Abuse In Aging Populations

Executive Summary

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Introduction

Older adults are a growing demographic in Canada, comprising 19% of the population in 2021, with those over the age of 65 outnumbering individuals under 15 years old. Declining community engagement increases the risk of elder abuse (EA), which impacts an estimated 8% of Canadian adults over 65. Police-reported family violence against older adults has been observed in Canada's territories, Saskatchewan, Manitoba, and Alberta. EA remains widely under-reported due to reluctance to disclose, inconsistent reporting systems, and barriers including cultural differences, limited access to services, and digital literacy challenges. Definitions of EA In Canada vary across jurisdictions, complicating identification and response.

Background

Ageism, prejudice, discrimination, and stereotypes based on age negatively affects older adults' health, social engagement, and financial security, and amplifies vulnerability to EA. Further, EA rarely occurs in isolation and intersects with ageism, sexism, ableism, and racism, and structural inequalities that disproportionality impact women, racialized communities, and Indigenous populations.

Key Findings

Scope and Types of Abuse: EA includes physical, psychological/emotional, sexual, financial/material abuse, and neglect, with individuals aged 75 and older at the highest risk. It can occur outside trusted relationships, including in institutional, digital, spiritual, or culturally specific forms.

Consequences: EA results in serious health and social outcomes, including hospitalization, cognitive decline, and higher mortality. Victims are three times more likely to die within a year compared to non-abused peers.

Economic Impact: EA costs Canada an estimated $6 billion annually across healthcare, social services, and criminal justice.

Barriers to Reporting: Personal, familial, and cultural obstacles, including dependency on the abuser, fear, restrictive family dynamics, and lack of culturally sensitive services limit reporting, especially in immigrant and Indigenous populations.

Risk Factors: Vulnerability arises from individual (cognitive/physical impairments, social isolation), relational (family dynamics, caregiver stress), and systemic factors (ageism, limited supports). Perpetrators may have mental health issues, substance use problems, financial dependence, or trauma histories.

Protective Factors and Interventions: Social support, community engagement, resilience, access to services, financial guidance, multidisciplinary collaboration, and screening tools such as the Elder Abuse Suspicion Index (EASI) reduce risk.

Implementation Considerations: Inconsistent screening tools and lack of standardized frameworks hinder identification and intervention. Culturally sensitive practices, harm reduction approaches, and timely assessments improve outcomes.

Continuing Care Risks: Staff-to-resident physical, verbal, and emotional abuse are fuelled by staff shortages, burnout, inadequate training, resident isolation, and limited oversight.

Legislation and Reporting: Alberta's Protection for Persons in Care (PPC) Act guides prevention and reporting in regulated care settings but excludes private arrangements and limits recognized abuse types.

Data Gaps: Older adults, particularly in continuing care or from marginalized populations (Indigenous, LGBTQIA+, immigrants, persons with disabilities), are underrepresented in research. Lack of standardized definitions, culturally sensitive tools, and consistent reporting impedes measurement, prevention, and policy development.

Implications for Practice: Effective EA prevention in continuing care requires enhanced surveillance, accessible culturally sensitive assessment tools, staff training, and interventions that support resident autonomy and safety. Inclusive approaches are essential for equitable, effective prevention and response strategies.

Recommendations

Advancing EA research requires standardized definitions and reliable measurement tools to improve prevalence estimates, enable cross-study comparisons, and support more effective identification and reporting across diverse populations.

Future research must adopt culturally inclusive frameworks, including Indigenous-led studies, and prioritize older adults with cognitive impairments, who are often excluded despite being at increased risk of abuse and reduced ability to report it. Longitudinal designs integrating legal, financial, and medical data, can illuminate patterns of abuse, perpetrator characteristics, and cumulative vulnerabilities. Research should also examine economic and systemic impacts, perpetrator motivations, and risk/protective factors in community and care settings to inform targeted prevention, interventions, and policy.

Conclusion

EA is a pervasive, underrecognized issue with serious consequences, including physical harm, psychological trauma, social isolation, and increased mortality. Gaps in definitions, research, and reporting, as well as social isolation, hinder detection and intervention. Addressing EA requires prioritizing the voices and experiences of older adults – particularly those from marginalized populations – through culturally sensitive, interdisciplinary research to inform prevention, early detection, and intervention

For The Brenda Strafford Foundation, addressing EA within continuing care includes accessible screening and assessment tools, staff training on reporting procedures and recognizing abuse, and support programs that promote resident autonomy while supporting family and caregivers. Collaboration with researchers and advocacy groups can guide best practices, and culturally-informed approaches can help address diverse resident needs. Integrating interventions and technologies, such as monitoring systems or anonymous reporting tools, can further strengthen protections and foster a safe, resident-centered care environment.