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Preventing and Responding to the Mistreatment of Older Adults: Gaps and Challenges Exposed During the Pandemic

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The views expressed in this report may not reflect the official position of a particular jurisdiction.

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List of abbreviations

2SLGBTQI+

Two-Spirit, Lesbian, Gay, Bisexual, Transgender, Queer, Intersex and additional terminologies

AQRP

Association québécoise des retraité(e)s des secteurs public et parapublic

CASI

Computer-Assisted Self-Interviewing

CINAHL

Cumulated Index to Nursing and Allied Health Literature

COVID-19

Corona Virus Disease of 2019

CSBE

Commissaire à la santé et au bien-être

CSQ-FSQ

Fédération de la santé du Québec

FPT

Federal, Provincial, Territorial

ID

Identity Document

IT

Information Technology

LTC

Long-Term Care

MOA

Mistreatment of older adults

N/A

Not Applicable

PPE

Personal Protective Equipment

PSW

Personal Support Worker

WHO

World Health Organization

Executive Summary

People who have fought pandemics know it:
things never go perfectly. In the turmoil,
successes are unnoticed and the losses leave scars.
(Free Translation, Alec Castonguay, 2021)

There are those who will be looking for villains—politicians, care home operators, workers who walked off the job. But the real villain in this tragedy is society's profound and long-standing neglect of elders. A reckoning is in order.

(André Picard, 2021)

Mistreatment of older adults (MOA) is a pervasive issue in our society that carries serious consequences. Approximately one out of every ten Canadian older adults living in the community experiences some form of MOA each year, and the scope of this problem is increasing in accordance with older adult population growth. MOA victimization is associated with detrimental individual consequences, such as premature mortality and physical/mental health morbidities, financial hardship, as well as societal costs such as increased rates of healthcare utilization.

The COVID-19 pandemic had a profound impact on the issue of MOA, as well as efforts to prevent and respond to MOA. The pandemic triggered a set of circumstances that magnified known MOA risk factors, such as social isolation and dependency on others. In turn, both the prevalence and severity of MOA increased substantially during the pandemic. The elevated rates and intensified levels of MOA during the pandemic highlighted a need to identify the gaps and challenges that exist in our systems of MOA prevention and intervention response. An understanding of these gaps and challenges will inform future work focused on the development of effective prevention and response strategies.

The objective of this project was to identify gaps and challenges in preventing and responding to MOA in Canada that were exposed or exacerbated during the pandemic. This project undertook the following two strategies to meet this objective: 1) a comprehensive review of the literature focusing on MOA prevention and response during the pandemic, and 2) a survey of stakeholders across Canada directly involved in MOA prevention or response throughout the pandemic. The comprehensive literature review examined peer-reviewed articles from several databases and grey literature sources such as government and non-governmental organizational reports, in both English and French. Informed by literature review findings, the stakeholder survey followed a mixed-methods, computer-assisted self-interviewing approach with a final analytic sample of 249 stakeholders across provinces and territories in Canada. In both the comprehensive literature review and stakeholder survey, findings about gaps and challenges were organized according to the following categories that represent key phases or considerations in MOA prevention and response: *primary prevention*

(preventing the initial occurrence of MOA), *identification/detection* (identifying older adults at risk of or experiencing MOA), *response/support intervention* (direct response intervention designed to support older adults experiencing MOA), and *centralized systemic/structural supports*.

Based on the comprehensive literature review and stakeholder survey, a summary of key gaps and challenges related to MOA prevention and response exposed during the pandemic (detailed throughout the report) are as follows:

- MOA awareness-raising efforts targeted toward the general public or professionals who work with older adults were insufficient throughout the pandemic, including training to recognize signs of MOA. Awareness-raising initiatives would have benefited from a more tailored approach that accounted for the varying needs and experiences of older adults from diverse communities.
- Older adults experienced levels of social isolation above and beyond the social distancing requirements affecting the entire population, which substantially elevated their risk of mistreatment. Older adults experienced these heightened levels of social isolation and MOA risk while simultaneously facing barriers in accessing protective connections with informal supports in their social networks, community social gatherings, or formal support services (e.g., social services, healthcare services).
- MOA perpetrators throughout the pandemic could more easily mistreat older adults, leverage social distancing protocols to exert a heightened level of power and control over victims, and obstruct attempts by informal supporters or formal service providers to detect and support victims.
- The availability of frontline MOA response programs was severely lacking in communities across Canada, leaving many older adults at risk of or experiencing MOA without appropriate forms of formal support. Considerable attention is needed around the development of community-based MOA response systems across Canada, including coordinated referral pathways, specialized response programs, and identification and scaling of evidence-based practices.
- Social distancing requirements and restrictions to in-person services made it challenging to connect with, identify/detect, or respond to and support older adults at risk of or experiencing MOA during the pandemic. Our current understanding of service delivery through remote/virtual forms of interaction (e.g., video-conferencing, telephone, email, chat) was not a fully adequate replacement for in-person interactions as it relates to effectively identifying/detecting or providing responsive support for older adults at risk of or experiencing MOA.
- Dependence on remote/virtual mediums of interaction for social connection or to receive formal service delivery represented an inequitable new standard for many older adults who lacked access to the necessary technology or internet

connectivity, lacked sufficient digital literacy to navigate technology, and/or who were living with physical (e.g., vision, hearing), functional or cognitive challenges that impeded their capacity to use such technology. Internet and technology access barriers were exacerbated for older adults from communities who experienced disadvantage on the basis of their social-cultural identity, socio-economic status, and/or geographic location.

- Community-based MOA networks experienced challenges maintaining a collaborative and coordinated effort among partner agencies and organizations throughout the pandemic in order to provide supports at the local level.
- Organizations responsible for the prevention, identification/detection, and response/support of at-risk older adults experienced workforce instability, shortages in personnel, and resource constraints that impeded their capacity to effectively implement MOA prevention and response objectives.
- Knowledge of and mechanisms to disseminate and share best practices about MOA prevention and response during the pandemic were underdeveloped, which inhibited organizational capacity to pivot and effectively adapt service delivery.

Based on the findings synthesized across the comprehensive literature review and stakeholder survey, a set of recommended future directions are provided. These future direction recommendations represent key opportunities and actionable steps to address the identified gaps and challenges in preventing and responding to MOA that were exposed during the pandemic.

1 Introduction

The mistreatment of older adults (MOA) is recognized by policymakers, researchers, and clinicians as a pervasive issue affecting an aging population with major individual and community consequences. The World Health Organization (WHO) has highlighted MOA as a key issue affecting older adults in its World Report on Ageing and Health (WHO, 2015) and as a part of its recent Decade of Healthy Ageing (2021 – 2030) initiative (WHO, 2022). The current report on MOA is guided by the WHO definition: "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" (WHO, 2002)[1]. Consistent with the WHO approach and other authoritative definitions, MOA comprises several subtypes, including financial abuse or exploitation, emotional or psychological abuse, physical abuse, sexual abuse, and neglect by others (Beaulieu & St-Martin, 2022; Centers for Disease Control and Prevention, 2016; National Research Council, 2003; Pillemer, Burnes, Riffin, & Lachs, 2016).

However, MOA is defined differently across jurisdictions in Canada and in some cases comprises additional subtypes. For example, across jurisdictions in Canada, MOA also includes mental cruelty, irresponsible medication practices (overmedication, withholding medication), humiliation, intimidation, censoring, invasion of privacy, denial of access to visitors, violation of human/civil rights, self-neglect, and spiritual, religious or cultural forms of abuse (Beaulieu & St-Martin, 2022). The issue itself is also referred to by different terms, such as *elder abuse, elder mistreatment, elder maltreatment,* and *senior abuse*. The term used in this report, MOA, includes the word "mistreatment" which accurately captures both abuse *and* neglect subtypes without confusion. MOA also uses the word "older adult," which avoids terms associated with discriminatory/negative stereotypes (Gerontological Society of America, 2022) or language that carries culturally specific meaning, for example, in Indigenous communities.

Recent population-based MOA studies in Canada have highlighted the pervasive scope of this issue. Based on large, random samples of older adults across Canada, Burnes et al. (2022) and McDonald et al. (2018) found one-year MOA prevalence rates ranging between 8.2% and 10% among older adults living in the community. Therefore, each year, approximately one out of every ten community-dwelling older adults experience some form of MOA. These prevalence rates likely under-estimate true population prevalence since studies have excluded particularly vulnerable sub-groups of older adults living with cognitive impairment and/or in institutional settings. Barring the development of effective prevention strategies, the absolute number of MOA cases is expected to increase substantially over the next two decades in proportion with projected older adult population growth. MOA victimization is associated with serious physical, mental, financial and social consequences such as premature mortality, poor physical and mental health, diminished quality of life, and increased rates of emergency

[1] There are a series of definitions of mistreatment of older adults (elder abuse and neglect or other related terms) in use in Canada (see Beaulieu and St-Martin, 2022). The definition produced by WHO in the Toronto Declaration of 2002 is being used as an international reference.

services use, hospitalization, and nursing home placement (Beaulieu et al, 2021a; Yunus et al., 2019).

Natural disasters and times of crisis have a profound impact on family violence and the efforts designed to prevent these dynamic interpersonal issues (Parkinson & Zara, 2013). Similarly, the COVID-19 pandemic was a global eye-opener on the issue of MOA (Mikton et al, 2022). The pandemic magnified a set of conditions among older adults, including heightened levels of social isolation, poor health, loneliness, depression, and dependency on others, which represent known MOA risk factors (Burnes et al., 2022; Pillemer, Burnes, Riffin, & Lachs, 2016). Different measures taken to limit the spreading of the virus, such as lockdown and restriction in visitors, were associated with MOA from a violation of rights' perspective (Rebourg & Renard, 2022, Vignon-Barrault, 2022). Under pandemic circumstances, some mistreated older adults were confined to the home with their perpetrator who could leverage stay-at-home, self-isolation, and social distancing protocols to exert a heightened level of power and control. Within this context of the pandemic, in the USA, evidence suggests that the prevalence of MOA almost doubled (Chang & Levy, 2021) and that the severity of mistreatment experiences increased (Weissberger et al., 2022). Also in the USA, COVID-19 disproportionately affected older adults identifying with marginalized communities in relation to race, socio-economic status, and level of ability (Abedi et al., 2021). Therefore, our understanding of associations between MOA and COVID-19 must be viewed through an intersectional lens that is sensitive to the varying experiences of older adults identifying with different sociocultural identities. Overall, the heightened levels of MOA during the pandemic highlighted a need to identify the gaps and challenges that exist in various systems of MOA prevention and intervention response. An understanding of these gaps and challenges will inform future work focused on the development of effective prevention and response strategies.

2 Objectives

The purpose of this project was to identify gaps and challenges in preventing and responding to MOA in Canada that were exposed or exacerbated during the height of the pandemic. This project undertook the following methodologies to identify these gaps and challenges:

1) A comprehensive literature review
2) A survey with service providers and stakeholders

3 Comprehensive Literature Review

Methods

A comprehensive literature review was conducted as one source of information to identify gaps and challenges in preventing and responding to MOA that were

exacerbated or exposed during the pandemic. The literature review drew from multiple sources, including peer-reviewed literature; government reports at federal, provincial, and territorial levels; as well as reports from relevant stakeholder organizations in the MOA sector.

Eligibility Criteria

Eligible records for the literature review included peer-reviewed papers from academic journals; grey literature reports, blog entries, and testimony to standing committees; government (federal, provincial, territorial) reports and commissions of inquiry; ombudsman reports; and reports generated from non-profit or non-governmental organizations/networks that were directly involved in MOA policy, advocacy, research, and/or service. Eligible records also met the following criteria: 1) focus on MOA in the context of the pandemic; 2) focus on one or more of the following MOA subtypes: financial, physical, emotional/psychological or sexual abuse, or neglect by others; 3) published from year 2020 onward; 4) English or French language; 5) peer-reviewed literature from anywhere in the world; 6) government or non-profit/governmental reports from Canada; and 7) a focus on MOA occurring in either community or institutional settings.

Search Strategy

The following electronic databases were searched from January 2020 onwards: Cairns, Erudit, PubMed, Medline, PsycINFO, Social Work Abstracts, CINAHL, AgeLine, greynet.org, and open grey. The search strategies were translated using each database platform's command language, controlled vocabulary, and appropriate search fields for concepts related to MOA and COVID-19. Relevant government and non-profit/governmental reports were identified through internet searches, consultations with the Project Authority, and feedback from the Federal/Provincial/Territorial (FPT) Seniors Forum working group and/or other FPT officials.

Data Charting

Reviewers extracted the following study/report-level data from each eligible record using a common Excel data collection tool: source reference, location, type of record (peer-reviewed, report, other), MOA subtypes, context (community, institution), gap or challenge in addressing or preventing MOA during pandemic, category of gap/challenge in addressing/preventing MOA, and lessons learned. The following broad categories were used to organize findings related to gaps and challenges that represent key phases in preventing or responding to MOA: *primary prevention* (preventing the initial occurrence of MOA), *identification/detection* (identifying older adults at risk of or experiencing MOA), and *response/support intervention* (direct response intervention designed to support older adults experiencing MOA). Beyond these sequential phases of prevention and response intervention, it was necessary to include a broader *systemic/structural* category to capture gaps and challenges that occur at more centralized systemic or structural levels requiring coordination across jurisdictions,

systems, and/or sectors. Within these broad categories, gaps/challenges identified in the literature were further organized into themes, which provided a more specified level of organization to group and understand the findings. For example, a gap/challenge from a record related to difficulties engaging older adult victims of MOA within a response intervention using remote/virtual forms of communication was assigned to the broad category *Response/Support Intervention* and a theme of *Remote/Virtual Forms of Service Support*.

Results

Primary Prevention: Preventing Initial Occurrence of MOA

Primary prevention refers to preventing MOA before it happens in the first place. Several gaps and challenges related to primary MOA prevention throughout the pandemic were identified in the literature review and organized under the following themes: ageism, informal caregiver burden and availability, homecare availability, social isolation, healthcare service access, and mental health challenges.

Ageism

Ageism against older adults was highlighted throughout the pandemic (FPT, 2022; Fraser et al, 2020; Perks, 2021; Sutter et al., 2022). According to the World Health Organization, ageism is defined as "stereotypes (how we think), prejudice (how we feel) and discrimination (how we act) toward others or oneself based on age" (WHO, 2023). Poor quality care and disproportionate rates of COVID-19-related deaths in long-term care settings highlighted a lack of attention and resources in addressing older adult needs. In the community, measures intended as protection resulted in older adults experiencing heightened levels of social exclusion and isolation in their homes without equivalent measures to provide connection (Rouleau, 2022). The proliferation of and reliance on internet-based platforms to facilitate such social connections carried ageist assumptions, as it required a certain level of digital literacy and functional and cognitive capacity that some older adults did not have and, in turn, led to difficulties accessing informal and formal social supports. Use of such internet-based technology became an accepted norm throughout the pandemic without acknowledging a digital divide across age groups or addressing issues of digital literacy and access to technology among older adults.

Ageist discourses related to older adults as burdens to society were magnified during the pandemic along with resentment toward older adults, including views that older adults should sacrifice themselves for the good of younger people (Barrett et al., 2021; FPT, 2022; Lagacé, et al., 2022). Older adults experienced intimidating looks, as well as derogatory and/or aggressive comments (Thivierge & Guay, 2020). Healthcare protocols that prioritized younger age groups and served to devalue the health and well-

being of older adults emerged as institutionally based ageist practices throughout the pandemic (Ontario Human Rights Commission, 2020). There is a need to develop care models and support services based around the needs of older people (Abdi et al, 2019). Since long-term care settings across Canada are underfunded, they were not ready to face the pandemic (Meloche, 2022).

Using an intersectional lens, ageism did not operate in isolation from, but rather interacted with, other socio-cultural processes that contribute to unequal social arrangements (i.e. processes related to gender, race/ethnicity, socio-economic status, level of ability, sexual orientation, and other systems of inequality). An older adult's intersection with other social identities and systems of inequality influenced the level of ageism experienced and, in turn, the extent to which ageism contributed to MOA (Pillemer et al., 2021).

Overall, ageism throughout the pandemic increased vulnerability to and provided justification for MOA and represents a critical target for primary prevention efforts (CSQ-FSQ, 2020; Pillemer, Burnes, & MacNeil, 2020).

Informal Caregiver Burden and Availability

Older adults living with day-to-day functional impairments and/or physical health issues requiring daily care and assistance are disproportionately affected by MOA (Burnes et al., 2021b; Burnes et al., 2022b). Therefore, mechanisms to support informal caregivers providing such care to older adults represent an important form of primary MOA prevention.

Informal caregivers (family, friends) providing day-to-day care for older adults experienced elevated levels of stress and burden throughout the pandemic (Liu er al., 2021; Makaroun et al., 2021). Supplemental caregivers (e.g., other informal caregivers, formal homecare providers) who would normally be available to help primary caregivers with care responsibilities were less available or unable to access the home (Chin-Tung et al., 2021), which placed a greater load on individual primary caregivers. Informal caregivers did not have access to the same levels of respite support or other forms of support (e.g., support groups) to alleviate stress and burden during the pandemic. Some of them were also dealing with competing demands, such as supporting school-aged children doing online learning at home and/or increased levels of financial hardship (Makaroun et al., 2020). Similarly, community programs for older adult care recipients that would normally provide a break for caregivers were shut down or restricted at various times throughout the pandemic (Poulin et al., 2021). In sum, informal caregivers did not have access to the same resources or sources of support and respite throughout the pandemic which, in turn, resulted in elevated levels of stress and burden, which can translate into a higher propensity to mistreat.

Homecare Availability

Related to the challenges experienced by informal caregivers was the availability of formal homecare supports throughout the pandemic. The number of homecare assessments, for example, declined substantially by 44% in April 2020 and remained lowered over subsequent months of reporting (Canadian Institute for Health Information, 2021). The availability of formal homecare to meet the day-to-day needs of older adults living with functional, cognitive, and/or physical impairments is an important form of primary MOA prevention. Without homecare support, basic care needs are unmet and older adults are put in a vulnerable position to depend on others. Throughout the pandemic, some homecare workers were unable to continue caring for older adults due to illness, agency policy, or social distancing restrictions. Other workers were unwilling to provide care due to fear of contracting or spreading COVID-19 either in traveling to/from the older adult's home or in providing care. In some scenarios, families chose to cease homecare to reduce potential virus exposure. Reduced homecare also placed greater strain on informal caregivers (as mentioned above), who were already suffering from increased levels of burden and stress (Liu et al., 2021).

Social Isolation

Older adults in particular experienced increased levels of social isolation throughout the pandemic. Social isolation represents a strong risk factor for MOA (Burnes et al., 2022a; FPT, 2021; Perks, 2021). With heightened vulnerability to the negative health consequences of COVID-19, older adults were encouraged and socialized throughout the pandemic to remain cautiously homebound, above and beyond the social distancing requirements and widespread stay-at-home mandates affecting the entire population. As a result, older adults were disconnected from informal and formal social support structures in their lives that represented important sources of protection against MOA (Han & Mosqueda, 2021). Interaction with peers and participation in activities outside of the home are important mechanisms to build social capital, which buffers against social isolation and mistreatment. Specifically, many older adults were socially disconnected (or experienced substantially lower levels of connection) from family and friends, community activities (e.g., senior centres, day programs, faith-based gatherings), as well as health and social services that were shut down or restricted. Older adults also experienced barriers to leaving the home to access important supplies, such as food and medications (Liu et al., 2021). For reasons detailed throughout this report, some older adults did not use the internet as a substitute to connect with social supports via telecommunication or video-conferencing platforms (Liu et al., 2021).

Certain subgroups of older adults were disproportionately impacted by social isolation, including 2SLGBTQI+-identified older adults, who may have been disconnected from their communities of support or chosen families. In jail settings, the lockdown in cells for 24 hours per day was considered a serous violation of rights and magnified the stress of older inmates. They were not only isolated from other inmates but also from visitors who were suspended from making visits, and were often denied the possibility of out-of-jail

permissions (Aubut et al., 2022). In congregate housing facilities (apartment building for older adults), new forms of resident-to-resident aggression occurred out of the restrictions (Falardeau et al, 2021).

Healthcare Service Access

Due to a focus on COVID-19 cases and emergency care in the healthcare system throughout the pandemic, access to health services was restricted (Benhow et al., 2021). Further, a reduced availability of informal supports provided by family and friends elevated the strain placed on the formal healthcare system (Beaulieu et al, 2021a). Poor physical health represents a strong MOA risk factor (Burnes et al., 2021b; Burnes et al., 2022a), and older adults experienced restrictions and barriers accessing important health services throughout the pandemic. In some cases, confusion existed as to which services were available. Some older adults were also reluctant to engage with health services in the belief that such interactions would increase their risk of contracting COVID-19. These service restrictions and barriers limited older adults from addressing new or worsening health needs and, in turn, elevated their risk of MOA (Benhow et al., 2021). As indicated above, older adults also faced heightened difficulties accessing medications to help manage their health issues.

The Canadian Armed Forces report on long-term care (LTC) settings in Québec and Ontario highlighted several issues during the pandemic. Some facilities were severely understaffed, new employees lacked proper training and orientation, and staff were overworked, exhausted and/or had poor overall morale (Canadian Armed Forces, 2020a, 2020b). General physicians were also overworked, had a lack of training in psychiatric gerontology, and lacked coordination with other mental health specialists. Psychiatrists were unavailable because of growing demand. In addition, access to psychotherapy was limited because of sanitary restriction measures. With lower access to psychotherapeutic methods, the solution was to compensate with medication therapy. However, medical reassessment and surveillance was limited because of the sanitary restriction measures in effect, so medication therapy treatments were less safe or personalised (Loussaief, 2022).

The pandemic exacerbated many difficulties already present in LTC settings. The lack of resources and institutional culture of efficiency makes it so employees of LTC facilities can only do the minimum to ensure the safety and survival of residents, and this, to the detriment of their well-being (Lord, Drolet, Vicogliosi, Ruest & Pinard, 2022). To compensate for the staff shortage made worse by the pandemic, provincial governments established an accelerated training program for new workers. However, in some instances, this training omitted adequate training on MOA. This lack of MOA training can lead to MOA, an absence of mistreatment case reporting, and a lack of MOA prevention (Beaulieu, & Cadieux Genesse, 2021).

Mental Health Challenges

Poor mental health also represents a strong MOA risk factor (Burnes et al., 2022a; Perks, 2021). Poor mental health contributes to lower levels of self-worth or issues of denial, self-blame, and isolation that, in turn, increase susceptibility to MOA and/or may also serve to reduce a person's capacity to protect themselves. A higher proportion of older adults reported feelings of sadness, loneliness, and being overwhelmed throughout the pandemic compared to beforehand (Liu et al., 2021; Thivierge & Guay, 2020). Some older adults experienced elevated levels of anxiety around leaving the home to avoid COVID-19 (also contributing to social isolation). A study in France found that social distancing increased the risk of depression and anxiety, as well as hospitalizations due to suicide attempts (Loussaief, 2022). Mental health challenges among older adults were exacerbated by restricted access to medications and psychotherapy, as indicated above (Liu et al., 2021).

Beyond older adults, mental health risk factors linked to potential perpetrators of MOA were also exacerbated during the pandemic, such as mental health issues, substance abuse, and the stress or burden linked to being a caregiver (Laforest & Tourigny, 2021).

The implemented COVID-19 measures prioritized physical health over mental health, which can lead to the exacerbation of psychological mistreatment of older adults (Beaulieu & Cadieux Genesse, 2021).

Identification and Detection: Identifying Older Adults at Risk of or Experiencing MOA

An important initial phase within the process of addressing MOA is to identify or detect older adults who are at-risk of or experiencing MOA. Gaps and challenges related to identifying and detecting MOA throughout the pandemic were organized under the following themes: social isolation, perpetrator control tactics, surveillance by informal concerned others, homecare availability, and remote/virtual services.

Social Isolation

Social distancing and stay-at-home mandates throughout the pandemic removed or substantially reduced contacts with informal concerned other social supports (i.e., family members, friends, or neighbours in a victim's social network who provides them with support); formal social service, law enforcement, and healthcare providers; social, recreational, and religious activities in the community; and other social support structures. This social isolation has resulted in fewer opportunities to detect MOA or for older adults to disclose the problem themselves. Agencies involved in preventing and responding to MOA were concerned about the loss of contact with older adults and the lack of possibilities for them to be heard in public spaces (Bachelet & Broché. 2022). Social isolation is a central, recurrent theme throughout this report that is closely tied to other themes.

Perpetrator Control Tactics

MOA identification through older adult self-referral/help-seeking was more challenging throughout the pandemic, especially during periods of stay-at-home, self-isolation or quarantine mandates. It was particularly difficult for older adults who lived with their perpetrator. In these shared living scenarios, older adults could not as easily leave the home or find personal space to make phone calls. A perpetrator could use social distancing and stay-at-home mandates as leverage to further limit social interactions with friends and family, which limited opportunities for third-party detection. Detection was also a challenge during remote/virtual-based healthcare and social service sessions, as it was not possible to know whether an older adult was alone or in the presence and under the influence of their perpetrator. Power and control dynamics embedded within the victim-perpetrator relationship were heightened for recently immigrated older adults under the influence of a family member (perpetrator) sponsor, who could use the threat of deportation and financial dependency over the older adult. Recently immigrated older adults also experience language barriers in accessing formal supports outside of the home (Gill, 2022).

The prevention measures linked to COVID-19 increased the use of technology to obtain services and maintain contacts. Yet, older adults who are less skilled in the safe use of technology had more trouble understanding fraud attempts and financial abuse. These tactics were widespread by perpetrators (Meisner, Boscart, Gaudreau et al., 2020).

Surveillance by Informal Concerned Others

Informal concerned other supporters in the older adult's life (family, friends, neighbours) were less available to visit or make contacts with older adults at risk of or experiencing MOA, which limited the availability of these important third-party informal groups to become suspicious of and detect MOA. Concerned others who would typically check on older adults were reluctant to visit given the risk of exposure to the virus, both for themselves and the older adult, causing further isolation. Similarly, limits on in-person contact also limited opportunities for informal caregivers (who would normally have eyes on the situation) to detect MOA. Informal places of gathering, such as senior centers and faith-based ceremonies, were closed or restricted throughout the pandemic, resulting in less access to informal concerned others in the community, increased social isolation, and fewer opportunities for informal surveillance, detection, and reporting. Informal concerned other supports play a critical role in the lives of older adults at risk of or experiencing MOA in both detecting the problem and enabling help-seeking (Burnes et al., 2019).

Homecare Availability

As outlined above, the availability of homecare workers throughout the pandemic was limited due to illness, agency policy, and fears of contracting COVID-19 from the perspectives of both workers and families. A reduction of homecare workers decreased the possibility of detecting or witnessing potentially abusive or neglectful behavior.

Remote/Virtual Services

Social distancing mandates throughout the pandemic elevated the threshold required to justify in-person evaluations from social service, healthcare, and law enforcement professionals, which lowered the likelihood of identifying MOA. In parallel, there was a greater reliance on remote/virtual forms of assessment. However, remote/virtual forms of assessment did not afford practitioners with the same scope of opportunities and information to observe for signs of MOA. Specifically, practitioners could not as easily pick up on or attune to specific psycho-emotional or behavioral responses exhibited by an older adult or observe certain physical indications of MOA over telephone or video-conference platforms. Remote/virtual forms of assessment did not adequately substitute for in-person assessment interactions as they related to detecting MOA.

Response and Support Intervention: Direct Response Intervention to Support Older Adults Experiencing MOA

Another important phase within the process of addressing MOA is responding to and supporting older adults who are experiencing MOA (Burnes, 2017). Gaps and challenges related to responding to and supporting older adults experiencing MOA throughout the pandemic were organized under the following themes: availability of supportive response services, safety planning, perpetrator control tactics, remote/virtual forms of service support, responder safety, supporting diverse communities, age-friendly shelters or other alternative living arrangements, and organizational capacity.

Availability of Supportive Response Services

As an overarching theme, program interventions designed to respond to and support MOA cases are substantially lacking in general, and the pandemic circumstances exacerbated this existing service systems gap. Access to services was limited by social distancing measures, restrictions to in-person services, personnel shortages, and in some cases shutdowns. The pandemic created a particularly vulnerable set of circumstances in which many older adult victims of MOA experienced heightened levels of social isolation without adequate access to responsive support services.

Safety Planning

Safety planning is a critical form of crisis intervention to escape and/or receive help in the face of mistreatment. However, escaping a mistreatment situation was difficult throughout the pandemic for older adults who were cautioned not to leave their home. Finding escape was challenging with restricted access to informal and formal supports due to social distancing measures. Safety planning was particularly difficult for older adults who lived with and were isolated in their home with a perpetrator who had a heightened level of control over their whereabouts. In these scenarios, older adults could not as easily leave the home as a part of their safety plan or contact others outside of the home without personal space to make phone calls.

Perpetrator Control Tactics

The COVID-19 virus and associated social distancing restrictions provided new opportunities for perpetrators to exercise power and control tactics. Perpetrators could provide misinformation to older adults about how the virus spread to promote unnecessary levels of isolation above and beyond those recommended by authorities. Especially in shared living scenarios, perpetrators could impose or convince older adults to endorse unnecessary social restrictions that prevented others from accessing the home (e.g., informal concerned other supporters, cleaning services, homecare, etc.). In turn, older adults could refuse services and deny access to others who would otherwise provide them with support or serve as third-party monitors holding perpetrators accountable. Deprivation of social interaction and physical contact with support structures made it easier for perpetrators to control, manipulate and mistreat older adult victims. Diverse subgroups of older adults experienced control tactics differently. For example, 2SLGBTQI+-identified older adults may have been housed and isolated with a perpetrator that used outing (e.g., "I will tell your children if you don't…") or created barriers in accessing necessary healthcare (e.g., hormone medication) as mechanisms of control.

Remote/Virtual Forms of Service Support

Several challenges were identified in using remote/virtual forms of service support to MOA victims throughout the pandemic. It may not be safe for victims to speak over remote telephone or video-conferencing platforms if they reside with their perpetrator. The perpetrator may be in the same home or room during a virtual meeting, which threatens the older adult's safety and the integrity of the support provided. The perpetrator may even prevent the older adult from having access to this technology. In addition, some older adults had limited ability to communicate through remote technology due to cognitive or physical (e.g., hearing, visual) impairments and/or did not have the digital literacy or access to the technology necessary to navigate these virtual mediums. Important aspects of the work were undermined through remote forms of service delivery, such as limitations building relationships and trust with clients, which are central components to working with MOA victims and doing work to heal trauma. In some cases, the limitations of remote services were perceived to be potentially harmful because the practitioner was unable to pick up on visual clues or the client's body language as easily.

Responder Safety

MOA responders are accustomed to certain worker safety concerns such as unfriendly or hostile perpetrators and witnesses, aggressive animals, infectious pests, or dangerous household hazards. However, the pandemic highlighted additional safety concerns to the workforce. Practitioners had concerns about being infected by COVID-19, infecting clients, or infecting other staff members and family members as a result of in-person interactions. With a reduced availability of informal concerned other

supporters in the lives of victims, MOA responders had a particularly critical role in meeting the needs of vulnerable older adults. The unpredictable access to and supply of personal protective equipment (PPE), such as high-quality masks, hazmat suits, and gloves, compounded COVID-19-related safety concerns and impeded responders from engaging in in-person sessions. In some cases, clients did not have proper PPE themselves, and responders needed to have a sufficient supply for their clients as well. Finally, many MOA responders lacked sufficient training and knowledge around combatting infectious diseases.

Supporting Diverse Communities

Older adult immigrants or those from linguistic minority communities may find information about COVID-19 and MOA inaccessible due to language barriers. Immigrant and refugee older adults can be reluctant to access formal support services or receive information about COVID-19 from government-sanctioned entities if they have had negative experiences with law and government in their home country. Culturally sensitive services and first-language supports are important to ensure that services offered are inclusive, received positively, and that clients fully understand the information shared and can communicate their needs. The way older adults experience the convergence of COVID-19 and MOA varies according to their intersection with different socio-cultural identities, which impacts how they are willing to engage with support services. The potential for bias within the system throughout the pandemic in using health status as a mechanism to discriminate against older adults from marginalized communities must also be recognized and guarded against.

Informal Supporters/Concerned Others

Some victims of MOA access support from informal concerned others in their social network (e.g., friends, family, neighbours), rather than working with formal services (Burnes et al., 2019). These concerned others were less available throughout the pandemic to make home visits or support older adults. Older adults also experienced restrictions in their ability to reach out to these informal concerned other supporters.

Age-Friendly Shelters or Other Alternative Living Arrangements

There are very few age-friendly shelters geared toward the needs of MOA victims. Out of a total 500 emergency and transitional shelters in Canada, only 13 (2.5%, in 5 provinces) are focused on older adults. Among the 13 shelters for older adults, only eight shelters offer full or partial accessibility for people living with functional impairments (CNPEA, 2022). Older adults may need to access alternative shelter models due to age-associated vulnerabilities. Alternative living settings often lack the capacity to support age-associated vulnerabilities, including physical, health and cognitive needs. They also often contain infrastructure that favors younger ages (e.g., stairs, cots that are difficult to enter/exit) and program policies that are unrealistic for older adults (e.g., requiring residents to leave the shelter all day) (MacNeil & Burnes, 2022). Without suitable age-friendly shelter options or open doors within their social

network throughout the pandemic (due to social distancing restrictions), it was challenging to leave abusive scenarios at home.

Organizational Capacity

Programs serving MOA victims and their families experienced several challenges at an organizational level related to service capacity throughout the pandemic. MOA responders and program staff who became ill or presented with COVID-19-related symptoms were encouraged to stay home or not work to prevent transmitting the infection to others. There was also a loss of employees due to voluntary layoff. These circumstances contributed to instability (e.g., staff turnover, inconsistent schedules) or shortages in personnel (Protecteur du citoyen, 2022). In turn, some programs lacked organization personnel capacity to effectively respond to and support older adults experiencing MOA.

Personnel also experienced strain and mental health challenges as they transitioned to virtual modes of delivery (Montesanti et al., 2022). Many practitioners experienced the mental exertion known as “Zoom fatigue” in which they felt more drained after multiple online sessions. For some providers, it took time to adjust to using virtual video-conferencing platforms; shifting to virtual delivery considerably altered the way they provided services to clients. Many workers also had to navigate the challenges of technology as a part of their daily services with little idea as to how to troubleshoot or fix tech-related problems.

From a resource perspective, the shift to remote work was a serious challenge for many organizations responding to MOA. Throughout the pandemic, organizations incurred additional expenses associated with the adoption of online service delivery, such as purchasing online platforms and equipment to support employees to work from home and conduct remote services, updating existing technological infrastructure to serve online clients at a larger volume, strengthening secure servers, training service providers and clients on how to use virtual platforms, and accommodating clients who had difficulty accessing technology (Montesanti et al., 2022). The shift to remote work required a substantial amount of information technology (IT) support to negotiate the issuance and maintenance of tablets, smart phones, and computers.

For many years, the Association québécoise des retraité(e)s des secteurs public et parapublic has claimed more investment in homecare to better prevent MOA at home (knowing that the majority of older adults live at home); this plea was renewed during the pandemic (AQRP, 2021). LTC settings also experienced capacity issues with an influx of older adults in facilities as a result of a lack of homecare services to meet their needs in the community (Meloche, 2022).

Centralized Systemic Support: Issues Requiring Coordination Across Jurisdictions, Systems, or Sectors

Beyond the various phases of MOA prevention and intervention, it is also important to understand gaps and challenges that exist at centralized systemic or structural levels that involve coordination across jurisdictions, systems, and/or sectors. Gaps and challenges in this category were organized under the following themes: changing COVID-19 guidelines, internet access, systems capacity, organizational resources and sustainability, and sharing lessons learned.

Changing COVID-19 Guidelines

Although changes in social distancing guidelines throughout the pandemic were an inevitable and reasonable reality in response to a virus with various strains affecting different numbers of people over time, these guideline changes presented a challenge to organizations involved in MOA prevention and intervention. As guidelines changed, many organizational leaders found themselves building and rebuilding protocols to optimally and safely serve older adults, while preventing exposure to workers. When COVID-19-related guidelines or mandates were introduced or modified throughout the pandemic, the implications of how this changing information affected organizational protocols and operations were not always clear. Program response interventions, for example, needed to clearly understand how changes in COVID-19-related restrictions impacted the way services were delivered. Without this clarity, organizations scrambled to figure out how to deliver services and conduct operations most effectively.

Internet Access

Access to the internet became a fundamental need throughout the pandemic (CSQ-FSQ, 2020). As described throughout this report, remote communication was necessary for older adults to maintain social contact with informal supports and to engage with formal healthcare and MOA social services. These connections were critical to both the prevention and response/support for MOA. Internet access was also critical to conduct certain instrumental activities of daily living, such as banking and shopping for food or other supplies. Despite the importance of accessing reliable internet throughout the pandemic, some older adults faced access barriers, including the cost of purchasing computer equipment and adequate internet data plans and/or having adequate digital literacy around navigating technology and the internet. Access barriers were exacerbated for older adults from marginalized communities who experienced disadvantage on the basis of their social-cultural identity, socio-economic status, and/or geographic location. Certain rural, remote and/or Indigenous communities lacked the tele-communications infrastructure to access reliable internet.

Systems Capacity

"Many preventable deaths occurred in nursing homes under COVID-19. Some deaths were from lack of timely care, water, food or basic hygiene, not from COVID-19 infection. This underscores the frail and highly vulnerable condition of older adults in nursing homes. It epitomizes our failure. Many are not mobile or cannot vocalize their needs. This was more than a communicable disease crisis." (Estabrooks et al., 2020, p. 667)

Leaders adopted a "hospital-centric" model to manage the pandemic (Meisner, Boscart, Gaudreau et al., 2020; Protecteur du citoyen, 2022; CSBE, 2022b). There was an offloading of beds from hospitals to LTC settings. LTC facilities were not all prepared with additional measures or means to adequately face outbreaks that happened after these changes. Thus, many older adults were infected. The management of these outbreaks was affected by many elements. LTC facilities have a dual purpose that is misunderstood by authorities: they are both a place to live and a place to receive complex care. This misunderstanding has maintained LTC facilities low on the priority list for preparation of a crisis since they are not hospitals (Protecteur du citoyen, 2022; CSBE, 2022b).

The absence of an onsite manager in many living environments led to the disorganization of services and rendered impossible the implementation of many sanitary guidelines and changing directives. Risk management was carried out by leadership without the necessary expertise to do it well, and a lack of consultation and coordination prevented the implementation of directives in a timely manner. Moreover, infection prevention and control practices and knowledge were not implemented in LTC settings. Outdated information technology also meant LTC facilities lacked information that affected the management of the pandemic. The authorities could not count on updated data to support their daily decision making (Protecteur du citoyen, 2022; CSBE, 2022b). All of these factors created a lack of fluidity in the implementation of guidelines and important negative impacts on the organization of services that, in some cases, contributed to cases of resident neglect. With the outbreak of the virus, many older adults died (Protecteur du citoyen, 2022).

The healthcare system was overwhelmed during the pandemic in response to high numbers of COVID-19 cases. However, interaction with the health system represents a key opportunity to identify and detect older adults at risk of or experiencing MOA. With restricted capacity and access to healthcare encounters in the community and hospital settings, these opportunities were missed and older adult victims were more likely to remain hidden. The constrained hospital capacity during the pandemic meant that at-risk older adults who interacted with hospitals without a threshold medical need for admission were sometimes sent back home to a potentially unsafe environment, as the capacity for hospitals to admit and manage these complex social situations was reduced.

Organizational Resources and Sustainability

Availability of emergency COVID-19 funding was necessary to support the rapid adoption and implementation of virtual services and interventions among community-based organizations involved in family violence prevention (Montesanti et al., 2022). Some organizations had no funding to support the transition to virtual delivery. Before organizations could apply for emergency COVID-19 funding, many organizations had already incurred costs due to the rapid and urgent need to adapt services and programs to virtual or remote-based delivery. Compounding this financial situation, the re-direction of resources and effort toward pivoting online at the onset of the pandemic meant that usual fundraising activities were put on hold. The unanticipated costs related to transitioning online and a reduction of fundraising revenue resulted in an unstable financial position for some organizations that affected the ability to operate at full capacity toward the prevention and response to MOA.

Sharing Lessons Learned

As the pandemic unfolded over time, service providers had to pivot and adapt their approaches in accordance with restrictions. Service providers involved in MOA prevention and intervention adapted to social distancing restrictions and the needs of older adults in different ways throughout the pandemic. Further coordination was required to capture and share emerging adaptive practices and lessons learned among service providers across Canada (FPT, 2021). Relatedly, mechanisms and pathways to exchange this knowledge among MOA stakeholders were required to strengthen the system of MOA response.

4 Survey with Service Providers and Stakeholders

Methods

A survey with MOA service providers and stakeholders was conducted as a second source of information to identify gaps and challenges in addressing and preventing MOA during the pandemic. The survey provided an opportunity to contextualize and understand gaps and challenges within the Canadian context specifically and to expand upon the gaps and challenges identified in the literature review. The survey followed a mixed-methods data collection approach that included both quantitative Likert scale fixed-response questions, as well as open-ended qualitative text questions. The open-ended, qualitative questions were designed to elicit more in-depth, unanticipated insights around gaps and challenges in MOA prevention throughout the pandemic and, specifically, to elicit information from stakeholders about lessons learned and promising practices in adapting to the pandemic. Questions in the survey were informed by the themes identified in the comprehensive literature review, as well as input from the project authority and FPT working group members. The survey was administered in

both English and French. The overall purpose of the survey was to identify gaps, challenges and lessons learned in preventing or addressing MOA across jurisdictions in Canada exposed or exacerbated during the pandemic.

The survey was organized around the following four sections that parallel the organizational framework of the comprehensive literature review and that reflect the major phases involved in preventing or responding to MOA: *primary prevention* (preventing the initial occurrence of MOA), *identification and detection* (identifying older adults at risk of or experiencing MOA), *response and support intervention* (direct response intervention designed to support older adults experiencing MOA), and *centralized systemic/structural supports*. The full survey can be found in Appendix B.

Participant Recruitment

The survey was intended for MOA stakeholders with direct knowledge or involvement in MOA prevention and/or response intervention efforts, including individuals from non-profit MOA organizations, networks, and associations; healthcare and social service programs; and governments at federal, provincial and territorial levels. An initial list of prospective survey respondents was generated based on the following sources: input from members of the FPT working group who represent each of the provinces and territories across Canada, input from the project leads who are involved with several MOA networks in Canada, and extensive internet searching to find new MOA stakeholders in each province and territory across Canada. The final list of prospective survey respondents included 240 MOA stakeholders with representation from each province and territory across Canada. To broaden the reach of the survey, established MOA organizations in Canada with extensive networks of MOA stakeholders (e.g., Canadian Network for the Prevention of Elder Abuse, Elder Abuse Prevention Ontario) were invited to distribute the survey throughout their networks. Finally, using a snowball sampling approach, individual stakeholders on the list were invited to share the survey with relevant individuals in the field. In the end, a comprehensive and robust outreach strategy was used to reach as many stakeholders as possible with representation across each province and territory.

Data Collection

The survey was administered through computer-assisted self-interviewing (CASI) using a secure online platform, Qualtrics. Survey respondents followed a single, anonymous link and were assigned a random ID number that could not be traced back to their identity. A computerized survey approach offered several advantages to respondents, such as a reduction in survey burden (e.g., using automatic branching and skip rules), a heightened sense of autonomy and confidentiality, and convenience/flexibility around when to complete the survey. The CASI approach also facilitated instantaneous data collection/entry.

Prospective respondents on the stakeholder list were sent four different email reminders to fill out the survey. Additionally, over time, it was identified that certain provinces or

territories did not have survey response representation. Therefore, three separate emails were sent to each of the groups of stakeholders living in these jurisdictions as a more targeted and personalized attempt to bolster their representation. Despite these relatively aggressive, targeted efforts to ensure representation across every province and territory, certain jurisdictions were unresponsive compared to others.

Sample

Our initial proposed goal was 150 survey respondents. Based on the outreach efforts described above, 489 individuals started to fill out the survey. Of these, 240 people did not go beyond the initial section on basic socio-demographic information into the main sections of the survey on gaps/challenges in preventing or responding to MOA. For the purpose of analysis, we have excluded these 240 individuals who did not provide responses around gaps and challenges. Therefore, the analytic sample for the current project is n = 249. The sample size varies across different questions, since respondents were not required to answer every item and reserved the right to skip questions. Given the budget for this project and, consequently, the non-random sampling strategies employed, the analytic sample is not representative of the Canadian population.

Analysis

Analysis of the open-ended, qualitative text responses followed an iterative, constant comparison process allowing the emergence and reorganizing of gaps/challenges themes as new information across surveys arose (Corbin & Strauss, 2008). Quantitative data was analyzed using SPSS statistical software. Analyses combine responses from the English and French administrations of the survey. For the purpose of this report, a "majority" was defined as more than 50% of respondents agreeing or disagreeing with a given survey item statement. A strong majority was defined as more than two thirds (66%) of respondents agreeing or disagreeing with a given survey item statement. With five item response options in the survey Likert scale (strongly disagree, disagree, neutral, agree, strongly agree), a "disproportionate" number of respondents agreeing (agree, strongly agree) or disagreeing (disagree, strongly disagree) was defined as more than 40% of responses in either the agreement or disagreement options. Given the variation across survey items in missing responses, survey findings reported on gaps and challenges are based on the valid percentages of item responses.

Results

Sample Characteristics

The sample (n = 249) included both English (n = 236) and French (n = 13) administrations of the survey. As mentioned earlier, our inability to solicit survey responses from the province of Quebec contributed to the underrepresentation of French-speaking surveys. Table 1 presents characteristics of the sample. A majority of respondents identified as female (67.5%), followed by male (29.3%), non-binary (1.6%),

and two-spirit (0.4%). Some respondents identified as First Nations, Inuk (Inuit), Métis citizen, or other Indigenous identity (7.7%), and 7.6% of respondents identified as a member of an ethno-cultural or visible minority group. Most respondents were between the ages of 40 and 74 (79.1%). A majority of respondents were from Ontario (62.2%) followed by Alberta (9.2%), Manitoba (7.6%), Northwest Territories, (4.8%), British Columbia (3.6%) and Nova Scotia (3.6%), Québec (2.4%), New Brunswick (2.0%), Newfoundland and Labrador (1.2%), Saskatchewan (0.8%), Prince Edward Island (0.8%), Nunavut (0.4%), and Yukon (0.0%). Respondents worked in urban (45%), rural (34.9%), and suburban (19.3%) geo-cultural contexts. They worked in a range of employment sectors, including social services (23.3%), healthcare (22.5%), government (11.2%), non-profit (6.8%), education (6.0%), business (4.8%), law enforcement (2.0%), and other (13.7%), as well being retired (8.8%). As it relates to the issue of MOA, respondents described their main role/responsibility as practitioner/provider (43.8%), advocacy (37.3%), policy (6.0%), research (4.4%), and other (24.9%). A majority of respondents identified their main role as involving direct service provision with older adults (57.4%).

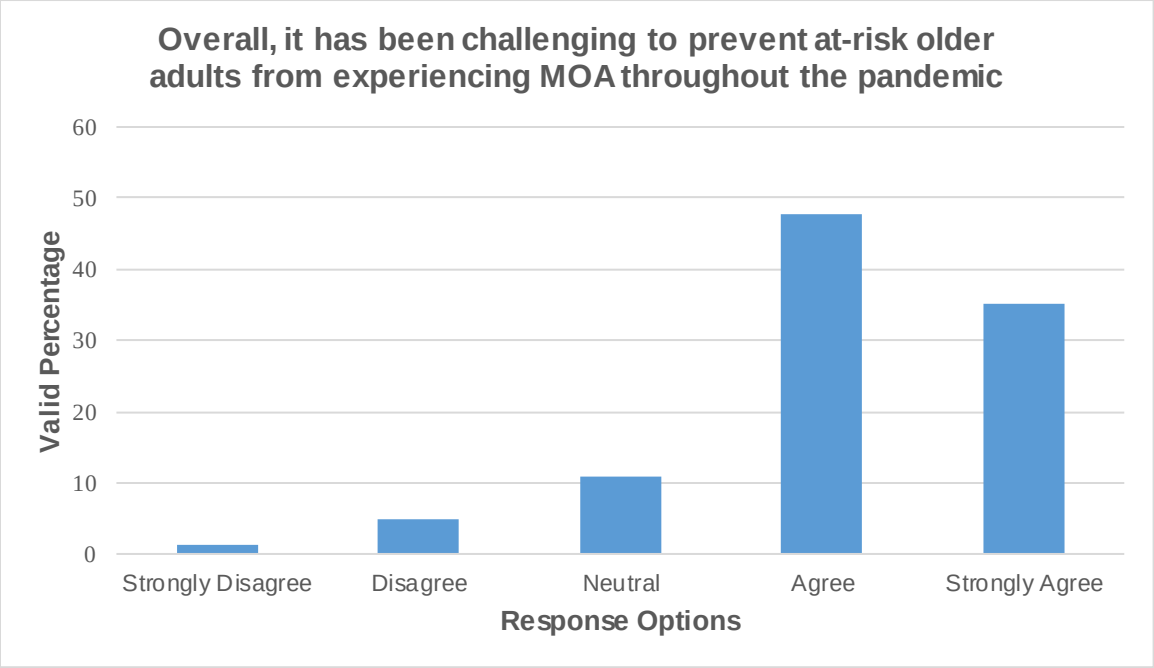
Primary Prevention

Quantitative Survey Responses

Table 2 provides a detailed breakdown of survey responses on items related to the topic of primary MOA prevention. Key survey findings related to primary prevention are summarized as follows:

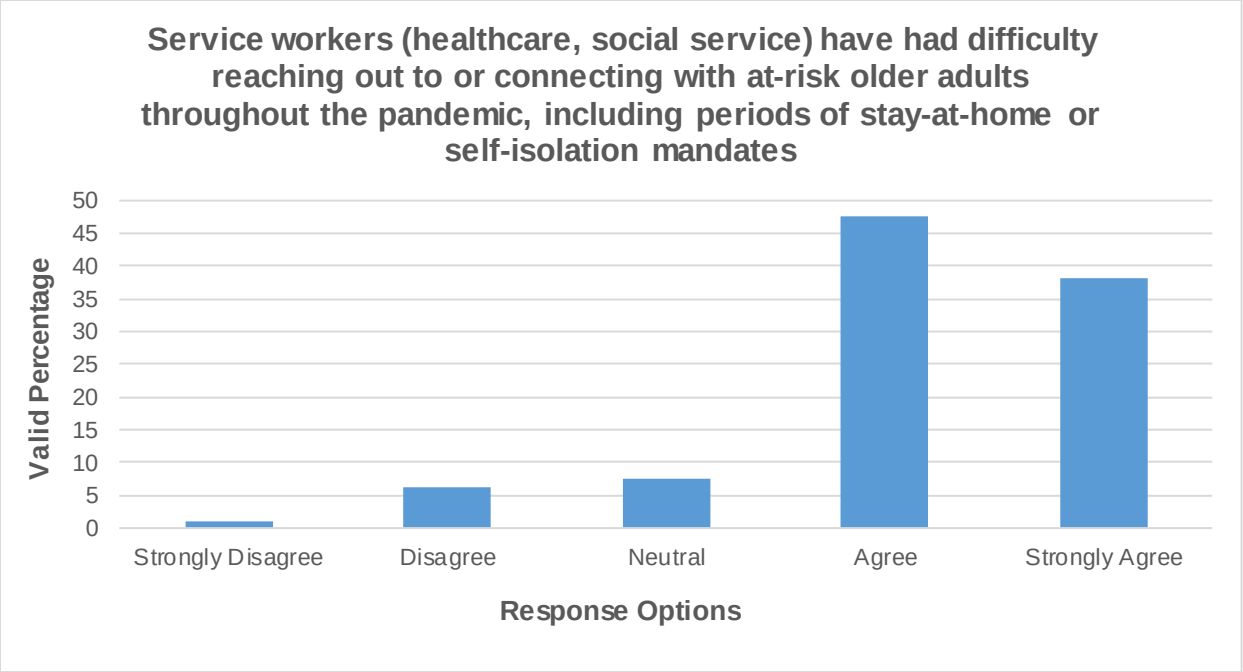
- Overall, based on a catch-all question related to primary MOA prevention, over 80% of respondents agreed that it was challenging to prevent at-risk older adults from experiencing MOA during the pandemic (Figure 1)

Figure 1



- A majority of respondents perceived that further MOA awareness-raising efforts were required during the pandemic that targeted both the general public and professionals who work with older adults. A majority of respondents also perceived that awareness-raising initiatives for the general public require a more tailored strategy to account for the needs and experiences of older adults from diverse communities. Respondents also disproportionately believed that an inadequate amount of training was available during the pandemic for professionals who work with older adults on how to recognize MOA
- Over 85% of respondents agreed that both formal service providers (Figure 2) and informal family/friends had difficulty connecting with older adults during the pandemic. A strong majority of respondents agreed that older adults themselves had difficulty engaging with social activities in their communities, accessing supplies within their communities, and that older adults with physical, cognitive, or functional limitations had difficulty accessing at-home informal or formal care supports

Figure 2



- A majority of respondents disagreed that virtual/remote forms of interpersonal or digital communication, such as video-conferencing, telephone, email, chat, or instant messaging were feasible or suitable ways of connecting with older adults throughout the pandemic
- Over 90% of respondents agreed that informal caregivers experienced heightened levels of stress or burnout throughout the pandemic
- A strong majority of respondents agreed that ageism toward older adults was elevated throughout the pandemic and increased vulnerability to MOA

Qualitative Survey Responses

Stakeholder responses to the open-ended, qualitative survey questions reinforced many of the results found from the closed survey questions. When asked about what they perceived as being the top challenges or gaps related to MOA prevention throughout the pandemic, the most common response was the heightened levels of social isolation and loneliness experienced by vulnerable older adults. Stakeholders expressed that restrictions to in-person home visits by health and social service programs represented a major challenge in their capacity to assess older adults or conduct check-ins. Further, they described that virtual/telephone-based services as a replacement of in-person appointments was inappropriate and carried heightened MOA risks. They indicated that many older adults struggled with basic technology skills and/or had age-associated impairments (vision, hearing, movement) that precluded their use of such virtual service delivery. Stakeholders described the disproportionate impact of restricted or cancelled

service access on low-income older adults who relied on subsidized or volunteer programs to access basic needs such as food, cleaning, transportation, and library internet access. Several stakeholders mentioned that the absence of transportation services denied older adults access to appointments or obtaining basic resources.

Stakeholders indicated that informal caregivers experienced heightened levels of stress/burden throughout the pandemic as a result of the closure of respite services and the limited opportunities for older adult care recipients to attend senior day programming or other community activities. Relatedly, many stakeholders described the elevated MOA risks associated with the shortage and limited access to personal homecare services. They believed that older adults experienced worsened physical and mental health conditions as a result of insufficient home care, limited access to healthcare, and depleted social stimulation, which elevated MOA risk. Restricted access to community-based social services, homecare, healthcare, and social and spiritual activities affected opportunities for contact with others which, in turn, elevated MOA risk. Stay-at-home mandates forced people to live and stay at home alone together for extended periods of time under stressful conditions, which increased opportunities and risk of MOA.

Respondents were also asked an open-ended question about lessons learned or perceived best practices in approaching MOA prevention throughout the pandemic. Most commonly, stakeholders indicated the need to maintain some degree of in-person services throughout the pandemic dedicated to older adults. Respondents understood that precautions needed to be taken, such as the use of PPE; however, in-person wellness checks were required to put eyes on the situation and understand a person's needs. Respondents indicated that regular check-ins were helpful. Respondents described the importance of strengthening efforts in the community that take responsibility for older adult welfare. Such efforts include strengthening existing MOA networks in the community and the communication between agencies that serve older adults. Several stakeholders remarked that further MOA awareness and education efforts were required to prevent the problem. One respondent suggested a large-scale, free online module describing MOA to raise awareness.

Given the emphasis on internet-based technology throughout the pandemic, respondents suggested the need for programs that teach older adults about using this type of technology. Other suggestions or lessons learned included keeping libraries open, making transportation available (particularly in rural areas), offering grocery delivery services without an extra cost burden, respite services for caregivers, more robust financial monitoring systems to identify abusive, irregular patterns of transaction, and using local community-based newspapers to communicate about MOA with older adults who live in rural areas. One respondent described a program involving additional outreach workers in the community to assist low-income older adults with basic needs (e.g., transportation, reminders about appointments, dropping off food). Several stakeholders described how volunteer friendly visiting programs would help maintain connections with older adults who would otherwise be isolated. Another respondent

from a retirement home described how they created small bubbles within their larger home community and created hallway activities and fitness classes to get people out of their suites and moving around. Finally, respondents recognized the need for further research to understand effective MOA prevention strategies.

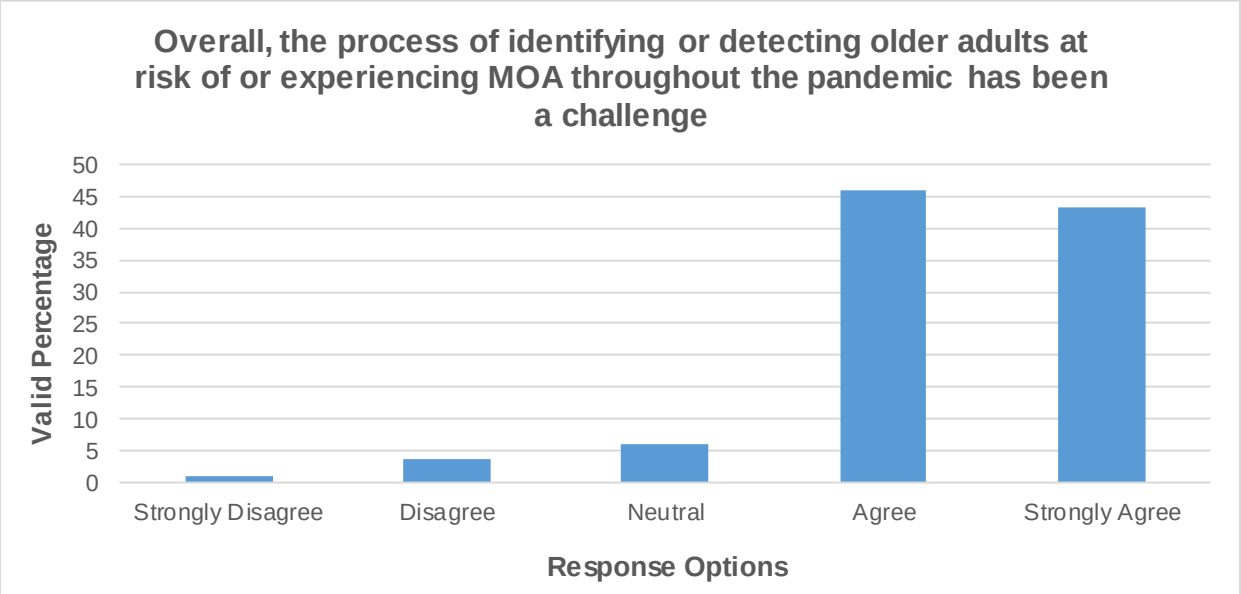
MOA Identification and Detection

Quantitative Survey Responses

Table 3 provides a breakdown of survey responses on items related to the gaps/challenges in identifying and detecting older adults at risk of or experiencing MOA. A summary of key findings are as follows:

- Overall, based on a catch-all question related to MOA identification/detection, nearly 90% of respondents agreed that the process of identifying and detecting older adults at risk of or experiencing MOA was challenging throughout the pandemic (Figure 3)

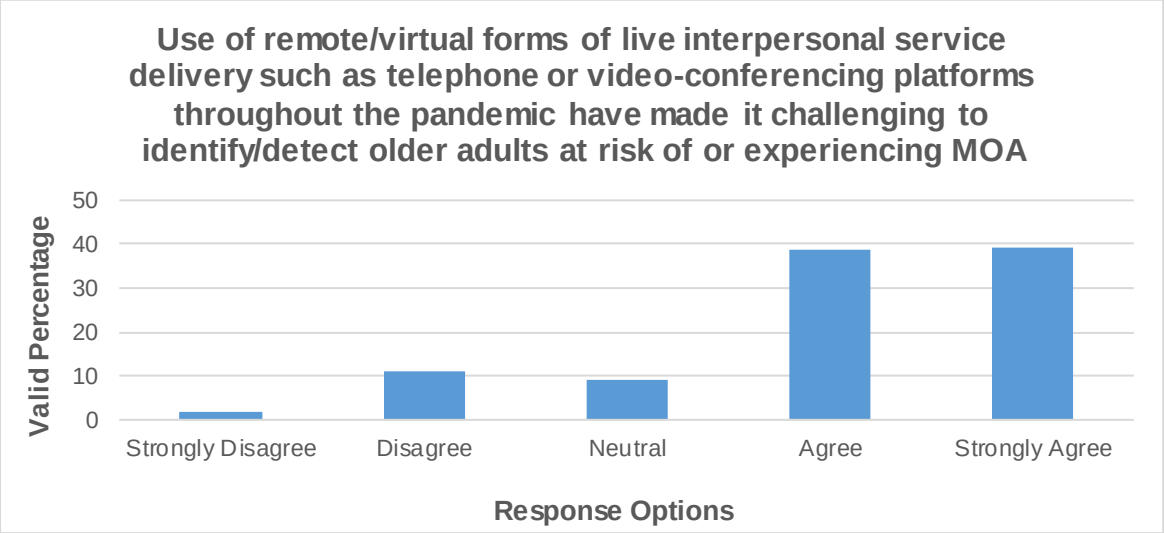
Figure 3



- Approximately 80% of respondents agreed that social distancing requirements and restrictions to in-person services during the pandemic created challenges in identifying/detecting older adults at risk of or experiencing MOA. Relatedly, a strong majority of respondents agreed that service delivery using remote/virtual

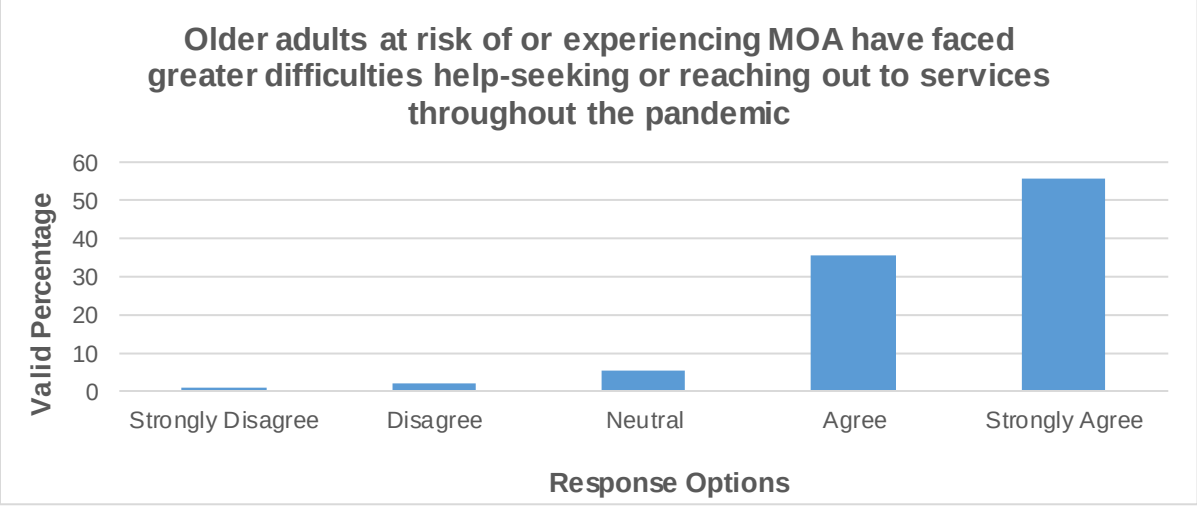
forms of live interpersonal communication (Figure 4) or digital forms of written communication made it challenging to identify/detect vulnerable older adults

Figure 4



- Over 90% of respondents agreed that older adults at risk of or experiencing MOA faced difficulties seeking help or reaching out to services during the pandemic (Figure 5), and a strong majority agreed that perpetrators of MOA could more easily use control tactics to divert identification/detection attempts

Figure 5



- A strong majority of respondents indicated that their employment sector or organization experienced instability or shortages in the workforce, which made it challenging to identify/detect older adults at risk of or experiencing MOA

Qualitative Survey Responses

The qualitative, open-ended questions provided further context to the gaps and challenges in identifying and detecting MOA during the pandemic. The most common response among stakeholders was the difficulty identifying at-risk older adults (e.g., red flags, signs of MOA) without seeing them during in-person service encounters. During certain periods, there were no options to conduct home visits or easily meet with clients, and it was difficult to assess older adults for MOA through virtual or telephone-based media. To exacerbate the situation, many clients did not have internet access, technology, and/or the skills or functional capacity necessary to attend virtual assessments and appointments, or they had unstable connections (particularly in rural areas). Providers also expressed confidentiality concerns when conducting meetings from their home if other family members were also working from home and/or kids were at home doing online learning. Pandemic restrictions also created limitations on older adult privacy as it related to having separation from their perpetrator, which created difficulties in identifying MOA. Safe spaces away from a perpetrator (e.g., seniors centres, religious venues) were not open/available for older adults to access and reach out for help. Similarly, it was unclear during virtual/telephone-based sessions whether others were listening to the conversation. An inability to access formal or informal external supports outside the home placed older adults in a position of vulnerability in having to depend upon a perpetrator. Similarly, the physical distancing requirements preventing others from entering the home precluded the possibility of them observing signs of and identifying MOA. Overall, MOA became even more hidden and challenging to identify during pandemic conditions.

When asked about lessons learned or best practices related to MOA identification and detection during the pandemic, stakeholders commonly stated that there is no replacement for in-person interactions with older adults. Regular in-person contact is necessary to listen, ask questions, and observe possible injuries or other signs of mistreatment. These details were missed without in-person contact. Meeting older adults in the community is the best option when possible to ensure safety away from the perpetrator. Access to primary care visits was also mentioned as an important opportunity for identification/detection. Several stakeholders remarked how lockdown and isolation periods during the pandemic created substantial harm for older adults as it related to MOA. Respondents described how important it was to strengthen community partnerships that involve information sharing and developing mutual referral processes. Developing partnerships between community homecare services and MOA response programs was seen as critical to the process of identifying cases and meeting their needs. Particularly in rural areas, establishing such partnership networks was challenging if organizations were competing for the same funding dollars. Several stakeholders remarked how banks could play a larger role in detecting financial abuse and called for greater accountability in the financial sector. Some respondents described the need for a more robust system of checks and balances for Powers of Attorney. Several stakeholders reiterated the need for more training and education among frontline workers and the general public to bolster identification and detection

efforts. Finally, it was acknowledged that best practices have not yet been established, and there is a need for further research in this area.

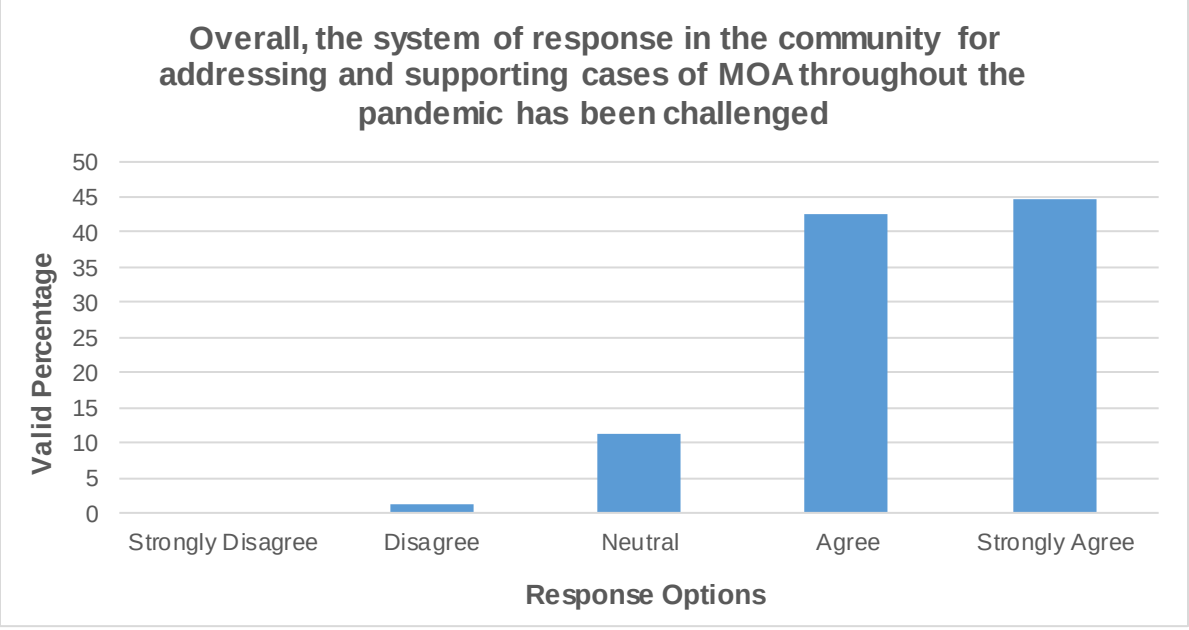
MOA Response and Support Interventions

Quantitative Survey Responses

Table 4 provides a detailed breakdown of sample responses in relation to survey items on the topic of MOA response and support interventions during the pandemic. Key findings from this section of the survey are summarized as follows:

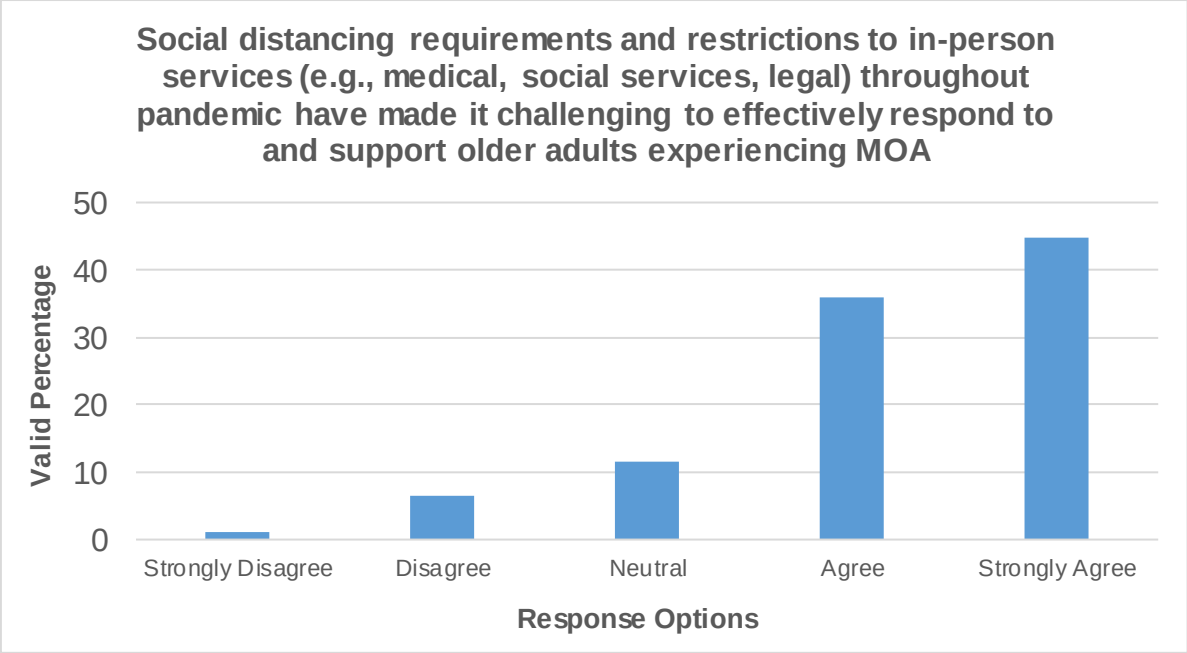
- Overall, based on a catch-all question related to MOA response/support intervention, nearly 90% of respondents indicated that the community-based system of response for addressing and supporting cases of MOA was challenged throughout the pandemic (Figure 6)

Figure 6



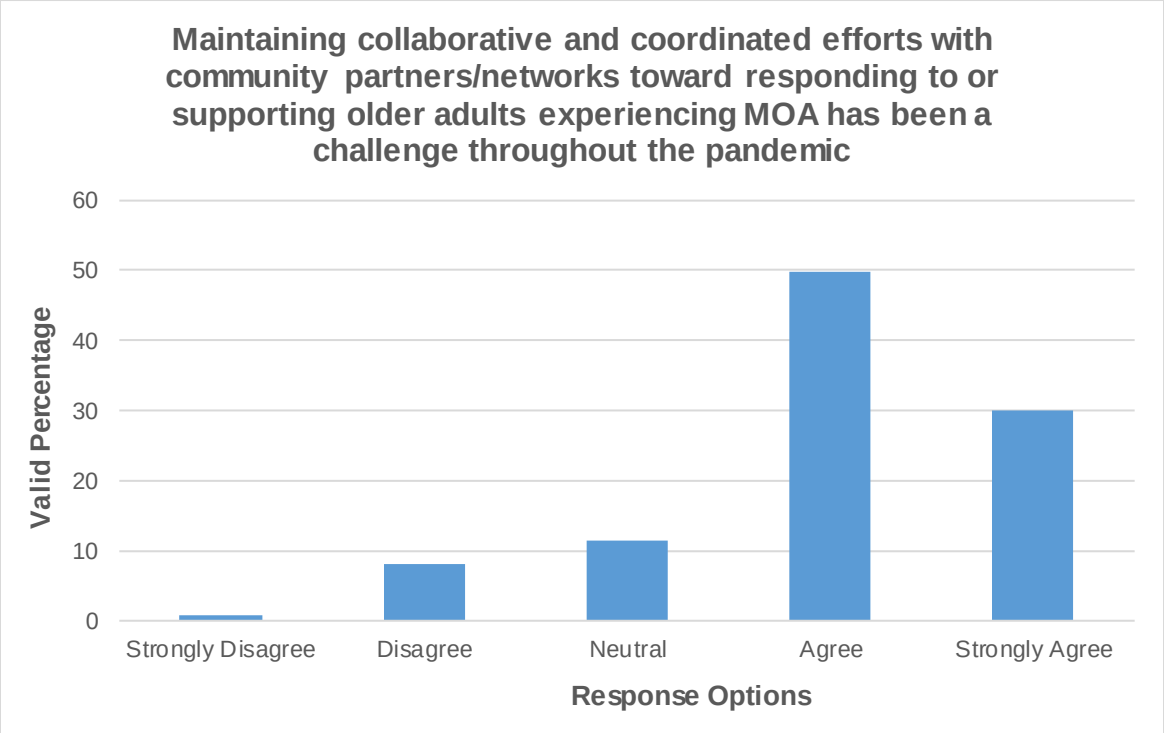
- Over 80% of respondents agreed that social distancing requirements and restrictions to in-person services made it challenging to respond to and support MOA victims during the pandemic (Figure 7)

Figure 7



- Over 80% of respondents indicated that it was challenging to effectively respond to and support MOA victims through remote/virtual forms of live interpersonal communication (e.g., video-conferencing) or digital forms of written communication (e.g., email, chat)
- Nearly 90% of respondents agreed that MOA perpetrators could more easily mistreat victims and obstruct attempts by service providers to support victims during the pandemic
- Over 70% of respondents agreed that their sector or organization experienced instability or shortages in personnel throughout the pandemic, which made it challenging to respond to and support MOA victims
- A strong majority of respondents agreed that it was challenging to maintain a collaborative and coordinated effort within community-based MOA networks throughout the pandemic (Figure 8)

Figure 8



- A majority of respondents disagreed that community-based social services, healthcare services, or other relevant services were available or equipped throughout the pandemic to effectively respond to and support MOA victims

Qualitative Survey Responses

The qualitative open-ended questions provide a more nuanced portrayal of gaps and challenges in responding to MOA throughout the pandemic. Stakeholders overwhelmingly expressed that the availability of frontline MOA response programs is severely lacking in communities across Canada. Although certain sectors or service organizations end up working with cases of MOA, they are generally not equipped with the specialized knowledge and skills necessary to address this complex issue. Further, referral pathways for MOA response programs are uncoordinated in many communities across Canada. Overall, these MOA response service system gaps were exacerbated during the pandemic, leaving older adults with limited appropriate formal supports. Generally, support programs were unavailable, not easily accessible, and/or understaffed and lacked capacity throughout the pandemic. Many stakeholders expressed that virtual-based programs were not appropriate for older adults who lacked the basic skills to navigate the technology. Several respondents challenged the basic idea of responding to vulnerable older adults (e.g., who may be living with physical hearing/vision or digital literacy issues) using virtual/telephone-based media, and they

emphasized the barriers to access such technology. Some telephone-based MOA helpline services had long wait times during the pandemic that impeded service engagement. Beyond the availability of direct MOA response programs, the surrounding network of auxiliary support organizations that could typically help support the needs of MOA cases, such as homecare, food delivery, health visits, and others, were also difficult to access.

When asked about lessons learned in responding to and supporting MOA cases throughout the pandemic, stakeholders described the importance of building trust and rapport with older adults as critical for them to open up and move forward with support work. Response/support models must allow adequate time to develop these trusting working relationships. One stakeholder from a rural community described a two-year position strictly focused on developing connections with older adults to gain trust and have open lines of communication. Programs needed to be delivered in a way that engages the older adult and provides the flexibility to adapt to the needs of each case. Throughout the pandemic, in particular, it was important to be able to connect with and reassure MOA victims through regular contact. Stakeholders described that response interventions, in general, need to target the perpetrator as well as the victim to address the reasons they are mistreating the older adult. To fully address MOA, assessment and response plans must consider cases in relation to individual, relationship, and family-level factors. A more robust, community-based MOA response system was needed. Some stakeholders stated a need to develop and train a specialized workforce of frontline MOA responders who carry the requisite knowledge and skills to work with cases. Such training should be available through dedicated certificate programs and/or as a part of post-secondary educational programs.

Other lessons learned or suggestions included strengthening the broader MOA networks and communication between programs that are involved in the response system. Several stakeholders identified that MOA-specific shelters needed to be expanded to include more beds and longer, more flexible stay periods until adequate alternatives have been identified. This issue was exacerbated during the pandemic when the alternative could have been to socially isolate with the perpetrator. MOA responders required stable access to PPE. In rural, isolated areas another respondent suggested a need for positions that are dedicated to the needs of older adults.

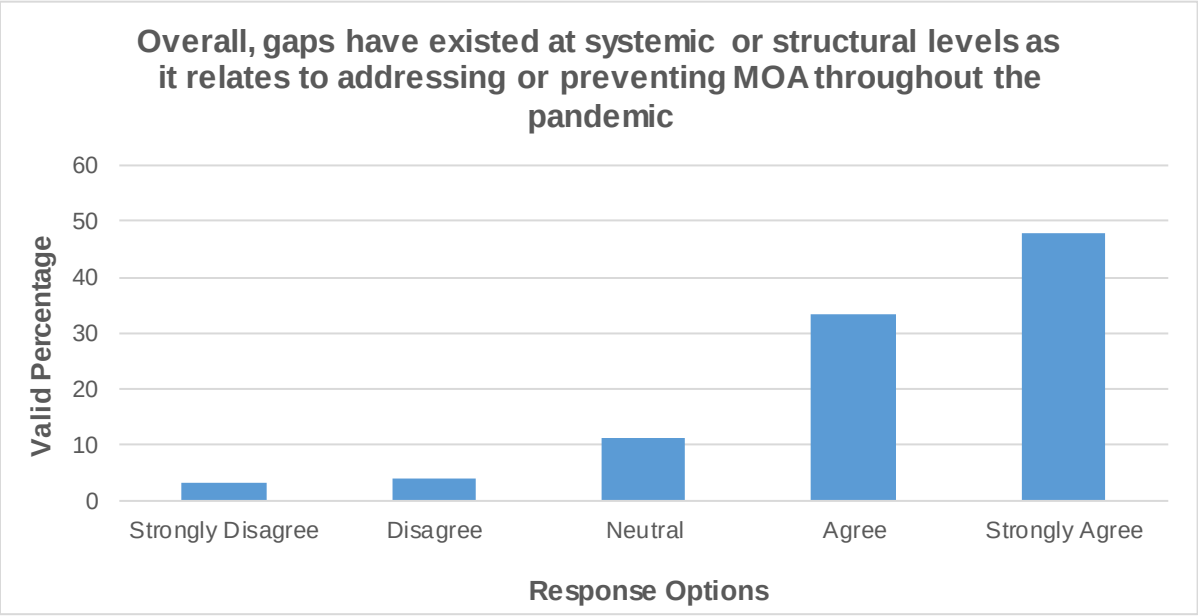
Centralized Systemic Support

Quantitative Survey Responses

Table 5 provides a detailed breakdown of survey responses in relation to items on the topic of centralized/systemic MOA support during the pandemic. Key points related to this section of the survey are summarized as follows:

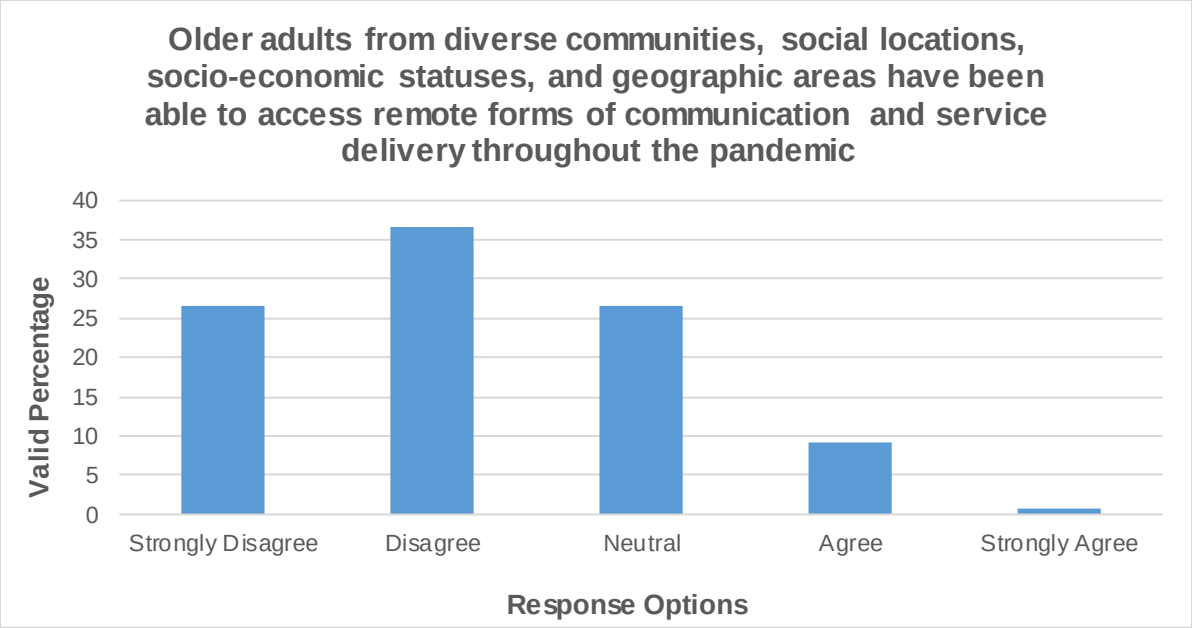
- Overall, as a catch-all question, over 80% of respondents agreed that gaps existed at systemic or structural levels around preventing or responding to MOA throughout the pandemic (Figure 9)

Figure 9



- Approximately 70% of respondents disagreed that efforts to prevent, identify/detect, or respond to and support MOA cases throughout the pandemic were well coordinated across service systems, sectors, and disciplines
- A majority of respondents disagreed that older adults from diverse communities and geographic locations were able to access remote forms of communication and service delivery throughout the pandemic (Figure 10)

Figure 10



- A majority of respondents disagreed that enough resources have been available throughout the pandemic to offset gaps in opportunities to pursue fundraising activities
- A majority of respondents disagreed that systems designed to collect MOA-related data at provincial, territorial, and federal levels worked well throughout the pandemic
- A majority of respondents disagreed that sufficient resources were directed toward evaluating evidence-based practices in preventing, identifying/detecting, or supporting/responding to MOA throughout the pandemic. Relatedly, most respondents disagreed that knowledge around lessons learned in preventing, identifying/detecting, or responding to MOA throughout the pandemic was effectively shared across jurisdictions and service systems

Qualitative Survey Responses

The open-ended question reiterated some of the above themes in relation to centralized support. Stakeholders expressed concerns about the general coordination across systems and disciplines as it relates to MOA prevention and intervention. It was perceived that coordination of services to address the basic needs of older adults in rural areas, in particular, needs to be strengthened. As a labour force issue, respondents suggested that centralized systems have not adequately responded to staffing shortages, for example for homecare, nursing home PSWs, or community-based MOA responders. A common concern raised from a systems perspective was a lack of access to internet technology (e.g., internet access, equipment, in-person

technical assistance), particularly among low-income or marginalized communities, which contributed to inequitable access to services or opportunities for social connection online. Stakeholders stated that campaigns to address the issue of ageism needed to integrate an intersectional lens, for example the perspectives and experiences of older adults representing diverse income, gender, and racialized identities. One stakeholder identified how the Personal Directives and Adult Guardianship/Trustee Acts permit those with designated Powers of Attorney and agent status to conduct older adults' business without considering their best interest and, consequently, finances and assets are dissolved by the time an investigation commences. Some stakeholders suggested that MOA should be organized as a stand-alone issue, rather than being subsumed under the umbrella of family violence, which tends to be dominated by other domains of interpersonal violence.

5 Future Directions

The following set of recommended future directions is based on a synthesis of findings across the three main sources of data collected in this study, including findings from a comprehensive literature review and both quantitative and qualitative data collected through a survey with stakeholders across Canada who are directly involved in MOA prevention and intervention. These future directions represent key opportunities and actionable recommendations to address the gaps and challenges identified throughout this report in preventing and responding to MOA. They are designed to help inform government decisions on the allocation of resources and development of funding opportunities aimed to advance the state of MOA prevention and response throughout Canada. Largely based on the experiences and perspectives of MOA stakeholders across various sectors, these recommendations are also meant to promote and support ongoing innovation among MOA-related programs, organizations, and researchers. As a note, our knowledge of effective MOA prevention and intervention strategies represents the largest gap of knowledge in the field. Therefore, it is not possible to identify established, effective solutions in preventing or addressing MOA alongside the identified gaps and challenges. A systematic review and synthesis of the identified promising prevention and response intervention strategies would be required to establish their effectiveness and impact, which is beyond the scope of the current project.

Primary Prevention

- Address ageism more clearly. This can be done by avoiding spreading a discourse that encourages ageist attitudes (Perk, 2020; Laforest & Tourigny, 2021); providing a detailed picture of older adults as being a very heterogeneous group (Perks, 2020; Laforest & Tourigny, 2021); favouring intergenerational exchanges and solidarity (Burnes et al., 2019); respecting the rights of older adults and giving them a voice in decision making, (Laforest et Tourigny, 2021), and ensuring that communication from all sectors is sensitive not to promote

ageist language and messages. Efforts to address the issue of ageism need to integrate an intersectional lens that accounts for the perspectives and experiences of older adults from different sociocultural identities.

- Development, implementation, and evaluation of primary prevention *education and awareness-raising* initiatives about MOA that are sensitive to the experiences of older adults from diverse communities, which target different audiences including: 1) older adults themselves, 2) concerned others in the informal social support networks of older adults, and 3) professionals and service providers who work with older adults. Initiatives are required that can be successful both during times when no social distancing mandates are in place and during times of social distancing and in-person restrictions.
- Development, implementation, and evaluation of initiatives that support informal caregivers of older adults from diverse communities. Caregiver stress is a known risk factor of MOA, and levels of caregiver stress have been exacerbated by pandemic conditions.
- Development and implementation of initiatives to bolster the availability and accessibility of formal homecare services for older adults throughout a pandemic. Formal homecare supports were limited throughout the pandemic and the labour force in this sector experienced significant shortages, which left older adults in need of day-to-day care in vulnerable positions.
- Development, implementation, and evaluation of initiatives that connect and provide older adults with access to supplies such as food and medication during pandemic periods of isolation and restriction.
- Promote strong management, enough qualified staffing, and the development of infectious disease management protocols in LTCs in preparation for future pandemic waves.

Identification and Detection

- Existing methods of assessing older adults for MOA over virtual/telephone-based platforms are inappropriate and/or inaccessible for many older adults. Protocols are needed during pandemic restriction periods that ensure safe and private in-person access to older adults in spaces away from potential perpetrators.
- Research is needed to determine the feasibility and effectiveness of using virtual/telephone-based platforms to detect and identify MOA and to develop evidence-based guidelines and best practices in this area, including screening tools and observational (e.g., psycho-emotional and behavioural signs) strategies that are sensitive to the limitations of online interactions and the possibility that perpetrator others may be present in an older adult's home environment.
- Development, implementation, and evaluation of training initiatives on how to recognize and detect older adults who are at risk of or experiencing MOA, which target different audiences including: 1) professionals and service providers who

work with older adults, and 2) formal caregivers of older adults (e.g., homecare workers, personal support workers), 3) informal caregivers, 4) volunteers who work with older adults, and 5) concerned others in the informal social support networks of older adults.

Response and Support Intervention

- Dedicated frontline MOA response programs are severely lacking in communities across Canada, and many community organizations who do work with MOA cases are not equipped with the specialized knowledge and skills necessary to address this complex issue. This service system gap was exposed and exacerbated throughout the pandemic, leaving many older adults at risk of or experiencing MOA without appropriate forms of support. A major investment into the development of a community-based MOA response system is needed, including coordinated referral pathways, specialized response programs, and identification and scaling of evidence-based practices. Successful response programs have the capacity to build relationships with and work with an older adult victim, perpetrator, the victim-perpetrator relationship, and others in the family system or informal social support network (Burnes et al., 2022b; Lewis et al., 2022; Mosqueda et al., 2016). Programs must also incorporate culturally sensitive, safe, and inclusive strategies to support older adults who are experiencing MOA within diverse communities. A culturally safe and inclusive practice orientation involves highly reflexive, client-centered, and collaborative approaches that de-center dominant assumptions and facilitate an openness to various ways of knowing. The development of community-based response programs should directly involve the voices of MOA survivors themselves and members who represent diverse perspectives to generate culturally centered, meaningful and relevant practice strategies. Within the overall effort to develop a dedicated community-based MOA response system is the need to train a specialized workforce of frontline MOA responders who carry the prerequisite knowledge and skills to work with MOA cases.
- Telephone lines that serve as a central point of initial contact for MOA reporting need appropriate resources to maintain reasonable wait times.
- Existing methods of conducting community-based MOA intervention over virtual/telephone-based platforms are inappropriate and/or inaccessible for many older adults. Protocols are needed during pandemic restriction periods that ensure safe and private in-person access to older adults in spaces away from potential perpetrators.
- Development of evidence-based guidelines and best practices on conducting MOA response and support intervention work across diverse communities in the context of physical distancing and use of personal protective equipment, including how to establish effective engagement and relationship building strategies, conduct assessments, and engage in ongoing treatment sessions that

are sensitive to the barriers attached to physical distance and personal protective equipment.

- Development of evidence-based guidelines and best practices on conducting MOA response and support intervention work across diverse communities via online virtual platforms, including how to establish effective engagement and relationship building strategies, conduct biopsychosocial assessments, and engage in ongoing treatment sessions that are sensitive to the limitations of online interactions and the possibility that perpetrator others may be present in an older adult's home environment.
- Community-based MOA networks are largely supported through volunteers. More consistent infrastructure and support is needed to maintain and strengthen MOA networks in the community and the collaborations among organizations. These networks are critical in providing community supports at the local level, including training, education and awareness, and sharing knowledge.
- Expansion in the number of shelters dedicated to the needs of older adults experiencing MOA, including more beds, and longer, more flexible stay periods until adequate alternative living arrangements have been identified, particularly during times of pandemic restrictions when the only alternative is to return home in isolation with a perpetrator.
- Development, implementation, and evaluation of culturally sensitive and safe LTC-based MOA interventions that respond to and support cases involving older adults who are at risk of or experiencing MOA. LTC settings represent a distinct environment with unique considerations as it relates to MOA intervention.

Social Connection

- Development, implementation, and evaluation of innovative initiatives to initiate and/or maintain social connectedness between older adults and members of their *informal* social support network, including peers, family members, and concerned others, as well as community-based groups and activities. Initiatives are needed that meet the needs of older adults living in diverse communities and that can be successful during times when no social distancing mandates are in place and/or during times of social distancing and stay-at-home mandates.
- Development, implementation, and evaluation of innovative initiatives to initiate and/or maintain contact and connectedness between older adults and members of their formal support network (e.g., social services providers, healthcare providers). Initiatives are needed that meet the needs of older adults living in diverse communities and that can be successful during times when no social distancing mandates are in place and/or during times of social distancing and stay-at-home mandates.

Workforce Stability

- The pandemic demonstrated that staff shortages and workforce instability in certain sectors and organizations was an impediment to MOA prevention and

response. A reserve of staff or other initiatives are needed that stabilize and maintain adequate workforce personnel throughout a pandemic in sectors/organizations with responsibilities to identify/detect older adults at risk of or experiencing MOA or who have a responsibility to respond to and support them in both community and LTC settings.

Centralized Support

- Development and adoption of a common definition of MOA across provincial, territorial and federal jurisdictions in Canada, which can be used to support a more consistent and cohesive body of research, policy, and programming activities.
- Initiatives are needed to promote equitable access among diverse older adults to internet, internet technical assistance, and the bandwidth and technology necessary to participate in online virtual forms of social connection and service delivery, regardless of the older adult's intersection with sociocultural identity, socio-economic status, and geographic location. Simultaneously, training workshops to teach certain older adults how to use internet-based technology are needed to ensure they have the skills to navigate this online environment.
- Initiatives are needed to support organizational investment into the infrastructure, equipment, and capacity necessary to pivot their services and workflow online.
- Initiatives are needed to develop infrastructure and mechanisms to collect MOA-related data that is coordinated across jurisdictions and systems. Related to the above point, a common MOA definition would help facilitate more consistent MOA data collection across jurisdictions and systems.
- Initiatives are needed to develop infrastructure and pathways to disseminate and share best practices and lessons learned about MOA prevention, identification/detection, and response/support intervention to stakeholders across jurisdictions and systems.
- Initiatives are needed to support research efforts that evaluate, identify, and scale evidence-based practices in preventing, identifying/detecting, or supporting/responding to MOA.

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Appendix A: Tables

Table 1: Descriptive Sample Characteristics

Characteristic	**Sample** (n = 249) % (n)
Gender	
Female	67.5 (168)
Male	29.3 (73)
Non-Binary	1.6 (4)
Two-Spirit	0.4 (1)
Prefer Not to Answer	1.2 (3)
Minority Status	
First Nations	3.6 (9)
Inuk (Inuit)	0.9 (2)
Métis Citizen	1.6 (4)
Other Indigenous	1.6 (4)
LGBTQ2	5.2 (13)
Person with Disability	8.4 (21)
Ethnocultural or Visible Minority Group	7.6 (19)
Official Language Minority Community	5.6 (14)
Prefer Not to Answer	6.0 (15)
Age	
Less than 25	0 (0)
25 – 39	10.8 (27)
40 – 59	41.8 (104)
60 – 74	37.3 (93)
75 or more	9.6 (24)
Province	
Alberta	9.2 (23)
British Columbia	3.6 (9)
Manitoba	7.6 (19)
New Brunswick	2.0 (5)
Newfoundland and Labrador	1.2 (3)
Nova Scotia	3.6 (9)
Ontario	62.2 (155)
Prince Edward Island	0.8 (2)
Québec	2.4 (6)
Saskatchewan	0.8 (2)

Northwest Territories	4.8 (12)
Nunavut	0.4 (1)
Yukon	0 (0)
Geo-Cultural Context	
Urban	45.0 (112)
Rural	34.9 (87)
Suburban	19.3 (48)
Employment Sector	
Business	4.8 (12)
Education	6.0 (15)
Government	11.2 (28)
Healthcare	22.5 (56)
Social Services	23.3 (58)
Non-Profit	6.8 (17)
Law Enforcement	2.0 (5)
Retired	8.8 (22)
Other	13.7 (34)
Employment Role/Responsibility Related to MOA	43.8 (109)
Practitioner/Provider	37.3 (93)
Advocacy	6.0 (15)
Policy	4.4 (11)
Research	24.9 (62)
Other	
Role Involves Direct Service Provision with Older Adults	
No	42.2 (105)
Yes	57.4 (143)

Table 2: Survey Responses on Items Related to Primary Prevention

Primary Prevention					
Survey Item	**Strongly Disagree** % (n) [valid %]	**Disagree** % (n) [valid %]	**Neutral** % (n) [valid %]	**Agree** % (n) [valid %]	**Strongly Agree** % (n) [valid %]
There have been enough awareness raising initiatives about MOA throughout the pandemic directed toward the general public	19.7 (49) [19.7]	41.8 (104) [41.8]	17.3 (43) [17.3]	18.5 (46) [18.5]	2.8 (7) [2.8]
Awareness raising initiatives directed toward the general public about MOA throughout the pandemic have taken the needs and experiences of diverse communities into account	20.1 (50) [20.7]	32.9 (82) [33.9]	24.5 (61) [25.2]	16.1 (40) [16.5]	3.6 (9) [3.7]
There have been enough awareness raising initiatives about MOA throughout the pandemic directed toward professionals who work with older adults	18.5 (46) [18.8]	34.5 (86) [35.1]	19.3 (48) [19.6]	21.7 (54) 22.9]	4.4 (11) [4.5]
Education and training initiatives directed toward professionals who work with older adults on how to recognize signs of MOA have been available throughout the pandemic	16.1 (40) [16.7]	30.5 (76) [31.7]	26.1 (65) [27.1]	18.9 (47) [19.6]	4.8 (12) [5.0]
Service workers (healthcare, social service) have had difficulty reaching out to or connecting with at-risk older adults throughout the pandemic, including periods of stay-at-home or self-isolation mandates	0.8 (2) [0.9]	5.6 (14) [6.1]	6.8 (17) [7.4]	43.8 (109) [47.6]	34.9 (87) 38.0]

Family and friends have had difficulty reaching out to or connecting with at-risk older adults throughout the pandemic, including periods of stay-at-home or self-isolation mandates	1.6 (4) [1.8]	4.0 (10) [4.4]	4.8 (12) [5.3]	41.8 (104) [46.0]	38.6 (96) [42.5]
Older adults have had difficulty engaging with social activities in their communities throughout the pandemic (e.g., senior centres, day programs, faith-based gatherings)	1.6 (4) [1.7]	2.0 (5) [2.2]	2.8 (7) [3.1]	21.3 (53) [23.1]	64.3 (160) [69.9]
Remote/virtual forms of live interpersonal communication such as telephone or video-conferencing platforms have represented feasible and suitable ways of connecting with at-risk older adults	16.1 (40) [17.1]	31.7 (79) [33.8]	17.3 (43) [18.4]	25.3 (63) [26.9]	3.6 (9) [3.8]
Remote digital forms of written communication such as email, chat, or instant messaging have represented feasible and suitable forms of connecting with at-risk older adults	20.9 (52) [22.4]	35.3 (88) [37.9]	16.9 (42) [18.1]	16.9 (42) [18.1]	3.2 (8) [3.4]
Older adults living with physical, cognitive or functional limitations have had difficulty accessing at-home personal care support throughout the pandemic, either through paid homecare or unpaid informal caregiving support, to help them with daily care needs	1.6 (4) [1.8]	3.2 (8) [3.6]	6.0 (15) [6.7]	31.7 (79) [35.3]	47.4 (118) [52.7]
Informal caregivers providing care to older adults have experienced heightened levels of stress or burnout throughout the pandemic	0.8 (2) [0.9]	1.2 (3) [1.3]	5.2 (13) [5.8]	22.1 (55) [24.6]	60.6 (151) [67.4]
Ageist attitudes, stereotypes or prejudices toward older adults have been elevated	0.8 (2) [0.9]	7.2 (18) [8.1]	14.5 (36) [16.2]	27.7 (69) [31.1]	39.0 (97) [43.7]

throughout the pandemic and have increased older adult vulnerability to MOA					
Older adults have had difficulty accessing supplies in the community throughout the pandemic (e.g., groceries, medication)	0.8 (2) [0.9]	6.4 (16) [7.1]	10.0 (25) [11.1]	41.0 (102) [45.3]	32.1 (80) [35.6]
Overall, it has been challenging to prevent at-risk older adults from experiencing MOA throughout the pandemic	1.2 (3) [1.4]	4.4 (11) [5.0]	9.6 (24) [10.8]	42.6 (106) [47.7]	31.3 (78) [35.1]

Table 3: Survey Responses on Items Related to MOA Identification and Detection

Identification and Detection					
Survey Item	**Strongly Disagree** % (n) [valid %]	**Disagree** % (n) [valid %]	**Neutral** % (n) [valid %]	**Agree** % (n) [valid %]	**Strongly Agree** % (n) [valid %]
The use of personal protective equipment (e.g., hazmat suits, masks, gloves) throughout the pandemic has made it challenging to identify/detect older adults at risk of or experiencing MOA	2.4 (6) [3.1]	17.7 (44) [22.7]	20.1 (50) [25.8]	24.5 (61) [31.4]	10.4 (26) [13.4]
Social distancing requirements and restrictions to in-person services (e.g., medical, social services, legal) throughout the pandemic have made it challenging to identify/detect older adults at risk of or experiencing MOA	0.8 (2) [1.0]	6.0 (15) [7.7]	7.6 (19) [9.8]	28.5 (71) [36.6]	34.1 (85) [43.8]
Use of remote/virtual forms of live interpersonal service delivery such as telephone or video-conferencing platforms throughout the pandemic have made it challenging to identify/detect older adults at risk of or experiencing MOA	1.2 (3) [1.6]	8.4 (21) [10.9]	6.8 (17) [8.8]	29.3 (73) [37.8]	29.7 (74) [38.3]
Service delivery using digital forms of written communication such as email, chat, or instant messaging throughout the pandemic have made it challenging to identify/detect older adults at risk of or experiencing MOA	1.2 (3) [1.6]	5.2 (13) [6.7]	8.8 (22) [11.4]	25.3 (63) [32.6]	34.5 (86) [44.6]
Older adults at risk of or experiencing MOA have faced greater difficulties help-	0.8 (2) [1.1]	1.6 (4) [2.2]	4.0 (10) [5.4]	26.5 (66) [35.5]	41.8 (104) [55.9]

seeking or reaching out to services throughout the pandemic					
Perpetrators of MOA could more easily use tactics throughout the pandemic to divert attempts by service providers or concerned family/friends to identify/detect older adults at risk of or experiencing MOA	1.2 (3) [1.6]	1.6 (4) [2.2]	8.8 (22) [11.8]	24.1 (60) [32.3]	39.0 (97) [52.2]
My organization understood how to adapt our approach in identifying/detecting older adults at risk of or experiencing MOA throughout the pandemic based on the varying needs and vulnerabilities of older adults from diverse communities and identities	2.8 (7) [4.2]	8.8 (22) [13.3]	18.5 (46) [27.7]	28.5 (71) [42.8]	8.0 (20) [12.0]
My organization has had the resources, technology, and tools needed to pivot and adapt throughout the pandemic to identify/detect older adults at risk of or experiencing MOA	3.2 (8) [4.8]	18.5 (46) [27.5]	16.9 (42) [25.1]	23.3 (58) [34.7]	5.2 (13) [7.8]
My sector or organization has experienced instability, changes, or shortages in workforce personnel throughout the pandemic that have made it challenging to identify/detect older adults at risk of or experiencing MOA	0.8 (2) [1.2]	7.6 (19) [11.4]	13.3 (33) [19.8]	21.3 (53) [31.7]	24.1 (60) [35.9]
Overall, the process of identifying or detecting older adults at risk of or experiencing MOA throughout the pandemic has been a challenge	0.8 (2) [1.1]	2.8 (7) [3.7]	4.4 (11) [5.9]	34.5 (86) [46.0]	32.5 (81) [43.3]

Table 4: Survey Responses on Items Related to MOA Response and Support Intervention

Response and Support Intervention					
Survey Item	**Strongly Disagree** % (n) [valid %]	**Disagree** % (n) [valid %]	**Neutral** % (n) [valid %]	**Agree** % (n) [valid %]	**Strongly Agree** % (n) [valid %]
Personal protective equipment (e.g., hazmat suits, masks, gloves) has been available throughout the pandemic when needed to respond to and support older adults experiencing MOA	4.8 (12) [7.5]	10.8 (27) [16.9]	13.3 (33) [20.6]	25.3 (63) [39.4]	10.0 (25) [15.6]
The use of personal protective equipment throughout the pandemic (e.g., hazmat suits, masks, gloves) has made it challenging to effectively respond to and support older adults experiencing MOA	2.4 (6) [3.7]	13.7 (34) [21.1]	13.7 (34) [21.1]	24.1 (60) [37.3]	10.8 (27) [16.8]
Social distancing requirements and restrictions to in-person services (e.g., medical, social services, legal) throughout pandemic have made it challenging to effectively respond to and support older adults experiencing MOA	0.8 (2) [1.2]	4.4 (11) [6.6]	7.6 (19) [11.4]	24.1 (60) [35.9]	30.1 (75) [44.9]
Reaching out to and making contact with older adults experiencing MOA throughout the pandemic, including periods of stay-at-home or self-isolation mandates, to provide response and support has been a challenge	0.8 (2) [1.3]	2.8 (7) [4.4]	4.8 (12) [7.6]	24.9 (62) [39.2]	30.1 (75) [47.5]
Use of remote/virtual forms of live interpersonal service delivery such as telephone or video-conferencing platforms throughout the pandemic have made it	1.2 (3) [1.9]	4.0 (10) [6.4]	5.6 (14) [9.0]	26.9 (67) [42.9]	24.9 (62) [39.7]

challenging to effectively respond to and support older adults experiencing MOA					
Service delivery using digital forms of written communication such as email, chat, or instant messaging throughout the pandemic have made it challenging to effectively respond to and support older adults experiencing MOA	1.2 (3) [1.9]	3.6 (9) [5.8]	7.6 (19) [12.2]	24.1 (60) [38.5]	26.1 (65) [41.7]
Perpetrators of MOA could more easily mistreat older adults or use tactics to divert attempts by services or concerned family/friends to support older adults (e.g., restricting access to older adult) throughout the pandemic	0.8 (2) [1.3]	1.2 (3) [1.9]	5.2 (13) [8.3]	20.9 (52) [33.3]	34.5 (86) [55.1]
My organization has had a good understanding of how to effectively integrate remote/virtual practices into day-to-day workflow, operations and/or services	1.6 (4) [2.8]	5.6 (14) [9.9]	13.7 (34) [23.9]	26.5 (66) [46.5]	9.6 (24) [16.9]
My organization has had the resources, technology, and tools needed to pivot and adapt throughout the pandemic to effectively respond to and support older adults experiencing MOA	2.8 (7) [5.0]	10.4 (26) [18.7]	18.9 (47) [33.8]	17.7 (44) [31.7]	6.0 (15) [10.8]
My organization has had a good contingency/resiliency plan in place to keep operations going to effectively respond to and support older adults experiencing MOA in the event of employee absenteeism or shortages throughout the pandemic	2.8 (7) [5.1]	11.6 (29) [21.0]	14.9 (37) [26.8]	19.7 (49) [35.5]	6.4 (16) [11.6]
My sector or organization has experienced instability, changes, or shortages in	0.4 (1) [0.7]	5.2 (13) [9.4]	10.4 (26) [18.7]	21.3 (53) [38.1]	18.5 (46) [33.1]

workforce personnel throughout the pandemic that made it challenging to effectively respond to and support older adults experiencing MOA					
Maintaining collaborative and coordinated efforts with community partners/networks toward responding to or supporting older adults experiencing MOA has been a challenge throughout the pandemic	0.4 (1) [0.7]	4.8 (12) [8.2]	6.8 (17) [11.6]	29.3 (73) [49.7]	17.7 (44) [29.9]
Staff at my workplace have felt informed enough about COVID-19 to safely work toward effectively responding to and supporting older adults experiencing MOA	0.8 (2) [1.5]	6.4 (16) [11.9]	12.9 (32) [23.9]	25.3 (63) [47.0]	8.4 (21) [15.7]
My organization understood how COVID-19 affected older adults from diverse communities and identities differently	2.4 (6) [4.3]	7.2 (18) [12.8]	12.4 (31) [22.0]	26.5 (66) [46.8]	8.0 (20) [14.2]
My organization understood how to adapt our approach in responding to and supporting cases of MOA based on the varying needs and vulnerabilities of older adults from diverse communities and identities	2.0 (5) [3.8]	9.6 (24) [18.3]	12.4 (31) [23.7]	22.5 (56) [42.7]	6.0 (15) [11.5]
Community social services have been available and equipped to effectively respond to and support older adults experiencing MOA throughout the pandemic	13.3 (33) [21.7]	20.9 (52) [34.2]	15.3 (38) [25.0]	8.4 (21) [13.8]	3.2 (8) [5.3]
Healthcare services (e.g., hospitals, family doctors, home care) have been available and equipped to effectively respond to and support older adults experiencing MOA throughout the pandemic	12.9 (32) [21.3]	26.1 (65) [43.3]	12.0 (30) [20.0]	5.6 (14) [9.3]	3.6 (9) [6.0]

Other services (e.g., legal, courts, financial) have been available and equipped to effectively respond to and support older adults experiencing MOA throughout the pandemic	13.3 (33) [23.6]	21.3 (53) [37.9]	17.7 (44) [31.4]	2.8 (7) [5.0]	1.2 (3) [2.1]
Overall, the system of response in the community for addressing and supporting cases of MOA throughout the pandemic has been challenged	0 (0) [0]	0.8 (2) [1.3]	6.8 (17) [11.3]	25.7 (64) [42.7]	26.9 (67) [44.7]

Table 5: Survey Responses on Items Related to Centralized/Systemic Support

Centralized/Systemic Support					
Survey Item	**Strongly Disagree** % (n) [valid %]	**Disagree** % (n) [valid %]	**Neutral** % (n) [valid %]	**Agree** % (n) [valid %]	**Strongly Agree** % (n) [valid %]
Efforts to prevent MOA throughout the pandemic have been well coordinated across service systems, sectors, and disciplines	10.8 (27) [22.1]	21.7 (54) [44.3]	10.8 (27) [22.1]	4.0 (10) [8.2]	1.6 (4) [3.3]
Efforts to identify/detect older adults at risk of or being victimized by MOA throughout the pandemic have been well coordinated across service systems, sectors, and disciplines	12.0 (30) [24.8]	22.1 (55) [45.5]	8.4 (21) [17.4]	4.8 (12) [9.9]	1.2 (3) [2.5]
Efforts to respond to and support cases of MOA throughout the pandemic have been well coordinated across service systems, sectors, and disciplines	11.6 (29) [24.4]	20.9 (52) [43.7]	10 (25) [21.0]	4.4 (11) [9.2]	0.8 (2) [1.7]
A common understanding about the definition and meaning of MOA exists across provincial, territorial, and federal jurisdictions, sectors, and service systems	10.4 (26) [21.3]	18.9 (47) [38.5]	10.4 (26) [21.3]	6.8 (17) [13.9]	2.4 (6) [4.9]
Older adults from diverse communities, social locations, socio-economic statuses, and geographic areas have been able to access internet-based, remote forms of communication and service delivery throughout the pandemic	12.9 (32) [26.7]	17.7 (44) [36.7]	12.9 (32) [26.7]	4.4 (11) [9.2]	0.4 (1) [0.8]
Systems designed to collect MOA-related data and information at provincial,	11.2 (28) [24.8]	15.3 (38) [33.6]	14.9 (37) [32.7]	3.2 (8) [7.1]	0.8 (2) [1.8]

territorial, or federal levels have worked well throughout the pandemic					
Emerging knowledge throughout the pandemic related to lessons learned or best practices on preventing, identifying/detecting, or responding to MOA has been effectively shared across jurisdictions and service systems	11.2 (28) [23.9]	16.5 (41) [35.0]	12.9 (32) [27.4]	6.0 (15) [12.8]	0.4 (1) [0.9]
Enough resources have been available throughout the pandemic to offset gaps in fundraising activities	14.1 (35) [30.2]	16.1 (40) [34.5]	12.0 (30) [25.9]	4.0 (10) [8.6]	0.4 (1) [0.9]
Resources directed toward evaluating and identifying evidence-based practices in preventing, identifying/detecting, or responding to MOA throughout the pandemic have been sufficient	13.3 (33) [28.9]	16.5 (41) [36.0]	12.0 (30) [26.3]	3.6 (9) [7.9]	0.4 (1) [0.9]
Overall, gaps have existed at systemic or structural levels as it relates to addressing or preventing MOA throughout the pandemic	1.6 (4) [3.3]	2.0 (5) [4.1]	5.6 (14) [11.4]	16.5 (41) [33.3]	23.7 (59) [48.0]

Appendix B: Survey of Service Providers and Stakeholders

Survey to Understand Gaps and Challenges in Preventing and Addressing Older Adult Mistreatment in the Community During the COVID-19 Pandemic

Preamble

The mistreatment of older adults (MOA) is a pervasive issue with serious consequences affecting approximately 1 in 10 community-dwelling older adults in Canada (Burnes et al., 2022)[2]. MOA comprises several subtypes including financial, emotional/psychological, physical and sexual abuse, and neglect by others. MOA is defined differently across jurisdictions in Canada, which complicates a capacity to reach consensus (Beaulieu & St-Martin)[2]. However, for the purpose of this survey, MOA will be defined according to the World Health Organization 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*.

The COVID-19 pandemic and associated response measures put in place to reduce community spread (e.g., stay-at-home mandate, self-isolation, social distancing) have had a profound impact on older adults, as well as the services and organizations that serve them. The pandemic circumstances magnified a set of conditions among older adults such as heightened levels of social isolation, poor health, and dependency on others, which represent known MOA risk factors, as well as limited access to social services, medical care, and other informal social support structures. Accordingly, studies have found that the prevalence of MOA has almost doubled during the pandemic, and that efforts to prevent and address this issue in the community have been challenging. **The purpose of this survey is to understand the gaps and challenges in preventing and addressing MOA in the community in Canada that have been exacerbated or exposed during the COVID-19 pandemic.**

This survey is being conducted on behalf of the Federal/Provincial/Territorial Ministers Responsible for Seniors Forum in Canada. It was developed by Dr. David Burnes at the University of Toronto and Dr. Marie Beaulieu at the Université de Sherbrooke. Results from this survey will help inform future MOA prevention and response efforts. You are being invited to participate in this survey based on your expertise and commitment to addressing MOA issues. Your perspective is valued, and we greatly appreciate you taking the time to fill out this survey. The survey will take approximately 20 minutes to complete.

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[2] Burnes, D., Pillemer, K., Rosen, T., Lachs, M.S., & McDonald, L. (2022). Elder abuse prevalence and risk factors: Findings from the Canadian Longitudinal Study on Aging. *Nature Aging*, 2, 784-795. doi:10.1038/s43587-022-00280-2

[2] Beaulieu, M. & St-Martin, K. (2022). Enhancement of Canadian Data on the Abuse of Older Persons: An exploratory study - Final Report. Report produced for the Department of Justice Canada. 127p.

Please note that your responses to this survey are anonymous and will be assigned to a random survey ID number that cannot be traced to your identity. The survey itself does not collect personally identifiable information. Survey response data will only be analyzed and reported in aggregate.

Section 1: Basic Information

Which province or territory do you work in?

Alberta British Columbia Manitoba New Brunswick Newfoundland and Labrador Nova Scotia Ontario Prince Edward Island Quebec Saskatchewan Northwest Territories Nunavut Yukon

Which of the following best describes the geographical context of where you work?

Urban Suburban Rural

Please select one or more of the following categories that best describe your main role and responsibilities as they relate to the issue of MOA

Practitioner Advocacy Policy Research Other_____

Please select one of the following categories that best describes the sector of your employment:

Government Healthcare Social Service Post-Secondary Education Business Other_____

Does your role involve direct service provision with older adults?
Yes No

With which age category do you identify?_____

Less than 25 25 - 39 40 - 59 60 - 74 75 or more

Do you identify as:

Female Male Non-Binary Two-Spirit Prefer Not to Answer
Prefer to Self-Identify_____(open)

Do you identify as any of the following? Choose all that apply.

First Nations Inuk (Inuit) Métis citizen Indigenous – other Member of an ethno-cultural or a visible minority group Member of the LGBTQ2 community Person with a disability Member of an official language minority community (French-speaking communities outside Quebec and English-speaking communities in Quebec) None of the above Prefer not to answer

Section 2: Primary Prevention of Mistreatment of Older Adults (MOA) in the Context of the COVID-19 Pandemic

Primary prevention efforts are important in *preventing MOA from occurring in the first place*. Please indicate the extent to which you agree or disagree with the following statements as it relates to various aspects of primary MOA prevention.

(*Awareness*) There have been enough awareness raising initiatives about MOA throughout the pandemic directed toward the general public

Strongly disagree Disagree Neutral Agree Strongly Agree N/A

(*Diversity*) Awareness raising initiatives directed toward the general public about MOA throughout the pandemic have taken the needs and experiences of diverse communities into account

Strongly disagree Disagree Neutral Agree Strongly Agree N/A

(*Awareness*) There have been enough awareness raising initiatives about MOA throughout the pandemic directed toward professionals who work with older adults

Strongly disagree Disagree Neutral Agree Strongly Agree N/A

(*Training*) Education and training initiatives directed toward professionals who work with older adults on how to recognize signs of MOA have been available throughout the pandemic

Strongly disagree Disagree Neutral Agree Strongly Agree N/A

(*Isolation*) Service workers (healthcare, social service) have had difficulty reaching out to or connecting with at-risk older adults throughout the pandemic, including periods of stay-at-home or self-isolation mandates

Strongly disagree Disagree Neutral Agree Strongly Agree N/A

(*Isolation*) Family and friends have had difficulty reaching out to or connecting with at-risk older adults throughout the pandemic, including periods of stay-at-home or self-isolation mandates

Strongly disagree Disagree Neutral Agree Strongly Agree N/A

(*Isolation*) Older adults have had difficulty engaging with social activities in their communities throughout the pandemic (e.g., senior centres, day programs, faith-based gatherings)

Strongly disagree Disagree Neutral Agree Strongly Agree N/A

(*Remote Communication*) Remote/virtual forms of live interpersonal communication such as telephone or video-conferencing platforms have represented feasible and suitable ways of connecting with at-risk older adults

Strongly disagree Disagree Neutral Agree Strongly Agree N/A

(*Remote Communication*) Remote digital forms of written communication such as email, chat, or instant messaging have represented feasible and suitable forms of connecting with at-risk older adults

Strongly disagree Disagree Neutral Agree Strongly Agree N/A

(*Personal Care)* Older adults living with physical, cognitive or functional limitations have had difficulty accessing at-home personal care support throughout the pandemic, either through paid homecare or unpaid informal caregiving support, to help them with daily care needs

Strongly disagree Disagree Neutral Agree Strongly Agree N/A

(*Caregivers*) Informal caregivers providing care to older adults have experienced heightened levels of stress or burnout throughout the pandemic

Strongly disagree Disagree Neutral Agree Strongly Agree N/A

(*Ageism*) Ageist attitudes, stereotypes or prejudices toward older adults have been elevated throughout the pandemic and have increased older adult vulnerability to MOA

Strongly disagree Disagree Neutral Agree Strongly Agree N/A

(*Isolation*) Older adults have had difficulty accessing supplies in the community throughout the pandemic (e.g., groceries, medication)

Strongly disagree Disagree Neutral Agree Strongly Agree N/A

(*Open-ended*) If Agree or Strongly Agree in prior question: Please identify which supplies have been difficult to access_____

(*Overall*) Overall, it has been challenging to prevent at-risk older adults from experiencing MOA throughout the pandemic

Strongly disagree Disagree Neutral Agree Strongly Agree N/A

(*Open-ended*) If Agree or Strongly Agree in prior question: Please list the top five challenges experienced or gaps identified from your perspective/role in **preventing MOA** throughout the pandemic. If applicable, please use this space to expand upon or explain responses to any survey questions in this section

_____

(*Open-ended*) Based on your experience dealing with gaps and challenges, please describe any lessons learned or best practices that have evolved or been developed in approaching MOA prevention throughout the pandemic_____

As your organization moves forward into possible future waves of the pandemic, in what ways could you continue to evolve or apply lessons learned in approaching MOA prevention?_____

Section 3: Identification and Detection of the Mistreatment of Older Adults (MOA) in the Context of the COVID-19 Pandemic

A key step within the process of addressing MOA in the community is to *identify or detect older adults who are at-risk of or experiencing MOA*. Please indicate the extent to which you agree or disagree with the following statements as it relates to **identifying and detecting MOA cases** throughout the pandemic.

(*Personal Protective Equipment*) The use of personal protective equipment (e.g., hazmat suits, masks, gloves) throughout the pandemic has made it challenging to identify/detect older adults at risk of or experiencing MOA

Strongly disagree Disagree Neutral Agree Strongly Agree N/A

(*Social Distancing*) Social distancing requirements and restrictions to in-person services (e.g., medical, social services, legal) throughout the pandemic have made it challenging to identify/detect older adults at risk of or experiencing MOA

Strongly disagree Disagree Neutral Agree Strongly Agree N/A

(*Remote Interpersonal Services*) Use of remote/virtual forms of live interpersonal service delivery such as telephone or video-conferencing platforms throughout the pandemic have made it challenging to identify/detect older adults at risk of or experiencing MOA

Strongly disagree Disagree Neutral Agree Strongly Agree N/A

(*Remote Digital Services*) Service delivery using digital forms of written communication such as email, chat, or instant messaging throughout the pandemic have made it challenging to identify/detect older adults at risk of or experiencing MOA

Strongly disagree Disagree Neutral Agree Strongly Agree N/A

(*Isolation*) Older adults at risk of or experiencing MOA have faced greater difficulties help-seeking or reaching out to services throughout the pandemic

Strongly disagree Disagree Neutral Agree Strongly Agree N/A

(*Perpetrator Tactics*) Perpetrators of MOA could more easily use tactics throughout the pandemic to divert attempts by service providers or concerned family/friends to identify/detect older adults at risk of or experiencing MOA

Strongly disagree Disagree Neutral Agree Strongly Agree N/A

(*Diversity*) My organization understood how to adapt our approach in identifying/detecting older adults at risk of or experiencing MOA throughout the pandemic based on the varying needs and vulnerabilities of older adults from diverse communities and identities

Strongly disagree Disagree Neutral Agree Strongly Agree N/A

(*Organizational Capacity*) My organization has had the resources, technology, and tools needed to pivot and adapt throughout the pandemic to identify/detect older adults at risk of or experiencing MOA

Strongly disagree Disagree Neutral Agree Strongly Agree N/A

(*Organizational Capacity*) My sector or organization has experienced instability, changes, or shortages in workforce personnel throughout the pandemic that have made it challenging to identify/detect older adults at risk of or experiencing MOA

Strongly disagree Disagree Neutral Agree Strongly Agree N/A

(*Overall*) Overall, the process of identifying or detecting older adults at risk of or experiencing MOA throughout the pandemic has been a challenge

Strongly disagree Disagree Neutral Agree Strongly Agree N/A

(*Open-ended*) If Agree or Strongly Agree in prior question: Please list the top five challenges experienced or gaps identified from your perspective/role as it relates to **identifying or detecting** older adults at risk of or experiencing MOA throughout the pandemic. If applicable, please use the space to expand upon or explain responses to any survey question in this section_____

(*Open-ended*) Based on your experience dealing with gaps and challenges, please describe any lessons learned or best practices that have evolved or been developed in identifying or detecting older adults at risk of or being victimized by MOA throughout the pandemic_____

As your organization moves forward into possible future waves of the pandemic, in what ways could you continue to evolve or apply lessons learned in the process of identifying or detecting older adults at risk of or being victimized by MOA?_____

Section 4: Response and Support Intervention for the Mistreatment of Older Adults (MOA) in the Context of the COVID-19 Pandemic:

Another important phase within the process of addressing MOA is *responding to and supporting older adults who are experiencing MOA*. Please indicate the extent to which you agree or disagree with the following statements as it relates to responding to and supporting MOA cases throughout the pandemic.

(*Personal Protective Equipment*) Personal protective equipment (e.g., hazmat suits, masks, gloves) has been available throughout the pandemic when needed to respond to and support older adults experiencing MOA

Strongly disagree Disagree Neutral Agree Strongly Agree N/A

(*Personal Protective Equipment*) The use of personal protective equipment throughout the pandemic (e.g., hazmat suits, masks, gloves) has made it challenging to effectively respond to and support older adults experiencing MOA

Strongly disagree Disagree Neutral Agree Strongly Agree N/A

(*Social Distancing*) Social distancing requirements and restrictions to in-person services (e.g., medical, social services, legal) throughout pandemic have made it challenging to effectively respond to and support older adults experiencing MOA

Strongly disagree Disagree Neutral Agree Strongly Agree N/A

(*Isolation*) Reaching out to and making contact with older adults experiencing MOA throughout the pandemic, including periods of stay-at-home or self-isolation mandates, to provide response and support has been a challenge

Strongly disagree Disagree Neutral Agree Strongly Agree N/A

(*Remote Interpersonal Services*) Use of remote/virtual forms of live interpersonal service delivery such as telephone or video-conferencing platforms throughout the pandemic have made it challenging to effectively respond to and support older adults experiencing MOA

Strongly disagree Disagree Neutral Agree Strongly Agree N/A

(*Remote Digital Services*) Service delivery using digital forms of written communication such as email, chat, or instant messaging throughout the pandemic have made it challenging to effectively respond to and support older adults experiencing MOA

Strongly disagree Disagree Neutral Agree Strongly Agree N/A

(*Perpetrator Tactics*) Perpetrators of MOA could more easily mistreat older adults or use tactics to divert attempts by services or concerned family/friends to support older adults (e.g., restricting access to older adult) throughout the pandemic

Strongly disagree Disagree Neutral Agree Strongly Agree N/A

(*Remote Transition*) My organization has had a good understanding of how to effectively integrate remote/virtual practices into day-to-day workflow, operations and/or services

Strongly disagree Disagree Neutral Agree Strongly Agree N/A

(*Organizational Capacity*) My organization has had the resources, technology, and tools needed to pivot and adapt throughout the pandemic to effectively respond to and support older adults experiencing MOA

Strongly disagree Disagree Neutral Agree Strongly Agree N/A

(*Organizational Capacity*) My organization has had a good contingency/resiliency plan in place to keep operations going to effectively respond to and support older adults experiencing MOA in the event of employee absenteeism or shortages throughout the pandemic

Strongly disagree Disagree Neutral Agree Strongly Agree N/A

(*Organizational Capacity*) My sector or organization has experienced instability, changes, or shortages in workforce personnel throughout the pandemic that made it challenging to effectively respond to and support older adults experiencing MOA

Strongly disagree Disagree Neutral Agree Strongly Agree N/A

(*Community Networks*) Maintaining collaborative and coordinated efforts with community partners/networks toward responding to or supporting older adults experiencing MOA has been a challenge throughout the pandemic

Strongly disagree Disagree Neutral Agree Strongly Agree N/A

(*Organizational Capacity*) Staff at my workplace have felt informed enough about COVID-19 to safely work toward effectively responding to and supporting older adults experiencing MOA

Strongly disagree Disagree Neutral Agree Strongly Agree N/A

(*Diversity*) My organization understood how COVID-19 affected older adults from diverse communities and identities differently

Strongly disagree Disagree Neutral Agree Strongly Agree N/A

(*Diversity*) My organization understood how to adapt our approach in responding to and supporting cases of MOA based on the varying needs and vulnerabilities of older adults from diverse communities and identities

Strongly disagree Disagree Neutral Agree Strongly Agree N/A

(*Service Availability*) Community social services have been available and equipped to effectively respond to and support older adults experiencing MOA throughout the pandemic

Strongly disagree Disagree Neutral Agree Strongly Agree N/A

(*Open-ended*) If Strongly Disagree or Disagree in prior question: Please identify gaps or challenges in the community social services sector in effectively responding to and supporting cases of MOA_____

(*Service Availability*) Healthcare services (e.g., hospitals, family doctors, home care) have been available and equipped to effectively respond to and support older adults experiencing MOA throughout the pandemic

Strongly disagree Disagree Neutral Agree Strongly Agree N/A

(*Open-ended*) If Strongly Disagree or Disagree in prior question: Please identify gaps or challenges in the healthcare services sector in effectively responding to and supporting cases of MOA_____

(*Service Availability*) Other services (e.g., legal, courts, financial) have been available and equipped to effectively respond to and support older adults experiencing MOA throughout the pandemic

Strongly disagree Disagree Neutral Agree Strongly Agree N/A

(*Open-ended*) If Strongly Disagree or Disagree in prior question: Please identify gaps or challenges in other service sectors in effectively responding to and supporting cases of MOA_____

(*Overall*) Overall, the system of response in the community for addressing and supporting cases of MOA throughout the pandemic has been challenged

Strongly disagree Disagree Neutral Agree Strongly Agree N/A

(*Open-ended*) If Agree or Strongly Agree in prior question: Please list the top five challenges experienced or gaps identified from your perspective/role as it relates to the **system of community response for effectively responding to and supporting** older adults experiencing MOA throughout the pandemic. If applicable, please use this space to expand upon or explain responses to any survey questions in this section

_____

(*Open-ended*) Based on your experience dealing with gaps and challenges, please describe any lessons learned or best practices that have evolved or been developed in responding to and supporting older adults experiencing MOA throughout the pandemic_____

As your organization moves forward into possible future waves of the pandemic, in what ways could you continue to evolve or apply lessons learned in responding to and supporting older adults experiencing MOA?_____

Section 5: <u>Centralized Systemic/Structural Support</u> in the Context of the COVID-19 Pandemic

An important aspect to understand is the extent to which centralized systemic or structural supports are required in the effort toward addressing and preventing MOA. Please indicate the extent to which you agree or disagree with the following statements

as it relates to *centralized systemic or structural forms of support requiring coordination across systems or jurisdictions*.

(*Systems Coordination*) Efforts to prevent MOA throughout the pandemic have been well coordinated across service systems, sectors, and disciplines

Strongly disagree Disagree Neutral Agree Strongly Agree N/A

(*Systems Coordination*) Efforts to identify/detect older adults at risk of or being victimized by MOA throughout the pandemic have been well coordinated across service systems, sectors, and disciplines

Strongly disagree Disagree Neutral Agree Strongly Agree N/A

(*Systems Coordination*) Efforts to respond to and support cases of MOA throughout the pandemic have been well coordinated across service systems, sectors, and disciplines

Strongly disagree Disagree Neutral Agree Strongly Agree N/A

(Open ended) If relevant, please use this space to expand upon any gaps or challenges in the coordination of efforts across service systems, sectors, and disciplines to prevent, identify/detect, and/or respond to cases of MOA throughout the pandemic

_____

(*Definitions*) A common understanding about the definition and meaning of MOA exists across provincial, territorial, and federal jurisdictions, sectors, and service systems

Strongly disagree Disagree Neutral Agree Strongly Agree N/A

(*Remote Access and Diversity*) Older adults from diverse communities, social locations, socio-economic statuses, and geographic areas have been able to access internet-based, remote forms of communication and service delivery throughout the pandemic

Strongly disagree Disagree Neutral Agree Strongly Agree N/A

(*Data Collection*) Systems designed to collect MOA-related data and information at provincial, territorial, or federal levels have worked well throughout the pandemic

Strongly disagree Disagree Neutral Agree Strongly Agree N/A

(*Knowledge Dissemination*) Emerging knowledge throughout the pandemic related to lessons learned or best practices on preventing, identifying/detecting, or responding to MOA has been effectively shared across jurisdictions and service systems

Strongly disagree Disagree Neutral Agree Strongly Agree N/A

(*Resources – Sustainability*) Enough resources have been available throughout the pandemic to offset gaps in fundraising activities

Strongly disagree Disagree Neutral Agree Strongly Agree N/A

(*Resources – Evaluation*) Resources directed toward evaluating and identifying evidence-based practices in preventing, identifying/detecting, or responding to MOA throughout the pandemic have been sufficient

Strongly disagree Disagree Neutral Agree Strongly Agree N/A

(*Overall*) Overall, gaps have existed at systemic or structural levels as it relates to addressing or preventing MOA throughout the pandemic

Strongly disagree Disagree Neutral Agree Strongly Agree N/A

(*Open-ended*) If Agree or Strongly Agree in prior question: Please list the top five gaps or challenges that exist at centralized systemic or structural levels as it relates to addressing or preventing MOA throughout the pandemic. If applicable, please use this space to expand upon or explain responses to any survey questions in this section

_____

(*Open-ended*) Based on your experience dealing with gaps and challenges, please describe any lessons learned or best practices that have evolved or have been developed at systemic or structural levels as it relates to addressing or preventing MOA throughout the pandemic _____

Moving forward into possible future waves of the pandemic, how can centralized systemic or structural levels of support continue to evolve or apply lessons learned as it relates to addressing or preventing MOA?_____