



Counterpoint Tools

Resources to Enhance Practice

Take Action
to Prevent Abuse
of Older Adults

The Counterpoint Project—Discussion Paper

Moving From Scrutiny to Strategy: An Analysis of Key Canadian Elder Abuse and Neglect Cases

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1. Introduction

(a) Responding to Elder Abuse and Neglect: The Challenge for Health Care Workers

The population of Canada is aging. In 2001, people over the age of 65 accounted for 13% of the population; in 2011 they are expected to account for 15%, and by 2026 they will form approximately 20% of the population of Canada.¹ People are also living longer lives: average life expectancy reached 80 years for the first time in 2004.² This pattern of aging, combined with advances in technology, means that a greater number of adults are living for lengthy periods of time during which they may face greater vulnerability to abuse. As our population ages, the incidence of elder abuse is likely to increase—if only as a function of demographics.

Like many professionals who work with an older adult clientele, health care and community service workers appreciate that elder abuse is a growing phenomenon, but encounter significant barriers in responding to concerns in the context of their practice. People working in health care and community services are uniquely positioned to detect circumstances of abuse and neglect or identify older adults at risk by virtue of opportunities to interact with older adults in their homes, communicate with their other formal and informal caregivers, and make observations about their health and well-being. By virtue of their mandate to deliver care and services, this community of professionals is also well situated to develop relationships of support that could mitigate against increased vulnerability and further abuse or neglect.

However, in practice, addressing elder abuse and neglect raises difficult questions and poses ethical dilemmas. Here are but a few of the tricky questions health care and community service workers are confronted with on a regular basis:

- What is my obligation to respond to abuse and neglect?
- Does my duty apply to risk of abuse?
- How can I simultaneously adhere to professional practice guidelines, adult protection laws and other relevant legislation, and employer policies?
- What is my duty when these rules appear to conflict?
- What confidentiality rules apply to practice?
- How can I respond to concerns regarding risk in a manner that respects an older adult's right to privacy and independence and decision to live at risk?
- How can I support the older adults I work with to live (and sometimes die) with dignity, and to age in place, without abandoning them to abusive relationships?

¹ Health Canada, *Canada's Aging Population* (Ottawa: Division of Aging and Seniors, 2002) at 3.

² Government of Canada, *Addressing the Challenges and Opportunities of Ageing in Canada*, prepared for the United Nations Commission for Social Development for the 5th Anniversary of the 2002 United Nations Second World Assembly on Ageing (2007) at 5.

- How can I accomplish the above in a context of increasing deinstitutionalization of health care and greater emphasis on community care?

Elder abuse is a complex social problem and the network of rules and guidelines surrounding adult protection can present a maze of information. None of the above questions lends itself to a simple answer, and collectively they begin to illustrate the extent to which addressing elder abuse and neglect may present practitioners with additional daily stressors on top of a job description that is likely very demanding.

The goal of the Counterpoint Project is to produce for health care and community services professionals an assortment of tools that will support practice with respect to elder abuse and neglect prevention and response by clarifying obligations under the various laws that impact on this area. This discussion paper, which will explore the questions outlined above, is intended to lay a foundation for developing these tools.

(b) The Role of Past Court Decisions in Furthering Our Understanding of Elder Abuse and Neglect

This paper uses past court decisions to enhance understanding of elder abuse and neglect law in a number of respects. First, these stories of abuse and neglect are intended to frame our understanding of the social dynamics that conceal elder abuse and neglect, increase an older adult's vulnerability, and present ethical and legal dilemmas in terms of identifying the appropriate response. Second, these cases will provide a backdrop for clarifying the law in different jurisdictions. Finally, the facts underlying these cases will help to ground our discussion in a shared understanding of the meaning of elder abuse and neglect—a subject that is the source of significant controversy.

This paper moves forward from the premise that the dynamics of elder abuse and neglect are best understood in the context of real or invented stories: it is tough to convey in the abstract the social factors that render a person vulnerable to abuse, and it may be difficult to explore prevention and response without reference to specific facts. However, incidents of elder abuse and neglect involve deeply personal information. Court decisions are publically documented in judgments and newspaper articles, and so they present an opportunity to analyze specific incidents of elder abuse and neglect without violating privacy rights. Incidents of elder abuse are also extremely varied. Reviewing a number of stories—in this case six—allows us to provide a rich portrait of the dynamics of vulnerability and potential support.

In order to produce a discussion paper that will be relevant to the practice of a broad range of health care and community service professionals, we have selected cases that represent the diverse intersections among elder abuse and health care and community support. The six cases cover different regions in Canada (different provinces, urban and rural communities), multiple kinds of relationships of abuse and dependency (such as abuse by a family member, paid lay caregiver, health care facility staff, and circumstances where no ostensible caretaking appears to be taking place), different environments (home versus institution), as well as different types of abuse (such as financial abuse, physical abuse and neglect). In order to avoid overwhelming readers with information we have limited the discussion to six recent cases.

Each of the cases discussed in this paper presents a victim of abuse. However, viewed in another light, these decisions also provide an opportunity to discuss how workers can deliver support and assistance to an older adult in a manner that navigates the ethical and legal challenges identified at the outset of this paper. These cases also provide a context for considering the infrastructural changes required to support enhanced practice with respect to elder abuse and neglect. In a sense this paper attempts to re-tell these stories, imagining how different interventions could have produced different, more positive, outcomes for the older adult.

In some instances, making a legally sound decision to honour a capable older person’s decision to live, and die, at risk, is the only proper response. In other circumstances the law permits, if not requires, action. However, in many instances, determining the appropriate intervention is a complex task. Following up on concerns about elder abuse and neglect requires creative problem-solving that respects both an older person’s social reality and legal and professional obligations—not an easy undertaking. The Counterpoint Project was born out of a desire to shed light on this aspect of practice.

In line with our methodology of using the facts surrounding a number of court decisions to ground our discussion of the law and social dynamics, this paper starts with case summaries and then moves on to discuss the law and social context, finally bringing the three elements—law, case facts, analysis of social context—together in the penultimate section of this paper. Having thus framed the challenge, in the final section we will look at where to go from here in terms of supporting practice. We make recommendations for institutional change and for the development of tools to enhance coordinated practice amongst the various communities of professionals with the capacity to collaborate in order to facilitate timely and appropriate action in relation to elder abuse and neglect.

At a glance, below, is an outline of the components of this paper:

Section 1	Project overview and methodology
Section 2	Summary of key elder abuse and neglect cases
Section 3	The meaning of key concepts: elder abuse, neglect and vulnerability
Section 4	Obligations under legislation
Section 5	Health care context including obligations under professional licensing
Section 6	Integration of law, facts and analysis of social dynamics
Section 7	Conclusion and recommendations

2. The Case Studies: Elder Abuse and Neglect in Canada

(a) The Cases

i) *R. v. Grant*³ (New Brunswick)

- Re “failure to provide the necessaries of life” (s. 215(2)(b) of the *Criminal Code*)

Margaret Grant pled guilty to a charge of failing to provide the necessaries of life to her 78-year-old mother. On January 10, 2007, Grant called emergency services and reported that her mother was not feeling well. The paramedics arrived at the home to find Kathleen Grant (the mother) seated in a living room chair, from which she had likely not been moved for several months. The elderly woman was dirty, malnourished, sitting in urine and faeces, and suffering from rotting wounds and gangrene. She died in hospital a few days later.

Margaret Grant was about 45 years old and working as a janitor at the time she was charged with failing to provide the necessaries of life to her mother. Margaret had lived, and shared expenses and responsibilities, with her mother for most of her life. Margaret ran errands, bought groceries and paid rent. She had three children of her own, aged 17, 21 and 25, each of whom had been placed in foster care by the Department of Health and Community Services many years previous. Margaret was an only child.

Kathleen Grant was a widow, predeceased by her husband by over 25 years. She had been diagnosed with peripheral vascular disease. She was referred to a vascular surgeon, but no follow-up appointment took place. She had not seen a doctor since May 2006.

When Kathleen Grant was admitted to hospital on January 10, 2007, she was found to be a “very frail, thin-looking lady with very little response.”⁴ She had advanced gangrene on both legs, with rotting flesh and parts of her bone and tendons exposed. She also had sores on her back, arms, elbow, and ears. Her buttocks were infected and swollen, and some of her organs were exposed. A disease specialist, Dr. Gordon Dow, summarized her condition as being “a terrible state of neglect” he had never seen previously in his practice.⁵ Dr. Dow was of the opinion that her condition had “undoubtedly been present for a prolonged period of time and did not develop acutely.”⁶

Grant was sentenced to four years in prison.⁷

ii) *Vallée*⁸ (Quebec)

- Re exploitation under the Quebec *Charte des droits et libertés de la personne* (art. 48)⁹

³ *R. v. Grant*, 2009 NBPC 17 [*Grant*].

⁴ *Ibid.* at para. 15.

⁵ *Ibid.*

⁶ *Ibid.*

⁷ This decision has been appealed.

⁸ *Vallée c. Commission des droits de la personne et des droits de la jeunesse*, 2005 QCCA 316, [2005] R.J.Q. 961 [*Vallée*].

⁹ *Charte des droits et libertés de la personne*, R.S.Q. c. C-12, art. 48 [*Charte des droits*].

Roland Marchand, age 81, met Jeanne Vallée, age 47, at the end of 1998. That year Marchand had suffered a number of significant losses: his wife of 60 years passed away; he became legally blind and unable to drive a vehicle; and he was diagnosed with a number of serious health problems, including a heart condition. At the time, Vallée was working as a waitress and also doing housework for a number of older adults, including Marchand. The older man fell in love with Vallée and proposed marriage to her in the fall of the following year.

During 1999, Marchand, previously very conservative with his funds, drastically changed his spending practices to the point that by the end of 2001 he had spent all of his \$118,000 in savings and owed income taxes that he was unable to pay. Between November 1999 and February 2000 Marchand bestowed upon Vallée the following gifts: payments on a house (\$15,000); a ring (\$9,000); and a vehicle (\$29,000). He gave her a necklace valued at \$3,599 in November 2000. Marchand made subsequent payments toward the purchase of a home.

Marchand had two daughters. Vallée required Marchand to distance himself from his daughters as a condition of maintaining her affection.

In September 2001, Marchand was declared incapable and the Human Rights Commission filed a complaint that Vallée had violated Marchand's right to be free from exploitation under the Quebec *Charte des droits*. At trial medical evidence indicated that Marchand had suffered from dementia associated with Alzheimer's since at least late 2000, and that he likely developed the disease in 1997 or 1998.

At trial, Vallée was ordered to pay to Marchand \$66,599 in damages: \$20,000 for moral damages, \$10,000 punitive damages, and \$36,599 in damages to compensate Marchand for material losses. The Court of Appeal upheld the judgment.

iii) ***R. v. Chartrand*¹⁰ (Ontario)**

- Re “failure to provide the necessities of life” (s. 215(2) of the *Criminal Code*)

Daniel Chartrand was found guilty of failing to provide the necessities of life between January 1, 2005 and August 19, 2005 to Henry Matthews, a 76-year-old man with Parkinson's disease. Matthews had agreed to pay \$3,000 a month to Chartrand in exchange for caregiving services. Matthews had also provided financial assistance to Chartrand and signed guarantees for his debts in previous years.

In July 2005, a neurologist had noticed a significant deterioration in Matthews' mental and physical health. Dr. Stotts opined that this was attributable to poor nutrition and a lack of lifeline support.¹¹ He had informed Chartrand that Matthews was “in need of care on a daily basis and that if Chartrand was not prepared to deliver that care, Matthews would have to be institutionalized, or at least placed under someone else's care.”¹²

¹⁰ *R. v. Chartrand*, [2009] O.J. No. 1742 [*Chartrand*].

¹¹ The expression “lifeline support” refers to an easily accessible emergency response system.

¹² *Ibid.* at para. 50.

On August 19, 2005, a neighbour called emergency services to Matthews' home. The ambulance staff found Matthews lying on his back on his bedroom floor, among multiple urine and faeces stains. Matthews was taken to hospital where he was found to be suffering from mild dehydration.

Upon discharge from hospital, Matthews was admitted to the Sterling Place Retirement Home. Hospital staff believed that returning Matthews to his home would give rise to a number of life-threatening concerns such as head injuries, risks of falling, and broken or fractured hips, each of which could lead to death, unsanitary conditions and other potential health hazards.¹³ Employees at the retirement home described Matthews as emaciated, with bones protruding and his face extremely drawn, and as not able to care for himself. Upon receiving close care from a registered nurse, Matthews' physical and mental health improved. He died approximately two years later, in 2007.

iv) ***R. v. Foubert***¹⁴ (Ontario)

- Re Assault (s. 265(1) of the *Criminal Code*)

Allan Foubert was a personal support worker at the Perley and Rideau Veterans' Health Centre ("PRVHC") for ten years. His job duties involved caring for elderly residents by assisting them with their daily living needs, including feeding, bathing and toileting. He worked in a locked wing for veterans who had been diagnosed with Alzheimer's or dementia. Employees at PRVHC noticed bruising to residents who had been in Foubert's care and contacted Ottawa Police Service. After the police investigation, Foubert pled guilty to assaulting four residents and three employees. The facts of those assaults are as follows:

1. On February 14, 2006, a nurse witnessed Foubert assault Ernest Carter, who was 92 years old at the time. Foubert lifted Carter by the arm and leg and then dropped him onto the bed with his buttocks soiled. Foubert also scolded Carter by yelling repeatedly, "See what happens when you don't listen."
2. On February 20, 2007, a personal support worker witnessed Foubert assault Robert Lowe, who was 84 years old at the time. Foubert held Lowe over his wheelchair, while impatiently instructing the support worker to change him. Foubert refused to put him down on the bed, despite the fact that Lowe stated, "Put me down. You're hurting me."
3. On February 21, 2007, a personal support worker witnessed Foubert assault Lomer Luceyer, who was 81 years old at the time. Luceyer had bit the support worker in the hand. In an angry response, Foubert squeezed Luceyer's hand hard. Luceyer yelled out: "Let go of my hand, you're hurting me." Luceyer's hand was swollen, purple and puffy immediately after the incident.
4. Sometime in February 2007, a personal support worker witnessed Foubert assault Arthur Kinchen, who was 85 years old at the time. Foubert forcefully kneed Kinchen in the hand twice. Kinchen suffered bruises and broken bleeding skin on his hand.

¹³ *Ibid.* at para. 27.

¹⁴ *R. v. Foubert*, [2009] O.J. No. 5024 [*Foubert*].

Between June 1, 2004 and February 28, 2007, Foubert also exhibited some strange and abusive behaviour toward employees including three incidents where he threw co-workers over his shoulder and then ran down the corridor. All three of these employees made it clear that they did not consent to Foubert's behaviour.

Employees who reported abuse experienced high levels of stress and were either called a "snitch" by other workers or made to feel uneasy after notifying the authorities.

Foubert was sentenced to eight months' imprisonment, with two years' probation, and was prohibited from possessing weapons for ten years.

v) ***R. v. Matthias***¹⁵ (British Columbia)

- o Re Second degree murder/Manslaughter (s. 229(a)(ii) of the *Criminal Code*)

On August 1, 2008, Parker Kooper Matthias called emergency services to his home in Blackpool, British Columbia. Police and ambulance crew arrived at the home to find Matthias's mother, Kathleen Jennings, lying on the floor with severe burn injuries. Apart from her blue jeans, all of her clothing had burned or melted off. Jennings died five days later as a result of her injuries.

Matthias was 52 years old at the time. He had been addicted to alcohol for approximately thirty years and to cocaine for approximately ten years. He was also HIV positive with Hepatitis. Police had attended the home on many occasions for issues relating to the mental health of Matthias. He had previously been hospitalized for being at risk of causing harm to himself or others, from age 19 onward. His symptoms included paranoia, depression, and suicidal thoughts. He was taking medication for depression and anxiety. He was known to both the operator who answered the 911 call and the paramedics who arrived on scene.

Kathleen Jennings was 79 years old when she died. Although she had a long-term relationship with a man named "Art", she did not have a spousal partner at the time of her death. She had two other adult children who are, respectively, nine and seven years older than Matthias.

Matthias and his mother lived alone together in a trailer. For income, they relied on her government pension and his disability allowance. Both of them contributed towards the cost of their home. Matthias and his mother appeared to be socially isolated. They occasionally went shopping for groceries and liquor, but they did not know anyone who was living in the community. They had a habit of drinking alcohol together and would often argue while drinking. Matthias had broken a number of windows during one of these previous arguments. In summarizing the evidence, the judge stated with respect to Matthias's isolation: "He is clearly very much alone and disconnected from others."¹⁶ The judge also described Matthias as "dependent" on his mother.¹⁷

On August 1, 2008, Matthias and his mother were having an argument about the renovations to their trailer. In an attempt to scare his mother and cause her to "shut up," Matthias poured gasoline on the trailer floor and tried to light the gasoline. When she did not react as he had hoped, he

¹⁵ *R. v. Matthias*, 2009 BCSC 1729, [2009] B.C.J. No. 2514 [*Matthias*].

¹⁶ *Ibid.* at para. 82.

¹⁷ *Ibid.* at para. 104.

proceeded to pour gasoline on his mother's purse and set her purse on fire. Then he poured gasoline on her dog while the dog was in her lap. Then he set his mother and the dog on fire. The fire lasted 45-60 seconds before Matthias put out the flames, using blankets and a hose.

Matthias was found not guilty of second-degree murder, but guilty of manslaughter.¹⁸

vi) ***R. v. Morin*¹⁹ (Alberta)**

- Re Assault (s. 265 of the *Criminal Code*)
- Assault with a weapon (hairbrush, phone, and cane) (s. 267(a) of the *Criminal Code*)
- Confinement without lawful authority (s. 279(2) of the *Criminal Code*)
- Uttering a death threat under (s. 264.1(1)(a) of the *Criminal Code*)

Clifford Leo Morin was charged with four counts: assault; assault with a weapon; confinement without lawful authority; and uttering a death threat, all in relation to his elderly mother. From November 1, 1999 to July 4, 2002, he lived with his mother, Elizabeth Lussin. They shared an apartment and living expenses. He was responsible for household chores and tending to his mother's needs. Lussin was receiving regular treatment from specialist doctors and a medical caregiver, Jan Cooper. Morin was involved in caring for his mother and became obsessed with his mother's treatment. In particular, he became irritated with her scratching.

Lussin had another adult child, June Yuedall. The relationship between Morin and his sister was significantly strained by the sadness and frustrations over their mother's condition. Morin admitted to experiencing frustration and "a good deal of stress" while carrying out his responsibilities. He was prone to yelling at his mother. In order to control his mother's scratching, he would put mittens on her hands. He would also bind her to her bed, or a chair, and cover her with blankets. On one occasion he was overheard threatening to throw his mother off the balcony of their home.

On July 4, 2002, Yuedall observed bruising on her mother's face. She notified the police, who conducted an investigation of Morin. At trial, the judge expressed reasonable doubt about whether Morin intentionally struck his mother with slaps, blows, or used weapons (e.g. a hairbrush, phone, or cane). Morin was found not guilty of assault and assault with a weapon, but guilty of confinement without lawful authority and uttering a death threat.²⁰

(b) Summary of Elder Abuse and Neglect Case Studies

For ease of reference, the following page shows a comparative table that highlights key elements of each case.

¹⁸ To be convicted of a murder, a person must intend to cause bodily harm that he or she knows is likely to cause death or be reckless about whether or not death will occur. This definition of culpable homicide (*Criminal Code*, R.S.C. 1985, c. C.-46, s. 299) is cited in *Matthias*, *supra* note 15, at para. 86. At trial the judge had reasonable doubt as to whether Matthias intended to do anything more than scare his mother, and that Matthias had failed to appreciate, in the moment of lighting the fire, the potential consequences of his actions, however obvious they might have appeared to another person. Matthias's mental illness and agitated state impaired his perception of events: "his thinking was either so narrowly focussed or so generally disorganized ... that he lacked the subjective foresight of consequences, and thus the specific intention required for murder" (at para. 105).

¹⁹ *R. v. Morin*, 2009 ABQB 486, [2009] A.J. No. 889 [*Morin*].

²⁰ *Ibid.* at para. 126.

Table 1: Summary of Elder Abuse and Neglect Case Studies

Case Name	Facts of the Case	Type of Abuse	Criminal Conviction
<i>Grant</i>	Margaret Grant lived with her 78-year-old mother. Grant was the only person with whom her mother had contact during the last months of her life. By the time Grant called 911, her mother was malnourished, sitting in urine and faeces, and suffering from advanced gangrene to the point that some of her organs were exposed. The older woman was seated in a chair from which she had likely not moved for several months.	Neglect	Failure to provide the necessities of life <i>Criminal Code</i> , s. 215(2)(b)
<i>Vallée</i>	Jeanne Vallée worked as a housekeeper for a number of other older adults. In the year after 81-year-old Marchand's wife passed away, Vallée became his housekeeper. The older man quickly fell in love with 47-year-old Vallée. Within a year of meeting Vallée, the man had spent all his life savings on extravagant gifts to Vallée. Marchand suffered from a number of health problems including Alzheimer's associated dementia and blindness. Previously he had been a conservative and prudent spender.	Financial abuse	None Exploitation under the Quebec <i>Charte des droits et libertés de la personne</i> , art. 48 Order to pay damages
<i>Chartrand</i>	Daniel Chartrand was the sole caregiver for 76-year-old Henry Matthews. Matthews paid at least \$3,000 a month for care from Chartrand. Matthews was found in his apartment lying amongst urine and faeces stains, in a state of malnourishment and dehydration. In previous years Matthews had given Chartrand a great deal of money, sometimes as much as \$8,000 a month.	Neglect Financial abuse	Failure to provide the necessities of life <i>Criminal Code</i> , s. 215(2)
<i>Foubert</i>	Allan Foubert was employed as a personal support worker at a veterans' care facility, on a locked wing for residents with dementia and Alzheimer's. Staff witnessed him: (a) apply excessive force to residents, (b) knee a resident in the hand, breaking skin, (c) order a second worker to change a resident while Foubert suspended the resident in mid-air over his wheelchair, and (d) drop a resident with soiled buttocks on a bed, yelling repeatedly, "See what happens when you don't listen."	Dehumanizing and degrading treatment Physical abuse Threats Psychological abuse	4 counts of assault <i>Criminal Code</i> , s. 265(1)
<i>Matthias</i>	Parker Matthias lived alone in a trailer with his 79-year-old mother. In the context of an argument he set his mother on fire, causing burns to half of her body. She died as a result of her injuries.	Physical abuse	Manslaughter <i>Criminal Code</i> , s. 229(a)(ii)
<i>Morin</i>	Clifford Morin shared an apartment with his 75-year-old mother. In order to manage her compulsive scratching, he bound his mother's hands in mittens and restrained her in her bed or a chair. Morin threatened to throw his mother off the balcony.	Physical abuse Forced confinement Threats	- Uttering a death threat, <i>Criminal Code</i> , s. 264.1(1)(a) - Confinement without lawful authority, s. 279(2)

(c) Overview of Case Selection

In the absence of an overarching legal definition of elder abuse, we characterize the above cases as involving elder abuse or neglect. However, for a host of reasons, identifying elder abuse and neglect cases is a conceptually and practically challenging, if not also logically circular, enterprise.

As will be discussed further in section 4, elder abuse and neglect is not a crime *per se*. The above cases present, rather, a selection of recent decisions involving older adult victims who experienced different types of mistreatment that resulted in criminal prosecution or, in Quebec, a human rights violation. The cases include crimes such as assault, criminal neglect and forced confinement and in Quebec, exploitation of an older adult. In each instance what marks these cases as elder abuse and neglect is the fact that in addition to the advanced age of the victim, a relationship of intimacy (family, friend, life partner) or support and assistance existed between the older person and the abuser.

It is challenging to conduct an exhaustive search of elder abuse cases as there is no criminal offence or civil cause of action called “elder abuse.” Researching elder abuse and neglect jurisprudence requires culling cases for subtle reference to the age of a victim or a plaintiff and the facts surrounding the offending behaviour. Hundreds of cases have been documented in Canada over the years as involving older adults who have been mistreated in some way. Many of these decisions, which contain little if no discussion of the circumstances that enhanced an older adult’s vulnerability to abuse, and offer few details that could provide insight into prevention, do not further our understanding of the phenomenon of elder abuse and neglect in a manner that contributes to the goals of the Counterpoint Project. This is often the case with both home invasion cases and abuse of trust civil litigation involving estate planning and financial planning instruments like wills and powers of attorney. So while such cases may form a significant component of the reported cases involving elderly victims, and might meet some definitions of elder abuse, they are not represented in our selection of cases.

For various reasons it is impossible to be certain as to whether the cases we discuss in this paper are representative of elder abuse and neglect in Canada more broadly. One of the problems is that no comprehensive prevalence study of elder abuse and neglect in Canada has been conducted in recent years. The most recent national study was published in 1990.²¹ It found that 4% of participants had recently experienced abuse.²² However, like most studies of elder abuse, by virtue of involving random telephone interviews with older adults residing in private dwellings, it accessed only a sub-group of victims of abuse. We simply do not have access to adequate national statistics on elder abuse and neglect to use as a point of reference.²³

²¹ Elizabeth Podnieks, Karl Pillemer, J. Phillip Nicholson, Thomas Shillington and Alan Frizzel, *National Survey on Abuse of the Elderly in Canada: Final Report* (Toronto: Ryerson Polytechnic Institute, 1990), cited in Elizabeth Podnieks, “National Survey on the Abuse of the Elderly in Canada,” *Journal of Elder Abuse and Neglect* 4(1 & 2) (1992), 5 at 5. Other sources cite the synopsis compiled by Valerie Pottie Bunge and Daisy Locke for Statistics Canada using data from 1999 as the most recent study of elder abuse. See Valerie Pottie Bunge and Daisy Locke, “Family Violence in Canada: A Statistical Profile 2000” (Ottawa: Statistics Canada, 2000), online: <<http://www.statcan.gc.ca/pub/85-224-x/85-224-x2000000-eng.pdf>>. However, the Bunge and Locke study was limited to family violence, only a facet of elder abuse.

²² Podnieks, *ibid.* at 48. Podnieks speculated that the study likely understated the prevalence of elder abuse, at 50.

²³ These circumstances will hopefully change. The National Initiative for the Care of the Elderly currently has funding to conduct research that would lay a foundation for a Canada-wide prevalence study.

More recent studies from other nations present both significantly higher or lower numbers: a study conducted in Israel indicates that 18.4% of older retired adults were exposed to at least one form of elder abuse during the previous 12 months;²⁴ a comparable study from leading researchers in the United Kingdom reported only 2.6%.²⁵ Interestingly, a Spanish study published in 2008 indicated that 1% of adults, age 65 or over, describe themselves as having been a victim of abuse, whereas 4.5% of caregivers of older adults acknowledge having abused an older person.²⁶ All of these studies are partial inasmuch as they exclude older adults who are residents of care facilities. The diverse results of the studies offer very little by way of clarification of the scope of abuse in Canada.

For various reasons, statistics on elder abuse likely under-represent the scope of the problem. It is only recently that elder abuse has emerged on the national agenda and made the headlines—generally as a result of the publicity surrounding a number of the cases discussed in this paper—and still, there remain very few reported criminal cases that fall into the category of elder abuse and neglect. Indeed, underscoring commentary on the cases that make the news is a prevailing concern that there are many similar hidden victims for every reported instance of elder abuse or neglect.

Although we know reported court cases provide but a partial picture of elder abuse and neglect in Canada, it is impossible to accurately determine how partial that picture is. This is because we do not have an accurate figure on the number of instances of elder abuse that result in criminal charges (or human rights complaints in Quebec) but ultimately settle out of court or are not pursued by the state. Also, not all court decisions are reported.

For the purpose of this paper, which is concerned with how to enhance the capacity of health care and social service workers to respond to instances of abuse and neglect, as well as to assist with abuse and neglect prevention, we assembled a set of cases that, collectively, meet the following three criteria. First, each of the decisions is somewhat recent, by virtue of being reported in a law reporter in the late 2000s.²⁷ Second, the group of cases collectively represent diverse circumstances of abuse in a number of respects:

1. They take place in various regions of Canada (Ontario, British Columbia, Alberta, New Brunswick, Quebec);²⁸
2. They involve different types of abusive behaviour (physical abuse, financial abuse, neglect, forced confinement, degrading treatment, verbal abuse, threats);

²⁴ Ariel Lowenstein, Zvi Eisikovitz, Tova Band-Winterstein and Guy Enosh, “Is Elder Abuse and Neglect a Social Phenomenon? Data from the First National Prevalence Survey in Israel,” *Journal of Elder Abuse and Neglect* 21 (2009): 253.

²⁵ Simon Biggs, Jill Manthorpe, Anthea Tinker, Melanie Doyle and Bob Erens, *Mistreatment of Older People in the United Kingdom: Findings from the First National Prevalence Study* (London: Institute of Gerontology, King’s College London, 2009).

²⁶ Isabel Iborra, *Elder Abuse in the Family in Spain* (Valencia: Queen Sofia Centre, 2008).

²⁷ All decisions, except *Vallée*, *supra* note 8, were reported in 2009. *Vallée* was reported in 2005. One case, the *Morin* decision, *supra* note 19, involved facts that occurred up to 12 years prior to the 2009 decision, prosecution having been delayed as a result of the offender’s poor health and own advanced age.

²⁸ This selection reflects our best attempt to provide balance with respect to the different provinces and territories, but due to under-reporting of elder abuse and neglect, the desire to represent different types of scenarios, and the limited length of this paper, it is simply not possible to give even coverage to all the provinces and territories.

3. They involve different crimes under the federal *Criminal Code* (assault, manslaughter, failure to provide necessities of life, assault with a weapon, confinement without lawful authority, uttering threats) as well as exploitation under the Quebec *Charte des droits*; and
4. They cover different contexts (home, institution, urban, rural).

Third, in each case abuse or neglect arose in the context of a relationship of intimacy (family, friend, partner) or support and assistance. The act or omission was committed by someone known to the older adult, thereby excluding cases where the harm was caused by a stranger.

Our selection process was not informed by a consensus regarding the meaning of elder abuse and neglect, but rather by a desire to select cases that would be useful to our enterprise: cases involving known offenders, such as family members and different types of people providing assistance or support to the older adult, are most likely to present opportunities for health care and social service intervention prior to escalation. Mistreatment by strangers, con artists and other people previously unknown to the older adult is more random. This utilitarian rationalization admittedly employs somewhat circular reasoning in terms of defining the term “elder abuse.” However, as will be discussed in the following section, this focus on relationships of intimacy and support and assistance is also consistent with leading trends in definitions of elder abuse and neglect.

A rich but obviously partial portrait of elder abuse and neglect emerges out of the facts contained in these cases. Although it is impossible to know to what extent these six cases represent the broader phenomenon of elder abuse and neglect, these cases certainly present some extreme examples of harm. It should be kept in mind throughout this paper that the category of elder abuse and neglect captures subtler forms of mistreatment, some of which are not criminal behaviour. For example, elder abuse and neglect includes the licensed practical nurse employed in a care facility who regularly fails to assist an older person to use bathroom facilities to the point that the elderly resident contracts repeated bladder infections and is ultimately catheterized;²⁹ it includes the man who persuades his sister to grant him a power of attorney, puts all her wealth into a joint account, and then systematically spends all the woman’s money on his own ventures, including paying off his own pre-existing debts, while neglecting to address his sister’s expenses and significantly compromising her lifestyle; abuse captures the daily demeaning and ageist comments of a grand-daughter who aggravates her grandmother’s pre-existing depression and harms the older woman’s self-esteem while nonetheless providing excellent and often demanding physical care. For various reasons, it is unlikely any of these circumstances would result in criminal prosecution even though all three older adults suffered harm.

Framing our discussion with court cases to some extent focuses our attention on the more extreme facts. The hope is that this approach will allow us to move forward with our thinking about response and prevention while the controversy regarding a definition advances toward a conclusion. Clarifying obligations and options in relation to the most radical examples of elder abuse and neglect may be a first step toward problem-solving through more subtle fact scenarios. As later discussion will illustrate, even when the facts underlying abuse appear extreme, obligations can be muddy, and dilemmas will emerge.

²⁹ We borrow this example from Charmaine Spencer. See *Abuse and Neglect of Older Adults in Institutional Settings: A Discussion Paper Building from English Language Resources* (Ottawa: Mental Health Division, Health Services Directorate, Health Canada, 1994) at 15.

3. Abuse, Neglect and Vulnerability: Clarifying the Meaning of Key Terms

(a) What Is Elder Abuse and Neglect?

What is elder abuse and neglect? This is a complex question. There is no agreed upon definition that underlies provincial or federal law. Definitions of elder abuse and neglect are generally found in policy and academic literature, where there is a lack of agreement about the meaning of the term.

The term “elder abuse” is not defined anywhere in Canadian law, in either legislation or jurisprudence. Rather, Canadian laws that are relevant to the protection of older adults who have been abused or neglected, or may be at risk of abuse or neglect, define the terms “abuse” and “neglect” in the context of legislative regimes designed to protect other categories of adults, such as vulnerable adults or adults in need of protection—categories that capture the circumstance of some older adults who have been mistreated as well as the mistreatment of younger adults whose circumstances meet the criteria set out in the statute. No law that defines abuse in Canada applies exclusively to people over the age of 65.

It is not clear that every form of mistreatment of an older person presents an example of elder abuse. In others words, more than just the advanced age of the victim may be required to mark an act as elder abuse or neglect. However, there is no consensus on the nature of this additional component of the definition.

Most definitions reference harm or mistreatment, or a violation of rights. Many definitions avoid a general statement and instead allow the meaning to emerge from a list and descriptions of categories of abuse that always include the core types of physical, financial and psychological (also called mental or emotional) abuse, and sometimes also include sexual assault, withholding medication or overmedicating a person, abandonment, neglect or forced confinement.

A major theme running through definitions of elder abuse and neglect is the notion of a violation of a trusting relationship. For example, the Toronto Declaration on the Global Prevention of Elder Abuse states:

Elder abuse is a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person.³⁰

Conceptually, the violation of trust approach may be too narrow. It excludes some large categories of criminal activity characterized by targeting older adults for victimization, such as home invasion cases and telephone scams. The violation of trust approach also excludes random acts of violence by strangers. These offences may involve taking advantage of a person’s vulnerability as a result of age and illness as well as repercussions for the victim that are aggravated by age—two common

³⁰ Toronto Declaration on the Global Prevention of Elder Abuse (2002) online:

<http://www.who.int/ageing/projects/elder_abuse/en/> or

<http://www.inpea.net/images/TorontoDeclaration_English.pdf> [Toronto Declaration]. The Toronto Declaration is an international call to action jointly authored by the World Health Organization, the University of Toronto, and the International Network for the Prevention of Elder Abuse. The definition was developed in a multi-disciplinary context. The Toronto Declaration adopts the definition of elder abuse and neglect originally developed by the UK organization Action on Elder Abuse.

markers of older adult exploitation and mistreatment—regardless of the lack of a relationship between the victim and the offender.

From a social policy perspective, what makes elder abuse and neglect of particular urgency is likely the link between age and vulnerability, as well as the growing number of aging vulnerable adults, given demographics. A similar commitment to vulnerable communities fuelled child protection, domestic violence, and violence against women policy development in previous decades. Viewed with the parallel to child abuse in mind, the language of vulnerability and dependency makes sense; this perspective on elder abuse underlies adult protection regimes we will discuss later in this paper that emphasize mandatory reporting, sometimes at the expense of respecting the privacy of an older adult. However, one must be cautious about any parallel to child abuse, for there is no question that the assumption of a connection between age and vulnerability is an over-generalization: a large number of older adults remain healthy, robust and resourceful into old age.

For the purpose of this paper, we focus on abuse that occurred in the context of relationships of dependency, assistance or support, and relationships of intimacy, such as abuse by friends, family, life partners or other loved ones. We avoid the term “trust” for a number of reasons. In Canada “breach of trust” is a legal term with a specific meaning that is likely narrower than the category of behaviour the drafters of the Toronto Declaration intended to capture.³¹ Moreover, identifying whether a relationship is a relationship of trust is a complex question. Older adults are abused by family and friends they cared about, but should not have trusted, as is arguably the case when the dynamics of the relationship reveal a history of abuse, domestic violence or manipulation. People are also often isolated in relationships of inter-dependency with abusive people they do not trust, and yet for various reasons beyond the scope of this discussion paper people stay in these dangerous, unhealthy or unsafe relationships. Do these descriptions denote relationships of trust? “Trust” is as complex a term as “elder abuse” and itself requires significant clarification.

Another slightly controversial aspect of the definition of elder abuse and neglect is the conceptual relationship between “abuse” and “neglect.” Is neglect a type of abuse? Or is neglect a distinct but related concept? For the purpose of this paper, we discuss elder abuse and neglect as an umbrella term that captures a range of acts and omissions that result in harm to an older adult. In the following section, where we describe the law across the country, we indicate whether a statute mentions “abuse” or “neglect” or both. However, these terms are not as discrete as this language might suggest, inasmuch as neglect may be a type of abuse.

Ultimately, although we may grapple over the key elements of a comprehensive definition of elder abuse and neglect, in the context of practice, many of us think we “know it when we see it.” For the purpose of this discussion paper, we set aside the problem of defining elder abuse and neglect and rely on the examples of abuse presented by the six cases discussed in this paper. This paper takes a relationship-of-trust approach insofar as in the cases we discussed all the offenders were known to the victims and an ongoing relationship of dependency, inter-dependency or affection likely existed.

³¹ Any act done by a trustee contrary to the terms of his trust, or in excess of his authority and to the detriment of the trust; or the wrongful omission by a trustee of any act required of him by the terms of the trust. Also the wrongful misappropriation by a trustee of any fund or property which has been lawfully committed to him by a fiduciary character. Every violation by a trustee of a duty which equity lays upon him, whether wilful and fraudulent, or done through negligence, or arising through mere oversight and forgetfulness, is a “breach of trust.” *Black’s Law Dictionary*, with pronunciations, 6th ed., s.v. “breach of trust.”

But this choice is largely pragmatic, routed in the desire to discuss prevention and highlight cases that present missed opportunities for intervention and support.

(b) What Is the Meaning of Vulnerability?

During the late 1980s and early 1990s, the rhetoric of elder abuse and neglect moved away from a paternalistic age-based definition towards an age-neutral, disability model, such that any adult who faced societal challenges was labelled “vulnerable.” Although this analytical shift was intended to be progressive, “vulnerability” has proven to be an inherently problematic concept. There are primarily four arguments against using the term:

1. It is vague, imprecise, and overbroad: under the right conditions, any person may be vulnerable.
2. It masks paternalism and is used to justify otherwise unwarranted intervention.
3. It defines a person based on assumptions associated with a perceived disability or medical diagnosis.
4. It renders factors external to the adult an intrinsic part of an adult’s individual identity.³²

In this paper we employ the word “vulnerable” as an umbrella term to capture the notion of greater risk of abuse or neglect—a concept referenced variously in the different adult protection regimes across the country. But this is a paper about the law, and vulnerability is not, strictly speaking, a legally defined term. Very few statutes define “vulnerable” or “vulnerability.”

Manitoba’s *Vulnerable Persons Living with a Mental Disability Act*, defines a “**vulnerable person**” as “an adult living with a mental disability who is in need of assistance to meet his or her basic needs with regard to personal care or management of his or her property”.³³ As the title of this statute points out, this law, and thus also this definition, apply only to people with mental disabilities. *The Public Guardian and Trustee Act* of Saskatchewan defines a “**vulnerable adult**” as “an individual, 16 years of age or more, who has an illness, impairment, disability or aging process limitation that places the individual at risk of financial abuse.”³⁴ Again, the scope of this definition is limited by context: it applies only vis-à-vis financial abuse. The federal *Criminal Records Act* defines “**vulnerable persons**” to mean:

- Persons who, because of their age, a disability or other circumstances, whether temporary or permanent,
- (a) are in a position of dependence on others; or
 - (b) are otherwise at a greater risk than the general population of being harmed by persons in a position of authority or trust relative to them.³⁵

³² For more information on personhood, see: Centre for Research on Personhood in Dementia, online: <www.crpdc.ubc.ca>

³³ *The Vulnerable Persons Living with a Mental Disability Act*, C.C.S.M. c. V90, s. 1(1).

³⁴ *The Public Guardian and Trustee Act*, S.S. 1983, c. P-36.3, s. 40.5(1).

³⁵ *Criminal Records Act*, R.S.C. 1985, c. C-47, s. 6.3(1).

Canadian laws concerned with either protecting adults who may be either especially vulnerable to abuse or neglect, or mandating protective intervention by the state when certain categories of adults have been mistreated, use combinations of the following expressions to characterize the category of adults who are considered vulnerable to abuse and warrant state protection:

- “unable to seek support or assistance”³⁶
- “physical restraint” or “physical handicap ... illness, disease, injury or other condition that affects their ability to make decisions about the abuse or neglect”³⁷
- “physical or chemical restraint” or “physical or intellectual disability ... illness, disease, injury or other condition”³⁸
- “illness, impairment, disability or aging-process limitation that places the individual at risk”³⁹
- “aged or handicapped person who may be exploited”⁴⁰
- “physical disability or mental infirmity”⁴¹
- “disabled or elderly person”⁴²
- “physical or mental disability or other incapacity”⁴³

We will discuss the concept of protected adults employed in each jurisdiction in greater detail in the following section of this paper. We raise these excerpts from legislation here strictly to clarify the meaning of the term “vulnerable.”

The impact of this diversity is that while adult protection regimes may exist in a number of provinces and territories, the same circumstances of abuse would not necessarily require a response in all jurisdictions.

We rely on the following conceptualization of “vulnerability,” explored in the Vanguard Project:

1. *Vulnerability is relative.* A person is more or less vulnerable. The term does not describe an absolute state.
2. *Vulnerability is relational.* A person is always vulnerable to something, not vulnerable generally.
3. *Vulnerability is not reducible to a disability issue.* A disability or a medical condition may or may not give rise to vulnerability depending on the circumstances. Conversely, other social circumstances may render a person vulnerable whether or not the person has a disability.

³⁶ *Adult Guardianship Act*, R.S.B.C. 1996, c. 6, s. 46(1); *Adult Protection and Decision-Making Act*, Schedule A, S.Y. 2003, c. 21, s. 59(b).

³⁷ *Adult Guardianship Act*, *ibid.*, s. 44.

³⁸ *Adult Protection and Decision-Making Act*, *supra* note 36, s. 59(b).

³⁹ *The Public Guardian and Trustee Act*, *supra* note 34, s. 19.

⁴⁰ *Charte des droits*, *supra* note 9, art. 48.

⁴¹ *Adult Protection Act*, R.S.N.S. 1989, c. 2, s. 3. Newfoundland uses the similar language of physical or mental infirmity: *Neglected Adults Welfare Act*, R.S.N.L. 1990, c. N-3, s. 2(i).

⁴² *Family Services Act*, S.N.B. 1980, c. F-2.2, s. 34(1) and (2).

⁴³ *Adult Protection Act*, R.S.P.E.I. 1988, c. A-5, s. 1(i).

4. *Vulnerability is a social condition.* This social condition may arise out of diverse social factors such as isolation, a lack of education, poverty, absence of citizenship, a language barrier, a mental health diagnosis, an illness, a developmental disability, an addiction, homelessness or housing instability, a history of abuse, gender or sex, gender identity, and/or sexual orientation. These group memberships or characteristics are indicators of vulnerability.
5. *Vulnerability is not an inherent quality.* Vulnerability does not represent a flaw of an individual. Rather, it arises out of the relationship between a person's characteristics and/or circumstances and a potential abuser. The concept of vulnerability would be meaningless without the possibility of abuse and the presence of the individual or institution that might affect the abuse. In this sense vulnerability is a social construction.
6. *Vulnerability is not a static concept.* Social circumstances change and people do too.⁴⁴

Vulnerability is thus socially determined, not inherent to any adult. Below are some of the factors that might indicate vulnerability:

- Current or historical abuse or neglect
- Isolation, including both physical and social
- Lack of supportive family, friends, and other people
- Lack of education
- Low income/poverty
- Absence or uncertainty of citizenship
- Recent immigration
- Language barriers
- Mental health diagnosis
- Illness
- Developmental disability
- Physical challenges or frailty
- Addiction
- Homelessness or housing instability
- Gender/sex
- Gender identity
- Sexual orientation
- Culture of origin, including Aboriginal culture
- Transportation barriers

None of these indicia are themselves entirely determinative, nor are they reflective of any inherent personal challenge of the adult. Rather, this list presents a number of the socially constructed challenges that people may face. For example, sexual orientation is not an inherent challenge; however, discrimination based on homophobia is a socially constructed vulnerability which some adults may be forced to contend with, and which might increase an adult's vulnerability under

⁴⁴ BC Adult Abuse / Neglect Prevention Collaborative, *Vulnerable Adults and Capability Issues in BC: Provincial Strategy Document* (Vancouver: 2009), online: <<http://www.bcli.org/ccel/projects/vanguard#tabs-projects-2>> at 16.

certain circumstances. Disability may be linked to a functional impairment, but it is the lack of accessibility, resources and education in a person's community that connects vulnerability and disability. Vulnerability arises out of the interaction between a personal characteristic or social group membership and a particular abuser or a rigid social norm.

The above list is obviously extremely broad. Under the right circumstances, almost anyone could be vulnerable to abuse.

Vulnerability tends to be characterized by a lack of social power, and vulnerability is relative, existing in degrees. The presence of multiple indicators suggests greater vulnerability.

4. Overview of the Laws Governing the Abuse and Neglect of Older Adults in Canada

(a) Introduction

Canada is a federal state, meaning that the responsibility for making laws in specific areas is divided between the federal and provincial and territorial governments. In practice, there is considerable overlap between federal and provincial legislation, and elder abuse is one area of law where the provinces and territories have created some laws and the federal government has passed others. Whereas criminal laws relevant to elder abuse and neglect are federal, most laws that apply to health, social services, consumer protection and adult guardianship are provincial and territorial. In terms of elder abuse legislation, the provinces and territories have taken varied approaches. Consequently, options for response depend on the region in which a practitioner is delivering services.

Many laws are associated with elder abuse and neglect and they vary from province to province. This section provides an overview of relevant legislation in order to help health care practitioners and community service workers appreciate legal obligations in relation to elder abuse and neglect. This outline of the law:

Subsection (b) Briefly sets out relevant provisions of the federal *Criminal Code*;

Subsection (c) Describes adult protection, domestic violence and other provincial and territorial legislation most relevant to elder abuse and neglect, with an emphasis on where the laws set out obligations to respond to or report concerns;

Subsection (d) Discusses the meaning of mental capacity and its relevance to elder abuse and neglect; and

Subsection (e) Summarizes the law in relation to the confidentiality of personal and health information.

Section 4 of this paper follows a comparative approach, reviewing the various regimes according to type, and distilling the information into a number of tables to facilitate comparison and quick reference.

(b) The Canadian *Criminal Code*

Unlike some American jurisdictions, the Canadian *Criminal Code* (the Code) contains no specific crime of elder abuse or neglect. However, in five of the cases we discuss in this paper, the offender was charged with a crime listed in the Code. The offenders were charged with general crimes such as theft, fraud, assault, confinement without authority, manslaughter (murder without specific intent to kill), uttering threats, and failure to provide the necessities of life (criminal neglect).⁴⁵ The crimes provide the foundation for charging a person with a criminal offence when an older adult is mistreated. However, in practice, not all incidents of mistreatment will result in conviction or prosecution or even fit easily within the criminal law paradigm. In this section we discuss briefly the law around criminal neglect as its meaning is not self-evident and this provision comes up frequently in high profile elder abuse and neglect cases.

Under section 215 of the Code, there is a legal duty to provide the necessities of life to someone under a person's "charge" if that person is (a) unable to withdraw himself from the other person's charge for reasons of "detention, age, illness, mental disorder or other cause", and (b) "unable to provide himself with necessities of life."⁴⁶ The courts have interpreted this description to impose, under certain circumstances, a duty on an adult child to provide adequate care for an aged parent (e.g. *Grant*) and on a paid caregiver to provide adequate care to a client (e.g. *Chartrand*), in circumstances where the older adult was permitted to deteriorate to a state of malnourishment, or reside in a state of astonishingly poor personal hygiene and filth, to the point that the older adult either died or the person's life became endangered.

As the cases contained in this discussion paper illustrate, criminal neglect cases tend to contain extreme examples of neglect, likely in part because the law uses the language of "endangering the life" and "permanent injury."⁴⁷ Consider the two neglect cases highlighted in this paper. Kathleen Grant and Henry Matthews were both found unresponsive and lying or sitting in faeces. Kathleen Grant's gangrene had progressed to the point that organs and bones were exposed and she died within a few days of hospitalization. In the *Chartrand* case, earlier intervention extended the older man's life by a couple years. These two cases reflect the range of neglect cases that are documented in law reporters. However, most reported decisions present facts closer to the appalling circumstances underlying the *Grant* case.⁴⁸

⁴⁵ The vulnerability of a victim by virtue of age can also have an impact on sentencing and in this sense the Code (under section 718.2) treats crimes against older adults as worthy of harsher sentences than crimes against less vulnerable victims. The concept of vulnerability is thus an aspect of the criminal law in relation to elder abuse and neglect.

⁴⁶ *Criminal Code*, *supra* note 18, at s. 215.

⁴⁷ *Ibid.*, (2) Every one commits an offence who, being under a legal duty within the meaning of subsection (1), fails without lawful excuse, the proof of which lies on him, to perform that duty, if

- (a) with respect to a duty imposed by paragraph (1)(a) or (b),
 - (i) the person to whom the duty is owed is in destitute or necessitous circumstances, or
 - (ii) the failure to perform the duty endangers the life of the person to whom the duty is owed, or causes or is likely to cause the health of that person to be endangered permanently; or
- (b) with respect to a duty imposed by paragraph (1)(c), the failure to perform the duty endangers the life of the person to whom the duty is owed or causes or is likely to cause the health of that person to be injured permanently.

⁴⁸ See also, for example, *R. v. Noseworthy*, 2007 Carswell Ont 9064 (Ont. S.C.J.) [*Noseworthy*], *R. v. Nanfo*, 2008 ONCJ 313, 78 W.C.B. (2d) 580, [2008] O.J. No. 2742 (Ont. S.C.J.) [*Nanfo*], and *R. v. Chappell*, Oral decision April 17, 2000 (Ont. S.C. (T.D.)) [*Chappell*]. In *Noseworthy* and *Nanfo* the victims died before the authorities were contacted. In the *Chappell* case the victim died a few days after being removed from Chappell's care.

(c) Adult Protection and Related Legislation

Each province and territory has taken a unique approach to creating laws and obligations in relation to adult abuse and neglect. The differences in approach reflect differing ideologies regarding the importance of intervention for the purpose of protection versus the need to safeguard as much as possible the adult's independence and right to live at risk. Some regimes require reporting if an adult has been abused or neglected; others permit or require intervention in the presence of risk to a vulnerable adult.⁴⁹ Some laws apply only to adults residing in care facilities; others apply to all adults who meet the statutory definition of an adult in need of protection.

No adult protection law applies exclusively to older adults. Instead, the laws create responsibilities vis-à-vis groups of people such as adults at risk, vulnerable adults, persons who may be exploited, victims of violence, and adults in care.

The various legal frameworks can be categorized as follows:

- i) Comprehensive Adult Protection Regimes
- ii) Residential Care Regimes
- iii) Protectionist Regimes
- iv) Patchwork Regimes
- v) Neglect Legislation

This section is comparative. We consider laws from all thirteen jurisdictions. We review the different approaches, highlighting the implications for mandatory reporting or response by health care workers and the protections afforded to the worker who reports abuse.

This section highlights the laws most relevant to practice in each jurisdiction. In each case the regime types emerge out of the interplay between the various relevant laws that exist in each province or territory.

- i) **Comprehensive Adult Protection Regimes
(British Columbia, Yukon, New Brunswick, Prince Edward Island)**

A law that creates a comprehensive regime is a law that deals specifically with adult abuse and neglect. The jurisdictions with comprehensive regimes generally address abuse and neglect as part of a broader guardianship or supported decision-making scheme.⁵⁰

Guardianship and supported decision-making frameworks deal with the appointment of alternative or assistant decision-makers for adults who lack the mental capacity to make their own decisions, a characteristic that can also render an older adult vulnerable to abuse or neglect. Under these regimes

⁴⁹ Also, some jurisdictions discussed later on in this section are silent regarding reporting.

⁵⁰ The term “comprehensive” is not employed to express a value judgment indicating the superiority of this approach. Rather, it simply reflects that these regimes 1. provide for a number of potential responses to abuse and neglect (not strictly, for example, a duty or ability to report abuse), and 2. address abuse and neglect in the context of a statute tailored to address adult protection broadly (as compared with a statute that deals exclusively with domestic violence, one of many forms of elder abuse).

mental capacity becomes a key concept in relation to adult abuse and neglect.⁵¹ Four jurisdictions—British Columbia, the Yukon, New Brunswick and Prince Edward Island—have comprehensive regimes governing adult protection.⁵²

Each law defines a specific class of adults who are protected from a list of forms of abuse and neglect. Comprehensive regimes apply to adults regardless of their living circumstances and so apply to adults living independently as well as adults residing in care facilities.⁵³ The laws grant an agency the power to investigate allegations of abuse and neglect, permit voluntary reporting by any person, and provide people who report suspected abuse (whistleblowers) with protection from legal and employment consequences associated with reporting abuse. These laws also emphasize the innate decision-making autonomy of vulnerable adults, promote consultation with adults in need of protection, and permit or require a broad range of options for intervention. The Prince Edward Island *Adult Protection Act* characterizes the potential assistance that may be provided to the adult in need of protection as follows:

10. Without limiting the generality of section 9, assistance may include provision of, arrangement of, payment for or referral to such services as
 - (a) assessment and case planning;
 - (b) counselling and other social work;
 - (c) speech and hearing therapy;
 - (d) occupational therapy and physiotherapy;
 - (e) respite care and day care;
 - (f) socio-recreational activity and vocational training;
 - (g) homemaker, nutrition, friendly contact;
 - (h) legal counsel and financial management;
 - (i) application for trustee or guardianship functions;
 - (j) residential accommodation and personal or nursing care, and any other health, social or other type of service that may be determined necessary for the person's welfare.⁵⁴

Here is an example from the British Columbia law, the *Adult Guardianship Act*, to demonstrate the obligation to respond to abuse and neglect and the protections afforded to health care workers and other employees who report abuse:

⁵¹ Older adults with Alzheimer's or other diseases that lead to dementia are an example of adults who may not have capacity. Under a guardianship regime, a substitute decision-maker may be appointed for an adult who lacks the mental capacity to make all decisions or a category of decisions. In select jurisdictions, as a less intrusive alternative, it is possible to address limited incapacity through an agreement, authorization or order designating an *assistant* decision-maker. This is possible where capacity is such that a person would be able to handle decisions if they had someone helping them with decision making. We discuss the concept of mental capacity in greater detail in subsection 4(d).

⁵² Nova Scotia also has a general adult protection statute. We discuss Nova Scotia in a separate section as a protectionist regime because, unlike the four jurisdictions characterized in this section as comprehensive regimes, Nova Scotia has in place both an adult protection law and a law that applies exclusively to the protection of adults residing in care facilities. The overall impact of the presence of these two laws is a slightly different legal landscape in terms of adult abuse and neglect.

⁵³ In British Columbia the law governing care facilities also creates a limited duty to report: licensees of care facilities must report and investigate incidents of abuse and neglect pursuant to the *Community Care and Assisted Living Act*, R.S.B.C. 2002, c. 75 and the *Residential Care Regulation*, B.C. Reg. 96/2009, s. 77.

⁵⁴ *Adult Protection Act*, *supra* note 43, s. 10.

Reporting abuse or neglect

- 46 (1) Anyone who has information indicating that an adult
- (a) is abused or neglected, and
 - (b) is unable, for any of the reasons mentioned in section 44 [restraint/handicap/illness, injury, disease that affects mental capacity], to seek support and assistance, may report the circumstances to a designated agency.
- (2) A person must not disclose or be compelled to disclose the identity of a person who makes a report under this section.
- (3) No action for damages may be brought against a person for making a report under this section or for assisting in an investigation under this Part, unless the person made the report falsely and maliciously.
- (4) A person must not
- (a) refuse to employ or refuse to continue to employ a person,
 - (b) threaten dismissal or otherwise threaten a person,
 - (c) discriminate against a person with respect to employment or a term or condition of employment or membership in a profession or trade union, or
 - (d) intimidate, coerce, discipline or impose a pecuniary or other penalty on a person because the person makes a report or assists in an investigation under this Part.
- (5) In subsection 4, “discipline” includes
- (a) a refusal to issue or renew a licence or certificate to practice a profession or trade, and
 - (b) a denial or cancellation of permission to practice in a hospital or a refusal to renew that permission.⁵⁵

British Columbia is somewhat unique in that while reporting abuse is voluntary under the language of the above provision, the regional health authorities are required to investigate suspected abuse and report abuse to the police as well as report suspected crimes against adults protected under this law.⁵⁶ In practice, the health authorities have interpreted these provisions to require mandatory response by all employees of the various health authorities. Therefore, in British Columbia, whether responding to concerns regarding abuse or neglect is mandatory or voluntary depends on the identity of the employer: if you work for a public hospital you must report abuse to a supervisor to generate an investigation and you must report suspected crimes to the police; if you work for a private health care facility or an agency that is not delivering services under a contract with a health authority, then responding to abuse and neglect is voluntary.

Under the Yukon regime, reporting is entirely voluntary, but designated agencies must investigate suspected abuse.⁵⁷ In Prince Edward Island reporting is voluntary and applies to adults at risk of abuse:

4. (1) Any person who has reasonable grounds for believing that a person is, or is at serious risk of being, in need of assistance or protection may report the circumstances in such manner and to such authority or person as may be designated by the Minister.⁵⁸

⁵⁵ *Adult Guardianship Act*, *supra* note 36, s. 46.

⁵⁶ *Ibid.*, ss. 1, 47, 50, 61(a.1), and *Designated Agencies Regulation*, B.C. Reg. 19/2002, ss. 3 and 4. The health authorities include the Fraser Health Authority, the Interior Health Authority, the Northern Health Authority, Vancouver Coastal Health Authority, and Vancouver Island Health Authority. Providence Health Care Society has also been added as a designated agency.

⁵⁷ *Adult Protection and Decision-Making Act*, *supra* note 36, ss. 61(1) and 62(1). Currently, the only designated agency is the Seniors' Services / Adult Protection Unit, which is based in Whitehorse.

⁵⁸ *Adult Protection Act*, R.S.P.E.I., *supra* note 43, s. 4(1).

The New Brunswick *Family Services Act* approach is slightly unique in that adult protection is addressed in the context of a law that deals largely with child protection. A small section of the Act deals with adults in need of protection. The Act makes reporting abuse voluntary for “professional persons,” and permits a professional to share confidential client or patient information to support an investigation:

35.1(1) A professional person may disclose information to the Minister respecting a person whom the professional person has reason to believe is a neglected adult or an abused adult, including information that has been acquired through the discharge of the professional person’s duties or within a professional relationship.⁵⁹

The definition of “professional person” captures most health care and social services workers.⁶⁰

One of the reasons why we describe these four jurisdictions as possessing comprehensive regimes is that where there are concerns regarding abuse the laws provide for a range of options from offering support and community resources to applying for a guardianship order. Also, guardianship orders may be tailored to demand as little intervention into decision making as is necessary to address the protection of the adult and his or her assets. However, these statutes do reflect a tension in the emphasis placed on the autonomy of the vulnerable adult. The Guiding principles of the *Adult Guardianship Act* of British Columbia place high value on the adult’s autonomy and participation in decision making regarding supportive interventions:

Guiding principles

- 2** This Act is to be administered and interpreted in accordance with the following principles:
- (a) all adults are entitled to live in the manner they wish and to accept or refuse support, assistance or protection as long as they do not harm others and they are capable of making decisions about those matters;
 - (b) all adults should receive the most effective, but the least restrictive and intrusive, form of support, assistance or protection when they are unable to care for themselves or their assets;
 - (c) the court should not be asked to appoint, and should not appoint, decision makers or guardians unless alternatives, such as the provision of support and assistance, have been tried or carefully considered.⁶¹

The law also states the following with respect to the involvement of the adult in determining the appropriate response to concerns:

Adult's involvement in decision making

- 52** The designated agency must involve the adult, to the greatest extent possible, in decisions about how to
- (a) seek support and assistance, and

⁵⁹ *Family Services Act*, *supra* note 42, s. 35.1(1).

⁶⁰ *Ibid.*, s. 35.1(5). The provision states:

For the purposes of this section

“professional person” means a worker in any adult day care center or residential or institutional facility, a vocational counsellor or trainer, an educator, a physician, a nurse, dentist or other health or mental health professional, a hospital administrator, a social work administrator, social worker or other social service professional, a police or law enforcement officer, a psychologist, a guidance counsellor or a recreational services administrator or worker and includes any other person who by virtue of his employment or occupation has a responsibility to discharge a duty of care towards an elderly person or a disabled adult.

⁶¹ *Adult Guardianship Act*, *supra* note 36, s. 2.

- (b) provide the support and assistance necessary to prevent abuse or neglect in the future.⁶²

In contrast, the *Adult Protection Act* of Prince Edward Island espouses a set of guiding principles that places mixed emphasis on both protection and autonomy, ultimately granting paramountcy to protection:

Principles

- (a) society has an obligation to afford its members, regardless of individual abilities or conditions, the opportunity to have security and the necessities of life;
- (b) persons afflicted with disability that impairs their capacity to care for themselves deserve that quality of necessary treatment, care and attention that is most effective and yet least intrusive or restrictive in nature;
- (c) although the capacity to express it may be diminished by disability, adults have a need for self-determination and to have their person, estate and civil rights protected;
- (d) an adult is entitled to live in the manner he wishes and to accept assistance or not, provided it is by his conscious choice and does not cause harm to others;
- (e) any intervention to assist or protect a person should be designed for the specific needs of the individual, limited in scope, and subject to review and revision as the person's condition and needs change;
- (f) *in relation to any intervention to assist or protect a person the paramount consideration shall be the best interests of that person.*⁶³

The statutes described in this section tend to be lengthy and detailed. Although they are clustered in this section of this paper to permit comparison and conceptual thinking, each law uses unique language to define the class of adults protected by the law and the interventions permitted by each statute. Practice requires particular knowledge of the statutes that apply in the province or territory in which a health or social services practitioner is delivering services. Table 2 has been included at the end of section 4(c) to outline obligations to respond in each jurisdiction.

ii) Residential Care Regimes (Ontario, Alberta, Manitoba)

In Ontario, Manitoba and Alberta there is no general adult protection legislation. In these provinces there exists instead specific legislation regarding the protection of adults who reside in, or receive services from, certain kinds of institutions.⁶⁴ In these provinces either staff or the general

⁶² *Ibid.* s. 52.

⁶³ *Adult Protection Act*, R.S.P.E.I., *supra* note 43, s. 3 [emphasis added].

⁶⁴ Manitoba also has *The Vulnerable Persons Living with a Mental Disability Act*, *supra* note 33, which applies to a small category of older adults who meet the following definitions:

- **"mental disability"** means significantly impaired intellectual functioning existing concurrently with impaired adaptive behaviour and manifested prior to the age of 18 years, but excludes a mental disability due exclusively to a mental disorder as defined in section 1 of *The Mental Health Act*.
- **"vulnerable person"** means an adult living with a mental disability who is in need of assistance to meet his or her basic needs with regard to personal care or management of his or her property.

The impact of these definitions is that the law applies only to adults who were diagnosed with a mental or developmental disability (not a mental illness) prior to adulthood, and who require assistance with basic personal care or basic financial and property management. The law imposes a mandatory duty on a service provider, substitute decision maker or committee member to report abuse (s. 21(1)), legislates some protection for individuals who make honest reports (s. 162(1) and (2), and makes it an offence, punishable by fine or imprisonment, to fail to report abuse (s. 164(1)). Nova Scotia also possesses a specific law dealing with the protection of care facility residents. Nova Scotia is dealt with in the following section of this paper as overall its system is different because the province has also passed general adult protection legislation.

population is required to report suspected abuse or risk of abuse and the failure to report abuse is an offence.⁶⁵

Ontario's *Long-Term Care Homes Act* is a lengthy statute that applies to private nursing homes and care facilities.⁶⁶ The law deals with many matters concerned with the regulation of care facilities other than abuse and neglect. Under the law operators of care homes have a duty to protect residents from abuse and neglect:

Duty to protect

19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.⁶⁷

The Ontario law also provides that any person other than a resident has a duty to report abuse or risk of abuse to the "Director":⁶⁸

Reporting certain matters to Director

24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act or the *Local Health System Integration Act, 2006*.⁶⁹

The law makes it an offence for any of the following people to fail to report abuse:

- Staff;
- Care home managers;
- Any person who provides professional services to a resident in the areas of health, social work or social services work; and

⁶⁵ *Long-Term Care Homes Act*, S.O. 2007, c. 8, s. 24(5); *The Protection for Persons in Care Act*, C.C.S.M., c.P144, s. 12(1). *Protection for Persons in Care Act*, S.A. 2009, c.P-29.1, s. 7(5). In two other jurisdictions there is a more limited duty to report abuse of adults residing in care facilities. In B.C. and Saskatchewan, licensees of care facilities, i.e. individuals who hold the licence to operate a care facility, are obligated to report abuse and neglect and other critical incidents involving the harm of a resident to specific individuals or agencies. See footnote 53 (B.C.) and footnote 83 (Saskatchewan).

⁶⁶ *Long-Term Care Homes Act*, *ibid.* This law replaced the previous *Nursing Homes Act*, R.S.O. 1990, c. N-7, on July 1, 2010. This newer law applies to a slightly broader category of licensed care facilities housing older adults. Retirement homes are governed by the *Retirement Homes Act 2010*, S.O. 2010, c. 11. According to this law, every person who suspects harm, abuse, neglect or risk must report to the Registrar of the Retirement Homes Regulatory Authority (s. 75(1)) and the licensee must protect residents from abuse and report incidents to the Registrar (ss. 67(1) and 74). These provisions of the *Retirement Homes Act* are not yet in force.

⁶⁷ *Long-Term Care Homes Act*, *ibid.*, s. 19(1).

⁶⁸ The term "Director" refers to a person appointed by the Government, not the director of the particular care home.

⁶⁹ *Long-Term Care Homes Act*, *ibid.*, s. 24(1).

- Any person who provides professional services to a licensee in the areas of health, social work or social services work.⁷⁰

This duty to report applies to confidential information,⁷¹ and employees who make honest reports based on reasonable grounds are protected from discipline or other negative employment consequences.⁷²

The *Protection for Persons in Care Act* of Alberta and that of Manitoba differ from Ontario's *Long-Term Care Homes Act* in a number of respects. First, rather than dealing with the regulation of care facilities more broadly, these shorter statutes deal exclusively with abuse and neglect of adults receiving services from a hospital and other health service agencies. The laws also apply to a broader category of vulnerable adults, in the sense that they apply to adults receiving services from a facility, not exclusively to residents.⁷³

The *Protection for Persons in Care Act* of Alberta and that of Manitoba impose a duty on the general population to report suspected abuse, by virtue of making it an offence punishable by a fine to fail to report abuse to the Ministry responsible for care facilities in the province. Unlike the comprehensive regimes, the residential care regimes deal only with reporting and do not address intervention to support the vulnerable adult or adult guardianship. The duty to report applies to confidential information. In Manitoba the duty also applies to patients at risk of abuse:

REPORTING ABUSE

Duty to report abuse

3(1) A service provider or other person who has a reasonable basis to believe that a patient is, or is likely to be, abused shall promptly report the belief, and the information on which it is based, to the minister or the minister's delegate.

If information confidential

3(2) The duty to report applies even if the information on which the person's belief is based is confidential and its disclosure is restricted by legislation or otherwise. But it does not apply to information that is privileged because of a solicitor-client relationship.⁷⁴

The law further states:

Information and records

6(2) The investigator may require any person who is able, in the investigator's opinion, to give information about the matter being investigated,

(a) to give the information to the investigator; and

(b) to produce for examination or copying any record or other thing — including personal health information as defined in *The Personal Health Information Act* — that, in the investigator's opinion, relates to the matter being investigated and that may be in that person's possession or control.⁷⁵

⁷⁰ *Ibid.*, s. 24(5).

⁷¹ *Ibid.*, s. 24(4).

⁷² *Ibid.*, s. 26(2).

⁷³ The Alberta legislation defines a “client” as “an adult who receives care or support services from a service provider”: *Protection for Persons in Care Act*, R.S.A., *supra* note 65, s. 1(b); the Manitoba law defines a “patient” as “an adult resident, in-patient or person receiving respite care in a health facility,” excluding vulnerable adults covered by *The Vulnerable Persons Living with a Mental Disability Act*: *The Protection for Persons in Care Act*, C.C.S.M., *supra* note 65, s. 1.

⁷⁴ *The Protection for Persons in Care Act*, C.C.S.M., *ibid.*, at s. 3.

⁷⁵ *Ibid.*, s. 6(2).

The Alberta law does not reference risk:

Report of abuse

7 (1) Subject to subsection (6), every individual who has reasonable grounds to believe that there is or has been abuse involving a client shall report that abuse within the time period referred to in section 8(1)

- (a) to a complaints officer,
- (b) to a police service, or
- (c) to a committee, body or person authorized under another enactment to investigate such abuse.⁷⁶

The law is clear that the relationship between the confidentiality of personal and health information and adult protection law is that the duty to report abuse and share information to support an investigation supersedes all concerns regarding confidentiality other than solicitor-client privilege.

The Alberta legislation places an additional duty on health care and social service workers to protect clients from abuse:

Duties of persons who provide care or support services

10 (1) Every service provider or individual employed by or engaged for services by a service provider who provides care or support services to a client has a duty

- (a) to take reasonable steps to protect the client from abuse while providing care or support services, and
 - (b) to maintain a reasonable level of safety for the client.
- (2) Every service provider and individual employed by or engaged for services by a service provider shall take all reasonable steps to provide for the immediate safety, security and well-being of a client in respect of whom a report of abuse is made and any other clients who may be at risk of abuse when the service provider is notified that a report of abuse has been made under this Act.
- ...
- (5) A person who fails to comply with this section is guilty of an offence.⁷⁷

iii) **Protectionist Regime (Nova Scotia)**

Nova Scotia has arguably the most protectionist regime in the country. The province combines aspects of the two previously discussed approaches. Nova Scotia has a split system: the *Adult Protection Act* applies to people living in the community; the *Protection for Persons in Care Act* applies to care facility residents.

We characterize the province as taking a protectionist approach in part because its *Adult Protection Act* imposes a duty on the general population to report abuse of vulnerable adults, regardless of whether or not an adult resides in a private residence or a care facility, and makes failing to report abuse an offence. This approach is in contrast with the comprehensive regimes discussed earlier, which mandate investigation under certain circumstances but generally do not require individuals to report abuse and neglect. The *Adult Protection Act* describes the duty as follows:

⁷⁶ *Protection for Persons in Care Act*, R.S.A. *supra* note 65, s. 7(1). This law has been in force since July 1, 2010. The statute replaced the previous *Protection for Persons in Care Act*, R.S.A. 2000, c.P-29, which stated a duty to report at 2(1).

⁷⁷ *Protection for Persons in Care Act*, R.S.A., *ibid.*, s. 10.

Duty to report information

5 (1) Every person who has information, whether or not it is confidential or privileged, indicating that an **adult is in need of protection** shall report that information to the Minister.⁷⁸

- 3 (b) "adult in need of protection" means an adult who, in the premises where he resides,
- (i) is a victim of physical abuse, sexual abuse, mental cruelty or a combination thereof, is incapable of protecting himself therefrom by reason of physical disability or mental infirmity, and refuses, delays or is unable to make provision for his protection therefrom, or
 - (ii) is not receiving adequate care and attention, is incapable of caring adequately for himself by reason of physical disability or mental infirmity, and refuses, delays or is unable to make provision for his adequate care and attention.⁷⁹

This characterization indicates that the law applies to older adults who are incapable of protecting themselves from abuse or neglect due to a physical disability or mental infirmity.

The *Protection for Persons in Care Act* resembles the regimes discussed in section (ii), with slight differences. The act contains separate provisions that set out, respectively, the duty of health care facility administrators, service providers,⁸⁰ and the general population in terms of responding to abuse:

Duties of administrator of health facility

- 4 (1) The administrator of a health facility has a duty to protect the patients or residents of the facility from abuse and to maintain a reasonable level of safety for the patients or residents.
- (2) The administrator of a health facility shall report to the Minister all allegations of abuse against a patient or resident that come to the knowledge of the administrator.

Duty of service provider

- 5 (1) A service provider who has a reasonable basis to believe that a patient or resident is, or is likely to be, abused shall promptly report the belief, and the information on which it is based, to the Minister or the Minister's delegate.
- (2) The duty to report applies even if the information on which the person's belief is based is confidential and its disclosure is restricted by legislation or otherwise, but it does not apply to information that is privileged because of a solicitor-client relationship.

Duty to report abuse or likely abuse

- 6 (1) Any person who has a reasonable basis to believe that a patient or resident is or likely to be, abused may report the belief, and the information on which it is based, to the Minister or the Minister's delegate.
- (2) A person may report under subsection (1) even if the information on which the person's belief is based is confidential and its disclosure is restricted by legislation or otherwise, but it does not apply to information that is privileged because of a solicitor-client relationship.⁸¹

According to these provisions, administrators have a responsibility to protect residents and patients from abuse and must report allegations of abuse to the Minister, service providers must report concerns that a resident or patient has or is likely to be abused, and every person may report

⁷⁸ *Adult Protection Act*, R.S.N.S., *supra* note 41, s. 5(1).

⁷⁹ *Ibid.*, s. 3(b).

⁸⁰ "Service provider" means a person who provides services to a patient or resident and is employed by, or provides the services on behalf of, a health facility. *Protection for Persons in Care Act*, S.N.S. 2004, c. 33, s. 2 (f).

⁸¹ *Ibid.*, ss. 4, 5 and 6.

concerns that a resident or patient has or is likely to be abused even if the information is based on confidential information other than information subject to solicitor-client privilege. However, since the *Adult Protection Act* of Nova Scotia imposes a general duty on every person to file a report with the Minister for Community Services where he or she has information that an adult is in need of protection, it is possible that under certain circumstances a person other than a service provider or an administrator may be legally required to report abuse occurring within a care facility. The two laws are silent on their interrelationship.

We describe Nova Scotia as being protectionist because every person in the province has a legal obligation to report abuse of vulnerable adults, and combined, the two statutes apply to care facility residents and adults living independently. Also, as compared with the more modern adult protection and guardianship statutes of British Columbia and the Yukon, the *Adult Protection Act* contains little language that emphasizes the importance of respecting the wishes of a vulnerable adult and instead espouses the protectionist overarching principle that:

In any proceeding taken pursuant to this Act the court or judge shall apply the principle that the welfare of the adult in need of protection is the paramount consideration.⁸²

iv) **Patchwork Regimes (Northwest Territories, Nunavut, Saskatchewan, Quebec)**

Domestic Violence Approach (Northwest Territories, Nunavut, Saskatchewan)

In a number of jurisdictions there is no legislation that deals specifically with either adult protection or the protection of people who reside in care facilities. In these jurisdictions family violence legislation primarily fills the void.

In the Northwest Territories and Nunavut, the only legislation that deals with the physical abuse of older adults is domestic violence legislation. In Saskatchewan, in addition to domestic violence legislation, the law governing care homes requires licensees of care facilities to report serious incidents to a number of agencies, including the regional health authority, and defines a “reportable serious incident” to include “harm or suspected harm suffered by a resident as a result of unlawful conduct, improper treatment or care, harassment or neglect.”⁸³ *The Public Guardian and Trustee Act* of Saskatchewan also applies to vulnerable adults with respect to financial abuse only,⁸⁴ but this law does not mandate reporting abuse. These two additional statutes bear mentioning because they form part of the adult protection legal landscape in Saskatchewan; however, in terms of the practice of front-line health and social service practitioners, the domestic violence statute discussed in this section is likely the most relevant statute in terms of options for intervention, even if domestic violence addresses but a facet of elder abuse and neglect. But in Saskatchewan the notion of a patchwork regime is most apropos, for the legislative regime is made up of quite a number of statutes.

Other jurisdictions discussed elsewhere in this comparative analysis of adult protection legislation also possess domestic violence legislation.⁸⁵ These provinces and territories are not discussed here

⁸² *Adult Protection Act*, R.S.N.S. 1989, *supra* note 41, s. 12.

⁸³ *Personal Care Homes Regulations*, 1996, R.R.S. c. P-6.01 Reg. 2, s. 13(1).

⁸⁴ *The Public Guardian and Trustee Act*, *supra* note 39, s. 40.7.

⁸⁵ These jurisdictions include Alberta, Manitoba, Yukon, Prince Edward Island, Nova Scotia and Newfoundland. See *Protection Against Family Violence Act*, R.S.A., c. P-27; *The Domestic Violence and Stalking Act*, S.M. 1998, c. 41; *Family Violence*

as patchwork or domestic violence regimes because, for the reasons discussed below, domestic violence legislation is an instrument tailored to address only a sub-category of incidents of elder abuse and neglect. In this sense, in provinces and territories discussed earlier in this paper, the domestic violence statute may be of less relevance to the practice of health care and social service workers than it is in the Northwest Territories, Nunavut and Saskatchewan, where there is no alternative legal framework. However, it is important to be aware that domestic violence legislation exists in numerous jurisdictions and so the remedies discussed below will be relevant to practice in many provinces and territories.

The family violence laws of the Northwest Territories and Saskatchewan are very limited in their application. They apply only to abuse that occurs when the victim and the abuser reside together or resided together at some point.⁸⁶ In these two jurisdictions the laws do not apply to residents of care facilities vis-à-vis mistreatment by employees and other caregivers. The *Family Abuse Intervention Act* of Nunavut applies more broadly to family relationships, relationships of intimacy, and relationships of care—current or past.⁸⁷ The Nunavut Act uniquely uses the word “abuse,” other family violence legislation refers to “violence.”

Responding to abuse is voluntary under these laws in the sense that they are silent on the issue of reporting abuse and there is no positive duty imposed on anyone to respond to violence against an older person. But in reality these laws do not set up a regime for responding to vulnerable adults and encouraging the reporting of abuse is not a goal of family violence legislation. Rather, the purpose of domestic violence statutes is to provide authority to obtain protection orders and short-term emergency protection orders in circumstances where family violence has occurred.

Domestic violence legislation grants the judiciary wide discretion in tailoring an award to serve the circumstances surrounding family violence; however, the nature of a protection order does not encapsulate delivering services in support of the victim. Typical terms of an emergency protection order are no-contact provisions, exclusive occupation of the home by the victim, or a weapons prohibition on the abuser; the goal is “immediate protection” translated into keeping the victim and the abuser apart.⁸⁸ The goal of a protection order is to affect a slightly broader remedy to the problem, and could include a requirement that the abuser follow anger management counselling or provide restitution for the victim’s monetary losses.⁸⁹ In Nunavut the language of “Community Intervention Order” is used as opposed to protection order, but the scope of intervention is largely the same, being limited to counselling.⁹⁰

In all contexts, accessing a remedy via the domestic violence framework requires engaging the courts and the police, which will mean, depending on the jurisdiction, filing a police complaint or laying charges, making an appearance in criminal court, giving evidence or contacting other witnesses, and all the stigma or public exposure associated with being part of a criminal proceeding. Domestic

Prevention Act, R.S.Y. 2002, c. 84; *Victims of Family Violence Act*, R.S.P.E.I. 1998, c. V-3.2; *Domestic Violence Intervention Act*, S.N.S. 2001, c. 29; *Family Violence Protection Act*, S.N.L. 2005, c. F-31.

⁸⁶ *The Victims of Domestic Violence Act*, S.S. 1994, c. V-6.02, s. 2(a) and *Protection Against Family Violence Act*, S.N.W.T. 2003, c. 24, s. 2.

⁸⁷ *Family Abuse Intervention Act*, S.Nu. 2006, c. 18, s. 2.

⁸⁸ See, for example, *The Victims of Domestic Violence Act*, *supra* note 86, s. 3(3) and *Protection Against Family Violence Act*, *supra* note 86, s. 4(3).

⁸⁹ *The Victims of Domestic Violence Act*, *ibid.*, s. 7, and *Protection Against Family Violence Act*, *ibid.*, s.7.

⁹⁰ *Family Abuse Intervention Act*, *supra* note 87, s. 17.

violence legislation is very much tied to criminal remedies and sentencing procedure, and victim protection is addressed in only a limited sense. In this respect, this approach provides a rather blunt instrument for responding to the circumstances of vulnerable adults at risk of abuse and neglect, but may be very appropriate when family violence is involved and there is a need to keep an abusive person away from an older adult and his or her home. A protection order may be a key intervention where there is a desire to protect the right of an older adult to “age in place” rather than be removed to an institution in the name of protection.

Another feature that distinguishes a domestic violence approach from an adult protection approach is the role of victim consent. Under the Nunavut *Family Abuse Intervention* only the victim or an agent with consent may apply for an order.⁹¹ The other two laws discussed in this section require victim consent or leave of the court to apply for an order. In contrast, a number of adult protection statutes discussed in this paper contain explicit language overriding the decision-making autonomy of a vulnerable adult.⁹²

Human Rights Approach (Quebec)

In Quebec the only legislation that refers to the mistreatment of older adults is the *Charte des droits*, which accords older adults a right to be free from “exploitation.” The law states that:

48. Every aged person and every handicapped person has a right to protection against any form of exploitation.

Such a person has a right to the protection and security that must be provided to him by his family or the persons acting in their stead.⁹³

The placement of adult protection within the *Charte des droits* grants these rights quasi-constitutional status.⁹⁴ As such, the meaning of exploitation has been interpreted fairly liberally to encompass different forms of elder abuse where there was an element of dependency and vulnerability present on the part of the older adult. In one decision, the Human Rights Commission clarified:

The “aged person” is not defined in article 48; it refers simply to a person who is elderly and the notion of exploitation refers to a state of dependence that aged persons could find themselves in. Exploitation includes the notion of profiting from a position of force to the detriment of the interest of the vulnerable person. It is not limited to economic exploitation; it could also be physical, psychological, social or moral.⁹⁵

The notion of vulnerability by virtue of dependency is an aspect of the meaning of “exploitation.” In this sense the law protects only *dependent* vulnerable older adults, even though article 48 refers to “every aged person.”

⁹¹ *Family Abuse Intervention Act*, *ibid.*, s. 62(1) requires consent, although in certain circumstances consent is deemed to have been provided (s. 26(2)).

⁹² *The Victims of Domestic Violence Act*, *supra* note 86, s. 8(1); *Protection Against Family Violence Act*, *supra* note 86, ss. 2(2) and (3).

⁹³ *Charte des droits*, *supra* note 9. In Quebec there is also the *Public Curator Act*, R.S.Q. c. C-81, but this law is silent regarding abuse and reporting.

⁹⁴ *Vallée*, *supra* note 8 at para. 26.

⁹⁵ *Commission des droits de la personne c. Brzozowski*, 1994 CanLII 1792 (QC T.D.P.).

The *Charte des droits* approach also has significant implications for the interventions available to assist vulnerable older adults. First, intervention is authorized by law only where abuse has already occurred; there is no authority for action intended to address a risk or likelihood of abuse, or to prevent abuse. Second, to address the matter, someone—the older adult victim or her legal guardian, the Human Rights Commission, a witness—must file a complaint with the Human Rights Tribunal. Third, the only available remedies appear to be monetary, either pecuniary, to reimburse the abused adult for financial losses, or additional exemplary (punitive) or moral damages, in the event of certain egregious conduct. Perhaps it is for this reason that a significant percentage of the reported cases on article 48 pertain to financial abuse. However, the Commission does have the power to investigate abuse and indicates it initiated 48 investigations for elder exploitation in 2009.⁹⁶

v) Neglect Legislation (Newfoundland)

Newfoundland is unique in that although there is no legislation that applies to the physical abuse of older adults in the province, neglect of older people is specifically addressed under the *Neglected Adults Welfare Act*.⁹⁷ This law applies only to mentally or physically incapable adults who are unable to care for themselves but are not residing in a mental health facility.⁹⁸ Under the *Neglected Adults Welfare Act* any person who suspects neglect is guilty of an offence if they fail to report.⁹⁹ The law also creates an offence of contributing to a person's neglect through an act or omission.

There is no language in this statute that emphasizes the right of an adult to refuse services or choose to live at risk; rather, the law grants the state broad powers to override the autonomy of an adult:

- (i) who is incapable of caring properly for himself or herself because of physical or mental infirmity,
- (ii) who is not suitable to be in a treatment facility under the *Mental Health Care and Treatment Act*,
- (iii) who is not receiving proper care and attention, and
- (iv) who refuses, delays or is unable to make provision for proper care and attention for himself or herself.¹⁰⁰

These broad powers include the power to remove the adult from home if in the adult's interests:

Temporary custody

8. At any time pending the final determination of an application the judge may order the removal of the adult to a hospital or other place without delay if a medical practitioner certifies that in his or her opinion it is necessary to do so in the interest of the adult.¹⁰¹

⁹⁶ Commission des droits de la personne et des droits de la jeunesse, Press Release, "A team of specialists of the Commission des droits de la personne et des droits de la jeunesse ready to intervene to protect the elderly" (1 April 2010) online: <http://www.cdpedj.qc.ca/en/publications/docs/COMM_exploitation_elderly_team.pdf>.

⁹⁶ *Ibid.*

⁹⁷ *Neglected Adults Welfare Act*, *supra* note 41. A number of the laws discussed in this paper address abuse AND neglect; Newfoundland is unique in that the law applies exclusively to neglect, which is defined to include the concept of self-neglect (s. 2).

⁹⁸ *Ibid.*, s. 2(i).

⁹⁹ *Ibid.*, s. 4.

¹⁰⁰ *Ibid.*, s. 2.

¹⁰¹ *Ibid.*, s. 8.

vi) **Summary of Adult Protection and Related Legislation in Canada**

Table 2, located on the following page, outlines key features of the laws discussed in section 4 of this paper in terms of:

What?	What is the title of the law or laws relevant to the province or territory?
Where?	What adults are protected under the legislation, e.g. adults living in a care facility, adults receiving services from a hospital versus adults living in the community more broadly? Must the abuser reside with the older adult?
When?	Under what circumstances does the law apply (e.g. abuse versus risk)? How is vulnerability characterized?
Who?	Who has a duty to respond or report? Who is the person or agency that accepts reports of abuse and neglect?

**Table 2: Summary of the Law in Each Province and Territory
Responding to Elder Abuse and Neglect**

	What	Where	When	Who
B.C.	<i>Adult Guardianship Act</i> , R.S.B.C. 1996, c. 6.	Adult is living anywhere (except in a prison).	An adult is being abused or neglected and is unable to seek support or assistance.	Any person may notify a designated agency. In BC the designated agencies are the regional health authorities and Providence Health Care Society.
			A report of abuse or neglect has been received; there are reasons to believe an adult is abused or neglected; or a representative, decision maker, guardian or monitor is hindered from visiting or speaking with the older adult.	An employee of a designated agency must: refer to health care, social, legal, accommodation, or other services; assist older adult in obtaining services; inform public guardian and trustee; investigate abuse or neglect; or report criminal offence to police.
	<i>Community Care and Assisted Living Act</i> , R.S.B.C. 2002, c. 75.	Adult is residing in a community care facility or assisted living residence.	A person in care witnesses or experiences abuse or neglect.	Licensee of the facility must notify: the parent or representative, or contact person of the person in care; medical practitioner or nurse practitioner responsible for the care of the person in care; medical health officer; and funding program.
Alta.	<i>Protection for Persons in Care Act</i> , S.A. 2009, c. P-29.1.	Adult receives care or support services from a lodge accommodation, hospital, mental health facility, nursing home, social care facility, or other service provider.	An adult who receives care or support services is being abused, or has been abused.	Every person must report to a complaints officer, a police service, or a committee, body or person authorized under another enactment to investigate abuse.
Sask.	<i>Victims of Domestic Violence Act</i> , S.S. 1994, c. V-6.02.	Adult is living in the community (i.e. not in care).	Domestic violence has occurred.	A victim , a person on behalf of the victim who has the victim's consent, or a person on behalf of the victim with leave of the court or designated justice of the peace may apply for an <i>ex parte</i> order or restraining order from the court.
	<i>Personal Care Homes Regulations</i> , R.R.S. c. P-6.01 Reg. 2.	Adult is a resident in a personal care home.	A serious incident has occurred. "Serious incident" is defined to include "harm or suspected harm suffered by a resident as a result of unlawful conduct, improper treatment or care, harassment or neglect."	Licensee must inform the resident's supporter or a member of the resident's family, resident's personal physician, the department and the regional health authority.

	What	Where	When	Who
Man.	<i>Protection for Persons in Care Act</i> , C.C.S.M. c. P144.	Adult is a resident, in-patient or person receiving respite care in a health facility.	A resident, in-patient or person receiving respite care in a health facility is being abused, or is likely to be abused.	Employee or service provider at a health facility must promptly report to the Minister.
	<i>Vulnerable Persons Living with a Mental Disability Act</i> , C.C.S.M. c. V90.	Adult has had a mental disability since childhood and is in need of assistance to meet basic needs.	An adult who has had a mental disability since childhood is being abused or neglected, or is likely to be abused or neglected.	A person who provides care, support services or related assistance, substitute decision-maker, or committee must report to the executive director appointed by the Minister.
Ont.	<i>Long-Term Care Homes Act 2007</i> , S.O. 2007, c. 8.	Adult is residing in a long-term care home.	Harm, abuse or neglect has occurred or may occur.	A staff member, any person who provides professional services (i.e. health, social services) and licensee must report to the director appointed by the Minister.
Que.	<i>Charte des droits et libertés de la personne</i> , L.R.Q., c. C-12.	Adult is living anywhere.	Older adult is the victim of exploitation.	Victims , group of victims, or advocacy organization may apply to human rights commission. Commission may initiate investigation.
N.B.	<i>Family Services Act</i> , S.N.B. 1980, c. F-2.2	Adult is living anywhere.	Adult is being abused or is at risk of abuse.	Professional person (i.e. care worker, physician, nurse, or other health or mental health professional, social worker, etc.) may report to the Minister.
N.S.	<i>Protection for Persons in Care Act</i> , S.N.S. 2004, c. 33.	Adult is a patient of a hospital or a resident of a health facility (i.e. special care home).	Adult is being abused or is likely to be abused.	Employees and service providers of a health facility must promptly report to the Minister.
	<i>Adult Protection Act</i> , R.S., c. 2.	Adult is living anywhere.	Adult is the victim of abuse or not receiving adequate care, is incapable of protecting himself/herself and refuses, delays or is unable to protect himself/herself.	Any person must report to the Minister of Community Services.
P.E.I.	<i>Adult Protection Act</i> , R.S.P.E.I. 1988, c. A-5.	Adult is living anywhere.	Adult is in need of assistance or protection, or is at serious risk.	Any person may report to the Minister.
N.L.	<i>Neglected Adults Welfare Act</i> , R.S.N.L. 1990, c. N-3.	Adult is living anywhere (except a mental health facility).	An adult is incapable of caring properly for himself or herself, not suitable to be in a mental health facility, not receiving proper care and attention and refuses, delays or is unable to make provision for proper care and attention for himself or herself.	Any person must give information to Director of Neglected Adults, or to a social worker (who must report the matter to the Director).

	What	Where	When	Who
NU	<i>Family Abuse Intervention Act</i> , S.Nu. 2006, c. 18.	Adult is living in the community (i.e. not in care).	Family abuse has occurred.	A victim , a person on behalf of the victim who has the victim's consent, or a person on behalf of the victim with leave of the court or designated justice of the peace may apply for an <i>ex parte</i> or restraining order from the court.
N.W.T.	<i>Protection Against Family Violence Act</i> , S.N.W.T. 2003, c. 24.	Adult is living in the community (i.e. not in care).	Family violence has occurred.	A victim , a person on behalf of the victim who has the victim's consent, or a person on behalf of the victim with leave of the court or designated justice of the peace may apply for an <i>ex parte</i> or restraining order from the court.
Y.T.	<i>Adult Protection and Decision-Making Act</i> , S.Y. 2003, c. 21, Sch. A.	Adult is living anywhere (except a prison).	An adult is abused or neglected and unable to seek support or assistance.	Any person may report to the Seniors' Services/Adult Protection Unit, currently the only designated agency in the Yukon.

(d) The Impact of Mental Capacity Law on Elder Abuse and Neglect

The law of mental capacity is relevant to the delivery of services to older adults and intervening in response to concerns regarding abuse and neglect in a number of respects. However, first, before discussing the relationship between mental capacity and adult protection law, it is crucial to clarify a few basic principles of mental capacity law.

At its core, mental capacity is about decision making.¹⁰² A person with mental capacity has the right to make his or her own decisions. Although mental capacity legislation varies from province to province, most jurisdictions espouse the underlying principle that all adults of legal majority are presumed to be mentally capable of making their own decisions unless and until the contrary has been proven.¹⁰³ This proposition applies regardless of age. Some medical conditions, such as Alzheimer's and other conditions characterized by dementia, may impact on capacity. Although these conditions are often linked with aging, this connection does not justify any inference that a person lacks capacity by virtue of advanced age. Rather, it is ageist to assume a person lacks capacity as a function of aging. Ageism is a form of discriminatory treatment based on a perception of advanced age.¹⁰⁴ Ageist assumptions about capacity can result in a lack of respect for an older adult's wishes and a denial of inherent human dignity.

Definitions of capacity vary across jurisdictions and have evolved over the years. However, the key to recently revised definitions is the notion that a capable adult must be able to understand information and appreciate the consequences of decisions.¹⁰⁵ In this sense capacity is about a person's decision-making *process*, and it is neutral as to the outcome of that process. All adults retain the right to make unwise or risky decisions, where they make these choices with capacity, regardless of age, disability or illness. Guardianship laws do not restrain adults who are mentally capable of choosing to take risks. For example, an adult who has been a habitual gambler cannot be prevented from continuing to take financial risks just because the person is older. And in the absence of a court order, such as a protection order, capable adults retain the right to choose the people with whom they live or associate—including people who treat them poorly or are abusive. It is ageist to disrespect a person's risky choices on the basis that the person is an older adult. Ageist assumptions about incapacity can underlie seemingly well-meaning intentions to "protect" older adults from their own decisions.

¹⁰² Mental capacity is also referred to in some sources as "mental capability" or "mental competency."

¹⁰³ See for example, *Adult Guardianship Act*, *supra* note 36, s. 3; *Representation Agreement Act*, R.S.B.C. 1996, c. 405, s. 3; *Health Care (Consent) and Care Facility (Admission) Act*, R.S.B.C. 1996, c. 181, s. 3; *Adult Guardianship and Trusteeship Act*, S.A. 2008, c. A-4.2, s. 2; *Adult Guardianship and Co-decision-making Act*, S.S. 2000, c. A-5.3, s. 3; *Vulnerable Persons Living with a Mental Disability Act*, *supra* note 33, Preamble; *The Health Care Directives Act*, C.C.S.M. c. H27, s. 4; *Substitute Decisions Act*, 1992, S.O. 1992, c. 30, s. 2; *Code civil du Québec*, L.R.Q., c. C-1991, s. 154; *Health Care Consent Act*, 1996, S.O. 1996, c. 2, Schedule A, s. 4(2); *Consent to Treatment and Health Care Directives Act*, R.S.P.E.I. 1998, c. C-17.2, s. 3; *Hospitals Act*, R.S.N.S. 1989, c. 208, s. 52; *Advance Health Care Directives Act*, S.N.L. 1995, c. A-4.1, s. 7; *Guardianship and Trusteeship Act*, S.N.W.T. 1994, c. 29, s. 1.1; *Guardianship and Trusteeship Act*, S.N.W.T. (Nu.) 1994, c. 29, s. 1.1; *Adult Protection and Decision-Making Act*, *supra* note 36, s. 3.

¹⁰⁴ See section 6(d) for a more lengthy definition of ageism.

¹⁰⁵ *Adult Guardianship and Trusteeship Act*, *supra* note 103, s. 1; *The Health Care Directives Act*, *supra* note 103, s. 2; *Health Care Directives and Substitute Health Care Decision Makers Act*, S.S. 1997, c. H-0.001, s. 2; *Advance Health Care Directives Act*, *supra* note 103, s. 14; *Personal Directives Act*, S.N.S. 2008, c. 8, s. 2; *Adult Guardianship and Co-decision-making Act*, *supra* note 103, s. 2; *Consent to Treatment and Health Care Directives Act*, *supra* note 103, s. 7.

Under a number of existing legal systems a determination of incapacity requires the presence of a disabling condition or diagnosis.¹⁰⁶ The trend in revised, more modern, guardianship regimes has been to dispense with this requirement. However, definitions of capacity still vary with respect to whether a determination is global (also called plenary), or whether capacity is domain or decision-specific.¹⁰⁷ A finding of incapacity may, for example, be limited only to financial matters or a particular subset of personal care decisions. A person may be incapable of some decisions or types of decisions only.

Guardianship and substitute decision-making systems exist to assist persons unable to make their own decisions (for example, persons in a coma at the extreme) or to protect individuals liable to injure themselves or undermine their assets through compromised decision making. These laws also purport to protect vulnerable adults from being taken advantage of by individuals or institutions that do not have the adult's best interests at heart.

Sometimes a mentally incapable adult will be subject to a guardianship order.¹⁰⁸ However, if no prior investigation or intervention has occurred in the life of an older adult, there may be no guardianship order in place, regardless of capacity. Alternatively, a person might have agreed to an assistant or supportive decision-maker if independent decision-making capacity is compromised but the adult remains able to make decisions with support or assistance.¹⁰⁹ It is up to the health care or community services worker who meets with the older adult to provide additional support or alert the appropriate authorities if mental capacity seems compromised and the adult appears to be experiencing abuse or neglect (or be at risk of either in some jurisdictions).

At the level of front-line practice, the issue of mental capacity can surface in a number of contexts. First, a person must have legal capacity to make decisions in order to consent to or refuse treatment or services, including interventions directed to respond to concerns regarding abuse and neglect. A number of laws affirm that the state can override an adult's refusal of services or health care if the adult is unable to give informed consent.¹¹⁰ Some adult protection laws explicitly permit emergency intervention where an adult *appears* to be abused or neglected and *appears* to be incapable of giving or refusing consent:

Emergency assistance

- 59** (1) A person from a designated agency may do anything referred to in subsection (2) without the adult's agreement if
- (a) the adult is apparently abused or neglected,

¹⁰⁶ *Patients Property Act*, R.S.B.C. 1996, c. 349; *Incompetent Persons Act*, R.S.N.S. 1989, c. 218; *Infirm Persons Act*, R.S.N.B. 1973, c. I-8;

¹⁰⁷ Under modern guardianship regimes the powers of the guardian are expressed and limited rather than plenary: See, for example, *Adult Guardianship and Trusteeship Act*, *supra* note 103, s. 33; *Guardianship and Trusteeship Act*, S.N.W.T., *supra* note 103, s. 11; *Adult Guardianship and Co-decision-making Act*, *supra* note 103, s. 15. In Ontario a guardian of the person may be full or partial: *Substitute Decisions Act*, *supra* note 103, s. 58.

¹⁰⁸ In BC the term is committee, pronounced KAW-mi-TEE: *Patients Property Act*, *supra* note 106, s.6.

¹⁰⁹ In Alberta a person may appoint a supportive decision-maker or be subject to a co-decision-making order: See *Adult Guardianship and Trusteeship Act*, *supra* note 103, ss. 4 and 13. In Saskatchewan the court may appoint a co-decision-maker: *Adult Guardianship and Co-decision-making Act*, *supra* note 103, s. 14. In the Yukon an adult may enter a supported decision-making agreement: *Adult Protection and Decision-Making Act*, *supra* note 36, s. 6.

¹¹⁰ *Consent to Treatment and Health Care Directives Act*, *supra* note 103, s. 11; *Adult Protection Act*, R.S.N.S., *supra* note 41, s. 10(1).

- (b) it is necessary, in the opinion of the person from the designated agency, to act without delay in order to
 - (i) preserve the adult's life,
 - (ii) prevent serious physical or mental harm to the adult, or
 - (iii) protect the adult's assets from significant damage or loss, and
 - (c) the adult is apparently incapable of giving or refusing consent.
- (2) In the circumstances described in subsection (1), the designated agency may do one or more of the following:
- (a) enter, without a court order or a warrant, any premises where the adult may be located and use any reasonable force that may be necessary in the circumstances;
 - (b) remove the adult from the premises and convey him or her to a safe place;
 - (c) provide the adult with emergency health care;
 - (d) inform the Public Guardian and Trustee that the adult's financial affairs, business or assets need immediate protection;
 - (e) take any other emergency measure that is necessary to protect the adult from harm.
- (3) After providing the adult with the assistance and services mentioned in subsection (2), the designated agency may conduct investigations under sections 48 and 49.¹¹¹

In a jurisdiction where the language of appearances is used, no formal capacity determination is required to rationalize intervention in emergent circumstances.

Second, as will be discussed in further detail in the following section, consent can be required to share an adult's personal or health information in the context of responding to concerns regarding abuse and neglect, and consent requires capacity.

Third, some abusive treatment is inherently connected to the abused person's lack of capacity and the abuser's knowledge of the older adult's compromised decision-making ability. For example, in terms of financial abuse, if a person knowingly persuades an older adult who is mentally incapable to grant the other access to the older adult's funds by signing a power of attorney or other legal instrument, that is arguably financial abuse. The mentally incapable person cannot consent to the power of attorney because this person cannot appreciate the consequences of this choice and the knowing financial abuser is taking advantage of vulnerability. Sexual contact with a person who lacks the requisite capacity to consent is also a form of abuse. Disregarding the right of a capable adult to consent to treatment, by failing to seek consent or by forcing an advance care plan on the person, is also a form of elder abuse. Here the problem is the opposite of the previous two examples, for this older adult has a right to consent that cannot be taken away in the absence of incapability.

Fourth, under some adult protection laws, the obligation to file a report or intervene exists where an adult is being abused or neglected **and** the adult is unable to access support, assistance or protection independently. Although, subject to solicitor-client privilege, any person has the right to report a suspected criminal act to the police, or contact a support agency in the jurisdiction if they have concerns regarding a person who might be in need of protection or assistance, it is the inability of the adult to access assistance or support independently that characterizes the older adult as a person in need of protection under the law and triggers the duty to respond to concerns. A lack of capacity can be a reason why an adult is considered unable to access support or assistance independently.

¹¹¹ *Adult Guardianship Act*, *supra* note 36, s. 59.

The *Adult Guardianship Act* of British Columbia indicates right in the statute that capacity may be relevant to whether it is appropriate to respond to concerns about abuse and neglect:

Reporting abuse or neglect

- 46** (1) Anyone who has information indicating that an adult
- (a) is abused or neglected, and
 - (b) is unable, for any of the reasons mentioned in section 44, *to seek support and assistance, may report the circumstances to a designated agency.*
- 44** The purpose of this Part is to provide for support and assistance for adults who are abused or neglected and who are unable to seek support and assistance because of
- (a) physical restraint,
 - (b) a physical handicap that limits their ability to seek help, or
 - (c) *an illness, disease, injury or other condition that affects their ability to make decisions about the abuse or neglect.*¹¹²

As a number of the cases discussed in this paper illustrate, an absence of capacity combined with a reluctant or inadequate caregiver can be a recipe for neglect and self-neglect. In the absence of capacity, an older adult's decision to refuse services or treatment or inability to request assistance could cause an adult harm from which he or she may be protected under mental capacity law. On the other hand, just like anyone else, an older adult with capacity has the right to refuse treatment and services. Consider, for example, Henry Matthews. He may have required support to identify appropriate support and assistance and with support might have realized that relying exclusively on Daniel Chartrand for support and assistance was not prudent. However, in contrast, it may have been appropriate to honour Kathleen Jennings' decision to cohabit with her troubled son—depending on facts not revealed in the *Matthias* case which may be too late to investigate. Kathleen Jennings may have been reluctant to permit any kind of support service intrusion into her relationship with her son. It is not illegal for two alcoholic family members to reside together and argue; likely these circumstances are fairly typical. In this sense capacity can be a decision-making lynchpin for health care and social service workers.

The key issue for health care and social services workers is that an adult with mental capacity has the right to refuse services, and unless other factors, such as the presence or control of a person who is abusing them in some way, appear to be limiting freedom of decision making, an adult may refuse services or treatment a professional considers warranted. It is also important to be aware that while the law may be black and white in terms of the definition of capacity, in practice, incapacity manifests in shades of grey. Some people experience fluctuations in capacity throughout the day and may go through longer episodes of reduced or improved capacity. Therefore, appropriate intervention requires attention to the nuances of a person's ability to make decisions: it may require outreach at a time when an adult is at his or her cognitive best; but it may demand consideration of the degree of safety when an adult is at his or her cognitive worst.

¹¹² *Adult Guardianship Act*, *supra* note 36, at ss. 44 and 46 [emphasis added].

(e) Disclosure of Private Confidential Personal and Health Information

i) Introduction

Protecting the confidentiality of personal information is important to almost everyone. The growth of the Internet and the increasing prevalence of identity fraud have heightened consumer concerns regarding privacy. This context has placed increased pressure on health care and social service workers to conduct their practice in a manner that respects people's privacy and also minimizes unnecessary sharing of personal and health information.

Although colloquially we use the word "privacy" to reference the sanctity of personal or confidential information, privacy is a much broader area of law that encompasses both physical intrusions and confidential information. We will be discussing only the latter in this paper, and even then only to the degree that is permitted by the limited length of this publication.

Few laws create absolute rules and privacy law is no different in this regard. In general, it is legal to intrude on privacy and share information in order to enforce another duty. The reality of everyday practice is that responding to and preventing elder abuse may require information sharing amongst front-line staff who work with older adults. Intervention may also require sharing personal information with the police and other authorities. We discuss both of these potential violations of privacy in this section. The decision to share an adult's personal information with another individual or agency is an important decision that must be made in the context of an understanding of how all the different laws and rules of practice interact to determine the legal responsibilities of a worker or professional.

The collection, use and distribution of personal information by public and private bodies is now regulated by a number of laws, some of which were enacted fairly recently. This section of this discussion paper provides a brief overview of federal and provincial legislation in relation to privacy and the disclosure of personal information, and relates this material to the previous sections that discussed the law of consent and capacity and the law with respect to reporting and responding to abuse. At the end of section 4 of this paper you will find a table that summarizes the laws discussed in this paper, including key aspects of the rules and exceptions applicable in each jurisdiction to the disclosure of confidential personal and health information (Table 3).

ii) What Laws Apply?

One of the challenges in thinking about the law in relation to confidential personal and health information is determining which laws apply. Three distinctions are relevant. First, privacy law is an area of law where both the federal and provincial governments have the power to make laws. Whether the federal law or provincial law applies to the practice of a health care or social services worker depends on the identity of the employer. If the employer is a federal government department, then the federal law applies. If the person works for, or is under contract with, a provincial health authority, a municipality, or a hospital, then the worker will be governed by provincial legislation.¹¹³

¹¹³ Federal legislation also applies to employees who work in industries that are federally regulated, such as banking, transportation and telecommunications: *Personal Information Protection and Electronic Documents Act*, S.C. 2000, c. 5, s. 2. It is

Second, different laws also apply to public bodies (hospitals, government agencies) versus private bodies (private companies such as long-term care facilities).¹¹⁴ Again, which law applies to disclosure of personal information depends on the identity of the employer.

Third, select provinces have also created separate laws that apply exclusively to health information. In these regions the health information statute applies to health-related information and the general law on access to information applies to other personal information in the possession of health care and social service providers. So two laws may apply to a person's confidential information depending on whether or not the information is exclusively health-related. At the time of writing, Ontario, Manitoba, Saskatchewan, Alberta and Newfoundland have passed distinct laws in relation to health information.

While all this sounds very complicated, as the following section will illustrate, there is a great deal of similarity between the various laws in terms of the circumstances under which disclosure or sharing of personal or health information is permitted without a person's consent. The exceptions to requiring consent are also broadly worded. The implications for practice are that in certain circumstances health care practitioners, community service workers and health agencies may exchange information with each other, or report information to a third party such as police or the public guardian, in all Canadian jurisdictions, without breaching privacy rights, in the context of preventing elder abuse and responding to it. Generally speaking, the duty to respond to emergencies, assist with law enforcement and obey other laws supersedes a person's right to confidentiality of information, in the absence of solicitor-client privilege. However, legal obligations are less clear in the absence of a clear emergency or a duty to report under adult protection legislation.

The other important point is informed consent. If a person has mental capability and gives you permission to share his or her information with another person, in the context of making a police report or consulting with another worker, then there is no violation of confidentiality in any jurisdiction. The simplest way to avoid a violation of a client or patient's rights is to get consent before taking the next step. This approach has other benefits in terms of keeping a client or patient informed and encourages a patient/caregiver relationship characterized by greater consumer or patient empowerment.

iii) **Disclosure without Consent**

Below are three broad exceptions to the requirement to get consent to disclose confidential personal or health information that are applicable to every province and territory in Canada. Privacy laws contain many more categories of exceptions. For the purposes of this review, we highlight exceptions most relevant to the practice of health care and social service workers responding to concerns regarding elder abuse and neglect.

highly unlikely that health and social service workers will work in these sectors, so in practice, in the context of this paper, readers can think of the distinction as hinging on whether the federal government is the employer.

¹¹⁴ In the provinces or territories where no law has been created to deal with confidential information in the possession of private (as opposed to public) bodies, the federal law, the *Personal Information Protection and Electronic Documents Act, ibid.*, will apply. Only Alberta, British Columbia and Quebec have created legislation that applies to private companies. All other jurisdictions are governed by federal law.

Disclosure authorized by another law: Disclosure of information by public or private body employees without a person's consent is permitted in all jurisdictions where disclosure is authorized or required by another law. Therefore, in any jurisdiction where there is adult protection legislation permitting or requiring an individual or employee to report abuse or neglect of an older adult, it will not be a violation of privacy or confidentiality to report abuse.

Police investigations: All jurisdictions also permit disclosure for the purpose of assisting the police with law enforcement or a police investigation, such that if a health care worker is asked to provide information to police authorities or the lawyer prosecuting the case for the Crown, providing personal or health information would not amount to a violation of personal information protection legislation. This exception does not address the capacity of workers to share information amongst themselves. In some instances this will be permitted under the following exception.

Consistent with purpose: All laws that protect personal information permit disclosure of information for a purpose consistent with the reason for which the information was collected in the first place. Such an exception would permit health care workers and medical professionals working with older adult clients to communicate with each other about the needs of a client and share information for the purpose of delivering services clearly under the mandate of a health authority or care facility.

iv) **Disclosure for Health and Safety Reasons**

A more complex exception to the requirement to get a person's consent before disclosing personal information is the health or safety exception that appears in all jurisdictions, under the guise of slightly varied wording. In the various provinces or territories, an organization or a person may disclose another individual's personal information without the knowledge or consent of that individual:

- If the disclosure is ... made to a person who needs the information because of an emergency that threatens the life, health or security of an individual and, if the individual whom the information is about is alive, the organization informs that individual in writing without delay of the disclosure.¹¹⁵
- If there are reasonable grounds to believe that compelling circumstances exist that affect the health or safety of any individual and if notice of disclosure is mailed to the last known address of the individual to whom the personal information relates.¹¹⁶
- If the disclosure is clearly in the interests of the individual and consent cannot be obtained in a timely way.¹¹⁷
- To any person if the custodian believes, on reasonable grounds, that the disclosure will avert or minimize an imminent danger to the health or safety of any person.¹¹⁸

¹¹⁵ *Personal Information Protection and Electronic Documents Act, ibid.*, s. 7(3)(e).

¹¹⁶ *Personal Information Protection Act*, S.B.C. 2003, c.63, s. 18(1)(k); *Freedom of Information and Protection of Privacy Act*, R.S.O. 1990, c.F.31, s. 42(1)(h); *Access to Information and Protection of Privacy Act*, R.S.Y. 2002, c.1, s. 36(n); *Personal Information Protection and Electronic Documents Act*, S.C. 2000, c.5, s. 7(3)(e).

¹¹⁷ *Personal Information Protection Act, ibid.*, s. 18(1)(a).

¹¹⁸ *Health Information Act*, R.S.A. 2000, c.H-5, s. 35(1)(m); *The Health Information Protection Act*, S.S. 1999, c. H-0.021, s. 27(4)(a). The Saskatchewan law states "avoid" instead of "avert".

- If a reasonable person would consider that the disclosure of the information is clearly in the interests of the individual and consent of the individual cannot be obtained in a timely way or the individual would not reasonably be expected to withhold consent.¹¹⁹
- [If] the disclosure is necessary for the medical treatment of the individual and the individual does not have the legal capacity to give consent.¹²⁰
- To any person if the trustee reasonably believes that the disclosure is necessary to prevent or lessen a serious and immediate threat to
 - the health or safety of the individual the information is about or another individual, or
 - public health or public safety.¹²¹
- To protect the mental or physical health or the safety of any individual or group of individuals.¹²²
- To prevent or reduce a risk of serious harm to the mental or physical health or safety of the individual the information is about or another individual.¹²³
- To a person to whom the information must be disclosed because of the urgency of a situation that threatens the life, health or safety of the person concerned.¹²⁴
- In order to prevent an act of violence, including suicide, where there is reasonable cause to believe that there is an imminent danger of death or serious bodily injury to a person or an identifiable group of persons.¹²⁵
- To protect the health, safety or security of the public or of an individual.¹²⁶

Some jurisdictions contain a health- and safety-related exception but require consultation with the head of the public body before disclosure occurs. In other jurisdictions, the front-line health care or social service practitioner makes the decision.¹²⁷

The varied wording demonstrated by the above list imposes a higher burden of required care in some jurisdictions ranging from the presence of:

- a health emergency
- a health urgency
- imminent danger to health or safety
- necessary medical treatment
- serious harm, or

¹¹⁹ *Personal Information Protection Act*, R.S.A. 2003, c. P-65, s. 20(a).

¹²⁰ *Personal Information Protection Act*, S.B.C., *supra* note 116, s. 18(1)(b).

¹²¹ *The Personal Health Information Act*, C.C.S.M., c.P33.5, s. 22(2)(b).

¹²² *The Freedom of Information and Protection of Privacy Act*, C.C.S.M., c. F175, s. 44(1)(l); *Access to Information and Protection of Privacy Act*, S.N.W.T. 1994, c.20, s. 48(q).

¹²³ *Personal Health Information Act*, S.N.L. 2008, c.P-7.01, s. 40(1)(a).

¹²⁴ *An Act respecting access to documents held by public bodies and the protection of personal information*, R.S.Q., c. A-2.1, art. 59(4).

¹²⁵ *Ibid.*, art. 9.1.

¹²⁶ *Protection of Personal Information Act*, S.N.B. 1998, c.P-19.1, s. 3.4(a).

¹²⁷ For example, Nova Scotia, Prince Edward Island, British Columbia, Newfoundland in relation to non-health information; federal government bodies; Alberta in relation to public body employers.

- compelling health or safety circumstances

to the slightly lower standard of:

- clearly in a person's interests
- lessening a health threat, or
- protecting the mental or physical health or safety.

The weaker the language, the greater the capacity to share or disclose information without violating confidentiality. In each case the language is discretionary. In some jurisdictions discretion falls to the head of a public body, for example, the director of a hospital; in other cases the discretion is exercised by the front-line worker, or any "person."

(f) Bringing It All Together

The following table highlights key information in section 4, according to province and territory. It summarizes relevant features of adult protection and related statutes and the law in relation to disclosure of confidential information.

Table 3: Overview of Obligations to Respond to Abuse and Neglect of Older Adults

Jurisdiction	Duty to Respond	Protected Group	Abuse, Neglect or Risk?	Protection for Worker	Worker May Disclose Information without Consent If...	Summary
British Columbia 1. <i>Adult Guardianship Act</i>	-Any person may report to a designated agency. -Mandatory for health authority employees to report crimes to police. -Designated agency must investigate if receives a report or suspects abuse.	All abused or neglected adults unable to seek assistance living anywhere other than correctional facility	Abuse Neglect	-Can make anonymous report -Protection from work-related consequences	-Authorized by a law. -Assist police investigation. -Consistent with purpose of collection. -Compelling circumstances that affect health or safety of a person (PRIV*). -Consent not possible and in a person's interests (PRIV). -Necessary for treatment and no mental capacity (PRIV). -Requires head of public body to approve (PUB*).	Health authority staff must report abuse. No violation of privacy laws to report. Other workers may report without violating privacy. In cases of risk greater caution required—health exceptions limited.
	2. <i>Community Care and Assisted Living Act</i>	Licenses of facilities must report to medical health officer, funding program.	Person residing in a community care or assisted living residence	Abuse Neglect	None	In B.C. the designated agencies are currently the regional health authorities plus Providence Health Care Society.
Alberta <i>Protection for Persons in Care Act</i>	Mandatory duty imposed on general population to report to police, complaints officer, or person / body authorized by law to investigate abuse.	Anyone receiving services from a hospital or living in a care facility	Abuse	-Anonymity in terms of investigation under the act -No action or employment consequences may be brought against a person making an honest report.	-Authorized by a law. -Assist police investigation. -Consistent with purpose of collection -To avert or minimize imminent danger to the health or safety of any person (HEA*). -Consent not possible and in a person's interests (PRIV). -Requires head of public body to approve (PUB).	Hospital and care facility staff must report abuse. No privacy violation. No provincial law on reporting neglect or risk of abuse, or on adults living independently. Re risk, may disclose health information without consent if imminent danger to health or safety.

Jurisdiction	Duty to Respond	Protected Group	Abuse, Neglect or Risk?	Protection for Worker	Worker May Disclose Information without Consent If..	Summary
Saskatchewan 1. <i>Victims of Domestic Violence Act</i>	Victim, or with victim consent, other workers including victim assistance program coordinator, may apply for protection order.	Victim has been abused by a co-habitant (spouse, roommate or resident caregiver)	Physical abuse	None	-Authorized by a law. -Assist police investigation. -Consistent with purpose of collection. -To avert or minimize imminent danger to the health or safety of any person (HEA).	Only the licensee of a care facility has a duty to report abuse (harm of residents). Worker may disclose health information without consent to avert or minimize imminent danger to health or safety.
2. <i>Public Guardian and Trustee Act</i>	Financial institutions must advise the public guardian.	Financial abuse of vulnerable adult	Financial abuse	Must cooperate with public guardian investigation		Must provide information requested by the public guardian re financial abuse There is no privacy violation when information is provided to comply with such an investigation.
3. <i>Personal Care Homes Regulations</i>	Licensees must report abuse to regional health authority and others (see Table 2)	Care facility residents	Abuse Neglect	None		
Manitoba 1. <i>Protection for Persons in Care Act</i>	Mandatory for everyone to report to Minister or delegate.	Anyone receiving services from a hospital or living in a care facility	Risk Abuse	-Anonymity in terms of investigation -No adverse action or employment consequences against a person making an honest report	-Authorized by a law. -Assist police investigation. -Consistent with purpose of collection. -Necessary to prevent or lessen serious and immediate threat (HEA). -To protect mental or physical health or safety of any person (PRIV).	Hospital and care facility staff must report abuse and risk. No privacy violation. No provincial law on neglect. No law applies to abuse of adults in private dwellings (exception: vulnerable adults with developmental disabilities). Re risk, may disclose health information without consent if “immediate threat.”
2. <i>Vulnerable Persons Living with a Mental Disability Act</i>	Service providers, substitute decision-makers and committees appointed under <i>Mental Health Act</i> must report to executive director appointed by Minister.	Adult living with a mental disability since age of majority who is in need of assistance to meet basic needs	Risk Abuse Neglect	No action or proceeding for good faith report		

Jurisdiction	Duty to Respond	Protected Group	Abuse, Neglect or Risk?	Protection for Worker	Worker May Disclose Information without Consent If..	Summary
Ontario <i>Long-Term Care Homes Act</i>	-Any person who suspects may report to director appointed by Minister. -Staff, licensees, any person who provides health, social work or social services to resident or licensee must report.	Adults residing in a nursing home	Risk of abuse Neglect Abuse	No action or employment consequences may be brought against a person making an honest report.	-Authorized by a law. -Assist police investigation. -Consistent with purpose of collection. -Compelling circumstances that affect health or safety of a person (PUB).	Nursing home staff must report abuse, neglect and risk. No privacy violation to report. No provincial law on abuse of adults living independently or governing private facilities (federal law applies). May disclose information in the case of risk without privacy violation to protect health or safety.
Quebec <i>Charte des droits et libertés de la personne</i>	Anyone may report to the human rights commission. Commission may initiate investigation.	Exploited older adults	Abuse	None	-Authorized by a law. -Assist police investigation. -Consistent with purpose of collection. -Urgent situation threatening life, health or safety of that person (PUB). -To prevent act of violence, including suicide, causing imminent danger of death or seriously bodily injury (PUB).	No requirement to report abuse, neglect or risk. Public employees may disclose health information under certain urgent circumstances.
Nova Scotia 1. <i>Adult Protection Act</i>	Every person must report to the Minister.	Victim of abuse or not receiving adequate care, incapable of protecting self and refuses, delays or is unable to protect self	Abuse	No action against a person who makes an honest report	-Authorized by a law. -Assist police investigation. -Consistent with purpose of collection. -Requires head of public body to approve (PUB).	Hospital and care facility staff must report abuse or risk. Every person must report abuse of an older adult, but not risk or neglect. No privacy violation.
2. <i>Protection for Persons in Care Act</i>	Any person may report to the Minister.	Patient or resident	Abuse Risk	-No (court) action against person for good faith report -No adverse action against a service provider (includes employee) for good faith report		

Jurisdiction	Duty to Respond	Protected Group	Abuse, Neglect or Risk?	Protection for Worker	Worker May Disclose Information without Consent If..	Summary
New Brunswick <i>Family Services Act</i>	Professional person (any care facility worker, physician, nurse or other health or mental health professional, social worker...) may report to the Minister.	Disabled and older adults who are abused or neglected	Abuse Neglect	No action against a person who makes an honest report	-Authorized by a law. -Assist police investigation. -Consistent with purpose of collection. -To protect the health, safety or security of a person (PUB).	May report abuse or neglect of any older adult. No privacy violation. May disclose information in the case of risk without privacy violation if disclosure to protect health or safety.
Prince Edward Island <i>Adult Protection Act</i>	Any person may report to the Minister.	Adult incapable of fending for self and unable to make provision for necessary care, or who refuses, delays or fails to address either self-protection or self care	Serious risk Abuse Neglect	-Can make anonymous report -Protection from civil law suit	-Authorized by a law. -Assist police investigation. -Consistent with purpose of collection. -Requires head of public body to approve (PUB).	May report abuse, neglect or risk. No privacy violation.
Newfoundland <i>Neglected Adults Welfare Act</i>	Every person who has information about a neglected person.	Adult who is incapable of caring properly for self, not suitable to be in a mental health facility, not receiving proper care and attention and refuses, delays or is unable to make provision for proper care and attention for himself or herself	Neglect	None	-Authorized by a law. -Assist police investigation. -Consistent with purpose of collection. -To prevent or reduce a risk of serious harm to mental or physical health or safety (HEA).	Must report neglect. No privacy violation. No law on abuse. May disclose health information to prevent or reduce risk of serious harm.

Jurisdiction	Duty to Respond	Protected Group	Abuse, Neglect or Risk?	Protection for Worker	Worker May Disclose Information without Consent If...	Summary
Yukon <i>Adult Protection and Decision-Making Act</i>	Any person may make a report to designated agency.	All abused or neglected adults unable to seek assistance living anywhere other than correctional facility	Abuse Neglect	-Can make anonymous report -Protection from work-related consequences	-Authorized by a law. -Assist police investigation. -Consistent with purpose of collection. -Compelling circumstances that affect health or safety of a person (PUB).	May report abuse or neglect of adults unable to seek assistance. No privacy violation. May disclose information in the case of risk without privacy violation to protect health or safety.
Northwest Territories <i>Protection Against Family Violence Act</i>	Victim or various family members (or other person designated in the regulations) may apply for a protection order.	People being abused by a co-habitant (spouse, roommate, caregiver)	Physical abuse	None	-Authorized by a law. -Assist police investigation. -Consistent with purpose of collection. -To protect mental or physical health or safety of any person (PUB).	No duty to report. Re risk, may disclose information to protect mental or physical health or safety of adult.
Nunavut <i>Family Abuse Intervention Act</i>	Victim, family member, friend, lawyer, RCMP (others with consent) may apply for a protection order.	People being abused by a co-habitant (spouse, roommate, caregiver)	Physical abuse	None	-Authorized by a law. -Assist police investigation. -Consistent with purpose of collection. -To protect mental or physical health or safety of any person (PUB).	No duty to report. Re risk, may disclose information to protect mental or physical health or safety of adult.
Federally regulated employees	n/a	n/a	n/a	n/a	-Emergency that threatens life, health or security of a person (PRIV). -Compelling circumstances that affect health or safety of a person (PRIV). -Requires head of public body to approve (PUB).	Variable

PRIV – private employer (long-term care service provider, not-for-profit organization)

PUB – public employer (government agency, hospital)

HEA – health information

5. The Role of the Health Care Provider

(a) The Health Care and Community Service Context

We currently live in a time of increasing deinstitutionalization of health care in Canada. Health care workers provide care in a context in which more services are delivered through community care and increasing care is delivered privately through paid trained and untrained caregivers, family caregivers and neighbourhood volunteers: the *Romanow Report* on Canadian health care identified home care as “one of the fastest growing components of the health care system” in Canada.¹²⁸ It no longer makes sense, conceptually or practically, to talk about delivering health care services to vulnerable older adults without considering at the same time the community care component.

Health care is regulated at the provincial level and there exists tremendous diversity in access to services across the country. However, all jurisdictions have seen reductions in services. In British Columbia, for example, there has been a growing emphasis on community care as a function of deinstitutionalization of certain forms of caregiving, changes in the administration of health care, such as revisions to long-term care facility legislation reducing access to residential care, and a decrease in access to home support caused by stricter eligibility requirements.¹²⁹ Increasingly, you need to be in poorer and poorer health to have access to either institutional care or publicly funded community care services. Given the costs associated with professional or quality care, the limited number of spaces in care facilities, and the reluctance to leave the long-term care of a loved one to strangers, many people who require regular support and assistance are living independently or quasi-independently.

Changes in technology have also resulted in more outpatient care and a shift toward community delivery of some forms of care previously provided institutionally, resulting in an expansion in both the prevalence and complexity of community care. A positive outcome of this reality is a potential for increased independence and autonomy for some people with disabilities and a heightened capacity on the part of the elderly to “age in place”—assuming there is someone in the community available to assist with tasks no longer covered by provincial health care programs. A negative outcome has been increasing isolation of vulnerable older adults, less scrutiny of the quality of informal or volunteer caregiving, and fewer opportunities to investigate the health or well-being of a vulnerable older adult who may have mental capability issues. The facts of *Grant, Morin* and *Chartrand* remind us of this danger.

This paper is part of a larger enterprise of trying to prevent and respond earlier to elder abuse and neglect by targeting the health care and community support sector. One of the premises underlying this focus is a sense that older adults, by virtue of disability, illness and declining health and mobility associated with aging, are likely to have some contact with health care providers. As an individual moves along the care continuum from home to institutional care and from community to acute care, there will be opportunities to detect and respond to concerns of adult abuse and neglect. However, recent changes in the delivery of health care in Canada and increasing emphasis on community care

¹²⁸ Canada, Commission on the Future of Health Care in Canada, *Building on Values: The Future of Health Care in Canada – Final Report* (Ottawa, 2002), online: <<http://publications.gc.ca/pub?id=237274&sl=0>> at 171. (Commissioner: Roy J. Romanow).

¹²⁹ Marcy Cohen, Jeremy Tate, and Jennifer Baumbusch, *An Uncertain Future for Seniors: BC’s Restructuring of Home and Community Health Care 2001-2008* (Vancouver: Canadian Centre for Policy Alternatives, 2009).

may have rendered elder abuse and neglect more invisible, and made it more challenging to offer timely prevention services.

Not all older adults maintain regular contact with health or social service practitioners. Many older adults remain strong and healthy long into old age, requiring no ongoing community or institutional support or assistance in order to maintain independent living. Other older adults may suffer various ailments but choose not to receive treatment. Some of these older adults may have capacity limitations that suggest they have not made an informed decision to avoid health care or social services; however, like their younger counterparts, older adults with mental capacity sometimes choose, as is their right, not to maintain regular contact with a physician or not to receive medical care to address a chronic or emergent health issue.

(b) Caregiving, Dependency and Elder Abuse and Neglect

As even the limited cases discussed in this paper reveal, the relationship between caregiving and abuse or neglect is complex.

What is caregiving? In addition to the more obvious forms of care provided by health care professionals, such as intervening in response to emergencies, prescribing and administering medication, and delivering treatments to address chronic health problems, caregiving includes a broad range of tasks associated with managing illness or disability.

Caregiving is often delineated according to categories of care. Pat Armstrong and Olga Kits divide care into the following overlapping groupings:

- Care management: identifying and arranging formal care services, mediating between and dealing with care providers, advocating for the rights of the care receiver, completing forms;
- Assistance with instrumental activities of daily living: cooking, shopping, household tasks;
- Assistance with activities of daily living: dressing, bathing, eating, personal care, administration of medication and other health equipment; and
- Emotional and social support.¹³⁰

Although activities are often the marker of care, caregiving is ultimately characterized more as a “complex social [or professional] relationship”, not reducible to a set of actions.¹³¹ This relationship can be a source of protection or danger (or both) for the older adult.

Caregiving can be the site of abuse. Allan Foubert was an employee who provided care in an abusive manner. In this context abuse was detected because other staff witnessed the abusive treatment and reported the abuse, but only ten years after Foubert’s employment began. In the *Morin* case, Elizabeth Lussin had a regular caregiver coming into her home, but she was also receiving assistance and support from her abusive son.

A failure to provide care can amount to neglect. There is no evidence that Margaret Grant provided her mother with any care, other than assisting with tasks of household administration, and yet she was

¹³⁰ Pat Armstrong, and Olga Kits, *One Hundred Years of Caregiving* (Ottawa: Law Commission of Canada, 2001) at 3-4.

¹³¹ *Ibid.* at 1.

convicted of a crime for failing to provide the necessities of life to someone who was considered dependent on her by virtue of isolation and illness. In other words, at law, Margaret Grant *should* have either provided appropriate care herself or arranged for adequate care, even if in reality she may have been dependent on her mother in some respect.

Elder abuse can occur in the absence of a caregiving or dependency relationship. For example, was Parker Matthias caring for his mother? The case contains no evidence that he was caring for his mother; however, the case description distills the facts down to what is considered relevant to the conviction or sentencing, and unlike the neglect cases, there is no need to establish a relationship of care to establish the crime of manslaughter.

Elder abuse can occur in the context of relationships of interdependency. Parker Matthias may have been helping his mother out with activities included within the list on the previous page even if this information is absent from the case. The decision mentions that Kathleen Jennings and her son went to town together to deal with some activities. Conversely, Matthias, who resided with his mother, and betrayed a number of health and mental health difficulties, may have been dependent in some respect on his mother. Overall, the facts of the case hint of a relationship of interdependency.

Older adults are abused by people who are dependent on them. Margaret Grant may have relied on her mother for support until her mother became too ill to help her cognitively disabled daughter manage her life. Both Kathleen Jennings and Kathleen Grant may have been *caregivers* rather than recipients of care. Daniel Chartrand was financially dependent on Henry Matthews. In addition to paying Chartrand to provide support and assistance he appears to have given additional funds to Chartrand over the years as a result of his previous commitment to Chartrand's mother to help her adult child out.

The older adult's dependency on another person ought not to be equated with the presence of a caregiving relationship, and, in particular, of the older person *receiving* care by another, generally younger, person. Some older people are vulnerable to abuse by virtue of dependency on a younger person, in particular, a family member, who ought to be assisting the older adult, but is not providing appropriate assistance. The relationship between caregiving and elder abuse is complex.

(c) The Impact of Professional Regulation on Responding to Abuse and Neglect

One of the challenges health care and social service workers face in negotiating their legal obligations is that in addition to adult protection, mental capacity and access to information law, professional regulatory and licensing legislation, professional codes of conduct, and rules attached to the place of employment may impose additional obligations that may conflict, or appear to conflict, with other legal obligations relevant to responding to elder abuse and neglect. In the cases we discuss in this paper, social workers, psychologists, nurses and doctors were, or could have been, involved in providing health services or delivering care to the older adult, either as front-line service providers or in their capacity as facility administrators. Health care professionals and social workers are regulated professions governed by legislation, some of which impose limits on disclosure of the personal information of clients, and these limits may appear to pose barriers to intervention. Many of the professions have also issued codes of professional conduct or ethics that inform practice.

Given the sheer volume of material governing the professions, this paper uses the six cases as a framework for limiting material. We discuss the legislation and conduct rules relevant to adult

protection in the five provinces at issue in these cases. We further focus on those rules that impact on the duty to report and impose limits on sharing client or patient information. One significant theme that emerges is that while the professions are regulated provincially, most of the provincial regulatory bodies reference national standards of practice. There is also similarity amongst professions. Essentially, confidentiality is safeguarded but not an absolute: information may be shared where authorized by another law, such as adult protection legislation. Most professionals are cautioned to limit disclosure to the minimum amount of information required to serve the purpose at hand, but a certain amount of information sharing is presumed in the course of practice.

In the following subsections, we discuss legislation and codes of practice under a single heading. Material is organized according to the different communities of professionals. We first discuss health professionals generally. The following sections discuss rules specific to physicians, nurses and social workers.

i) **Health Professionals**

A number of laws apply to more than a single category of professionals. In British Columbia health care professionals, which are broadly defined to include nurses, doctors and psychologists, are governed by the *Health Professions Act*.¹³² The law states:

Confidential information

- 53 (1) Subject to the *Ombudsperson Act*, a person must preserve confidentiality with respect to all matters or things that come to the person's knowledge while exercising a power or performing a duty under this Act unless the disclosure is
- (a) necessary to exercise the power or to perform the duty, or
 - (b) authorized as being in the public interest by the board of the college in relation to which the power or duty is exercised or performed.¹³³

The *Regulated Health Professions Act* of Ontario permits disclosure without consent for reasons that parallel the exceptions under personal information legislation, including to aid a police investigation, where required by another law, or:

if there are reasonable grounds to believe that the disclosure is necessary for the purpose of eliminating or reducing a significant risk of serious bodily harm to a person or group of persons.¹³⁴

A number of Ontario regulations that target specific professions confirm that disclosing “information concerning the condition of a patient or any services rendered to a patient” to another person other than an authorized representative is only permitted where the patient consents or disclosure is “required by law.”¹³⁵ Otherwise the practitioner commits professional misconduct.

In Alberta, the *Health Professions Act*¹³⁶ includes social workers; however, the law is silent with respect to the confidentiality of personal or health information.

¹³² *Health Professions Act*, R.S.B.C. 1996, c. 183.

¹³³ *Ibid.*, s. 53(1).

¹³⁴ *Regulated Health Professions Act*, 1991, S.O. 1991, c. 18, s. 36(1)(i).

¹³⁵ *Professional Misconduct*, O. Reg, 856/93, s. 10. The Regulation specific to nurses is slightly more generous, replacing “required by law” with “required or allowed by law.” *Professional Misconduct*, O. Reg, 799/93, s. 10.

¹³⁶ *Health Professions Act*, R.S.A. 2000, c. H-7.

ii) **Physicians**

The confidentiality obligations of doctors were virtually indistinguishable in the jurisdictions we reviewed. The Ethics Committee of the British Columbia College and the Alberta College of Physicians and Surgeons' Health Standards of Practice reference the Canadian Medical Association, College of Physicians and Surgeons' Code of Ethics. The Code states the following with respect to the confidentiality of patient information:

Privacy and confidentiality

31. Protect the personal health information of your patients.
32. Provide information reasonable in the circumstances to patients about the reasons for the collection, use and disclosure of their personal health information.
33. Be aware of your patient's rights with respect to the collection, use, disclosure and access to their personal health information; ensure that such information is recorded accurately.
34. Avoid public discussions or comments about patients that could reasonably be seen as revealing confidential or identifying information.
35. Disclose your patients' personal health information to third parties only with their consent, or as provided for by law, such as when the maintenance of confidentiality would result in a significant risk of substantial harm to others or, in the case of incompetent patients, to the patients themselves. In such cases take all reasonable steps to inform the patients that the usual requirements for confidentiality will be breached.¹³⁷

The language of the College of Physicians and Surgeons of New Brunswick Code of Ethics is almost identical.¹³⁸

In Quebec, the physicians' code of ethics is codified in the Civil Code. The Act emphasizes the importance of protecting the confidentiality of patient information but provides that a physician:

- (5) may not divulge facts or confidences which have come to his personal attention, except when the patient or the law authorizes him to do so, or when there are compelling and just grounds related to the health or safety of the patient or of others.¹³⁹

The Quebec law requires the physician to identify the dangers disclosure of personal information is intended to avert.¹⁴⁰

¹³⁷ Alberta College of Physicians and Surgeons, online: <<http://www.cpsa.ab.ca/Resources/standardsofpractice.aspx>>. See also the College of Physicians and Surgeons of BC, online: <<https://www.cpsbc.ca/files/u6/HPA-Bylaws.pdf>>. To date, both website materials refer to the Canadian Medical Association Code of Ethics, online: <<http://policybase.cma.ca/PolicyPDF/PD04-06.pdf>>.

¹³⁸ s. 31-34, online: <<http://www.cpsnb.org/english/code-of-ethics.html>>.

¹³⁹ *Code of ethics of physicians*, 2002 G.O.Q. 2, 5574, s. 20(5).

¹⁴⁰ *Ibid.*, s. 21.

iii) **Nurses**

Nurses are similarly subject to national standards of practice. The Professional Standards of Registered Nurses and Nurse Practitioners of British Columbia reference the Canadian Nurses Association Code of Ethics for Registered Nurses, which includes the following practice guidelines under the heading “ethical responsibilities”:

1. Nurses respect the right of people to have control over the collection, use, access and disclosure of their personal information.
2. When nurses are conversing with persons receiving care, they take reasonable measures to prevent confidential information in the conversation from being overheard.
3. Nurses collect, use and disclose health information on a need-to-know basis with the highest degree of anonymity possible in the circumstances and in accordance with privacy laws.
4. When nurses are required to disclose information for a particular purpose, they disclose only the amount of information necessary for that purpose and inform only those necessary. They attempt to do so in ways that minimize any potential harm to the individual, family or community.¹⁴¹

The Alberta and New Brunswick nurses’ code of ethics and practice standards also incorporate the national code with respect to confidentiality.¹⁴²

In Quebec, the nurses’ code of ethics requires disclosure of personal information in a manner consistent with the *Professional Code*, which permits disclosure where authorized by law and also under the following circumstances:

The professional may, in addition, communicate information that is protected by professional secrecy, in order to prevent an act of violence, including a suicide, where he has reasonable cause to believe that there is an imminent danger of death or serious bodily injury to a person or an identifiable group of persons. However, the professional may only communicate the information to a person exposed to the danger or that person's representative, and to the persons who can come to that person's aid. The professional may only communicate such information as is necessary to achieve the purposes for which the information is communicated.¹⁴³

iv) **Social Workers**

In Quebec, social workers, like doctors and nurses, are governed by a code of ethics that forms part of the Civil Code. Breach of “professional secrecy” regarding all confidential information is permitted where authorized by the client or required by law.¹⁴⁴

In British Columbia, while health professionals are governed by a single law, social workers are governed by a separate piece of legislation. The *Social Workers Act* states that:

¹⁴¹ College of Registered Nurses of BC, online:

<https://www.crnbc.ca/downloads/128_Prof%20Standards%202005.pdf>. See the Canadian Nurses Association, online: <http://www.cna-nurses.ca/CNA/practice/ethics/code/default_e.aspx>.

¹⁴² College and Association of Registered Nurses of Alberta, Nursing Practice Standards, online: <http://www.nurses.ab.ca/Carna-Admin/Uploads/new_nps_with_ethics.pdf>. Nurses Association of New Brunswick, online: <http://www.nanb.nb.ca/index.php/practice/standards>.

¹⁴³ *Code of ethics of nurses*, 2003 G.O.Q. 2, 64, s. 31.1; *Professional Code*, R.S.Q. c. C-26, s. 60.4.

¹⁴⁴ *Code of ethics of social workers*, R.R.Q. 1981, c. C-26, r.180, s. 3.06.01.

- 48 (1) Subject to the *Child, Family and Community Service Act*, the *Ombudsperson Act* and the *Representative for Children and Youth Act*, a person must preserve confidentiality with respect to all matters or things that come to the person's knowledge while exercising a power or performing a duty or function under this Act unless the disclosure is
- (a) necessary to exercise the power or to perform the duty or function, or
 - (b) authorized as being in the public interest by the board.¹⁴⁵

The Ontario *Social Work and Social Service Work Act* is silent with respect to confidentiality obligations.¹⁴⁶ However, the Professional Misconduct Regulation that applies to social workers confirms that a social worker may share information about a client where the worker has “the consent of the client or his or her authorized representative,” or the disclosure is “required or allowed by law.”¹⁴⁷ The Regulation also imposes an obligation with respect to termination of services that may also be relevant to elder abuse protocol. It is professional misconduct to discontinue services unless:

- i. the client requests the discontinuation,
 - ii. the client withdraws from the service,
 - iii. reasonable efforts are made to arrange alternative or replacement services,
 - iv. the client is given a reasonable opportunity to arrange alternative or replacement services, or
 - v. continuing to provide the services would place the member at serious risk of harm,
- and, in the circumstances described in subparagraph i, ii, iii or iv, the member makes reasonable efforts to hold a termination session with the client.¹⁴⁸

The code of ethics of the British Columbia Association of Social Workers states:

A social worker shall protect the confidentiality of all professionally acquired information by disclosing such information only when required or allowed by law to do so or when clients have consented to disclosure.¹⁴⁹

The national standards set out in the Canadian Association of Social Workers Code of Ethics are referenced in Alberta and New Brunswick. The Code of Ethics identifies “Confidentiality in Professional Practice” as a core value of practice,¹⁵⁰ and goes to describe the obligation in detail:

Value 5: Confidentiality in Professional Practice

A cornerstone of professional social work relationships is confidentiality with respect to all matters associated with professional services to clients. Social workers demonstrate respect for the trust and confidence placed in them by clients, communities and other professionals by protecting the privacy of client information and respecting the client’s right to control when or whether this information will be shared with third parties. Social workers only disclose confidential information to other parties (including family members) with the informed consent of clients, clients’ legally authorized representatives or when required by law or court order. The general expectation that social workers will keep information confidential does not apply when disclosure is necessary to prevent serious,

¹⁴⁵ *Social Workers Act*, R.S.B.C. 2008, c. 31, s. 48(1).

¹⁴⁶ *Social Work and Social Service Work Act*, 1998, S.O. 1998, c. 31.

¹⁴⁷ *Professional Misconduct*, O. Reg. 384/00, s. 11.

¹⁴⁸ *Ibid.*, s. 8.

¹⁴⁹ BC Association of Social Workers Code of Ethics, online: <<http://www.bcasw.org/Content/About%20BCASW/Code%20of%20Ethics.asp>>.

¹⁵⁰ Canadian Association of Social Workers Code of Ethics, online: <<http://www.casw-acts.ca/index.html>>.

foreseeable and imminent harm to a client or others. In all instances, social workers disclose the least amount of confidential information necessary to achieve the desired purpose.

Principles:

- Social workers respect the importance of the trust and confidence placed in the professional relationship by clients and members of the public.
- Social workers respect the client's right to confidentiality of information shared in a professional context.
- Social workers only disclose confidential information with the informed consent of the client or permission of client's legal representative.
- Social workers may break confidentiality and communicate client information without permission when required or permitted by relevant laws, court order or this *Code*.
- Social workers demonstrate transparency with respect to limits to confidentiality that apply to their professional practice by clearly communicating these limitations to clients early in their relationship.¹⁵¹

v) **Conclusion**

In summary, professional licensing rules do not pose a barrier to either exchanging information or reporting abuse in the context of practice. Rather, rules and laws that apply to the professions are consistent with the laws that apply to adult protection and the confidentiality of personal and health information. Informed patient or client consent is always the ideal. Disclosure should also be limited as much as possible: only as much information as is necessary in order to address concerns regarding abuse or neglect should be disclosed. However, personal and health information may be disclosed without consent where authorized by adult protection and related legislation.

6. **The Social Dynamics of Elder Abuse and Neglect: A Discussion of Key Facts Involved in the Cases Studied**

(a) ***Grant, Chartrand, Vallée and Foubert: Mental Capacity As a Risk Factor***

Although mental capacity, which we discussed in section 4(d) of this paper, was not the core legal issue addressed in any of the six cases discussed in this paper, capacity was relevant to a number of the convictions.

Under the neglect provisions of the *Criminal Code* (failure to provide the necessities of life), an element of the offence is that the victim must have been unable to withdraw from a relationship of dependency. In both *Grant* and *Chartrand* the judge decided that the older adult lacked the requisite mental capacity to withdraw from a dependency relationship. There is nothing on record to indicate that a capacity assessment ever took place in these cases, and obviously, in the *Grant* case, by the time Margaret Grant called 911, circumstances had progressed to the point that it was too late to assess the capacity of Kathleen Grant: inasmuch as the older woman was barely conscious and had not moved in some time, Kathleen Grant was unable to make any decisions. Henry Matthews was unconscious by the time paramedics arrived on the scene, although it is not clear how long he was in this state. The facts revealed by the judgment on record suggest that Matthews maintained some physical abilities and mental capacity, but not to such an extent that he was able to withdraw himself

¹⁵¹ *Ibid.*

from Chartrand's care, given the overall social and health dynamics at play. In the absence of adequate care, Matthews' health had deteriorated to the point that capacity was impacted, if only temporarily.

Both Kathleen Grant and Henry Matthews potentially lacked the capacity to direct their own care. However, there is no reference in these cases to a capacity assessment, a guardianship order or supportive decision-making network. The question arises as to whether these older adults required some kind of assistant or substitute decision-maker involved in their lives in order to ensure they received adequate support and assistance with decisions about their health. Neither Margaret Grant nor Daniel Chartrand seem to have been appropriate informal substitute decision-makers—Margaret Grant seems to have lacked either the necessary sophistication or sense of responsibility and Chartrand was financially abusing Matthews. However, these two individuals appear to have been the only people with whom the older adults in question had regular contact. Absence of a substitute or assistant decision-maker may have enhanced the vulnerability of these adults to abuse and neglect.

Roland Marchand was pronounced incapable by a physician some time after financial abuse took place and the medical evidence indicated that at the time he was financially exploited by Jeanne Vallée he was already suffering from Alzheimer's-related dementia, exhibiting signs of a change of personality traits in terms of spending practices, and that likely his mental competency vis-à-vis financial decisions was compromised. Marchand appears to have been incapable with respect to some types of decision making at the time that the abuse took place.

The victims of Allan Foubert were all patients with dementia residing in a locked-down ward. Patients' responses to Foubert's mistreatment suggest that some patients maintained a degree of capacity, but the larger context of their restrained living arrangements indicates either fluctuating capacity (or poor care and patient abuse in the form of excessive restraint). However, it is not clear from the circumstances of abuse that compromised capacity was directly relevant to Foubert's abusive care. It is more likely that mental and physical capacity issues are one of the reasons why the abused residents found themselves living in a care facility that employed an abusive patient support worker. Compromised capacity may have undermined their ability to live independently. However, a lack of regard for the capacity of a resident was a facet of Foubert's violent behaviour. In a number of the incidents involved in this case, Foubert ignored the residents' lack of capacity, disregarding their expressed wishes.

Although the judge in *Morin* stated that Elizabeth Lussin's perception of events was likely skewed, aspects of her testimony were accepted at the trial, suggesting some cognitive ability. Only in the *Matthias* case is there no issue raised with respect to the older adult's capacity. Although substance abuse may have impaired Kathleen Jennings' mental abilities, there is no relationship revealed in this case between capability and abuse or vulnerability. However, this absence could reflect a lack of information. Jennings was isolated, not apparently receiving any services, and she died within days of the police arriving on the scene. It would be poor practice and ageist to assume Kathleen Jennings lacked capacity simply by virtue of age and addiction. But it is simply impossible to ascertain from the facts recorded in the court decisions whether she lacked capacity.

Why is capability such a focal point? The capability of an older adult has bearing on both vulnerability to abuse and appropriate intervention. The notion of capability connects back to our previous discussion of the confidentiality of personal information. It means the individual may not be able to provide or withhold consent to an intervention. A lack of capacity can impact on a

person's ability to access support and assistance or protect themselves from abuse, a factor that will trigger an obligation to report abuse or neglect in some jurisdictions.

(b) Social Isolation as an Indicator of Vulnerability or Risk

Linking back to our discussion of vulnerability in section 3, the dynamics underlying these cases exhibit many of the indicators of vulnerability. A major theme underlying all of these cases is isolation.

Kathleen Grant had not left her home in some time and the only reference to external caregiving is a reference to a missed specialist appointment in the previous year. She was known by a doctor and a specialist to be ill but was not receiving any formal care. Although her daughter was considered her caregiver, in the court decision there is nothing on record to suggest her daughter ever *provided* care. Rather, more likely, the two women had resided together throughout the younger woman's life, and at some point the elderly woman, once the caregiver for her young daughter, became too ill to care for herself or her adult daughter. Her daughter is a type of default caregiver, guilty for never either providing care or securing appropriate care for her mother. *Grant* is a case where providing support would have been a challenge for health care and social service workers because the older woman was not accessing services and no one in the neighbourhood admitted to even knowing she resided in the apartment occupied by the daughter. Kathleen Grant appears to have been isolated in the year leading up to her death.

In the *Matthias* case, the mother and son are described as leading a socially isolated life in their rural trailer park home. They were low-income people, living on a fixed income, and their major pastime was to stay at home drinking together. Although their lifestyle was isolated, Matthias was certainly well known to local paramedics and police by virtue of incidents associated with his mental illness. The isolation was not absolute.

The facts of the *Chartrand* case stand out because the victim of abuse had once been a wealthy and successful businessperson.¹⁵² Compared to Kathleen Grant and Kathleen Jennings, Matthews had at one point been a person of significant social privilege. However, disability, in this case Parkinson's, had reduced him to dependency on a caregiver, the child of his former deceased girlfriend, who also appears to have spent all Henry Matthews' money. Isolation is evident from the fact that Matthews rarely left the home except occasionally to get groceries with Chartrand's assistance.

The facts of the *Vallée* case suggest a degree of isolation arising out of the recent death of a long-time spouse and estrangement from other family members. The case also reveals deliberate efforts to isolate the victim from other loved ones who could have provided some protection against abuse: Jeanne Vallée pressured the older man to distance himself from his two daughters as a condition of maintaining Vallée's affection.

The *Fonbert* case is unique in that it involved an employee of a licensed facility. In terms of isolation and vulnerability, institutional abuse often arises out of circumstances in direct opposition to the other cases discussed earlier in this paper, for the victims are isolated *from* rather than *within* family. It thus becomes especially incumbent upon health care and social services workers to bear witness to

¹⁵² Jon Willing, "Millionaire neglected by caregiver," *Ottawa Sun*, (30 April 2009), online: CNews, <<http://cnews.canoe.ca/CNEWS/Crime/2009/04/30/9297936-sun.html>>.

and respond to abuse because other than the victim, depending on the degree of contact with family and friends, no one else may be in a position to witness mistreatment or notice the physical and emotional harm to the older adult. Other residents may not be able to report abuse.

In the *Morin* case, the elderly woman was bound to a chair or a bed for extended periods of time during 2001 and 2002. While mother and son, who lived alone together in an apartment, likely spent a significant amount of time alone together, thereby creating a number of opportunities for abuse, the relationship benefited from greater scrutiny by virtue of the presence of a home care worker, and the occasional presence of another adult child. However, the reality of Elizabeth Lussin's confinement speaks of isolation. It is likely she spent a great deal of time in her home.

In terms of the social dynamics of abuse, isolation is not only a risk factor but also a barrier to intervention. How can social service and health care professionals identify and connect with these hidden older adults? Consider, for example, Margaret and Kathleen Grant, who resided alone and did not appear to be using existing health services. How could the circumstances of that family have come to the attention of health care or community service workers? Accessing isolated but vulnerable older adults presents a tremendous challenge for practice.

(c) The *Matthias* Case: Substance Use, Mental Illness, Family Conflict and a Complex History of Family Dynamics

The *Matthias* case involves a fight between mother and son that culminated in a single fatal violent act. This case presents an especially complex set of facts that involves both causes connected to the circumstances of the individual abuser, including a history of mental illness, substance abuse (alcohol and cocaine), and serious physical health problems (HIV), as well as interpersonal dynamics, including a history of family dysfunction, estrangement, conflict and renewed interdependency or support. There is a suggestion in the court decision that this abuser is also a survivor of some kind of family violence. While there is no excuse for abuse or assault, this example of elder abuse cannot be fully understood except upon a close examination of the circumstances and the history surrounding Matthias's attack on his mother. Conducting a full examination of these facts is beyond the scope of this paper, in part because the reported decision only glosses over what is likely a complex family history, but the causative factors are worth touching upon because they bear on barriers to and options for intervention.

Alcohol is one of the most commonly cited risk factors in relation to elder abuse.¹⁵³ Elder abuse is often associated with excessive alcohol consumption by either the older adult or an abuser.¹⁵⁴

(d) *Foubert and Morin*: the Connection between Ageism and Mistreatment

Ageism may also have been a factor in at least the *Foubert* and the *Morin* cases. Allan Foubert's treatment of patients was infantilizing and demeaning, suggesting a general attitude of ageism and hostility toward the residents under his care. Clifford Morin's treatment of his mother also suggests a kind of paternalism toward her expressed needs. In both cases it appears that the abuser has violated the dignity of the older adult.

¹⁵³ Denise Bradshaw, and Charmaine Spencer, "The Role of Alcohol in Elder Abuse Cases" in Jacki Pritchard, ed. *Elder Abuse Work: Best Practices in Britain and Canada*, 1st ed. (London: Jessica Kingsley Publishers, 1999) at 332.

¹⁵⁴ *Ibid.* at 334-5.

What is ageism? The term was coined in 1968 by Robert Butler, then National Director for the Institute on Aging in the United States, who stated that, “ageism allows the younger generations to see older people as different than themselves; thus they subtly cease to identify with their elders as human beings.”¹⁵⁵ Ageism involves demeaning social attitudes and stereotypes toward older adults.¹⁵⁶ It is, in a sense, a form of discriminatory treatment based on a perception of advanced age. Ageism can result in a lack of respect for an older adult’s wishes and a denial of the person’s inherent human dignity, and may be manifested in an infantilization of the older adult demonstrated in language, tone and behaviour. The Final Report of the Special Senate Committee on Aging characterized “ageism” as follows:

Ageism can be outright discrimination which strips people of their rightful place in society on the basis of their age alone. Ageism can also be more nuanced. It can be externally imposed on seniors through rules and policies. And it can be internally imposed, where people try to comply with societal expectations by limiting their own possibilities.

Ageism is defined as discrimination on the basis of age that:

- Makes assumptions about capacity;
- Removes decision-making process;
- Ignores older person’s known wishes; and
- Treats the older adult as a child.¹⁵⁷

The Ontario Human Rights Commission identifies two types of ageism, the first involving assumptions about individuals, and the latter denoting systemic ageism:

The first involves the social construction of age, including incorrect assumptions and stereotypes about older persons. Another form of ageism involves a tendency to structure society based on an assumption that everyone is young, thereby failing to respond appropriately to the real needs of older persons.¹⁵⁸

In both *Morin* and *Foubert* the aggressive behaviour of the abuser demonstrates ageism.

(e) The *Foubert* Case: Institutional Abuse and Persecution of the Whistleblower

Care facilities will sometimes have codes of conduct that impact on practice. The Perley and Rideau Veterans’ Health Centre, Allan Foubert’s employer, has in place, at the time of writing, a number of publicly available policies, possibly as a product of the publicity and liability issues surrounding Foubert’s conviction.¹⁵⁹ The Residents’ Bill of Rights and the Facility Code of Ethics reinforce a resident’s right to confidentiality of personal information “in accordance with the law.” But they

¹⁵⁵ Robert Butler, *Why Survive? Being Old in America* (New York: Harper & Row, 1975) cited by the Canadian Network for the Prevention of Elder Abuse, “Ageism”, online: <<http://www.cnpea.ca/ageism.htm>> [CNPEA].

¹⁵⁶ CNPEA, *ibid.*

¹⁵⁷ Ontario Network for the Prevention of Elder Abuse, *Stop Abuse. Restore Respect: Response to Senate Interim Report: Issues and Options for an Aging Population* (May 9, 2008) cited in Special Senate Committee on Aging, *Canada’s Aging Population: Seizing the Opportunity* (Ottawa: 2009) at 12.

¹⁵⁸ Ontario Human Rights Commission, *Time for Action: Advancing Human Rights for Older Ontarians* (Toronto: Ontario Human Rights Commission, 2001) at 15.

¹⁵⁹ Perley and Rideau Veterans’ Health Centre, “Ethics”, online: <<http://www.prvhc.com/BoardGovernance/BoardGovernanceEthics.aspx>>.

also emphasize a culture of respect—the anti-thesis to Foubert’s approach to working with older adults.

In the *Foubert* case the missed opportunity is partly rooted in the workplace culture, which discouraged reporting the behaviour of other employees: indeed the case mentions that staff who reported abuse faced a certain amount of persecution from other employees. Although in the end these incidents of abuse were prosecuted because employees reported Foubert, the man worked at the facility for ten years before he was the subject of complaints, a factor that suggests abuse may have been occurring long before incidents were reported to the police.

A risk of victimization of the whistleblower is likely a concern employees who witness signs of institutional abuse will have to come to terms with. In all jurisdictions the law permits staff to report mistreatment; in some jurisdictions the law requires it and makes it an offence to fail to report the behaviour. These same laws provide some protection in terms of the capacity to make an anonymous report; however, in a small workplace, the complainant’s identity may be obvious. If institutional abuse is to be addressed, staff must become empowered to report abuse. The question becomes: what can be done to foster a work culture in which preventing elder abuse is commended? How can we inculcate zero tolerance of violence—against clients *and* staff?

(f) Missed Opportunities for Support and Intervention

In the *Grant* case, Margaret Grant is described in newspaper coverage as having cognitive and mental difficulties of her own, a grade 5 education, as being so inadequate a caregiver that she failed to provide one of her children with solid food by the time he was five years old.¹⁶⁰ Grant was well known to child protection services as they had apprehended all three of her children a number of years ago. Given the involvement of a specialist and a general practitioner, the question arises as to whether it would have been appropriate for the doctor to require a community health visit in the absence of follow-up. And if it was known that Margaret Grant was the only person providing support or assistance to Kathleen Grant, an assessment of the home could have been warranted.

Although the *Matthias* case does not reveal Parker Matthias to be providing care to his mother, there is a relationship of emotional and social dependency or interdependency, however dysfunctional. There are indicators of vulnerability, but do they illustrate points of intervention? In some respects *Matthias* is the most challenging case to re-imagine. For if Matthias is not so unwell that he must continue to be institutionalized, then surely in the absence of documented violence or abuse he should have been permitted to live with his mother. However, there is a reference in the decision to the police having attended due to conflict resulting in smashed windows, which suggests that perhaps follow-up by a social worker would have been appropriate or that there was a history of domestic violence. The question arises as to whether Matthias was offered adequate mental health support services on release and whether the facts present a history of violence warranting further scrutiny.

In the *Chartrand* case there appear to have been red flags that could have drawn earlier support and assistance to Henry Matthews. First, Matthews’ doctor allowed his patient to remain at home only because he was receiving assistance and support from Chartrand; however, the physician did not

¹⁶⁰ Craig Babstock, “Jail sought for elder neglect,” *Times & Transcript* (20 March 2009), online: *Times & Transcript* <<http://timestranscript.canadacast.com/rss/article/609459>>.

confirm whether Matthews' needs were being met. Did a home care assessment ever occur? We cannot know the answer to this question, based on the bare facts of the case, but the circumstances surrounding the case raise the issue of to what extent a health professional releasing an older adult to informal caregiving should be required and empowered to review or assess a plan of care. Second, police had also received a number of crime stoppers' tips that Chartrand was alleged to be spending the money of a sick elderly man, and Chartrand was known in the community to be Matthews' caregiver. This information could have led the police to send someone to visit Matthews before he became as ill as he was when the paramedics arrived on scene. The facts of the *Chartrand* case raise the issue of interagency communication in the interests of elder abuse and neglect prevention.

The *Vallée* case arose out of intervention by the state in the form of a human rights complaint filed by the Quebec Human Rights Commission upon learning of the results of the competency assessment and the financial circumstances of the victim. The question emerges as to whether earlier intervention could have prevented loss and suffering. The diagnosis of Alzheimer's appears to have been made significantly after Marchand likely developed the disease and showed signs of dementia. Was anyone in the community providing Marchand with support and assistance other than Vallée? Did any of them notice his sudden engagement to a much younger woman and his new extravagant spending practices? Such behaviour is a red flag for abuse and mental incapability or undue influence.

In the *Morin* case, at least one and maybe two paid caregivers were present on multiple occasions and gave evidence at trial as to either Morin's behaviour or his level of distress in attending what he perceived to be his mother's needs. There is no excuse for abuse. But the question arises as to whether in this case offering support to the abuser could have presented an opportunity for successful non-intrusive intervention. Interventions could have helped Morin to provide more appropriate assistance to his mother or supported Elizabeth Lussin to identify safer living arrangements, apart from her abusive son. A protection order requiring Morin to leave could have been put in place much sooner.

Indeed, in a number of these cases, offering services to an older adult *or* a family member or support person could have had an impact on an older adult's well-being. These cases present a number of adult family members with significant needs that impacted on the crimes discussed in our case studies. Parker Matthias had a well-documented mental health history. Margaret Grant appeared to have cognitive disabilities that impacted on her ability to be responsible for her mother's care. Clifford Morin had shown signs of distress.

7. Conclusion

(a) Overview of the Law

At the beginning of this paper we highlighted eight questions of importance to health care and social service workers who are concerned about responding to elder abuse and neglect in the context of their practice:

- What is my obligation to respond to abuse and neglect?

- Does my duty apply to *risk* of abuse?
- How can I simultaneously adhere to professional practice guidelines, adult protection laws and other relevant legislation, and employer policies?
- What is my duty when these rules appear to conflict?
- What confidentiality rules apply to practice?
- How can I respond to concerns regarding risk in a manner that respects an older adult's right to privacy and independence and decision to live at risk?
- How can I support the older adults I work with to live (and sometimes die) with dignity, and to age in place, without abandoning them to abusive relationships?
- How can I accomplish the above in a context of increasing deinstitutionalization of health care and greater emphasis on community care?

Below are the answers. In most respects the answers are not simple and rather lead to additional questions, some of which are discussed in the recommendations section of this paper.

Obligations under various provincial laws in relation to adult protection and mandatory response depend on:

- The province or territory of practice
- The identity of the employer
- Where the abuse or neglect is occurring
- Whether the matter involves abuse or neglect or risk of either.

Table 2, located in section 4, summarizes obligations according to jurisdiction.

Based on our review, any conflict between law, practice guidelines and employer rules is illusory. In each jurisdiction, disclosure of confidential personal health is permitted, where authorized by law or required to assist with a police investigation. In terms of practice, it is important to be aware of whether the law requires or permits reporting in the relevant province or territory. Privacy law complements adult protection law: where there is an obligation to report abuse or neglect, personal information law also allows practitioners to disclose confidential information without consent where necessary. Any employment-based rule to the contrary should not govern practice: otherwise practitioners will find their practice fails to meet legal obligations.

Similarly, under most practice guidelines, confidentiality is a sacred tenet. But exceptions are permitted where disclosure is authorized by another law. All legislation that requires reporting also imbeds into the law some protection for workers against employment or legal consequences arising out of an honestly made report.

The easiest way to avoid an appearance of conflict in this area is to involve the clients in the decision-making process and get consent from them to share their personal information. As some codes of ethics caution, restricting disclosure of confidential information to as little as is necessary to make appropriate interventions is good practice, effecting a balance between safety and privacy as much as is reasonably possible.

In each jurisdiction, a health care or social service worker may share a patient's or client's personal or health information in some circumstances without the vulnerable adult's consent. The personal information statutes applicable to each province and territory permit disclosure where health and safety are at risk. Each jurisdiction uses unique language to describe the degree of danger to the older adult that must be present to trigger the power of the worker to act without consent. The language of these statutes is broad, requiring the worker to interpret whether the facts of the circumstances match the exception set out in the law bearing in mind the value in striving for consent and empowering the client. Many employers may have created policies to guide front-line workers in appreciating their obligations in this area. Each institution should create policy that provides staff with support with respect to this complex element of practice.

Table 3, located in section 4, summarizes aspects of adult protection and related laws and privacy law, identifying the impact of these laws on the ability to share a client's or patient's confidential personal and health information in the final column of the table.

Practice also requires consideration of the role of mental capacity in triggering obligations to report, and the right to consent to disclosure of personal information or reject social service or health intervention to address concerns regarding abuse or neglect. In some jurisdictions capacity can be relevant to whether intervention is appropriate.

(b) Recommendations

The following recommendations flow from research into the law governing elder abuse and neglect and our analysis of the six cases discussed in this paper:

1. Provide workplace resources, including comprehensive training, to support health care and social service staff to identify elder abuse and neglect in all its diversity. Framing the discussion of elder abuse with court cases is a useful strategy in terms of allowing us to talk about specific examples without violating confidentiality, but this approach focuses our attention on the more extreme cases of abuse. Elder abuse includes less overtly violent actions and less extreme examples of neglect. Criminal cases also highlight abuse by family caregivers, which is likely only a facet of elder abuse and neglect in Canada. Older adults are abused not only by lay and professional caregivers, but also by family members who are dependent on older adults for care and financial support. Abuse occurs in contexts of interdependency, and relatively healthy and active older adults may experience abuse. Elder abuse and neglect occurs in all sorts of circumstances, and health care and social service workers must be empowered to recognize mistreatment in different settings and relationships.

2. Develop or utilize thoughtful resources that support practitioners to make good decisions in complex situations. Education efforts must recognize that responding to concerns about abuse and neglect raises complex ethical questions that do not lend themselves to simple solutions. Health care and social service staff require resources and support that will empower them to navigate these challenges in

a thoughtful manner. Comprehensive and appropriate training includes both developing educational tools and teaching staff.

3. *Explore what can be done within your own institutions to facilitate the development of a workplace culture that values elder abuse and neglect prevention.* Commend staff efforts to reveal abuse and deliver compassionate care in spite of significant demands on their time and energy. Consider how to foster zero tolerance of violence against staff, residents and patients in a manner that recognizes the challenging behaviours that may be exhibited by adults diagnosed with conditions associated with dementia and aggression.

4. *Support health care and social service staff to understand and respond to ageism before it leads to abuse and neglect.* Ageism may be a factor in perpetuating abuse. A number of the abusive actions and comments discussed in the cases reviewed for this project were infantilizing and demeaning, showing a general lack of respect for the older adult's autonomy and dignity, and demonstrating ageist attitudes toward older people. Action to combat ageism will require both developing educational tools and teaching staff.

5. *Develop tools, and provide comprehensive training, to support health care and social service workers to make inquiries about abuse and neglect and to document risk.* Information that indicates a client or patient is vulnerable to abuse or neglect, especially by virtue of factors such as social isolation, alcohol issues, and/or a history of significant interventions in the home by police, paramedics, mental health or child protection authorities—indicators that came up in the cases reviewed as part of the Counterpoint Project—can be instrumental to a timely response. The Counterpoint Project discussion paper contains a discussion of vulnerability and risk that may be of assistance in developing these tools.

6. *Ensure health care and social service workers and other staff are able to easily access the appropriate contact numbers for reporting abuse and neglect.* It is not always easy to identify the appropriate agency or supervisor.

7. *Develop best practices on how to offer services in a non-invasive manner that respects the unique lifestyle choices of each older adult and recognizes the social and emotional factors that make it challenging for adults to disclose abuse or neglect and accept assistance.* All adults with mental capability have the right to choose to live in risky circumstances. Staff may be called upon to investigate whether an adult truly chooses his or her circumstances by offering services and exploring whether the adult's decision making is being manipulated by an abuser.

8. *Develop policies and protocols to assist front-line staff to apply their discretion to share a client's or patient's confidential personal and health information without consent.* Health care and social service workers may disclose confidential information without consent in order to respond to concerns regarding abuse and neglect in circumstances that fall short of triggering the duty or option to report under adult protection or other relevant legislation. Health and safety exceptions under personal information laws are slightly different in each province and territory, and they use general language that requires interpretation. Employers should provide direction at the policy level by spelling out what these exceptions mean in practice. Such a step will empower staff to act and also generate greater consistency in practice.

9. *Emphasize, in all policies and protocols, the importance of always striving for a patient's or client's informed consent to interventions perceived to be in the adult's best interests.* In some instances it will be impossible or inappropriate to get consent (for example, in circumstances of great urgency or where the adult lacks mental capacity or consciousness). However, consent is always the strongest response to allegations of a breach of confidentiality, and informed consent is a cornerstone of a professional practice that empowers a client or patient through active involvement in decision making. Elder abuse is often characterized by an abuse of power, and victimization undermines an individual's sense of personal power and self-determination. Develop best practices that dismantle this pattern of undermining the older adult's will.

10. *Ensure all health care and social services professionals who interact with older adults understand the concept of mental capacity.* This means understanding the relationship between capacity and adult protection law and any other legislation relevant to responding to elder abuse and neglect in the jurisdiction in which they work. It also means being aware of the legal and conceptual relationship between capacity and the disclosure of personal information. Make this teaching an aspect of professional development for relevant professions, such as physicians, nurses, social workers and other health professionals. Mental capability is an intrinsic aspect of law and professional practice guidelines in relation to elder abuse and neglect.

11. *Develop processes for scrutinizing the adequacy of caregiving relationships that do not involve a professional accountable to an employer or a licensing body.* Older adults who receive care from individuals who do not have formal training may not be at greater risk of abuse, but there is a greater risk that abuse that occurs in private homes will go unnoticed. Isolation is a significant risk factor in terms of elder abuse and neglect. Safeguards that make this invisible care more visible may help prevent the escalation of abuse and neglect. While older adults who are receiving caregiving services by family and other informal or untrained caregivers represent only a fraction of the victims of elder abuse and neglect, additional scrutiny of these relationships by health care and social service workers may prevent abuse and neglect.

12. *Offer support services to non-professional, informal, and volunteer caregivers of older adults to enhance their capacity to manage this physically, emotionally and technically challenging responsibility.* Although abuse and neglect are wrong regardless of the motives or circumstances, some abuse and neglect might be preventable if non-professional caregivers received greater support from health and social services. Isolation, lack of skill and an absence of support on the part of the caregiver sometimes contribute to abuse and neglect. Family and informal caregiving save the state significant funds.

13. *Develop protocols and mechanisms to facilitate, in a respectful manner, periodic contact with older adult clients and patients with significant health problems who fail to attend medical appointments or maintain medical follow-up.* While mentally competent older adults maintain the right to refuse medical treatment and support services, physical and other barriers may undermine an older adult's efforts or desire to maintain contact with health care providers. Some safety measures should be put in place to ensure that these adults, who may have heightened vulnerability to abuse and neglect, do not disappear from the system unless they make an informed decision to stop or refuse treatment.

14. *Develop mechanisms to facilitate interagency communication amongst police, health and social services in circumstances where an older adult appears to be at risk of abuse or neglect.* Ensure these policies and practices hold high regard for the confidentiality of personal and health information. However, bear in mind that confidentiality should not become a barrier to making inquiries to confirm that an older adult is safe.

(c) Last Words

This paper began with a discussion of six reported court decisions involving elder abuse and neglect—five criminal cases and one case reviewing a decision of the Quebec Human Rights Tribunal. The cases are intended to frame our discussion of the laws relevant to elder abuse and neglect, providing a context to assist us in highlighting ethical dilemmas and practical challenges that pose barriers to response, clarifying obligations and options under the existing legal framework, and making recommendations for the development of resources, educational tools, policies and protocols that would help support the practice of health and social service workers who deal with older adults and must identify the appropriate response to concerns regarding abuse and neglect.

Elder abuse and neglect is a vast and complex social phenomenon, and there is no question that as much as we attempted to present a diverse cross section of cases in this paper—covering different provinces and territories, types of abusive behaviour, criminal offences and relationships or contexts of abuse – six cases will present a partial portrait of elder abuse and neglect. Moreover, although in our review of the cases we underscore some of the social dynamics at play in the circumstances involved in each case, this discussion paper is not a sociology paper; rather, this paper contains legal research and analysis. As a result, our analysis of social dynamics is partial as well.

Elder abuse is a complex problem that cannot be explained by a single theory.¹⁶¹ Literature on elder abuse and neglect has identified a number of theories to explain the causes or dynamics underlying elder abuse. They include:

- Feminist theory based on domestic violence models
- Intergenerational transmission or social learning
- Intra-individual dynamics, such as those involving mental illness and alcoholism
- Situational theory wherein abuse is linked to stress
- Political economy theories, blaming structural forces and the marginalization of older adults within society, including ageism
- Exchange or power/control theory—abusive relationships characterized by reciprocity, dependence or interdependence and tactics developed in family life and continued into adulthood, such as forms of mistreatment for gain.¹⁶²

The cases discussed in this paper illustrate some but not all of these theories. There are notable absences from this paper. Domestic violence is at best illustrated by the *Matthias* case, which fails to capture the more common dynamic of gendered spousal violence in which an older woman is being

¹⁶¹ Rosalie Wolf, “Elder Abuse and Neglect: History and Concepts” in Richard J. Bonnie and Robert B. Wallace, eds. *Elder Mistreatment: Abuse, Neglect and Exploitation in an Aging America* (Washington, DC: National Academies Press, 2003) 238 at 241.

¹⁶² Silvia Perel-Levin, “Discussing Screening for Elder Abuse at Primary Care Level” (London: World Health Organization Ageing and Life Course, 2008) at 7. See also Wolf, *ibid.*

victimized by an abusive spouse or partner. For various reasons we were unable to locate an appropriate case that illustrated this type of dynamic, but it should not be inferred from this omission that spousal abuse of older women is not a serious problem that must be addressed by any comprehensive response to the problem of elder abuse and neglect. Likewise, financial abuse by substitute decision-makers of older adults, including family members, is a serious problem not reflected in the criminal cases that we focussed on.

There is no excuse for abuse. However, understanding some of the dynamics that lead to abuse can help us identify barriers to practice and appropriate tools for response within the existing limited legal framework.

This paper highlights obligations to report abuse and neglect and the circumstances under which the personal and health information can be shared—with or without client consent. It should not be deduced from this focus that reporting abuse is the ideal or only solution; nor should it be concluded that disclosing confidential information without consent ought to be encouraged. The goal is that health care and social services practitioners appreciate the legal boundaries that constrain practice. There is a lot of grey to navigate in determining the most appropriate response in each instance. Identifying the black and white will hopefully assist practitioners to better focus their problem-solving energy in the context of a demanding and complex practice.

Isolation emerged from this case review as a primary risk factor in terms of abuse and neglect. The provision of health care and social services reduces isolation. Given the many points of possible entry of social and health service intervention as a person's need for assistance evolves as he or she moves along the life course, there are opportunities for detecting and responding to concerns regarding abuse and neglect. As an individual moves along the care continuum, from home and community care to long-term care, from public health to acute care, the person will come into contact with numerous health care workers with the ability to intervene—*if* they appreciate the law surrounding their obligations in some circumstances to respond as professionals and their duty to respect an individual's decision-making autonomy.

In some contexts, there is a clear legal obligation to step in: for example, there are strong indicators that violence has occurred; there is a clear absence of mental capability or consciousness. In other circumstances, there is no legal means of protecting an older person from further decline in health or harm because it is evident that a mentally capable adult has chosen a risky lifestyle or no one is mistreating him or her. In some instances the adult must be permitted to live in dangerous circumstances because he or she appears to freely choose such a lifestyle, even though it puts the person at risk. However, in between these two poles, there is a grey area into which many circumstances will fall.

One of the major goals of the Counterpoint Project is to support health care workers, community services providers and other health care professionals to walk this fine line: to know when they are required to intervene; to know when they must walk away; to know when they must report abuse to authorities; to identify when intervention might mitigate against further abuse and neglect. Another goal is to provide information that clearly identifies legal responsibilities, such that workers can respond with less fear of being deemed responsible for the poor state of the adult who is being abused or is at risk of abuse. The hope is that this information will further empower health care and community support workers to take appropriate and timely action.

For health care and social service workers it is challenging to know when and how to intervene. Laws vary across jurisdiction. Multiple laws and practice guidelines apply within a single province or territory of practice. Information tools are required to translate these laws into clear practice guidelines in a manner that recognizes many factors such as the social dynamics that impact on elder abuse and neglect, the diversity of abusive relationships, the current institutional contexts and social culture in which workers are delivering services, and the larger community involved in responding to elder abuse and neglect. The goal of the second part of the Counterpoint Project is to produce some of these educational tools to support practice. However, some changes will also be required at the institutional level in order to support enhanced practice with respect to elder abuse and neglect prevention and response and to facilitate a coordinate response amongst the different professionals that an older adult facing abuse or neglect may encounter. We mentioned a number of these changes in the recommendations section of this paper.

There is significant will to prevent elder abuse and neglect. However, there is reluctance to respond to concerns about elder abuse and neglect that is rooted in genuine apprehension about intruding into the lives of mentally capable adults, second-guessing their choices, violating their privacy, and undermining their independence at a time of life when independence is especially highly valued. For how can you incorporate community and professional scrutiny without violating privacy, independence and human dignity? Reluctance is also a function of a lack of information on existing adult protection laws and related legislation, which are currently undergoing change in a number of provinces, and which vary in fundamental ways from jurisdiction to jurisdiction. Ultimately, no practice tool can render simplistic the challenge of responding to elder abuse and neglect. Hopefully, however, additional educational tools—combined with practice guidelines and infrastructural change—will further empower health care and social service workers to better navigate the ethical dilemmas and legal issues that arise in the context of responding to the complex phenomenon of elder abuse and neglect.