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Harm Reduction and Abuse in Later Life

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Background

Abuse and neglect of older adults reflects a complex combination of sociological, psychological and medical factors operating at and between structural, organisational, family and individual levels.

Background

- 4-10% of adults in Canada experience some form of abuse or neglect in later life (156,000- 390,000 seniors)
- **Primary types of harms:** physical, psychological, sexual, financial, active or passive neglect, violation of rights
- **Sources:**
 - Spousal abuse
 - May continue into later life, lasting 20-50 years, intermittent or newly developed (health change, dementia)
 - Abuse by family- which may or may not be in the context of giving support or care
 - Abuse by friends/ acquaintances

Outcome Measures

- Identifying and measuring successful outcomes for abused or neglected individuals is difficult
 - there are multiple forms of abuse,
 - more than one form can occur at the same time.
- Abuse and neglect in later life is multi-factored. No approach is likely to work for all persons or even most persons.

What Are We Trying to Accomplish?

- **When assisting abused older adults**, it is important to recognize that the type and degree of abuse creates substantially different kinds of needs for the person, including immediate and longer term needs.

What Are We Trying to Accomplish?

- Where resources are scarce, the assistance available to abused or neglected older adults tends to have a crisis focus
 - services often become involved only when the abuse reaches an “unacceptable” level, rather than focussing on working to reduce harms earlier or prevent the abusive situation from escalating to a crisis.
- Leads to less than optimal outcomes.

Outcome Measures for Assessing the Success of Interventions

- **Acceptance of help**
 - Is the person willing to accept the service being offered?
- **Changes in harm**
 - Has the specific harm stopped or is it occurring less often (a reduction of harm)? Does the older adult feel as if she or he has more control over the situation? And, very importantly, have any other unintended harms occurred?
- **Sphere of control and autonomy**
 - Has the approach been implemented in a way that is least intrusive in the person's life but still accomplishes the desired ends? If the person stays in the harmful situation, does she or he feel greater control of the situation?
- **Ethical principles**
 - Which ethical principles are given prominence and which are given less weight? How is a balance between different values achieved?

Acceptance of Help

- A review of 128 cases coming to the attention of local community service agencies in Quebec noted the greatest obstacle to intervention was victim or perpetrator's refusal of services. (Lithwick, Gravel et al, 1999)
- **The victims declined help in 58% of the cases. The perpetrators declined help in 47% of the cases they studied.**
- The high rates of refusal may reflect what is offered and the way in which it is offered (Bergeron, 1999)

Refusal of Service and “Non Compliance”

- Refusal of service/ assistance in senior abuse is extremely commonplace (> 40% of the cases).
- But what we are offering and how?
 - Offering what we have available.
 - Offering based on our expectations of what others should do.
 - Offering what we think abused older people need.
 - Offering what they want or say they need the most.
- Service refusal is not limited to, but can be commonplace, where the family violence victim or perpetrator has a substance use or mental health problem (factor in 17-35% of all senior abuse cases)

Reasons Why Many Abused Older Adults Decline Help

- Current stage of change. **Is the person ready—both psychologically and in terms of taking specific actions—to confront the issue.**
 - “He doesn’t treat me nicely, but this isn’t (really) abuse.”
 - “It’s not that bad. I can handle it myself. “
 - “You are interfering”.
- Lack of trust.
- The situation feels hopeless.
- I don’t want this abusive relationship, but the alternatives are as bad.

More Reasons Why

- Other problems/ harms are more important in my life/ more pressing
- Fear, of abuse, of losing relationship, of having no one, of being alone, of losing more independence.
- Stigmatization.
- Your “solutions” or help are too costly, emotionally or in some other way.
- “Help” offered attempts to remove an important coping strategy without having another coping strategy in place.



Harm Reduction

Harm Reduction

Refers to a specific set of approaches and corresponding policies to reduce risks for people who engage in behaviours that put them “at risk”. Increasingly harm reduction is deemed to be a realistic, pragmatic, humane and successful approach to addressing alcohol or drug problems of individuals and communities.

- It applies equally well to other “risky behaviours” such as abuse.


Types of Harm in Senior Abuse


- **Harms from the Abuse**
 - Harms affecting self
 - Harms affecting others
- **Harms resulting from Long and Short Effects of the Abuse**
- **Harms Functioning Independent of the Abuse**
- **Harms from Systems**
 - Attitudes and behaviours of service providers (e.g., “Why doesn’t she just leave; why does she stay”), including ageism
 - Policies
 - Assumptions of mental (in)capability
 - Cultural assumptions by professionals

Harm Reduction Principles

- Nonjudgmental
- Trust building
- Work where the person is
- Build on person's strengths

- May need to go to the person, rather than expecting them to come to you.

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- Many existing emerging good practices in family violence are harm reduction- e.g.
 - safety planning;
 - support, empathy and listening from staff;
 - empowering the older adult;
 - staff follow-through (both on-going and long-term support);
 - working with families to broaden the basis of support and safety networks; and
 - a culturally sensitive approach to healing, programs, and supports.

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- Harm reduction programs operate with the assumption that some people who engage in high-risk behaviors are unwilling or unable to change, stop or leave at this point.
 - Using a "low-threshold approach," they do not require that clients stop or make a specific change in order to gain access to services, nor do they expect the person has to adhere to one service to be eligible for another.
 - Rather than having goals set for them, clients in take part in a goal-setting process.

Important Principles

- The basic principle behind the harm reduction approach is
 - to work with the person on the needs that are most pressing for the person.
- 2. When working with seniors make sure the "solution" is no worse (from the senior's perspective) than the original problem.

Guiding Principles for Harm Reduction

1. Build Trust

2. Be Flexible and Accessible

3. Understand and Respect the Older Person

4. Take a “Whole Person” Approach

- Abuse or substance use problems seldom exists in isolation. It is important to take into account all aspects of the person’s physical, psychological, social, financial and spiritual needs.

5. Recognize the Older Person’s Strengths and Needs

6. Be an Advocate

7. Work with Others

- Draw on the skills of others and collaborate between volunteer and formal organizations, work together in an integrated way.

Starting Points for Harm Reduction Strategies

- The attempt is to identify and deal with the risks associated with abuse or correlated behaviours in a concrete, pragmatic way.
- Understanding staying in an abusive situation as purposeful
- It is inappropriate to remove a person's sole means of coping with emotional pain and distress

Harm Reduction Strategies Mean...

- Focussing on the most immediate and achievable changes that can reduce the threat to the health and well-being of the older adult and of society.
- While helping the person leave the abuse, make changes in the relationship or abstain from alcohol or drugs may be one appropriate long-term goal, **harm reduction** strategies place the emphasis on practical, short-term improvements.

Harm Reduction...

- Looks to the abused persons' lives and values, as well as gives a window into understanding how people experiencing abuse or neglect envision a better quality of life.
- Challenges traditional ways of measuring outcomes based solely on quantity and frequency of abuse.
- The extent to which abused persons organize their lives around the abusive relationship and how much this relationship is integrated into their lives and negatively impacts other aspects of their lives.

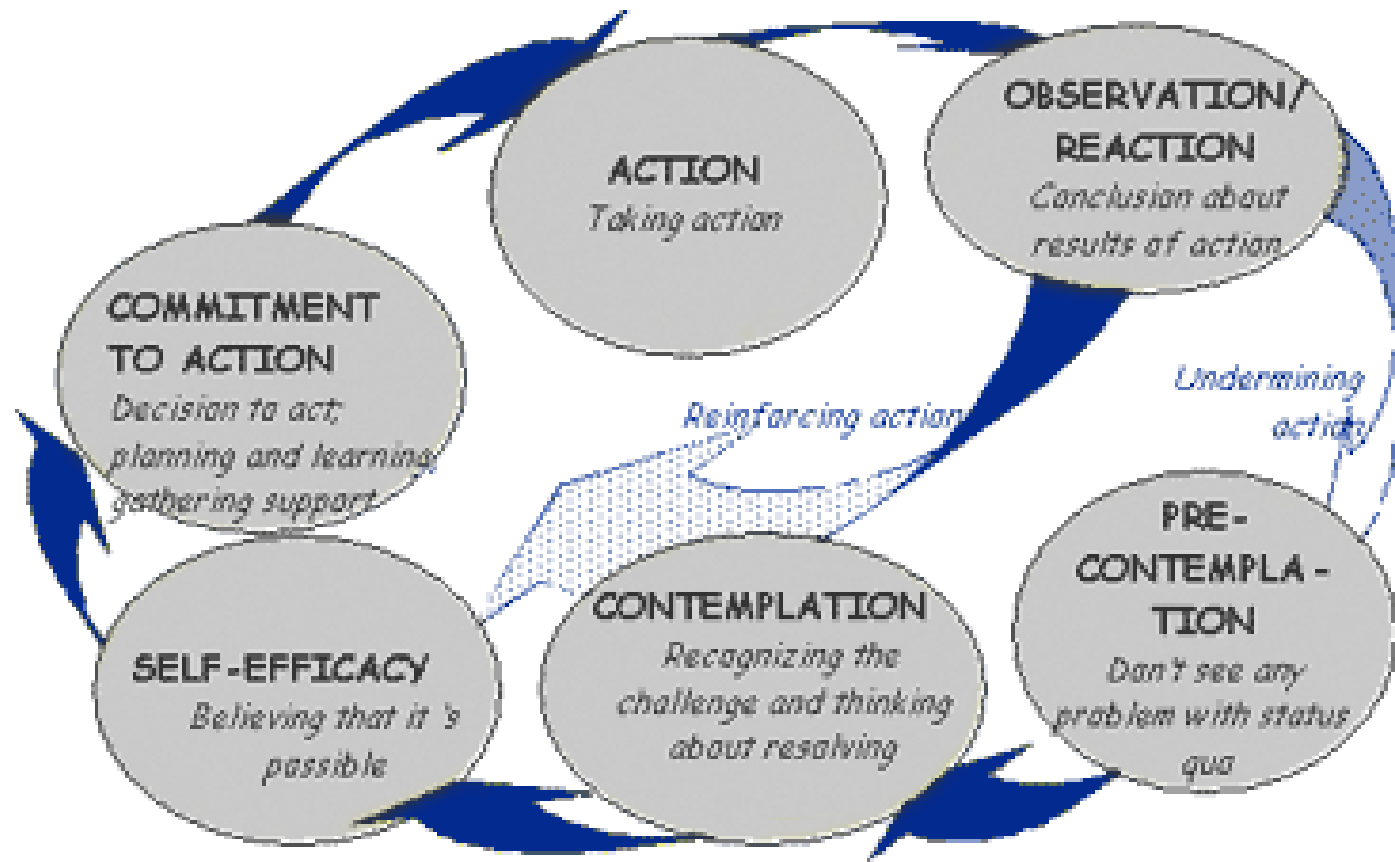
Harm Reduction Tries to Avoid...

- A disrespectful or judgmental approach to abused older adults- including lack of truthfulness, use of coercion
- Making assumptions about relationships as inherently good or bad
- Looking for simple and quick answers
- Lack of staff awareness about the dynamics and multi-faced nature of the problem
- Paternalism, ageism, sexism, racism
- Unclear policy and guidelines regarding abuse



Stages of Change

Stages of Change



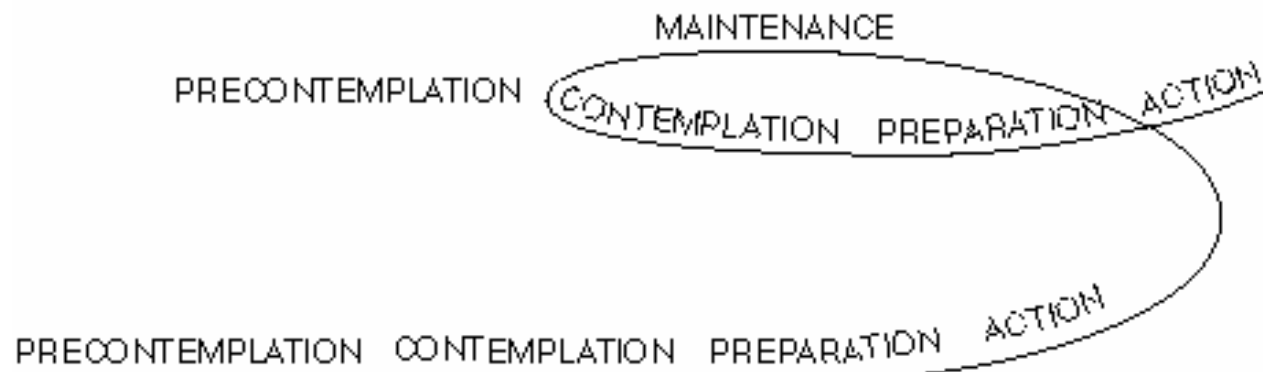
from After Prochaska and Diclemente

Stages of Change

- **Stage 1--Precontemplation.** Individuals in this stage do not believe they have (there is) a problem and have often constructed defenses that aid in denial of the problem.
- **Stage 2--Contemplation.** Individuals acknowledge there is a problem and begin to deliberately increase awareness and knowledge related to the problem.
- **Stage 3--Preparation.** Before initiating behavior change, individuals re-evaluate themselves with respect to the problem, develop commitment to change, and construct a plan for changes. **Can involve help of others.** By the time they reach this stage, individuals begin to perceive greater benefits than barriers to change.

- **Stage 4--Action.** Behavior change is initiated. Others are likely to recognize a person's progress toward change. After several months or years in the action stage, the person may move into the fifth stage.
- **Stage 5--Maintenance.** Though change is maintained more easily now, some vigilance is still required to avoid slips or setbacks. If and when the change becomes so automatic that there is no possibility of reverting to a former behavior, the goal--"Termination"--is reached.

TERMINATION



Spiral of change

From Prochaska, DiClemente & Norcross, 1992, p. 1104

Key Features of the Stages of Change Model

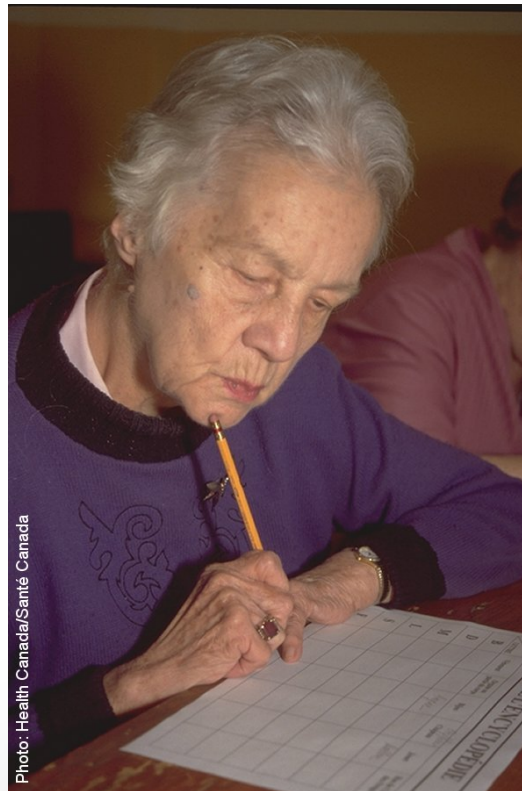
- Deals with intentional behaviour change
- Views change as a process rather than an event
- The change process is characterised by a series of stages of change
- In attempting to change a behaviour a person typically cycles through these stages of change

Harm reduction may focus on outcomes other than “just abuse”

The outcomes may include ways of

- 1) relating to families/friends;
- 2) getting needed programs/benefits/services;
- 3) handling physical and mental health problems;
- 4) handling negative emotions;
- 5) having money throughout the month;
- 6) being adequately housed and having food;
- 7) improving one's skills
- 8) handling legal problems and
- 9) handling abuse problems.

Joan



Joan

- 76 year old woman with a long standing drinking problem
- Has own home
- 35 year old female “tenant” comes to share the home
 - Begins controlling more and more of Joan’s life
 - Takes over the top floor of the house
 - No longer paying rent
 - Joan is increasingly anxious, fearful of her- afraid to say anything in own home, but unwilling to speak up
 - Tenant challenges those who visit, including service providers

Len and Mary



Len & Mary

- Friends for years, took care of each other. Live together off and on.
 - Some pre-existing substance use & mental health issues for both.
 - Len “comfortably off”; Mary has little income, relies on Len for money a lot over the years.
- Len’s health deteriorates; diabetes; strokes. Hospitalized. Making decisions becomes difficult for both. Depression?
- Hospital SW not think he can live on own. Tries to convince him to go into care facility

At Home

- Environmentally isolated (no ramp) & can't build one for months; home care (meals) not available when he comes out of hospital. "Planned crisis."
- Mary starts giving care: meals and assisting to bathroom. Mary is signing Len's name to his cheques and cashing them (for him and her).
- Care responsibilities start to wear on Mary. Not showing up, or show up late or drinking. Threats to abandon Len.
 - "Be nice or I'll leave."
- Situation becomes physically abusive: calls to family; respite care
- The decision for Len to move to a care facility

In the Care Home

- Mary as intermittent visitor to the care home; Len is isolated
- Problems in the care home
 - Care home sold; change of operator who is less able to provide care for Len.
 - Privacy and rights violations
 - “Liver for supper again.”
 - The broken wheelchair lift.
- Has one set of harms been exchanged for another?

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- Lithwick, M., Beaulieu, M., Gravel, S. & Straka, S.M. (1999). Mistreatment of older adults: perpetrator victim relationships and interventions. *Journal of Elder Abuse and Neglect*. 11 (4), 95-112.

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- Prochaska, J.O., Velicer, W.F., Rossi, et al. (1994). Stages of change and decisional balance for twelve problem behaviors. *Health Psychology*, 13(1), 39-46.

Useful Internet Resources

- www.cnpea.ca
- www.bcceas.ca
- www.bcifv.org
- www.phac-aspc.gc.ca/ncfv-cnivf/familyviolence/
- www.bccrns.ca

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