

EXPLORATION OF THE ROLE OF
THE COMMUNITY RESPONSE NETWORK
IN KELOWNA

by

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Abstract

The Community Response Network in Kelowna was formed from the policy-driven elder abuse committee and as a response to the Adult Guardianship Act of British Columbia enacted in 2000. After the inception of the act that addresses abuse, neglect and self-neglect of adults, the Community Response Network – a community development initiative that was implemented from social policy – was unsure of its role in the community. The purpose of this qualitative research is to assist the network in defining its role in supporting adults who may be vulnerable to harm. What is the role of the Community Response Network? What did the network do in the past? How effective was it? Who should be involved? It was thought that the network would continue to offer education and awareness to community members. Through a purposeful convenience sample of participants in both a focus group and individual interviews, various themes such as structure, values, context and tasks were evident through verbatim analysis. As well, through a feminist analysis, several dichotomies and inconsistencies were interpreted. Recommendations for the network include continuing education and awareness workshops, strengthening linkages in the community, and inviting a diverse group of people to become involved in the committee.

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Introduction

The Community Response Network (CRN) is a group of agency and organizational representatives as well as seniors and caregivers who have an interest in serving the needs of vulnerable adults by addressing the issues of abuse, neglect and self-neglect. This research paper focuses on the role of the CRN in Kelowna. This study was not intended to research the causes of elder abuse, violence against women and others with disabilities, or the extent of abuse, but rather to explore the role of a particular committee in a particular location.

Seniors and adults with disabilities have been targeted as the main two sectors of the adult population served by the CRN as it adapts its role in responding to the Adult Guardianship Legislation. The CRN was formed as part of the *Adult Guardianship Act* that was enacted by the Province of British Columbia in February 2000. Part three of the act provides support and assistance to abused and neglected adults. The following will provide a background to this legislation, a review of the literature, and a study of the exploration of the role of the Community Response Network in Kelowna.

The CRN is redefining what their role in the community should be after the inception of the *Adult Guardianship Act*. (Please refer to Concept Map #1 in the Appendices.) The purpose of this qualitative research project is to assist the CRN in defining its role in attempting to work towards facilitating effective development of community resources to support and inform service providers and caregivers of vulnerable adults. The research will help the CRN to focus on and explore

options that the committee can consider in supporting vulnerable adults and the community. The objectives of the study are:

- to assist in the development of CRN's in the province of B.C. as recommended by the *Adult Guardianship Act*;
- to act as a catalyst in assisting the CRN in Kelowna to move forward;
- to solicit information from CRN members and;
- to formulate information into a report that may assist the CRN in developing its role in the community.

Rationales for the study are outlined under professional, practical and personal. Professionally, it is hoped that an in-depth look at the role of the CRN can assist the committee in supporting helping professionals in their efforts toward improving services for those covered by the *Adult Guardianship Act*. Practically, this research study may assist the author and others in providing support to vulnerable adults. On a personal note, this research is important to me because I feel passionate about my work with vulnerable adults in preventing and reducing harm to this segment of the population.

The main research question is what is the role of the CRN? Sub-questions include: what did the CRN do in the past; how effective was it; and, what would the structure of the CRN be? It is assumed that the CRN does have a role in the community, but it may not be what it was in the past or what the committee members had hoped it would be. After a year of stagnation, it is assumed that a new and perhaps different profile of the CRN may be forthcoming. The following paper will provide:

- information on the background of the *Adult Guardianship Act* and the CRN;
- theoretical perspectives and the conceptual context on assisting vulnerable adults in the community;
- the research methods used in this study and;
- details of the findings and implications for the development of the CRN committee.

Demographics

The older adult (over 55 years of age) group is the fastest growing sector of the population in the community and has been increasing rapidly over the past several years. Older adults from across Canada and from other parts of the world are retiring in Kelowna due to the quality of life and diverse opportunities the city and the Okanagan Region can offer. According to the City of Kelowna, Department of Planning and Development, Report on Seniors' Housing, those over the age of 65 comprised 18% of the population or 16,445 in 1996. Those aged 55 to 64 years comprised another 9% of the population, or 8,175 people. This means that a total of about 27% of the population is aged 55 and over. Future estimations see an increase to 21% of those aged 65 and over by the year 2016, and almost 30% by 2031 (City of Kelowna, 1998). The Report on Seniors' Housing compiled by the City of Kelowna estimates that about 4,530 (29%) seniors lived on their own, about 10,210 lived with a partner and about 550 lived with someone other than a partner or relative (City of Kelowna, 1998).

When allocated as to housing type, the major locations included the South Pandosy/KLO or Glenmore areas for adult communities, the Central City area for

apartments, and room and board homes. "Nursing homes are distributed throughout the urban areas of the City..." (City of Kelowna, 1998). The types of housing for seniors include private dwellings (detached homes), seniors apartments and town homes, nursing homes, and rooming and boarding homes.

The number of older adults who lived in some form of housing allocated to seniors was about 8,400, whereas those who lived in single or multi-family housing not allocated to seniors totalled about 8,050. Of the 8,400 residents who lived in housing restricted to seniors, they were distributed as:

- 45% in adult communities;
- 42% in apartments;
- 12% in seniors' nursing homes and;
- 1% in rooming and boarding homes. (City of Kelowna, 1998).

It is estimated that approximately one in six Canadians of all ages have a disability (Government of Canada, 1999). According to the Canadian Transportation Agency (2002), "it is estimated that 3.8 million Canadians 15 years of age and over have some level of disability" and "the incidence of disability increases with age" (p. 4). Given this information, we can assume that about 17,000 adults in Kelowna have some form of disability.

Background

This section will outline statistical information, definitions of concepts used in this study, risk factors that may lead to abuse or neglect, focussing on isolation as a recognized risk factor of abuse, and background information on the CRN.

Definitions of Concepts

There is a lack of consensus in the meaning of “vulnerable” and “abuse” in the literature. According to Rothman (1994), a vulnerable adult would be someone who requires “protracted and multifaceted service, often extending over a lifetime” (3). He includes in this category, those who are elderly, those with disabilities and those who have mental health impairment. The Public Trustee of B.C. (1999b) considers vulnerable adults to be seniors and persons with disabilities who have been marginalized, unable to seek assistance due to physical restraint, physical handicap, illness, disease, injury or any other conditions that affect the person’s decision-making ability. The *Adult Guardianship Act* of British Columbia does not define vulnerability but does state that the Act covers those adults who are physically restrained, unable to care for themselves or unable to make decisions that affect their well-being. The Act serves to protect those who cannot protect themselves from harm (Public Guardian and Trustee of B.C., 2000).

Slater (2001) reports that in the document entitled “No Secrets”, produced by the Department of Health in England, a vulnerable adult is defined as one who is or might be requiring services because of disability, age or illness, who is also unable to care for or to protect his/herself against harm. Vulnerability, according

to Fox and Abraham (1991), is a multidimensional concept that is holistic, in that it includes social, physical, economic, environmental and psychological aspects of the individual. The resources that a person has as well as the interaction of his/her functional ability will determine their vulnerability. However, as one Community Response Network committee member stated, vulnerability is seen as a weakness. She prefers to come from a strengths perspective and not label a person as "vulnerable" but perhaps as a person in need of care. Vinton (1999) suggests that "by categorizing individuals we can seriously risk the safety of victims of abuse" (p. 87).

As research indicates, abuse as well, is not always easily defined or assessed. Abuse comes in many forms, is seen in many faces and differs from one culture to the next. In defining abuse, some policy makers refer to the terms psychological, physical, material, and neglect. First Nations groups add the categories of sexual abuse, incest and spiritual abuse; and, other groups include self-neglect (Health Canada, 2000). Health Canada includes the terms abuse of rights and freedoms, and abandonment (McNaught, 1999). Furthermore, the British Columbia Coalition to Eliminate Abuse of Seniors (BCCEAS) and the Public Trustee Office of B.C. include medication abuse (BCCEAS, 1999; Public Trustee Office of B.C., 1999b).

Given the multicultural aspect of Canada and the differing views of abuse among various cultures and the diversity within those cultures, the perspectives of individuals and groups across Canada will differ (Moon, 2000; Health Canada, 1997). There has been much debate over the definition and many studies have

researched the perspectives of individuals and groups (Reis & Nahmiash, 1995). However, national and provincial policies on adult abuse have attempted to include the varying views of the issue and have set forth guidelines for definitions.

Elder abuse is currently defined as the maltreatment of an older person that focuses on the perpetrator being in a position of trust and power, perhaps responsible for that person's care (Reis & Nahmiash, 1995; Health Canada, 1999). Forms of elder abuse include those mentioned above: psychological/emotional, physical (including sexual), financial or material, abuse of rights or freedoms, neglect and self-neglect (America, 2000; BCCEAS, 1999; Bennett et al, 1997; Bradley, 1996; Health Canada, 1999; One Voice, 1995; Public Trustee Office of B.C., 1999b; Reis & Nahmiash, 1995).

In this study, definitions as outlined in the *Adult Guardianship Act* of British Columbia (Public Trustee of B.C. 1999b) will be used. Abuse is defined as the "deliberate mistreatment of an adult that causes the adult physical, mental, or emotional harm, or damage to or loss of assets" (p. 6). Neglect refers to the "failure to provide necessary care, assistance, guidance or attention to an adult that causes the adult, or is reasonably likely to cause within a short time serious physical, mental or emotional harm, or substantial damage to or loss of assets" (p. 7). Self-neglect is defined as "any failure of an adult to take care of himself or herself that causes, or is reasonably likely to cause within a short time serious physical or mental harm, or substantial damage to or loss of assets" (p. 7).

Occurring in a variety of settings and systems – family, institutional and political – abuse is under-reported and under-recognized by both the victim and the public (Bradley, 1995; Health Canada, 1999). Given that abuse differs among cultural groups and individuals, victims are fearful of reporting or do not know who to call, and the definition of abuse is ambiguous, the number of reported incidents of abuse is considered to be very low. It also does not include people who have been victimized by society, social service agencies, political agendas, and social policy.

Statistical Information

An estimated 8 to 10 percent of the senior population in British Columbia has experienced some form of abuse, neglect and self-neglect. Most victims are women – as women tend to live longer than men – and are most likely to live with a caregiver other than a spouse (Public Trustee of B.C., 1999). According to statistical data, between 4 and 8 percent of elderly Canadians have experienced some form of abuse (BCCEAS, 1999; Health Canada, 1999; McNaught, 1999; One Voice, 1995). Petersilia (2000) reports that a recent study showed “more than 70 percent of women with developmental disabilities are sexually assaulted in their lifetime, which represents a 50 percent higher rate than the rest of the population” (Sobsey and Doe, 1991, in Petersilia, 2000, p. 1).

Sobsey and Doe (in Petersilia, 2000) also suggest that compared with persons without disabilities, those with developmental disabilities are 4 to 10 times more likely to be victims of crimes. As well, Swedlund and Nosek (2000) report that thirty-three to eighty-three percent of women with physical disabilities

had experienced some type of abuse. The Roeher Institute (1996) supports this by reporting that 39% of adult women with a disability or disabling health problem suffer from physical or sexual assault by their partners. As well, "women with disabilities are more likely than women without disabilities to be subjected to serious violence...60 compared with 50%" (Roeher Institute, 1996, p. 110). Moreover, those with disabilities are more likely to be victimized repeatedly (Petersilia, 2000; Swedlend and Nosek, 2000). Chenoweth (1996) agrees saying that those with disabilities are at a greater risk of abuse and more insidious forms of violence. Historically, the elderly and those with disabilities have been seen as marginal populations. Women with disabilities generally are extremely marginalized and excluded which makes them more vulnerable to abuse than other segments of the population (Chenoweth, 1996). Vulnerable adults deserve and require support from the communities in which they live.

In Kelowna, the senior segment of the population is growing at an unusually fast rate as compared with other cities and regions in Canada and British Columbia. According to the City of Kelowna Social Plan (1996), "seniors are becoming a larger component of society...Kelowna, in particular, offers a desirable climate and lifestyle for the senior population" (p.21). As well, the Report on Seniors' Housing (1999) reports that in 1996 the senior population in Kelowna composed approximately 18% of the population, whereas, only 13% of the population across the province was seniors. According to the housing report, the number of seniors in Kelowna is "expected to continue to grow in total numbers but remain between 18% and 19% of the population until 2011" (p.5).

However, the percentage is expected to grow to 21% in 2016 and to almost 30% by 2031.

So, although seniors are considered to be a marginal population, the numbers of elderly persons are growing. This will impact the demand on social programs and resources for this group. As well, according to the Roeher Institute (1996), persons with disabilities, who may or may not be elderly, make up approximately 6 to 10 percent of the overall population. In the United States, an estimated 3 to 5 percent of the population are believed to be persons with developmental disabilities (La Plante and Carlson, 1996, in Petersilia, 2000).

Violence in institutions can be just as prevalent as, or more so than, in the community (Petersilia, 2000). Swedlund and Nosek (2000) suggest that it is possible for victims to be abused by family members, personal assistants or those who work in institutions. Because the majority of vulnerable adults will not be living in institutions – but will be living in their own homes or the homes of their relatives – the need for communities to respond to the demands and required supports for families and individuals is increased. As well, Parsons and Cox (2000) explain that families and caregivers of the elderly and persons with disabilities will become more involved in making decisions that affect them and their loved ones. However, say Parsons and Cox, it is most important to realize that the individuals who are affected by these decisions – seniors and those with disabilities – must be involved in the decision-making process.

Risk Factors That May Lead to Abuse or Neglect

When looking at the following risk factors, one can only imagine the ethical dilemmas that might face service providers in their work with the vulnerable adult. Although the worker has a duty to report an incidence of abuse or neglect and to help the adult make decisions and wise choices about living with the abuse, the adult still has the freedom of choice to decide to stay in the abusive or harmful situation. The worker also must respect the adult's right to self-determination.

Very often it is the adult children who abuse an older parent (BCCEAS, 1999; Health Canada, 1999; McNaught, 1999; One Voice, 1995). Explanations for abuse have been inconsistent but tend to consider the dependency of the abuser on the abused and vice versa; the mental health and the social characteristics of the abuser; situational stress; trans-generational family violence; social isolation; and, pervasive societal power imbalance (Health Canada, 1999).

According to the literature (Bennett et al, 1997; Choi and Mayer, 2000; Petersilia, 2000; Slater, 2001; Swedlund and Nosek, 2000), risk factors can be categorized with regard to characteristics of both the victim and the offender. The victim is very often:

- severely physically or mentally impaired;
- very old;
- usually female;
- repeatedly victimized;
- living with the abuser;

- unable to verbally report, run from or fight the offender;
- living in poverty and unsafe community settings;
- lacking in information and accessibility to resources;
- fearful of retaliation and of losing independence and/or;
- experiencing difficulty with communication, depression and isolation.

Whereas the offender is very often:

- experiencing negative psychological difficulties including individual make-up, substance abuse or cycle of abuse from one generation to another;
- caring for the victim;
- in a position of power;
- experiencing severe stress;
- untrained to address abuse and lack information on abuse intervention or prevention;
- not guided by service standards or registration processes and/or;
- spending long hours with the care-receiver (Bennett et al, 1997; Choi and Mayer, 2000; Petersilia, 2000; Slater, 2001; Swedlund and Nosek, 2000).

However, as Bennett et al (1997) suggest, the most quoted risk factors tend to be individual make-up of the abuser, intergenerational cycle of violence, dependency and exchange relationships, stress, and social isolation. The Roeher Institute (1996) also lists other risk factors, such as a general social and cultural climate that gives people permission to abuse, negative stereotype, unequal social and economic position, reliance on others, unequal power, poverty, lack of control, lack of information about rights, and low self-esteem.

According to BCCEAS (1999), Health Canada (1999), McNaught (1999), and One Voice (1995), the victim of elder abuse tends to be isolated, powerless, and dependent on the offender. Most survivors are women, they say, – as women tend to live longer than men – and are likely to live with a caregiver other than a spouse. The abusers are likely to be male if it is physical abuse, female if the maltreatment is neglect or financial abuse. Very often it is the adult children of an older parent who abuse. Explanations for abuse have been inconsistent but tend to focus on the dependency of the abuser on the abused and vice versa; the mental health and the social characteristics of the abuser; situational stress; transgenerational family violence; social isolation; and, pervasive societal power imbalance (Health Canada, 1999).

As stated above, isolation can be a determining risk factor for abuse or neglect. Moreover, as seen here, isolation can be a reason why many incidents of abuse or neglect go unreported. This section will elaborate on the issue of isolation as it relates more especially to the elderly.

Isolation As a Recognized Risk Factor of Abuse

Browne (1998) found that a report produced by the United Nations General Assembly (1973, in Browne, 1998) stated that isolation increased with age and that “relatively more women than men were often alone, and this tended to correspond with the larger proportion of women who were found to be widowed and living alone” (p. 5). Browne also states that Shanas et al (1968, in Browne, 1998) discovered that social isolation was more likely if several factors

(such as living alone, older, single or widowed, no children and no relatives living close by, retired or infirm) were present rather than just one factor.

Related to isolation are the concepts of socialization, social adjustment and social functioning. Bennett (1980) suggests that socialization is the process by which people learn about and introduce themselves to the norms of the group to which they consider themselves belonging. Song and Singer (2001) state that social support along with other characteristics are associated with a person's social functioning. In other words, is the adult functioning strictly at a survival level or is he/she interacting in relationships with others?

MacRae (1995) suggests that friendships contribute to the well-being of older persons by offering emotional support, companionship, social activity and personal identity. As well, Gill (1993) states that for persons with disabilities, social isolation can be the greatest source of emotional pain. They feel "treated differently – separated somehow from the class of humanity in which they had once held natural membership" (p.20).

Isolation can be voluntary and/or involuntary; one can choose to be isolated or one can be isolated by others. For instance, some people choose to be by themselves with little or no contact with outside social supports. As well, those who have been forced to retire due to mandatory retirement policies sometimes find themselves cut off from work relationships. Moreover, many elderly adults are isolated as a result of children moving away, spouses dying, the loss of mobility and the loss of organizational membership. Those adults who have been admitted into hospitals and institutions without their consent and not

receiving socialization opportunities may be isolated due to involuntary circumstances. Voluntary isolation assumes that one has been given the choice to be isolated from social support, whereas involuntary isolation assumes that one has not been given that choice and relates to the idea of social exclusion – being ignored or neglected by society. Exclusion may not always be social or physical, but also can be emotional, such as ignoring or neglecting a person who has spoken.

In regard to elder abuse, Browne (1998) suggests, some societies honour age and thus introduce an expansion of roles for the older individual, whereas, in other societies, ageing means a constriction of roles which may result in isolation and segregation. Isolation and segregation, she says, “are usually reserved for all categories of social undesirables and public nuisances” (p.9). In western society, Browne states, this segregation of the elderly seems to be normal and accepted. Bennett et al (1997) agree that ageist practices and beliefs can be very threatening to older people and their safety. According to Choi and Mayer (2000), those frail elderly who lack social support might lose their ability to care for themselves and may suffer from self-neglect. Slater (2001) recommends that prevention of abuse can be supported through the social inclusion and support of marginalized people.

The National Elder Abuse Incidence Study conducted by the U.S. Administration on Aging (1998) found that unreported incidents were almost four times those reported. Vinton (1999), Administration on Aging (1998) and LA4Seniors.com (2002) state that most elder abuse goes unreported due in part

to isolation of the victim. Vinton states that the victim also does not report the incidence due to fear of retaliation, threats, potential loss of support, ongoing health problems and the encouragement of maintaining the status quo. She suggests that "friends and relatives who may share generational values that suggest women are responsible for relationships and should self-sacrifice, that stigmatize assertive behaviors and separation and divorce, might not support older women in taking action to stop family violence" (p. 89). Moreover, suggests Petersilia (2000), "victims with cognitive disabilities often lack the vocabulary to report the abuse" (p.3).

Community Response Network

Many communities in British Columbia formed elder abuse committees as set out in a policy developed by the Ministry of Health in the 1980's. The Community Response Network (CRN) in Kelowna and other communities evolved from the elder abuse committee. As part of the Adult Guardianship Legislation that was proposed in 1989, which addresses the issues of abuse, neglect and self-neglect of vulnerable adults, CRNs across the province of British Columbia were developed. The CRN is a small representation of the community including health care and social service providers, seniors, caregivers and interested parties. Guided by the values of inclusivity, full and meaningful participation, flexibility, equality, teamwork, effective and understandable communication, respect, diversity and accountability, this network helps to develop a co-ordinated response to the legislation (Public Trustee of BC, 1998).

There are many CRNs around the province. However, the CRN in Kelowna was said to be one of the most developed and co-ordinated. Although the network consists of committed and interested individuals, it sometimes lacks consistent leadership. Because of lack of resources and funding opportunities, the CRN has had its ups and downs. However, the network has also done some good work in the community by providing workshops and educational forums. These sessions have helped to bring together many participants in the community who work directly with those individuals who are served by the legislation as well as the individuals themselves.

Theoretical Perspectives

Current and Past Research Limitations or Concerns

Research into the issue of elder abuse has suggested several inconsistencies and limitations. For instance, the causes of elder abuse have not been sufficiently supported by theoretical frameworks or empirical data (Harbison & Morrow, 1998). As well, methodological problems arise because of the differences in sampling and data-collection techniques. According to Galbraith (1989), most studies until the year of publication had not used comparison control-group techniques, but rather, used small non-representative samples that could not be generalized to the greater population. This could be seen as a methodological concern in that the results would not be considered reasonable or provable. As well, very little research on violence against women and other persons with disabilities has been conducted (Petersilia, 2000; Swedlund and Nosek, 2000).

Harbison and Morrow (1998) suggest that the elderly themselves have not been heard, which is consistent with Galbraith's (1989) findings. He suggests that data has been "derived from health and social service professionals providing retrospective case material, agency records, and, least frequently, elderly abused individuals and abusers themselves" (1989, p. 38).

As previously mentioned, there exists a diversity of definitions of abuse making it difficult to explore the causes, variables, extent, and frameworks of the issue, as well as parameters and characterization (Bennett, et al, 1997; Galbraith, 1989; Harbison & Morrow, 1998; Sprey & Matthews, 1989). Competing

constructions of elder abuse such as “adults in need of protection”, “victims of family violence”, and, “persons subject to illegal acts” (Harbison & Morrow, 1998) can lead to unfocused and inconsistent policy decision-making. Social barriers such as differing values and attitudes towards the elderly and the vulnerable continue to slot a large segment of the population into a category known as “the frail elderly”. The above limitations to research can subsequently lead to limitations in family social policy development.

Given the above concerns about current research, this study attempts to alleviate the problems and barriers by introducing the qualitative nature of research as a way of understanding the complex nature of abuse and how abuse is interpreted in vulnerable adults.

Theory Regarding the Causes and Interventions of Abuse

According to Bennett et al (1997) and Harbison and Morrow (1998) because of the various dimensions of elder abuse, theoretical models and frameworks can be classified as micro, mezzo and macro. The situational model, symbolic interactionism theory, social exchange theory, psychopathological frameworks, role theory, feminist theory and disengagement theory can be classified as micro level. The mezzo level includes feminist theory, gerontological theory, family systems theories, family violence frameworks, frustration-aggression theory, situational model and interactionist theory. The macro level considers feminist theory, political economy, structured dependency and institutional agism (Bennett et al, 1997; Harbison & Morrow, 1998). However, there may be some debate about classifying models and frameworks in this way.

Not one of these perspectives on its own truly addresses all levels or dimensions of elder abuse (Sprey & Matthews, 1989). Rather, several frameworks and models must be integrated to fully explain the issue. Most framework models tend to ignore ageism, sexism, racism, marginalization, social exclusion and other discriminatory elements perhaps because theory deals with causes and these concepts are considered symptoms. In order to provide an all-inclusive model or framework, researchers must address the diversity of society in all its aspects such as gender, age, culture, value systems and belief systems. This may seem a daunting task because of the many theories and frameworks that attempt to explain the many aspects of elder abuse, but, theory, research and values will help determine the implications for family social policy.

Societal Values

Societal values affect and impact the definitions of abuse and influence the formation of policy and the development of response initiatives. Individual, group and societal values will help to formulate family social policy in addressing the issue of elder abuse. Individuals who are now considered the "elderly" tend to fit into two different segments of the population. According to Harbison and Morrow (1998), the two segments are: 1) those who are over 75 years old, and, 2) those who are 65 to 75 years old. The over 75 group are individuals who were raised in a society that had predominantly self-reliant viewpoints where the family would take care of its own. However, the 65 to 75 year-old group were raised in an era where the government was expected to take care of the more vulnerable. As well, the older segment of the elderly population tend to have more physical

limitations due to their age. The younger group tends to be more active and independent. Therefore, there seems to be "two generations of elderly people, with differing values and needs" (Harbison & Morrow, 1998, p. 696). These values and needs are socially constructed by the society in which the person is raised.

Societal values, too, are socially constructed. Harbison and Morrow (1998) state that ageism is a concept that has been constructed out of a need for society to find a scapegoat. Generally, in mainstream white Canadian society, older people are considered to be frail and dependent, unproductive and needy, a burden on society and in need of protection. The elderly are assumed to be unable to make decisions for themselves. This is a paternalistic and narrow view which fosters "and reinforces a fear and denigration of the ageing process, and stereotypic presumptions regarding competence and the need for protection" (Harbison & Morrow, 1998, p. 698). As well, Canada is a multicultural society and many groups within this society will not view the older adult in this way, but will in fact see their elders as strong, independent and vibrant members of the group.

Bennett et al (1997) suggest that knowledge, attitudes and values "will affect both awareness of the problem and views concerning strategies for intervention" (p. 47). For instance, Rothman (1994) states that the community values and attitudes will impact service delivery and social support. As well, health and social care providers often harbour agist attitudes. Institutional ageism is evident in the discrimination of clients based on age. Social workers often

prefer to work with the young, are often paid less, and have lower qualifications if working with the elderly (Bennett et al, 1997). Ageist values and the values of privacy within the family reinforce the prevention of the elderly from seeking help or reporting the abuse. When viewed in the family context, insufficient attention has been paid to the abuse of older women by male family members or caregivers. According to Harbison and Morrow (1998) the interaction between ageism and sexism helps to keep family violence hidden from society's view. These values, combined with theoretical perspectives can help to guide Canadian policy.

Professional Values and Ethics in Addressing the Issue of Abuse

The social work values of respect, self-determination, dignity and equality fit with the belief that seniors and those with disabilities be encouraged to make informed choices. As social workers, we can refer to the approach outlined by *In Unison*, which is a federal vision that emphasizes the importance of "full participation of persons with disabilities" (Government of Canada, 1999, p.1). This vision consists of values, principles and building blocks that are consistent with social work values, principles and skills. Equality, which includes "self-determination, autonomy, dignity, respect, integration, participation and independent living" is embraced by this vision (Government of Canada, 1999, p. 2). The principles of inclusion and full citizenship are used to guide the policy.

The Roeher Institute (1996) states "disability is more than an individual condition. It can be understood as being the result of social, economic and environmental factors. There are many disabling environments and attitudes in

society that need to be adjusted” (p. xi). Paternalistic and stereotypical attitudes added to the need for professionals to fit the individual into categories work against the person’s right to self-determination and equality (Maida, 2000). Therefore, it is not only the individual’s personal challenge of living with the disability itself, but also the barriers to full participation in the decision-making process that must be addressed (HRDC, 1999).

Empowering individuals and groups in communities to be involved in the decisions that will affect them will assist in creating “workable solutions that provide numerous benefits to all citizens” (Kaminsky & Yellot, 2000, p. 231). As well, the Roeher Institute (1996) suggests that more people are realizing the importance of adhering to such principles as self-determination, equality and democratization through advocacy, social development or research regarding disability-related issues. By including seniors and those with disabilities in community forums; by encouraging them to participate in debates; by assisting them to attend and be heard; and, by making accommodations so that these forums are accessible and equitable, creative solutions that are effective can be realized.

Lotz (1997) warns us that “the ethical and moral dimensions of community development are often overlooked in the search for quick answers to complex problems” (p. 27). As well, ethical issues arise in working with “vulnerable adults”. In respecting the person’s right to make his/her own decisions, how do we balance his/her right to autonomy and our responsibility to help protect him/her from abuse? As professional social workers, our professional ethics are provided

as a foundation that may help to guide our practice and to assist us in finding the correct method of addressing situations (Loewenberg and Dolgoff, 1992).

However, ethical dilemmas will ultimately arise in our practice when a contradiction of values takes place. For instance, in assisting vulnerable adults who may be experiencing abuse or neglect we balance the person's right to choose with our value in protecting that person from harm.

Social Planning and Community/Locality Development

The *Adult Guardianship Act 2000* was enacted as a result of pressure from the Public Trustee Office of B.C. Under part three of this legislation, support for the formation of Community Response Networks (CRNs) was outlined. These CRNs were formed by various members of the community who had an interest in protecting vulnerable adults from harm. The formation of CRNs, then was a result of both social planning and community development initiatives.

Rothman (1995) describes social planning as a model of change based on scientific and analytical premises, and on data and needs assessments whereby change is carefully planned. Macro level social problems such as housing and health care are addressed through the evaluation of research and statistics. Goals are based on tasks such as "conceptualizing, selecting, establishing, arranging, and delivering goods and services to people who need them" (p. 30). Important to this model is encouraging coordination of agencies, avoiding duplication of services and filling in the gaps in the community.

According to Rothman (1995), this type of change model does not rely on or encourage grassroots participation from the community. It is a "data-driven

form of planning and policy practice" (p. 31). Rothman states that Webber and Rittel (1973, in Rothman, 1995) claim the approach is flawed due to its "assumption that problems are easily definable, well-bounded, and responsive to professional intervention" (p. 31). As well, the model is affected by both politics and financial resources. Politics will encourage many varying interest groups to have input into the goals and development strategies of the model making it contentious. Financial constraints will impact the social planning model in that economic developments within and outside of the government agenda will affect the options of program development.

Community development, according to Rothman (1995), however, is based on grassroots participation. A broad spectrum of members of the community will come together to determine a particular course of action. It is a process that relies on community initiative to promote and create progress or programs for the whole community. This model focuses on process goals, rather than task goals, which emphasize problem solving through self-help of community members, and co-operative and collaborative relationships among diverse groups of people. As Rothman suggests, it is a "process of educating participants and nurturing their personal development" (p. 29). This model overlaps the feminist perspective on organizing in that they both focus on wide participation, democratic procedure and education (Rothman, 1995).

According to Twelvetreets (1991), there are many forms of community work that combine both social planning and community or locality development. He suggests that an umbrella organization may involve members of both local

authority groups and grassroots community groups. As well, Twelvetreestates states that both process goals and product (or task) goals “are important throughout community work and both are intertwined” (p. 11). The circumstances or the situation will determine which goals will be required.

Community Development and “Vulnerable Adults”

According to Pancer and Nelson (1990), guidelines for community mobilization for health promotion would include the following:

- community involvement;
- planning;
- needs and resources assessment;
- comprehensive programming;
- integrated programming;
- long-term change;
- altering community norms;
- research and evaluation;
- sufficient resources; and,
- professional and community collaboration.

The combination of both social planning and community development initiatives can be recognized.

In meeting these guidelines for work with vulnerable adults and their health promotion, a grassroots approach combined with collaboration of local authority organizations may be successful in addressing abuse. For instance, Swedlund and Nosek (2000) found that a multi-faceted approach for independent

living centres in abuse intervention for women with disabilities was important. This included collaboration with existing programs so that services were more accessible. Cross-training of staff, cross-referral between programs, and outreach efforts were initiated.

Chenoweth (1996) finds that negotiating between two different sectors of the community can be a dilemma. For instance, when working with women with disabilities, often one sector consists of women's groups who approach the endeavour from feminist frameworks, and one sector consists of disability service providers who approach it from a framework of inclusion of all members of the general community. This means that women with disabilities may feel uncomfortable. The women's groups expect a validation of the women's experience, and the service providers expect a validation of the disability experience.

In community work with vulnerable adults perhaps meeting with groups of seniors, vulnerable adults and their caregivers separately from other interested parties can help to build trust and rapport. The group may feel more comfortable in voicing their concerns, barriers and challenges in dealing with or in networking with other parties. As well, separate meetings with other interested parties such as representatives from the local health region, from local agencies and service providers, and from City Hall encourages discussion among professionals regarding their issues, concerns, policies and mandates. Conducting several meetings this way may take many months or only just a few weeks depending on the length of the individual meetings, availability of individuals and financial

constraints of agencies. However, in my experience, a worker who has been involved in the community on an ongoing basis for several years has already built rapport, trust and communication among and between these various parties which may shorten the process somewhat.

It is necessary to assess the extent to which the parties are able to participate in the process. For instance, vulnerable adults must have the capacity to participate and to understand what is being negotiated. A person's ability to participate rests on his/her understanding of the process, his/her cognitive abilities, his/her physical accessibility to the process, his/her physical abilities to perceive the process and his/her ability to express his/herself adequately. If a vulnerable adult does not have equal power in the mediation, the mediator's responsibility is to help provide a level playing field for the individual (Maida, 2000; Parsons & Cox, 2000).

In providing this level playing field, accommodations must be made such as taped materials, interpreters, amplification equipment, speaking in plain language without jargon, barrier-free amenities, or designated parking that is close to the entrance of meeting places. Moreover, for some individuals or groups, it may be necessary to provide transportation to and from the meetings in order for those parties to attend and be involved in the process. If required, the mediator may insist on having caregivers, advocates, or helping professionals available to represent the best interests of the parties if any of the parties are not capable of representing themselves. Full and equal participation of all parties is required (Maida, 2000; Parsons & Cox, 2000). In order to address issues of

concern that may impact the quality of life for vulnerable adults, local resources and community programs including the policies that guide and direct them, must evolve with the changes in demographics and demands of society.

A community development model that includes the voices of seniors and those with disabilities would be most effective and desirable especially when the issues concern these individuals specifically. As the Roeher Institute suggests, "disability is more than an individual condition. It can be understood as being the result of social, economic and environmental factors. There are many disabling environments and attitudes in society that need to be adjusted" (1996, p.xi).

Paternalistic and stereotypical attitudes added to the need for professionals to fit the individual into categories work against the disabled person's right to self-determination and equality in the mediation process (Maida, 2000). Therefore, it is not only the individual's personal challenge of living with the disability itself, but also the person's barriers to full participation in the decision-making process that must be addressed (Human Resources Development Canada, 1999).

Ellis (1996) suggests that changing the environment to be more responsive to the unmet needs of the vulnerable adult is essential. By helping individuals to make social changes in the community in partnership with other community members, the relationships within that community will be enhanced and more open communication in the future will occur. Perhaps this will help prevent problems, or at least help to address problems before they become overwhelming.

Feminist Perspectives

Social Context

Vinton (1999) writes that abuse and manipulation is a result of a “social context that includes gender inequality of power and cultural acceptance of the control and domination of women by men” (p. 89). She explains that ageist and sexist attitudes emphasize the societal view that women have domestic and sexual functions that involve services and availability to men. Moreover, she says, the stereotypical view of older women is one of dependence, passivity and incompetence. The consequence of ageist and sexist attitudes, she explains, is that women become invisible and lack credibility so that their voices and opinions are not heard.

Choi and Mayer (2000) agree that elder abuse is a serious social problem whereby timely prevention and intervention must be forthcoming. They go on to say that survivors very often do not report the abuse for fear of retaliation by the abuser or perhaps out of shame. Thus, the problem tends to be hidden from view. Moreover, the person’s emotional, cognitive or physical barriers may affect her decision-making ability (Choi and Mayer, 2000; Vinton, 1999).

Societal messages such as ageist attitudes and sexist beliefs make it seem that women are dependent, passive, incompetent and lacking financial support. This means that older women remain invisible, unheard, impoverished and lacking credibility (Choi and Mayer, 2000; Vinton, 1999). Moreover, the people who often care for elderly women are also women who have little support. This can add to caregiver stress and financial dependence on the elderly care-

receiver. Browne (1998) suggests that social welfare programs and politics must address financial and other needs of the elderly and correct the inequities.

Hyduk (1996) states that "social workers must include an assessment of the older adult's support system as part of the care plan" (p.161). Because the older adult's support system can impact the stress on the caregiver, support for the caregiver is also needed, says Hyduk. She suggests that the promotion of programs that utilize the strengths of older adult volunteers can be most helpful. Using a partnering or buddy system approach, using a peer role model program and making the most of naturally occurring support networks are several ways, says Hurdle (2001), that health promotion for women can be enhanced. Hurdle suggests that small-group formats for programs and the training of natural helpers are most helpful. Co-operative learning strategies and incorporating social supports as a part of the educational process, she states, are very empowering.

Education, Advocacy and Empowerment

Education, advocacy and empowerment models of community awareness and community strategies are recommended by many researchers (Chenoweth, 1996; Choi and Mayer, 2000; Petersilia, 2000; Slater, 2001).

Education includes education of practitioners and service providers as well as caregivers, seniors, persons with disabilities and the general public. Education consists of appropriate training in assessment, prevention and intervention strategies. As well, public awareness initiatives consist of workshops and

conferences on diversity, abuse definitions and meanings, risk factors, indicators of abuse, and the meanings of experiences of those with disabilities.

Advocacy includes a "framework for action within which all responsible agencies work together to ensure a coherent policy for the protection of vulnerable adults at risk of abuse and a consistent and effective response..." (Slater, 2001). It involves the use of pressure or influence to initiate action in an organization, agency or person that is desired by an individual. Advocating for someone who may not be able to advocate for themselves could be one way in which communities can assist vulnerable adults (Rothman, 1994).

Empowerment is achieved when a person or community has gained power through acting or making decisions that have a positive effect on self-confidence, capacity and strengths, and environment. It also involves motivating people by giving them independence and responsibility for taking care of themselves (Payne, 1997). Chenoweth (1996) recommends breaking the silence that surrounds the experiences of women with disabilities by giving them a voice. But also suggests that all "women must work together to shift the position of women with disabilities from one of marginalization to one of inclusion..." (p. 12). By including women in the conditions that affect their lives, by the willingness of people to challenge formal authorities in order to do things for themselves, by building individual capacity through mobilizing resources, and by developing co-operative relationships, women can be empowered (Rubin & Rubin, 1986).

Empowerment, as a basis for feminist organizing, allows the powerless or less powerful to engage in activities to correct the imbalance of power (Reisch et

al, 1991). This strategy can improve one's ability to gain control over and the condition of his/her life. It is a feminist strategy that assists in linking women in a common struggle (Ristock & Pennell, 1996). Empowerment can be used in combination with other strategies to provide a new vision for feminist community work. It is generally referred to as the enhanced ability to control one's own life while developing some sense of a collective voice over social conditions. As individuals, people draw from inner strengths, asserting themselves in order to have some control over a situation. They share resources and work co-operatively for the mutual benefit of all concerned. Democratic processes, equal participation of all involved, shared decision making and political development come together in order for people to take political or social action to change circumstances. Community research comes from an empowerment model when conscious thinking about power relations, cultural contexts and social action are addressed. If a diverse range of individuals and groups are included, and modes of consultation and collaboration are used in research in order to build knowledge that will help to change the conditions of and illuminate people's lives and social situations, empowerment is being used (Ristock & Pennell, 1996).

Garner (1999) agrees with collective problem solving by using those strengths that the older person has named through sharing life stories. Older women can connect to one another by telling stories of their lives, she says. By coming together in groups and sharing, suggests Garner, older women can feel a sense of empowerment and improve their quality of life by developing and strengthening their interpersonal relationships. However, she reports, in order to

increase staff and worker success with the older adult, colleagues would be well off to increase their feminist skills. As she says, "feminist practice focuses on respect and the value of women for their intelligence, support, skills, talents, and abilities" (p.9).

The feminist approach for workers includes collaborative interaction, honesty and openness, challenging rather confronting, and encouragement of independence and self-sufficiency (Garner, 1999). She adds that advocacy is a necessary part of the feminist approach. Advocacy, suggests Garner (1999), includes speaking out and pressuring governments to address the needs of elderly women while attempting to eliminate stereotypes, to change attitudes and to extend women's roles. According to Garner, the fundamentals of feminist gerontology include "education, egalitarianism, empowerment, and inclusion" (p.10), that can greatly improve the health of the aging woman.

When recommending community services, Vinton (1999) reports that feminist based resources such as safe shelters, sensitizing and educating, cross-training and coalition building, integrated support, community awareness, advocacy and buddy programs are essential. Choi and Mayer (2000) suggest caregiver support, in-home support such as homemakers, substance abuse screening, and public education should be included.

Feminist Community Organizing

Callahan (1997) states that feminist community organizing is different from other approaches because of "its insistence that all activities must be informed by an analysis of gender (and race and class) and modified on the basis of this

analysis" (p.183). She also suggests that feminist community organizing is committed to a social movement and connecting local efforts with those outside of the locality. The concern is focused on helping women in a particular place and basing local issues on local solutions. Callahan discusses the idea that women working in feminist community movements are often volunteering their time and energy regardless of the skills that they have. Although the work often calls for special training and skills, women are often expected to do the work without pay or recognition. This situation, however, raises the concern of creating hierarchies between paid co-ordinators and volunteers within an organization.

As Callahan (1997) suggests that with provincial governments increasingly giving communities more control over health and social services, it may be that women will be expected to pick up the responsibilities and tasks on a volunteer basis. Callahan states that "it will be women, working in the home for free and in low-paid care jobs in community agencies" (p.198). In this case, says Callahan, coalition building and bridging between agencies is very important. She recommends that all public and private institutions should consider the benefits of collective well-being.

Research Methods

Neysmith (1995) suggests that a feminist researcher will explain to the participants the purpose of her research, who she is, and what experiences she has or not had in the area and will include the participants in the research design. According to Neysmith, the researcher might also request feedback from the participants regarding the findings and how to disseminate them. This process,

says Neysmith, emphasizes knowledge that can assist in social analysis leading to empowerment and social change which is also common with participatory and action research models.

Feminist research strategies have also been outlined by Cummerton (1986). Cummerton states that "a feminist perspective is one in which women's experiences, ideas, and needs are valued in their own right...women's experiences are seen as constituting a different view of 'reality'" (p. 85). Cummerton suggests that "a feminist research perspective differs from the patriarchal perspective in that there is a clear recognition that the results of research are neither value-free nor objective" (p.86). She says that feminist methodology, when possible, allows and encourages "intersubjectivity" – a dialectical relationship between the participants and the researcher. The research can be shared with the participants and the questions asked by the researcher can develop from the researcher's experiences and concerns. As well, says Cummerton, the power is shared between researcher and participant throughout the research and the research is process oriented.

Feminist strategies could help to link women of diverse backgrounds in their common struggle to address violence in the world. By allowing women to tell their stories and relate their experiences, improvements may be made on the basic tenets of feminism. Determining social conditions that lead to unequal distribution of power in society could be combined with viewing the various ways in which "discursive conditions affect women's lives" (Ristock & Pennell, 1996, p.6). By addressing the ideological and contextual aspects of women, and by

including both qualitative and quantitative research methods, a broader picture of the issue at hand could be produced.

Brotman and Pollock (1997) agree with Ristock and Pennell (1996) in that more progressive theories and approaches to social work need to be introduced in order to change the inequities that exist. Ristock and Pennell suggest that researchers "develop new theoretical insights into underlying causes of conditions and potential alternatives" (Ristock & Pennell, 1996, p. 7). Others agree that social work research practice models must be re-adjusted.

According to Wills (1992), social work must be challenged to re-evaluate its values and approaches to community. She suggests that the traditional values of community work (ie. liberalism, improving the social construct through inclusivity and individual participation, social planning and reform) might not be the appropriate or efficient way of addressing change. Perhaps rather than simply changing the existing order, the basics of society need to be reconstructed. Wills states that the effects of globalization and trans-national capitalism are having a devastating effect on individuals and communities that social work is simply not recognizing. The world may need transformative and radical practice modalities that are consistent with radical social work (Wills, 1992).

In formulating a structural social work approach, Wachholz and Mullaly (1997) suggest that practice that has been driven by an oppressive power imbalance between researcher and subject has resulted in unjust and unethical methods. Structural social work frameworks focus on the inability of social

institutions to properly and appropriately address the needs of the people. The existing social order operates to benefit mainly upper class white men to the detriment of oppressed groups such as women and minorities. In order to deconstruct these structures of society, we need to connect the political to the personal, help to strengthen collaboration among and between interest groups, encourage involvement and participation, and participate in transforming the existing social order (Wachholz & Mullaly, 1997).

All of the above strategies need to be combined into a new vision for social work and community practice including research methods in order to achieve a more efficient and effective way to change the existing patriarchal society that simply is not working for the benefit of all people. I believe that we, as social workers and members of society, must work together to find specific strategies to achieve a new way of doing things that will be inclusive, egalitarian, and co-operative. If it is understood that the existing social order is not working, but is in fact destructive, all of us must make changes. Day to day interactions with others, with groups, with organizations and with institutions must reflect what we believe.

A feminist community development model that includes the voices of seniors and those with disabilities and that encourages the building of relationships would be most effective and desirable especially when the issues concern these individuals specifically. Within this model of community development, teamwork and collaboration would be central concepts and practice methods.

Teamwork and Collaboration

According to Garner (1994), teamwork means different things to different people. It could mean positive attitudes or a collaborative working relationship. All teams are not created equally. They differ in purpose, structure, membership, size, power and leadership, as well as in the amount of independence of each member. There are multidisciplinary teams and interdisciplinary teams.

Multidisciplinary teams consist of professionals from many disciplines or organizations who share a common goal or task. Each professional stays relatively autonomous. Interdisciplinary teams, however, consist of two or more professionals from different disciplines who work together toward a common goal or task using a team decision-making process (Garner, 1994).

Co-operation, collaboration and co-ordination are important components. Members accept and respect the overlapping of their skills, knowledge and duties. They work toward clarifying the issues in order to reduce role conflicts and to increase effective use of their resources. The team process assists in empowering team members in decision-making and creating effective changes. Team members are equally responsible for the processes they undertake and leadership is shared. Consensus decision-making and equal participation of all members means that the values, expertise and perspectives of all members are pulled together to solve problems (Garner, 1994).

According to Mulroy (2000), collaboration with a few key stakeholders can be a first important step for community organizations. Over time, the group can increase membership. Mulroy suggests that "strategy is important to direct the

formation and structure of a community-based collaborative” and that “each collaborative should consider the characteristics and purposes of potential ... members, the interpersonal skills of their...leaders... as well as the unique characteristics, needs, and assets of each target neighborhood or community” (p. 28). Moreover, managers of human service organizations are continuously balancing inter-organizational change with external relationships based on both co-operation and competition.

Mulroy (2000) also reports that according to Himmelmen (1992, in Mulroy, 2000), collaboration among and between many sectors of the community “is a social change strategy that can operate either as collaborative betterment or as collaborative empowerment” (p. 29). The difference is that betterment begins outside of the target community and empowerment begins within the community. Therefore, both strategies are initiating change but focusing on change in different areas. However, Rothman (1994) states that “understanding and fostering interagency coordination entails a high level of complexity” (p. 221). This is partly because the internal workings of each organization are often difficult to understand, but also because a number of organizations have to be brought together at the same time on a common ground. He also suggests that the community can be valuable in providing resources and networking among services.

Collaboration of various sectors of the community can result in a positive network of individuals and agencies. It is through this networking that a community organization can recruit for volunteers. Castelloe and Prokopy (2001)

suggest that networking can make recruitment quicker and provides a common ground around which people can organize. Informal social networks, they say, build relationships and trust among people. Castelloe and Prokopy report that “feminist models of community organizing view leadership as facilitating the development of local leaders, teaching by tapping into people’s experiences, and using informal networks to connect people with shared concerns, thereby heightening community members’ awareness of their shared perspectives” (p. 36).

Conceptual Context

Social Policy in Addressing Abuse of Vulnerable Adults

In formulating policy in the area of abuse, policy-makers focus on the individual and family models of intervention wherein there is a perpetrator and a victim who have an intimate relationship such as family members or caregiver/care-receiver (Bennett et al, 1997). Policy is also focused on the need for protection of older adults or those with disabilities as a frail and vulnerable segment of the population. This decision-making interacts with the needs of those people who wish to remain independent and private (Harbison & Morrow, 1998). Therefore, perhaps policy-makers need to take a fresh look at the policy directions taken in Canada.

"Research provides information that guides decision about interventions, staffing needs and legislation. Multidisciplinary research is needed to advance knowledge..." (Health Canada, 1999:2). A consistent and comprehensive definition for abuse, along with empirically sound data collection and research on the views of older persons and those with disabilities, is needed in order to provide policy-makers with adequate information for policy decision-making.

Other research initiatives need to include a standardization of definitions and measures; a study of trends in prevalence and incidence and of the staffing and training implications of these trends; a look at the nature of abuse; consideration of other research methodologies; a refinement of available screening and assessment instruments; an evaluation of existing programs; a study of the effects of recent changes to support systems in the community; an

evaluation of the education of service providers and; a monitoring and evaluation of legislative changes (Health Canada, 1999).

Societal values are reflected in the social policy of the country. Elder abuse "is embedded in a multitude of controversial and often conflicting values" (Sprey & Matthews, 1989, p.59). As we generally believe that the elderly and those with disabilities are incapable of making decisions for themselves, that they are frail and vulnerable and that they need protecting, policy decisions have been aimed at guardianship, protection, criminal acts and perceived individualistic needs. This is reflected in policies, programs, and legislation.

In Canada, social policy addresses abuse by focussing on the family violence model and other individualistic or micro-level frameworks. The individual is provided with services and programs; the individual is seen as the perpetrator or the victim and; the individual is provided with education and support. Policies and programs outlined by Health Canada (1998) address care for the caregivers, violence within the family, abuse of seniors in the family context, adult guardianship, adult protection, injury prevention, community awareness, health and safety, quality of care, substance abuse, research and information, economic needs, housing, and improving quality of life.

Provisions for these programs are made through legislation. These include the *Canadian Charter of Rights and Freedoms*, the *Criminal Code of Canada*, and provincial adult guardianship legislation. The *Canadian Charter of Rights and Freedoms* states that all people have the right to life, freedom and safety unless these rights override the need for justice (McNaught, 1999). The *Criminal*

Code of Canada enacts the laws that make physical, emotional and financial abuse, and the omission of providing the necessities of life for a person responsible for an elderly person a criminal offence. However, there is often a reluctance of the individual to involve police in family matters, and to have friends or relatives charged.

New Brunswick, Nova Scotia, Prince Edward Island, Ontario, Manitoba, Saskatchewan, Alberta and British Columbia have passed provincial legislation that addresses the protection and guardianship of older persons. However, there is much debate regarding mandatory reporting and the incapability of the elderly to make choices for themselves (McNaught, 1999; Public Trustee Office of B.C., 1999).

Perhaps policy-makers would be wise to take another look at how decisions are made and how these policies affect the older person. "Policy enactment, for lack of a sound foundation in substantive and theoretical knowledge, must be directed toward controlling poorly understood problems and alleviating the consequences – rather than the causes – of a range of mistreatment...(we need to) strike a balance between the state of knowledge about the phenomena in question and common sense" (Sprey & Matthews, 1989, p.60). As Sprey and Matthews point out, the number of cases of elder mistreatment does not matter. It is socially unacceptable to have just one case.

Adult Guardianship Legislation

The Adult Guardianship Legislation of British Columbia includes the *Adult Guardianship Act*, the *Health Care and Care Facility Act*, the *Representation Agreement Act* and the *Public Guardian and Trustee Act*. These four laws have been introduced to help protect and guide adults who may not be able to make their own decisions. Part three of the *Adult Guardianship Act* focuses on support and assistance for abused and neglected adults. The purposes of part three of the act are:

to provide for support and assistance for adults who are abused or neglected and who are unable to seek support and assistance because of physical restraint, physical handicap that limits their ability to seek help; or...other condition that affects their ability to make decisions about the abuse or neglect (Public Trustee of British Columbia, 1999, p. 2).

The guiding principles of the act are self-determination and choice for the adult, most effective but least intrusive support of the adult, and court as a last resort. According to the Act, all adults are presumed to be capable until proven otherwise. As well, all adults are recognized to have different methods of communicating. For those persons who require interpreters, special equipment or someone to speak for them, these accommodations will be made. If a person refuses treatment and is capable of making that decision, their request will be respected. Three government agencies have been assigned to accept and assess reports of abuse, neglect and self-neglect. They are called "designated agencies". Under the public health authorities, they are Mental Health and Community Care; under the Ministry for Children and Families, it is Community Living Services. The RCMP is also designated (Public Trustee of B.C., 1999).

The Public Guardian and Trustee of B.C. (PGT) recognizes and supports the role of the Community Response Networks (CRN) across the province. Included in the literature available from the PGT is an outline of the role of a CRN and network participants. The role of a CRN is "to ensure a coordinated response to adult abuse, neglect and self-neglect" (Public Trustee, 1999, p. 18). Some activities could be providing education and awareness to communities, providing advocacy for abused adults, supporting the staff of the agencies designated to respond to allegations of abuse, tracking the success of the response, and assisting in developing community and agency protocols (Public Trustee, 1999).

It is recognized by the Public Trustee (1999) that "each community is unique, with its own mix of personalities, expertise, organizations and relationships" (p. 18). In this light, members of the network may include anyone in the community who is interested in the workings of the CRN, anyone who is concerned about abuse and neglect, and any community service providers who may work with adults who may be at risk. Some agencies or service providers could be legal services, counselling services, transition houses, family services, ethno-cultural groups, financial institutions, health care providers, social workers, senior peer counsellors, victim services, substance abuse counsellors, mental health workers, or First Nations groups. There are many other possible community members who could be part of the CRN.

Community Response Networks in B.C.

Despite the interest in Community Response Networks (CRNs) across the province of British Columbia and other regions of Canada, it is surprising that so

little research has actually been conducted on the success of CRNs and their role in the community. An evaluation report submitted to the Public Guardian and Trustee of B.C. in February of 2000 emphasized the need for CRNs and their role in outreach, education, prevention, team and relationship building, and advocacy. The Planning Group included representatives of government, committees, agencies and CRNs. What is not clear is whether the vulnerable adult had a clear and significant part in the evaluation.

This report reiterated the role of the CRN in bringing together individuals and organizations to coordinate support and assistance for adults experiencing abuse or neglect in providing the services already mentioned. Although the evaluation reported that CRNs were needed and achieved positive results, specific information on why they were needed or on what the results were or how they were successful was not forthcoming (Public Guardian and Trustee of B.C., 2000). Moreover, now that the legislation has been enacted and put into practice for over two years (enacted in February 2000), the role of the CRNs may have changed or may need improving. As well, each CRN may have a different role to play depending on the community in which it is located.

As the Haldimand and Norfolk Community Response Network in Ontario states, "there is no single model of response that will work in every community" (Second National Conference on Elder Abuse, 2000, p. 2). Because every community is different and has different needs, resources and characteristics, each CRN will be structured in a different way and will provide different supports. The Haldimand and Norfolk CRN was modelled after the CRNs in British

Columbia. In January 2000, this network developed a framework from which the policies, protocols and procedures would be created. It was officially named as a CRN in January 2001 and now consists of several committees that will guide and assist in further development (Haldimand and Norfolk Community Response Network, 2001). It is believed that this case study will assist the CRN in Kelowna in developing its own framework.

The CRN in Kelowna

Because there are no written reports of the CRN in Kelowna, background information has been obtained through the interviews conducted as part of the research for this paper. The following account of the history of the CRN in Kelowna is given according to a representative from the CRN who has been involved since the beginning. (Refer to Concept Map #1 in the appendices for my idea on the connections between the CRN and other groups.) The CRN in Kelowna evolved from the Elder Abuse Committee that was formed in response to the Principles, Procedures and Protocols for Elder Abuse (InterMinistry Committee on Elder Abuse, 1992). Mental health and long term care teams were assigned to respond to allegations of abuse; thus, representatives from these two sectors of community care formed a committee inviting representatives from the community to be involved. Members included seniors, caregivers, service providers and non-profit agency representatives. When the *Adult Guardianship Act* was proposed, the Elder Abuse Committee members agreed that this committee would be in a good position to form the Community Response Network.

A proposal was sent to the Public Trustee Office of B.C. and the Community Response Network was born. The committee members included representatives from mental health, long term care, human resources, seniors counsellors, community health networks, caregivers, regional transit and volunteer agencies. Vulnerable adults were included as anonymous committee members. Due to the concern over confidentiality, adults at risk or who had experienced abuse or neglect in the past were consulted and their opinions and ideas were brought to the table.

In 1998, the first contract was signed with a co-ordinator who would provide services for the CRN committee. This was a learning process for the committee. The contract lasted only three months because their expectations were too high. They realized that the wording of any contract must be clear and concise, allowing for mediation to take place if and when the situation changes. The second contract lasted 6 months in 1999. Much work was done by the service co-ordinator that included education, awareness and public relations activities. The third contract was signed in 2000 with a non-profit agency. This agency offered education, awareness, and public relations services as well as information and referral services for anyone who accessed the agency.

Funding for the three contracts came from the Public Trustee and private donations. When the funding ran out in September of 2000, the CRN committee continued to meet and momentum was still high. However, the committee was "working off the sides of their desks" for about a year and could no longer do the work. Another proposal was submitted to the Public Trustee Office and some

funding was secured. However, the committee lost momentum in September 2001 and no meetings or services were scheduled. The committee is slowly pulling people back in and gaining momentum.

The CRN committee members would like to hear from participants in the community regarding a vision, philosophy, guidelines and structure. The CRN members need to know what the community would like the CRN to look like, where the CRN should be going and what the purpose of the CRN is. This process may assist the community in bringing together services providers, agency representatives, seniors, vulnerable adults and caregivers in order to negotiate an agreement regarding the purpose and structure of the CRN.

The CRN is a small representation of the community including health care and social service providers, seniors, caregivers and interested parties. Guided by the values of inclusivity, full and meaningful participation, flexibility, equality, teamwork, effective and understandable communication, respect, diversity and accountability, this network helps to develop a co-ordinated response to the legislation (Public Trustee of BC, 1998). The CRN helped the community prepare for the enactment of the legislation.

In the past, some vulnerable adults and their caregivers have not received the support and services they feel they deserve from the government, health care systems and other providers. As well, those agencies that have been designated by the legislation as being the first responders to issues of abuse, neglect and self-neglect have been busy formulating internal protocols and have not been concerned with a community process. As I see it, this has contributed to a sense

of mistrust of the service providers by the general population. Thus, the CRN is not sure what to do next.

Other than meeting minutes and workshop notes, there is no research literature to date that specifically focuses on the CRN in Kelowna. However, some historical accounts, evaluations and development strategies of CRNs in other areas have been conducted. In the *Adult Guardianship Act Part 3: Support and Assistance for Abused and Neglected Adults, a Guide for Communities*, the role of the Community Response Networks is outlined, explaining that the "role is to ensure a co-ordinated response to adult abuse, neglect and self-neglect" (Public Trustee of B.C., 1999, p.18). This guide suggests that some activities could include the provision of community education and advocacy, support of staff of designated agencies in carrying out their role, work towards prevention, understand protocols among members, and track how the response is working.

Community of Kelowna

Kelowna is dominated by neo-conservative political and social values as reflected by the political parties that represent the region, by the mayor's actions toward members of the community, by the numerous churches in the city, and by the income distribution of the people. Both the federal Alliance and the provincial Liberal parties are based on neo-conservative platforms as can be seen by the positions that the Alliance takes on issues such as abortion, and the recent drastic cutbacks to social programs that the Liberals have implemented in B.C.

The Federal Alliance Party has a stronghold in the Okanagan through representation in Kelowna by Werner Schmidt, Kootenay-Boundary-Okanagan

by Jim Gouk, Kootenay-Columbia by Jim Abbott, Kamloops, Thompson and Highland Valleys by Betty Hinton, and Okanagan-Shuswap by Darrel Stinson. The Okanagan-Coquihalla riding is represented by former Alliance leader Stockwell Day.

The Provincial Liberal party is represented in the Okanagan region by George Malcolm Abbott in the Shuswap, Bill Barisoff in Penticton-Okanagan, Sindi Hawkins in Kelowna-Mission, Kevin Krueger in Kamloops-North Thompson, Claude Richmond in Kamloops, Sandy Santori in West Kootenay-Boundary, Rick Thorpe in Okanagan-Westside, John Weisbeck in Kelowna-Lake Country.

According to the phone book yellow pages there are over 100 Christian churches in and around Kelowna. Most of these religions, which include Roman Catholic, Pentacostal, Anglican, Jehovah's Witness and Evangelical, are based on a patriarchal and right wing conservative belief system. The United Church is one that is a bit more egalitarian and tolerant of diversity. With this many right wing believers in the area, it has an impact on the politics and values of the community.

Because the majority of the community members are of the Christian faith, many fundamental beliefs of the patriarchal hierarchy are imbedded into all aspects of the community, such as institutions, organizations, politics, social agenda and so on. This influence of the traditional, rigid restrictions on the roles of women legitimizes and reinforces oppression of women and other groups. As well, many men are threatened by competent women (Cruikshank, 1990). The

"old boys network" is still apparent although many women are making strides to address this issue.

I have observed that the people of Kelowna are sometimes artificially nice and pleasant with each other, trying to avoid disagreement and keeping their differences hidden. However, sometimes, the people of the community resist change by bringing their differences out into the open in an attempt to erase them rather than to address them. For instance, in 1997 the mayor of Kelowna refused to proclaim "Gay Pride Week" saying that it was not appropriate for him to endorse one group more than any other. However, he regularly passes proclamations for other groups. The Okanagan Rainbow Coalition filed a Human Rights complaint against the mayor and the city in 1997. This resulted in the mayor getting a "slap on the wrist" and told not to do it again (Daily Courier, 1999). The mayor stated that he learned a valuable lesson, but that he is not anti-gay.

According to the Economic Development Commission of the Central Okanagan Regional District (1999), the income distribution in Kelowna shows that almost 35% of the population make more than \$50,000 per year, 24.5% make between \$30,000 and \$49,000, and 40.7% make under \$30,000 per year. The average annual income for a person in Kelowna is \$45,546 which has been lower than the B.C. average since 1981.

As stated by the commission, "some of the reasons for the lower than average income as compared to B.C. are as follows:

- A larger population of retired people that do not have employment income.

- A higher than average proportion of smaller, non-unionized companies.
- A higher proportion of the labour force that is self-employed. Often these are very small businesses with high expenses.
- The lifestyle attracts a higher percent of Social Assistance Recipients than some other areas" (Economic Development Commission, 1999).

It is not clear why the commission makes this last statement, however, it is true that many people move to the region because of the climate and the lifestyle. Some people who are new to the valley come to pick fruit or come looking for jobs that are simply not available.

The average household income in the Central Okanagan is gradually catching up to the B.C. average by growing 10.7% between 1991 and 1996 compared to 8.0% in Canada and 8% in B.C. over the same period. While the median income for individuals in 1996 (\$18,284) was lower than that of B.C. (\$19,982) and Canada (\$18,891), the average household income has increased at a faster rate (10.7%) from 1991 to 1996 than B.C. (8%) (Economic Development Commission, 1999).

Although many people living in Kelowna refer to the locality as a "community", this writer believes that it is not a true community, but rather a pseudo-community moving into the stage of chaos (Peck, 1987). As Peck (1987) suggests, "[f]ighting is far better than pretending you are not divided" (p.94). In order to have a true community, says Peck, these differences are to be celebrated; diverse groups are to be included; and, there must be a willingness

for these diverse groups to coexist (p.61-62). The mayor of Kelowna is fighting, but is pretending that the community is not divided.

Many women still face barriers to full participation in the decision-making aspects of the community. Challenges that women have to attaining and maintaining political power include poverty, safety issues, accessible services, full employment status, equal pay for work of equal value, disabilities and inadequate health care services. Moreover, there is an underlying distrust of the decision-makers, their philosophy and their political agenda.

According to Peck (1987), "decisions in genuine community are arrived at through consensus, in a process that is not unlike a community of jurors, for whom consensual decision making is mandatory" (p. 63). True community can be encouraged by bringing diverse groups together and emphasizing capacity building; by empowering people through consciousness-raising and self-awareness; by encouraging and enabling people to help themselves; and, by emphasizing inclusivity, capacity building, empowerment, conscientization, and nurturing diversity (Kretzmann & McKnight, 1993; Peck, 1987; Reisch, et al, 1981).

Callahan (1997) suggests that the media has helped to distance many women from the feminist movement by portraying a certain stereotype of feminists. By showing that feminists are caught up in a belief system that does not take into account the individual differences of women, the media has helped to pull women apart instead of drawing them together in the struggle against inequities in the systems of society. As Callahan suggests, it is "not the feminist

credentials of the participants but the desire to work with women on their behalf to improve their collective lot" that distinguishes one project from another (Callahan, 1997, p.199). The challenge, she says, is to discover the diversity of all women and appreciate how women can oppress other women while understanding that all women are struggling against the patriarchal society. However, this may not be the case in all places. It could be that many women in Kelowna find a common cause with the wealthy men that they perhaps

Reisch et al (1981) suggest that social workers have been separated by the dichotomy of micro versus macro practices. By dividing social work into two distinct categories of activities, there has been "a mis-reading of the role of social work practice within the political-economic environment" (Reisch et al, 1981, p.189). They go on to say that social work should attempt to link the economic, social and political forces with individual, family and community needs. We need to build bridges between the client and the worker, and to re-establish a linkage between social treatment and social action (Reisch et al, 1981). By introducing the concepts of empowerment, conscientization and animation, we can develop a new focus for practice.

Research Study

This paper is a case study of the CRN in Kelowna. As a qualitative study, it offers an interpretation of data collected through a focus group and three individual interviews, and suggests implications for practice.

The CRN is formulating and discovering what their role in the community should be after the inception of the *Adult Guardianship Act*. The purpose of this qualitative research project is to assist the CRN in defining their role in attempting to work towards facilitating effective development of community resources to support and inform service providers and caregivers of vulnerable adults.

The research will help the CRN to focus on and explore options that the committee can consider in supporting vulnerable adults and the community. The objectives of the study are: to assist in the development of CRN's in the province of B.C. as recommended by the *Adult Guardianship Act*; to act as a catalyst in assisting the CRN in Kelowna to move forward; to solicit information from CRN members; and, to formulate information into a report that may assist the CRN in developing its role in the community.

Rationales for the study are outlined under professional, practical and personal. Professionally, it is hoped that an in-depth look at the role of the CRN can assist the committee in supporting the helping profession in its efforts toward improving services towards those covered by the *Adult Guardianship Act*. Practically, this initial research study may assist the writer and others in providing support to vulnerable adults. On a personal note, this research is important to

the writer because of feeling passionate about working with vulnerable adults in preventing and reducing harm to this segment of the population.

The main research question was what is the role of the CRN? Sub-questions included what did the CRN do in the past and how effective was it? It is assumed that the CRN does have a role in the community, but it may not be what it was in the past or what the committee members had hoped it would be. By hearing from various members of the CRN committee after a year of stagnation, it is assumed that a new and perhaps different profile of the CRN may be forthcoming.

The themes that emerged from the data point to and are consistent with the feminist principles of inclusion, empowerment, education, and a focus on strengths. For instance, the group suggested educational forums, the inclusion of vulnerable adults on the committees, advocacy initiatives and community partnerships. The group seems motivated to move forward with their ideas. This case study will hopefully divulge information that will be useful for the members of the committee to explore their new role(s) in the community.

The following definitions are being used to provide an understanding of the research and the concepts that form the foundation of the study:

- *Vulnerable*: seniors and persons living with a disability who have been marginalized, unable to seek assistance due to physical restraint, physical handicap, illness, disease, injury or conditions that affect a person's decision-making ability (CRN spokesperson, 2001);

- *Abuse*: the “deliberate mistreatment of an adult that causes the adult physical, mental, or emotional harm, or damage to or loss of assets” (Public Trustee of B.C., 1999);
- *Neglect*: “failure to provide necessary care, assistance, guidance or attention to an adult that causes the adult, or is reasonably likely to cause within a short time serious physical, mental or emotional harm, or substantial damage to or loss of assets” (Public Trustee, 1999);
- *Self-neglect*: “any failure of an adult to take care of himself or herself that causes, or is reasonably likely to cause within a short time serious physical or mental harm, or substantial damage to or loss of assets” (Public Trustee, 1999).

Method

Data was collected from two main sources – a focus group and three individual interviews. This project was approved by the Ethics Review Board of the University of British Columbia. The names of the participants are kept confidential. Possible risks considered are that the participants may have felt uncomfortable about answering some questions due to political or personal issues. Some practitioners who are employees of an organization or agency in the community may have felt that divulging information about internal or community politics may put them in a position of vulnerability. To maintain confidentiality, all identifying information was removed from the data.

Focus Group

A purposeful convenient sample of six participants was recruited to participate in a focus group. Adults over the age of nineteen years who have been involved with the CRN or who are affected by the Adult Guardianship Legislation of B.C. were chosen. Anyone who did not meet the criteria was excluded. As well, anyone who was not a volunteer and where informed consent had not been assured was not included. Anyone who decided to withdraw from the study before or during the process was excluded. Any vulnerable adult who is not mentally competent was excluded.

Initial contact and an invitation of voluntary participation was provided by letter from the CRN committee to its members giving contact information about the principal investigator and co-investigator. A flyer was sent to all those who wished to attend the focus group. Written approval by the CRN committee was

obtained in order to conduct the research and written informed consent from all participants was received. The participants were assured that if they chose to withdraw at any time, they could do so without penalty or repercussion and that all information was confidential and that debriefing after the interviews was conducted.

A semi-structured focus group took place at a convenient location in central Kelowna. The discussion was approximately two hours in length with a break halfway and refreshments were provided. By consent of the participants, the focus group discussion was taped on audio-cassettes for the co-investigator to transcribe at a later date. Verbatim transcripts of the tapes were not reviewed by the participants, by their choice. The interviewer took notes during the focus group and themes were written on a white board during the discussion for all participants to see and refer to. Open-ended questioning initiated the interview in the anticipation that the participants would discuss their viewpoints and feelings in a full and comprehensive way.

Of the six participants, four of the individuals had past direct experience with a CRN either by volunteering on the committee in Kelowna or assisting in forming a CRN in another location. The remaining two people were invited to participate as representatives from community organizations who would have an invested interest in the CRN. Of the six participants, three were employees of one of the designated agencies assigned by the Public Trustee under the act to respond to allegations of abuse; two were employees of community social service agencies and one was an employee of a career placement agency. All

participants were women. Five of the women were between the ages of 50 and 60; the other woman was in her twenties. All participants were well-educated (post-secondary degree or diploma) and had several years of experience with the vulnerable adult population.

Individual Interviews

As with the focus group, a purposeful convenient sample of participants was recruited to participate in individual interviews. Four female adults over the age of nineteen years who have been involved with the CRN or who are affected by the Adult Guardianship Legislation of B.C. were chosen. However, one person decided that their scheduling did not allow for the interview to take place in a timely manner and decided to withdraw. All three interviewees were volunteers and were mentally competent. Two of the participants were employees of one of the designated agencies and the other was an employee of a provincial agency that works with vulnerable adults. All participants were well-educated (post-secondary degree) and had many years experience working with the vulnerable adults population.

Initial contact and invitation of voluntary participation was provided by letter from the CRN committee to its members giving contact information about the principal investigator and co-investigator. The volunteers who chose to be interviewed contacted the co-investigator by telephone or email to set up arrangements. Written approval by the CRN committee was obtained in order to conduct the research and written informed consent from all participants was received. The participants were assured that if they chose to withdraw at any

time, they could do so without penalty or repercussion and that all information was confidential and debriefing after the interviews was conducted.

Three separate semi-structured individual interviews took place at a convenient location in Kelowna. Each interview was approximately one hour in length and was tape-recorded by approval of each participant. The interviewer also took notes at the time of the interview. Each interview was subsequently transcribed onto hard copy. The tapes and the transcripts are kept in a locked filing cabinet for which only the co-investigator has the key. Verbatim transcripts of the tapes were not reviewed by the participants by their choice.

The first participant had been involved with the CRN from the beginning when it was the elder abuse committee. The second participant had been involved with another CRN in a different location when it was started from the elder abuse committee in that location but also had some insight as to the workings of the Kelowna CRN. The third interviewee had been somewhat involved with the CRN in Kelowna but had also attended CRN meetings in other locations in B.C.

The research method was founded on a feminist view that listening to people tell their stories and listening to their interpretation of events would elicit valuable information for the case study. By hearing what women have to say about their involvement in the CRN and their client's experiences, the study would create some meaning for the researcher and for the participants. This in turn would assist the CRN to explore its role in the community.

Data Analysis Procedures

The taped focus group and individual interviews were transcribed and analyzed. The content of the transcripts was interpreted using a literal and verbatim translation that indicated the presence of several themes regarding the direction in which the CRN members would like to take the organization. This verbatim translation can be analyzed using feminist theory. This reveals the presence of covert themes arising from the context in which individuals were located. It also reveals gender issues. Consequently, the analysis adds texture to the data that is important to understanding what the participants said and why. The following describes how the focus group and the individual interviews were analyzed and how a feminist analysis was applied.

Focus Group

In accordance with the principles and steps recommended by both Carey (1994) and Kreuger (1994), the following analytical procedures were adopted. Using the transcripts as the source for information, the discussion was interpreted by drawing out overt and verbatim themes. By looking at the actual words that were spoken, several themes were seen to emerge. As well, covert and underlying themes were identified given the political and work-related interests of the participants. Under each of these themes, specific items were categorized. An attempt was made to understand the whole picture in relation to the particular pieces and to understand the pieces in relation to the whole. A more holistic understanding is possible using this approach. Data analysis was

ongoing throughout the data collection. Direct quotes from the interviews have been used as much as possible to support the findings.

It was difficult to break up the narrative of those interviewed because it flowed from one idea to another without much encouragement from the researcher. Most participants had worked together previously on the CRN and seemed comfortable discussing the ideas. They seemed to have no difficulty in building on one another's ideas as well as challenging, rather than confronting, each other. This process is characteristic of communication among women.

Once the group discussion had begun, little prompting from the facilitator was needed to elicit information and opinions. This could have been partly because of the participants' understanding of what the purpose of the group was to be before the study began, as well as a shared value system. For example, after one participant described her idea of the structure of the CRN another participant asked her for clarification. The first participant shared her view by expanding on her explanation. "You may have volunteer working groups that would set up a block program, that sort of thing. So do you see the CRN purpose...these responders could bring their cases to as one and the same or... No. See I see the CRN as being the advisory body..."

Individual Interviews

As recommended by Creswell (1998), this case study has been analyzed using categories, patterns and direct interpretation of the interviews in order to arrive at generalizations that may help direct the CRN in discovering what its role

will be in Kelowna. As in the focus group analysis, the interview transcripts have been used to guide the discovery of the findings.

As in the focus group, the individual interview narratives were difficult to break up. The narratives flowed easily. Each participant expressed opinions and ideas without much prompting from the interviewer. This could have been partly because the interviewer had built rapport and trust with the participants prior to the interviews through previous working relationships. The participants involved in the research knew beforehand the purpose and focus of the study. This is consistent with a feminist framework for research. During the interviews, the participants were allowed to speak freely without interruption.

The participants of both the focus group and the individual interviews were invited to review the transcriptions of the interviews and the findings, and to clarify their perceptions as they relate to the interpretations and themes outlined in the research. However, none of the participants chose to do this. Once the findings have been reviewed by me, the participants will be invited to peruse the information and make recommendations on who should have access to the findings and how this should take place. If this case study is to benefit the CRN committee, the community and vulnerable adults, it would be advantageous to these groups to have the study findings available in order to improve services to the community.

Feminist Analysis

According to Reinharz (1991), feminist content analysis includes examination of both the text and the processes. As well, Reinharz explains that

one type of material that is used as an object of study for feminist researchers is that of narratives and visual texts. The transcripts of the focus group and the individual interviews used in this study can be deconstructed and the processes can be analyzed. Therefore, although overt and verbatim themes were evident in the transcripts, a feminist analysis will help to explain the themes and processes in terms of power, traditional societal structures, dichotomies and feelings. In the following section, after each of the focus group and individual interviews findings, a feminist analysis of the content is included.

My study and subsequent analysis included qualitative approaches regarding the engagement with the participants and the understanding of the things they said. There is a connection made between the participants' narratives and my intuition, feelings and beliefs regarding the power struggles that take place in a traditional patriarchal structure.

Presentation of the Findings

The following section will outline the findings of both the focus group and the individual interviews that were conducted. It was discovered that more data was forthcoming from the individual interviews than from the focus group due to the interviews being of longer duration – over one hour each, totalling over three hours - compared with just less than two hours for the focus group. The individual interviews created a freer atmosphere for the participants, allowing them the comfort to express their ideas more easily. The overt and verbatim themes are discussed for the focus group transcripts and the individual interview transcripts. A feminist analysis follows each of these discussions.

Focus Group

Interpretation of the transcripts of the discussion revealed several themes. Overt/verbatim themes were related to structure, values, context and tasks. The following section will provide quotes from the focus group that provide substance for the findings. The themes are then outlined. (Refer to Table #1 in the appendices for classification of the themes.)

Facilitator: So you were talking about a community vision...

Group member: I see the role of a steering committee as that vision that kind of a common thread that pulls everything together and looks at the big picture not as designated agencies.

Group member: Now in my mind, the CRN steering committee if you will, would oversee that so they would appoint as _____ said, an advisory committee made up of those people with confidentiality agreements....I think the people who need to be on the steering committee is those that are well connected in the community...not the ones involved in the day to day activities but the one who have a vision, have a passion for the issues around that and that can remove roadblocks that have the power to. And most steering committees that you see are people that are very influential that can remove the roadblocks, the problems that people bring to them. And they're the ones that can do that, not do the work, but again involve the community. You may have volunteer working groups that would set up a block program, that sort of thing....

Group member: So do you see the CRN purpose in this example, the CRN steering committee and what I'll call a multi-agency case review committee that these responders could bring their cases to as one and the same or...

Group member: No. See I see the CRN as being the advisory body that would if for example... a block program they would perhaps appoint somebody to pull that together and report back. So it's almost like they're a ... I don't like to use the word controlling body...but again there's got to be accountability to someone because right now I don't think there's ... the region have accountability to certain people, the RCMP, Victim's Assistance...all of those people are accountable to who.... It just kind of... There is no one body that is unbiased that basically will look at it objectively and I think that is where CRN would play a role. To monitor all of that and kind of...

Group member: I think the other role there is too - and that was always from the very beginning - that the CRN is to be able to identify where there is gaps where people are falling through the cracks, that would be covered under this legislation and unless that was sort of an outside control kind of a body, that would not really be possible because certainly we can't identify for ourselves who is falling through our cracks. That's not appropriate right.

Group member: I mean these people here that are - talking case workers - are already dealing with existing and what you're working on is the preventative. So as you work more on the preventative you're going to free up to provide more resources to them to work with on their existing cases so then there will be more interagency inter resources shared, etc. if we can create together from the other area.

Group member: That's going back to what you said if you get it more community-based where you've got people looking out for each other, that's going to take the load off of them.

Group member: And we need seniors on those committees.

Group member: And there's lots of people who'd love to volunteer.

Group member: And it's people from the community, it doesn't have to be you know those of us that are involved in ...

Group member: Quite the opposite...

Group member: Yeah, I would say...

Group member: The other big role I continue to see for the CRN once there is actually a sort of identifiable body in place which there is not now is this whole overarching role of community education. Like uh I really think that that's been quite wonderful work that's been done through the 90s around this but that's really ground to a halt. And it's the ongoing work that needs to be done because players change, people in banks change, people in designated agencies change, people in community organizations change and so it's going to have to be an ongoing effort to do that community-based education. And perhaps really have the idea of doing community based education to the general public but also offer education and training to volunteers that perhaps work out of Seniors Outreach to have some specialized training for those volunteers to maybe offer the training to seniors counsellors that a lot of the community based resources have ongoing training around those abuse issues as well. And it doesn't have to be a CRN coordinator that puts that on but it has to be someone to organize this. And then we've got lots of resources in the community and we could go out and give little things here or there it's just that we really can't organize that.

(Later)

Group member: And again a steering committee quite often will have sub-committees and so you may have an education committee...

Group member: Yes...

Group member: Again they are accountable back to the steering committee you may form an advisory committee you may have committees that are comprised of volunteers that will actually...I mean what better way to sell your story than to have a senior that's been a victim of abuse and some of them would love to go tell their story and it just brings credibility to it.

(Later)

Group member: I really would like to see the CRN cultivating an attitude of respect for the senior population in general, you know, there's some nurturance of that coming out of that and sort of building awareness among would be perpetrators because ultimately if we can get to those people um and say look you know we know you are working hard to look after your mom but it doesn't entitle you to sort of get in to that overblown sense of entitlement that can so easily grow in these stressful family situations. You know, so family education around abuse issues, how does it start, what does it look like, what is happening to me. You know, what's happening between me and my aging parent or me and my family.

Group member: So it's up to us in our community to do that education because it's there you know, they can put out all the resources they want but somebody has to disseminate that information.

(Later)

Group member: Oh, I agree...too to get to the grassroots and how do you get there. And one thing we've been for many years is trying to infiltrate the neighbourhood associations. Of course, their interests are often, well they're varied and depending on they tend to be into more on city by-laws or whatever and that but yeah infiltrating that or community centres in neighbourhoods. They kind of have a more neighbourhood kind of approach.

Group member: No, I agree...it doesn't mean anything really until the neighbourhoods themselves are open to it.

(Later)

Facilitator: So, you're saying it's two-fold, it's not just the action, it's the structure.

Group member: Yes. The worst thing you want to do is to let people know and then not be able to react to it.

Group member: Yeah...yeah

Group member: Which is I think what really happened during the 90s before the legislation was in play, we did all this education and let everybody know and then it kind of fizzled out because nothing ever happened, right.

Group member: Yeah, right..

Group member: Yeah....

Group member: You'd know who to phone or you'd know who to contact, we have all the stuff all into...the community themselves is that they knew there was a problem but they didn't know what to do about it. So the end result was most of the time they did nothing. That was their decision.

Group member: Yes...

(Later)

Group member: I really think that this is a community kind of based agency like a CRN that should be the contact point and that should be able to pull the community together and say we'll take some of this and try to develop some legal advocacy resources in Kelowna and there is a huge need. And it's that kind of developmental thing that I would see the CRN doing as well.

Group member: Yeah...

Facilitator: So... actually doing proposals...

Group member: Well, just being a contact like just like _____ would be in Vernon right. To just sort of be a contact point, not even doing a lot yourself but being a contact point that is able to connect those resources together right. To maybe even call... the proposal has already been done by the provincial organization right, but maybe even to call a meeting of appropriate community groups to start supporting this. This is really I think where the contact point needs to be. Facilitator, I think that's really the word that I am looking for.

(Later)

Group member: Well, again I think part of it is we have funding now to hire a coordinator and I think that part of their role like _____ was saying to be aware of what grants are being allocated to what agency and try and form partnerships with them so that it would give us that...to certainly write proposals and say well, maybe, um jointly we can work together, because that really is the way of the future is partnering with other organizations so we are not duplicating services. Um but I don't see the steering committee no, I think it needs to be the coordinator, someone that really has the time to be aware of what's happening in the province what's happening with government, you know that has

Group member: The steering committee will be volunteers people who already

Group member: Personally I think there should also be representation from all the organizations that represent some of those consumers of the legislation like the Head Injury Society, maybe the Alzheimer Society um and some of those, I think there should be representation from those groups. Um just so that this is actually modelling on how to pull the community together around those adults who are the most vulnerable.

Structure.

Under the theme of structure, the participants talked about a paid co-ordinator, a volunteer steering committee or overseer, a volunteer advisory or review committee, sub-committees or working groups, and other volunteers. The paid co-ordinator could act as a facilitator to bring together community members

in a forum format to assist in structuring the CRN. They talked about having a steering committee comprised of volunteers and several sub-committees. The steering committee would act as an overseer and the sub-committees would be working groups that could be involved with the actual tasks of the CRN. As one person put it, "a steering committee will quite often have sub-committees".

Another suggested: "you may form an advisory committee...committees that are comprised of volunteers". They discussed the need for an advisory or review committee comprised of professionals from the community, such as a lawyer, a police officer, a social worker and so on, who could assist other service providers in reviewing difficult cases or who could act as information sources. The structure that was described is consistent with a traditional hierarchical and patriarchal structure, giving prominence to professional qualifications and credentials that are, for the most part, determined within professional and educational systems dominated by male power and values.

Values.

When the participants spoke of values, they included the need for accountability and credibility, confidentiality and respect, community-based and preventative focus, and an unbiased and objective approach. As one person said, "there's got to be accountability". They talked of objectivity, respect, confidentiality, prevention and a community-based initiative. For instance, the participants used phrases like: "we've got to look at it objectively"; "cultivating an attitude of respect"; "what you're working on is the preventative"; and it needs to be "more community-based where you've got people looking out for each other".

Context.

The context theme seemed to be evident when the group talked about community and family, resources and funding, legislation and legal issues, designated agencies, and grassroots and multi-agency perspectives. As they discussed the opportunity for “family education around abuse issues”, they agreed that “we need to take the onus on ourselves and our community” and the importance of getting “to the grassroots and how do you get there”. They mentioned the desire to “develop legal advocacy resources”, “connect the resources together” and to know “what grants are being allocated to what agency and try and form partnerships”.

Tasks.

Given the foundation of the above themes, the next theme was seen to be tasks. In this category, the group saw the CRN overseeing partnerships, pulling things together, writing proposals and grants for funding of the service contracts, conducting forums, offering education and training, providing support and advocacy, and acting as a contact point and as a facilitator. Participants suggested the CRN could offer “information and support to health and social care practitioners in the community”, act as a “common thread that pulls everything together and looks at the big picture”, and “not even doing a lot yourself, but being a contact point that is able to connect those resources together”. They also saw the CRN as a group that could “identify where there is [sic] gaps where people are falling through the cracks”. Through their experience in working in the community, the participants discovered that more information and education for

the community regarding abuse and neglect would be beneficial in assisting those who may be vulnerable to harm.

Some participants represented government agencies and may have had some influence over the discussions in the focus group in that they were expressing certain political viewpoints that could influence the future of the CRN. As representatives for one of the designated agencies, these participants are working for an organization that has a mandate to respond to the allegations of abuse and may not want a community-based group to tread on its "territory". Moreover, as one person suggested, it wasn't really their place to point out cracks in the system because they worked for the system.

The roles of the CRN that were suggested in the focus group reflect the fact that participants had varying backgrounds and varying experiences with the CRN. The participants were a diverse group of people who have different political viewpoints and view the process through different paradigms and interests. However, all participants were interested in focusing on the best interests of vulnerable adults. For instance, the language they used indicated inclusiveness of the people at the table as well as the community at large. They referred to "we" and "us" rather than "I" and "them" which seems to reflect a similar value system.

Feminist Analysis of the Focus Group

All members of the focus group were women who worked as professionals in community and health care agencies. All were involved with the CRN at some time and in some capacity. At the time of this study, there were no men involved with the CRN in Kelowna. Is this due to the emphasis on women as "helpers" in

Canadian society, who not only work outside of the home and care for family members but who also volunteer in the community? As volunteers committed to community, the emphasis on collective – as opposed to individual – values is also worthy of note. The “enterprise” of the CRN is a profoundly different one than a business undertaking where individual initiative and competition are values seen to be important to success. We might ask: “Why are activities characterized by sharing, co-operation and a community focus dominated by women as participants?”

The participants are committed to the collective rather than to the individual or institutional organizations. For instance, they speak of involving the community and of being “community-based”. Although they have a passion for the work they do in the community, they continue to think along the lines of a patriarchal structure. For instance, one participant states:

I think the people who need to be on the steering committee is those that are well connected in the community...not the ones involved in the day to day activities but the one who have a vision, have a passion for the issues around that and can remove roadblocks that have the power to...involve the community.

They also use words like “education”, “respect”, “nurturance” and “building awareness”.

The participants go on to discuss ways in which the CRN can develop a more traditional hierarchical structure than these words indicate, such as a committee that oversees the sub-committees. It seems, then that the participants, committed to inclusion and grassroots organization – commitments consistent with what feminist analysis would identify as values common to the

ways in which women organize - have nevertheless assumed the necessity of organizational structures that are hierarchical, potentially elitist and seemingly at odds with these values.

The participants speak of individuals who work for bureaucratic organizations who have the power to break down barriers and have a passion for work with vulnerable adults. Another person states that they do not want to make trouble by pointing out who may be falling through the cracks. She says: "we can't identify for ourselves who is falling through our cracks. That's not appropriate, right". This statement works against the feminist ideology that looks at breaking down barriers and changing the patriarchal systems by working within those systems to make changes. The participant was concerned with her mandated job description and what she has to do to survive in the organization. She seemed to be concerned about "rocking the boat" and its affect on the credibility of the CRN as well as on her function and her future with the organization that she worked for. It illustrates a common dilemma and conflict between doing what you think is right and doing what you perceive must be done to survive – an example of how power warps and distorts the way women would otherwise do things. There is evidence here that the participant feels conflict and tension between what she would like to do and what she has been sanctioned to do.

Another participant said:

See I see the CRN as being the advisory body that would if for example...a block program they would perhaps appoint somebody to pull that together and report back. So it's almost like they're a I don't like to use the word controlling body but again there's got

to be accountability to someone because right now I don't think there's the region have accountability to certain people, the RCMP, victim's assistance.

So, although they don't want to call it "control", they want to be in control.

This is not consistent with a feminist ideology that would encourage the sharing of power and control. The women in the group seem to lack the power – political, individual or organizational power – to make the changes that they want and seem trapped between their ideals as women and a perceived need to create structures and relationships patterned after the hierarchies to which they relate. There are issues of power in relation to other institutions in the region that act as limiting factors on what these women can do.

Most of the women are working for organizations that are traditional patriarchal institutions, such as the health region, that would be based on a medical model of bureaucracy. Similarly, the RCMP victim services program is influenced by traditional bureaucratic and hierarchical forms of organizational structure. Therefore, the struggles of a grassroots volunteer organization such as the CRN, driven by women, will have difficulties in being recognized as a legitimate entity and to have the power to make changes in the community if it organizes in a way that challenges or questions the status quo. The patriarchal structures that have been sanctioned and strengthened in the region for many years are not about to move over and make room for them. So, although the participants in the focus group talk about inclusion and community, they also keep coming back to proposing a patriarchal structure for the CRN. They quite understand that the people who have available funding also have the power to

distribute the funding according to specific criteria, such as structuring the organization in a particular way. They must meet these criteria in order to receive the funding they want to expand and organize. What is missing from their conversation is recognition and questioning of the legitimacy of these structural realities. This suggests that these structures are part of a "taken-for-granted world" that has successfully been internalized as a "normal" way of doing things and are therefore not subject to critical analysis.

One participant states: "there is no one body that is unbiased that basically will look at it objectively and I think that is where CRN would play a role". This use of the concept of objectivity runs contrary to the feminist value of making personal issues, political ones. It assumes that there is some conclusion or fact outside of personal experience that is more valid than what can be derived from personal experience and one's personal values. This denial of the importance of subjectivity breaks the relationship between the personal and the political – a foundational relationship for the development of feminist theory and action.

The women unwittingly became pawns in the system despite the values they have expressed. They have been forced by the Ministry of Health and the Public Trustees Office – traditional patriarchal structures – to organize a grassroots organization. Subtle influences that societal structures impose upon individuals have affected the CRN members' decision making. The women seem not to realize that they have been indoctrinated into thinking in a traditional way and in organizing in a traditional manner.

Individual Interviews

The patterns that emerged from the individual interviews were similar to the focus group in that they can be categorized under the same headings of structure, values, context and tasks. (Please refer to Table #2 in the appendices.) Although the patterns were categorized, it was evident that they could be deconstructed using a feminist analysis. The following section outlines the categories under the headings mentioned above and provides a feminist analysis of the content. Excerpts from the narratives will be given, followed by an examination of the themes.

Interview #1:

Interviewer: So what was the transition like from elder abuse to adult abuse as far as the committee was concerned?

Interviewee: It was confusing because we really had to look at who our committee members were. At that time, our committee members were comprised mainly of seniors. And when we were looking at a steering committee for the CRN we had to look at a more inclusive committee that would include adults that have a higher risk of being abused or self neglecting

Interviewer: So what happens next?

Interviewee: Well, so much has changed. We are so much wiser now three years later. In the beginning when it was called the CRN, we were like little verbs, waiting to respond and now we realize it is more like a support network. So we are like little nouns trying to hold people up and give them identity. I think that is the biggest change, the whole understanding of what the CRN would do has now come to something that I understand, and that being supportive to those people who do the investigation. Supporting the designated agencies in this community who are mental health, Ministry for Children and Family-CLS, community care. Supporting them in the work they do. Support those designated agencies by trying to increase awareness about abuse, neglect and self neglect. I think mainly we have to promote a zero tolerance by trying to get as much info as we can and by building relationships. It's such a simple thing to say "build relationships" but it's the hardest thing I've done in my life is building relationships. And not the kind of relationships that I build everyday where I have the power and I'm helping you and you need me. But those kind of relationships where I am sharing the power and I'm grateful for anything you can contribute. I want your participation. I've realized over the past three years – it isn't about what we will become in the next five years as the CRN, it's the process that we've gone through to get there. Because if we've done it at all, we have to do it by talking to people we've never talked to before by sitting down and trying to work out ways that we can work with different groups in the way that group tells us is the best way to work with them.

(Later)

There was an end date of the contract and we carried on until then. Unfortunately when the money ran out, the motivation was high. We still felt that we were able to accomplish some of our goals and our number one goal was pretty much based around building relationships in the community. So we continued to meet, we just couldn't hire, so as a group the steering committee tried to do it off the sides of our desks. We did that for about a year. It was pretty close to a year when we were finally told that there would be another chance to apply for another proposal. We applied throughout the three years to the city and different groups. We were one of the lucky ones, because we managed to keep going on \$7,000 for 3 years and it was mainly through donations and monies that we were able to raise.

Interviewer: What the hardest part about building that relationship?

Interviewee: I think the hardest thing is bringing together people realizing that you don't have to have them together all at the same time. That there is a time where it's good to bring certain people in then not. It's got to be productive. I really think that the big meetings are not productive. I think that on some level, comfort is a really big thing, acceptance is a really big thing and you have to meet people where they are. And I think that if I could change anything that we've done, I now see CRN as more of an outreach group not bringing people in to us. The only reason why I think that is because some of the small groups that we would go to as a speakers bureau and go out to as some of the seniors centres is that people are actually meeting you in their own complex. There might only be 10 or 12 of them there and those have been some of the best conversations we've had. I learned more about people in those conversations and those are really a lot of our people that have come to our groups. I think we have to do that with the other areas like the adults who are hard to reach. I don't think it's fair to them to bring them into this room and to sit them down at the table with someone who is wearing a suit and a tie and expect them to feel equal. We go to where they are and we try and just look and listen and ask them how they see us. How they see themselves as being part of this group, so it can be helpful to theirI think if we want to see people of peers, we have to get out there. This is where I think we have gone astray. That's why I really believe the process is everything. The process is where we are going to give information and where we are going to learn. If we can just hang in there, I think....we may not have a CRN, but we will have a stronger community.

Interviewer: Do you want to go from grassroots to formal structure?

Interviewee: I would hate to see that happen, hate to see it get formal. Because adult abuse and neglect is... you have a hard time hearing about it anyway and if you make it too rigid, you're never going to hear from them. It has to be simple. That's why I struggle with the CRN. I'm not sure I like the idea. I always have struggled, I know it's a beginning and you can never look at beginnings. They're really just.... The point where you have started, you have to value where the journey is. But what I hope will come out of it is not so much a CRN but what we'll have is a really good resource centre. Where we will be a part of the resource centre, offering a little bit of education on what particular area but we will be another resource and we are part of the community. I don't want us to be set apart from the community because we should be so integrated with the community that you wouldn't know we are there...I think I would like us to be part of a big resource centre and what we could contribute to it might be to help all the other bits and pieces of it to develop protocol on the best way to access support and assistance. I would like it to be like the telephone book, someone could come and look for a place.

Interviewer: Is there anything else you would like to tell me about the CRN?

Interviewee: I just have a lot of passion for it. I've had it right from the start when I worked with adult abuse in Alberta. It's just there. I just have so much hope for the community to be able to figure it out with a little help. I think education is key as goofy as it sounds, it comes down to that. I think if you can educate people, and develop a relationship with that vulnerable portion of our population, and get some advocacy going.

Interviewer: So how do you do that? How do you provide education?

Interviewee: Well, I think that, I hope that is one of the main ways the CRN could have a role. Be able to make yourself available to people. I think we have a lot of work to do. How people get educated now, how they learn now. Financially we have been able to hook up using the media. That's one of our goals this year is to try and use the media and use it in a format that's useful. Maybe a story telling format and look at publications... I'm thinking of a lot of different areas that we can look at. Like sitting in Starbucks and reading a little pamphlet. You have to start everywhere I think there are lots of places we can look at once we get into it.

Interview #2

Interviewer: So what was the focus for the group? You mentioned education. Was it education and awareness?

Interviewee: It was education primarily and we discussed the awareness and interestingly enough I wanted to be able to put out info around the concept of elder abuse, what is elder abuse. We had some pamphlets that were we used from before and they were put in different locations like the seniors drop in centre, doctors offices and whatnot... So even though it wasn't being talked about publicly, what I learned was that these people knew exactly what I was talking about. And so it was opening those doors to talk about both on a general level as well as having someone to talk about it right now. And that seems to be a consistent theme in most communities, that is a very similar scenario. That a person would come if invited and participate in the presentation, but always afterwards, some needed that extra information on a personal level. They've all got stories about a neighbour or something and that's consistent.

Interviewer: So maybe a need for more education in the housing institute itself. Or is it more than just education?

Interviewee: It's more than education. Well I guess a part of it is the kind of education... I'm a strong believer, in my experience the way people make changes is to go through experiential learning. Very much like in the social work program where we had the three day orientation at the Indian Friendship Centre and we listened to people's stories and having the opportunity to deal with it in a non-threatening learning environment. So that style of education is really effective but I don't see it being supported in any kind of institutional way.

Interviewer: The leg has been implemented, the designated agencies are working on protocol, so given that info where do you see the CRN going? What do they want to look at?

Interviewee: One of the things that I talked about with my colleagues is successful CRN process has to be driven by health care providers or people who are in the formal sector but I think we really need to have a really good liaison relationship. Possibly be sitting at the table maybe... there might be a place at the table... envisioning a very large table or a smaller sub group that would be a working group that would be formed under the CRN process where there might be an opportunity to sit there as a health care providers with

CRN members and looking at the concerns that are being generated and coming... health care providers could provide some support or also receive from the CRN information that would be supportive. So I don't know if that's answering your question or not. I think that my initial involvement where I saw it being driven by...and maybe that was necessary because part of the education we were giving about the leg was primarily directed at people who were already in the system. So it was easy for people to work off the corner of their desk not necessarily in time, but people understood the concepts and so they could do that work and they wanted to see it go and people who were interested who wanted to come and facilitate that. So it was easy for it to be taken over by that whole, you know, all of us who were in there. And then realizing no it's not going to work that way, the time and energy you don't have it, our employers are saying that's fine and well but you can't be doing that, shirking your job....so I guess maybe the best way to sum it up it's likely be the relationship as being a really good link but not necessarily the same function. There's going to be two different functions. The channels need to be clear and one of the frustrations that's always been and probably always will be is that it's such a fluid concept when people come and go. Not only the CRN but on the health care side of things too and there's a new learning curve when someone else gets involved. So now with the justice system we'll try to establish linkages, and maybe this is a good analogy good comparison. We're trying to establish good linkages with the local RCMP that will be stable enough so that even though you've got different RCMP members coming and going, there's going to be somebody there who gets it so when you talk to them you're not having to explain it all to them again.

Interviewer: So you are saying that the CRN should not necessarily be driven by health care professionals or by the RCMP or by anyone in particular but it should be more broad?

Interviewee: Yeah
(Later)

Part of it is the efficiency of how you get info back and forth. So if you think about it in term of the different groups within the community who can feed into the broader CRN process. I mean just saying well just any interested person. Who are the interested people in the financial industry? Who have the ability to go back and talk to the people in the other financial end of things, so bankers, lawyers, notaries, people who are going to be involved because there are going to be lots of.. and I've already had the experience of talking to one notary who is almost traumatized by his experience of knowing there was an incapable person who was being manipulated a power of attorney. He didn't know where to go with that, so how do you get people at the table at the professional level who can go back and talk to their own profession. And then voluntary organizations, so you've got seniors centre, seniors counsellors, church groups, looking at kind of the typical organizations who are going to have access to thenow I say seniors because that's just my focus, partly because I work with people who are over 65 and partly because that's how I got introduced to it. In terms of vulnerable people, getting the people who are going to be at the table who then have access to other people who are going to be somehow connected to the people who are going toI see it as a series of circles feeding into a circle and then the people who are at the heart of the process are the vulnerable people to what extent do they have the ability to participate in the process. And what is the best environment for them to do that and would it necessarily be at the table or meeting with one or two or three people at a coffee shop somewhere and talking about how it's going. Those people are the ones who are going to be able to take it back wherever they need to go with that. So I see it as very fluid.

Interviewer: And certainly in the community, not only do we have those circles, but we have circles overlapping..... and some of the circles on the left might amalgamate with the circles on the right in some capacity.

Interviewee: Right, and if you do a large community genogram, whatever that is called, and start making those connections I think that the denser the whole pattern is then that would be an indicator as how closely are people are able to....how well is it working... we know that with a sociogram, the denser the social network is, the less vulnerable a person is. So could that be a model that could be applied to a community.

Interviewer: So where do you see that network going? What would that network be used for? Is it to come together and address concerns within the community at a macro level or to continue with public awareness or all of that?

Interviewee: I'd say both.... I don't see it as an either/or. And I think that ultimately the goal would be to strengthen the community, bring it up several notches as far as awareness and working towards eliminating the barriers and concerns that cause abuse, neglect and self-neglect in the first place. But that's not a one-time objective, that's ongoing, but as you raise the standard, the entry level comes a little higher. So if you think of it as a spiral, each time you're a little further along.

(Later)

They may not be people who would be comfortable sitting at a table on an ongoing basis but on an invitational basis, they may be willing to share some of their stories, and they might be willing to do that in a very safe environment. Certainly not in something that looks like a professional table, but where you get together with them in their own environment they are very forthcoming. Not all of them but some of them. There are people and vulnerable adults who I think could be invited to the process. The ones I work with I don't think that it would be realistic to think they would be ongoing members. And I might be wrong, there might be someone who would like to be actively involved. So you know I ... certainly embrace that philosophically but I realize there are a lot of barriers why this doesn't happen and I think it's this concept of what we've come up with is a very professional concept in some ways. For pretty high functioning people, and for the people who are being served by the legislation often feel that they don't have a right to the process. It has to be broken down into a lot smaller bits ... formal system to provide some avenue into that as well. These family councils, care facilities it's possible there are some avenues in there. There might be councils of residents...

Interview #3

Interviewer: OK, so talking about the CRN in the past...when Seniors Outreach became the contractor for that, what sorts of things did the group focus on?

Interviewee: I think it was really attempting to pull together a group of individuals to the table who could speak to or represent the concerns of vulnerable adults about abuse and neglect - what are the issues - really inspire some commitment in terms of broadening the participation in the group. Maybe identifying some areas that they wanted to focus their efforts on, so whether that be prevention and then identifying some tools or mechanisms that can address the prevention issues. So maybe it's a speakers' bureau, education, so I think really identifying the areas that they really wanted to focus in on. What the role would be.

Interviewer: We have talked about the CRN being in a state of flux. So where do you think it could move to?

Interviewee: Well, I guess where it is right now is that these folks in community, service providers are just starting to get their heads wrapped around the implications of the legislation. What it compels them to do. I went to this workshop the end of February and it's really quite amazing to me that even after we talked about it for four hours, the

presenters did, there were still people who were really unclear that you are compelled to report this. And it was like, my gawd, the writing is on the wall here. Yeah, you're going to have to compromise this relationship that this man has with his brother, but bear in mind that he's beating the guy. I mean...the legislation - I think is still sort of sinking in for people but ... I do think that as that sinks in, community, it sinks in for service providers, the service providers will see the value of that more. As service providers embrace it and endorse it, they pass that on to community members. And then as community members embrace it and endorse it they get more involved. I think it's a slow inching thing but I do think it is unfolding. But because it's inching, we don't see movement in two months at a time. I think it's a long-term commitment. And it's an unfolding, there's that piece, and then perhaps the other piece for me personally was it was something that happened in my conversation with _____ last fall that crystallized the thing for me. It was like a paradigm shift. It was in the way that I was perceiving the role and function of the CRN. When I started to perceive it as a grassroots movement, a community consumer driven movement, that's when I got more excited about it again. Because quite frankly there was an awful lot to do and to expect people who are service providers who are being stretched thinner and thinner and thinner are going to do this on the corner they've created on the corner on the corner of their desk it's just not realistic. So I really see the group that's sitting at the table right now as possibly moving away from being the network itself to being in a steering or advisory capacity supporting the work of the CRN and I think the CRN eventually my vision, I would like to see it pretty much, not the majority of consumers, but pretty much everybody sitting at the table is somebody who might be described as a vulnerable adult in some way. Maybe it's a consumer from schizophrenic society sitting on one end of the table and a consumer from the seniors club down the road that has a support committee or something, or visitation committee of more able people who go out and visit more unable people who have some concerns that come and participate and see how they can help or assist. So a mix of people who might come from all walks of life and different levels of abilities but they are all there because they're concerned about this issue. They want to empower and enable other people in the community to participate in addressing the issue. Maybe the role of the current committee takes more of a back seat and when this core group needs some direction or doesn't know where to find the resource, whatever, that can be taken back to the committee. They can't go any further until they take it back to the health region because they need some help or to address it at the regional level. Maybe that can mean that maybe they meet once a month for an hour or I don't know.... I think it's hard to predict. It needs some breathing room to develop it's own way on it's own terms.

Interviewer: So when we're talking about structure. One person said we need to have that leadership, an advisory committee, with sub-committees. Another person said it needs to be grassroots.... But you see it as both of those things put together?

Interviewee: I really think it's the kind of thing that has to have.... _____ as the regional coordinator for the Brain Injury Program needs to have as her mandate sanctioned by her supervisor, the CRN is going to be part of her role. You have to sit at the table with your community partners and participate in this. If that isn't there or it becomes an optional thing or my supervisor doesn't support... you're not going there again are you... you're not doing community CRN thing again are you. I think there really hasn't been the support for it within the formal system structure.

Interviewer: When we're talking about different models of community or social planning, you've got social planning that is top down, community development is really grassroots, so you really see both of that.

Interviewee: I do think so, it's sort of like, I don't mean to suggest in this statement what it might imply, but if you have people who like children can only operate at a certain functional level without the assistance of other supports.... We have vulnerable adults ..

they range in terms of their strengths and functional capacities, but let's assume they are limited in those capacities, you are going to get some who are stronger. You can't expect that the strong ones are going to hold up the ship indefinitely for those who are not as able. So somebody has to support that to make sure the life.... Like if it starts to fizzle out the life just kind of gets breathed back into it. You kind of keep the fire burning underneath it. I think it needs the support of the community particularly will flourish more quickly with the social planning model if you will kind of providing some fuel to insure that it has the resources and the support that it needs to move it forward...As an analogy.. the residents associations are sanctioned by the city and are invited to give their input to planners....I think it's got to be driven by the consumers, in this case the vulnerable adults, they're the people who will be the beneficiaries of the efforts of the CRN. The more involved they are in directing and controlling this the more it will reflect their needs. Be more reflective and hit home exactly where they need it to hit.

Interviewer: It will be more successful.

Interviewee: Absolutely.

Interviewer: So how do we get these people to come?

Interviewee: Maybe I'm going to find some opportunity to say you know I haven't seen you at the CRN meetings and I'm just kind of curious. Is it that people just don't know about it. Or maybe they don't value it. Maybe he's just never heard of it. I don't know. But just to open the discussion and plant the seed of curiosity in his mind about what that's all about, the new legislation. Or maybe I just phone him up and ask can I get a copy of your protocols as a designated agencies around abuse and neglect because we're looking at our agency to develop protocols that more reflect considerations on your end, or the health authority end but given that the population is a little bit different. And then we get into a discussion about the CRN. But maybe someone else has a contact in mental health, someone else in the hospital, someone else in the MS society. Maybe if it hasn't been successful with the more direct approach, maybe it's the seed planting time. Getting and making personal connections. Having the discussions that open up the possibilities. Where they can address their concerns or questions, well I don't know what it's about, so I really... I'm so busy that I don't have the time to do something I don't know anything about... So really in talking about you know how many times in the past year you've come across a situation where one of your clients really got shafted or someone got really abused and is injured to the point of being injured either physically or emotionally and it was a horrible experience and your heart bled for them and you felt so helpless, this is a way of helping them help themselves. You can't undo what happened to them or to those people that you know, but it's nice to know you're participating in something that down the road will empower them. I think it might just be, that whole model they talk about with change...So I think it's got to be the community but it's also got to be my supervisor and supervisor's supervisor saying this is important and you need to get with the program and stick with it and I'll be checking back with you in two months to see how it's going...I think we invited people who are able to participate right now who might have areas of vulnerability who are capable of participating. Just ask them, come and be a part of this. If you can't sit that long, just come for half an hour. Here's the agenda, just come and speak to or participate in the things you have time for. I think they should be involved right now if they can. If we know someone who is interested well, like come on in, come and sit at the table and give us your ideas, come and participate... I don't see any reason we have to wait to a certain time ... fluff up the pillows just this way and they'll be ready for it.... I think there's some people who are going to need a little structure experience to participate in that in a meaningful way and there are other people that you can just see... there's a guy over there who has a health issue, but he's not in a period of decompensation right now. He's stable, he's bright, he's interested in this issue... I'm not

going to say we're going wait until we get the pillows fluffed just right before we ask... maybe he could participate right now maybe in creating that next step or whatever.

Structure.

In discussing the structure of the CRN, the interview participants spoke of social planning concepts and grassroots or community development initiatives. This seems to be a dichotomy that will be examined in the feminist analysis. They told me that many CRNs were developed from the elder abuse committees in various communities – Penticton, Peachland, Vernon, Kelowna and others – and the elder abuse committees were developed as a result of policy directives from the Ministry of Health. As one participant said, “the Ministry of Health had an abuse policy. And out of that abuse policy, the formation of the elder abuse committee came out.” It was some time after that, she said, that they

heard about the possibility of getting funding through the Public Trustee. We had a little bit of information and we gleaned from it that it was a more community based organized response to elder abuse. At that time we didn't realize that the whole name was going to be called adult abuse, neglect and self-neglect.

It was through a social planning model that the CRN members were directed to organize a grassroots initiative. CRNs were developed as a result of the *Adult Guardianship Act*. The CRN concept, however, is one of community involvement and the development of a grassroots movement. So, it would seem that the CRN has been developed out of a social planning direction but is based on community development ideas. In referring to the Concept Map in the appendices, we can visualize what this relationship may look like.

Although the interviewees spoke of the CRN being a grassroots movement that is consumer-driven and inclusive (in other words, led and influenced by vulnerable adults), they also said that they could see the current members of the committee acting as an advisory group guiding and supporting the working group that would consist of vulnerable adults, consumers, advocates and community members. "So the organizational structure has to be a top down and a bottom up process" and "a successful CRN process has to be driven by health care providers or people who are in the formal sector ... envisioning a very large table or a smaller sub group that would be a working group ..." This is another example of the participants coming back to a traditional bureaucratic structure which is not consistent with their espoused value system.

As well, the members of the group would come and go as their role or participation changed. One participant said that the CRN must be a grassroots movement in order to be successful in educating and increasing the awareness of the community. However, this participant also spoke of the need and desire to have protocols and contracts in place. These contracts would include service contracts between the co-ordinator and the CRN. It is important to note that while protocols and contracts perform a useful (and some would argue, necessary) role in dealing with organizational behaviour, they are also what happens to grassroots groups as they move toward becoming increasingly bureaucratic in the name of preserving, paradoxically, the initial intent.

During this study, two contracted co-ordinators were hired to help provide the leadership and to help facilitate the CRN in moving forward.

We decided to go with these people because they have strong community background, strong linkages with the people who we have never been able to bring to the table. And that's been a concern that we've not been able to bring a lot of the entrepreneurs because of the cutbacks. We're seeing a lot of small businesses coming up that are breeding places for abuse to happen because they are isolated ... and our two coordinators are part of that community.

The concern was that many small businesses that care for vulnerable adults have started up because of funding cutbacks from the government to health and social care and are not licensed or monitored. In this way, abuse and neglect can take place more readily and can be hidden more easily because these facilities don't necessarily have in place a standard of care or a procedure for monitoring this care.

Values.

The feminist values that the participants discussed included: participation of all members of the community, inclusion of a diverse group of people, empowerment of community and of individuals, least intrusive measures, and relationships and linkages. All three participants talked of including not just seniors, as they had in the past, but also inviting any adult who may be at risk of abuse or who may be considered "vulnerable" to sit on the committee.

The people who are at the heart of the process are the vulnerable people. To what extent do they have the ability to participate in the process? And what is the best environment for them to do that? I think it's got to be driven by the consumers, in this case, the vulnerable adults. They're the people who will be the beneficiaries of the efforts of the CRN. The more involved they are in directing and controlling this the more it will reflect their needs.

Empowerment was a concept that all three participants named as important. They spoke of coming from a "strengths source not a weakness one", forming productive relationships with comfort and acceptance. In doing so, it would empower the community and those adults at risk. "Comfort is a really big thing, acceptance is a really big thing and you have to meet people where they are." We need to "respect that sometimes their choices are that people are exactly where they want to be."

By participating, members of the community can be empowered and in turn help others to empower themselves. "So a mix of people who might come from all walks of life and different levels of abilities but they are all there because they're concerned about this issue. They want to empower and enable other people in the community to participate in addressing the issue... it's nice to know you're participating in something that down the road will empower them."

Related to the concept of values, is ethics. One participant talked of the ethical decision making that is involved with working with adults at risk. "They can be a great person and they can know that ethically there are some things that they are really challenged by." In talking of respecting the adults right to choose, she says, "what point does the threshold get crossed that I have a duty to be involved now because this person is vulnerable in a way that they don't understand the risks. I can't even get in the door to find out."

Context.

The context of the CRN was discussed. All interview participants stated that the CRN concept is a process. "The process is everything." This is

consistent with a feminist value system. Motivation to be involved was part of the process, as was passion for the issue and for assisting adults at risk. They also mentioned that agency and bureaucratic support and sanctioning was part of the process that would facilitate professionals in agencies and organizations to become involved with the CRN as part of their roles in their jobs. This is one example of the participants pushing the traditional structures to recognize their feminist values. They talked about professionals having to “work off the sides of their desk” which meant that it wasn’t really a part of their job description and they were not given the time to do it, but that they felt that they should be in order to assist their clients.

As one participant said, “you need to have people within the different sectors of the community who are going to be supported by their own workplace, to have time to sit at this table. It needs the support right throughout and a lot of that is education.” Another person explained that: “it’s got to be the community but it’s also got to be my supervisor and my supervisor’s supervisor saying this is important and you need to get with the program and stick with it and I’ll be checking back with you in two months to see how it’s going.”

As well, making linkages between agencies and groups, and forming relationships with other practitioners in the community were seen to be important. As one person said: “so we’re working on how to exchange that information and how do we establish those linkages ... And people who are at that table are the people to make linkages back to each of those different pieces of the community where they’re going to be able to fan out.” Another stated that: “maybe someone

else has a contact in mental health, someone else in the hospital, someone else in the Multiple Sclerosis Society. Maybe if it hasn't been successful with the more direct approach, maybe it's the seed planting time." In other words, perhaps the CRN members could make suggestions to other practitioners and community members about what the CRN is and what the members plan to do. This CRN member was suggesting that direct invitations to people to come to the meetings were not necessarily working and perhaps it was time to try to plant ideas in a less direct way. This is an example of the way in which the CRN members are trying to influence traditional bureaucratic structures.

As service providers embrace it and endorse it, they pass that on to community members. And then as community members embrace it and endorse it they get more involved. I think it's a slow inching thing but I do think it is unfolding. But because it's inching, we don't see movement in two months at a time. I think it's a long-term commitment.

Another participant said:

... our number one goal was pretty much based around building relationships in the community ... but it's the hardest thing I've done in my life is building relationships. And not the kind of relationships that I build every day where I have the power and I'm helping you and you need me. But those kind of relationships where I am sharing the power and I'm grateful for anything you can contribute. I want your participation.

Through the process there will be a stronger community. "I think that ultimately the goal would be to strengthen the community, bring it up several notches as far as awareness and working towards eliminating the barriers and concerns that cause abuse, neglect and self-neglect in the first place. But that's not a one-time objective, that's ongoing, but as you raise the standard, the entry level comes a little higher." Several participants discussed the need to listen to

people's stories to help in understanding what their unique situations are and how best to support them consistent with their espoused values. The CRN members need to be given the opportunity to do this.

Tasks.

The participants had clear ideas about the tasks of the CRN such as prevention activities aimed at education and awareness strategies, support and assistance to vulnerable adults, caregivers and the designated agencies, outreach strategies, and community resource and information tasks. "A lot of it's just letting people know what their rights are and what the rights of the users of their business are. It's always education I think ... the education of rights, of abuse, of guardianship, of legislation." Another stated, "I think if you can educate people and develop a relationship with that vulnerable portion of our population, and get some advocacy going ... I hope that is one of the many ways the CRN could have a role. Be able to make yourself available to people." One participant stated:

...it has to be simple ... where we will be a part of the resource centre, offering a little bit of education on that particular area but we will be another resource and we are part of the community ... we should be so integrated with the community that you wouldn't know we are there. I think I would like us to be part of a big resource centre and what we could contribute to it might be to help all the other bits and pieces of it to develop protocol on the best way to access support and assistance.

Feminist Analysis of the Individual Interviews

As with the focus group, all three participants who were interviewed were women working as health care and social work professionals for the health region. There were no men interviewed because there were no men who – at the

time of this study – were involved with the CRN in any capacity at the local level. Although the participants were indeed committed to the CRN as a community response to abuse and neglect of vulnerable adults, there was discussion about the sanctioning of their involvement by the organizations for which they worked. Sanctioning was not be readily forthcoming by the agency, their supervisors and co-workers. This could be due to job descriptions, workloads and the relative importance given to the work of the CRN. Their involvement in the CRN was viewed as volunteer work rather than as part of their role as a professional in the agency and as such was not endorsed because it was not included in their job description. Rather than change the job description, the work with the CRN was simply not authorized and therefore, the work was not respected or seen as valuable.

Although it was a Ministry within the province of British Columbia that advocated for the *Adult Guardianship Act* and the designation of certain agencies to be the responders to the complaints covered by the Act, the designated agencies (headed by another provincial government ministry) did not sanction the workers' involvement in the organization that was named by the Public Trustee as being the one which would provide the community response to the Act. This may be one of the many ways in which the social planning and community development models can be seen as being in opposition.

As was stated previously, the CRN was implemented using a social planning model through guidance from the Public Trustee Office and the *Adult Guardianship Act*. It was also recommended, however, that the CRN involve

community and grassroots initiatives. The social planning model emphasizes a top-down approach and the community development model emphasizes a bottom-up approach to community organizing. In the case of the CRN it seems that the two models are in direct opposition to each other. On the one hand, the designated agencies are to respond to accusations of abuse and neglect. On the other hand the workers in those agencies are not sanctioned by those agencies to be involved in the community response to abuse and neglect.

The difference between the participants in the individual interviews and those in the focus group is that the individuals in the interviews seemed to realize that there was a traditional patriarchal influence at work with which they did not necessarily want to align themselves. This suggests an inconsistency between the social planning model as directed by the Public Trustee Office and the grassroots initiative that was recommended. The first interviewee talked about not having a particular structure. She felt that this might ruin the grassroots initiative and take away from the empowerment model that she had in mind. As well, the second interviewee talked about circles within circles. She explained that her vision was people connecting in a "series of circles feeding into a circle and then the people who are at the heart of the process are the vulnerable people...". She did not see the structure as a hierarchy. Yet, she also understood the barriers to working within the traditional model. This is a dichotomy that could make it difficult for the CRN to find consensus among its members.

One of the other dichotomies is between feminist values and patriarchal structure. Although the interviewees used words such as "empowerment",

“building relationships”, “inclusivity”, “grassroots”, “connections”, and “education” which are seen to be feminist ideals, they also talked about the patriarchal structures that are evident in their workplaces and in the CRN itself. It is not surprising to note that at the time of this study, the CRN had not been successful in attaining and maintaining membership. These internal contradictions may have contributed to this lack of membership. It might also be the case that members felt uncomfortable with strategies: aspiring to those that would be used for a feminist-based organization, but being confronted (because of apparent necessity) with conventional ones associated with traditional hierarchical and bureaucratic institutions. Finally, some members may not be aware of these inconsistencies.

Summary of the Findings

When combining the findings of both the focus group and the individual interviews, consistencies can be found. Referring to table 3 in the appendices helps to clarify this information. Both groups of participants generally agreed that although the CRN was implemented from policy decisions, it has a mandate to be a grassroots community movement. Participants spoke of the need to have a steering committee that would oversee the tasks of a volunteer working group.

They stated that the steering committee would be most effective if it consisted of professionals from the community who would be representatives of the health care, social service, legal, justice, non-profit, and mental health sectors. The working group(s) or sub-committee(s) would consist of the general members of the community including caregivers, “vulnerable adults” and

interested parties. All members of this group would be volunteers. It was agreed that some form of leadership or facilitation role would be best accomplished through the contracting of a co-ordinator or shared co-ordinator situation. This contract position would help to ensure consistency, facilitation, co-ordination of tasks and assistance in providing stability. As well, the co-ordinator(s) could help in formulating protocol, policy and guidelines for practice. This may be another area where the participants were not aware of the inconsistencies.

By including members of the community from all sectors, the values of inclusivity and participation, empowerment and relationship building could be actualized. The focus group emphasized the need for confidentiality and accountability whereas the individuals emphasized the need for empowerment and comfort level – going to where the people are. Both groups spoke of the need to be community-based and consumer driven.

Given the above information, the participants generally agreed that it was a process that would include the formation of linkages with agency representatives and adults at risk in a context of reduced funding and stress on resources that are already stretched. The need for workplaces and organizations to sanction the committee members' role in the CRN and the legislated mandate of the designated agencies to respond to reports of abuse and neglect were considered very important. All participants spoke of the need to hear people's stories, to listen to what adults at risk were saying and to understand that every situation is different.

The tasks that were considered part of the responsibility of the CRN included writing proposals for grants to provide funding for a co-ordinator, overseeing partnerships in the community and acting as a facilitator and contact point for information and support. Other tasks that were seen as important were the continuation of education and community awareness, and beginning to identify gaps in the system(s). All of the above tasks were to be focussed on the importance of providing support and assistance to adults at risk of being abused, neglected or self-neglected.

Given the feminist analysis that has been used and the information that has been gleaned, perhaps it would be beneficial for this to be shared with the participants. It could be used as a consciousness-raising experience.

Discussion

The following will look at this study and its findings as they relate to the theoretical perspectives outlined above. In doing so, research concerns and theory regarding abuse, societal and professional values, social planning and community development, and feminist perspectives will be discussed in an attempt to move forward with recommendations for the CRN.

Research Concerns and Theory Regarding Abuse

This study has taken a qualitative approach to viewing the role of the CRN in Kelowna. Thus, listening to people telling their stories has been at the heart of the exploration. Although the study interviewed only committee members of the CRN, the voices of the older adult and of persons with disabilities were heard through the participants because of their work and close relationships with the adults who may be at risk. The participants related events and incidences of their clients throughout the study. Because there were no vulnerable adults on the CRN committee at the time of this study, none were included in the interviews. Thus, direct input from the vulnerable adult was not included here.

The methodological problems referred to earlier are not of concern in this particular case because this study was not intended to research the causes of elder abuse, violence against women and others with disabilities, or the extent of abuse, but rather to explore the role of a particular committee in a particular location.

It has also been noted that there is a vast array of definitions for "vulnerable adults" and for "abuse" as well as many varying risk factors for

abuse. However, in exploring the role of the CRN that has been guided by the *Adult Guardian Act of B.C.*, the definitions and risk factors outlined in that Act are the ones that will be considered reasonable for these purposes. This study has attempted to pull together various theoretical perspectives that focus on social planning, community development, and feminist frameworks in order to understand the role of the CRN in Kelowna.

Societal and Professional Values

As mentioned above, Bennett et al (1997) state that values and attitudes will affect the awareness of the situation as well as the strategies for intervention. Those values that were spoken of by the participants in this study seemed to reflect that very statement. The values of accountability, confidentiality, objectivity, inclusivity, empowerment and community reflect the professional values of the participants and also the professions represented by the participants. The participants were nurses working in a community setting, outreach social workers, community workers and advocates. Their understanding of the problem revolves around the abuse of older adults and mental health clients, legal issues as they relate to the *Adult Guardianship Act of B.C.*, and community and outreach initiatives.

In this case, their professional values as reflected in their statements are ones shared throughout feminist social work practice; advocating for social change based on inclusion and addressing the power and control aspect of abuse. As has been pointed out previously, the words that they used during the interviews and the focus group were not consistent with their ideas. It seems that

the group was trying to organize in a way other than in a traditional manner but they weren't sure what it would look like. It could be that the individuals were not aware of their contradictions or that they did not want to voice their true opinion for some reason. The participants were of different backgrounds and had varying experience with the CRN. Some of the participants may have been perceived to have influence in organizing the committee. In these ways, the participants in the focus group could have been influenced by the dynamics of the group and simply agreed with the themes and issues. Perhaps some of the participants were influenced by the others due to the others' place in the community or past experience with the committee. In light of these contradictions and dynamics, the CRN may want to revisit the discussion and try a different approach.

Social Planning and Community Development

Although the CRN was implemented as part of a policy guideline attached to legislation, it is expected to be a community initiative and grassroots movement. It would seem that these two approaches may be mutually exclusive. However, it could be that given the endorsement and the mandate of the government and of governmental organizations, the CRN may be in a good position to expand its horizons and envelope the members of the community – such as persons with disabilities, mental health advocates, caregivers and older adults – simply because of this endorsement.

As one of the participants explained, it may take our networking skills to plant the seed and to motivate others to become involved. Another participant said that it is the relationship building with other practitioners that is the difficult

part of forming the CRN. However, once the seed is planted and the idea has been cultivated, perhaps the CRN movement will grow and flourish. By continuing to meet with vulnerable adults on their own terms and in their own setting, their right to autonomy and freedom of choice is showing them the respect that they deserve but is also assisting them to see that the CRN is there to support them. Through showing them support as well as creating awareness about the issues, perhaps they will show interest in becoming involved because they are building the trust and rapport that will be needed.

As the participants stated, it is a process. Community development models generally focus on process goals, however social planning models generally focus on task goals (Rothman, 1995). Process goals that were discussed include relationship building, forming linkages in the community, increasing awareness, and inviting community members to be included and encouraging participation. Task goals that were discussed include proposal and grant writing, planning education forums, identifying gaps in service, and hiring a co-ordinator. Clearly the CRN wants to do both. As Twelvetreets (1991) suggests, there are many community initiatives that combine both models and indeed both are intertwined.

The CRN committee is considering an advisory committee that will consist of representatives from government agencies, health and social care organizations, and legal authorities that will guide and support the working group, consisting of various members of the community. This would be a model of community work that would combine the goals of both approaches – social

planning and community development. However, the CRN would do well to be aware of the dichotomy evident in organizing at a grassroots level with a social planning implementation.

Feminist Perspectives

Feminism is a perspective through which we can guide research and practice. It seems that perhaps the participants were viewing the world through a feminist perspective when they spoke of empowerment, letting people tell their stories, building relationships, sharing power, and approaching the CRN as a grassroots, community prevention initiative. However, these concepts are also consistent with other perspectives such as community development. As well, there are several contradictions such as using feminist wording but wanting to organize around traditional patriarchal and hierarchical ideas.

As a feminist practitioner, I attempted to approach this study from a feminist perspective. By providing a comfortable and reflective atmosphere for the discussions, this qualitative research methodology encouraged the participants to tell their stories. In this way, the participants seemed empowered and encouraged. Interviews took place at a time and in a place that was convenient and comfortable for the participant. Consistent with a feminist approach, I attempted to use participatory and action research strategies. For instance, the participants were kept informed as to the purpose of the study, the questions that would be asked and the progress of interpreting the findings. Although they declined the invitation, the participants were invited to review the transcripts. As well, the CRN committee members – those who participated in the

research and those who did not – were invited to attend a presentation of the research findings.

Furthermore, the participants knew me from previous work in the community and knew what my skills and experiences were in the community development and working with vulnerable adults. Therefore, they knew that I would value their opinions, experiences and ideas. The study was based on a dialectical relationship whereby the participants and I shared ideas and spoke openly about the process.

As well, a feminist approach to data analysis was used. The narratives from the focus group and the interviews were deconstructed by challenging the themes and processes in terms of power, traditional structures, dichotomies and feelings. Content analysis included looking at the participants' way of speaking, considering the larger context within which participants work and are socialized and their professional alliances.

Feminist approaches would be well suited in looking at strategies for prevention and community work. Focussing on education and awareness campaigns, encouraging active participation and inclusion of all members of the community, assisting the community to be strong and healthy, and basing the CRN on a belief in collaboration and teamwork are goals that the CRN committee have suggested. All of these goals are based on feminist ideals. Education of professionals as well as other community members would strengthen the community as well as encourage active participation in preventing abuse and awareness of the need to report incidents of abuse. Bringing together

professionals and vulnerable adults in workshops, forums, support groups, and coffee shops will strengthen the collaborative model and will encourage teamwork. When people from various backgrounds and experiences are working toward a common goal and are being successful with it, teamwork can be facilitated.

If the CRN can provide assistance for vulnerable adults to come together to tell their stories, participate in a movement that will benefit their well being, and challenge them to be involved in something that will encourage empowerment and self-sufficiency, the feminist approach can be actualized and the adults can improve their quality of life. As mentioned above, Garner (1999) suggests that by strengthening their interpersonal relationships, women can develop a sense of empowerment and can improve the quality of their lives. Moreover, the current model of the CRN as outlined in legislation, is consistent with a feminist approach. Broad participation is encouraged and power is given to the community.

By encouraging broad participation, collaboration among and between interest groups can be strengthened, and involvement and participation can be encouraged. In this way, as Wachholz and Mullaly (1997) suggest, the existing structures can be reconstructed by connecting the personal with the political and assisting institutions to appropriately address the needs of the people. A new egalitarian and cooperative vision for practice, research and knowledge can be achieved. However, it will remain to be seen if the CRN members will

consciously consider the way in which they choose to be organized and how this will affect the community.

Conclusion

Given the dichotomies, incongruencies and inconsistencies discussed, several questions arise. Could the CRN organize in a way that would be more consistent with their feminist values and that would not hamper their legitimization by funding sources and organizations with whom they will be working and forming partnerships? Is there a way of avoiding protocols and other bureaucratic tools in creating a distinctly different organization or are these inevitable as any organization develops? How could the CRN members who work for other organizations be recognized for their role in the CRN? What are the implications for feminist based organization being guided by a social planning model but built on a grassroots ideology?

There are several feminist-based organizations that may provide a starting point for the CRN. Many feminist-based organization have been built on a consensus decision-making model and a co-operative foundation for board members and workers to work collectively to make decisions regarding the organization while achieving and maintaining an efficient and effective structure. These organizations have been successful in securing funding from various sources while maintaining a positive profile in the community. Although the members attempt to stay true to their feminist values in some ways, such as consensus decision-making, in other ways they are drawn back to the traditional structure of formulating policy, protocols and terms of reference. So perhaps these traditional bureaucratic tools are inherent in any organization.

Although there may very well be challenges in organizing the CRN in a similar way, such as finding members who will consistently practice feminist ideology and limited funding from the usual sources like the Public Trustee Office, there may also be successes, such as an increase in membership due to a fixed ideology and finding different funding opportunities such as through the City of Kelowna. Once the CRN does have a particular structure and goal-setting method, perhaps the organizations for which the women are working will then more easily support their involvement in the initiative.

As well, the organizations for which the members work may do well to learn more about the role of the CRN and its importance in the community in order to understand the initiative. Once the education and information is shared, perhaps the administrators of these organizations may come to understand that through partnering with the CRN, their clients and their workers would be better served. Support and understanding of the issues surrounding abuse and neglect may prevent additional trauma in the lives of the clients and additional caseload intervention for the workers.

Given that many of the CRN members work for one of the organizations designated by the *Adult Guardianship Act* to be responsible for responding to allegations of abuse, neglect and self-neglect, are they in a favourable or a non-favourable position to help guide the structure of the CRN? Many of the concerns of the CRN members who were interviewed reflected a discomfort with being responsible for structuring the CRN while at the same time working for the designated agency.

Future Research

This study did not include the vulnerable adult sector of the population in the interviewing process. Further study in this area would be most helpful to assist the vulnerable adult to have their voices heard. In order to increase and improve relationships for vulnerable adults – which is important in reducing and preventing harm and improving quality of life – they should be invited to share their stories with each other and with the professionals who help to provide support to them. Through participation and inclusion in groups, committees and other community initiatives, perhaps the vulnerable adult can be empowered to improve their lives in many ways. The CRN would like to hear from vulnerable adults in the community in order to help provide better supports and services, to help agencies and organizations to improve their services and to help the CRN to provide information to the Public Guardian and Trustee Office in order to improve upon and expand the roles of the CRNs in British Columbia.

Further research could be aimed at how vulnerable adults and their caregivers have been helped or not helped by CRNs and the designated agencies since the inception of the *Adult Guardianship Act*. For instance, is it easier or more difficult to report incidents of abuse and neglect? Does the average person in the community know how to report abuse? Do people know what abuse and neglect are? Would they recognize it or acknowledge it?

As well, a follow-up study may be advantageous in exploring where the CRN is going at this point in time. At the time of the study several changes were already taking place, such as the hiring of two co-ordinators and the expansion of

members on the committee. The CRN members may want to explore what direction they are taking and if this direction is the most beneficial to the community as well as consistent with the members' value systems.

Statistical information, as well, especially for the community of Kelowna in particular would be most beneficial. Information regarding the number of reported incidents, types of abuse/neglect, outcome of the reports and demographic information could be kept. The agency or organization to take on this responsibility should be one that already has a direct contact with the designated agencies and can act as a central point for statistical information. This information would be helpful for organizations, agencies, researchers and students for use in funding proposals, reports, research and other written papers.

It seems quite clear to me that the CRN is indeed a vital entity for the community of Kelowna in providing support, information, education, advocacy and other services to the vulnerable adult population and to those who work on their behalf. What is not clear is what the specific role(s) will be in the future. The CRN will need to discuss this and the inconsistencies presented here, and perhaps set out a strategic plan or other goal-setting process based more on their feminist value systems.

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Appendix 1

**Map 1
Concept Map**

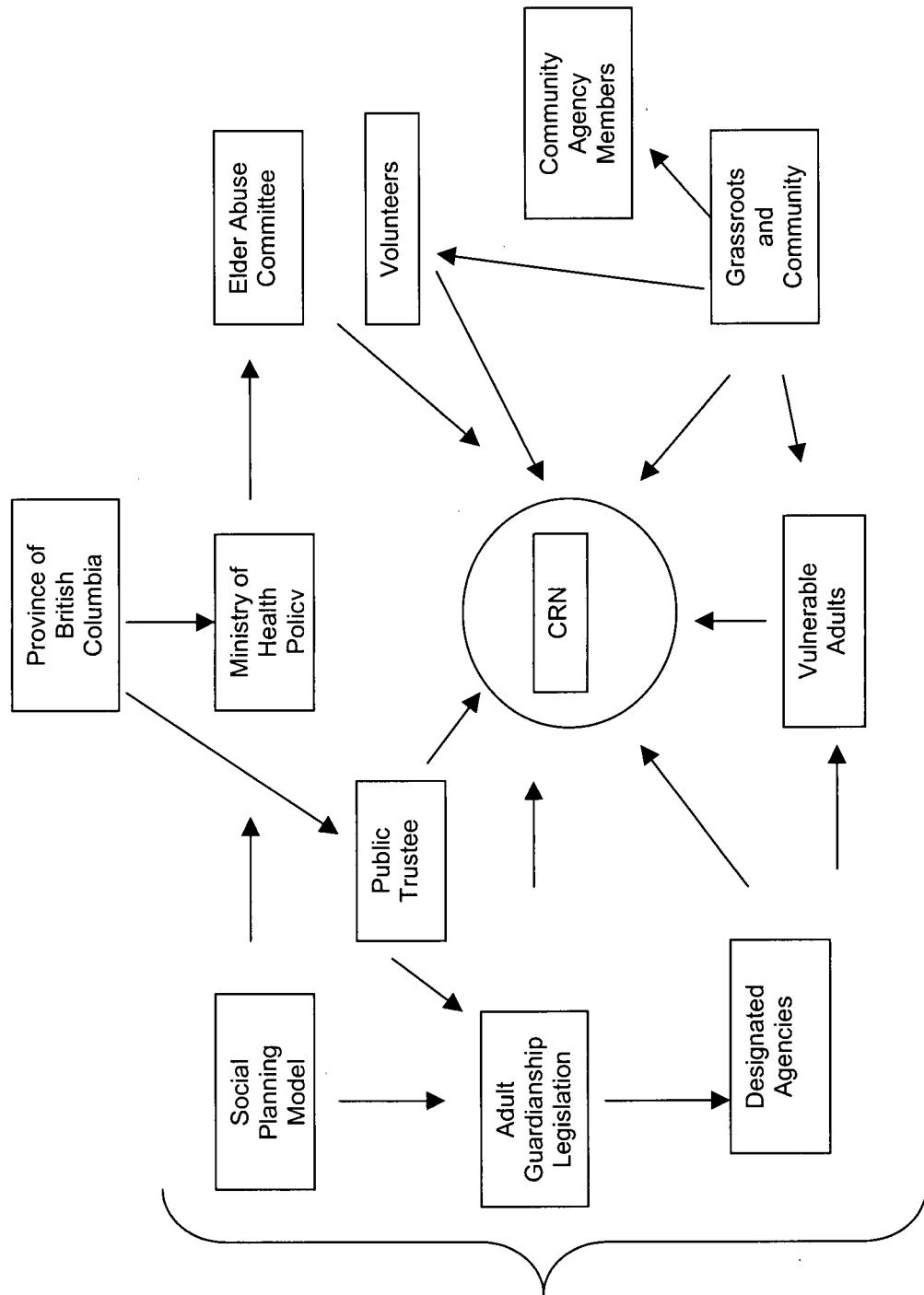


Table 1
FOCUS GROUP FINDINGS

Structure	Paid co-ordinator	Steering Committee/ overseer	Advisory/ review committee	Sub-committees/ working groups	Volunteers	
Values	Accountability/ credibility	Confidentiality/ Respect	Preventative	Unbiased/ Objectivity	Community-based	
Context	Resources/ funding	Designated agencies	Legislation/ legal	Community/family	Grassroots/ Multi-agency	
Tasks	Proposals/ grants	Oversee partnerships	Pull things together	Forums, education, training	Support/ advocacy	Contact point/ Facilitator

Table 2
INDIVIDUAL INTERVIEW FINDINGS

Structure	Paid co-ordinators	Advisory/support Committee		Working group	Volunteers	Professionals and vulnerable adults
Values	Inclusivity	Empowerment	Least intrusive	Relationships/ Linkages	Community-based	
Context	Process/relationships/linkages	Agency sanctioned	Legislation/policy	Strong community	Grassroots movement	Social planning model
Tasks			Outreach	Education/ awareness	Support/ assistance	Resource/ information

Table 3
SUMMARY OF FINDINGS

Structure	Paid co-ordinator	Steering Committee/ overseer	Advisory/ review committee	Sub-committees/ working groups	Volunteers		
	Paid co-co-ordinators	Advisory/support Committee		Working group	Volunteers	Professionals and vulnerable adults	
Values	Accountability/ credibility	Confidentiality/ Respect		Preventative	Unbiased/ Objectivity	Community-based	
	Inclusivity	Empowerment	Least intrusive	Relationships/ Linkages		Community-based	
Context	Resources/ funding	Designated agencies	Legislation/ legal		Community/ family	Grassroots/	Multi-agency
	Process/relationships/linkages	Agency sanctioned	Legislation/policy	Strong community		Grassroots movement	Social planning model
Tasks	Proposals/ grants	Oversee partnerships/ Pull things together	Forums/ education/ training	Support/ advocacy		Identify gaps/cracks	Contact point/ Facilitator
		Outreach	Education/ awareness	Support/ assistance			Resource/ information

APPENDIX 4

RECOMMENDATIONS

Recommendations resulting from this study are outlined under the headings of education, community awareness, process, funding and information and referral. These are strategies that focus on both task goals and process goals as discussed above.

Education

1. Continue to provide workshops for community members on issues of abuse, neglect and self-neglect.
2. Continue to provide educational forums for caregivers, health care and social service professionals. Topics: Adult Guardianship Legislation, Community Response Network concepts, prevention strategies and feminist perspectives on abuse of vulnerable adults.
3. Assist in forming small group get-togethers for client groups, consumers of mental health and community care services, and other vulnerable adults. Help to provide opportunities for people to tell their stories and share their concerns.
4. Assist in providing opportunities for experiential learning for health professionals and social workers. Vulnerable adults who have experienced abuse and who feel comfortable sharing their experience may like to volunteer to speak with groups.
5. Implement the formation of a speakers bureau to help to put these strategies in place.

Community Awareness

1. Encourage CRN committee members and the co-ordinators to participate in "Fifty-Five and Alive", Volunteer Fairs and Community Events in order to initiate public relations and community awareness.
2. Have a celebration for CRN committee members and interested parties to recognize achievements and progress to date. Put a positive spin on community initiatives and encourage each other to keep moving forward.
3. Continue networking, building relationships and coalitions, and making linkages in the community.
4. Invite vulnerable adults to participate in any way they feel comfortable and have the ability to do so.
5. Ask volunteers to write stories in newspapers, newsletters and bulletins.
6. Formulate a media relations campaign. Ask to speak on Shaw Cable community shows, CHBC community events spots and radio talk shows.

Process

1. Understand that the CRN concept is a process that will be successful given time and encouragement.
2. Encourage participation at all levels – designated agencies, client groups, City of Kelowna, Interior Health Authority, non-profit organizations, neighbourhood associations, and so on.
3. Bring together CRN committee members in a presentation format so that the findings of this study and its recommendations can be discussed.

4. Encourage CRN committee members to meet to set short-term goals and strategies for achieving them.
5. Provide education to agencies and organizations about the CRN concept and the legislation to help encourage sanctioning of workers' involvement.
6. Appeal to the Public Guardian and Trustee of B.C. to assist in advocating on CRN's behalf to designated agencies and others to act as a support to their workers.

Funding

1. In educating community members, solicit donations from corporations and "for profit" sector.
2. In providing workshops and educational forums to professional groups, charge a registration fee to cover costs plus administration fees.
3. Encourage CRN committee members to include organizations from the "for profit" sector when making linkages and building relationships so that they would be more inclined to offer donations of supplies and funding.
4. Form partnerships with other non-profits organizations wherever possible to encourage joint ventures in service provision and educational forums that will reduce costs and share responsibilities.

Information and Referral

1. Approach Kelowna Community Resources again with a written proposal outlining possible program, funding, resources that the CRN can provide and what the CRN can bring to the agency.

2. Offer to do a free in-service presentation to Kelowna Community Resources in order to pass along the information about the CRN and its goals, encouraging linkage to their agency.
3. Propose to the designated agencies that the CRN could help set up a central statistics database to collect and collate statistical information on reports of abuse, neglect and self-neglect, agencies that provide support and assistance to vulnerable adults, and resource information for designated agencies and others.