HOUSE OF COMMONS
CHAMBRE DES COMMUNES
CANADA

Standing Committee on the Status of Women

FEWO • NUMBER 005 • 1st SESSION • 41st PARLIAMENT

EVIDENCE

Thursday, October 20, 2011

Chair

Ms. Niki Ashton

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● (1530)

[*English*]

The Vice-Chair (Mrs. Tilly O'Neill Gordon (Miramichi, CPC)): I want to welcome everybody here this afternoon.

We have three witnesses, who are each going to make a 10-minute presentation. Following that 30 minutes, we will turn to our seven-minute round of questioning.

I want to welcome the witnesses and say how happy we are that you are with us today. I realize that this has been your life's work, so I know that you'll have a lot to offer and that you're very passionate about it, as are we.

We are beginning with Charmaine Spencer.

Please begin your presentation.

Ms. Charmaine Spencer (Co-Chair, Canadian Network for the Prevention of Elder Abuse): Good afternoon, members of the standing committee.

Thank you very much for this opportunity to participate in this consultation. My name is Charmaine Spencer. I am the co-chair of the Canadian Network for the Prevention of Elder Abuse. CNPEA—RCPMTA in French—is a national non-profit organization that has been working on abuse and neglect issues since before 1991. That was about two years after the first Canadian study on abuse and neglect of older adults came out. The network itself was actually the brainchild of Dr. Elizabeth Podnieks, the lead researcher on that now classic study.

The best way to describe our organization is as a network of individuals, organizations, and regional and community networks. It's unique in its composition and its approach. Our 19-member board includes representatives from each of the provincial and territorial networks, who work with communities on these issues. We are proud of the fact we have representatives from each province and territory. Currently about one half of our board members are seniors, many of whom have been engaged in family violence and related issues for about a quarter of a century. The board includes provincial staff, as well as professionals and academics in the areas of gerontology, medicine, social work, and law.

At CNPEA or RCPMTA, we focus on two key things. The first is sharing current Canadian information about the many different legal, health, social, and cultural aspects of abuse and neglect of older adults, as well as developing information on new and emerging topics. We place this very much in a Canadian context and at a Canadian angle because of the many important and unique features of our country's approaches relative to those of other countries.

We also focus in terms of helping to link local, regional, and provincial and territorial networks by sharing ideas and information and helping them to keep informed about developments in everyday practices, in awareness building, and in practice and policy. This way, communities can find out what is happening in other jurisdictions on particular aspects of the issue and see if that makes sense for their local or regional efforts. That multidirectional sharing is key.

Although this social issue has been around for decades, each jurisdiction in Canada is at a different stage of awareness, knowledge, resources, and community development in this area. As a country, we are still in the early stages of development, but we have seen significant strides made in provinces such as Ontario, Quebec, the Northwest Territories, Alberta, Manitoba, and Nova Scotia. Those are some examples.

In most jurisdictions, that awareness building and that local support is carried out through very time-limited kinds of funding, not ongoing support. The federal elder abuse initiative over the past few years has helped build awareness, but sometimes at a cost to communities who have few, if any, resources to support that awareness and to help individuals. Awareness and appropriate resources need to go hand in hand. Nonetheless, at a community level we are seeing the beginnings of community resources and community responses coming together.

Across the country, our members encourage people to recognize older women and men as a socially, economically, and culturally diverse group that also spans at least two different generations.

Abuse and neglect of older women is a complex, multi-faceted issue that can occur in community settings, as well as in seniors' residences and care-and-support settings such as nursing homes and personal care homes. Older women can experience physical, emotional, financial, and sexual harms, as well as violations of basic rights that other adults take for granted. Commonly, they experience several harms at the same time. Sometimes the harms can occur not from active behaviours, but through neglect from a lack of awareness, lack of knowledge, or lack of personal or community resources. At other times, the neglect may be intentional.

Our organization also emphasizes non-ageist approaches and responses. There is considerable paternalism at one end of the helping spectrum: basically wanting to jump in and rescue or jump in and punish someone. Conversely, at the other end of the helping spectrum, there is the expectation that you can fix the problem simply by providing older women with information while ignoring the dynamics of the relationships that underlie the abuse or neglect, and the policies and practices within the community that help support it.

This is an area that is rife with many myths and misconceptions. We find that older women are often characterized as weak, vulnerable, and less capable people. You'll often hear abused older women described as naive, ill-informed, too trusting, too caring, and too dependent. There is a strong inclination to go around her and to do what people think is best for her.

People hope to be able to distill the often complex issues in this area and try to look for easy answers. There is much less attention given to the social and economic circumstances, such as gender roles and life experience, resource allocation, and social policies, that may facilitate and perpetuate abuse or neglect. Even well-intentioned helpers may ignore or dismiss older women's values, beliefs, and often remarkable strength in the face of adversity.

● (1535)

To better understand how older women are affected, I would like to draw on the lives and experiences of four older women I know in B.C. They have permitted me to share their stories to help illustrate some of the issues and the ways they are being addressed across the country. Their stories are common to many parts of the country.

If you have questions afterwards, I am happy to talk more about the issues, the community challenges, and the progress that has been made in helping these older women and in preventing and addressing situations similar to theirs. In case you are wondering, yes, the names and circumstances have been modified a bit to help protect the women.

Magda is the first woman. She is now in her mid-sixties. She lived in a small community in B.C. and has lived with physical, sexual, and emotional abuse throughout most of her married life. In the 1960s, when she was a young bride being assaulted by her husband, local police typically treated these situations as private matters and took a hands-off approach. There were no transition houses or shelters—there aren't any in her community even today—and the family doctor who treated her broken bones was reluctant to ask questions. Silence was the common response. The expectation of her church, culture, and community was that it was her responsibility as a wife to make things better.

Len doesn't assault her anymore. He simply wore her down through his name-calling and intimidation. Plus, he controlled all the finances. About five years ago, one of her children had almost convinced her to separate from Len and was helping her to live on her own. But Len's health started to decline.

Today he is starting to develop the mid-stages of Alzheimer's disease and once again is showing aggressive behaviour. She won't leave him now. The community health services trying to support the two of them are not necessarily aware of this long history. If an emergency arose and Magda had to leave suddenly, the local women's shelter probably wouldn't be able to accommodate her, and the only place for Len would be the hospital.

Her faith has been a pillar of strength for her throughout this time, and it is part of her resiliency. However, it is only in very recent years that there has been any work done in Canada to explore the role of faith communities and how they might be more supportive and how they might more appropriately help older women in situations like Magda's.

Then there's Helen. Helen is in her eighties. She is another woman who certainly knows about ongoing emotional abuse, as well as financial abuse. About 10 years ago, shortly after one of her sons committed suicide, her youngest son, Matt, started living with her. Matt had lost his job, and his girlfriend had broken off their tumultuous relationship. People who don't know Matt speak about how caring of his Mom he is. That's a very common stereotype for adult children caring for parents.

What they don't know is that up until the last two years, it was Helen who worked eight and nine hours a day babysitting, six days a week, to have enough money to support the two of them and to pay off Matt's mounting debts. She borrowed from each of her friends simply to get by.

Over time, friends became tired and frustrated with what they perceived to be her failure to boot him out. They also worried about their own safety. Matt has been involved with petty crime, including selling drugs to local teens and possession of stolen property. He was charged with assault against his girlfriend. While it might be possible for Helen to get a peace bond or a restraining order, that's often not a logical answer for people who are in her circumstances. It is too easy for him to come back. She wants help for Matt. She very sincerely wants that. But she's clear that she doesn't want him to go to jail, even for the things he has done to others.

Recognizing that, what has been developing only within the last few years in some communities within Canada are specialized police units that are used to dealing with the complexities of these kinds of situations. They also know how to work at the pace of the older woman or older man. They often involve a combination of a police officer and a social worker working together.

There are many other women in situations similar to Helen's. Sometimes they are persuaded by their adult children to cash in their RRSPs or to sell off their primary assets. Sometimes those transactions occur without their knowledge; they have lost their prime asset, but can't get it back. Because of the high cost of lawyers, the narrow scope of legal aid in most jurisdictions, and the retrenchment of legal support in poverty law, these women are effectively left out in the cold.

● (1540)

The Vice-Chair (Mrs. Tilly O'Neill Gordon): Excuse me, but you only have 30 seconds left. Maybe you can go to the recommendations.

Ms. Charmaine Spencer: First of all, I'd like to thank Status of Women for beginning this important and complex process of exploring the structural issues. It's important to look at the effect and the intersection of the provincial, territorial and federal government policies in the area. In many cases what appears to be a neutral policy in health care, housing, immigration, and access to justice can facilitate an environment in which abuse and neglect can occur more frequently and more easily.

Some of my colleagues and I have an interest in immigrant seniors, particularly those who are under sponsorship, and how those policies leave them and their families vulnerable.

We also recognize that direct funding for most of the services is the responsibility of the provinces or territories; however, we encourage the committee to help emphasize not only the importance of the issue, but the need for core funding for the agencies that are endeavouring to help, especially those offering specialized services to meet the special needs of older women, and to help provide training and services to service providers. We don't want to continue to be in a situation where provincial organizations have to hold teas in order to raise funds for our dedicated provincial abuse lines, as is the case currently in Ontario.

There is a need for the next step in training. There is a lot of basic information out there for service providers; however, we're finding an increasing need for specialized people and more sophisticated and in-depth information to help people, whether they are service providers, practitioners, or policy-makers, understand the complexities. As well, there is also a lack of critical analysis in this area, and we need to help understand the connections better.

Thank you.

The Vice-Chair (Mrs. Tilly O'Neill Gordon): Thank you.

Gloria Gutman is next.

Dr. Gloria Gutman (President, International Network for the Prevention of Elder Abuse): Thank you.

Elder abuse is very much a women's issue. It is fact that, even after adjusting for greater numbers, proportionally more older women than older men are abused. It's also fact that abused older women seeking help are often in situations of triple jeopardy, experiencing ageism, sexism, and victim blaming.

Elder abuse is not gender-neutral. As some of us are old enough to remember, when maltreatment of older people first came to public attention in the 1970s, it was called "granny bashing". In the ensuing years, the gendered nature of elder abuse seems to have been lost.

Why? And with what consequences? Was it a reaction to the growth of the feminist movement? Was it a reflection of the social values and perspectives of the mostly male researchers? Or was it because of the dominant assumption in an ageist society that old age means dependency and diminished competence?

One of the consequences of thinking about old age as a time of diminished competency and dependency is that it tends to lead to viewing all old people as sick and weak, sexless and impotent, and incapable of making valid decisions on their own behalf. Another consequence is that it leads to legislation and services that are developed on a model appropriate for kids but not necessarily for old people.

I'm not here today to argue the pros and cons of mandatory reporting requirements, which tend to be the trend in the U.S.A., in Israel, in the former Yugoslav Republic of Macedonia, and in several of our provinces. I am here to draw attention to the situation of ignoring gender neutrality and the fact that what that does is remove from visibility the differences in power between men and women and some of the challenges of abusive behaviour.

I also want to point out that despite the fact that it's been known for some years now that the rates of physical abuse are similar among young women and women aged 50 and over, the myth still persists that violence against women is violence against young women.

Also, I want to draw attention to the fact that abuse and neglect of older women and older men is an international issue. There is overwhelming evidence that it's not just a social problem for the northern countries or the developed world, but rather that just as population aging is taking place worldwide we also have abuse of older women and older men taking place all over the world, including within those societies that traditionally have been viewed as venerating their old people.

When it comes to what elder abuse is, there are three definitions commonly used around the world. The most common is one that was developed by a U.K. charity in 1995 and subsequently adopted by the World Health Organization and my organization, the International Network for Prevention of Elder Abuse. It is “a single or repeated act or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person”.

A common theme in several of the definitions is this idea of abuse of power; hence, there is emphasis on the relationship between victim and perpetrator. What we see in elder abuse is to some extent classically the same kinds of things we see in bullying in younger people: threats, intimidation, and aggression. These are used to maintain power and control of older people.

But there is more. As Charmaine mentioned, the types of abuse that typically are viewed on the international scene would be physical, psychological, financial, and sexual. then there's the issue of neglect, and there's also systemic abuse, wherein we talk about rules and regulations that discriminate against older people. In institutions, you add to these the physical or chemical restraining of residents, depriving them of their dignity and choice of activities, etc.

● (1545)

In terms of the extent of the problem, I can give you details on homicide deaths attributed to elder abuse in Europe. In a recent WHO report, they estimate that approximately 8,300 people aged 60 and over die per year from homicide. About a third of those deaths are at the hands of a family member. That third is considered as an estimate of elder maltreatment as the cause of their demise.

As to hospital admissions, data from six European countries show a U-shaped pattern of hospital admissions for assault: high for people aged 60 to 64, falling for several successive five-year age bands, and then rising then again, tellingly, for people aged 90 and over.

There have been a number of surveys conducted around the world. Not all of them are methodologically sound. Of those that are, the suggestion that comes out from them is that somewhere between 3% and 10% of older people—60 and over—living in the community experience abuse and neglect in a one-year period. The most common types are financial and psychological, but it's not uncommon to have several types of abuse experienced by the same person. Institutional rates are harder to estimate, as there are very few sound studies.

Lynn has been involved in this area for a number of years and will talk more about definitions.

I want to mention that prevalence rates depend a lot on who is doing the reporting. What you will see is that what is viewed as abuse by a general practitioner is different from what is abuse as viewed by an old lady or her caregivers. There also are differences in what is viewed as abuse depending on people's ethnic backgrounds.

The implication is that it's not easy—this, as Charmaine said, is a complex area. There's a very diverse victim population that includes people of different socio-economic strata—rich, poor, and in between. It occurs in ethnocultural minorities. It occurs in the gay and lesbian community, as well as among straights.

In terms of perpetrators, in the case of community-dwelling elderly, the perpetrators are mainly within the informal support system: family, neighbours, and friends. We're only just beginning, really, to look at the situation of home care providers and home support workers of various types. In institutions, of course, the focus has been mainly on staff, but there's also some consideration of family who come to visit and, more recently, of systemic issues.

In terms of consequences, the impact of abuse and neglect goes much beyond the event. Physical abuse of old people, for example, can be more serious than abuse of younger people, because their bones are thinner, among other things, and it takes longer for them to heal.

There has been quite a lot of work done in looking at risk factors. Dating back to the early 2000s, there was an American study done that put them into three categories: those that are possible risk factors, those that are probable, and those that are contested.

● (1550)

It is interesting that the more recent data has picked up on one of the contested ones, which is this idea that somehow elder abuse is a result of caregiver stress. This is a really important one, because it can be used as an excuse. The data simply does not support that this should be considered as a major cause. If you do consider it a major cause, what happens is that the old lady gets blamed. Somehow she's the victim and she should be complying with and being nicer to this person who is caring for her. It takes away from looking at the power differences and at the characteristics of the perpetrator.

To sum up, if we want to move this field to the point of zero tolerance—which in my opinion is where it should be—then we need everybody to come together to the playing field. We need the women's movement. We need government at all levels. We need the gerontological community. We need the faith groups. In the past, there has been too much silo action in this area and not enough as a cohesive whole.

Thank you.

● (1555)

The Vice-Chair (Mrs. Tilly O'Neill Gordon): We'll move on to Lynn.

When you have one minute left, I'll you know.

Dr. Lynn McDonald (Scientific Director, National Initiative for the Care of the Elderly): I'm going to try not to speak to what has already been said.

I would like to thank you for inviting me here as a witness, and I would like to commend the committee for looking at a very serious issue that has been hidden for a very long time.

I am the director of the Institute for Life Course and Aging at the University of Toronto. Our mandate is research and education.

I'm also the scientific director of the National Initiative for the Care of the Elderly, which is an organization committed to knowledge transfer, generally in the field of aging. We have 1,400 members. We produce knowledge in the form of what we call pocket tools, which we've had over 400,000 requests for. This easy tool was developed by a physician—he may be coming to this committee—and it's for identifying if elder abuse is suspected. There are only eight questions. It's very simple and is based on research.

Everything that NICE does is based on research—all of the pocket tools. As well, these pocket tools have been put up onto hand-helds for professionals to use, but older people use them and caregivers use them. Anybody and everybody can use them. As I've said, we've had tons of requests.

NICE is made up of an interdisciplinary group of people who bridge the university to the community. We have doctors, lawyers, anthropologists, psychologists, social workers, nurses, physicians, etc. They're all formed into teams that work together to produce these pocket tools. There are seven teams. The last two teams that were formed are on financial literacy in older women and on elder abuse. Everyone here is on the elder abuse team, which has produced a lot of work.

Having said that, what I want to talk about, given what everybody else has said, is research in this country, in which I think the government has played a very important role and needs to play an even more important role in the future. I'm going to make four points.

Number one is that in this country the last study of prevalence of elder abuse was done in 1999. The one prior to that, already alluded to, was done in 1989. We are way behind schedule in terms of knowing what's going on. The first study, which was done by Podnieks in 1989, was a very fine study of 2,008 people, but what was found in that particular study was that gender didn't matter, so hat being female did not matter.

The second study, by Pottie Bunge, which was done on the General Social Survey run by the federal government through Statistics Canada, also found that gender didn't matter, which is very interesting. Today, I will tell you, there are exactly 14 studies of prevalence. Prevalence is how many cases occurred in one year, as opposed to incidence, which is how many new cases occurred in one year.

What the problem has become is that we actually don't know the size of the problem in this country, yet we keep throwing money at it, hoping to solve it. What I'm arguing for is that we need to do better research that actually starts at the beginning. The beginning is how we define elder abuse.

I can talk about the 14 studies that have been done in the community and the nine that have been done in institutions, and I can say to you, for example, that in Sweden, 11% of people are abused in institutions, compared to 72% in Germany—right off the wall. Because there is no agreement around.... I mean, we do use the World Health Organization's definition, but it has to be operationalized into a study.

The problem is that nobody agrees on what elder abuse is. In the community, you can go from 0.8% in Spain to 18% in Israel. The variation is huge. In the Canadian studies it came out around 4%. In the latest U.K. studies, it was 2.6%. In Ireland it was 3%.

Why do definitions matter? They matter to all of us for the following reasons.

Definitions matter because that's who we include when we count the size of the problem. If we don't have a definition or we have a weak definition, we never know exactly how big the problem is.

● (1600)

Secondly, if we don't know how big the problem is, or if we don't even know what elder abuse is and what we include in it, we don't know what the legislation should cover. If we don't know the nature of the problem, we don't know what type of treatment to offer people. If we don't know the nature of the problem, we don't know who's eligible for services.

As a simple example, if you decide you are not going to include sexual abuse, your numbers are going to be lower, the problem is going to remain as big, and you probably can't compare it with those of other countries like Israel, Great Britain, and Spain.

All of this turns into money. The government has been arguing that we need core services and we need to pay for them. How many core services do we need and how much should they be? If we don't know what the problem is, we can't make that decision. That's the first point I want to make.

The second is that the two studies we have done in Canada basically didn't find gender to be a relevant variable at the time. I'm not saying that a whole bunch of other studies in the world have found that gender matters. As Dr. Gutman has been saying, the Americans did the risk factors for abuse: those that we know for sure are confirmed, those for which we have contesting evidence, and those in between, for which we have some evidence for and some against. Most studies out there today are for and against the matter of gender.

What I'm trying to say is that in Canada, we really don't know. We don't know for sure if gender is an issue. I would argue that gender will be an issue in the most neglected area, which is institutional abuse. I have done a study with Charmaine. The fastest-growing population in this country is 85 years of age and over. That population is women. That population is most likely to be housed in a nursing home.

Of the people in nursing homes today, the average age is 85. They tend to be cognitively impaired. They tend to have two or three diagnoses. They are socially isolated. Only 12% of them still have companions or partners. Something like 60% live away from their families. You can see the opportunity in the institutions just waiting to happen. When you talk about cutbacks and all the rest of it—like lack of staffing—you may have a disaster on your hands. Just from anecdotal information from where I've been, there are horrendous cases there. I'm not saying there aren't in the community, too, because there are.

The third point I want to make is that we talk a lot about intervention. We say that we need intervention. The problem from a research perspective, worldwide, is that we do not have good evidence to support what intervention we should be using. The latest study was done—fortunately by a Canadian—in 2009. It looked at 1,253 studies of interventions around the world, in two languages. It found only eight studies qualified to be included as a half-decent piece of research.

Of those eight, the researchers could not conclude which approach was best. It seemed to suggest, in conformity with what this government is doing today, that education was a good thing. Educating people about abuse seemed to be one of the mechanisms that had some support. So we have to be careful when we talk about what we need. We don't know for sure what it is.

The last point I want to make is that Canada may be ready to move forward. We're all involved in this. NICE has done a huge study on the definition of elder abuse in the Canadian context. It can be expanded or contracted to be used locally, nationally, or internationally. Almost everybody involved in preventing elder abuse in Canada has been part of this. We have had consensus meetings. We are going to have one tomorrow. I don't know how much consensus we will get, but we're going at it all day tomorrow with government policy-makers, practitioners, and researchers.

● (1605)

I would argue that HRSDC has put a lot of money into this and into developing the Canadian scene. Some of the way we went about it is really different from around the world.... We've had the data analyzed by outsiders and they say that Canada has made a huge contribution in starting to move forward in the field, at last. Done. I think you guys need to think about it. You've already invested a lot of money in this and I think it's time to move forward for a prevalence and incidence study, both in the community and really in the institutions.

The Vice-Chair (Mrs. Tilly O'Neill Gordon): I want to thank all three of you for your great presentations. I assure you of our government's support all the way.

I will now turn to questions. The first round will be for seven minutes, beginning with Madam Truppe.

Mrs. Susan Truppe (London North Centre, CPC): Thank you, Madam Chair.

Thank you, Charmaine, Gloria, and Lynn, for coming in today to enlighten us on all of your findings and studies. We really appreciate that.

Lynn, this question is for you. You mentioned bridging the community. You had seven teams. One of them was on financial literacy. Can you elaborate more on this project and on the financial fraud abuse of older women?

Dr. Lynn McDonald: Yes. Actually, it's a really exciting project. You do have a lot of the financial literacy tools that we've developed.

First, we trained trainers. We trained older women themselves around the whole issue of financial competency, knowledge, and abuse. We have several tools on financial abuse so that women can be alerted if they are in fact being abused, or if something is happening, or if their bank is not acting properly.

We have over 300 women. We've trained about 20 who go across the country and run two-day workshops with older women around financial literacy. That includes the whole notion of financial abuse.

In fact, at this time, we're testing a really excellent 25-item tool that has been validated in the U.S. The Government of Illinois uses it. We're using that in our workshops and testing, because we're looking for something that's really good, short, and sweet, so we can get to the point where women themselves know. Then we hope to pass it on to bankers, law firms that do estate planning, and so on.

Mrs. Susan Truppe: Thank you.

This question can probably be for either of you. Can anyone explain what are the causes or reasons that contribute to elder abuse? Has that been studied or does it come up when you're interviewing everyone?

Dr. Lynn McDonald: There are about seven different theories that have been offered to explain elder abuse. From what Gloria was talking about, the family stress model, which is flat-out wrong, through to intergenerational violence, the cycle of violence, that if you were abused as a child you're going to be abused as an older person.... There is the ageism theory, which may have some traction; it basically says that ageism attitudes in our society, which of course are all well hidden, are the cause behind elder abuse.

What other theories can you remember? Is that about it?

There are numbers of them. Those are probably the main ones. None of them have been shown to be true. What is going on now is that people are starting to say that different types of abuse probably have different causes. There may be an overarching paradigm. In fact, what we are testing right now is a life course perspective. This is really interesting. This gets to the intergenerational issue, where we actually found in a survey of 300 people—not random—that if they had been abused as a kid, they're abused as an older person. We're the first people who have ever researched that, so we were quite surprised to see that it was true.

● (1610)

Mrs. Susan Truppe: If the elderly person was abused as a child, the cycle continues throughout their whole life...?

Dr. Lynn McDonald: Yes. We were quite shocked. But it's not a random sample at this point, so I wouldn't like to say that.

Mrs. Susan Fruppe: For sure. Okay.

The Vice-Chair (Mrs. Tilly O'Neill Gordon): Did you want to comment, Gloria?

Dr. Gloria Gutman: The risk factors for the different types of abuse seem to be different, or the weighting of them. What will apply for financial abuse may not necessarily be exactly the same set of risk factors as you see for physical abuse.

Similarly, when you try to apply theories, as Lynn was saying, we have a very diverse group of women out there. There are some who, from the time they were children, were abused by fathers. Then they got married and were abused by a husband. There are other people who, for the first time in their lives, experience this when they're old, with a new partner, or because their old partner develops a dementia and loses control of understanding of who's friend and who's foe.

So one-size-fits-all is not anything that will work.

Dr. Lynn McDonald: There's a cycle of violence, caregiver stress, and the situation model, which means you're in a bad situation, so you'd be person who would steal their money, and... [*Technical Difficulty—Editor*].

Ms. Charmaine Spencer: Just following up on a couple of those points...[*Technical Difficulty—Editor*]...it's quite different. In general, we find that younger women—by which we mean women in their sixties, maybe into their early seventies—actually are at greater risk of physical abuse and psychological abuse within the community than older women are. However, older women appear to be more susceptible to neglect. There are differences there in terms of.... Again, it's really important to recognize that we're talking about at least two generations—and in some cases we're talking about more, depending on the beginning age that we're talking about—in terms of who's an older woman in the first place.

One of the things to be mindful of—it's one of those stereotypes out there around social learning—is that adult children may have experienced abuse or neglect when they were younger, and now it's turnaround time. We don't find much support for that. As a matter of fact, if you follow across the life course, for the children who experienced the most severe types of harm—physical abuse, sexual abuse—about a quarter of those go on to be abusers. So this idea that having experienced harm from somebody earlier in life sets you up to be an abuser later in life is not necessarily the case.

The Vice-Chair (Mrs. Tilly O'Neill Gordon): We'll move on to the NDP.

I understand that you're going to share your time. You have seven minutes.

[*Translation*]

Ms. Charmaine Borg (Terrebonne—Blainville, NDP): Actually, we are going to share our time.

I would like to thank our witnesses for being here today.

My question is for Dr. Gutman.

[*English*]

Is the translation working?

A voice: We're finding out who the culprit is—

Ms. Charmaine Borg: Okay.

[*Translation*]

You have done a number of studies and made several international comparisons with respect to this problem. I want to know whether Canada's weaknesses are comparable to those of other countries.

Have you seen models that work well in other countries and that we might be able to adopt here?

● (1615)

[*English*]

Dr. Gloria Gutman: The question is, have we seen models of different countries...?

Ms. Charmaine Borg: Yes, and if you've seen any comparable weaknesses in Canada compared to other countries.

Dr. Gloria Gutman: In my personal opinion, I think that Canada is doing as well or as poorly as the other countries. It's not that there's anybody else that's done a better job than we have. We're all in about the same boat of not really knowing what the best thing to do is.

Different countries have tried different things. There are a few, for example, that have gone to instituting mandatory reporting, but there is not enough research to know whether that in fact is the best way to go or the best way to go in a particular country.

Ms. Charmaine Spencer: I'd like to offer a slightly different perspective on that. I think Canada has been very strong in trying to avoid some of the challenges and problems within some other countries. For example, although there are some provinces that have been coming out with a protective approach, Nova Scotia is the only one that's based on a child abuse approach with mandatory reporting, and Newfoundland and Labrador has been modifying its laws and will have that kind of approach as well with its new changes to law. We've actually actively tried to avoid that because we recognize that it substitutes one kind of a taking away of power from the individuals. It is a very paternalistic approach.

In a couple of days, I'll actually be presenting some research that I've done comparing what happened in the child protection area and lessons learned from the adult protection area in the United States. What we find is that a very, very high level—a good third—of the reports that were received and that are investigated by the agencies that are required to investigate them are unsubstantiated. Now, that doesn't mean there's no harm occurring. It means that the agencies themselves have in many cases become overwhelmed with all of these calls that range in a wide continuum of harm, and that they establish significantly higher thresholds in policy and practice and basically treat all the ones that fall below that threshold as unsubstantiated, so those individuals don't get assistance.

The other thing we find is that much of the time our focus in terms of things like mandatory reporting is based on the assumption that there's going be support and services from government to meet the needs of older adults. What we find, however, unfortunately, is that the agencies have the mandate and tend not to have the funding and the resources to accomplish that mandate. We see that particularly when there's an economic decline: there are fewer services available for the individuals.

The other approach, again, that Canada has clearly and historically steered clear of, is trying to set up a special kind of law that tries to criminalize abuse and neglect of older adults. That is an American approach. There is no evidence to show that carving out a special law specifically for older adults in any way protects them more, or safeguards them more, than the general provisions within the criminal law.

● (1620)

The Vice-Chair (Mrs. Tilly O'Neill Gordon): Ms. Freeman.

Ms. Mylène Freeman (Argenteuil—Papineau—Mirabel, NDP): Thank you.

Thank you for being here. I only wish we had more time.

On Tuesday we spoke with the Public Health Agency about their awareness campaign. If I understood correctly, Ms. Spencer, is one of the shortcomings of campaigns for awareness and education—if they're solely directed at that—that they are perpetuating a myth that the reason people abuse elders is because they don't know enough?

That's putting a lot of pressure on the individual instead of actually on communities, on systems of health care, on social services, on the criminal justice system—generally, on structural things. I wonder if you could elaborate, although briefly, on why awareness isn't enough.

Ms. Charmaine Spencer: National awareness campaigns are expensive, just plain out-and-out really expensive. Of the $13 million earmarked for the federal elder abuse initiative, the federal government identified that about $9 million of that actually went to the national campaign.

It's not that the campaign doesn't have its value. It does, absolutely. The thing is, comparatively speaking, and without recognizing the level of resources within the community to be able to respond to that or to be able to work hand in hand with that, communities really feel under the gun, under pressure, to meet a need. The need was always there. It's just that to a large extent it has been hidden.

The Vice-Chair (Mrs. Tilly O'Neill Gordon): You have 30 seconds left.

Ms. Mylène Freeman: Briefly, in terms of structural recommendations you could make to the government...?

Ms. Charmaine Spencer: Looking at this federally, and particularly on the long-term care side, the big challenge will be those conversations in terms of health care, and so much of that responsibility falls on the provinces and the territories.

We need to be mindful of the fact that long-term care is part of health care. It's separate right now. It doesn't have the same kinds of safeguards and protections that other parts of health care have had in Canada.

We need to be really looking at the reasons why abuse and neglect occur within the long-term care setting. We tend to focus in terms of the profile of the residents, but we also need to understand the labour structures within that area. There is the fact that so many of the workers are female workers and casual labourers. That whole idea of continuity of care basically flies out the window in those circumstances.

The Vice-Chair (Mrs. Tilly O'Neill Gordon): So you feel....

Mr. Holder.

Mr. Ed Holder (London West, CPC): Thank you very much.

I'd like to thank our guests for attending today. I find your testimony very compelling. It's a little hard to absorb, if I might say, because you're sharing so much information with us.

I once asked my Cape Breton mum how you would eat an elephant, and she said “one bite at a time”, so I'm going to try to take this in little bites, if I may.

I'll start with you, Ms. Spencer. You mentioned that in terms of the Canadian Network, each jurisdiction is different. I presume you meant provincially, territorially, and federally. How would you rank them in terms of whether some provinces and territories are doing better than others? Do different provincial jurisdictions use different definitions within our own country in terms of how you define abuse and how it's reported?

Ms. Charmaine Spencer: They do have some differences in definitions in terms of their provincial strategies and things like that, but there are a lot of common elements. They draw fairly heavily on the World Health Organization definition, but there are different kinds—

Mr. Ed Holder: So would it be fair to say that it would be helpful if all the provinces and territories could come up with a common scoring, if I can be that crass about it, in terms of being able to validate your research and report back to those folks who need to be able to utilize that information for the greater good?

Ms. Charmaine Spencer: Sure. I think Lynn would probably speak to that, but—

Mr. Ed Holder: Ms. McDonald, would you speak to that?

Dr. Lynn McDonald: Absolutely: that's the whole point of what we're trying to do.

I would add—Charmaine knows about this, too—that part of this definitional issue is that we took all the definitions that are used in all the provinces, reviewed the case laws, which is what you do when you're a lawyer, and tried to match those legal approaches and definitions with the social science definitions so we could come out with a common view. This was not easy.

A year ago, I guess, we met with about 80 people from all over Canada. People made a lot of changes, but ultimately they all agreed. That's what we're going to try again tomorrow. We'll probably get way more feedback. It will be our last round. Then we're hoping that the various provinces, the researchers, and the practitioners—everybody—starts on the same page.

● (1625)

Mr. Ed Holder: I have some empathy for Ms. Gutman's efforts in terms of this international network, because if we can't even get our own definitions tightly defined—and I'm not sure I even want to say tightly defined—in terms that allow the response to the research given to the caregivers, to the scientists, to the folks we ultimately ask to implement solutions....

I guess where I'm troubled is that if you look at this bigger thing—and internationally as well—it seems to be, from what I heard today, a hodgepodge of different definitions of elder abuse. As I listened to testimony...respectfully, I'm not even sure you even agree yourselves. I'm not trying to provoke, I'm just trying to understand.

Ms. Gutman, you said—and let me get it here, please, because I think it is important that I say this—“Elder abuse is...a women's issue”.

Ms. McDonald, what I thought I heard you say is that we don't know if gender is an issue.

How do you reconcile that? I need to understand that a little better. Could you help us clarify this, please?

Dr. Gloria Gutman: I think the point Lynn was making is that in term of looking at risk factors for the different types of abuse, there has been a tendency to homogenize, to put all those different kinds of abuse together. There may be some types of abuse where men are more vulnerable than women and others where women are more vulnerable. If you moosh it all together, what tends to happen is that it is no longer clear which are the important characteristics. In terms of the amount of abuse that goes on, there is no question that more women are abused than men. I mean—

Dr. Lynn McDonald: There are more women.

Dr. Gloria Gutman: Because there are more women.

Dr. Lynn McDonald: There are more women, so more women are abused. But one thing we do know for a fact from the research is that when women are abused it's far worse than when it happens to men.

Mr. Ed Holder: Do you agree with Ms. Gutman? I'm not trying to start.... I'm just trying to understand. When you say that it's a women's issue—

Dr. Lynn McDonald: No, no, I noticed that myself.

Mr. Ed Holder: Yes, you might want to talk a bit—

Dr. Lynn McDonald: No, we're on the same team—

Dr. Gloria Gutman: We're on the same team.

Mr. Ed Holder: Okay.

Dr. Lynn McDonald: The point I'm making is that we don't really know, research-wise. We're gerontologists. We know, but we don't have it tightly proven—

Mr. Ed Holder: Fair enough.

Dr. Lynn McDonald: —and that's what we need to do.

Ms. Charmaine Spencer: I'd like to make a couple of points. There's one thing in terms of a definition.... Definitions sit within particular kinds of context and it's very useful for us to have a common definition in terms of our research. How that actually plays out at a policy level, how that actually turns into things like laws at a provincial or territorial level or federal level, is actually quite different. It depends on what we're trying to accomplish.

The other thing is in terms of understanding the level of the data that exists—or, more accurately that doesn't exist—within Canada. We're not just talking about specific prevalence and incidence data, but about the data coming from social agencies that are working on the issues with older women and older men. Their funding structure is so precarious in most circumstances that with any kind of data-keeping you can't get figures on things.

So even anecdotally, what the trends are, are you seeing more...? Well, the other day I was talking with the BC Centre for Elder Advocacy and Support, and they were saying yes, that in the last couple of years they have seen probably about a 50% increase in the number of calls they are getting, but they have introduced a brand new clinic—

Mr. Ed Holder: Ms. Spencer, I apologize for cutting you off.

Ms. Gutman, with regard to a hard number here, you indicated that 8,300 women in Europe die every year—

Dr. Gloria Gutman: People: men and women. Older people aged 60 and over die from homicides every year, a third of which were perpetrated by a family member.

Mr. Ed Holder: That's unbelievable. What's our statistic in Canada, please?

● (1630)

Ms. Charmaine Spencer: I think it's less than a dozen.

Mr. Ed Holder: Could I ask you to undertake something? Then I'll stop.

Ms. McDonald, you were showing us a very interesting book. Could I ask you to provide copies of that for our committee? I think that might be helpful.

Also, I thought your presentations were excellent. Could I ask you to provide those to the chair so we have copies? There's a lot of great information in there.

Thank you.

Dr. Lynn McDonald: Could I just say, though, that the evidence on gender is mixed? That is why Gloria says.... That's the reason: it's mixed. If we could get our research done, we would know for sure, and I'm sure it's that the women are targeted.

The Vice-Chair (Mrs. Tilly O'Neill Gordon): Mrs. Sgro.

Ms. Charmaine Spencer: To be clear about it, quite consistently across the country, about two-thirds of the calls that come to the attention of the community agencies relate to older women. It doesn't quite reflect the proportion within the population. But does that reflect that it's more hidden for older men or does that mean it's more common for older women?

The Vice-Chair (Mrs. Tilly O'Neill Gordon): Okay.

Sorry, Mrs. Sgro.

Hon. Judy Sgro (York West, Lib.): Thank you very much.

You spoke earlier—Ms. Spencer in particular—about the issue of families and how they have to be dealt with when you have a son or a daughter abusing the mother or the father.

Have we started to move forward in working in a multi-faceted way with the police when it comes to treating this issue? It's a very difficult issue to deal with the son or the daughter or the husband or whatever, so what's the approach? Surely we have progressed now to having a multi-faceted approach to these issues.

Ms. Charmaine Spencer: I guess the best I could offer is to look at what happens at an individual level. For instance, in the context of a particular teen, a police officer and a social worker would work together, as opposed to what happens more broadly.

Many of our approaches really are victim focused: they focus on the person who is experiencing the abuse. That creates a challenge, because in many instances it's both people—or the family—who need the support and assistance. If there is a mother whose son has a mental health problem or a substance use problem that may be part of the underlying reason for the situation, the focus still tends to be on her, as opposed to helping both of them.

We have that very strong victim-focused kind of approach. There are efforts—for example, within northern communities—to take more of a whole community and a whole family kind of approach, a well-being kind of approach. We're in the beginning stages of trying to figure out what makes sense in specific kinds of circumstances.

Hon. Judy Sgro: Is that holistic approach being taken throughout Canada as far as you're aware?

Ms. Charmaine Spencer: No, it's definitely not. We still tend to be very much focused on the individual as opposed to even the couple. As I say, we are starting to see these glimmers of hope in some communities. For example, within first nations communities, we're beginning to see some glimmers of trying to use a different kind of approach, because what we were offering before wasn't making sense.

The Vice-Chair (Mrs. Tilly O'Neill Gordon): Ms. McDonald, do you have a comment?

Dr. Lynn McDonald: I just want to add that I think part of the problem is in rural areas. I live in a huge city, and I train social workers, and they work with the police, nursing, medicine, and even the coroner. It's not always about the victim. It's more about how we can keep this person in their home and how we can keep an eye on them as much as we can to make sure they're there. I've seen a lot of service across Canada that tries to do that.

As to whether it's well funded, I agree with Charmaine that there's no way it is. We need more resources to support it, but it's the best way to do it. Gerontology, by definition, is interdisciplinary. There's no way around it.

Ms. Charmaine Spencer: I would just reinforce Lynn's comments that the multidisciplinary approach has gained a lot of prominence in this area, but "multidisciplinary" has typically tended to mean social work and health working together in most communities. Some cities are able to have other key players to help, sometimes with the individual and sometimes with family more broadly.

● (1635)

Hon. Judy Sgro: Thank you very much, Madam Chair.

The Vice-Chair (Mrs. Tilly O'Neill Gordon): I want to thank you very much for being here with us this afternoon. We are about to take about a two-minute break to let our witnesses leave and have our new witnesses arrive.

Thank you very much.

● (1635)

(Pause)

● (1640)

The Vice-Chair (Mrs. Tilly O'Neill Gordon): I will ask you to return to your seats so we can listen to our new witnesses.

First of all, I want to welcome Josette and Barb to our session here this afternoon. Thank you for being with us. It is a topic that is very dear to all of our hearts.

I will ask you to begin.

Ms. Barb Mildon (President-elect, Canadian Nurses Association): Good afternoon. Thank you for the opportunity to be here.

I am pleased to be joined by my colleague Josette Roussel. Both of us bring to you a clinical background in gerontology. It is indeed a subject dear to our hearts.

On behalf of Canada's 250,000 nurses, thank you for the opportunity to bring you the nursing profession's perspective on a significant and hidden problem: elder abuse.

Elder abuse is any action or deliberate inaction by a person in a position of trust that causes harm, or could reasonably be expected to cause harm, to an older person. This includes all types of abuse, including emotional, physical, sexual, and financial, as well as instances of neglect and violation of rights. According to Statistics Canada, seniors over the age of 65 represented 13% of our population in 2009. In that year, almost 8,000 instances of elder abuse were reported, an increase of 14% since 2004.

Elders are the pearls of our society. Just think of your own parents or grandparents and the many older adults who have had an impact on your lives. Recognizing the value of their contributions to our culture and our society must remain at the centre of their care and treatment.

Canada's nurses are concerned about elder abuse across the continuum of care and throughout the country, not simply because the rates are increasing, but also because it exists at all. As a society, we must have zero tolerance for elder abuse. By approaching this issue in a comprehensive, multi-faceted way, we can lay out a strategy that will build the culture of caring, dignity, and respect that our older Canadians deserve.

Elder abuse is not only a patient safety issue. It is also a public health imperative.

Our first recommendation to the committee is to develop a comprehensive strategy to prevent elder abuse. This strategy should include targeting outreach programs anchored in public heath services, supportive housing, and tax credits for seniors, as well as an accelerated focus on populations affected by conditions that create vulnerability.

Many of these populations are immigrants who experience barriers to accessing help, senior women who are homebound and living in poverty, and first nations, Inuit, and Métis peoples. An incomparable opportunity exists to challenge, through friendly visitor and day care programs and especially through public health nurse visits, the isolation and loneliness many seniors face.

Looking to an international example, Copenhagen has a program whereby public health nurses visit people over the age of 70 in their homes. They assess their needs, provide care, and generally ensure they have access to the wellness supports they need.

Evidence demonstrates that in addition to the visible interventions of nurses when working with the elderly, nurses bring a personal engagement and caring that reduces the feelings of isolation and profound loneliness that so many older Canadians experience. Such programs have the potential to address the high rates of depression that plague our elderly and are associated with the high rates of suicide in this vulnerable population.

We need a genuine investment in public health to restore the professional presence of nurses in the lives of our seniors. Nurses, through their holistic education and experience, and through their time spent with patients and families, see very real signs of neglect and abuse. Nurses are in one of the best positions to act.

As public health is our recommended vehicle to address elder abuse, education and awareness are the resources we need as care providers and as a society. We would like the thank the federal government for the funding they are directing to some important projects, such as the new horizons for seniors program. Through one of these projects, CNA has partnered with the Registered Nurses' Association of Ontario on the PEACE program, which is promoting the awareness of elder abuse in long-term care homes. This program is building these resources amongst care providers.

● (1645)

Ten long-term care settings were selected from across Canada to participate in the project. Each of these PEACE partners has developed and implemented tools, such as an education curriculum for health care providers, patients, and families, as well as printed materials, that are enhancing resident safety and quality of care.

Awareness programs based on these tools are currently being implemented to educate front-line workers. Topics include understanding and recognizing elder abuse; provincial, territorial, and federal laws surrounding elder abuse; what to do when elder abuse is present or suspected; and creating a work environment that values residents' safety and well-being.

Let me share with you one of the experiences reported by a PEACE project participant. A resident of a long-term care facility asks for toast. A care provider brings toast with jam. The resident says, “I wanted peanut butter, not jam.” The care provider says, “Well, I already brought you jam.” A colleague of the health care provider overhears this, remembers the learning module, and recognizes this as disrespectful behaviour toward the resident. The colleague intervenes to bring the resident what they requested, and then intervenes with the co-worker in a constructive way to identify the behaviour and promote dignity and respect.

This is the impact that a program can have. It may seem like a small example, but this kind of neglect is a pervasive problem in care settings across Canada. Programs like PEACE, that build awareness and give caregivers the tools to recognize and intervene in these situations, also give us hope and the power to promote the values of dignity, caring, and respect.

We'll include more of these examples and tangible results and impacts from the PEACE program in our written submission to each of you.

The PEACE partnership is an excellent first step, but we need to do more. Therefore, we recommend that the federal government fund the adaptation and implementation of the PEACE elder abuse tool kit across additional health care settings, such as acute and community care, and the development of the technological resources to support its implementation. Because the foundations of the program are universal, we could make a real difference by transporting it to other settings, such as hospitals, seniors residences, and home care situations.

Community-based service providers are an excellent front-line resource for preventing elder abuse. For example, a home care nurse or personal support worker is in an excellent position to identify signs of abuse in the home of a client, signs that might otherwise go unnoticed. They may notice that a client cannot buy food or personal care items, or pay bills, that valuable items suddenly go missing, or that bank statements are no longer going to their homes. Their client could well be a victim of financial abuse.

In addition to adapting the PEACE partner tools for use outside long-term care settings, they should also be delivered in the format that is the most appropriate for the end user. For example, if the home care worker described above uses a smartphone, a software app might be the best medium for her to access the necessary information. She could refer to it for an immediate, on-the-spot intervention, and to develop a specific plan of action for that particular instance of abuse.

Such tools could also be adapted for use in other sectors and settings, and for other age groups, allowing social workers, first responders, and family members to quickly and easily access advice, direction, and reassurance.

The beauty of this model is that elder abuse prevention tools adapted to various audiences and settings would be developed from a common framework. This would prevent a piecemeal approach, where concepts and terminology vary widely across regions and across settings. That spells better integration of services and interventions for the victims of abuse no matter what their circumstances.

Registered nurses across Canada will, of course, continue to promote the prevention of elder abuse, and we ask for your assistance in stepping up the intensity of our efforts. By transposing the successes of the PEACE project to new areas and investing in a public health-based prevention strategy, Canada can take a tangible and positive step towards ending the cycle of elder abuse, wherever it may occur—a crucial step towards a safe and healthy future where dignity and respect are a right, not a luxury.

● (1650)

Thank you so much for your time and attention today. I look forward to your questions.

The Vice-Chair (Mrs. Tilly O'Neill Gordon): Thank you for being with us.

We will start with our first question from Susan Truppe.

Mrs. Susan Truppe: Thank you, Barb and Josette, for being here today. It means a lot to the committee to hear your facts and your thoughts on elder abuse and women. I just have a couple of questions.

I wanted to know a little more about a project that you called "promoting the awareness of elder abuse in long-term care homes". I think you touched on it. You said that this project is to develop education sessions on elder abuse prevention and deliver them to front-line service providers in five long-term care homes across Canada.

Could you tell us about the further benefits of this project on elder abuse?

Ms. Barb Mildon: Yes, I will, and I will also invite my colleague Josette to respond.

The further benefit of this is simply a ripple effect. When you teach behaviour that should be emulated across sectors and settings, and when you embed that within a care professional group, you begin to show all of society what needs to happen.

We know there is mobility amongst health care providers. If they learn the right way to be in one of their settings and then choose to work in a different place, they take that learning with them. They then also become the vectors of change, as we saw in the example of the toast. It's a simple example, but that care provider taught another care provider. This is a ripple effect that can happen. That would be one of the further changes.

Josette, do you see others?

Mrs. Josette Roussel (Nurse Advisor, Canadian Nurses Association): I see that as a team approach: you create that awareness, that ownership of an issue, and that sharing of knowledge, and you learn from each other. That is also shared amongst the families and the residents. It has a really powerful effect overall on the culture around the long-term care homes, which sometimes do not have those resources—the educational material or even the tools—to support them in those difficult situations.

That, anecdotally, is what we are learning from the PEACE project. The initial evaluation is showing that staff, especially the unregulated health care providers, feel that they can recognize it and that they know what to do. They feel that they have that support and knowledge, that they can make changes and do better. The overall goal of their practice is to do no harm and to do the best for their residents. The project is creating that effect, and we'll know more after it's completed in March 2012.

Thank you.

Mrs. Susan Truppe: Thank you.

Am I still good for time?

The Vice-Chair (Mrs. Tilly O'Neill Gordon): You have four minutes.

Mrs. Susan Truppe: That's good.

When the Public Health Agency of Canada presented to the committee, they mentioned that a gender-based approach that considers treating older women and older men identically will not ensure beneficial outcomes because men and women occupy a different socio-economic status and experience different living conditions. I was wondering if you could tell me more about the gender-based differences that you have experienced with your organization.

● (1655)

Ms. Barb Mildon: It's a difficult question. I would always go back to at what point we're targeting the interventions. As we teach people about elder abuse across the age spectrum.... We should be starting to teach people in grade school, to be honest with you, from my perspective.

In that case, yes, I believe there needs to be attention paid to gender-based differences. We know that women still do not often occupy positions of power in their family circumstances, in society as a whole, or in their workplaces. Understanding that power imbalance at a young age is quite important. We also know that we need to address cultural differences and the way that various cultures perceive women and their place in society. That's important.

I would see that as the main emphasis for gender-based differences in teaching about elder abuse. However, in settings where our elders are vulnerable to elder abuse, I cannot personally see a difference with health care providers around gender-based differences. We need to teach health care providers a general way of being, a respectful way of being—in nursing, we would say a caring way of being—but also, certainly, a human way of being. To me, those principles are universal.

Mrs. Susan Truppe: Thank you.

If I still have two minutes, my colleague, Ed Holder, has a quick question. I'll share the remainder of my two minutes with him.

Mr. Ed Holder: Thank you.

Thank you to our guests.

Ms. Mildon, you indicated that there were some 8,000 incidents of elder abuse in I think 2009, a 14% increase since...forgive me, was it 1994 you said?

Mrs. Josette Roussel: It was 2004.

Mr. Ed Holder: It was 2004. Was that because there's an environment where it's more acceptable to declare that kind of abuse? I'm not even sure how to ask that. But if you understand what I'm saying, is it because there's more abuse or just that more is being reported? Do you have a sense of that?

Mrs. Josette Roussel: That's a very good point you're making.

I would have to go back to the statistics, but if I remember correctly from the report, it's related to, as you say, there being more awareness, and more reporting goes with the awareness. That would increase the numbers. But I would have to go back and double-check if they've made a link between the two.

Mr. Ed Holder: Speaking of links, we had three very thoughtful guests before you. On the information that relates to the incidents of abuse, how do you feed that into the kinds of information they utilize for their purposes?

Ms. Barb Mildon: Is it specific statistics that you're talking about?

Mr. Ed Holder: Yes, please.

Ms. Barb Mildon: My sense would be definitely that it's what we use to create the imperative for the kinds of programs that we're promoting, the kinds of programs that we're designing. So the first thing is that statistics at least raised the flag about the actual incidence of this problem, the actual scope and span of it.

I would add two other points to your question regarding statistics. Indeed, we are making it not only more acceptable to report incidents of elder abuse, but we're recognizing them sooner, and that, I think, underpins those statistics.

Mr. Ed Holder: What I'm trying to understand is in regard to the 8,000 incidents of abuse that you have in terms of data collected. Are you using that as the basis for programs that you see as appropriate to put in place? Or do you somehow give that information to others so they take a greater macro approach to appropriate programs? I guess is what I'm trying to understand is, are you using it for your own individual purposes?

Ms. Barb Mildon: I would say it's both, absolutely. Number one, it tells us that this in an important place to put our resources, our interest, and our focus. Number two, it gives us a baseline from which we can measure. The problem with that baseline is simply that there's a whole lot of abuse we're not measuring and not reporting, so to some extent it becomes an artificial baseline.

Mr. Ed Holder: Thank you very much.

The Vice-Chair (Mrs. Tilly O'Neill Gordon): We'll now go to the NDP. They are sharing their time between Ms. Hassainia and Ms. Borg.

Ms. Hassainia, please begin.

[*Translation*]

Mrs. Sana Hassainia (Verchères—Les Patriotes, NDP): Thank you.

First, I would like to thank the witnesses for being here today.

We are seeing that people who take care of the elderly in nursing homes are also victims of abuse, and that may lead to more situations of abuse toward their patients. Could this violence be the reflection of poor screening of staff, insufficient training, or a combination of the two? Could there be other factors?

● (1700)

Mrs. Josette Roussel: Certainly, the factors related to the abuse of residents may include lack of staff knowledge, insufficient initial training, experiences with an elderly person or the approach used.

As for the situation you spoke about of a member of the nursing staff being abused, that may also happen. We also see that type of situation. Programs have been put in place in the care environments. These programs are there to support the employees and help them report cases of abuse. There is a specific model that needs to be followed. It's a different approach, but it's also what happens in reality.

Mrs. Sana Hassainia: Are there tools for that?

Mrs. Josette Roussel: Yes.

Mrs. Sana Hassainia: Do you have any figures?

Mrs. Josette Roussel: I can't give you any figures off the top of my head, but this takes place mainly when we train people who have to work in these environments. We train them both on the approach and on how to react in certain situations and how to report them. Yes, there is a need for training in both cases. You raise a very good point.

[*English*]

Ms. Barb Mildon: May I add to that very excellent response that what we would like you to focus on, what I ask you to look at, is the situations in which we have bylaws or requirements that registered nurses be on site in long-term care facilities for at least one shift a day or that they constitute a certain percentage of the staff. Help us to ensure that we have good staffing or that we have the professional presence of nurses to guide the kind of care and care design that is taking place.

The other thing we need to remember is that the long-term care sector is perhaps the most poorly resourced sector of our health care system. This plays a role in the number of staff and the preparation of staff that are brought to bear to care for our vulnerable elderly.

The Vice-Chair (Mrs. Tilly O'Neill Gordon): You have four minutes left.

[*Translation*]

Ms. Charmaine Borg: We all know that with an aging population, public and even private institutions are overcrowded. The elderly often have to be cared for by informal caregivers.

As a nurse, can you tell us whether informal caregivers are getting enough training to truly prepare them for this role?

I think it's an interesting dynamic. These people jump into this without really knowing what is waiting for them. They may not really know how to react in an abuse situation.

[*English*]

Ms. Barb Mildon: Let me begin and then invite Josette to respond.

This is why we need so very badly to have a well-resourced public health nursing system. It is proactive visits by public health nurses that can help caregivers cope with the very real strain of caring for vulnerable elderly in their homes. They can provide resources, they can link to day care centres, and they can promote the wellness of the seniors themselves so that they stay better able to cope in those environments. We need to look at proactive approaches. As for training themselves, that is another thing that public health nurses can do quite well.

I can only bring you the example of my own grandmother. Certainly we had family involvement, but she benefited greatly from regular visits from a public health nurse. Those public health nurse programs have been seriously eroded across our country. The kinds of proactive visits I'm talking about are primary targets for reduction when budgets are an issue.

So I believe it's a combination of both.

There are other strategies in place to also look at supporting our caregivers, most of whom are working in a volunteer capacity as caregivers while balancing many stresses in their day-to-day lives and who can use all the support we can give.

● (1705)

[*Translation*]

Mrs. Sana Hassainia: Could you quickly give us some numbers on abuse in public organizations and in private organizations. You seem to favour public organizations, which would be more effective. Could you explain why you came to that conclusion?

[*English*]

Ms. Barb Mildon: I would be remiss if I were giving you the impression that I favour one or the other. They both have a very important place in our care system.

Private organizations have opportunities to influence their pricing and their admission criteria in ways that aren't in place in public organizations or among public providers. That's one key difference. If you have an ability to pay for service, you generally can influence a better or richer mix of staff, and perhaps a wider array of services. That's what I'm speaking to.

Long-term care settings that are public in nature, that are not for profit, receive all walks of life in terms of vulnerable elderly, so they perhaps don't have as much opportunity to influence the rich staff mix that's needed. I really shouldn't even use the words “rich staff mix”. I'm talking about a staff mix reflective of the continuum: registered nurses and registered or licensed practical nurses, as well as health care aids or personal support workers. That's really the difference I'm trying to alert you to.

The Vice-Chair (Mrs. Tilly O'Neill Gordon): We'll now move to Roxanne James.

Ms. Roxanne James (Scarborough Centre, CPC): Thank you, Madam Chair.

Thank you to both of our witnesses. I'd like to welcome back Ms. Mildon, a familiar face at our committee.

I have a question related to our family violence initiative, FVI, and our long-term commitment from the government to address violence within relationships involving kinship: intimacy, trust, and dependency.

The Public Health Agency of Canada leads and coordinates this program on behalf of 15 different partner departments, agencies, and crown corporations. Can you explain to the committee the impacts of this coordinated approach through the federal government? Would you please expand or elaborate on that for the committee?

Mrs. Josette Roussel: No. I don't have knowledge of this particular program. I can just comment on our experience with the PEACE project, which is really a Canadian approach and is showing that coordination is providing common language and common learning around the issue of elder abuse. We're seeing great benefits from that coordinated approach.

I cannot comment on the other program.

Ms. Barb Mildon: I regret that I, too, don't know it as well as I would like to, but what I do know from my experience as a home care nurse and also from nursing in general is that the kinds of tools that Josette has talked about and that I've talked about in reagrd to the PEACE program lend themselves beautifully to family violence interventions.

It's the emergency room nurses who may see the first signs of family violence. We need tools for them in order to alert them to what the family violence signs can be and what they can do to intervene. Home care nurses also see it in their settings. The family violence program, as I see it, has the greatest potential to do exactly as you've said, by going across the sectors: it is that seamless, integrated approach to elder abuse that will have the greatest effect.

I see this program as very pivotal to your deliberations.

Ms. Roxanne James: Thank you for the answer.

I want to also acknowledge that we have talked in this committee about the programs through the government that have been quite successful. One is the federal elder abuse initiative. I believe it has been a program and money that was well invested. In addition, the new horizons program is continuing, and our commitment to invest further moneys into it has been well received right across Canada. Of course, there is our Speech from the Throne and the commitment to tougher sentencing against elder abuse.

I'm just wondering, outside the throne speech, about the different programs that are in place right now with which you are familiar. Which ones do you see as having been most successful? Where do you see the fruits of the labour and the investments and so forth? I wonder whether you can comment on that and on why you feel that such is the case.

● (1710)

Ms. Barb Mildon: That is a wonderful question, and very comprehensive, and I really want to do it justice. If I may take the liberty, I will say that we will respond to these questions in writing as well afterwards, where we can be much more comprehensive.

All of these projects and programs that have been funded make a difference in going forward. The difference they make is that they lay down the evidence of what works. We saw that from your earlier presenters. We see that with the new horizons program, of which I've brought you an example.

Now what we need to do is integrate into an entire whole what we've learned from each of these disparate or separate programs. If funding were to be made available on a “next” basis, I would be looking for programs that bring these learnings into an integrated approach to elder abuse across sectors and settings and that provide demonstrated evidence that there is cross-sectoral collaboration and implementation of the programs.

We say in research that descriptive research is where you begin. Descriptive research gives you the evidence that you need, but then the next step is implementing that research. I think the greatest benefit of the projects that have been done is that of giving a voice to those who understand the issues and demonstrating that certain interventions make a difference. Now it is a concerted whole.

I believe that earlier in your deliberations you talked about despair over the definitions being different across provinces, territories, and indeed the world, and the presenters spoke of their work to achieve consensus on a definition. It's the same approach when you look at a program of interventions to prevent elder abuse.

I hope that's somewhat helpful. I promise you a more comprehensive answer.

Ms. Roxanne James: Thank you very much.

I would like to touch base on one more issue. Previously, one of the witnesses mentioned that when we think of abuse against women, we always assume that it's a younger woman. Again, we sometimes isolate that to a certain age bracket.

I thought I heard you mention something about suicide rates. That is another topic in which, when we think of people who commit suicide, we're always thinking of a younger generation. We don't really associate it with someone in their sixties or seventies.

I'm not sure whether I heard you correctly, but could you talk about whether this is happening within the elder community? How often is it occurring? Also, is it actually tied to, or can you see links back to, elder abuse?

Ms. Barb Mildon: I'll answer the easiest questions first.

First of all, yes, it is a reality in our seniors communities and in our seniors population. There is a rising incidence of seniors committing suicide. The reasons they commit suicide are probably as diverse as those for any age group in our population. We can speculate that loneliness, poverty, and despair create the situations in which people would choose to end their lives. I can tell you with certainty that it is rising, that we are concerned, and that we need to address it.

In terms of the more specific numbers, I would have to get back to you on the statistics, but I certainly know that's happening. As you may have heard me mention in my earlier presentation, my day-to-day world is mental health. We are definitely seeing this as a national concern.

The Vice-Chair (Mrs. Tilly O'Neill Gordon): Thank you.

Ms. Sgro has gone, so we'll move to Ms. Bateman for five minutes.

Ms. Joyce Bateman (Winnipeg South Centre, CPC): Thank you, Madam Chair.

Thank you both so very much for being here. It's very important to have this discussion.

As I'm sure you're aware, the government has taken unprecedented action to address the issue of supporting seniors positively and to combat elder abuse in all its forms. I'm fascinated to hear you speak to a number of the issues, and from the health care perspective.

I have two questions. We have invested a significant amount in an awareness program. There have been print, radio, and television advertisements. Could you speak to the effectiveness of that program, systemically, in your world of care? Also, perhaps you could tell us what else is needed on that piece.

● (1715)

Ms. Barb Mildon: Thank you for the question.

I'm so pleased with the question because I have seen the TV ads. In particular, I'll speak to those. There is one most profoundly affecting ad in which there's a gentleman who is with an elderly woman. He takes money forcibly from her. She offers him some; he takes the whole wallet. It's a most profoundly moving situation, and it is part of that awareness campaign.

First of all, I believe this campaign is truly having an effect. It is visible. It is eloquent. It certainly depicts the wrong behaviours and, therefore, the right behaviours.

I think what we need to do more, and next, is continue with the tools we need. That particular vignette shows a neighbour peering out of their window. The curtain is drawn aside a little and the neighbour is peering. What do we tell the neighbour to do when they see that? Do they phone the police? Do they phone public health? Do they go knocking on the door? What do they do? We need to make tangible advice and resources available to that neighbour who's peering and concerned.

Of course, I will also go back to this notion of an outreach program to those isolated elderly. Where could that woman go, knowing that she's not safe at home? Do we have a network of women's shelters she could turn to? Could she walk into the local police station, and would she be comfortable doing so? What resources are there for that woman who clearly knows in her heart that she's being abused? That would be my first answer.

Ms. Joyce Bateman: Thank you for that.

We've had a number of witnesses at this committee. The other day we had Health Canada representatives and the Public Health Agency. How does the Public Health Agency, which has been empowered with this program to some extent, work with your association of nurses? Again, how could we do it better or how could they do it better?

Ms. Barb Mildon: I must tell you that I am profoundly grateful to the Public Health Agency of Canada. They partnered, for example, with the Community Health Nurses of Canada. That is one of CNA's affiliate and associate groups of nurses.

Through that partnership, they made it possible for the Community Health Nurses of Canada to create new competencies and a new certification program that gave them the skills and knowledge they needed to be the best they can be in their field. Knowledge of elder care, which underpins an understanding of elder abuse, is definitely an outcome of that partnership. What they're doing wonderfully is that they're partnering and they're seeing the benefit that each group of health providers can bring to many issues in public health.

I think the other thing they do wonderfully well are their reports, which are quite profound, quite comprehensive, and very much accessible. I would suggest that they are doing all the right things now with the study they have brought together, which I understand they have presented to you.

I can't speak more on a concrete basis to a day-to-day intervention, because I suppose in some ways we're waiting for the outcomes of the current projects. I do know that they are putting the right resources in place, they are making the right partnerships, and they are truly putting that federal funding, from my perspective as a nurse and as a community health nurse, to good use.

Again, I would be happy to answer that better when we go away and make some...[*Inaudible—Editor*].

Ms. Joyce Bateman: Do I have...?

The Vice-Chair (Mrs. Tilly O'Neill Gordon): No.

Ms. Joyce Bateman: No? Okay. *Merci*.

The Vice-Chair (Mrs. Tilly O'Neill Gordon): I'm sorry.

Ms. Freeman.

Ms. Mylène Freeman: Thank you very much for being here.

I am actually looking at the policy brief from the Canadian Nurses Association, which is called "The Long-Term Care Environment: Improving Outcomes through Staffing Decisions". It talks about this:

> Fifty-four per cent of nurses working in [long-term care] report that there is not enough staff to get the work done. Staffing decisions therefore have an impact on patient outcomes.

This actually results in violence for nurses and for front-line workers as well. It also states:

> The Canada Health Act does not cover [long-term care], and the provision of this type of care falls under the jurisdiction of provincial and territorial governments. In consequence, there is a range of approaches to funding, regulating and governing LTC throughout the country.

The position statement of the CNA states that your association believes that a publicly funded not-for-profit health care system is the most efficient and cost-effective way of providing access to health care services for all Canadians. You also say that you support the principles of the Canada Health Act, which are universality, comprehensiveness, portability, and accessibility.

In reference to this position, which I think is amazing, could you speak specifically about support for long-term care facilities and how this might be helpful against violence, both for nurses and for patients?

● (1720)

Ms. Barb Mildon: I'll start and then invite Josette, who has experience on the front lines in implementing some of this, to comment.

First of all, the kinds of tools that are coming from the projects we've talked about are directed specifically to health-care workers in the long-term care setting. It is these kinds of tools—but perhaps even more importantly, the opportunity to learn about the processes that prevent elder abuse—that are having the greatest effect.

By that, I mean that we generally tend to think that any of our front-line health care providers need to spend 100% of their on-duty time providing care. In actual fact, in this knowledge age we need to take them away from their care-providing duties for some small periods of time to give them this kind of education and these kinds of resources. These projects generally provide funding to enable us to do that. Those opportunities to get the education and share and reflect on their experiences are having a beneficial effect in our care settings.

There are other factors that we need to look at in terms of what helps care providers be assertive, or aggressive, if you will, in preventing elder abuse. One is also having a work environment that's conducive to being healthy. So not only will the specific tools around elder abuse help them, but there is the more general principle that CNA is promoting of a 70:30 mix of full-time to part-time or casual staff. We believe that this 70% mark of full-time nurses or care providers assures a continuity and understanding of those patients, and that translates into better care.

We believe that attention to work environment issues, such as a place where they can have a break, getting their breaks, looking after their musculoskeletal health through ceiling transfer lifts, and those kinds of things, all play into a healthy work environment. When you feel healthy at work, you give better care and have better outcomes.

You're quite right in saying that patient safety and staff safety and well-being go hand-in-hand. But I will not let my colleagues off the hook by saying there's any excuse to not provide the best care, regardless of one's setting. We know as nurses how to advocate and we work under a code of ethics that CNA provides and that teaches us and informs us about how to provide care.

Mrs. Josette Roussel: In the PEACE project, we describe the awareness education curriculum. We didn't describe it in detail, but the awareness modules have an understanding of elder abuse as one component. They recognize elder abuse and have an understanding of the laws surrounding it and of intervention strategies. But the fifth component of that program is healthy work environments. Barb alluded to this going hand-in-hand; if you have a healthy work environment, you will have health, and the workers will provide better care.

The Vice-Chair (Mrs. Tilly O'Neill Gordon): Thank you.

We have time for one more question.

We'll go to Mr. Leung.

Mr. Chungsen Leung (Willowdale, CPC): Thank you, Madam Chair.

Thank you for an excellent presentation. It was quite comprehensive.

Here's what I would be interested in knowing. There are various departments for funding sources from the federal government, either through the minster responsible for seniors, or through Citizenship and Immigration, where some resettlement programs go into the education of seniors and their rights, and there are also some from our Ministry of Health. How could all of these be coordinated?

Or are they coordinated? It seems like they're going in scattered directions. I'd like to hear your comments on how this can be coordinated and delivered as more comprehensive aid or a form of elder abuse prevention.

Then, as a tangential question to that, we're in a pluralistic society. Besides the two official languages, there is a host of first nation languages, and in urban centres, 180 languages are spoken. Where do you get the skills to go in and do this? Seniors generally do not have very good linguistic skills in one of our official languages.

● (1725)

Ms. Barb Mildon: I believe you've asked two key questions. One is the integration question and the second is the education or outreach question.

On the integration question, I think you raise wonderful opportunities. It is true that when funding or programs are fragmented across several entities, whether that be in the health care system or the government funding system, I would suggest that their effect is diluted.

If there is an opportunity to somehow create a central point of seniors care and outreach seniors programming, call it what you will, that central point where all seniors-related effort is going through a single point, I think that may bring about a greater and more coordinated impact. That is something for your consideration. I certainly see that.

We've talked about silos that happen in our health care system. We have the acute care silo, where everything is funded globally in our hospitals, etc., but what happens during those transitions from hospital to home? There's a gap there. We often don't have the communications. We often don't have the transfer of information that enables us to then go from the hospital emergency room, from patient discharge, into the home, and have one seamless provision of care. That's a demonstration of where we have the gaps. Transitions invite gaps. I believe you're absolutely asking a good question, and there may be a remedy for that.

With regard to your excellent question, I'll take it down to a finite level of language skills. We certainly know that senior women in particular often have fewer opportunities to learn the language of the community they're living in. That's often the case. That adds to their sense of isolation. That adds to their inability to reach out for help, and it becomes a downward cycle.

Again, I want to sound like a broken record and say that it is services like public health nursing or services that go into homes—outreach services—that can identify these situations early, bring solutions, and connect those vulnerable seniors to services that will help them navigate. That I've seen in action over the years.

Mr. Chungsen Leung: I have one more question for the Canadian Nurses Association. Do you cut across all types of nursing, from the Victorian Order of Nurses to home care, home care assistance, the emergency room, the entire spectrum, so that no one falls outside of that nursing umbrella?

Ms. Barb Mildon: I'm so proud to say no. For registered nurses, no. Unfortunately, Quebec is not an official member of our organization, but we have many linkages with our Quebec registered nurse colleagues. I would further add that we have 43 associate and affiliate or emerging groups of nurses who are already RNA-CNA members but who also then choose to self-identify with a given specialty group. To look at me, I'm a member of the Community Health Nurses of Canada and, through that, certified. these nurses have the opportunity to develop their skills even further and receive a national credential for their knowledge. It is a comprehensive continuum.

The Vice-Chair (Mrs. Tilly O'Neill Gordon): Thank you.

I want to thank you for taking time to be with us today. I congratulate both of you on an excellent presentation.

Mr. Ed Holder: Just before we adjourn, Madam Chair, could I ask, perhaps through you to the clerk...? We've had a couple of sets of presentations now. It would be helpful for the presenters to provide those to us at the time so we can follow along with them. There is a lot of statistical information that I know we'll be getting, and it might be helpful for us in both official languages. Can I direct the clerk to make that ask of those very nice people who do present in the future?

● (1730)

The Vice-Chair (Mrs. Tilly O'Neill Gordon): Your point is well taken.

Ms. Barb Mildon: Please, for today, if you would like to take one, my colleague will make them available.

The Vice-Chair (Mrs. Tilly O'Neill Gordon): Thank you.

The meeting is adjourned.

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