the AAOA Unit also attempted to engage Mrs. A’s son. In her account of Mrs. A’s situation, Margo also noted the AAOA Unit’s attempts to care plan with Mrs. A’s son; however, “(i)n the end, this approach was not successful, but at least it was tried.”

The AAOA Unit’s role in Mrs. A’s situation was dependent on maintaining communication with necessary team members, and

… helping to bring the people without our very complicated system who needed to be included in the decision making – who has the power within our system.

The AAOA Unit was also involved with case conferencing with the health care teams across community, hospital and residential care, which provided the opportunity for care planning and information sharing.

**Providing education to staff.** For Margo, the involvement of the police detective constable not only ensured staff safety, but created an opportunity to educate staff on the legal system.

Staff in facilities is providing health care to the residents … being involved in these types of situations is not a normal occurrence for us, so a resource like this is invaluable. This type of situation appears to be increasing.
In summary, respondents identified the Abuse Against Older Adults Unit (AAOA) as assisting this case in four main ways:

1. Case Conferencing - the AAOA participated in case conferencing sessions to plan out interventions with health care staff and management.

2. Victim Support – the social worker’s role was highlighted in the victim support provided to the victim throughout the process. The social worker became a trusted individual who consistently met with the resident from her removal from the home, hospitalization and transfer to facility care.

3. Family Support – both the social worker and the police detective constable were reported to have collaborated with Mrs. A’s son in an attempt to include him in his mother’s care planning. The AAOA Unit took a lead role to serve as his advocate and liaison with the health care professionals.

4. Education on Legal System interventions- the police constable assisted staff in outlining boundaries with the abusive son – this included obtaining a restraining order, and making formal police complaints when staff were threatened by the son. Educating staff on the process of enacting these criminal interventions was noted by respondents.
6 Discussion

The data generated from this research began as a description of how the participants came to understand and define the role and functions of the Abuse Against Older Adults Unit (AAOA). In describing what they felt were the areas of strengths and challenges in this pilot project, the service providers were inherently discussing how the AAOA team was able to meet gaps in service that the participants’ own scope of practice were not able to address. What emerged from the data, then, could be seen as the beginnings of a best practice framework between the AAOA Unit and the external community agencies that worked with them. Four themes emerged from the data: issues related to overlapping roles in multidisciplinary practice; the need for shared responsibility; the impact of having an AAOA social worker; and recognition of resource limitations.

6.1 Overlapping Roles in Multi-Disciplinary Practice

In the process of evaluating the Abuse Against Older Adults Unit and its team members, participants inadvertently reflected on their own parallel practice to this team. The data began to show that the challenges of working within a police-social work partnership model are not exclusive to these two disciplines. One over-arching theme focused on the over-lap of roles – whether it be observed overlaps between the police and social worker, or overlaps in duties between the AAOA unit and the service providers who participated in this study.

On the one hand, these overlaps may create barriers to the working relationships between different disciplines, as similar activities are duplicated. This could be seen as a misuse of resources if, for example, the social worker has similar functions to that of the
community health care case managers. It becomes a challenge to justify the need for the AAOA social worker if an existing agency performs a certain task.

As Garrett (2004) described a “blurring of the social work identity” between the police officers and social workers is at risk for occurring. This same concern could be extended between the AAOA social worker and the health care providers – for example there are often overlaps between the roles of community nurse practitioners and community social workers: how, then, could the specific role of the AAOA social worker be differentiated? This might be even more complicated when community professionals are also social workers.

These concerns may have an impact on continued collaboration between the AAOA unit and other agencies; however, the data suggests otherwise. Participants did mention that their comfort in contacting either the police constable or the social worker for case consultation was an asset. The social worker’s knowledge of the criminal justice system provided another channel of access – especially if the police constable was unavailable, the social worker had the expertise to advise service providers. Similarly, the social worker could provide the same education/advocacy for police officers who enquire about the role of health care workers and other external agencies. Thus, it appears that there was a clear role for the social worker that was differentiated from the more general role of the community health professionals, even those who were social workers by profession.

Rather than focus on the drawbacks of overlapping roles, the participants demonstrated ways in overcoming this, specifically, by embracing the concept of shared responsibility.
6.2 The Need for Shared Responsibility

Another theme that emerged from the findings was determining who would take the “lead” in managing a particular case. In the case of Mrs. A, the AAOA social worker was given responsibility to case manage and follow Mrs. A through the various health care settings where she was transferred to (i.e. hospital, care facility). Whereas normally the community (health care) case manager would have assumed responsibility for this task, it appears to have been agreed upon by all the involved agencies that the AAOA social worker would assume this role. This was achieved through ongoing debriefing with all the disciplines and agencies involved.

This single case parallels the broader need for inter-agency cooperation and collaboration. This was alluded to in the findings, where feedback included inter-agency protocols pertaining to (confidential) information-sharing on client records.

Acknowledging the need for shared responsibility stems from the following:

- Recognizing the strengths of each discipline/service provider and based on ongoing negotiations/discussions/debriefing, agreeing who can best serve the needs of the client/situation.

- Acknowledging shared values and cultural intersections (rather than competing agendas). i.e. is the issue whether Mrs. A stays home or goes to a care facility versus, how can each agency do its best to ensure her safety/honor her wishes to see her son?
Minimizing expectations and a reliance on a particular agency/discipline program
the responsibility to assume the lead (Pinkney, L., Penhale, B., Manthorpe, J.,

While it was not a focus of this study, it appears that the participants were beginning to
express a need to formalize the working relationship between themselves (as external
agencies) and the AAOA unit. However, as the participants worked from a health care
background, this analysis cannot be applied across other disciplines.

6.3 The Impact of Having an AAOA Social Worker

While both the police detective constable and social worker in the AAOA unit
received positive feedback, it is worthwhile to explore the particular impact of that the social
worker had in this study. From the findings, the AAOA social worker was noted to have
previous experience working in the law enforcement cultured and was “trusted” there.

Another key experience that this social worker had was her experience working in a
police/social worker partnership model (with the local domestic violence program.)

Participants also valued her ability to provide education and support to front line staff, and
provided a broader perspective of intervention in working with the alleged abuser. It
appeared that these experiences solidified her credibility to the participants.

Incorporating social work values and a practicing from a strong theoretical
framework was another asset of the AAOA social worker. Her application of a feminist
framework to her practice created a victim-centered approach that appealed to the
client/patient-centred practice of the health-care based service providers. In addition, the
non-judgmental, advocate role allowed the social worker in introduce practice issues that
included the family unit. In this case, the family unit was also the alleged abuser, who participants did not incorporate into their own interventions.

It is difficult to analyze the findings about the role of the AAOA social worker as participants were not purposely asked how the role of the social worker significantly differed from her partner (open ended questions were used instead). So it needs to be considered whether these impacts were of the social worker role or the specific personality and practice of social worker herself. In other words, is it fair to expect that social workers in this role have the same qualifications? Does having a background in working in domestic violence add to this role, or was it a requirement?

6.4 Recognition of Resource Limitations

Resources issues in this study were identified in three ways: the service limitations that the AAOA was able to provide, the limited resources that directly affected the participants, and the management of information exchange.

The service providers who participated in this study expressed their desire to see the AAO\A unit expand. It appears from this feedback, then, that the team was not able to meet the current demand for their services. Increasing staff and having more than one AAOA unit to support the same area would provide more support to service providers. However, the participants’ comments to assign AAOA units to specific neighborhoods need to be considered in future program planning.

Although not specifically a focus of this study, the data raised concerns about the ongoing resource limitations of the service providers. Recalling that the Adult Guardianship Act created designated agencies from pre-existing front-line organizations, time and
workload constraints need to be acknowledged. The workload pressures placed on community health care case managers impacts their ability to spend on more complex cases such as elder abuse. Combined with the limited education that participants reported receiving, designated responders are more likely to seek and access programs like the AAOA unit.

Lastly, the data raised concerns about how information was shared between the police, the AAOA unit and the service providers. Participants were unsure when, how, and if the AAOA unit was received the initial reports that were made to the police. Questions of the security of this information were also raised. Future program planning, and if the development of inter-agency protocols are made a priority, may be able to funnel the appropriate resources to prevent this gap in communication.
7 Conclusion and Directions for Future Research

In reflecting back to my own experience with elder abuse, my thoughts wander back to the elderly Asian man whose story helped to inspire my desire to pursue research in the elder abuse and social work practice. If the Abuse Against Older Adults Unit was operating at that time, how would that have changed that man’s journey in being in an abusive relationship, and furthermore would that have impacted his journey in the health care system? Could he and his wife be able to return home? Would he have been moved to a care home? Would the involvement of the AAOA Unit provide alternate options to care for him, his wife and his son?

How would I have felt if I had access to a consultation like the AAOA Unit? Would I have been able to better advocate for this man? Although it is impossible to turn back the clock and change my response to that situation, there is the opportunity to promote a program like the AAOA Unit so that other service providers will not find themselves feeling as lost as “resource-less” as I had.

This research’s findings suggest that the participants responded in a positive manner to the services provided by the AAOA Unit. These findings are of course just a piece of a larger document prepared for the Family Services of Greater Vancouver who had initially requested that the AAOA Unit be evaluated. Since the start of this study, a second AAOA Unit is in operation in another Lower Mainland community and has also undergone a separate evaluation. It would be of value to compare the results from that evaluation so as to highlight the consistencies and differences in the results.
The data generated from this research also raises questions for future systematic inquiry. First, this study was not able to gather data from service providers from varying professions. What is largely missing is the evaluative component from law enforcement officials, including police officers and lawyers who also work with the AAOA Unit. Indeed, gaining access into the law enforcement environment continues to be a challenge in evaluative research (Patterson, 2004).

Another area that was not addressed in this study was how service providers determined whether the situation was deemed “criminal” and needed police involvement. What information did they use to help them decide whether there was a criminal element involved? It may be of interest to explore how service providers defined “crime” prior to interactions with the AAOA Unit and how those definitions may or may not have changed after working in consultation with the AAOA team members.

Lastly, the findings from this study raise important considerations for social work practice, particularly within a law enforcement setting. As previously mentioned, the social worker on the AAOA Unit had prior experience working with the police – this experience was noted and identified by the study’s participants as being valuable to the social work role.

How can this knowledge be incorporated into social work training and education? The literature mentions the need for social workers to be “prepared” for practice in a law enforcement setting, and suggestions have been made that this training be provided within the structures of formal education and training (Garrett 2004). Opportunities for social work students to participate in practicum with programs like the AAOA Unit or incorporating
content on social work in law enforcement in generalist social work courses may assist in preparing students who are interested in pursuing this field of practice.
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Appendix A – Focus Group Interview Guide

Opening/Introduction:
Please introduce yourself, and tell us, how did you first hear about this elder abuse unit?

Key Questions:
How do you understand how this program works? What is the purpose of this team?
How has this team been helpful to you?
   Can you give an example where the team was very helpful?
   Can you give an example where the team was less helpful?
How did this experience compare to any previous experiences reporting elder abuse? What makes this team different from the services that existed before?
What recommendations would you have for developing this service/team?
What criteria would you use to define a “successful” outcome by this team?
Is there anything I have missed?
Appendix B - Individual Interview Guide

Opening:

Tell me about your contact with this team:

   How did you hear about this elder abuse team?

Key Questions:

How do you understand how this program works? What is the purpose of this team?

How has this team been helpful to you?

   Can you give an example where the team was very helpful?

   Can you give an example where the team was less helpful?

How did this experience compare to any previous experiences reporting elder abuse? What makes this team different from the services that existed before?

What recommendations would you have for developing this service/team?

What criteria would you use to define a “successful” outcome by this team?

Is there anything I have missed?
Appendix C – Survey Emailed to Participants

Dear Service Provider:

The Abuse Against Older Adults Unit is a pilot project that is a joint collaboration of the Family Services of Greater Vancouver, the Vancouver Police Department and the B.C. Coalition to Eliminate the Abuse of Seniors.

Below is a short questionnaire that relates to your experiences/contact with this program.

Please answer as many questions as you feel comfortable responding to.

Every effort will be made to ensure confidentiality: any identifying information regarding your identity will be removed and a pseudonym will be used to reference use.

Thanks so much for taking the time to participate in this survey. If you have any questions, please do not hesitate to contact me.

Sincerely,

Elisse Tan
MSW Candidate

Elder Abuse Unit - Email Survey

1. How did you hear about the Elder Abuse Unit?

2. At what point in your assessment/investigation did you contact the Elder Abuse Unit?

3. How has this team been helpful to you?
   a. Can you give an example where the team was very helpful?
   b. Can you give an example where the team was less helpful?

4. What recommendations would you have for developing this service/team?