

Accessing Healthcare for Older Survivors of Abuse living with Disabilities



WomanACT

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On August 2024, the United Nations passed a resolution that is the next step to establishing an international convention for the rights of older persons. An UN Convention on the rights of older people would be a powerful legally-binding mechanism to safeguard their human rights and dignity across systems, including healthcare.

Introduction

The healthcare system is one of the most frequently engaged public services by survivors of intimate partner violence (IPV) (Williston & Lafrenière, 2013). However, older (aged 55+) IPV survivors frequently encounter difficulties accessing healthcare services due to barriers such as cost, transportation, and a lack of awareness or availability of services and programs that can support them (Sasseville et al., 2022). This is largely due to a disconnect in the communication between healthcare institutions, as well as discriminatory practices and assumptions related to ableism and ageism (Matin et al., 2021).

Ableism has been a strong influential factor in Canadian healthcare settings throughout history (Matin et al., 2021). The Ontario Human Rights Commission (2016) defines ableism as belief systems and social attitudes which devalue persons with disabilities. For example, forced institutionalization used to be a common practice despite evidence that it does not improve physical or mental health (Linton & David, 2022). These discriminatory practices primarily target people with

disabilities but are also experienced by older people, members of the 2SLGBTQ+ community, and those who identify as women (Department of Justice Canada, 2022). Medical institutionalization, an example of ableism in the Canadian healthcare sector, involved isolating people from community and resources, restricting freedoms, and forced sterilization (Department of Justice Canada, 2022). These past and current experiences with medical institutions shape marginalized women's perspectives of healthcare services and may create a sense of fear that their autonomy and connection to others and their community will be taken away "for their own good" (Linton & David, 2022). The lack of perceived safety and understanding from the healthcare system worsens the existing structural barriers experienced by survivors of abuse.

The aim of this brief is to increase awareness of the unique needs and experiences of older survivors living with disabilities in accessing and using health services. It presents a review and synthesis of existing scholarly literature as well as government and community reports about the lived experience of older survivors

with disabilities within the healthcare system. This brief will offer an intersectional analysis about the barriers to access, abuse tactics related to health, experiences with service delivery and health professionals, and how these practices directly and indirectly impact a survivor's health. This brief examines the barriers to physical and material access, the effects of verbal communication and discrimination, and explores how societal standards - such as ableism, sexism, and ageism - affect healthcare services, particularly in cases of sexual abuse. There is a dearth of literature on older IPV survivors living with disabilities in Canada; much of the existing research has only recently been conducted. Thus, the brief will conclude with a discussion of what WomanACT hopes to achieve, including recommended next steps for research and a discussion of promising practices that should be implemented to drive substantial change in the Canadian Healthcare System.

Older Women Living with Disabilities and Violence: A Hidden Population in Healthcare Systems

Women experiencing IPV are more likely than the general public to visit a hospital, especially the emergency department (Hinsliff-Smith & McGarry, 2017).

A study found that 44% of women who were later murdered by their intimate partner had gone to the hospital in the last year, but physicians only identified 5% of IPV cases (Khatib & Sampsel, 2022).

Unfortunately, women with disabilities are often sidelined within the healthcare system due to a combination of socio-economic and structural factors that create barriers which able-bodied individuals do not typically experience (Matin et al., 2021).

This includes non-inclusive language, dismissive or judgmental behaviours, high transportation costs, inaccessible equipment and transportation facilities, and a lack of medical transparency (Matin et al., 2021). A research report published by the DisAbleD Women's Network of Canada (DAWN-RAFH, 2011) provided notable examples of interpersonal and structural abuse by the healthcare system, such as refusal to provide necessary medical services, inappropriate touching by caregivers, being forced to live in unhygienic or inaccessible homes, and control of finances and personal choices.

The combination of living with a disability, being older, and being a woman leads to an intersectional invisibility in the eyes of many systems, including healthcare (Sasseville et al., 2022). Studies have found IPV survivors to be at an increased risk of depression, PTSD, gastrointestinal disorders, heart disease, injuries such as head trauma leading to memory loss and chronic pain, substance use disorders, and sexually transmitted infections (Makaroun et al., 2020). Thus, experiences of short-term and/or prolonged abuse can lead to lifelong disabilities for survivors (Edwards, 2009).

Among older survivors, IPV it is much more likely to be a lifelong issue instead of a new experience. Among a survey of 370 women over the age of 65, around 26.5% report lifelong IPV while 3.5% report the experience having begun in the past 5 years (Makaroun et al., 2020). Many older women with disabilities fear that evidence of abuse will be dismissed as a product of their disability and/or frailties associated with ageing (Marshall, 2016). Regardless of whether an older woman with a disability attempts to advocate for herself, a healthcare professional is much more likely to defer to their own judgment, or to a woman's "carer" who may be harming them

(Gajjalapurna, 2021). Additionally, IPV screening is very rarely done for women beyond child-bearing years despite the reality that older women are at risk of elder abuse and IPV (Makaroun et al., 2020).

The COVID-19 pandemic also exacerbated issues of healthcare access for older women and women with disabilities; a large portion of older women and women with disabilities are immunocompromised and took extra precautions (Evans et al., 2022). Many resources that were previously available were shut down or became inaccessible. During the lockdowns of the pandemic, in-person doctor's appointments became a health risk. Quarantining with one's abusive partner also caused IPV rates to skyrocket (Evans et al., 2022).

A combination of comorbidities and functional decline means the consequences of violence can be more severe for older women (Makaroun et al., 2020). Financial insecurity and poverty also contribute to poor health outcomes for older survivors living with disabilities. In general, older women tend to survive on very little disposable income, if any (Dickinson & James, 2017). Facing recurring challenges in securing safe and stable housing, medicine, and food means a higher likelihood of sickness and injury (Dickinson & James, 2017). Older women are often forced to physically and financially depend on family members, friends, or professionals which can increase the risk of exploitation and abuse (Dickinson & James, 2017).

A Hidden Problem: Sexual Abuse of Older Survivors Living with Disabilities

Social stigma and interpersonal expectations can often hinder a survivor from coming forward about their experience. This is especially true in cases of sexual abuse.

In 2017, Statistics Canada reported that disabled women are 14 times more likely to be sexually assaulted compared to men without a disability (Cotter, 2018). In cases of sexual assault, older women require ambulance involvement 25% of the time and sustain serious physical injury more than 50% of the time (Del Bove et al., 2005).

Ableist and ageist beliefs that older women or women with disabilities are not sexually active or desirable have also created false assumptions that they cannot be victimized (DAWN, n.d.); Decyznski, 2024). These biases can translate into profound gaps in the services, with healthcare professionals overlooking necessary conversations about sexually transmitted infections, birth control, and consent (DAWN, n.d.). This also means that women with disabilities are largely not made aware of accessible facilities that provide physical exams such as breast and vaginal check-ups or other resources that would increase their health literacy and understanding of their bodies and boundaries (Schopp et al., 2010). Consequently, older women with disabilities experiencing abuse are less likely to have the knowledge or capacity to access resources.

These beliefs can create obstacles that prevent older survivors and survivors with disabilities from disclosing or seeking help, while also invalidating the experiences of older survivors affected by sexual violence. This also means that healthcare professionals are unlikely to recognize the signs of abuse and provide adequate support or referral. Consequently, symptoms of trauma such as disorientation, insomnia, and flashbacks exacerbate existing health conditions and contribute to worsening overall health outcomes (Del Bove et al., 2005).

Controlling Healthcare: Dynamics of Abuse Experienced by Older Survivors living with Disabilities

Abusers often limit a survivor's access to healthcare services to further their control. When accessing hospitals and other healthcare institutions, older women with disabilities are much more likely to need accommodations such as translators, ramps, and descriptive audio (Varney, 2016). However, accommodations are not always guaranteed, creating an environment that makes necessary services inaccessible and non-inclusive. These non-inclusive spaces enable abusers to further isolate their victims from the healthcare system as an extension of their abuse and control (Heron & Eisma, 2021). This includes making threats of harm towards a survivor or her dependents if the abuse is disclosed, withholding or manipulating medication, making threats of institutionalization, and cutting off or harming aids such as service animals or accessibility devices (Rajan, 2011).

Another tactic is to accompany a survivor to their appointments and examinations, which makes disclosing to healthcare professionals or screening for abuse much more difficult (Campbell et al., 2022). These tactics make it nearly impossible for an older survivor with disabilities to seek help and can lead to poor health consequences long term, such as worsening symptoms of their pre-existing disabilities or developing additional health problems that go unattended (Schopp et al., 2010).

Recommendations and Promising Practices

Limited research on older IPV survivors living with disabilities in Canada means that most of the current research pertains to only older

women, IPV survivors, or women living with disabilities as distinct groups rather than as intersecting social identities. Due to the intersectional invisibility afforded to this community, it is unsurprising that collecting data and identifying service gaps is a struggle. Given the limitations of the current state of literature, this section offers directions for system changes by drawing on recommendations and promising practices presented in the adjacent research areas of violence against older women and IPV survivors living with disabilities.

Healing from trauma and abuse is most effective when it occurs within a supportive community, rather than in isolation (Weeks et al., 2021). A study by Weeks and colleagues (2021) found that older survivors felt more comfortable disclosing their experiences of IPV with those they recognized as peers and accessing services designed specifically for them. This is also important for older women with disabilities experiencing violence because mainstream services do not currently accommodate the complex health needs related to age, disability and/or IPV experience (Veccio, 2022). DisAbled Women's Network of Canada explains that there is a fundamental lack of understanding about the experiences of older women, women with disabilities, and women experiencing IPV. This contributes to a means lack of inclusive and accessible counselling and resources (Rajan, 2011).

Principles of woman-centred care should be applied in healthcare settings. This means prioritizing emotional connections and recognition of personal autonomy (Tarzia et al., 2020). A woman-centred approach to service delivery and care fosters a trusting relationship and environment with healthcare providers to properly process and heal from their trauma and experiences.

When it comes to IPV interventions in the healthcare setting, universal screenings should be a priority. A study of 4481 middle-aged and older women (over 45 years old) confirmed that performing routine IPV screenings improves detection, service delivery, and the mental and physical health of patients (Makaroun et al., 2020). The Emergency Department is a pivotal entry point for older survivors living with disabilities where screening can lead to warm referrals to specialized IPV or sexual assault care services (Khatib & Sampsel, 2022). It is also essential that there is a system put in place to flag patients who appear multiple times with the same complaint, chronic pain syndromes, mental health concerns, and substance use disorders so that they do not slip through the cracks of service (Khatib & Sampsel, 2022).

Due to the dynamics of abuse and control, recommendations for next steps in improving the performance of the healthcare system must take into consideration the social determinants of health (Matin et al., 2021). For preventative screenings and services to offer effective and meaningful support for older survivors living with disabilities there must also be consideration for wrap-around services such as safe housing and employment options, legal and financial aid, and community resources (Veccio, 2022). To identify and create solutions for inequitable service and access, there is a pressing need to focus on research and programs that centre older survivors in the conversation and prioritize their needs in these spaces.

If you are a woman experiencing abuse, we encourage you to contact a service for support.

Seniors Safety Line:
1-866-299-1011

Assaulted Women's Helpline (AWHL):
1-866-863-0511 TTY: 1-866-863-7868

Fem'aide:
1-877-336-2433 (1-877-FEMAIDE)
TTY: 1-866-860-708

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