Promising Approaches for Addressing/Preventing Abuse of Older Adults in First Nations Communities

A Critical Analysis and Environmental Scan Of Tools and Approaches

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DEDICATION

You hear about an older First Nations woman, Betty, who has had a fall and ended up in hospital with a broken hip, ankle and arm. Most of her adult children live far away. Her eldest son who lives about 5 hours away is very supportive of his mom but has a full time job and little kids so it's hard for him, and them to visit regularly.

When Betty was getting ready to leave the hospital, the staff was concerned about Betty having enough support at home while still healing from her broken bones. Home support and help with meals is arranged.

A few days after Betty returns home, a young nephew who Betty hasn't seen for many years comes home. At first it seems he is being helpful in his auntie's healing, but in time he starts telling the home support people not to come, that he will take care of his auntie. Over time it becomes clear he isn't looking out for her and when home support staff drop by to ask how she is doing, he won't let them see her, saying she is asleep, out, etc.

An elders' advocate comes to visit one day when the nephew is out. He finds Betty upset, disoriented, hungry and unkempt, with a bruise on her face. The advocate asked where the nephew is, and what has happened and Betty tells him he has taken her Residential School advance payment cheque which she reluctantly signed over to him, to the bank.

This report is dedicated to:

- abused aboriginal older adults like Betty who deserve to live free from abuse as a basic human right
- Elders who have the wisdom to guide us through this difficult issue
- the Home and Community Care staff working in local reserve communities who respond to this as well as o many many other local issues
- other community based supports and services both on and off reserve who do their very best every day to support women like Betty
- responders, community leaders, community-builders, policy makers working at all levels to promote safe and caring communities

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1. EXECUTIVE SUMMARY

Project Overview

Through a literature review and web-based search, 8 regional teleconferences and an in-person focus group, this project was designed to identify relevant principles, screening and intervention tools and approaches and prevention strategies being used in First Nations communities to address/prevent abuse of older adults. While the project was focused on gathering approaches and tools to assist First Nations older adults who are abused, on or off reserve, as opposed to all aboriginal peoples (Inuit and Métis) frequently the term "aboriginal" is used because there has been so little research done with regard to First Nations older adults generally, or abuse of First Nations older adults more specifically. Including more references, approaches and tools that are at least aboriginal if not specifically First Nations, seemed desirable.

What We Know About the Context

The health status of aboriginal people in Canada is significantly lower than the national average. Little statistical data on the incidence and prevalence of abuse of older adults in the Aboriginal population was found, despite the fact that 8.3% of aboriginal people are older adults. However, we do know that rates of violence against aboriginal women are three times higher that of non-aboriginal women.

The residential school experience has had and continues to have a huge impact of First Nations people because many of the outcomes contribute to putting older First Nations older adults at risk for abuse. For many it resulted in the loss of language, culture, identity and the intergenerational breakdown of family, clan and hereditary systems for many aboriginal people in Canada. Today's legacy of the residential school process includes human rights violations in all spheres, multigenerational abuse, racism, serious health issues and alcohol and drug misuse. These effects are exacerbated by: being a culture in transition, social engineering, lack of resources, distrust of authorities, illiteracy, poor transportation, shame, personal and social silence, and the intergenerational transmission of trauma.

What is Being Done

Addressing issues of health literacy, acknowledging the important role of knowledge and learning, including traditional knowledge, utilizing culturally appropriate and gender based lenses and working to create cultural safety across the cultural divide of First Nations/non-First Nations are key considerations in addressing and preventing abuse of older First Nations adults.

Protective factors mitigating against abuse of older adults include: overarching strategies and networks, addressing the issue at all levels of prevention, for example, r*aising community awareness, empowering elders to develo*p support groups and peer networks and developing linkages between community services. Effective prevention programs use a strengthening family and culture approach, are developed and offered within the context of the family, contribute to capacity building, use Aboriginal traditional healing approaches (i.e., sharing circle), raise awareness of the issue through a public campaign and utilize community knowledge.

Overarching principles for approaching the work generally are outlined followed by approaches and tools being used in First Nations or aboriginal contexts for addressing/preventing any form of family violence. Approaches and tools assessing and intervening are presented at the individual, family, community and societal levels (provincially/territorially, nationally and globally)

Approaches and Tools - Overall Findings

After reviewing the literature and the approaches and tools outlined in the paper, a flowchart emerged as a new, integrated and innovative conceptual model for respectfully addressing and preventing abuse and neglect of older First Nations adults at the individual, family, community and societal levels. It is much more than a series of disconnected approaches and tools that could be amended and selected from; it is a model that puts many of the bits and pieces identified in this project together into a new and integrated whole.

- General Orientation to Practice (which includes the AFN wholistic model and the Research based Integrative interpersonal meaning centered model)
- Indicators of abuse possible abuse and referral criteria from FN Re:Act
- AFN Balance – Cultural Framework – Possible Assessment
- Healing Journey Medicine Wheel – possible secondary assessment
- Family conferencing
- Community based interventions such as BC's Community Response Network movement and the Red Cross Respect Ed Program, Walking the Prevention Circle

Project Team Recommendation/Conclusion

Some of the tools embedded in the flowchart could benefit from being amended to better fit the needs of addressing abuse of older adults as

opposed to other forms of family violence, or to fit the wide variety of First Nations and other aboriginal contexts in Canada, but once done, the finished product would constitute a very practical, holistic and comprehensive tool kit to share with First Nations and other aboriginal communities.

No doubt such a tool kit would be welcomed by many aboriginal and non-aboriginal responders working on and off reserve and would go a long way to increasingly creating a hybrid future in which all aboriginal older adults live free from abuse in safe communities in which they are valued and respected.

2. PROJECT OVERVIEW

Components

This project was commissioned in May 2009 by the First Nations and Inuit Health Branch, Home and Community Care Program of Health Canada, in collaboration with the Division of Aging and Seniors, Public Health Agency of Canada to further the work on prevention of abuse of older First Nations adults in relation to Canada's Federal Elder Abuse Initiative. It includes the following components:

- A critical analysis of the abuse of older First Nations (FN) adults including:
  - an analysis/discussion of the historical context of abuse of older adults in FN communities
  - a discussion of current issues, risk factors, and outcomes of abuse of older adults in FN communities; and
  - a review and discussion of cultural awareness / cultural competence and how to consider these in approaching this issue in FN communities

- An environmental scan that gathers promising approaches in abuse education, training, intervention and prevention in First Nations communities on and off reserve, for use by front line responders, including:
  - screening, assessment, intervention, prevention, education and training tools and approaches in use
  - the (types of abuse and relationships considered; and.
  - the intended audience and any evaluation outcomes of the tools/approaches if available
  - a process to review findings and identify next steps

Methodology

For the critical analysis, the following databases were searched: Medline, PubMed and SocioFile. A comprehensive Internet search was also conducted (see extensive **REFERENCES** section, Section 14). A research alliance was formed with the Native Women's Association of Canada, which is currently doing another national project on abuse of older aboriginal women, in an effort not to miss any key resources and to help ensure the projects inform one another.

The environmental scan was conducted through a series of 8 regional teleconferences (one in French); each regional call was facilitated according to a consistent interview guide format. Participants for teleconferences were identified by the Assembly of First Nations, the First Nations and Inuit Health Branch's Home and Community Care Program and the BC Association of Community Response Networks. Participants were personally invited by email and telephone and as new contacts were identified, they were personally invited as well.

Project workers acknowledged that teleconferencing is not ideal in a cross cultural project such as this on such an emotionally charged topic. With these considerations in mind, each teleconference concluded with a number of evaluative questions to get feedback and to learn how to better construct the conversations. The effectiveness of the calls evolved over the course of the project.

The findings from the critical analysis and environmental scan were presented in a two-day in person focus meeting of the Project's Task Group (formed to help ensure cultural safety in the project) to obtain overall feedback and to develop next steps. The findings were also subsequently presented on one national teleconference.

Research Ethics

Due to the sensitivity of the topic, and because of a wish not to re-victimize anyone as a result of their participation in it, we relied upon two publications for guidance: (1) The guidelines listed in the NAHO publication, ***Ownership, Control, Access, and Possession (OCAP) or Self-Determination Applied to Research:*** *A Critical Analysis of Contemporary First Nations Research and Some Options for First Nations Communities; and (2)* **Principles** ***and Guidelines for Research with Vulnerable Individuals and Families*** (2003*).* These informed the entire project process, as did advice from our First Nations team member and our colleague from the Native Women's Association of Canada research project.

3. DEFINITIONS

Defining Health

Most aboriginal resources emphasize the importance of non-aboriginal people being able to understand and accept the meaning of health for aboriginal people. The meaning comes directly from worldview and likely cannot be understood completely by non-aboriginal people (and may have different meanings among the diversity of Canada's First Peoples). A lasting impression of the search for meaning is that an aboriginal viewpoint captures a more holistic understanding of life and wellness that shows reverence for an ecological view of life, the environment, the land, animals and people. The concept of balance and keeping well by being in balance seems fundamental; as does the concept of knowing the human's place in the complexity of life and understanding the connections in a deep, perhaps even spiritual way.

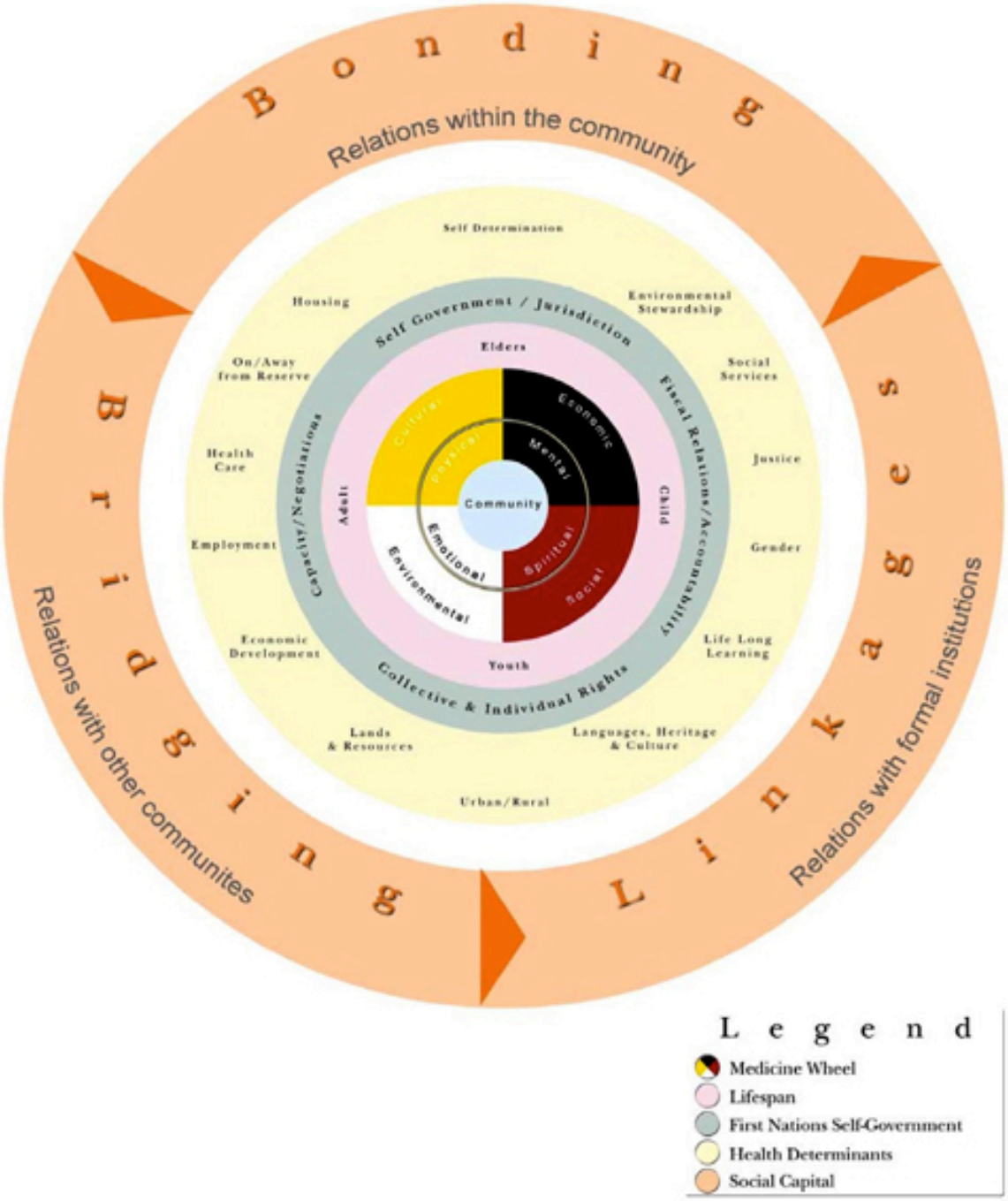
The concept of spirituality that explains the world's existence and peoples' place within it as being a central component of health is embedded in the accounts of worldview. Spirituality may be no less than a health determinant. There are definite parallels between the health determinants framework and traditional Indigenous notions of well-being (Statistics Canada 2006).

Assembly of First Nations Health Model

The Assembly of First Nations outlined a First Nations Health Model in its submission to the World Health Organization (WHO) Commission on Social Determinants of Health. It attempts a holistic approach and embeds health in a social context. This model (described in Appendix 1) includes:

- 'community' at its centre
- components of the Medicine Wheel with different aspects of the 'whole person' represented - Spiritual, Physical, Emotional and Mental
- the Four cycles of the lifespan (child, youth, adult, elder)
- four key dimensions of First Nations self-government (self-government/jurisdiction, fiscal relationships/accountability, collective and individual rights, capacity/negotiations)
- the social determinants of health
- the other elements with the three components of social capital (bonding, bridging, and linkage).

(Reading 2008)



(Reading, J. (2008) Wholistic Model of Social Determinants of Health)

Defining Healing

If the perspective on health is more holistic, the view of healing is also wider and more dependent on social links than a biological or medical Western view. Waldrem (2008) describes it in this way: "healing is ultimately about the reparation of damaged and disordered social relations. The individual, through outwardly and self-destructive behaviours, has become disconnected from family, friends, community, and even his or her heritage.'

Defining Abuse

The WHO defines elder abuse as "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"(Krug 2005). Abuse can take many forms. It can be physical, emotional, sexual or financial and is further defined in Appendix 2. In addition, spiritual abuse can occur for Aboriginal older adults. Bent (2009) states it can include, but is not limited to "'verbal put downs or physical punishment for discussing or practicing cultural/spiritual traditions, and the prevention of participation in a spiritual belief system.'

Family Violence or Abuse of Older Adults?

There are two distinct areas of research and practice for Aboriginal older adults which intersect in ways that are not completely sorted out. Family violence has many years of research, often rooted in feminist theory and social lens research, while the older adult abuse field is more recently developed often from the perspective of risk.

Abuse and neglect of older adults is subsumed in the World Health Organization's (WHO) typologies of violence as a form of interpersonal violence. Concepts in the WHO reports, (particularly in *Prevention of Violence* and *Guidelines to the Implementation of Recommendations in Prevention of Violence),* help to frame thinking about a general approach.

Family violence in Aboriginal communities has a specific characteristic, which separates it from non-aboriginal family violence. That is, it is seen as the product of particular social impacts from a dominant society; with its current expression rooted in a colonial history in Canada (Edwards 2008). A further discussion of family violence is in Appendix 3.

Defining First Nations Older Adults / Seniors / Elders

There is often confusion about terms used in referring to older adults. Mainstream discussion sees elder in reference to 'elderly' – a specific age distinction, (usually oldest of old; elder may mean 'older adult' or senior. For First Nations people, "Elder' defines a particular role – not strictly age related, but linked to cultural transmission and leadership (RCAP 1996). Elders are respected because of their perspective, knowledge, for providing traditional cultural links, for their thoughtfulness and wisdom.

This paper uses the term older adult to indicate people over the age of 55; rather than the terms elder or senior unless deliberately referring to Elders in their cultural/leadership role, or unless a direct quote written by someone else has been included.

This paper also focuses on First Nations people on and off reserve, as opposed to all aboriginal peoples (Inuit and Métis) although frequently the term "aboriginal" is used because there has been so little research done with regard to First Nations older adults generally, or abuse of First Nations older adults specifically. Including more resources that are at least aboriginal if not specifically First Nations, seemed desirable.

4. ABORIGINAL HEALTH STATUS AND ABUSE

Numbers and Related Trends

The 2006 Census states that more than one million persons in Canada reported that they were Aboriginal (1,172,790), with 81,095 being aged 55-64 and 56,460 being over 65. Of this number, Ontario has the largest number followed by BC, and then Manitoba/Quebec (Statistics Canada 2006). The following trends are reported by Statistics Canada in relation to the older Aboriginal population in Canada

- aboriginal older adults are younger than non-Aboriginal older adults, but with a trend to aging
- the number of Aboriginal older adults is projected to grow in the next decade
- women outnumber men among Aboriginal older adults, except in the Inuit population
- while the life expectancy of Aboriginal people has improved over time, life expectancy remains lower than that of the total population

Further trends are reported in Appendix 4.

Many aboriginal people do not have English or French as their first language: 'Fifty-five per cent of First Nations and Inuit Elders age 65 and older and 44 per cent of those over 55 claim an Aboriginal language as their mother tongue, with Cree, Inuktitut and Ojibwe the most widely used.' (NIICHRO 1997).

Dumont-Smith estimates Aboriginal older adults represent 8.3 per cent of the total Aboriginal population. Further, "it should be noted that very little information is available on the Aboriginal elder population, especially elderly women. The Canadian Panel on Violence Against Women concurs" (1993:156). (Dumont-Smith 2002).

Overall Health Status

The recently released Senate Sub-Committee Report on 'A Healthy Productive Canada: A Determinants of Health Report" states unequivocally: 'Currently, Aboriginal Canadians… have a health status that is well below the national average. The evidence obtained by the Sub-Committee shows that the Aboriginal experience in Canada is unequal. There are striking disparities between Aboriginal and non-Aboriginal Canadians in most health determinants and the gaps are widening.'

Abuse of Older First Nations Adults

Little statistical data on the incidence and prevalence of abuse of older adults in the Aboriginal population can be found:

- In one 1997 study, over half of the Aboriginal older women revealed that they had been or were victims of more than one type of abuse
- Overall, spousal violence against Aboriginal women remains more than three times higher than for non-Aboriginal women or men. They also are more likely than non-Aboriginal women to report the most severe and potentially life-threatening forms of violence (Edwards 2008)

Bent lists the following research highlights in a literature review of the Native Women's Association of Canada:

- aboriginal seniors living in rural or reserve settings fare worse than aboriginal seniors living in urban settings because of isolation issues and lack of resources
- predictors of abuse for non–aboriginal populations (who is depending on whom, geographical location, health of the abused person, health of caregiver, financial status, drug/alcohol dependence, mental health issues – depression, dementia,

psychiatric problems); may be the same as for aboriginal populations but too little is known in empirical research evidence to support this
- aboriginal seniors living in rural or reserve settings are less likely to report being abused
- NWAC states that where there is programming to prevent or ameliorate violence to women it is most often aimed at younger women and children. (Bent 2009)

Some believe that seniors issues are put on the 'bottom rung of the ladder' of concerns in Aboriginal communities because of the myriad of other serious issues they are presently dealing with: child welfare, economic and direct health issues-infection, chronic disease levels, lack of safe drinking water, and housing (Native Women's Association of Canada 2007).

5. HISTORICAL CONTEXT

> 'It is well known that violence is higher in the Aboriginal population and the known contributing factors to violence would suggest that older Aboriginal people, and in particular women, are abused at a rate that is similar or higher than in the mainstream population. Some of these factors include the experiences of colonization, feelings of devaluation among Aboriginal people, destruction of traditional ways of life, and a history of abuse in residential schools. Many older Aboriginal people experience the long-lasting effects of physical, sexual and emotional abuse in residential schools and were denied the opportunity to be exposed to examples of positive parenting. This may contribute to higher rates of violence in Aboriginal communities across generations.' (Edwards 2008)

Residential School Experience

Residential schools had a far reaching negative and destructive effect on Aboriginal people and communities across Canada. Residential Schools wrecked havoc within Aboriginal communities which included the obliteration of language, culture, identity and integrity. The fallout from the schools demarcated the continuous and current effects and impacts leading to the intergenerational legacy of pain, destruction and dysfunction. The breakdown of family, clan and hereditary systems are a direct result of the Residential School experience. There were no aboriginal people or communities across Canada left unscathed. This brings us to the present where the Residential School legacy continues

to plague Aboriginal populations. The recent acknowledgement by the Courts in 2007 and resultant Residential School compensation payments added further trepidation. The compensation payments heightened the exposure to abuse of older adults in First Nations communities.

Not all the stories and experiences are negative, but these are minute. The overarching experience has been destructive. Many aboriginal communities are facing cultural and language extinction. Losing the connection to land and culture contributes to the destructive behaviours born and currently practiced in communities. The collapse of tradition, beliefs and systems results in various abuses including abuse of older adults. Additionally, Aboriginal Elders face the threat of losing their esteemed place in community because the traditions are not practiced or understood. There are many distractions guised as development that have rendered traditional ways and methods as least important.

Legacy of the Residential School Experience

The legacy includes:

- Human rights violations in all spheres, from collective rights to self determination, lands, resources and territories to social, economic, cultural, political and civil rights violations
- Residential school sexual, physical, mental abuses leading to intergenerational impacts
- Epidemic incidence of diabetes, HIV/AIDS, infant mortality and lack of access to medical services
- drug & alcohol dependencies, gang membership, and other unhealthy coping mechanisms
- Gendered racism and resultant racialized, sexualized violence against Aboriginal women & girls
- Systemic racism (including gendered racism), poverty, unemployment, underemployment, marginalization

(Native Women's Association of Canada 2007)

Fortunately, much healing is also well underway among aboriginal and non-aboriginal people alike with many positive outcomes emerging from openly encountering our painful shared history in Canada.

It is this healing that provides an opportunity to co-create a new shared future to best deal with the issue of abuse of older First Nations adults.

6. RISK AND PROTECTIVE FACTORS

Risk Factors

Literature on abuse of older aboriginal adults mentions poverty and unemployment as predictors of abuse (Cyr, 2005; Dumont-Smith, 2002; NIICHRO, 1997; Pauktuutit Inuit Women of Canada 2006). Other factors that may increase risk for Aboriginal older adults include higher rates of dependency at younger ages due to poor health, and family breakdown (Edwards 2008).

The social context surrounding family interactions can contribute to risk. These can include:

- being a culture in transition
- social engineering
- lack of resources
- distrust of authorities (Bent 2009)

Bent remarks…" the Advisory Committee on Abuse Prevention (2005) has also reported illiteracy, poor transportation, cultural or language barriers, loss of confidentiality and feelings of shame (leading to not reporting abuse) to be major risk factors. Risk factors are explored further in Appendix 5.

Culture, circumstance, family composition and kinship considerations, and world view likely contribute to significant differences in risk for Aboriginal older adults compared to non- aboriginal older adults . The urban / rural divide may also contribute to risk; we can predict that the experience of people living in reserve First Nations communities, those living in rural off reserve communities, and those living in urban settings would differ.

Culturally Generated Personal Attitudes/Behavior Contributing to Risk

Bent (2009) reports that differences in worldview contribute to risk factors, which might not manifest the same way for non-aboriginal people. She cites Locklear (2005) who provides a list of cultural values specific to the Lumbee people as an example of potentially culturally generated risk factors:

- *placidity and silence (hiding feelings of discomfort so as not to embarrass the self or others; retreating if pressed too much in conversation)*

- *modesty (preferring not to call attention to oneself, therefore not wanting to ask for help; reluctance to bring a family problem to the attention of others in the community)*
- *family first (minimizing one's own needs, even to the point of self-neglect, so that others in the family will have what they need)*

Bent concludes that in spite of the diversity of cultures represented by Aboriginal people, there are likely some generalizations that can be applied due to commonalities in world view (2009), and that the example from the Lumby people likely has some resonance for older adults in other Aboriginal groups throughout Canada. (See further examples in Appendix 6).

Personal and Social Silence

Some of the above dynamics, combined with the erasing of 'voice' and language and increased self blame and shame from psychological abuse and pressures from the Residential School experience, manifests for some older adults in a very deep social silence, and a personal disbelief in their 'right' to have human rights.

This has dire consequences:

> 'In the long-term, however, silence, denial or forgetting had some ominous consequences for them and their children. Those measures intended to protect them when they were in the institution drove them to adopt self-destructive behaviours. They also recognize today that silence and denial maintains suffering in the communities.'
>
> (Aboriginal Healing Foundation 2007)

Intergenerational Transfer of Trauma

The dynamics of intergenerational transfer of trauma also adds to risk. Many people over the age of 40 are Residential School survivors (the last Residential School closed in the 1990's in the Canadian North). Many older Aboriginal adults carry some of the effects (some positive but many negative).

Their personal experiences also have affected succeeding generations through the intergenerational transmission of unresolved trauma (likely a form of Post Traumatic Stress Disorder). Appendix 7 lists further effects (Aboriginal Healing Foundation 1999).

In offering health care, there is a potential for re-victimization. Ways to avoid this are outlined in Appendices 8.

In summary, aboriginal older adults share many of the risk factors associated with abuse of older adults in the general Canadian population; but with increased numbers of coinciding factors including: specific cultural factors which are unique, a history of colonization that is unique, and a level of intensity of violence much higher than for other Canadian groups generally.

Protective Factors

The Importance of Overarching Strategies and Networks

Having a culturally appropriate response and prevention strategy of the sort developed for Inuit communities (possibly with detailed guidelines of how to implement it as in the Inuit model (Pauktututit National Strategy To Prevent Abuse In Inuit Communities and Sharing Knowledge, Sharing Wisdom A Guide To The National Strategy 2006) would be a good basis for supporting the identification, intervention and prevention activities specific to each particular indigenous culture in Canada. Supporting cultural groups to turn the generalities into specific targeted and appropriate community level action would be one approach.

The Native Women's Association of Canada has done background work on a strategy for ending violence against women and girls (Violence Against Aboriginal Women and Girls, an Issue Paper).

World Elder Abuse Awareness Day, envisioned by the International Network for the Prevention of Elder Abuse (INPEA), provides a global opportunity to raise awareness of the issue every June 15th and many First Nations communities are using this as a catalyst for organizing.

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Networks of practitioners of several professions, police, researchers front line health and social service responders and others are being formed. This has resulted in better coordination, more profile for the issue and planning for research agendas. These occur at several levels and include INPEA, noted above, the Canadian Network for the Prevention of Elder Abuse (CNPEA) and the National Initiative for the Care of the Elderly (Canada) (Bent 2009, CNPEA 2007).

Working at Different Levels of Prevention

NIICHRO says key elements of prevention are at different levels: individual, family, community. They suggest:

- *Raising community awareness* - through public/professional education, including workshops, presentations, and production of written materials

- *Empowering elders* - by facilitating active involvement of older adults. Develop support groups and peer networks.

- *Developing* linkages - between community services

Outlook 2007: Promising Approaches for Addressing and Preventing Abuse of Older Adults in Community Settings in Canada suggested that for Aboriginal older adults, a holistically balanced home and community life is the means to combat abuse of older adults (CNPEA, 2007). The following are critical aspects of abuse prevention programs in Aboriginal communities; programs must:

- use a strengthening family and culture approach
- be developed and offered within the context of the family
- contribute to capacity building
- use Aboriginal traditional healing approaches (i.e., sharing circle)
- raise awareness of the issue through a public campaign
- utilize community knowledge
- consult with communities

Bent notes that "… the extended family in Aboriginal communities is still a major source of strength and encouragement for seniors despite oftentimes dismal conditions" (2009).

Ageing in Place with Respect and with Dignity

Because of their need to remain in the community to maintain not only proximity to family members, but to maintain ties to language, culture, the land, and aspects of traditional medicine and foods, older Aboriginal adults consider moving off reserve to other forms of residential living as the last consideration in addressing their needs.

NIICHRO points out that traditionally extended Aboriginal families cared for aging members in place. Leaving the family and community or creating age specific housing or institutions is a foreign concept, although some reserve communities are developing such resources on reserve.

7. CONSIDERATIONS IN MINIMIZING RISK AND MAXIMIZING PROTECTIVE FACTORS

Having Access to Response/Prevention Tools

Part 9 of this report outlines a number of response/prevention tools and approaches that have been identified for screening and intervening in individual situations of abuse of older adults, as well as at the family, community and societal levels.

The considerations noted below, health literacy, knowledge/learning, the use of lenses and cultural awareness and safety serve as a backdrop to be consciously considered when using the tools and approaches.

Health Literacy

Health literacy is a huge issue for older adults. It has been labeled as a determinant of mortality (Rootman 2007). If it is a problem for mainstream society, then it is likely even more of a problem for Aboriginal older adults for all the reasons cited thus far that impact on health, Most health information is offered in print form Aboriginal societies generally have oral traditions more than a written style of communication and health information is often not available in traditional languages (Health Canada 1998).

Knowledge / Learning

Learning is intimately tied to health and health status. Education is one of the determinants of health. For Aboriginal peoples, the kind of knowledge produced and who owns it is a critical issue. Health status may be tied to use of appropriate knowledge and the honoring of the thousands of years of production of knowledge amongst Aboriginal peoples. The application of Aboriginal knowledge and recent Aboriginal research may have a catalyst effect on health improvements.

Use of Lenses

The Public Health Agency of Canada commissioned a Gender Based Analysis lens (Edwards 2008). As part of the Federal Elder Abuse Initiative it is intended to be used in evaluating responses at all levels and how they work for men and women. The author acknowledges that the current use of gender based analysis does not account for the effects of history,

particularly with regard to systemic forms of violence that Aboriginal women face; and that a culturally relevant gender based analysis of the sort developed by NWAC is better suited to analyzing programs and policies. Edwards also indicates that a bias-free tool is needed to ameliorate all biases (gender, culture/race etc) (Edwards 2008).

Culturally Relevant Gender Based Analysis (CRGBA)

The Native Women's Association of Canada integrates cultural relevance into a GBA framework in order to create more power balance in Aboriginal society (Appendix 9).

A culturally relevant gender based analysis could also be developed for men and for sub-groups of each gender; since needs differ between populations and for varying types of abuse.

▪ CULTURAL AWARENESS AND SAFETY

At the in-person focus group associated with this project an Elder commented, "when I left Residential School there were no services on reserve, no nurses, no help anywhere" Many in the room were moved by this. It is so easy to lose perspective and to feel like we have so far to go to improve things, despite the healing that is taking place among many aboriginal and non-aboriginal people.

The foregoing discussion on the health status of older Aboriginal adults and their place in contemporary society, points to the need for a fundamentally different and customized response from mainstream society based on a culturally safe, least intrusive/most effective, and respectful approach. This approach requires careful conceptualizing and a high degree of emotional intelligence.

Engaging in 'safe' Interactions is a challenge faced by front line workers every day. To do so requires teaching and learning on both sides of the cultural divide because care will continue to be provided by aboriginal and non-aboriginal workers for the foreseeable future.

First Nations communities are served by both aboriginal and non-aboriginal workers. In addition much health care (certainly secondary care) takes place off reserve or regionally. Health workers in mainstream institutions, or community based health centers off reserve may not have requisite cultural competence skills.

Traditional Considerations

Lack of personnel, lack of concurrent use of traditional medicine, cultural clashes because of differences of meaning, language and translation issues, and general communications difficulties associated with working across cultures are some of the barriers reported by NAHO in health systems (NAHO 2003).

Policies and procedures should be adapted whenever possible to incorporate approaches representing traditional ways of constructing 'health'. Knowledge Exchanges for non-aboriginal personnel that cover learning about traditional knowledge and ways of learning, traditional medicine and traditional foods are extremely useful. A 'model' of health and considerations for improving health status are discussed in Appendix 10.

A Hybrid Future

The concept of constructing a more balanced future for equitable relations, is one entertained by several writers about cross cultural interactions, who see it as a 'hybrid' mix of Aboriginal and mainstream aspects (Ball, Obesawin).

	PRE CONTACT	COLONIALISM	PRESENT	TRANS – NATIONALISM
FEATURES	Cultural heterogeneity	Cultural homogenization	Cultural re - construction	Hybrid cultures and identities
	Insular communities	Silencing and resistance	Persisting racism and essentialism	Braiding together 'Its About us"

Source: Ball 2007 Cultural Safety Poster

The implication of this table is that we can jointly construct, across culture and history; a co-joined future which is qualitatively different from the past. Most communities are likely in the 'Present" category with some doing significant work which will lead toward 'Trans-Nationalism', a more 'hybrid 'future. If it is possible to establish more balanced relationships then health status should rise, eliminating many of the risk factors which are a combination of historical legacy and current conditions.

The following section covers a number of components of such a relationship as it applies to abuse of older Aboriginal adults. It includes concepts of:

- cultural safety
- a cultural competency framework / framework for different health professions (Appendix 11); and
- a general orientation to worker practice, with points of meaningful contact between non-aboriginal workers and aboriginal communities.

The Road to Cultural Safety

Simply stated, 'cultural safety' is the outcome of a development of organizational context and individual practice over time that makes services, settings and encounters of any kind safe in the eyes of aboriginal people.

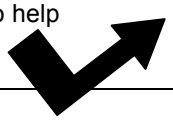
Cultural safety is an outcome of a complex equal relationship between practitioner, culture and client (patient, consumer). These must be negotiated. Whether an encounter, service, treatment or procedure or any interface with any more mainstream systems is culturally safe is determined from the viewpoint of the person who is the service recipient. We can only seek to create the conditions by which cultural safety may be produced.

The First Nations Partnership Program undertaken by Jessica Ball at the University of Victoria and 37 First Nations communities to design, deliver and evaluate culturally appropriate programs to support young children, has been labeled, based on evaluative data, as one of the 20 best practices in the world by UNESCO for incorporating indigenous knowledge. This initiative acknowledges that fundamental to the experience of cultural safely are:

- respectful relationships
- equitable partnerships so all may influence terms of engagement and
- quality of engagement contributes importantly to outcomes (Ball 2007)

The relationship can be guided by the following, with the work for non-aboriginal partners growing out of the left hand side of the matrix:

Cultural Perspectives	Practitioner Implications (of those being served)
1. Goals for development	**1** Goals for program, services, or intervention
2 How to support optimal development	**2** Conceptual understandings and quality of life
3 How to respond to development or life problems	**3** Choice of program activities, service method, intervention strategy
4 Who is best positioned to help	**4** Capacity development and deployment Recruitment, training, staff assignment



With these steps, each culture is fulfilling its role without power based impacts on the other (Ball 2007).

Indicators of Cultural 'Un-Safety'

These indicators are listed by Ball as happening if cultural safety is not present:

- low utilization of available services
- denial of suggestions that there is a problem
- non-compliance with referrals or prescribed interventions
- reticence in interactions with practitioners
- anger
- low self-worth
- complaints about lack of 'cultural appropriateness' of tools and interventions transported from dominant culture to minority culture (Ball 2007)

9. PRINCIPLES, TOOLS AND APPROACHES FOR ASSESSING AND INTERVENING

Principles for Approaching the Work

Principles that have been identified to guide the work and that have the best chance of leading to the "hybrid future" include:

- The 4 'R's (respect, responsibility, reciprocity and relevance)
- 'Grandmothers / Grandfathers' advice or other intergenerational guides for behaviors
- Whole community / whole family / intergenerational approaches (an evaluation of family violence program effectiveness by Indian and Native Affairs Canada states that the most effective programs to ameliorate family violence contain these elements)
- Holistic ways of conceptualizing the world, health - the Assembly of First Nations Social Determinants of Health Model reflects this and the 'General Orientation to Practice' reflects ways to develop this in co-creating meaning cross-culturally (Struthers and Neufeld 2009)
- Use of resources from inside First Nations/Aboriginal communities as well as outside or those jointly developed such as "Stopping Abuse: Responses from First Nations Communities (Public Guardian and Trustee of BC and BC Association of Community Response Networks) so many points of view can be expressed.

Collaborative Work Inside and Inside/Outside Communities

There is a range of workers and professionals, who intersect with the lives of older adults in First Nations communities. They include physicians, nurses, home care workers, social workers, financial aid workers, Elders coordinators, shelter workers, counselors, addictions workers, family members, physiotherapists, occupational therapists; faith leaders, police and others. Any one of them have the opportunity to recognize, identify, intervene, educate, or prevent abuse of older adults. Often more than one of these possible interveners can work together to be more effective, creative or analytical where complex dynamics or safety issues exist, a series of services is needed, and where pathways to support and assistance require a lot of coordination. The work then becomes inter-professional as well as cross-cultural.

Care Needed in Beginning the Conversations

Experience from speaking with older Aboriginal adults suggests there needs to be a 'way in', to beginning conversations about the issue; especially by non- aboriginal workers. Workers should not assume that silence means people do not want to engage in exploring aspects of their experience, but a safe and non-threatening system needs to be developed. Emphasizing being free from abuse being a basic human right and talking about factors that can contribute to both individual and community vulnerability are strategies that work. Worker willingness to appropriately self-disclose about themselves as individuals and their own lives is also important. Relationship-building over time is key.

Because of the level of unresolved trauma present, a direct approach is not likely to be useful and can be seen as blaming. A direct approach can also trigger flashbacks and memories of abuse. (Aboriginal Healing Foundation 1999).

Relationship Building Between Outside and Inside Resources

Often ways into reserve communities can be leveraged by 'allies". It takes time to identify allies, to assess their safety (for themselves and to others); and to create a relationship of equals. Once that occurs, allies can introduce outsiders to other workers and key community members, leaders and Elders. In dealing with Elders it is best to follow guidelines like those developed by Health Canada and the National Aboriginal Health Organization (Health Canada 1998, NAHO 2008).

There will be times when communities will call on 'outsiders' because of a lack of community services, the complexity of the situation; or because someone outside of kinship obligations or on reserve power dynamics of other kinds are better placed to identify, address, intervene or educate families, The label of 'outsider' may be given to those from another jurisdiction, those having specific tribal affiliations, those with specific skill sets or professional expertise or roles, those having power to intervene, having influence on family or community, or who are simply 'trusted'. The role of the 'outsider' is expanded upon in Appendix 12.

Orientation to Practice

A more detailed orientation to practice for British Columbia health authority home and community care workers which could be used by any health worker is being developed in relation to the Vanguard Project (Provincial Strategy Document: Vulnerable Adults and Capability Issues in BC, 2009). Here the concept of vulnerability in concert with the concept of capability is used as a vehicle to think about how best to address/prevent abuse of older adults. The context is an interpersonal stance; the way in which the worker thinks about and approaches response/prevention in all interactions in all relationships.

The interpersonal stance is based on adopting the Assembly of First Nations Social Determinants Model of Health; Clark's Integrative model, (Appendix 13) and using the Assembly of First Nations balance/ quadrants as a general culturally appropriate assessment tool, (Appendix 14) along with material from Vancouver Coastal Health Authority's First Nations Re:Act tool. Collectively, these elements are thought to maximize cultural safety. The advantage for the worker and the community is that this creates a sensitive, yet assertive, responsible and hybrid approach. This General Orientation to Practice is in the piloting stage (Struthers and Neufeld 2009).

Cultural Awareness/Safety Resources

Native Women's Association of Canada – Culturally Relevant Gender Based Analysis. This is a work in progress and focuses on the needs of women.

- www.nwac-hq.org/en/documents/nwac.crgba.june1707.pdf

A Review of Cultural Competency Programs
Summary Report; Cultural Competence in Primary Health Care
Rhymes, J, and D Brown, 2005. Developed by Capital Health, Atlantic Canada's largest integrated academic health district.

- includes self and other assessments for growing competencies
- includes commentaries on many cultural competency programs in North America and tools and resources
- www.cdha.nshealth.ca/default.aspx?page=DocumentRender&doc.Id=210

Cultural Safety Poster – Jessica Ball, University of Victoria, BC

- includes general guidelines of how to be culturally more proficient
- http://www.ecdip.org/culturalsafety/

On Line Cultural Safety Modules (3): University of Victoria- Contributors Dick, Hunt-Humchitt, John, Kelly, Morris, Smith, Voyageur.

- designed for self -study
- http://web2.uvcs.uvic.ca/courses/csafety/mod1/index.htm

Reaching Out: A Guide to Communicating with Aboriginal Seniors. Health Canada 1998.

- www.phac-aspc.gc.ca/seniors-aines/pubs/communicating_aboriginal/index_e.htm

Cultural Competency and Safety: A Guide for Health Care Administrators, Providers, Educators. National Aboriginal Health Organization. 2008.

- includes examples of how to be culturally safe
- www.naho.ca/publications/culturalCompetency.pdf

Diversity and Alberta Health Services

- online Diversity Competency Assessments
- http://www.calgaryhealthregion.ca/programs/diversity/resources.htm

Nuu-Chah-Nulth CASE Nursing Cross Cultural Competency System. **BC** The Nuu-Chah-Nulth have produced a system for their workers which includes expectations of gaining cultural and other knowledge in order to be effective in community (CASE Tool).

- www.nuuchahnulth.org/tribal-council/nursing/

Interventions at the Individual Level

Overall Approach

- Adopt an interpersonal approach based on -
  - high presence / rights based / universal human relations
  - worldview reflection / Including spirituality
  - listening for meaning / meaning centered
  - getting 'creatively lost / orienteering – 'Marlene Atleo'

- Build relationships /anecdotal assessments over time /family included
- Personal match for fit' i.e. matching a combination of traditional and more mainstream approaches to addressing situations as the older adult desires – Aboriginal Health Foundation Evaluation
- Ensure availability of accurate Information – attending to health literacy and diversity lenses

Screening and Assessment Tools

- **List of Indicators of Abuse -** (VCH FN Re:Act Manual, IOA Tool available through the National Initiative for the Care of the Elderly)
- **'Balance / Wheel"** – the Cultural Framework and the Wholistic Policy and Planning Manual it is associated with contains a possible assessment tool using balance/4 quadrants system (Assembly of First Nations)
- **Awo Taan Healing Lodge Assessment -** (Calgary, Alberta) – uses the four directions concept for older adults to self-evaluate
- **RCMP Domestic Violence Tool** – (Alberta) - brief assessment used at the scene of domestic violence – would likely need to be reviewed for fit in abuse of older adult circumstances, not developed specifically for aboriginal contexts
- **VCH FN *Re:Act Tool*** *–a collaboration between Vancouver Coastal Health and the BC Association of Community Response Networks*
    - Assessments-CHW Assessing situation / Designated Responder in REACT Manual
    - Community Health Worker Flow Chart outlining when to refer to outside agency
    - Physical assessments (secondary)
    - www.vchreact.ca/aboriginal_manual.htm

Intervention Tools/Approaches

- Particular counseling and other techniques including **Focusing** (Gendler), **Just Therapy** (Maori), giving choices of Western or Traditional therapies to suit the individual, and using narrative therapy; are seen as more effective. Some healing programs funded by the Aboriginal Healing Foundation have been evaluated more rigorously for effectiveness. (Waldram 2008); see Waldrem, J. (2008). Aboriginal Healing in Canada: Studies in Therapeutic Meaning and Practice. Aboriginal Healing Foundation, Ottawa, Ont. (2006)
  www.ahf.ca/pages/download/28_13344

- **The Healing Journey Tool Kit** – this Toolkit contains a medicine wheel assessment for domestic violence so it would need to be amended to be more relevant to abuse of older adults. Each part of the medicine wheel includes violence related questions which are quite direct. Because of the nature of the questions it might best be used as a second or follow up assessment in the context of a more fulsome relationship. The Toolkit is available for free at www.thehealingjourney.ca. Produced by Gignoo Transition House (New Brunswick)

Interventions at the Family Level

Overall Approach

- **Multi-disciplinary Team** + - have the person who knows the older adult in question best take the lead.
- **Whole Family** – everybody gets attended to including the alleged abuser
- **Intergenerational** – youth understanding / and involvement

Intervention Approaches

- **Family Conferencing –** is a way to include family and address sensitive and serious issues. This article provides insights into process and results in use in the United States with abuse of older adults in tribal communities**.** Holkup, P., E. Salois**,** E. Tripp-Reimer, C. Weinert. (2007). Drawing on Wisdom from the Past: An Elder Abuse Intervention with Tribal Communities. The Gerontologist. 47:248-254.

- **Legislative Remedies** – these can be seen as extremely intrusive and should only be considered when appropriate. The NWT has experience with tailoring a protective order for an older adult so he/she could have contact with a family member when it was safe, and have recourse if not safe

Interventions at the Community Level

Overall Approaches

- **Develop Elders Programming to Include Abuse Awareness - m**any communities are developing Elders Programming. Embed your response to abuse of older adults in programming for Elders.

To increase awareness, consider involving other older adults employing techniques like theatre, stories, and in the North-radio.

- **Build on Family Violence Programming** – some communities are already addressing domestic violence, for example, which can act as a good basis to begin addressing abuse of older adults
- **Consider Involving Local Leadership** – In some communities working with local leaders such as Chief and Council or Elders is what will help get this issue on the local community agenda
- **Consider Implementing or Adapting Existing Community Justice Circles** – Community Justice Circles are present in hundreds of communities in Alberta, both on and off reserve. They have impacted intergenerational work because they often include Elders and have influenced, among other things, how adult abuse situations play out as long as there is careful attention to the needs and safety of the older adult who has been victimized
- **Explore Using the Comprehensive Community Planning System** - although this Indian and Northern Affairs supported process primarily involves land use and other resource direction, there is a place for social planning which can include addressing abuse of older adults
- **Include Prevention of Abuse of Older Adults in Health Plans** – health plans are being developed by many First Nations reserve communities across the country. Many include direct or indirect objectives for intervention and prevention in family violence as part of general wellness
- **Don't Underestimate the Spin Off Effect of Addressing Other Issues -** although it cannot be counted or relied upon, the need to define and implement community healing on any issue can have a spin off affect on the issue of abuse of older adults, e.g. addressing prescription drug misuse as a community issue in communities throughout Alberta is having spin off effects re abuse of older adults
- **Use the Residential School Settlement Process as a Catalyst for Community Action** - compensation payments have brought the issue of abuse of older adults out into the open because of the potential for re-victimization, particularly through financial abuse. Significant programming has very recently been developed to address the Residential School legacy by the Aboriginal Healing Foundation and provincial programs such as those offered by the Indian Residential School Society of BC, and the Atlantic Congress, although the overall impact has not yet been evaluated (Bent 2009).

- **Consider Developing Intergenerational Initiatives** – for example, Susan Aglukark, the Inuit singer, has done a series of workshops/concerts with youth and parents in remote aboriginal communities in Alberta called "The 5th Season, the Season of Healing" which includes follow up and ongoing relationships-building between her and the community around social issues including violence and abuse. www.susanaglukark.com/home.html
- **Develop Local Anti-Violence Policies** – this is being done by the Klahoose First Nation living off the mid Vancouver Island east coast
- **Develop Partnerships Between Groups that Don't Normally Connect Informally** – examples include: Elders Programs and police in Saskatchewan and police out of uniform attending Elders lunches to build relationships (Wabano Centre, Ottawa, Ontario)
- **Deliberately Bridge Between On and Off Reserve Agencies** – do joint presentations across roles and cultures and consider involving a local Friendship Centre to assist. Friendship Centers play a key role in linking aboriginal and non-aboriginal communities and services; it is part of their mandate
- **Develop Knowledge Exchanges –** staff inside and outside of reserve communities can learn how to work together in a culturally safe way. Include knowledge exchanges on a variety of topics, and of all kinds - mentoring, allying, and joint learning circles. Professional education could involve placements in both mainstream and aboriginal contexts

Specific Community Based Interventions

- **BC Association of Friendship Centers Elders Tool** – the BC Association of Friendship Centres is developing a program to place Elders Coordinators in all centers and equip them with a tool kit which is in part based on the VCH FN Re:Act manual and BC Association of Community Response Networks CRN development approach
- **"Community Connections Plan Tool Kit"** - Working Together to Create Safer Communities in Saskatchewan has been developed by STOPS to Violence which is a provincial organization that operates according to aboriginal principles. Thus far their tool kit has focussed on child abuse and domestic violence but it is in the process of being adapted to include addressing/preventing abuse of older adults

- **Community Response Networks Approach** – The BC Association of Community Response Networks is a provincial network of local networks called CRNs that are creating coordinated approaches to adult abuse/neglect at the local level. The CRN Movement is based upon community development principles of inclusion, meaningful participation, power-sharing, and assuming capability/building capacity. This model is of increasing interest to First Nations communities in BC because of it can be tailored to fit local communities of any type. Community Response Networks are under development in other jurisdictions in Canada besides BC although the model may vary. **The VCH FN Re: Act Online Training Manual** includes a section on community capacity building and a possible vision for, and role of CRNs in First Nations communities.
- **The Healing Journey Tool Kit** – this domestic violence oriented Toolkit contains a number of community capacity-building resources that could be amended to better suit the needs of abused older adults. The Toolkit is available for free at www.thehealingjourney.ca. Produced by Gignoo Transition House (New Brunswick)
- **Walking the Prevention Circle Approach** – Red Cross (RespectED) – this nationally available community capacity-building program has been developed with and by aboriginal people from many communities across Canada. When communities request a workshop, staff determine what the community needs/wants and tailors a three-day workshop accordingly. Workshops are provided in the community's own or chosen language, and are reflective of the community's' history and traditions and employ traditional teaching resources. www.redcross.ca/article.asp?id=694&tid=030
- **Interagency Protocols –** examples include -
    - Between Vancouver Island Health Authority and ……..
        - the Kwakiutl District Tribal Council (Northern Vancouver Island, BC)
            - Allows open collaboration and development of joint working plans for better access and service from Primary Health services for the tribal council.
            - Allows front line workers to spend time developing relations and better pathways to service to and from hospital stays.
            - www.viha.ca/NR/rdonlyres/9A5C8ACA-OF39-43A4-84EB-04D9876D7BE5/0/bg_aboriginal_health_mou_14december2007.pdf
    - The Nuu-Chah-Nulth Protocols for intervention in abuse of older adults contains information on when to request that outsiders from Vancouver Island Health Authority in the Port Alberni area join local reserve community workers to look at situations jointly.

Interventions at the Societal Level

Provincially/Territorially

- **Prevention of Elder Abuse Policy and Program Lens**. Prevention of Elder Abuse Working Group. Ontario Secretariat /Elder Health Coalition. Toronto, Ont. This is a Lens on best practice in developing any programming for older adults www.culture.gov.on.ca/seniors/english/programs/elderabuse/docs/ElderAbuse_Eng_web.pdf
- **Aboriginal Healing and Wellness Strategy** - The Ministry of Health in Ontario is highlighting an aboriginal healing and wellness strategy, unique in Canada, which includes direction for prevention of family violence.

Nationally

- **Federal Elder Abuse Initiative** – this Critical Analysis/Environmental Scan project is an example of one of the many important initiatives being undertaken as part of the overall national strategy to address/prevent abuse of older adults in Canada
- **Aboriginal Human Resources Strategy** - Some First Nations organizations are partnering with larger heath institutions (i.e. Vancouver Coastal Health Authority. BC) and government training initiatives to create pathways of success for Aboriginal youth entering the life sciences and the health sector. As well, NICHRO is embarking on a major competency framework system for community heath representatives, who are key personnel in delivering health and anti-violence programs in communities across Canada (Hammond and Collins 2007)
- **Retaining Nurses** – the Aboriginal Nurses Association of Canada and some health authorities are working on initiatives to retain aboriginal and non-aboriginal nurses, and providing training on cultural competency for non-aboriginal nurses (Hart-Wasekeesikaw 2009)
- **The Nuluaq Strategy** – this strategy is being implemented throughout the North and Eastern Arctic based on Inuit principles and cultural assets, makes recommendations for the use of Inuit healers and healing principles; and makes links to guidelines for community mobilization (Pauktuututit Women's Association of Canada).

Globally

- **World Elder Abuse Awareness Day** – this global day can act as a catalyst for local level activity and raise awareness of this important human rights at all levels
- **World Indigenous/Aboriginal Solutions**
- **Major Reports and Positions** – many WHO and UN papers provide an overall framework in which to organize activities and initiatives

10. PROJECT AND FOCUS GROUP LEARNING

The teleconferences and in person focus group meeting revealed the following observations:

- There are virtually no assessment or screening tools that have been developed for use in First Nations communities for intervention with abuse of older adults, and almost nothing related has been evaluated
- There is a lot of activity at the program and community level, but people have a sense of isolation and would like to share information, approaches and tools. People in the field are doing what is right and will take risks to do that. Principled action underlies the activities.
- To return the hospitality and openness of many First Nations communities, people from outside the communities need to listen actively
- Work must be in the context of community and include community level activities

Next Steps

The Focus Group was very passionate about the importance of the following:

- relationship building between responders both on and off reserve and working inter-professionally
- developing local protocols so everyone understands one another's roles, capacities, mandates, but based on strong relationships where the focus is on assisting abused older adults in the best way possible

- cultural safety
- involving Elders in addressing this issue
- practical tools for front line workers
- building on and amending and then piloting some of the tools tat were identified in the project – primarily the AFN Health Model, VCH FN Re:Act, the Healing Journey Tool Kit, Walking the Prevention Circle although other approaches and tools were identified that are similar that could help inform amendments
- this issue being addressed at the community level as well as the individual "case" level
- the issue of abuse of older adults receiving national attention (FEAI)

Other suggestions include:

- Take advantage of technology. Look at the Knowledge Exchange Framework being developed for the Public Health Agency of Canada.
- Develop opportunities to learn together at all levels and across cultures
- Develop many forms of support and sharing for workers in this field
- Spread tools and explain them
- Pilot some approaches more deliberately
- Educate workers – or have workers educate each other – 'Buddies in prevention'. Educate in awareness and where to take concerns
- Develop a clearinghouse for tools / gray literature
- Analyze healing programs – some are evaluated, but focused on healing, not specifically abuse of older adults (Aboriginal Healing Foundation
- Co-develop strategies with other communities or outside agencies
- Attend to and strive for cultural safety
- Develop protocols so there are clear lines of communication, action and accountability
- Explore First Nations health research

11. CONCLUSION - PROJECT TEAM RECOMMENDATION FOR APPROACH AND TOOL DEVELOPMENT

After reviewing the literature and the approaches and tools outlined in this paper, the following flowchart emerged as a new, integrated and innovative conceptual model for respectfully addressing and preventing abuse and neglect of older First Nations adults at the individual, family, community and societal levels. It is much more than a series of disconnected approaches and tools that could be amended and selected from; it is a model that puts many of the bits and pieces identified in this project together into a new and integrated whole.

Underlying Assumptions Inherent in the Flowchart

Underlying inherent assumptions include the importance of:

- consciously working toward a hybrid future on the part of responders both aboriginal and non-aboriginal, working on and off reserve in all of what that means in terms of creating the conditions for cultural safety
- responding to situations of abuse of older adults within the context of deliberate relationships and relationship-building, recognizing that in different situations, different responders should take the lead, based on relationship and local realities
- recognizing that a response may occur and deepen in intensity over time as trust builds and more facts about the situation for the older adult come to light, mirrored by the use of first less, and then more direct and probing tools for assessing and intervening
- recognizing that responses as they deepen, need to be tailored to meet the unique needs of each older adult experiencing abuse
- recognizing that responses need to take place at the individual, family, community and societal levels
- having protocols in place between on and off reserve organizations
- community capacity building to involve the whole community in addressing the issue of abuse of older adults

Approaches and Tools Embedded in the Flowchart

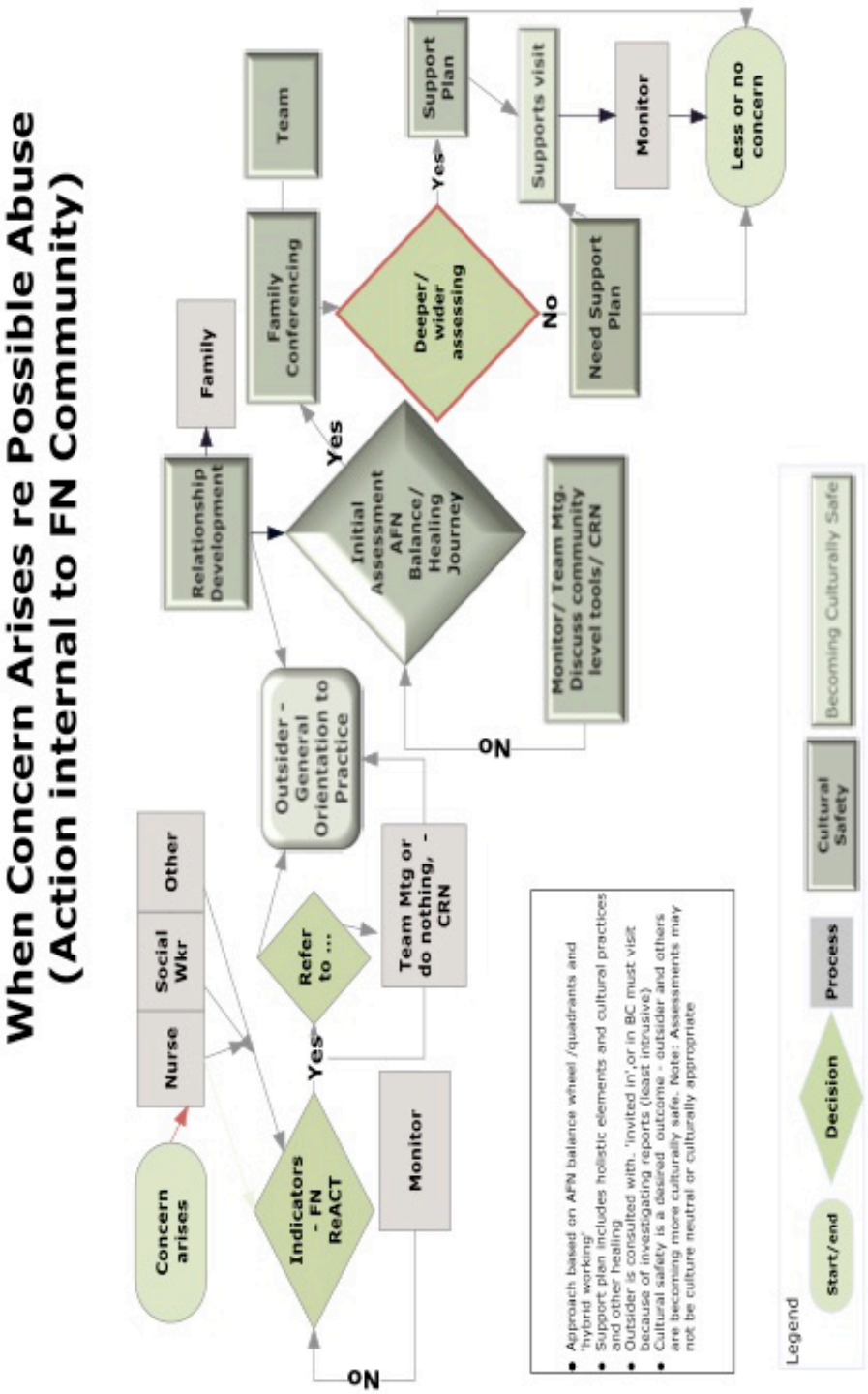
- General Orientation to Practice (which includes the AFN wholistic model and the Research based Integrative interpersonal meaning centered model)
- Indicators of abuse possible abuse and referral criteria from FN Re:Act

- AFN Balance – Cultural Framework – Possible Assessment
- Healing Journey Medicine Wheel – possible secondary assessment
- Family conferencing
- Community based interventions such as BC's Community Response Network movement and the Red Cross Respect Ed Program, Walking the Prevention Circle

For a more detailed description of how the tools are embedded in the flow chart, see Appendix 15.

Some of the tools embedded in the flowchart could benefit from being amended to better fit the needs of addressing abuse of older adults as opposed to other forms of family violence, or to fit the wide variety of First Nations and other aboriginal contexts in Canada, but once done, the finished product would constitute a very practical, holistic and comprehensive tool kit to share with First Nations and other aboriginal communities.

No doubt such a tool kit would be welcomed by many aboriginal and non-aboriginal responders working on and off reserve and would go a long way to increasingly creating a hybrid future in which all aboriginal older adults live free from abuse in safe communities in which they are valued and respected.


When Concern Arises re Possible Abuse
(Action internal to FN Community)
Concern arises
Nurse
Social Wkr
Other
Indicators - FN ReACT
Yes
No
Monitor
Refer to ...
Team Mtg or do nothing, - CRN
Outsider - General Orientation to Practice
Relationship Development
Family
Initial Assessment AFN Balance/ Healing Journey
Yes
No
Family Conferencing
Team
Deeper/ wider assessing
Yes
No
Support Plan
Supports visit
Monitor
Need Support Plan
Less or no concern
Monitor/ Team Mtg. Discuss community level tools/ CRN
Approach based on AFN balance wheel /quadrants and 'hybrid working'
Support plan includes holistic elements and cultural practices and other healing
Outsider is consulted with, 'invited in',or in BC must visit because of investigating reports (least intrusive)
Cultural safety is a desired outcome - outsider and others are becoming more culturally safe. Note: Assessments may not be culture neutral or culturally appropriate
Legend
Start/end
Decision
Process
Cultural Safety
Becoming Culturally Safe

12. ABBREVIATIONS

NAHO	National Aboriginal Health Organization
NIICHRO	National Indian and Inuit Community Health Representative Organization
NWAC	Native Women's Association of Canada
AFN	Assembly of First Nations
AHF	Aboriginal Healing Foundation
SSCR	Senate Sub-Committee Report
SOGC	The Society of Obstetricians and Gynecologists of Canada
CPVAP	Canadian Panel on Violence Against Women
RCAP	Royal Commission on Aboriginal Peoples
CNPEA	Canadian Network for the Prevention of Elder Abuse

13. Appendices

1. AFN Model of Health Discussion
2. Definition of Abuse
3. Family Violence – World Health Organization Comments
4. Statistics Canada Profile
5. Risk Factors
6. Possibly Culturally Generated Elements of Risk
7. Intergenerational Transmission of Trauma
8. Avoiding Re-Victimization in First Nations Communities
9. Culturally Relevant Gender Based Analysis
10. Traditional Considerations
11. Cultural Competency and Cultural Safety Guidelines
12. The Role of the Outsider in First Nations Community Intervention Responses
13. A Research-Based Integrative Model
14. Possible Assessment Tool
15. A General Flowchart of Intervention When Concerns are Raised

Appendix 1

Discussion of Significance of AFN Model of Health

This view of health sees that community health is as important as individual health and that they are integrated.

This model adds to the notion of balance, a lifespan approach, connection to social determinants and community capacity building (gaining of social capital).

Central to the model and fundamental to future development, is the concept that self-governance is the arena in which health context / status will change. This notion is common sense but is also somewhat supported by research; in the long term Harvard project, all sustainable First Nations development in a number of communities in the USA was tied to self-governance (Simeone 2007).

Non-aboriginal workers need to understand not only that there are differences in the fundamental approach to thinking about health and healing, but also to have a sense of what those differences are. We need to try to keep that picture in our heads as we write about Aboriginal health and wellness so we can sidestep the Western grounded scientific reason approach to health in which most non-aboriginal health providers, social workers, policy makers and researchers are trained. Only then can we be useful to our First Nations colleagues and only then can we develop a less colonial impacted future together.

Appendix 2

Definitions of Abuse

From ONPEA website retrieved September 8, 2009

www.onpea.org/english/elderabuse/formsofelderabuse.html

Physical Abuse

Any physical pain or injury that is willfully inflicted upon a person or unreasonable confinement or punishment, resulting in physical harm, is abuse. Physical abuse includes: hitting, slapping, pinching, pushing, burning, pulling hair, shaking, physical restraint, physical coercion, forced feeding or withholding physical necessities.

Sexual Abuse

Sexual abuse is understood as contact resulting from threats or force or the inability of a person to give consent. It includes, but is not limited to: assault; rape; sexual harassment; intercourse without consent; fondling a confused senior; intimately touching a senior during bathing; exposing oneself to others; inappropriate sexual comments; or any sexual activity that occurs when one or both parties cannot, or do not, consent.

Financial Abuse

The most common form of abuse of older adults, financial abuse, often refers to the theft or misuse of money or property like household goods, clothes or jewelry. It can also include withholding funds and/or fraud.

Psychological (Emotional) Abuse

The willful infliction of mental anguish or the provocation of fear of violence or isolation is known as psychological or emotional abuse. This kind of abuse diminishes the identity, dignity and self-worth of the senior. Forms of psychological abuse include a number of behaviors, for example: name-calling; yelling; ignoring the person; scolding or shouting; insults; threats; provoking fear, intimidation or humiliation; infantalization; emotional deprivation; isolation; and removal of decision-making power.

Neglect

Neglect can be intentional (active) or unintentional (passive) and occurs when a person who has care or custody of a dependent older adult fails to meet his/her needs.

Forms of neglect include: withholding or inadequate provision of physical requirements, such as food, housing, medicine, clothing or physical aids; inadequate hygiene; inadequate supervision/safety precautions; withholding medical services, including medications; overmedicating; allowing a senior to live in unsanitary or poorly heated conditions; denying access to necessary services (e.g. homemaking, nursing, social work, etc.) or denial of a senior's basic rights.

For a variety of reasons, older adults themselves may fail to provide adequate care for their own needs and this form of abuse is called self-neglect.

Other Forms of Abuse

Systemic Abuse - Our society, and the systems that develop within it, can generate, permit or perpetuate abuse of older adults. Most prevalent is discrimination, due to their age and often combined with any of these additional factors: gender, race, colour, language, ethnic background, religion, sexual orientation, ability, economic status, or geographic location.

Appendix 3

Family Violence – World Health Organization

The first World Health Organization Report (WHO \Report), *World Report on Violence and Health* (2002), shows the global picture (extent and range) of interpersonal violence. It also takes the significant step of characterizing violence as predictable and preventable.

Abuse and neglect of older adults is subsumed in the WHO's typologies of violence as a form of interpersonal violence.

The WHO report suggests that the problem can be addressed by using the same approach as for other health challenges (i.e., a public health approach). The report makes the case for using multi-sectoral strategies as a moral, economic, scientific, political and social imperative. It also suggests that because violence is a public health issue, that using health sector leadership is appropriate. It also supports 'targeted root cause primary prevention' (CNPEA 2007).

A number of initiatives used in Canada are labeled as **promising** in the WHO *Implementing Recommendations* document. They include:

- community policing
- coordinated community initiatives for prevention
- prevention and educational campaigns
- public information campaigns to promote pro-social norms
- training health-care professionals to detect and refer abuse victims, and
- shelters for abuse victims.

(CNPEA 2007)

Appendix 4

Seniors Trends: Statistics Canada (2001 and 2006)

- Statistics Canada notes that Elders are the present link to past 'teaching", although this has been impacted by prohibitions on ceremonies, gatherings, and removal of Aboriginal children from their communities. It is also noted that Aboriginal languages, without which culture cannot exist, is under threat from more dominant languages (Royal Commission 1996)
- Most Aboriginal older adults live in communities where most people are Aboriginal
- Aboriginal languages are more prevalent among Aboriginal older adults
- Aboriginal languages remain an important priority to the off-reserve Aboriginal population
- Many off-reserve Aboriginal older adults attended residential schools
- More Aboriginal older adults have post-secondary qualifications
- The unemployment rate of Aboriginal older adults is double that of non-Aboriginal older adults
- 'Trades, transport and equipment operators' topped the list of occupations held by Aboriginal men aged 65 years and over
- Aboriginal women 65 years and over work primarily in 'sales and service occupations'
- Most employed Aboriginal older adults work part-time or part-year
- Older Aboriginal people are less likely to use computers and the Internet than younger counterparts
- Income levels of Aboriginal older adults are lower than their non-Aboriginal counterparts
- More than one in three Aboriginal older adults is a widow or widower
- Aboriginal children benefit from spending time with Aboriginal older adults
- A majority of off-reserve Aboriginal older adults reported having social supports
- Many Aboriginal older adults live n homes requiring major repairs
- One in three report water contamination in the far North
- Crowded conditions contribute to other social stresses

Health and well-being of Aboriginal older adults (off-reserve)

- Off-reserve Aboriginal older adults are less likely to report 'excellent or very good' health' than younger counterparts

- Arthritis or rheumatism is the most commonly reported chronic condition among off-reserve Aboriginal older adults

- The APS 2001 found that the vast majority of off-reserve Aboriginal older adults (87%) are currently living with one or more chronic conditions.

- About 70% of off-reserve Aboriginal older adults report disabilities

- Living below the low-income cut-off affects the health of some Aboriginal older adults. Evidence shows that people with higher socio-economic status tend to report better health

- Off-reserve Aboriginal older adults with social support report better health

- Compared to younger counterparts, off-reserve Aboriginal older adults are less likely to smoke

- There are fewer people who drink in the off-reserve Aboriginal population than in the general population

- Aboriginal older adults are much less likely than their younger counterparts to be heavy drinkers.

- Continuous learning, work and participation in society are how Aboriginal people gain knowledge

- Nearly one in ten Aboriginal older adults are participating in the labour force

Appendix 5

Risk Factors

Additional risk factors according to the 2009 Native Women's Association of Canada Literature Review, can include:

- Shared living
- Lack of freedom
- Secrecy about worker performance (concern for worker's job security)
- Neglect of personal care
- Dementia
- Depression
- Psychiatric illness
- Cultural disruption
- Poverty
- Low Education
- Low self-esteem
- Ageism
- Unemployment
- Lack of resources
- Illiteracy
- Poor transportation
- Age of the caregivers
- Health of the care receivers
- Health of the senior
- Amount of care or assistance required
- Financial status
- Caregiver burden/stress
- Denial
- Social and geographical Isolation
- Racism
- Sexism
- Alcohol and drug dependence
- Cut backs to health care and community services
- Shortage of physicians (Bent 2009)

Social Context-Related Factors Contributing to Risk

Edwards in 'Elder Abuse: Gender Based Analysis', summarizes the categories of risk under the following headings:

- Ageism and Sexism (Social Environment)
- Chronic Illness, Disability, Dependency and Able-Bodyism
- History of Canada's Aboriginal People
- Caregiver Stress
- Socioeconomic Status
- Fractured Relationships
- Living Alone Versus With Another Person

(Edwards 2008)

The following are cited by First Nations organizations as other factors that can create risk for Aboriginal older adults:

- Overcrowded housing
- Older adults used for care giving for children
- Adult children living with older adults
- Unwelcome or inebriated visitors

(NIICHRO, 1997; Pauktuutit Inuit Women of Canada, 2006).

Appendix 6

Possible Culturally Generated Risk Factors

- Generosity and the land (family members live on family-owned property, often adjoining, or move in with family members if help is needed; people borrow things from each other and repay at a later date);

- Avoidance of bringing shame to the family (because gossip is prevalent in the Lumbee community, family issues, including abuse, are not discussed; and the abused older adult is also likely to remain silent to avoid embarrassing the family);

- Women as caregivers (practically all caregiving activities that take place in the home are done by Lumbee women, often by daughters or granddaughters who work full time and have their own children);

- Reluctance to admit disability, or fear of being labeled as disabled;

- Distrust; and

- Belief that there is a welfare stigma attached to receiving government assistance

(Bent 2009)

Appendix 7

Intergenerational Transmission of Trauma

Experiences of abuse in Residential School (the last Residential School closed in the 1990's in the Canadian North) went on over many generations. Those who were traumatized may have inadvertently passed their trauma on to children and grandchildren.

Psychosocial Impacts of Intergenerational Trauma

The Aboriginal Healing Foundation lists the following as possible impacts for individuals of intergenerational trauma:

- Inability to Assess Risk
- Lateral Violence
- Re-Enactments
- Fears of Authority and Intimacy
- Domestic Violence
- Mental Illness

These impacts further raise vulnerability for an individual.

For survivors, having their needs met and developing healthy relationships and stability in family life for any generation is subject to a great many challenges. In the face of this, First Nations communities are filled with examples of overcoming challenges and working towards health on an individual, family and community level – which speaks to both resilience and spirit.

Appendix 8

Avoiding Re Victimization in First Nations Communities

Re-Victimization

From the perspective of frontline workers who participated in the residential school abuse retreat, ***"re-victimization"*** refers to conditions or circumstances, whether intended or unintended, that replicate in whole or in part the original abuse. It includes any situation in which Survivors of historical trauma experience overwhelming loss of control resulting in feelings of disempowerment, disconnection or pain (including institutional indifference to their pain or suffering).

Just as some Aboriginal children suffered abuse at residential schools that were there to educate them, many Survivors have suffered further abuse from counselling and psychiatric services instead of healing.

Survivors of residential abuse are especially vulnerable to re-victimization due to ongoing marginalization and discrimination against Aboriginal people.

Aboriginal frontline workers believe that a shared understanding of the conditions that cause re-victimization will help ensure strategies are created to prevent it. They maintain Survivors of residential abuse are revictimized in any situation where:

- the full scope of their suffering as children is denied or minimized;
- they are blamed for the abuse;
- they are not believed;
- they are believed but not *credible* enough; and
- their cultural or language needs are not understood and taken into account.

Survivors of residential school abuse at a retreat in eastern Ontario provided the following examples of re-victimization from their own experiences:

- Any ***institutional environment or setting*** that replicates the long, echoing hallways, closed doors and sterile, dormitory settings of residential schools, such as hospital psychiatric wards and some homeless shelters
- An ***"institutionalized" cultural environment*** where rules are inflexible, appear arbitrary and seem to sacrifice emotional and spiritual health for the sake of time, efficiency and the *bottom line* such as hospital emergency departments or social welfare agencies
- ***Restraining practices in psychiatric or police facilities*** meant to protect people from self-harm, such as physically wrestling them to the ground, pinning their arms and/or using straitjackets, replicate aversive restraints against children in residential schools.
- Any situation in which the ***underlying assumption is that non-Aboriginal culture or knowledge holds the answer to the "problems" of Aboriginal people***, whether in trauma recovery, child protection, addictions recovery, HIV prevention, violence prevention and intervention or criminal justice
- Any ***situation in which human rights, basic necessities or opportunities*** that benefit other Canadians are denied or inaccessible to Aboriginal people.
- Any ***situation of prejudice*** due to Aboriginal culture, sexual orientation, level of ability, gender, education level, income or criminal record

Without full awareness of the conditions associated with re-victimization, frontline workers and counsellors risk compounding the pain of Aboriginal clients instead of assisting them.

In terms of re-victimization, the relationship between police and Aboriginal people requires special attention and sensitivity. Historically, this relationship has been characterized by deep-seated fear and mistrust on both sides.

In the context of residential school abuse, both the Royal Canadian Mounted Police and provincial police services enforced policies that, in effect, denied Aboriginal people the right to family life. Under the *Indian Act*, aboriginal children were made legal wards of the Crown in order to allow the government full control over assimilation through schooling. In many cases where families resisted sending their children to these schools, police intervened by forcibly removing the children from their parents.

Further encounters between many of these Aboriginal children and police occurred when they ran away from the schools to escape the abuse, only to be hunted down, captured and returned by police to the schools. In later years, police also assisted Children's Aid Societies in removing children from their parents.

The historic role of police in the lives of Aboriginal people and the mutual mistrust generated by it has contributed to the following situations:

- The chances of a 16-year-old Aboriginal boy being imprisoned at least once by the age of 25 are 70 per cent
- The rate of incarceration of Aboriginal men is 11 times the rate of non- Aboriginal men
- The rate of incarceration of Aboriginal women is 250 times the rate of non-Aboriginal women (although Aboriginal women comprise only 3 per cent of the population of Canada, they represent 30 per cent of the total population of federally sentenced women).

Chansonneuve, D. (2005). *Reclaiming Connections: Understanding Residential School Trauma Among Aboriginal People.* Aboriginal Healing Foundation, Ottawa, Ont.

Checklist to Avoid Re-Victimizing Residential School Survivors

Frontline workers and helpers, including traditional people, developed the following checklist as a tool to help prevent revictimization. (These guidelines apply from intake through to follow-up and/or referral.)

√ Offer unconditional compassion and support within a safe, confidential environment.

√ Understand holistic needs: provide resources for clients that are culturally appropriate and support all aspects of well-being: mental, physical, spiritual and emotional.

√ Understand and model the Seven Teachings with clients and co-workers: love, trust, courage, honesty, bravery, respect and honour.

√ Use a client-centered approach: the client directs the healing journey, not the counsellor; move at the client's pace trusting them to know their needs; and respect their choices.

√ It is important that clients do not have to repeat the details of their traumatic experiences over and over again; becoming more aware of feelings and coping strategies leads to positive change more readily than reinterpreting past factual events.

✓ Use appropriate terms and proper names, i.e., calling a client sweetheart" or "honey" may trigger a memory of sexual abuse: use language the client can relate to and understand; and do not use language based in theory or jargon.

√ Counsellors must *walk their talk*: counsellors can take clients only as far as they have gone on their *own* healing journeys and do not abuse substances when you counsel clients on relapse prevention, for example.

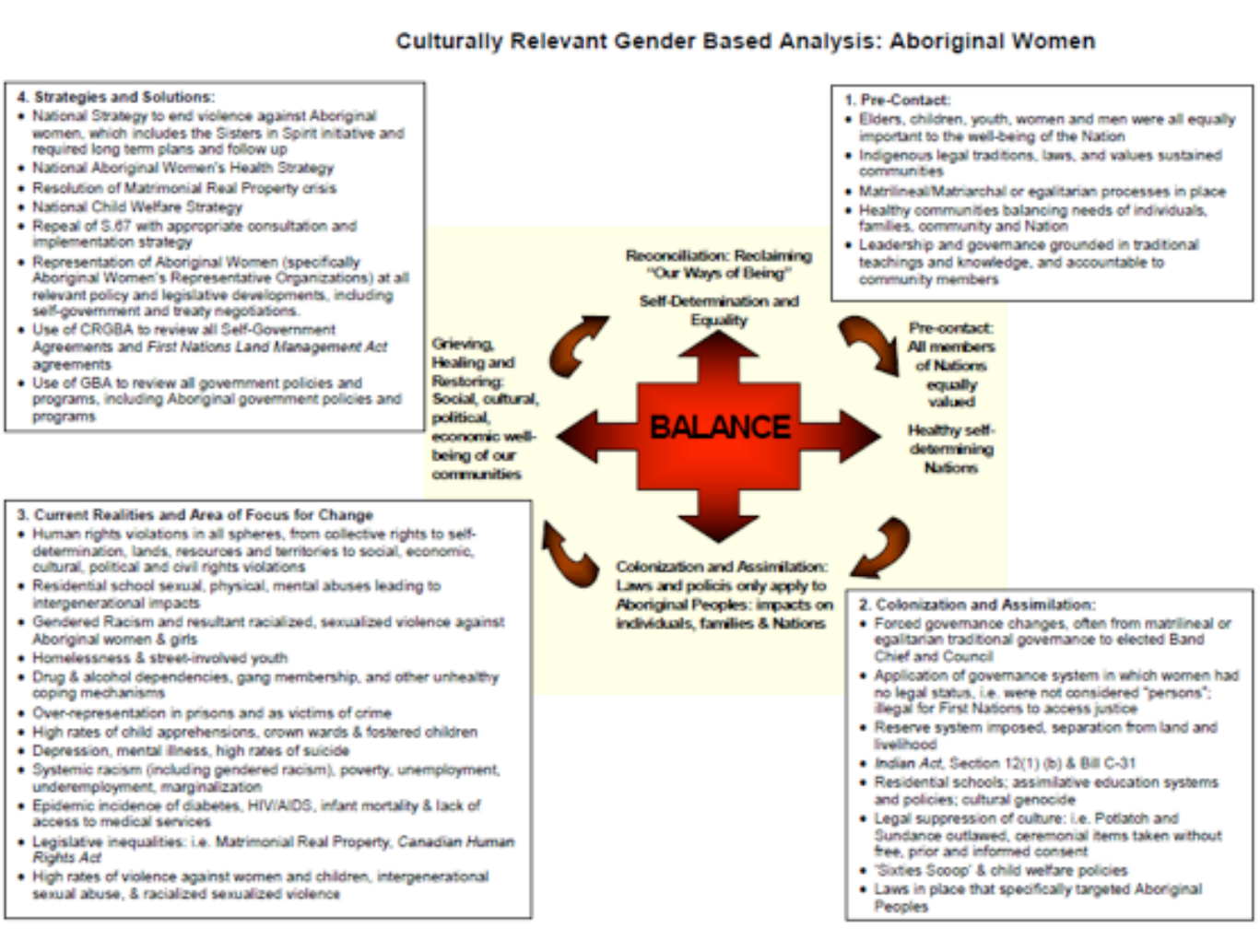
√ Fostering a confidential, safe and calming atmosphere creates comfort for clients; focus on internal, as well as physical, safety; and a healing-centered space and physical comfort is crucial for recovery.

√ Active listening, positive feedback and attention to body language are crucial aspects of helping clients feel safe.

√ Never try to force a client back from a flashback or dissociated state: in a soft voice talk to the client about what you see and hear; and allow time for regrounding before talking about what happened, how it felt back then and how it feels today.

√ Set healthy boundaries with clients: inappropriate relationships are disempowering for clients and unethical for counsellors.
√ Minimize power imbalances between client and counsellor.
√ Counsellors do not tell clients what to do, make judgements or have expectations: clients must be empowered to find their own answers, make their own decisions and take control over their own lives; and the counsellor or helper's role is to facilitate this process.
✓ Respect diversity: understand different cultures and faiths, know your own roots.
✓ Assumptions and stereotypes based on gender, race, culture, sexuality, age and/or physical and mental ability serve to further dis-empower and re-victimize clients and diminish the helper's effectiveness.
√ Each client is an individual: although patterns exist, it is important to recognize the unique resilience of each individual client; and one person's experience is never rated as more or less traumatic than another's.
√ Exposing clients to controlling, punitive or threatening attitudes or behaviours, even in a joking a way, is a form of revictimizing them.
√ Screen/educate referral services about attitudes or practices that may either trigger or re-victimize Aboriginal clients.
√ Openly discuss the counsellor's obligation to report suspicions of child abuse/neglect or danger to self and/or others.
√ Ask clients who self-harm to help identify creative ways of minimizing risk that do not re-victimize themselves or others.
√ Each organization and counsellor should have a formal process for client safety to assess triggers and create strategies that will prevent use of harmful forms of intervention, such as physical restraint.
√ Every organization should have a Code of Ethics that all staff sign and agree to respect. (The Seven Teachings can be used as a guide.)
√ Every organization should ***re-view*** its service environment through new eyes to assess whether, ***from an Aboriginal perspective***, it is a place of hope and belonging, (i.e., whether Inuit, Métis and First Nation people are represented, respected and welcomed there).
√ Healing work is sacred work: clients deserve counsellors and frontline workers who honour their own healing paths and can model self-care and respect of the body, mind, heart and spirit.

Appendix 9
Culturally Relevant Gender Based Analysis Native Women's Association of Canada 2004



Appendix 10

Traditional Considerations

A Model of Health

Acceptance by mainstream society of a model of health similar to that offered by the Assembly of First Nations would be a useful first step in working together. It is worthy of consideration because of the complexity of relations shown therein, and because it indicates where non-First Nations can intersect with First Nations – mainly on the edge of the model through 'bridging' and /linkages' - both aspects of social capital. Successful 'bridging' and 'linking' would mean successful health delivery experiences for the community, with workers from on and off-reserve, aboriginal and non-aboriginal learning how to work together in each community (moving from the edge of the model into the central health determinants in the model).

In this model, the weight given to particular relations of health determinants (gender, economic development, health care, land); and identifying priorities for resourcing for improvements, and the sequences which will result in them most effectively working together; need to be determined by communities and will happen community to community in unique ways. Investigating these might be a place where on and off-reserve researchers can work together.

Relations with First Nations Peoples

The National Aboriginal Health Organization says the following are points to consider in developing relations with First Nations Peoples in regard to their health:

- The low numbers of Aboriginal health professionals meet only a fraction of community needs
- The situation is particularly acute in Inuit and other remote Aboriginal communities
- Problems with cultural differences, communications, etc. negatively impact Aboriginal peoples' health care experiences and outcomes
- An increased presence of Aboriginal health professionals is central to the solution of these problems
- There is a need for cultural competence on the part of all health professionals who serve non-Aboriginal and Aboriginal people.

(NAHO 2003)

Appendix 11

Cultural Methods and Programs – Toward Cultural Safety
It is suggested that the stages of development for individuals (workers delivering health and social services to Aboriginal older adults) might be:

- **Cultural sensitivity** characterized by:
  - Awareness that there are differences amongst and between cultures. (Ball 2007) This may involve knowing about artifacts, art or ceremonial aspects of culture

- **Cultural competency** characterized by:
  - skill at understanding interactions amongst members of a culture (Ball 2007)

- **Cultural proficiency**
  - Characterized by being effective in cross-cultural interactions. It is also characterized by some comfort in cross-cultural situations, and skill in taking part in interactions with a high degree of reported effectiveness (the other person in the encounters needs to give feedback on efficiency and effectiveness). Effectiveness in terms of being understood and being least intrusive to that person should be the initial goal. Without growing effectiveness people will not access your service. Efficiency will grow over time.

The final stage also involves self-conscious examination of place and internal assumptions, as well as awareness of how structural constraints on equality exist and are replicated, and a commitment to anti-oppressive practice. This requires a sophisticated and mature practice on behalf of the worker.

Cultural Competency Models

There are a number of models of how to invoke competence for non-aboriginal workers, aimed at the individual level for different health workers and also at creating a change program within organizations in order to embed the principles and practices at all levels. While developed for practical and efficacy reasons, there is a strong argument that social justice drives a need for these approaches as well. If social justice is to be served and change is to be driven, then models that include examination of power relations and inequities need to be used.

These models have in common:

- The requirement for self awareness, self examination for individuals and organizations
- Assumed willingness to examine self, practice and organizational context
- Several stages of awareness and development over time
- Tools to assess self and organization

Those programs aimed at health workers mention the need to develop clinical cultural competencies (ability to accurately reflect what procedures are; across language and culture). Some programs also speak of the desire to develop these competencies needing to be present in individuals internally as part of the equation. One description sees this as an internal 'volcano' that fuels someone to want to undertake and persist in the learning and change required to make the competency real and effective (Rhymes and Brown 2005).

Most models recognize the need to understand intellectually but also emotionally.

A truly hybrid society would also require cultural safety not cultural competence (as defined by those served) to be the acceptable benchmark for health and other systems.

Appendix 12

The Role of the Outsider in First Nations Community Intervention Responses

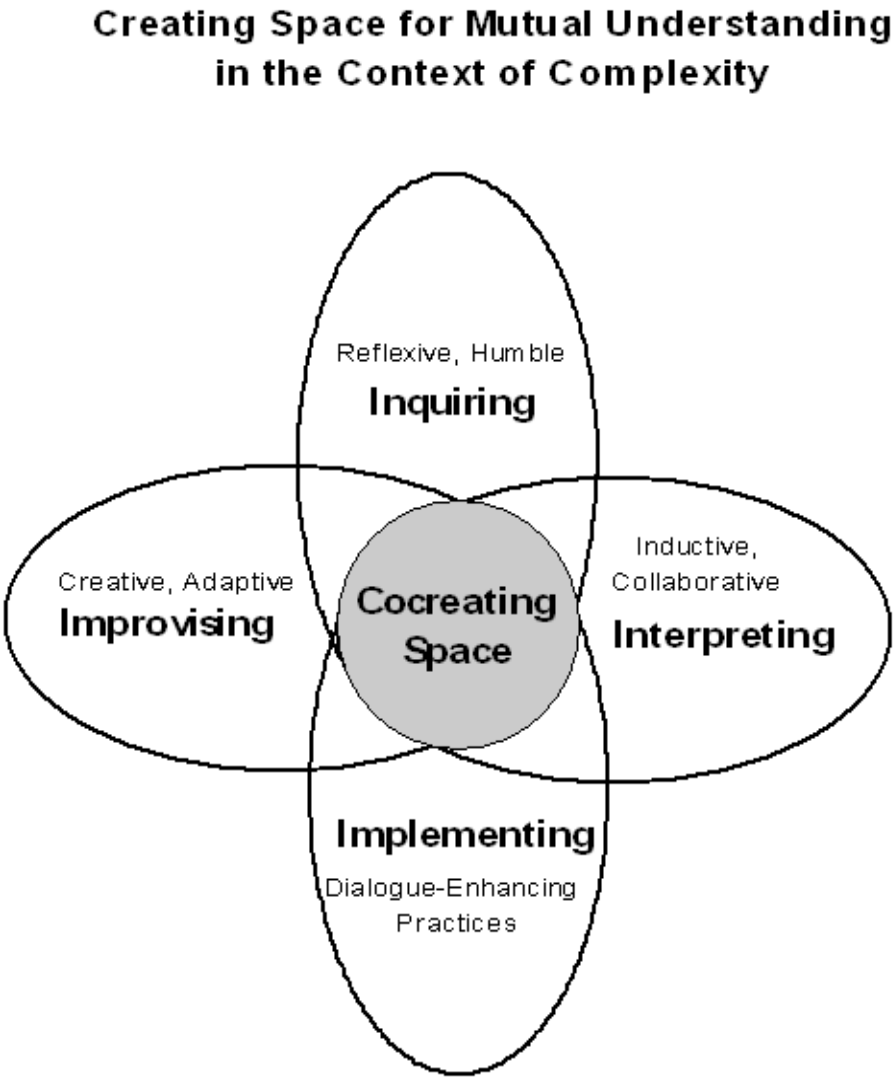
The 'outsider' needs to be sensitive to issues of past relations with outside authorities, and the considerable organizational and legal powers they carry. It is useful for the worker to have worked out his /her personal and professional stance on both the theory and practice of cultural safety. It is always better for the 'outsider' to be invited into the community or to work with an ally if the need arises to visit the community.

The work of the outsider going into communities on a temporary basis, is to assess, figure out what is going on in cultural / traditional terms, to create alliances with other workers and attempt a team approach whenever possible. The worker also can attempt to mobilize the assets of health and social services or community in a way others may not think of.

The work of the outsider over time is to listen for meaning in the context of the work and community, and to co-construct support where possible. (Clark 2006). This requires the high degree of interpersonal interaction called for by the American Medical Association (In Rhymes and Brown 2005). A research based integrative model which attends to more of the First Nations sense of interaction is proposed by Clark in Listening for Meaning: A Research Based Integrative Model for Attending to Spirituality, Culture and Worldview in Social Work Practice. This model is proposed in order to create the 'space' inter-culturally in which to co-create meaning in social work practice. (Clark 2006).

Appendix 13

A Research-Based Integrative Model



Janet L. Clark
Clark, J. (2006). Listening for Meaning: A Research Based Integrative Model for Attending to Spirituality, Culture and Worldview in social work practice. *Critical Social Work, Vol. 7, No. 1.*
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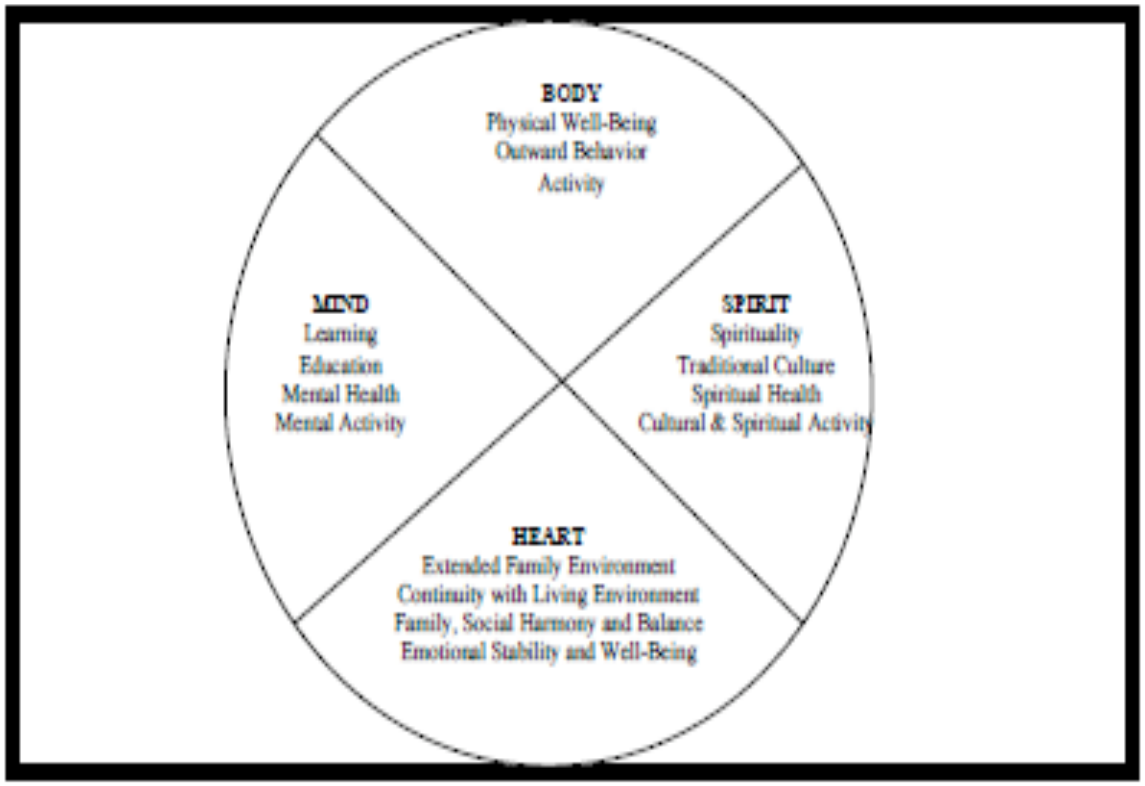
Appendix 14

Possible Assessment Tool

'Created from within the First Nations community, there also has been the development of the First Nations Regional Longitudinal Health Survey (RHS). This ten-year effort is the largest national First Nations-led research initiative, which comprises 22,462 surveys completed among adults, children and youth living in First Nations communities. A Cultural Framework was developed for the RHS to guide the analysis and interpretation of the survey data.'

Cultural Framework



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Appendix 15

A Comprehensive Approach to Concerns Arising in First Nations Communities Re Abuse of Older Adults

Please Note…the numbers in the notes below correspond to the numbers in the flow chart, "When Concern Arises Re: Possible Abuse" on the last page of this Appendix

Notes to Accompany Flowchart

1. The conceptual overlay used to think about interventions and to guide their appropriateness, is the wholistic policy and planning model of the Assembly of First Nations (prepared for the World Health Organization Commission on Social Determinants of Health) (Reading 2007). This is a significant model as it views health from First Nations worldviews and offers a cross cultural 'map' for mainstream organizations wanting to work jointly on health issues, abuse of older adults being but one of them.

   This lens brings into focus a definition of health, healing, and the place of spirituality in a different way than mainstream views. For instance, 'Community', needs to be the context in which any action is located in this health model. The health determinants (again slightly different than mainstream determinants) need to be considered both in assessing situations and in resolving them. A balanced approach looking at people and wellness as 'wholes', is used. Development of links to outside institutions and bridges to other mainstream activity are part of this model. This model has guided the development of a General Orientation to Practice of outsiders, which may be more respectful and wholistic than mainstream approaches to abuse of older adults.

2. The sequence of actions suggested here will have more overall effect if they are part of a multiple intervention program (actions at community, family, and individual level at the same time). (See Multiple Interventions Program Toolkit www.miptoolkit.com)

3. Coordinated activities strengthen a community's response to issues of abuse/neglect, and the Centre for Disease Control says this protects older adults from maltreatment. (Centre for Disease Control 2008). Coordination can occur at any level (team, on-off-reserve

through integrated partnerships, within any organization, or at community level through Community Response Network-like activity).

4. Having a community response to issues of adult of older adults located within planning processes which most First Nations are undertaking, will strengthen other activities – whether individual case work, or community level awareness raising and influencing of community standards around violence. An example of this is the Indian and Northern Affairs Canada (INAC)* Comprehensive Community Planning approach which includes social planning (a planned community response, for instance). Health plans can also address this issue. The more issues are recognized and community action validated in them, the more effective activities will be in creating social change and addressing root causes of abuse of older adults. Inclusion in plans also implies validation by leadership, which can have a powerful effect on the way communities decide to conduct themselves.

   ** INAC also offers Family Violence Prevention funds – applications through Band Managers.*

5. The more agreements, procedures, policies and protocols that are in place; the smoother the flow of activities will be. Protocols can range from those within an agency, amongst different agencies or departments, across a community, or between on and off reserve agencies (i.e. Kwakiutl District Health Council and Vancouver Island Health Authority).

6. Tools and assessments increase in intensity the further along the flow of activity one goes. and range from more general tools (indicators) used by many interveners, to more specific tools attached to professional approaches. These need to be used in the context of other activity and in the presence of trusted workers//family/healers. Sometimes interpreters and translators will be part of the context.

7. A concern about someone or a family situation may be brought by anyone who sees a situation such as home support, Elders Coordinator, nurse, social worker, CHR, social services worker, health worker, or family member. Awareness for these people, education and some form of coordination makes it easier to respond. The concerned person refers (2) or checks indicators (1) to test their perceptions. If there is not enough certainty to proceed, then someone monitors.

- If referred, that person takes the situation to a team meeting, consults internally with a department head, or externally with a professional supervisor; or consults with an outside resource (3) (in BC this could be a designated agency). If there is enough concern, the outside resource is invited in (or in BC if a report is made and the designated responder investigates). At a team meeting there are protocols, policies, procedures to consult and also relationships with useful resources to consider. Consequences of officially reporting are considered.

- It is hoped that the outside resource is culturally safe; i.e. has some cultural competence and uses an Orientation to Practice* that creates cultural safety. Ideally, the degree of cultural safety increases over time. This is reflected in the flowchart with the raised boxes that become a deeper colour as the 'flow' proceeds.

  **Such as that developed by Struthers and Neufeld.*

- The outsider consults with the team or individuals who have referred or have been involved, identifies allies in the community to work with, and perhaps joins team meetings. Relationships are developed with the team, family, and older adult in question. (4)

- As the relationship develops an initial assessment is done (5). Two culturally appropriate assessments that can help reveal a picture of the situation are:

  A. The AFN Balance Quadrant Assessment (cultural framework) with questions (General Orientation to Practice).

  B. If a picture of abuse of the older adult begins to emerge, the Healing Journey Family Violence Medicine Wheel, which includes more pointed questions about experiences of violence might be used (may need tailoring more to fit the experiences of older adults). If these reveal abuse dynamics then family conferencing might be an option, with the team supporting that.

- If abuse dynamics do not emerge, then the situation is monitored, prevention activities are discussed, a Community Response Network (CRN), if there is one, might suggest informal supports. Needs revealed in coordination, awareness, education, can be assessed here. (Maybe a CRN needs to be developed). Attention can be focused on bringing in awareness resources such as Walking the Prevention Circle RespectEd, mobilizing community/workers, doing WEAAD activities, talking to a mainstream CRN about joint activities, inviting in a regional CRN Mentor, presentations from health authorities /police/ or CRNs

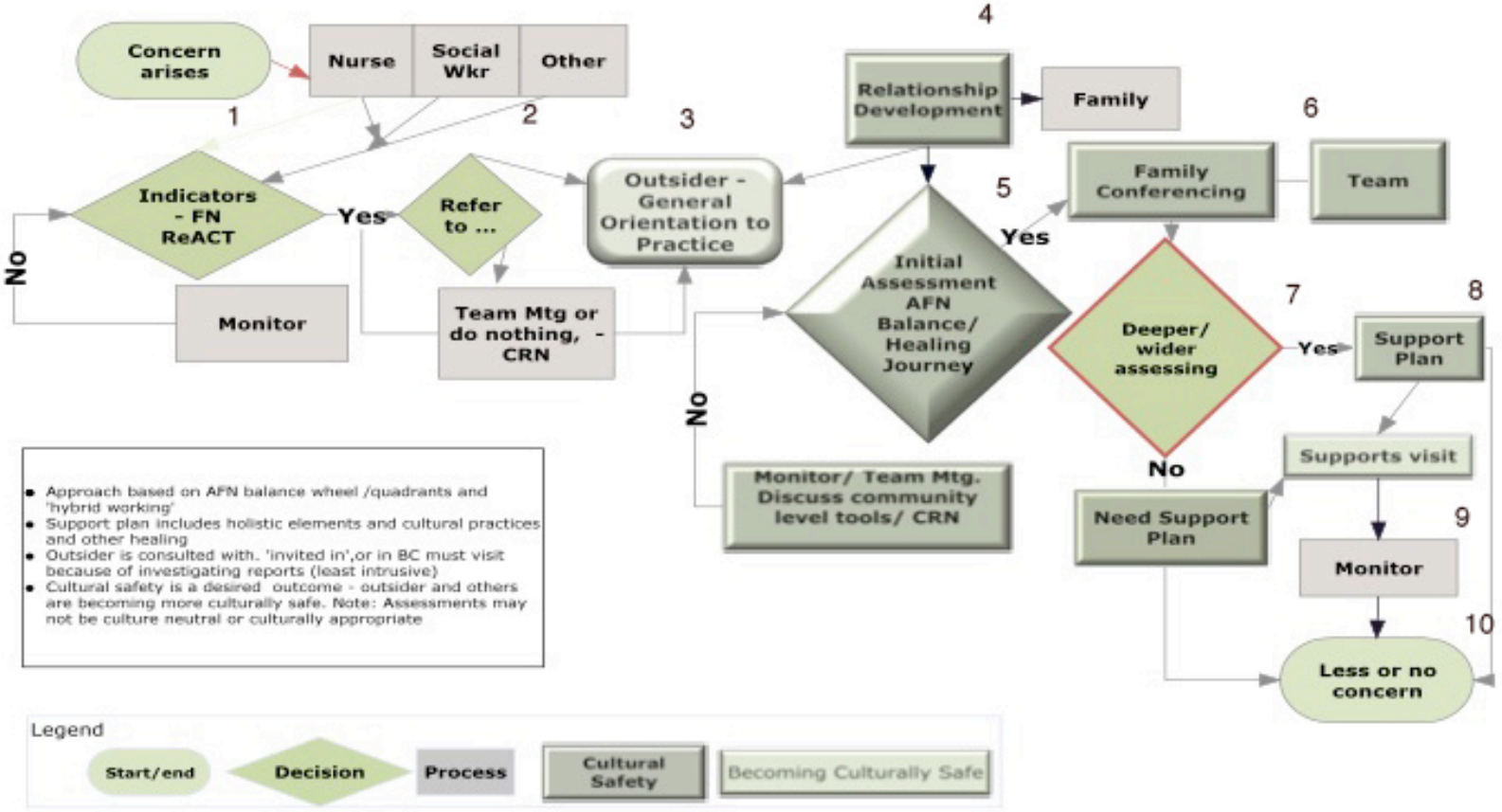
- If abuse is identified, family conferencing is considered (6); this is similar to the restorative activities of healing or justice circles where a fuller family narrative, identification of situations, and joint solutions are sought. Keeping safety needs paramount, it might be appropriate for the outsider to facilitate this or another respected figure with selected team members and outsider participating within their roles. Jointly a support plan is agreed upon.

- As part of this, deeper and wider assessing (7) is required. The outsider or specialized abuse responder may be well situated to do this.

- A support plan (8) is developed. It reflects cultural needs, and safety, the realities of resources. Impacts of health determinants in that community, and reasonable expectations from both a First Nations and mainstream point of view (for instance, the definition of neglect and conditions of risk may differ). The plan includes who will monitor and make visits.

- Monitoring (9) of the situation includes an evaluation of how well on reserve and outside workers felt they worked together, possible improvements, and what might happen the next time a situation arises. Joint learnings (10) are one of the most powerful offshoots of this process; attending to these is part of a complete action learning cycle and of the Multiple Intervention framework (Edwards, Mill and Hothari 2004).

When Concern Arises re Possible Abuse (Action internal to FN Community)



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