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Mistreatment of Older Adults



Québec 

Mistreatment of Older Adults

*Institut national
de santé publique*

Québec 

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Editorial Committee,
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Foreword

We now know that violence has an adverse effect on the development of individuals and communities and that the consequences of violence are felt throughout life. In view of the suffering caused by violence, the World Health Organization (WHO) considers violence prevention to be a public health priority. Therefore, in an effort to achieve sustainable health development objectives, precise targets have been set to eliminate violence, particularly that which affects women and children around the world.

Since the launch of the *World report on violence and health* by WHO in 2002, many actions and commitments have been undertaken by Member States in order to tackle the problem of violence. The *Global status report on violence prevention 2014* takes stock of the progress made in recent years, while above all reaffirming the importance of stepping up prevention efforts. Much work remains to be done. We thus have a moral obligation to build on recent knowledge about violence and to mobilize stakeholders for the purpose of combatting this scourge which undermines the ability of a significant proportion of the population to achieve their full health potential.

The present report is in response to the above call for action. Since it compiles knowledge on the various aspects of violence, it is an excellent tool for comprehensive upstream intervention and simultaneous prevention of several different types of violence.

Given the quality of the material it contains, I am convinced that this report will play a key role in preventing violence and mitigating its consequences, not only for individuals but also for communities and society at large.

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Preface

As recognized by the World Health Organization (WHO), violence is an undeniable problem in our societies that requires investment in prevention efforts by public health authorities.

Statistics and regular media reports on sexual assault, intimate partner violence, intra-family homicide, bullying and violence at school show that WHO's call to action is still relevant.

The Institut national de santé publique du Québec (INSPQ), in its role as a public health expertise and reference centre, aims to advance knowledge and propose cross-sectoral strategies and endeavours that will improve the health and well-being of Quebecers. It invests in violence prevention with this goal in mind.

In keeping with the National Public Health Program and the Governmental Policy for Prevention in Health, the INSPQ contributes to the prevention of the different manifestations of violence, including intimate partner violence, sexual assault, child maltreatment, mistreatment of older adults, and violence at school, in the workplace, and in First Nations communities. To that end, it can count on the input of experts in perinatal health, early childhood, youth health, mental health, safety, violence, and injuries, as well as in occupational and Aboriginal health. It also draws on well-established partnerships with various groups and university researchers interested in the various types of violence discussed in this document.

Without a doubt, this report will provide a reference tool that will help support the Ministère de la Santé et des Services sociaux, the public health network, and their partner networks in their efforts to prevent violence in Québec.

Nicole Damestoy
Chief Executive Officer
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Key messages

- Mistreatment of older adults involves 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 adult, whether or not the perpetrator deliberately intends to cause harm. It affects older adults living at home, in residential facilities, or in any other type of living environment.
- Two forms of older adult mistreatment have been defined in Québec: violence and neglect. Mistreatment may be physical, sexual, psychological, material, or financial. It can also be organizational, manifest itself as age-based discrimination (ageism), or involve violation of rights.
- Mistreatment of older adults is a complex multifactorial problem, which is part of relational dynamics that go beyond the victim-perpetrator relationship per se, because the problem is influenced by social, political, and cultural factors, as well as factors associated with older adults themselves, the people who mistreat them, and the environment in which the mistreatment occurs.
- Mistreatment can have an immediate short- to long-term impact on the overall well-being of older adults. It can also affect their family and friends, as well their neighbours and living environment. Since older adult mistreatment is a social problem, it also has general long-term effects on society. However, these effects are poorly understood, not well documented and not always easy to detect.
- Preventing mistreatment of older adults involves actions aimed at reducing at-risk situations for seniors and their family and friends, promoting positive attitudes toward older people, and raising awareness. In particular, it involves actions to inform and educate the general public about the risk factors for mistreatment (e.g. ageist attitudes) and about best practices for reducing the risk that such situations will arise (e.g. promoting well-treatment).
- In Québec, the fight against mistreatment is based primarily on the measures contained in the *Governmental Action Plan to Counter Mistreatment of Older Adults 2017-2022*.

Introduction

Although the first documents on older adult mistreatment started to appear in the 1970s [1], it was not until the early 2000s that this type of mistreatment was recognized internationally as a social and public health problem. In 1997, during a meeting of the International Association of Gerontology and Geriatrics in Australia, a group of researchers set up the International Network for the Prevention of Elder Abuse. Thanks to this network, a World Elder Abuse Awareness Day is held on June 15 of each year. In Québec, it is called the “purple ribbon campaign.”

In 2002, the World Health Organization (WHO) proposed a definition of elder abuse which is still widely used, and the United Nations (UN) included the themes of “neglect, abuse, and violence” in the Madrid International Plan of Action on Ageing.¹ Although this action plan is not binding for Member States, status reports related to it are presented regularly to the UN.

The question of mistreatment of older adults was first broached in Québec during regional symposiums on violence in the late 1970s. The first study on the subject, by the Association québécoise de gérontologie, was published in the early 1980s [3]. In 1988, the public health and social services network conducted the first exploratory study on the matter [4]. In 1989, the report *Vieillir... en toute liberté*, by the working committee on elder abuse set up by the Minister of Health and Social Services, pointed out the importance of having a comprehensive government policy in this area [5]. In 2010, Québec adopted the Governmental Action Plan to Counter Elder Abuse (hereinafter “AP-1”) [6]. This five-year plan, which was extended to 2017, proposed four structured actions² and over 30 measures to improve existing practices. Thanks to the commitment of 13 government departments and bodies and the allocation of funding, a series of changes were made in knowledge, laws, and practices. In 2017, following an assessment of the implementation of AP-1 [7], public consultations and an inventory of needs, the government released the Governmental Action Plan to Counter Mistreatment of Older Adults 2017-2022 (hereinafter “AP-2”) to the public. It comprises 52 measures grouped under four orientations: prevent mistreatment and foster well-treatment, encourage early detection and appropriate interventions, promote and facilitate disclosure of situations of mistreatment, including situations of financial and material mistreatment, and develop knowledge and improve knowledge transfer [8].

From this brief history, we can see that initiatives to counter mistreatment of older adults have been taken for over 40 years now. However, a suitable structure to coordinate them was only introduced in 2010. The number of actions has increased since that time and mistreatment now encompasses a series of related themes, such as the fight against bullying, recognition of self-neglect, and promotion of well-treatment.

¹ This action plan includes the following two objectives: “elimination of all forms of neglect, abuse and violence of older persons” and “creation of support services to address elder abuse” [2].

² Awareness campaign, research chair, referral and help line, regional coordinators.

Definition

The word mistreatment can be defined in many different ways, all of which have prompted considerable debate and questions. That being said, even though no consensus has been reached, there is one definition that has garnered general support internationally. It was adopted by WHO in 2002 through the Toronto Declaration at an international meeting of researchers, older adult associations, practitioners and public policy planners [9]. The Québec government drew inspiration from this definition in its first and second action plans on elder mistreatment (AP-1 and 2). The definition it proposed in AP-2 is as follows:

Mistreatment 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 adult, whether the person deliberately wants to cause harm or not [8].

According to this definition, it is not the intentional or unintentional nature of the violence (single or repeated act) or neglect (lack of appropriate action) that matters, but rather the results of such violence or neglect, the presence of a relationship of trust and the severity of the consequences, whether the latter are apparent or not. It should be noted that this definition excludes all forms of physical, moral, or material abuse by strangers. It should also be pointed out that it has drawn numerous criticisms, particularly with regard to the problems involved in rendering it operational in research [10,11].

In Québec, this definition has laid the groundwork for the development of a common language. Given that in the past many stakeholders did not have the same perception of the different forms and types of mistreatment or did not refer to common elements in describing them, steps were taken in 2015 to clarify these concepts [12]. This led to the recognition of two forms of mistreatment (violence and neglect) and seven types of mistreatment (Table 1), all of which are included in AP-2.

Table 1 Types of mistreatment

Types of mistreatment	Definition	Examples in the form of violence	Examples in the form of neglect
Psychological mistreatment	Gestures, words or attitudes that negatively affect a person's psychological well-being or integrity.	Emotional blackmail, manipulation, humiliation, insults, infantilization, belittlement, verbal and non-verbal threats, disempowerment, excessive monitoring of activities, etc.	Rejection, ignoring, indifference, social isolation, etc.
Physical mistreatment	Inappropriate gestures or actions, or lack of appropriate action, that negatively affect a person's physical well-being or integrity.	Shoving, bullying, hitting, burning, force-feeding, improper administration of medications, inappropriate use of restraints (physical or pharmacological), etc.	Failure to provide a reasonable level of comfort and safety, failure to provide assistance with eating, dressing, hygiene, or taking medication when a person is in a situation of dependency, etc.
Sexual mistreatment	Non-consensual gestures, actions, words or attitudes with a sexual connotation that negatively affect a person's sexual well-being, integrity, or gender identity.	Suggestive comments or attitudes, jokes or insults with a sexual connotation, promiscuity, exhibitionist behaviours, sexual assault (unwanted touching, non-consensual sex), etc.	Failure to provide privacy, failure to respect or denial of a person's sexuality, sexual orientation, or gender identity, etc.
Material or financial mistreatment	Fraudulent, illegal, unauthorized or dishonest acquisition or use of a person's property or legal documents, lack of information or misinformation regarding financial or legal matters.	Pressure to change a will, banking transactions without a person's consent (use of a debit card, online banking, etc.), misappropriation of money or assets, excessive price charged for services provided, identity theft, etc.	Failure to manage a person's assets in his or her best interest or to provide necessities as required, failure to assess a person's cognitive abilities, understanding, and financial literacy, etc.
Organizational mistreatment	Any prejudicial situation created or tolerated by organizational procedure in private, public or community organizations providing all types of care and services that compromises a person's ability to exercise his or her rights and freedoms.	Organizational conditions or practices that do not respect a person's choices or rights (e.g. services provided in a hasty or offhand manner), etc.	Services ill-adapted to a person's needs, lack of instructions or poor understanding of instructions by staff, limited organizational capacity, complex administrative procedures, inadequate training of staff, unmotivated staff, etc.
Ageism	Discrimination based on age, through hostile or negative attitudes, harmful actions, or social exclusion.	Imposition of restrictions or social standards based on age, limited access to certain resources, prejudice, infantilization, scorn, etc.	Indifference to ageist practices or comments, etc.
Violation of rights	Any infringement of individual and social rights and freedoms.	Forced medical treatment, denial of the right to: choose, vote, enjoy one's privacy, take risks, receive phone calls or visitors, practice one's religion, express one's sexual orientation, etc.	Lack of information or misinformation regarding a person's rights, failure to assist the person in exercising his or her rights, failure to recognize the person's abilities, etc.

Source: *Guide de référence pour contrer la maltraitance envers les personnes âgées*, 2nd edition [13].

Box 1 – Elder self-neglect

Self-neglect is a worrisome public health problem [14–19]. Like violence and neglect by others, it is often encountered in cases dealt with by Adult Protective Services in the United States. Self-neglect has not been widely documented in Québec and is not included in either AP-1 or AP-2. Below is a definition of this phenomenon that has been proposed in Québec on the basis of an international literature review and work by Neesham-Grenon [20]:

[TRANSLATION]

Self-neglect includes a wide range of behaviours, distributed along a continuum of severity, that are socially and culturally framed, intentional or unintentional, that result from failure to meet one's own needs or to obtain care, and that can potentially have negative repercussions on the well-being, health and safety of the self-neglected person or others [21].

The lack of an operational definition of self-neglect [15,22], together with conceptual differences, limit the comparison of studies, the development of knowledge, and the determination of prevalence and incidence rates [15]. In addition, several factors create barriers to the detection of self-neglect, namely, inadequate knowledge and awareness of the problem; limited supporting resources and systems; lack of training and intervention protocols; inadequate evidence determining risk factors and adjuncts that can predict the onset of self-neglect; and a lack of reliable, valid and culturally-appropriate assessment tools [15].

Consequences

As with mistreatment or bullying of older adults, the consequences of self-neglect are numerous. Moreover, they vary according to the severity of the self-neglect and individual reactions. Older adults may have difficulty looking after themselves, paying their bills, and following prescribed treatments. In self-neglect situations, they may refuse all types of services, which can lead to the deterioration of their home and living environment, electrical defects, excessive accumulation of garbage, and unsanitary living conditions, sometimes involving the presence of several animals [23]. Self-neglect can also affect a person's physical and psychological health and raise the risk of mortality from heart, lung, neuropsychiatric and other problems [15].

Prevention

A Québec study of social workers who have worked with older adults in situations of self-neglect has defined the challenges involved and identified possible interventions focused on risk assessment, biopsychosocial assessment, harm reduction, values and ethics, organizational support, and the acquisition of up-to-date knowledge [20]. The social workers said that they had difficulty intervening in certain self-neglect situations and were not properly equipped. These findings led to a proposal for the preparation of a practice guide entitled *L'intervention en contexte d'autonégligence* [24]. The guide defines the concept of self-neglect and describes the main characteristics of the problem. It also suggests possible interventions, such as contacting or visiting the self-neglected senior, doing an assessment of the person and his or her needs, analyzing urgency and danger levels, doing a critical appraisal of the person's support network and other available resources, and conducting an assessment of his or her ability to make informed decisions and give consent, etc. The guide encourages professionals to provide older adults with assistance and support that meet their needs, while ensuring the safety of the adults and others. Lastly, it presents possible solutions for the various challenges that social workers may encounter, as well as practical advice.

Scope

The lack of a benchmark for measuring mistreatment makes it more complicated to compare the results of different studies. This lack stems not only from the fact that there is no universal definition of mistreatment, but also from the absence of validated measures for each form and type of mistreatment. In a meta-analysis of published studies from around the world, Yon et al. found that in the 12 months prior to data collection the pooled prevalence rate for overall mistreatment of older adults living in the community was 15.7%, i.e. 1 older adult in 6. In all, 11.6% of the respondents had been victims of psychological mistreatment; 6.8%, of financial mistreatment; 4.2%, of neglect; 2.6%, of physical mistreatment; and 0.9%, of sexual mistreatment [25]. These findings were somewhat shocking to the international research community in this field, at least in the so-called developed countries that were reporting overall rates well below 10%.

In Canada, a study by Podnieks et al. identified a prevalence rate of 4%³ for mistreatment [26], while the General Social Survey [27] reported a rate of 7% in the 5 years prior to the survey. A study by McDonald reported a rate of 8.2% in the 12 months prior to the study [28]. No studies have focused specifically on Québec, but AP-2 announced that a study will be conducted in the near future on the prevalence of mistreatment [8]. This will make it possible to quantify the scope of the problem for the very first time.

No reliable data have been generated on the scope of mistreatment of older adults in residential or long-term care facilities. An analysis of 69 studies published on the subject identified many methodological problems: sample size, choice of participants, failure to consider structural factors, etc. [29]. The authors suggested that a pilot project be conducted to develop reliable measurements. Europeans have suggested that it be compulsory to keep a register of situations of mistreatment within institutions [30]; however, this would pose major clinical and methodological challenges.

³ In this study, prevalence was measured differently for each type of mistreatment. For example, neglect was measured over the previous 12 months, whereas financial exploitation was measured from the time the respondent reached the age of 65.

Risk and protective factors

Risk factors

Mistreatment of older adults is a complex multifactorial problem that is part of relational dynamics that go beyond the victim-perpetrator relationship per se, because the problem is influenced by social, political, and cultural factors, as well as factors associated with older adults themselves, the people who mistreat them, and the environment in which the mistreatment occurs [31–34]. As shown in Table 1 on the different types of mistreatment, the perpetrator is not necessarily a natural person, but can be an organization.

To be effective, measures designed to put a stop to situations of mistreatment must be based first and foremost on knowledge of the associated risk factors. The state of knowledge on risk factors not only varies depending on the type of mistreatment concerned [31,35], but is influenced by the definitions, theoretical framework and methodology used to conduct studies [36]. Consequently, it is difficult to draw up a clear, comprehensive and final list of all the risk factors for mistreatment. In any case, such an approach would be counterproductive, for the list would probably be very long and therefore not sufficiently specific to inform solutions. During international scientific symposiums in the past two years, researchers have suggested that risk factors for mistreatment should be refined according to the type of mistreatment involved and the dynamics of the relationship between the mistreated person and the person or organizational context that mistreats. Future scientific work can thus be expected to follow this approach.

Several studies [32,36,38] have used the categories of risk factors developed by the National Research Council [37]. The quality of the scientific evidence for each category of factors strengthens their power for explaining mistreatment situations [36].⁴ Three categories have been identified:

1. Risk factors validated by substantial evidence;⁵
2. Possible risk factors;⁶
3. Contested risk factors.⁷

Table 2 presents the three categories of risk factors for older adult mistreatment defined by the National Research Council. The risk factors are classified according to whether they are related to the individual at risk of mistreatment or to aspects of the individual's environment. Since the publication of this classification in 2003, other studies including literature reviews [32,36] have enriched its results. This additional information has been included in Table 2.

⁴ The studies identified have certain limitations, such as the fact that they are not based on longitudinal research designs aimed at determining the causal relationship between the different factors and situations of mistreatment. Therefore, the scientific quality of these factors and their reliability for indicating the presence of mistreatment depends on the preponderance of studies reaching the same findings. In other words, the results are based on unanimous or near-unanimous support from the studies identified [36].

⁵ These are factors that have been validated by many studies and for which there seems to be a scientific consensus.

⁶ These are factors that have been documented, but for which there is no consensus, particularly because the results are contradictory, or the studies were limited in scope.

⁷ These are factors for which there is little scientific evidence. They are identified by certain studies as being associated with increased risk for the emergence of mistreatment situations, but they need to be validated more extensively before they can be considered proven risk factors [36,27].

Table 2 Risk factors for mistreatment

	Specific to the mistreated person (intrinsic factors)	Specific to the environment (extrinsic factors)
Risk factors validated by substantial evidence	<ul style="list-style-type: none"> ▪ Dementia [32,36,37,39]; ▪ Low income [32]. 	<ul style="list-style-type: none"> ▪ Social isolation and weak social network [31,32,34,36,37]; ▪ Shared living arrangement [32,36,37,40]; ▪ Characteristics of the person who mistreats: <ul style="list-style-type: none"> ▪ Mental health problems; ▪ Hostility; ▪ Alcohol dependence; ▪ Dependence on the older adult [36,37]; ▪ Caregiver burden and stress [32]; ▪ Cognitive decline and dementia [32].
Possible risk factors	<ul style="list-style-type: none"> ▪ Sex (female) [32,36,37]; ▪ Personality traits (hostility, passive or avoidant ways of coping) [36,37]; ▪ Ethnic background [32,36,37,39]; ▪ Age [32]; ▪ Civil status [32]; ▪ Level of education [32]. 	<ul style="list-style-type: none"> ▪ Living alone [32,34]; ▪ Relationship between the mistreated person and the person who mistreats (spouses) [36,37].
Contested risk factors	<ul style="list-style-type: none"> ▪ Physical impairments, poor health [32,36,37]. 	N.A.

This table highlights the extent to which knowledge about older adult mistreatment has progressed since the National Research Council first published its findings [37]. The factors based on strong scientific evidence in 2003 are still included in the list of risk factors, but others have been added in recent years. In addition, the possible and contested risk factors have been documented more fully and garnered more scientific support; they are thus questioned to a lesser extent than in the past. It should be noted that some of the factors presented in the table appear, at first glance, to be contradictory. This is the case, for example, of social isolation and a weak social network, on the one hand, and shared living arrangements, on the other. The presence of these seemingly contradictory risk factors stems from the fact that they are not associated with the same types of mistreatment [31,32,36]. Lastly, it should also be noted that the impact of life-long violence or neglect on the risk of being a victim of mistreatment later in life is increasingly well documented [31,32]. More longitudinal studies would add to our knowledge in this area.

Factors specific to the person and factors specific to the environment

As shown in Table 2, the number of environmental risk factors validated by substantial evidence seems to be greater than the number of individual risk factors validated in this way. This is consistent with recent research data indicating that environmental risk factors are better predictors of mistreatment of older adults than individual risk factors are [41]. This observation could guide professionals in their clinical activities, for it might be easier for them to act on environmental factors than on certain individual ones (e.g. dementia, state of health, sex, ethnic background, etc.) in their efforts to counter mistreatment. It could also be of use to public decision-makers who have to design intervention programs and implement action plans using an evidence-based approach.

Most of the findings presented thus far concern mistreatment of older adults living at home. However, certain risk factors are related more specifically to residential facilities, such as residential and long-term care centres (CHSLDs). The organization of daily life in such facilities (e.g. care schedules, meal times, etc.) can lead to a loss of freedom for residents [42], while the kind of group living arrangements typically found there can cause negative resident-to-resident interactions [43]. Table 3 presents the most widely documented risk factors associated with the organization of the facilities themselves, their staff members, and the older adults who live there [44].⁸

Table 3 Risk factors in residential facilities

Factors associated with the organization of facilities
<ul style="list-style-type: none"> ▪ Lack or shortage of staff [10,45–47]; ▪ Heavy workload preventing professionals from delivering quality care in a timely manner [48–50].
Factors associated with staff members
<ul style="list-style-type: none"> ▪ Inadequate knowledge and limited training [10,45,51]; ▪ Personal problems, including a history of domestic violence, mental illness, or use of drugs or alcohol [45,51]; ▪ Stress, emotional fatigue, or burnout [10,45,51]; ▪ Negative attitude toward older adults in general and residents in particular, or toward working with this type of clientele [10,51].
Factors associated with the person or his or her network of family and friends
<ul style="list-style-type: none"> ▪ Social isolation or few or no visitors from outside the facility [10,45].

Source: Executive summary of the report *La maltraitance envers les personnes âgées en milieu d'hébergement. État de situation sur sa prise en charge et mise en perspective d'une approche visant le signalement obligatoire* [44].

Table 3 clearly shows that, although mistreatment may be perpetrated by staff members or even other residents in residential facilities, it can also occur within the broader context of organizational mistreatment.⁹

Multifactorial nature of mistreatment

The definition of mistreatment provided in section 1 explains that mistreatment situations are relational in nature, that is, they occur in contexts where there is an expectation of trust. As mentioned earlier, the characteristics of the victim (or the person at risk of mistreatment), the perpetrator (or the person who may be at risk of mistreating), and the older person's living environment can all have an impact on the incidence of mistreatment. The social, political, and cultural context in which mistreatment occurs can also be an influential variable.

At the social level, ageism towards older adults is reflected by negative stereotypes [52], which are shown to create a breeding ground for mistreatment [53,54]. For example, in residential facilities, ageism can have a negative impact on professionals' interactions with residents, as well as negative consequences [55].

⁸ For more information, see Beaulieu, M. and Leboeuf, R. (May 4, 2016). Synthèse exécutive du rapport Beaulieu, M., Manseau-Young, M.-E., Pelletier, C. et Spencer, C. (12 janvier 2015). *La maltraitance envers les personnes âgées en milieu d'hébergement. État de situation sur sa prise en charge et mise en perspective d'une approche visant le signalement obligatoire*. Submitted to the Québec government's Secrétariat aux aînés, 27 p. This document can be accessed free of charge at: www.maltraitancedesaines.com.

⁹ Organizational mistreatment: [TRANSLATION] "Any prejudicial situation created or tolerated by organizational procedure in private, public, or community organizations providing any type of care or service, and which compromises a person's ability to exercise his or her rights and freedoms." [12].

At the cultural level, mistreatment studies in cultural communities have shown that there are multiple perceptions of mistreatment [32]. For example, the Québec government’s perception of mistreatment may be different from that of a person who belongs, for example, to a Spanish-speaking [56] or Aboriginal community [57]. Moreover, being an immigrant or a refugee can also have an impact on the way a person views mistreatment [58]. Therefore, people who work with seniors from diverse cultural communities should adopt a culturally sensitive approach.

Protective factors

“Protective factors are characteristics specific to the person ... or to their environment ... that tend to reduce the risk of developing certain problems such as mistreatment” [8,36]. That being said, they are not the opposite of risk factors¹⁰ and their presence does not mean that risk factors are absent.¹¹ Since few studies have focused on protective factors, it is impossible at this time to provide a nuanced assessment.

The *Guide de référence pour contrer la maltraitance envers les personnes âgées* [13], developed in Québec, nonetheless suggests a number of possible protective factors specific to the person or to the environment.¹² They are presented in Table 4.

Table 4 Protective factors

Protective factors specific to the person	Protective factors specific to the environment
<p>Self-esteem:</p> <ul style="list-style-type: none"> ▪ e.g. self-knowledge, sense of responsibility, resourcefulness, etc. <p>Ability to seek help:</p> <ul style="list-style-type: none"> ▪ e.g. being able to confide in others, make oneself understood, take advice, etc. <p>Emotional competencies:</p> <ul style="list-style-type: none"> ▪ e.g. ability to cope with events and make sense of them, adoption of strategies for dealing with stress, etc. <p>Social participation:</p> <ul style="list-style-type: none"> ▪ e.g. sense of belonging, social inclusion, social support, feeling of social competence, etc. <p>Ability to learn about oneself and society:</p> <ul style="list-style-type: none"> ▪ e.g. having autonomy, being able to make choices, set personal goals, pursue lifelong learning, and find time to engage in hobbies, etc. <p>Good lifestyle habits:</p> <ul style="list-style-type: none"> ▪ e.g. ability to relax, laugh, build positive and beneficial relationships with family and friends, etc. 	<p>Network:</p> <ul style="list-style-type: none"> ▪ e.g. an appropriate network of available people, a legal representative available if necessary, a network adapted to the needs of older adults, etc. <p>Environment:</p> <ul style="list-style-type: none"> ▪ e.g. a safe living environment adapted to the needs of older adults and free from ageism and social exclusion, etc. <p>Financial situation:</p> <ul style="list-style-type: none"> ▪ e.g. adequate available income, various means in place to secure belongings and money, etc.

Source: *Guide de référence pour contrer la maltraitance envers les personnes âgées*, 2nd edition [13].

¹⁰ For example, dementia is a known risk factor, but the absence of dementia cannot automatically be considered a protective factor [8].

¹¹ For example, an older adult may have dementia or be assisted by a caregiver with an alcohol dependence problem (risk factors) but have good self-esteem and a social network including other adequate caregivers (protective factors).

¹² Since this information is based on data provided by the Canadian Mental Health Association – Québec Branch (2015), these protective factors are not specific to older adults.

Consequences

The definition of mistreatment proposed by WHO clearly states that this phenomenon causes harm and distress to older adults [8]. Like any other type of victimization, mistreatment can affect a senior’s family and friends, neighbours, and living environment (e.g. residential facility), etc. [8]. Since older adult mistreatment is a social problem, it also has general long-term effects on society. However, these effects are poorly understood and not well documented [59]. To date, it is the consequences of elder mistreatment that have been documented most extensively.

Consequences of mistreatment for older adults

Mistreatment has short- and long-term impacts on the overall well-being of older adults [39,43]. In addition to causing premature relocation to residential facilities [59–61], mistreatment has a significant effect on the morbidity [60,62] and mortality of seniors [59,62–66]. Although some consequences, such as physical (Friedman, Avila, Tanouye and Joseph, 2011, cited by Roberto [39]) and material or financial ones [12,67], tend to be more visible, others, such as those that are psychological or social in nature [13,59,63], can be fairly subtle. Table 5 gives a few examples.¹³

Table 5 Examples of consequences of mistreatment

Types of consequences	Examples
Physical	<ul style="list-style-type: none"> ▪ Temporary or permanent physical ailments [13,39,59,68]; ▪ Decline in health [13,60,62,69]; ▪ Functional decline [69,70]; ▪ Increased morbidity [60,62]; ▪ Mortality [16,59,62,64–66].
Psychological	<ul style="list-style-type: none"> ▪ Anxiety [13,43,59,68–71]; ▪ Depression [13,59,68,70,71]; ▪ Low self-esteem [13,43,68]; ▪ Sadness, low morale, unhappiness, dissatisfaction [13,43,68]; ▪ Suicidal ideation [13,72–74]; ▪ Growing sense of insecurity [13,73,75]; ▪ Shame [13]; ▪ Guilt [13]; ▪ Mistrust [13].
Material or financial	<ul style="list-style-type: none"> ▪ Loss of financial resources [13,67,76,77]; ▪ Loss of material possessions [13,77]; ▪ Being deprived of basic necessities [13,67,77]; ▪ Debts [13]; ▪ Insolvency [13]; ▪ Bankruptcy [13].

¹³ Augmented version of a table in the second edition of the document *Guide de référence pour contrer la maltraitance envers les personnes âgées* [13].

Table 5 Examples of consequences of mistreatment (cont.)

Types of consequences	Examples
Social	<ul style="list-style-type: none"> ▪ Loneliness [13,43,68,69]; ▪ Loss of contact with family and friends [13]; ▪ Conflicts [77]; ▪ Growing dependency [13].

Source: Based on a table concerning the consequences of mistreatment of older adults by type of mistreatment in the *Guide de référence pour contrer la maltraitance envers les personnes âgées*, 2nd edition.[13].

It should be noted that one type of mistreatment can have several different types of consequences. For example, the main consequences of material or financial mistreatment are usually financial in nature, but they can also be psychological, physical, or social [67].

Several of the signs of each of the seven types of mistreatment (psychological, physical, sexual, material or financial, organizational, violation of rights, ageism) [12] are also potential consequences that may be observed among mistreated older adults (Table 6).

Table 6 Signs of mistreatment for each of the seven types of mistreatment

Types of mistreatment	Signs
Psychological mistreatment	<p>Signs Fear, anxiety, depression, withdrawal, reluctance to speak openly, mistrust, fearful interaction with one or more people, suicidal ideation, rapid decline of cognitive abilities, suicide, etc.</p> <p>Caution Psychological mistreatment is undoubtedly the most common and least visible type of mistreatment:</p> <ul style="list-style-type: none"> ▪ It often accompanies other types of mistreatment; ▪ Its consequences can be just as detrimental as those of other types of mistreatment.
Physical mistreatment	<p>Signs Bruises, injuries, weight loss, deteriorating health, poor hygiene, undue delay in changing incontinence briefs, skin conditions, unsanitary living environment, atrophy, use of restraints, premature or suspicious death, etc.</p> <p>Caution Some signs of physical mistreatment may be mistaken for symptoms associated with certain health conditions. It is therefore preferable to request a medical and/or psychosocial assessment.</p>
Sexual mistreatment	<p>Signs Infections, genital wounds, anxiety when being examined or receiving care, mistrust, withdrawal, depression, sexual disinhibition, sudden use of highly sexualized language, denial of older adults' sexuality, etc.</p> <p>Caution Sexual assault is above all an act of domination. Cognitive impairment may lead to disinhibition, which can result in inappropriate sexual behaviour. Not recognizing or mocking the sexuality of older adults or preventing them from expressing their sexuality is a form of mistreatment, and it also makes it more difficult to identify and report sexual mistreatment. It is also important to keep an eye out for pathological sexual attraction toward older adults (gerontophilia).</p>

Table 6 Signs of mistreatment for each of the seven types of mistreatment (cont.)

Types of mistreatment	Signs
Material or financial mistreatment	<p>Signs Unusual banking transactions, disappearance of valuable items, lack of money for regular expenses, limited access to information regarding the management of a person’s assets, etc.</p> <p>Caution Older adults who are in a relationship of dependency (e.g. physical, emotional, social or business-related) are at a greater risk of material or financial mistreatment. In addition to the financial and material implications, this type of mistreatment can affect older adults’ physical or psychological health by limiting their ability to fulfill their responsibilities or meet their own needs.</p>
Organizational mistreatment	<p>Signs Treating a person like a number, inflexible care or service schedules, undue delays in service delivery, deterioration of the person’s state of health (wounds, depression, anxiety), complaints, etc.</p> <p>Caution It is important to be aware of organizational shortcomings that can violate a person’s right to receive care and services, or that can lead to conditions that negatively affect the work of staff in charge of providing care or services.</p>
Ageism	<p>Signs Failure to recognize a person’s rights, skills or knowledge, using condescending language, etc.</p> <p>Caution We are all influenced, to varying degrees, by negative stereotypes and language about older adults. These misguided assumptions lead us to misinterpret various situations that can ultimately lead to mistreatment.</p>
Violation of rights	<p>Signs Preventing an older adult from participating in choices and decisions that affect his or her life, failing to respect the decisions that he or she makes, allowing family members to answer on behalf of the older adult, restricting visits or access to information, isolation, complaints, etc.</p> <p>Caution Violation of rights occurs in all types of mistreatment. Everyone is entitled to fully retain their rights, regardless of their age. Only a judge can declare a person incompetent and appoint a legal representative. Persons declared incapacitated retain their rights, within the limits of their capabilities.</p>

Source: *Terminologie sur la maltraitance envers les personnes âgées* [12].

The signs mentioned above are not always clear indications of mistreatment. Therefore, service providers must do a meticulous assessment of situations of suspected mistreatment [78]. The comments in the “Caution” sections of Table 6 identify avenues that are worth exploring, in addition to providing information that might be useful for assessment purposes. Service providers should also be aware that certain consequences, such as isolation, can constitute risk factors.

The consequences of mistreatment are numerous and vary from one person to the next. Table 6 shows that different types of mistreatment are sometimes associated with the same signs or consequences, such as depressive symptoms. While this may depend on individual experience, it can also be explained by the fact that a person may be a victim of more than one type of mistreatment at a time.

Box 2 – Bullying of older adults

Context

The first Concerted Action Plan to Prevent and Counter Bullying 2015-2018 was made public in 2015 [79], following extensive consultation of stakeholders [80]. The action plan covers bullying at all ages. Of the 53 measures it contains, nine are specifically intended for older adults [79]. However, bullying, as experienced by seniors, is a little-known and poorly-documented problem in Québec and around the world.

Implementing an action plan for a problem that, in theory, is very similar to the problem of mistreatment gives rise to conceptual issues (How can we differentiate between bullying and mistreatment?) and practical issues (How can we ensure the coexistence of specific actions aimed at countering one or the other of these problems?) in a context where mistreatment is a social problem that has been the focus of specific actions for roughly 30 years [81].

This box briefly takes stock of existing knowledge on bullying of older adults. It is based on preliminary findings of research conducted in Québec, as well as on an international review of literature published since 2009.* Owing to the current state of research and the limited number of scientific publications on the topic of older adult bullying, the results presented in this section should be viewed mainly as avenues for further exploration.

Definition and scope

Although there are many definitions of bullying, none of them are specific to older adults. Several are based on bullying in the workplace or at school (American Psychological Association, 2016, cited by Goodridge et al. [83]; Einarsen and Skogstad, 1996, cited by Andresen and Buchanan [84]; Rayner and Keashly, 2005, cited by Bonifas [85]). Québec's action plan uses the definition provided in the *Education Act* (s. 13, para. 1.1):

Any repeated, direct or indirect behaviour, comment, act or gesture, whether deliberate or not, including in cyberspace, which occurs in a context where there is a power imbalance between the persons concerned and which causes distress and injures, hurts, oppresses, intimidates, or ostracizes [79].

Discussions held and briefs filed during a forum on bullying reflect subtle differences deriving from the bullying experiences specific to different populations, as well as from the settings where the problem occurs. A definition specific to bullying of older adults has been proposed on the basis of current knowledge about mistreatment of older adults:

[TRANSLATION]

Older adult bullying is a single or repeated and generally deliberate act or lack of such an act or action, occurring directly or indirectly within a relationship of power, authority, or control between individuals, with the intention** of negatively affecting or harming one or more older adults [86].

Although this definition contains elements that seem common to bullying at any age, it mentions certain subtle differences specific to older adults. A wide range of actors can be involved in bullying of older adults, regardless of whether the relationship between them is based on trust. The bullying can be repeated or occur only once, but it always has consequences for the victim. Think, for example, of a person who is ridiculed every day or is threatened with the withdrawal of services, even only once.

* Since 2015, the Research Chair on Mistreatment of Older Adults has been conducting a research project entitled *État des connaissances et clarification conceptuelle de l'intimidation envers les personnes âgées*. This project ties in with measure 5.2 of the Concerted Action Plan to Prevent and Counter Bullying, which aims to “document the phenomenon of bullying, including cyber-bullying, as it relates specifically to seniors, taking into account acquired knowledge on elder mistreatment and the available data relating to gender” [79]. As part of this project, the Chair has identified roughly 30 scientific articles, chapters, theses and so forth published between 2009 and 2017 that focus primarily on older adult bullying [82].

** The intention to harm is not taken into account when the person who bullies has major cognitive impairments.

Older adult bullying takes place within a relationship of power, authority or control between one or more people trying to gain the upper hand. A relationship of power may be based, for example, on physical strength or sheer numbers, while a relationship of authority may involve, for instance, an attendant in a position of authority over people under his or her care. As for a relationship of control, it may involve, for example, a resident of a nursing home monopolizing the TV remote control and imposing his or her choice of program on other people in a shared living room. In theory, contrary to what is said in the definition in the *Education Act*, the relationship between people trying to gain the upper hand is not necessarily unequal (e.g. two older adults in full control of their faculties vying for the position of president of an organization may be considered to be on an equal footing). Lastly, bullying of older adults is usually deliberate; in other words, it is done with the intention of harming others. However, the notion of intent may not always apply or, at any rate, may be hard to assess, particularly in cases where the perpetrator of the bullying has cognitive impairments [86].

Bullying of older adults can be verbal [83,84,87], physical [84,88], or social/relational, that is, characterized by antisocial behaviour [83–85,89]. It can also be material (e.g. vandalism, taking possession of other people’s property), although this type of bullying has not been documented specifically for older adults [79]. As well, older adult bullying can take the form of what is commonly called *cyberbullying*, which involves the use of information and communications technologies (ICTs).

Risk factors

Older adult bullying can occur in any setting where seniors are present. However, the most fully documented settings are group living environments (residential, care or service facilities), such as CHSLDs, and workplaces, particularly those where ageism is prevalent [91,92]. Although bullying behaviours towards older adults may be displayed by a range of actors [86], the best-documented examples to date involve senior-to-senior bullying [83–85,88,89,93,94]. This section focuses primarily on bullying experienced by older adults in group living environments and the workplace.

As indicated in the definition provided earlier, bullying arises during interactions between individuals. Therefore, special attention will be devoted to the main characteristics of people who are likely to be bullied or to bully others. Table 8 presents the characteristics that have been identified in the literature.

Table 7 Characteristics of older adults at risk of being bullied or at risk of bullying

Characteristics of older adults at risk of being bullied	Characteristics of older adults at risk of bullying
<ul style="list-style-type: none"> ■ Being introverted [93]; ■ Belonging to a visible minority [93]; ■ Having physical impairments [84]; ■ Having certain passive personality traits (e.g. being shy, having problems defending oneself, being quiet, submissive, dependent) [84]; ■ Having certain proactive personality traits (e.g.: being disruptive) [93]; ■ Having cognitive impairments [11,84,94]. 	<ul style="list-style-type: none"> ■ Having low self-esteem [93]; ■ Having one or more of the following personality traits: Feeling entitled; Being controlling; Seeking attention [84]; Needing to be in a position of power over others, seeking to benefit from the fact that the victim feels threatened [93]; ■ Having cognitive impairments [84,93,95]; ■ Having sufficient cognitive abilities to engage in bullying behaviour [95].

Table 8 shows that cognitive decline is a characteristic that is common to people who are at risk of being bullied and people who are at risk of bullying. However, there does not seem to be a consensus in the literature that cognitive impairments are a characteristic of potential perpetrators. In fact, although some studies report that acts of bullying are often committed by older adults with cognitive impairments, others report that, in order to intentionally engage in bullying behaviour, perpetrators must have sufficient cognitive abilities to be aware of the acts they commit [95].

Bullying of older adults can extend beyond the framework of the dyadic relationship between a bully and a victim [86]. In fact, it can occur between groups of people [85] and take place in the presence of witnesses [83]. A key factor is that bullying is necessarily part of a broader context where aspects of a social nature (e.g. media coverage [93]), a political nature (e.g. implementation of the Concerted Action Plan to Prevent and Counter Bullying 2015-2018) and a cultural nature (e.g. ageism [91]) can have an impact on not only the incidence and recognition of bullying but also the actions taken to prevent and counter it.

Consequences

Bullying experienced by older adults can have psychological, physical and social consequences. Table 8 provides a few examples.

Table 8 Consequences of bullying for older adults

Consequences	Examples
<p>Psychological</p> <p>(Bonifas, 2011, cited by Bonifas [85]; Bonifas and Frankel, 2012, cited by Bonifas [85]; [83,96])</p>	<ul style="list-style-type: none"> ▪ Anger; ▪ Anxiety; ▪ Fear; ▪ Decline in self-esteem; ▪ Sadness, depressive symptoms; ▪ Suicidal ideation; ▪ Etc.
<p>Physical</p> <p>(Bonifas and Frankel, 2012, cited by Bonifas [85]; [83,96,97])</p>	<ul style="list-style-type: none"> ▪ Trouble sleeping; ▪ Various physical problems; ▪ Functional decline; ▪ Etc.
<p>Social</p> <p>(Bonifas, 2011, cited by Bonifas [85])</p>	<ul style="list-style-type: none"> ▪ Withdrawal; ▪ Seeking vengeance; ▪ Etc.

Bullying can have long-term consequences even when it is experienced at an early age. In fact, it is more common for older adults with a history of childhood bullying to have suicidal ideation throughout their life than it is for seniors who were not bullied in childhood [98].

Since bullying occurs in a social and interactional context, it also affects people who witness it [83], in addition to having repercussions on the living environment in general [85]. For example, in group living environments such as CHSLDs, bullying can cause feelings of fear or insecurity among a number of the residents; reduce participation in social activities; lead to a low level of satisfaction with the living environment or workplace; reduce commitment to and feelings of loyalty toward the facility; increase staff turnover; and create more situations of bullying (Frankel, 2014, cited by Bonifas [85]).

Prevention

To our knowledge, no prevention or intervention programs or activities in the area of bullying have been validated and documented in Québec or internationally. However, since 2015, the Governmental Action Plan to Prevent and Counter Bullying has funded dozens of initiatives in Québec, several of which have been aimed at countering older adult bullying.* The most common prevention and intervention programs consist of awareness-raising activities designed to inform the general public and to propose possible actions, particularly in group living environments.

* Link to the *Together Against Bullying Financial Support Program* of the Ministère de la Famille du Québec: <https://www.mfa.gouv.qc.ca/en/intimidation/programme-de-soutien-financier/Pages/index.aspx>

A growing number of possible avenues for prevention and intervention are being documented internationally. For example, in CHSLDs, emphasis is being placed on the importance of:

- Assessing situations of bullying in these centres;
- Training staff and residents to identify such situations;
- Strengthening positive interactions among residents;
- Involving all actors in the implementation of positive activities intended to create an empathetic environment [99].

Although some programs, such as the Senior Culture Program [100], are designed more specifically for older adults, it is important to mention that bullying can be part of an organizational culture and that this problem must be addressed through measures intended directly for managerial and other staff [101]. Therefore, all intervention programs to combat bullying in group living environments must include components designed specifically for each of the three main types of actors: older adults who are bullied, older adults who bully and the organization as a whole [102].

Clarification of the difference between the concepts of mistreatment and bullying

Similarities

This box on bullying, together with the previous sections on the definition, risk factors and consequences of mistreatment, reveal the many similarities between bullying and mistreatment. In fact, a study on this question has highlighted the ways in which these two social problems resemble one another in regard to the following [86,103]:

- Personal, family, social, political and cultural contexts;
- Risk and vulnerability factors;
- Settings in which these problems occur;
- Interaction (two or more people);
- Violence or neglect;
- Single or repeated acts;
- Consequences;
- Cyberspace.

Therefore, prevention and intervention programs and measures put in place to counter mistreatment or bullying can have an impact on both problems at the same time. This is the case, in particular, of complaint mechanisms, user committees, the Elder Mistreatment Helpline and awareness campaigns [103,104]. Focusing on preventing and combatting ageism is also a good way to act on both problems. Indeed, it is recognized that ageism is related not only to mistreatment [38,105] but also to bullying [91].

Distinctions

Nevertheless, as shown in Table 9, mistreatment and bullying also have their own specific characteristics. Understanding their distinctive features is crucial to reading situations correctly, that is, to being able to determine whether mistreatment or bullying is taking place.

Table 9 Specific or essential characteristics of mistreatment and bullying

Mistreatment	Bullying
<ul style="list-style-type: none"> ■ The relationship between the people involved is based on trust (e.g. it involves family members, friends, neighbours, service providers); ■ The mistreatment may be intentional or not. 	<ul style="list-style-type: none"> ■ The relationship between the people involved may or may not be based on a relationship of trust (e.g. it may involve strangers); ■ The bullying is usually intentional; ■ The bullying may be direct (e.g. shoving) or indirect (e.g. spreading rumours); ■ The bullying occurs in a relationship of power, authority or control.

In short, although mistreatment and bullying are problems that can occur separately, they are not mutually exclusive [85]. In fact, a given situation may be considered to involve both mistreatment and bullying, particularly if it occurs in a relationship where there is an expectation of trust [86]. For example, a situation where a son threatens to stop visiting his mother unless she lends him money constitutes both mistreatment and bullying. The son mistreats his mother psychologically and financially by committing an act of bullying, that is, by threatening her.

Prevention

Several States have a structured vision of how to combat mistreatment. This is the case of Québec, with its action plans AP-1 (2010) and AP-2 (2017). Both of these action plans cover three phases of intervention: primary prevention, case finding (also called identification or detection), and one-off interventions or follow-up for mistreated older adults and, more rarely, for people and organizations that mistreat. Since very few practices have undergone implementation or outcome assessments, this section is based mainly on descriptions of practices. The few components that have been validated are clearly indicated. The text deals essentially with primary prevention and, more specifically, certain guidelines, and provides a short list of programs and tools—used particularly in Québec—along with best practices recommendations derived from the scientific literature. Given the number of practices applied in Québec and around the world, this list is not exhaustive. Information dealing specifically with older adults living at home or in residential and care facilities is provided when available.

Table 10 shows that existing practices have four different focuses: individuals, interpersonal relationships, the community, and society as a whole. To our knowledge, all of the examples given in this table, except for psychological programs for people who mistreat, are practices commonly used in Québec. However, detection and case finding are not done systematically, and emergency shelters are not available in every region.

Table 10 Overview of interventions and their effectiveness in preventing or reducing mistreatment of older adults

Preventive measures	Individual	Relational	Community	Societal
Promoting positive attitudes towards older adults and raising awareness		Intergenerational school-based programs	Training and awareness raising for professionals	Public awareness campaign
Reducing at-risk situations for older adults as well as their family and friends	Education campaigns for older adults	Training programs for paid caregivers Support programs for caregivers	Encouragement of positive attitudes among people who work with older adults	Programs to reduce the use of restraints
Ensuring early and adequate detection and follow-up of mistreatment situations	Legal, psychological and social support for mistreated older adults	Psychological programs for people who mistreat	Detection and case finding Help line Emergency shelters	Adult protection services Compulsory reporting

Source: Based on the report *Recherche de cas de maltraitance envers des personnes âgées par des professionnels de la santé et des services sociaux en première ligne* [106].

Policy and program directions

As indicated in Table 10, prevention of mistreatment of seniors involves actions aimed at “reducing at-risk situations for older adults as well as their family and friends” and “promoting positive attitudes towards older adults and raising awareness.” It also includes actions to inform and educate the general public [107] on the risk factors for mistreatment, as well as on best practices for reducing the risk that such situations will occur.

Examples of programs and tools

Preventing mistreatment involves, first and foremost, the transmission of information through promotional and public information campaigns [108,109]. This type of action targets the public as a whole with a view to effecting change on individual, relational, professional, and societal levels. Such campaigns use a range of strategies to enable people to take a critical view of interactions with a potentially negative impact on older adults. However, if we are to change ageist perceptions, we must go beyond mere awareness raising [109]. Québec has conducted four public awareness campaigns since 2010, as part of the implementation of AP-1. Various strategies have been used depending on the campaign: advertising on television, radio and the Web; production of posters and brochures; etc. While the first two campaigns were focused on explaining what mistreatment is, the third one illustrated the phenomenon by describing clear cases of mistreatment. The most recent campaign, in 2017, discussed actions to counter bullying, as well as actions to counter mistreatment.

Educational interventions help to improve knowledge and to change the attitudes of professionals towards the detection, reporting, and follow-up of mistreatment situations [106]. They enable professionals to play a more active role or to become more alert to signs of mistreatment as well as better equipped to take action in this regard. Educational interventions are just one of the 22 existing best practices identified in a systematic literature review [110]. Two validation studies were also identified in a systematic review of educational programs [33]. The first study discussed an educational presentation on older adult mistreatment that had been given to nursing assistants. The nursing assistants' reactions were recorded, but without any pre- or post-test measurements, random assignment of participants or control group comparisons (Smith, Davis, Blowers, Shenk, Jackson and Kalaw, 2010, cited by Day et al. [33]). In the second study, dental hygienists with training on mistreatment completed a pre- and post- test using a mail-in questionnaire, with no comparison group. The results of this study suggest that this training increased the hygienists' ability to recognize mistreatment and neglect (Harmer-Beem, 2005, cited by Day et al. [33]). A large number of educational interventions are offered in Québec; however, without a systematic survey, it is impossible to do a comprehensive review of these initiatives (number of hours, format, target audience, etc.). Nevertheless, here are three examples. The Elder Mistreatment Helpline team is responsible for training service providers in the public health and social services network throughout Québec, as well as for training trainers. University-level training programs for future practitioners (available, in particular, in the social work schools of Laval and Sherbrooke universities) offer 45 hours of credit courses on the fight against mistreatment or blocks of a few hours of training in undergraduate programs. Training is offered, as well, to various stakeholders, including the members of the Regroupement provincial des comités des usagers.

Preventing mistreatment also involves the use of various mechanisms and tools. The rare prevention tools that have a psychometric component are based on risk factors for mistreatment. One of these tools, the Social Vulnerability Scale, has been validated. It is not specific to a particular living environment, but it focuses on the social vulnerability of older adults with a view to detecting situations of financial exploitation before they occur [111]. The Trousse SOS Abus kit [112] has identified and made available to the general public a large number of prevention, detection, intervention, and training tools related to the problem of older adult mistreatment. Several of these tools have been developed since 2010. According to a number of community organizations approached in the course of various research projects, the most popular aspect of these tools are the skits, particularly those in which the public can participate.

In recent years, promotion of well-treatment has been developed in tandem with efforts to combat mistreatment in several French- and Spanish-speaking countries. Although Québec did not officially use the term "well-treatment" prior to the release of AP-2 in June 2017, some of the actions it has implemented are in keeping with this approach. Box 3 presents the key aspects of the promotion of well-treatment, which is centred in particular on the promotion of positive attitudes toward ageing [106].

■ Promotion of well-treatment

The definition of well-treatment recommended by the Québec government is as follows:

Well-treatment is about fostering the well-being and showing consideration for the dignity, self-fulfillment, self-esteem, inclusion and safety of a senior. It is expressed through attentiveness, attitudes, actions and practices that are respectful of the values, cultures, beliefs, life journeys, uniqueness and rights and freedoms of that individual [8].

This definition focuses on older adults themselves, while the definitions proposed in Europe also include the well-being of the various people with whom seniors interact [113]. In its broader sense, well-treatment is a full-fledged culture of respect for the individual as a whole that takes into account his or her history, dignity, and uniqueness. This culture also fosters individual actions and [TRANSLATION] “collective relations within facilities or services” [114]; it thus engages a multitude of actors. Well-treatment alone does not eradicate mistreatment or mean that there is no mistreatment in the situation being addressed.

Home-based prevention activities

A number of European countries have published guides on best practices in home settings. In 2016, the Ministère des Affaires sociales et de la Santé and the Secrétariat d'État chargé des Personnes âgées et de l'Autonomie in France worked together to publish the document *Aide à domicile aux personnes âgées : le guide de bonnes pratiques*. This best practices reference guide is based on: (1) freedom of choice for older adults and the delivery of quality information; (2) “fair prices”; and (3) professionals’ working conditions. In 2012, the Conseil Général de La Vienne proposed guidelines for each of the services provided to recipients in the *Guide des bonnes pratiques pour les professionnels de l'aide à domicile*.

Preventive strategies help not only to reduce the risk of mistreatment but also to prevent new mistreatment situations from arising [115,116]. For example, since caregiver burnout and depression can constitute risk factors for mistreatment, homemaking and meal preparation assistance, respite and education measures, and support groups are useful approaches that can be put in place. In Québec, organizations like the Regroupement des aidantes et aidants naturels (RAAN) have a mission to help caregivers improve their quality of life through participation in activities and access to services that meet their needs [117]. Other preventive measures like caregiver referral and help lines also have a role to play in prevention [110,118].

Prevention activities in care and residential facilities

Promotion of well-treatment in residential facilities helps to improve practices while fostering better quality of life for residents and service providers [119]. Since 2003-2004, Québec’s Ministère de la Santé et des Services sociaux has been conducting visits to CHSLDs in an effort to assess the quality of services offered there [120]. These assessments, like the certification required for private seniors’ residences under the *Act respecting health services and social services*, are aimed at ensuring the quality of home-care services and thus protecting clients. To obtain certification, services offered in seniors’ private residences must meet a series of standards [121,122]. Adopting a well-treatment approach in residential facilities is a positive step toward examining the [TRANSLATION] “conditions needed to successfully care for residents,” since it avoids focusing the spotlight on mistreatment [123].

Under the *Act to combat maltreatment of seniors and other persons of full age in vulnerable situations* [124], assented to in May 2017, all institutions in the health and social services network must adopt a policy involving prevention activities to combat mistreatment. The introduction of this *Act* bodes well for changes in practices in the near future. Table 11 provides a list of best practices identified in the literature.

Table 11 Best practices identified for residential and care facilities

Practices	Aims/objectives	Additional information
MobiQual (France)	“to improve the quality of professional services for older people in need of care and assistance and people with disabilities” [125].	Intended for professionals working in CHSLDs [125].
Core values for long-term care services (Sweden)	“Care must focus on the dignity and wellbeing of older people” [125].	With this legislation, municipalities have to develop a guarantee that care is focused on dignity. This guarantee is checked by public authorities [125].

■ Strategies to promote a culture of well-treatment in residential facilities

- Define facility-based projects and a quality approach;
- Identify leaders in the promotion of well-treatment;
- Improve external and internal communication;
- Develop a skills development plan in well-treatment, and a staff mobility policy;
- Implement a well-treatment recognition system, along with an assessment system;
- Provide training for care workers and a framework for their practices;
- Consolidate and update knowledge;
- Review work organization and inflexible approaches detrimental to the promotion of well-treatment;
- Consider using focus groups for the purpose of engagement and consultation;
- Use role-playing and simulated interventions with patients;
- Provide clinical supervision.

Source: “Comment prévenir une crise? Les leçons tirées des plaintes de maltraitance au Centre de soins de longue durée Saint-Charles-Borromée” [123].

The *European Quality Framework for long-term care services* [125], published in 2012, proposes a series of **quality principles** and **areas of action**.

Quality principles: a quality service should be respectful of human rights and dignity, person-centred, preventive and rehabilitative, available, accessible, affordable, comprehensive, continuous, outcome oriented and evidence based, transparent, gender and culture sensitive.

Areas of action: a quality service should also contribute to preventing and fighting elder abuse and neglect, empowering older people in need of care and creating opportunities for participation, ensuring good working conditions and a good working environment, and investing in human capital, developing adequate physical infrastructure, developing a partnership approach, developing a system of good governance, developing adequate communication and awareness-raising.

Source: European Quality Framework for long-term care services. Principles and guidelines for the wellbeing and dignity of older people in need of care and assistance [125].

Best practice recommendations

The best primary prevention practices recommended in the literature may be summarized as follows:

- Improve basic training for professionals who work with older adults [126,127];
- Provide ongoing professional training on older adult mistreatment [128];
- Encourage health professionals to use social media, online resources and public service messaging to combat ageism, and to raise the public's awareness of older adult mistreatment and the associated consequences [129];
- Ensure better preparation of older adults and adult children who will take care of their aging parents through public awareness and caregiver education and training [129];
- Prioritize research on older adult mistreatment in all its forms [129];
- Improve knowledge on the subject of older adult mistreatment [106].

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