TAB 10

Elder Abuse

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Elder Abuse

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On June 15, 2009, the Canadian federal government launched a nationwide awareness campaign entitled "Elder Abuse - It's Time To FaceThe Reality."

Led by Human Resources and Social Development Canada, the objectives of the campaign are to:

- Raise public awareness of what constitutes elder abuse and that it carries serious consequences;
- Inform seniors that help is available and where to find it; and
- Inform Canadians of their role in helping to identify and report elder abuse.

The campaign includes television, internet and magazine advertisements. The television ads can be viewed at the Seniors Canada website –www.seniors.gc.ca – by clicking on the button "Elder Abuse - It's Time To Face The Reality." There are also links to a number of brochures, fact sheets and papers associated with this awareness campaign.

The Federal campaign is interesting in that it steers away from any discussion or description of the law about elder abuse or legal remedies. From one perspective this was a smart decision on the part of the civil servants and politicians in charge of the campaign because the law about elder abuse is not a "neat package' nor would we want it to be. Other than abuses that fall under the Criminal Code, most abuse issues involve civil matters that fall under provincial jurisdiction therefore the remedies may vary across the country. From another perspective, this lack of discussion about the law is a serious shortcoming as elder abuse is a legal issue and responses to abuse involve an understanding of individual's rights and the remedies that people can seek to enforce their rights or to stop abuse.

The legal framework in respect to abuse and abuse prevention is complex. There is no one remedy because the term "abuse" can apply to a wide variety of problems. Depending on the type of abuse, there are various remedies in law. In effect the term "abuse" can apply to all legal problems where a person has been taken advantage of in some way, has had their rights abrogated, or has lost money because of the actions of another party.

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1 The Advocacy Centre for the Elderly is a community legal clinic funded by Legal Aid Ontario. ACE's mandate is to provide legal services to low income seniors in Ontario. The legal services include client advice and representation, public legal education, law reform activities and community development. ACE was the first legal clinic of its kind in Canada and has been in operation since 1984. For more information about ACE see www.acelaw.ca.

So if an attorney named in a power of attorney misappropriates funds of the grantor, the action may be for breach of fiduciary duty and restitution. If a spouse removes all funds from a family joint bank account without agreement of the other spouse, the latter will claim abuse and the remedy will likely be in family law. If a salesman takes advantage of a person through sharp practice or misrepresentation, the remedy may be under consumer protection law. If a con artist takes advantage of an elderly person who is cognitively impaired, having her transfer title to her property to him, after which he places mortgages on title and keeps the proceeds of the mortgages himself, actions for restitution, fraud and conversion (theft) may be appropriate. If a regulated health professional administers neuroleptics on a non emergency basis to a long term care home resident without an informed consent from him, if capable, or from his substitute decision maker as defined under the Health Care Consent Act, the remedy may be a request for investigation by the Ministry of Health and Long-Term Care, and a complaint to the College of Physicians and Surgeons of professional misconduct.

In addition to specific remedies in different areas of law, some provinces have either voluntary or mandatory reporting legislation that requires most people that observe an incident of elder abuse as defined by that legislation to report it to a social service agency for adults that is roughly equivalent to a Children's' Aid Society. That adult protection agency then is mandated to investigate allegations of abuse and take steps to protect an older adult from abuse by providing them with assistance and services. That protection may involve a process of trying to get the senior to voluntarily agree to services or assistance deemed appropriate by the adult protection agency, failing which the agency may have authority to apply to court for an order declaring the senior an "adult in need of protection". After that declaration the agency may obtain authority to make some or all decisions for the senior, whether that senior is mentally incapable or capable of their own decision making, in an effort to protect them from abuse. .

This type of reporting legislation has come under criticism for many reasons, the primary criticism being that it is based on child protection legislation. Seniors are not children but are adults and as such have the right, if mentally capable, to make their own decisions even if those decisions may place them at risk (in the opinion of others). There is little evidence that this type of reporting of abuse either prevents abuse or successfully assists victims of abuse in the long term as it fails to provide the necessary supports that victims need to stop abuse, such as long term shelter, social services, legal assistance, and home care. The legislation has been criticized as being a bandaid, giving the appearance of action and response, but in reality offering only a limited short term response. That response may end up being efforts by the adult protection workers to have the service provider that did the report in the first place to provide a service to the senior. Despite this lack of evidence of success, successive public surveys on elder abuse repeat the call for "a law" to address elder abuse and to have mandatory reporting because it sounds appropriate.

Ontario does not have mandatory or voluntary reporting legislation of this type, except a requirement for reporting of harm to residents in long term care homes to the Ministry of Health

and Long Term Care. There are some elements of adult protection legislation in the Substitute Decisions Act[2] This will be discussed later in this paper.

People often fail to identify that elder abuse is not "one "issue but a complex web of legal and social issues. The law, or a law , is only one piece of the puzzle in addressing elder abuse. Often the supports that victims of abuse need are housing, health and social services and income supports . The law or laws are tools to assist people but are not the only answer to this difficult issue.

This paper is an overview of what people commonly call elder abuse as well as a discussion of the law in Ontario that specifically applies to abuse and some legal remedies that may be pursued to address abuse.

The Face of the Older Client

In examining the issue of elder abuse and in looking at remedies and responses, including legal remedies and legislative response, it is important to understand who makes up the older population and who would be the clients. It is important to not make assumptions about aging that would lead to an ageist bias in acting for older adults as clients and in finding remedies for elder abuse issues.

It is also important to acknowledge that the clients are the seniors, who may be the victims of the abuse. If consulted by the senior, the families of the seniors are not the clients unless the senior is not mentally capable to provide instruction. Therefore the legal remedies and approaches should focus on how to resolve the problem for the senior, at his or her direction, and how to support the senior's choices about how to resolve/address the problem experienced.

Some legislative approaches to elder abuse, particularly the adult protection legislation models, look more at what service providers should do TO the senior rather than WITH, at the direction of the senior. So the legislation details obligations of reporting abuse to a third party rather than of helping the senior directly. Or it describes what orders can be made about the senior- orders to declare a person to be "an adult in need of protection", orders for the removal of the senior to an alternative place of accommodation to supposedly keep the senior safe from abuse, and orders directing other service delivery to the senior if such services are available in their particular community. It is submitted that what we should be looking at are remedies over which the senior has the power and direction – therefore the supports and assistance are made available and delivered to the senior with his or her consent.

This is the position of the Advocacy Centre for the Elderly. We have reached this conclusion based on our experience working with older clients, and after gaining a better understanding of the characteristics of the older client community. Unlike the image of the older adults portrayed in the elder abuse literature (frail, lacking capacity or with diminished capacity, vulnerable etc), our experience is that many seniors who are victims of abuse are able and competent individuals

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that may need assistance but that want that assistance on their own terms, with control over decision making remaining in their own hands, and not in that of the service providers. Many seniors reject the approach taken by some services that assume that they know better than the senior what the senior needs, and therefore must "protect" the senior even if the senior refuses the type of help offered.

Not all seniors are dependent and in need of protection. In fact, the vast majority of seniors are mentally capable and independent, describe themselves as in good to excellent health, and have a modest income. They live in their own homes and apartments, and only a small percentage require facility or institutional care. If community health and social services continue to develop, this need for facility care should continue to be limited to those persons requiring a high level of health care.

This is not to say that many seniors do not have some limitations in respect to physical activity and mobility. If disability is defined broadly to include conditions that limit activities, then more seniors than people under 65 have a disability, but this does not necessarily mean that they cannot manage or that they are dependent.

The experience at ACE is that most seniors fit this description of life at an older age. This is despite the fact that a number of the seniors who have been clients of ACE live in long-term care facilities or in care homes (retirement homes). They are still capable adults, and able to provide instruction to counsel.

If "defined" by their health condition (clinical diagnosis), disability or degree of physical need, many seniors would appear to be very vulnerable and dependent. If looked at as adults with the ability to instruct and to make decisions on their own, in their own best interests, the same group of people lose much, if not all, of their "vulnerable" status. In a number of instances, the vulnerability of the client is as a result of the way that "systems", service providers, and families treat the senior and not from a lack of ability due to age.

This is not to say that all seniors are able to deal with all the types of problems that they face from day to day or that seniors do not need to plan for possible problems that may arise as a result of possible physical frailty or disability or mental incapacity. Seniors, like any other clients, seek assistance from the legal community to address problems that they must face either in the present or future. Some of these problems, such as conflicts in long-term care facilities, may be more unique to an older population or population with disabilities than a younger population simply from the fact that seniors are the majority users of these services. In some instances, the law may impact on the senior population in a different or disproportionate way, such as in substitute decisions and health care consent, and therefore legal counsel must be aware of the "seniors twist" when practising in these areas of law for older clients. In other areas of law, there is little or no difference in serving an older or younger client.

Some statistics from *Facts on Aging in Canada* compiled by the Office of Gerontological Studies at McMaster are included in this paper to illustrate what the seniors' community actually looks like.

Demographics

The senior population in Canada is rapidly increasing. This is a result of the Baby boom post World War II and improvements in health and lifestyle. There are simply more people with the potential to live to an old age and people are living better and healthier into old age than in past history. According to Statistics Canada, in 1951, 7.8% of the Canadian population were 65 or older. Of these only 0.7% were between age 80-84 and only 0.4 were 85 or older. In contrast, by 1991, 11.6% of the population was 65 or older, and of these 1.4% were age 80-84 and 1.0% were 85 or older. It is estimated that by 2011, 14.6% of the population will be 65 or older, of which 2.0% will be between 80 and 84 and 2.1% 85 or older. By the year 2031, it is expected that 22.7% of the population will be over the age of 65, of which 6.4% will be between 65-69, 5.8% between 70-74, 4.5% between 75 and 79, 3.2% between 80-84, and 2.8% being 85 and older. The number of seniors in 2031 is estimated to be 8 Million Canadians.[3]

Gender

The older population is made up of a higher proportion of women than men. In 1991, there were 72 men to every 100 women, 65 and older. This is expected to remain approximately the same in the year 2031. Note that women form a much higher proportion of the older senior population. In 1991, in the age group 75-84, there were only 65 men to every 100 women and in the group 85 and older, 44 men to every 100 women. By 2031, there is expected to be 67 men to every 100 women age 75 -84 and 42 men to every 100 women, age 85 and older.[4]

Marital Status

The vast majority of older men are married however less than half of older women are in this position. More older women than men live as widows from the simple fact that more women live into "old" old age. The marital status of Canadians 65 and older by age and gender in 1991 were as follows:

Age Group	Divorced	Single	Widowed	Married
65+ Females	3.0	7.7	46.7	42.6
65+ Males	2.8	6.9	12.9	77.3
65-74 Females	4.0	6.5	33.5	56.0
65-74 Males	3.4	6.7	7.7	82.2
75-84 Females	1.9	8.8	59.2	30.1
75-84 Males	2.0	7.0	18.3	72.7

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3. Statistics Canada. Population Aging and the Elderly. Ottawa, 1993 (1991 Census of Canada; Cat.No. 91-533E, p.110) as cited at page 10 in *Facts on Aging in Canada*, Compiled by the Office of Gerontological Studies, McMaster University, Gail Elliot, Melanie Hunt, Kim Hutchinson, 1996 McMaster University, Office of Gerontological Studies.

4. Statistics Canada. J.A. Norland. Focus on Canada - Profile of Canadians's Seniors. Ottawa, 1994 (Cat. 96-312E, p.89) as cited at p.14, IBID.

85+ Females	0.8	10.4	78.8	10.0
85+ Males	1.2	8.7	39.2	50.9 [5]

Health Status

Although health status does decline to a degree as we age, most seniors describe themselves as in good to excellent health and not as frail or dependent. In a 1990 Health Promotion Survey, 74% of both Canadian men and women age 65 and older rated their own health as good to excellent and 26% rated themselves as in fair or poor health. In contrast, 87% of Canadians 15 to 65 rated their own health as good to excellent and 13% rated themselves as in fair or poor health.

This health status is reflected in the living arrangements of seniors. Only an estimated 6% of the Canadian older population live in long-term care facilities. It is argued that this percentage is high and would be less if adequate community resources existed to help people receive homemaking help and more health care in their own homes and apartments. This percentage of people living in long-term care facilities increases with old old age (85+) with 33% of that very old population living in "institutions" in Ontario.[6] Institutions are defined as including hospitals, long-term care facilities, retirement homes, and other group living arrangements.

Although people rate themselves as in good to excellent health, many seniors must cope with a degree of disability. In a 1991 Health and Activity Limitation Survey, "disability" was defined as "some level of disability or long-term health condition that limits the kind of activity at home, work, school, or in other activities such as travel, sport or leisure." By that broad definition, 37% of seniors 65-74 were defined as having a disability, with this number increasing to 79.6% to 85.5% for men and women age 85 and over. In contrast, 12.9% of the population 15 to 64 were defined as having a disability.

Many people fear suffering from a dementia in older age. In a 1994 study published in the Canadian Medical Association Journal, it was estimated that 7.7% of the population age 65 and older in Ontario were suffering from a dementia. Of these people, 58% lived in some form of institution. It would appear that an increasing number of seniors in long-term care facilities suffer from a dementia. Persons suffering from a dementia are particularly vulnerable due to their dependency on others and lack of ability to help themselves or to reach out for assistance. However, it must be remembered that even if a person has a dementia, they may still be mentally capable of decision making in many facets of their lives, including being mentally capable to instruct counsel for a number of purposes, particularly in the early stages of dementia. Dementia is a clinical diagnosis whereas mental capacity for decision making is a legal determination based on the analysis of the ability of an individual to understand information relevant to making a decision and appreciate the consequences of making or not making a decision.

A problem for seniors is the assumption by some service providers of all types, including lawyers and financial managers, that they lack mental capacity to make choices or to instruct

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5. IBID, P.18.

6 Senior Smart Ontario at http://www.gov.on.ca/citizenship/seniors/english/seniorsmart.htm

counsel or give directions to other service providers. Capacity is not the score on the Mini Mental Status Test (the MMSE). Nor is it always the results of an assessment by a health professional or by a capacity assessor. In Ontario, despite the fact the legislation on mental capacity – the *Substitute Decisions Act* and the *Health Care Consent Act* – has been in effect for 14 years, there are still basic misunderstandings about what is mental capacity, how it is determined and by whom it is determined

From the research on capacity cited above, the vast majority of seniors (92%) are likely to be mentally capable yet the capacity of seniors is often questioned, particularly if they make choices that other persons would not agree with. A complete discussion of capacity and how it affects abuse response is beyond the scope of this paper, but it is important for all persons reviewing remedies for abuse and in looking at abuse prevention, understand what capacity is and is not and the rights of the capable person.

What is "Abuse" of Older Adults?

The term "abuse" can apply to a wide range of behaviours and actions, including both deliberate actions and neglect. Abuse of older adults can be defined as "any action, or deliberate inaction, or neglect, by a person in a position of trust, which causes harm to an older adult".[7] This is not a definition from legislation but is a definition developed to describe the issue. The definition has been derived from research, from literature, and from experience with client case matters that could be classified as "elder abuse". This type of definition reflects the belief that abuse is harmful, can be either intentional or the result of neglect, and includes many different types of behaviours (activities in respect to property or the person, etc), crossing a wide range of areas of law.

A common theme in many definitions of abuse, including this one, is that abuse involves a power imbalance. This is the reason for the focus on the relationship between victim and perpetrator. Relationships are abusive when a person uses various tactics to maintain power and control over a person. In the seniors context, the abuse of power may be blatant threats or coercion but it may also be misuse of family relationships – "you will not see your grandchildren unless you give me money, or sign over your house to me or ...." . It may involve minimizing and blaming the older person, diminishing their self worth in order to manipulate them to do actions for the benefit of the perpetrator.

Considering the degree of ageism in our society that already diminishes the worth/value of the older adult, stereotyping them as incapable persons, this type of behaviour by the perpetrators helps them take control of the seniors and makes them believe that they don't have options and

[7] This definition is used by ACE and appears in the ACE Elder Abuse manual on the ACE website www.acelaw.ca .

alternatives to the abuse[8]

A perpetrator may isolate the older adult, particularly if the older adult has a degree of dependency on the perpetrator. This dependency may not be because the older adult lacks mental capacity or is very disabled but it could be a dependency on the perpetrator for simple assistance such as driving.

In one matter, a client of ACE lived in a semi rural area that had no parallel transit services and limited public transit. The woman, although mentally capable and quite independent generally, needed her nephew, the "abuser" to drive her to go shopping and to see her physician and to do the various tasks in her life. She was not aware of alternative services and thought that her nephew was her only option for transportation.

The nephew had been close to being successful in getting rid of all the in home help that she previously had had, arguing that he was helping her so there was no need for either the private pay or public services to assist her any longer. She would have been totally isolated by him had it not been for her homemaker from a publicly funded agency who insisted that she continue to do the housecleaning despite the nephew's presence in the home. The client wanted the homemaker to continue providing help. Initially the service providing the homemaker had listened solely to the nephew although the client was mentally capable and should have been the one who agreed or disagreed to the service being removed.

Eventually the client told the homemaker about what was happening to her in the household, which did involve various abuses, both physical and financial. The homemaker helped her get alternative help that enabled the woman to end the dependence on the nephew, She also helped her get access to a lawyer (from ACE) who helped her revoke the powers of attorney in favour of the nephew, regain control of her assets, get restitution for the moneys misappropriated by the nephew, and regain title to her property. The abuse came to an end when the various service providers started taking direction from the elderly woman and not her more dominating nephew.

Service providers may unintentionally feed into the abuse and the plans of the abuser by failing to pay attention to who is their actual client – the older person or the relative/friend that accompanies the older person or appears to be trying to "speak for" the older person. On a number of occasions, we have observed service providers taking direction from an attorney named in a Power of attorney without reviewing the power of attorney document to ensure that it gives the attorney the authority the attorney claims to have. In some cases the service provider has not confirmed that it is a valid power of attorney, particularly when the client had previously always been the instructing party to the service provider and would not ordinarily conduct business through an agent,

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8 A recent example of this ageism was a television ad produced by KFC. That ad depicted a family enjoying KFC products. Each family member comments on the food except the grandmother figure who has the chicken bucket on her head . Her comment is that she doesn't understand why the rest of her family does not want the "great party hat". Many groups across Canada and the USA, including ACE, contacted KFC in Kentucky in protest over this very ageist ad. The ad was modified to remove the segment showing the older woman and all references to the "party hat". Many ads show a milder variant of this ageism, usually depicting the older adult as having a diminished capacity as though that was the norm of older ageincluding ACE, contacted KFC in Kentucky in protest over this very ageist ad. The ad was modified to remove the segment showing the older woman and all references to the "party hat". Many ads show a milder variant of this ageism, usually depicting the older adult as having a diminished capacity as though that was the norm of older age.

This seems to be particularly prevalent in health facilities when the older person has named a relative as the attorney in a power of attorney for personal care. Despite the fact that the attorney in a power of attorney for personal care gets no authority to act as decision maker for personal care for the senior until the senior is not mentally capable for personal care, we have observed health providers taking directions for treatment for the senior from personal care attorneys, Many long term care home administrators/ staff ask attorneys to execute advance directives on behalf of the senior, contrary to the provisions of the *Health Care Consent Act*, and take directions from family members and attorneys over the protest of a capable senior.

This definition of abuse also captures the dynamic of the abuse – that it is perpetrated by a person in a position of trust. The term "position of trust" is meant to reflect a relationship between the perpetrator and the victim. This relationship can be that of family (son-mother, grandchild-grandparent etc), or of caregiver to older person receiving care services such as between a person living in long term care and the personal support workers in the LTC home. It also describe the situation where a scam artist makes efforts to get into a trusted position with a victim, fostering a relationship, although short lived, to persuade the senior to put their trust in them and give them their money, or sign documents, or engage in whatever activity that permit the scam to take place.

It is this dynamic that makes the abuse difficult to address as the older person may not want to reveal the abuse, out of love or fear of retribution from the perpetrator. The older person may not want to address the abuse as it may mean that in so doing he or she must take action against a family member or report the abuse that is a crime to the police.

A common theme of the "elder abuse" ACE client matters is the reluctance of the older person to, in effect, get their adult child "into trouble". In one instance an older woman had been victimized by her son who cleared out all her bank accounts, using a continuing power of attorney for property executed by her. He then moved to another jurisdiction. The woman was advised that, assuming the son could be found, it may be possible to take action against him to recover the misappropriated funds. As well, she could report the matter to the police as there may be evidence that the son could be charged with a theft by person holding power of attorney, a Criminal Code Offense[9]. The older woman said that she did not want to take either route as she was more concerned about losing her relationship with her son, who was her only surviving relative. She felt that although he had done a wrong to her, she would just do without her money. She said that her son would have inherited the funds one day in the future, after her death, so that idea in some way let her accept what had been done and excuse it, despite the fact she knew that her son had both committed a crime and had betrayed her trust.

This example illustrates the need for providing comprehensive legal advice to persons executing powers of attorney or any other such similar documents. This woman said that she did not know and had not been told by her lawyer the extent of the authority that she was giving to her son by creating a continuing power of attorney for property. The lawyer may have thought that he or she had given sufficient advice to her before executing the document however our experience is that

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9 Criminal Code Section s.331

this is not always done, or is done in a manner that does not explain the authority in practical terms.

As well, some people do not get legal advice before executing continuing powers of attorney for property, either completing a POA property from a kit that they have purchased or obtained for free, or completing a POA property at a bank or with a financial advisor or with the assistance of a health professional or social worker. Many kits are not appropriate for the jurisdiction in which the power of attorney is being executed or contain misleading or wrong information about the scope of authority of the attorney and other details on how a POA property should work. The other professionals assisting the senior to prepare the power of attorney may themselves have misunderstandings of how POAs work and contribute to the client's misunderstandings. All of this creates the potential for abuse.

Some service providers in long term care require the seniors moving into their homes to execute POAs of both types, usually naming relatives as the attorneys, prior to admission. After execution of such documents, the facility administration then deal with only the named attorneys despite the fact that the senior may still be mentally capable and therefore entitled to make both financial and health decisions for him or herself.

This practice is abusive and inappropriate as a long term care home cannot set up eligibility or admission requirements except as permitted by the applicable legislation, and this particular authority is not in that legislation. It is not a precondition of admission that seniors moving into long term care execute POAs of either type. As well, the capable senior does not lose the right to make their own decisions for finances and /or health care merely because they have executed these documents. In such situations, we assist the senior in making complaint to the facility administration, to the Ministry of Health and Long-term Care compliance office, and to the applicable health colleges (nurses, physicians etc) depending on which health providers are failing to obtain appropriate consent to treatment. If harm is caused by this misuse of the POAs, other appropriate civil action may be considered.

Many people assume that they understand how powers of attorney work when in fact they have fundamental misunderstandings about these documents. When ACE lawyers do education sessions on POAs , to seniors or to service providers to seniors that should understand these documents, we always get questions from the audience that show that many in the group think that the named attorneys only get authority to manage property after a formal assessment of incapacity (not true), that attorneys are "monitored" by some public office in the management of the senior's estate (not true), that all attorneys must register the POA at some government office before it is used (not true) and that a POA once given cannot be revoked (not true). [10]
Seniors also experience "systemic abuse". Whether it is because few lawyers in the past have focused attention on the legal problems of older adults, or few seniors have used the legal process to address some of the problems that they experience, "systems" get away with activities that are take away and limit a seniors rights even if these rights are supposedly protected in law.

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10 ACE produced a video on the key issues that should be considered before signing a POA of either type. That video is available for purchase form ACE from the ACE website. On that website is also a paper entitled "Twenty-five Common Misconceptions about the SDA and HCCA" that describes and clarifies many of the common misunderstandings held by service providers about this legislation. .

One current example of systemic abuse is in respect to discharge of seniors from hospitals into long term care facilities.[11] The discharge issues from hospital usually require individual advocacy but to date have not required representation in court. In Ontario, as probably in all provinces across Canada, the hospital discharge planners are under pressure to free up acute care beds and move persons that require either community care or long-term care out of the hospital as soon as possible. Section 16, Regulation 965 under the *Public Hospitals Act* states that when a patient no longer is in need of treatment in the hospital, the attending physician is required to make an order that the patient be discharged and communicate that order to the patient. The patient is then required to leave the hospital.

However, when a patient requires continuing care, like long term care, the hospital cannot just order him or her to leave without risking a claim in negligence should the he or she suffer harm as a result of the discharge. Regulations under the *Medicine Act* make it clear that doctors are under a general duty not to abandon patients in their care. It may be professional misconduct if a physician discontinues services to a patient unless the patient requests the discontinuance, or alternative services are arranged, or the patient is given reasonable opportunity to arrange alternative services.

Can the hospital argue that the patient must take the first available bed in any long-term care home if one is available, even if the facility is not one that they would want to move into? On the patient's side it can be argued that the hospital has no authority to do this as patients have the right to chose which long-term care homes they wish to apply to. Although its usually not the best arrangement to remain in hospital when a person needs long-term care, it may be the best arrangement for the patient if the bed that is available is in a home that is not suitable for the patient's needs and not one that the patient would want to live in.

Regulations under the *Nursing Homes Act, Homes for the Aged and Rest Homes Act* and the *Charitable Institutions Act*, the three pieces of legislation dealing with long-term care facilities in Ontario, establish the rules concerning eligibility and admission to long-term care. These regulations state that patients can select up to three facilities to make application and be on up to three waiting lists for homes. Patients, or a substitute decision maker for that patient, if the patient is not mentally capable, must consent to admission to long-term care, therefore patients cannot be forced to move into a facility not of their choice. Discharge planners may suggest that the patient and /or their family consider a bed in a home that they have not chosen as they may

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11. In an effort to provide the seniors community with better information on the law related to long-term care, the ACE staff produced a comprehensive manual on long-term care law, *Long-term Care Facilities in Ontario: The Advocates Manual* . It went through three editions and is over 600 pages in length. Chapters of this manual are available electronically on request by emailing wahlj@lao.on.ca. It is no longer being made available by purchase from ACE because the legislation dealing with long term care homes is going to change in the immediate future. The Nursing Homes Act, Homes for the Aged and Rest Homes Act and the Charitable Institutions Act will be replaced by the Long Term Care Homes Act which has been passed but not proclaimed. Proclamation is expected after the regulations to the legislation have been prepared. Proclamation is expected in the Spring 2010. ACE is in the process of writing a new text on Elderlaw, a large part of which will be current information on the law that applies to long term care homes.

have not considered that particular facility but if the patient refuses to replace one of their own choices with that new choice, the hospital cannot require the patient to do so.

Can the hospital require that the patient choose certain homes as one of the three homes for which they can be placed on waiting lists? It is not uncommon for hospital discharge planners to advise patients that they must select a particular home as one of their three choices or tell the patients that the hospital will choose one home for them and that they must choose one home from a particular hospital approved short list and the patient can choose the third (or some variant of this policy). As the application process for long-term care homes states clearly that patients must consent to any applications to homes, this hospital practice is inappropriate and can be challenged by the patient. The patient can refuse to pick the homes that the hospital directs as this is not a true consent.

Can the hospital require the patient to move into a retirement home pending transfer into a long-term care facility? As retirement homes in Ontario are not regulated care facilities but are rental accommodation in which the tenant may contract for care services, persons eligible and needing long-term care can refuse such a transfer. No one can be forced to pay for rental accommodation and private health care services when they need and are eligible for the care available in a regulated health facility. The retirement home may not be an appropriate option as it may not be able to meet the care needs of the patient except at a high cost to the patient for private care services. As well, the retirement home may not have the staffing appropriate to the care needs of a person needing long-term care because it is a tenancy and is not a health facility.

Can the hospital charge a per diem to the patient waiting transfer into a long-term care facility? Many hospitals have policies that state that the patient who needs long-term care and refuses to accept the "first available bed" in any facility, even if that facility is not one that they have chosen, must pay a per diem. The threatened per diem is different from hospital to hospital. Some policies list a per diem of $1200 a day whereas others cite lesser amounts such as $300 or $500 per day.

The *Canada Health Act* [12]does not permit hospitals to charge patients for care and accommodation. There are two exceptions to this. If a patient requires complex continuing care then a co-payment may be charged. This classification of complex continuing care applies to a patient with continuing complex care needs who needs to live in a hospital to receive ongoing care and does not apply to patients who require long-term care. Long-term care and chronic care are two different levels of care.

The second exception is in regulations under the *Health Insurance Act*[13], which permit general hospitals to accept a co-payment for accommodation and meals for patients who are awaiting placement for chronic care or a long term care home. This would mean that hospitals can charge a per diem that is equivalent to the daily rate for standard accommodation in a long-term care facility ($53.07per day). This rate is also subject to rate reductions based on monthly family incomes and numbers of dependents.

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12 Canada Health Act, R.S.C. 1985, c. C-6 , s. 19(2)

13 Health Insurance Act, R.R.O. 1990, Regulation 552, s.10

ACE has dealt with some situations where the patient is in hospital and is supposedly awaiting transfer to a long-term care facility however the patient is actually a psychiatric patient. In those circumstances, the hospital cannot charge the patient the co-payment for accommodation and meals as the patient is receiving psychiatric care. Hospitals cannot charge patients for psychiatric treatment or for accommodation and meals when they are in hospital for care, observation or treatment of a psychiatric disorder.

When representing clients who have made their choices and are awaiting transfer but are being threatened with these per diems or with forced transfers or discharges, ACE lawyers negotiate with the hospital on behalf of the client. The usual result is that the client is discharged only to one of the homes of their own choice. The underlying issue is a systemic problem in the health system that needs to be addressed. Parallel to advocating for individual clients, ACE is advocating with the Ministry of Health and Longterm Care to find a solution to the need to free up acute care beds for new patients that does not remove the right of choice from the older population and also addresses the needs of health facilities to free up acute care resources for acute care. 14

Other systemic abuses include practices of some banks to require seniors use the banking institution's own POA forms rather than use a Continuing Power of Attorney for Property as drafted by the senior's own lawyer, even if that POA property is in proper form and content and is available to be reviewed by the bank's own solicitors; failure of some retirement homes ("care homes" as defined in the *Residential Tenancy Act* to acknowledge that the seniors living at those homes are tenants with full tenancy rights including security of tenure, rights or privacy, rights to visitors and so forth; failure of health facilities/health providers to get consent to treatment prior to treatment; requirements of health services/facilities for seniors to execute advance directive forms or DNR orders as a condition of admission or continued residence.

The Response to Abuse from a Legal perspective

When ACE first opened in 1984, ACE staff did research on elder abuse as we assumed that these issues would be relevant to our practice. What was noticeable at that time, and what still continues today, although to a lesser degree, is a lack of literature and analysis of abuse from a legal perspective. There is much more literature on the legal issues now than was in 1984, however it is still fairly limited. Most of the literature comes from the social service/ health services perspective and focuses more on the response from health and social services and what these services can DO for seniors or how they can intervene. There is a need for more literature that looks at abuse and abuse response from the perspective of the older adult and how services/systems can assist older adults on their own terms, helping them address the abuse, based on their choices, getting the supports they need to stop the abuse and getting the remedies that they want.

14 Papers on the law on this issue are available o the ACE website www.acelaw.ca

In particular, little has been written about the criminal justice response to elder abuse and how the police and criminal justice system can more effectively respond to seniors who are victims of abuse. Again, more of this work is being done now but it is still fairly limited. Acknowledgement should be given to the Ontario Provincial Police, the Ontario Police College and to the police services that are members of LEAPS- Law Enforcement Officers Protecting Seniors that worked together, along with the Advocacy Centre for the Elderly, to develop police training on criminal elder abuse issues. A number of police services in the province have senior support units or officers that focus their work on seniors issues and act as a bridge between the rest of the police service and the senior or others who are reporting the elder abuse problem.

A police/crown/criminal justice project on elder abuse is also being developed in British Columbia and Nova Scotia in order to improve the response to elder abuse in the criminal justice system.

Many incidents of abuse may be offences under the *Criminal Code.* If the abuse is a criminal offence, the police and the criminal justice system have authority and responsibility to respond and intervene. Some examples of abuses that are Criminal Code offences include:

Physical Abuse -	Assault (s.265) Assault with a weapon or causing bodily harm (s.267) Unlawfully causing bodily harm (s. 269) Forcible Confinement (ss 279(1))
Sexual Abuse	Sexual assault (s.271)
Financial Abuse	Theft s.322 Theft by a Person Holding a Power of Attorney (s.331) Fraud (s.380) Extortion (s.346) Stopping Mail With Intent (s.345) Forgery (s.366)
Neglect	Breach of Duty to Provide Necessaries (s.215)[15]
Mental Abuse	Intimidation (s.423) Threatening

Financial abuse is not just "abuse" but can be fraud , theft or abuse of POA. Physical abuse, whether the victim is 20 or 80, is not just "Physical abuse"—it can be the crimes of assault or sexual assault. By not labelling the abuses of older adults as crimes that are crimes, the response to abuse is diminished and it makes it a less serious problem. The criminal justice response is not the only response to abuse but it is important to not let elder abuse just become a matter that the civil system or that health and social services just respond.

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15 See Appendix A for a short article from the Fall 2009 ACE newsletter on cases under s. 215 Breach of Duty to Provide Necessaries (s.215)

If the police believe that a crime has been committed, they can lay charges. The police are being encouraged to lay charges instead of advising victims to go through the steps alone. Many police services directives/orders now incorporate abuse of older adults into their directives/orders on vulnerable adults or domestic violence which directs police services to take a proactive role when they have evidence that an older person has been victimized. Some victims are more likely to support a prosecution of an abuser if they are not personally responsible for the abuser's arrest.

Many police services offer training to police officers, on the general issue of elder abuse, the criminal offences that are considered "elder abuse" offences, on ageism and appropriate investigation techniques, including methods of interviewing, and special considerations to keep in mind when dealing with an older victim. The Toronto Police service has had an elder abuse component in their Diversity course for officers and for civilian personnel for many years.

Many victims of abuse are concerned about what will happen to the abuser, particularly if the abuser is a family member or close friend. Victims should ask police for information on the criminal justice system and police should be prepared to answer such questions because this may make the victim more willing to cooperate with the police.

Although Ontario does not have adult protection legislation as in Nova Scotia, there are elements of adult protection in the *Substitute Decisions Act.* If anyone believes that an adult (person age 16 or older for personal care, 18 or older for property) is not mentally capable (as defined in that legislation) and is at risk of suffering or is suffering "serious adverse effects" to their property or their person, then that person may contact the Office of the Public Guardian and Trustee to inform them of this situation. [16]The OPGT has a duty to investigate these allegations and if appropriate, take steps to become the guardian of property and/or the person of the mentally incapable person and take steps to protect them.

"Serious Adverse effects" is defined as:
"PROPERTY - s. 27 Loss of a significant part of a person's property, or a person's failure to provide necessities of life for himself or herself or for dependants, are serious adverse effects for the purposes of this section."
and PERSONAL CARE – s. 62 "Serious illness or injury, or deprivation of liberty or personal security, are serious adverse effects for the purposes of this section".

In the Adult Protection Act of Nova Scotia, "abuse" is not defined but that legislation defines an "adult in need of protection" as "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".

These legal definitions are interesting in that these definitions from different jurisdictions reflect the two main approaches to abuse response.

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16 *Substitute Decisions Act,* s.27 and s.62

The Ontario approach has been to provide supports and assistance to older adults at their direction and at their request. The majority of older adults are mentally capable, and have the right to make their own choices no matter how old. This is a fact borne out by the research. Services and systems may need to consider how to better respond or orient their services to the aging population but the fact that persons are older does not justify an intrusion or intervention that would remove the senior's decision making rights and right to control their own lives. Interventions and assistance are encouraged to be rights based and senior focused and directed.

However it is also recognized some adults of any age are not mentally capable of directing assistance or of seeking out help and therefore need a greater degree of intervention from a third party. The Ontario legislation provides a particular intervention when an adult is not mentally capable. It focuses on abuse/harm to any adults that lack mental capacity, not just older adults. The *Substitute Decisions Act* provides an intervention by a public body, the OPGT, when the harm is being experienced by an adult that lacks mental capacity and therefore cannot seek out help or direct assistance/services that are available to help. Anyone can report this abuse to the OPGT for investigation and possible action. The OPGT can become the adult's guardian if necessary in order to direct care and services and address the abuse.

As well, the *Substitute Decisions Act* provides that others, usually family members, can apply to court to be named guardians of the person and/or property , or arrange for a capacity assessment of the older adult with the intent of getting a statutory guardianship in place over the seniors property. In both instances, the guardianship and statutory guardianship would be created only if the senior is mentally incapable. The guardianships would provide the authority to someone then to step in and "protect" the incapable person's property and/or person and thus address any abuse that may occur or that might be occurring.

The approach to abuse of adults who are mentally capable has been focused on raising awareness of abuse and abuse prevention amongst older adults, making older adults aware of their options, and assisting capable older adults on their own terms and at their direction. Equally efforts are being made to raise awareness of services and systems to respond to seniors and to raise concerns about abuse with older adults when that person is a consumer or client of those services.

As part of a provincial elder abuse initiative, the Ministry of the Attorney General, the Ontario Seniors Secretariat and the Ontario Network for the Prevention of Elder Abuse [17] has supported and organized education of the public on elder abuse prevention and response and are assisting communities across Ontario to develop local elder abuse response networks. These networks look at what services are available in the particular community that can assist and support seniors, whether labeled as elder abuse services or not, and encourage services, both formal and informal, funded or volunteer, to network to help seniors who are victims of abuse connect to whatever types of supports that he or she may need to address their particular problems of abuse.

Many other groups, like ACE, the Family Service Association, many seniors groups (United Senior Citizens of Ontario, Canadian Pensioners Concerned etc.) also have engaged in extensive

17 Ontario Network for the Prevention of Elder Abuse website http://www.onpea.org

education campaigns to the public on elder abuse and related issues (such as consent and capacity, rights of tenants in retirement (care) homes, rights of residents in long term care, elder abuse response and remedies) as a parallel complement to the provincial initiative.

Like domestic violence and spousal assault response, the emphasis has been to make supports available that respond to the needs of victims that they can access and choose and direct. Much effort has been made to make services sensitive to the needs of older adults and sensitive to a response that is not ageist but accommodates for frailty, for disabilities, for health problems that may arise in the aging process and also acknowledges the mentally capable adult of any age and any degree of disability and frailty as a decision making person who others may need to support and assist to have the confidence to make their own decisions and choices.

The Nova Scotia legislation, the adult protection model, reflect a more ageist , interventionist, and paternalistic approach to abuse that focuses on protection. It applies to both mentally capable and incapable adults that are experiencing harm. It is based on child welfare legislation models that treat the mentally capable adult that is refusing help like a child, providing a process to declare to be "an adult in need of protection". The intervention is justified as reasonable as the adult is "abused" as defined by a third party. It is argued that if that abused person is "refusing, or delaying" to take steps to address this abuse then something is wrong in that person's life preventing them from making "right" choices. This type of legislation sets up a societal norm of how people should live and justifies intervention on the basis that society should not allow choices by people that cause them harm. The specific terms of "physical abuse", "mental cruelty" etc are not defined in the legislation leaving it open to the court to interpret the legislation and the intervention broadly.

Adult protection jurisdictions tend to create legislation that provides a response from a special community agency to which other may "report" any incidents of abuse that they believe may be happening or might happen to an older adult. Those reports may be about capable or incapable persons as victims. The legislation often permits this reporting even if this disclosure would otherwise be a breach of confidentiality.

There is no general legislation in Ontario to require any person to report allegations of abuse of a mentally competent older person to a central agency or particular service to investigate the allegation. ACE has consistently resisted introduction and passage of such legislation in Ontario.

As stated earlier , this type of adult protection legislation does not reflect the rights of adults (such as the right to make informed choices) when made to apply to adult problems.

Seniors are NOT children, they are adults. As adults, all older adults have the right to liberty and the right to choose how to live. It is unlikely that anyone wants to live in an abusive situation, however, some adults choose to live in abusive situations even after their options, in terms of leaving/getting out of this situation, have been explained. Adults also have the ability to make choices to remove themselves from difficult situations that are harmful and to take steps to seek help to address the abuse. Adults may choose the form of help, and the degree of help, that they want.

Abuse results from an abuse of power therefore adults do need supports and services to address abuse as many cannot remove themselves from their situation on their own. However, the fact that they need help does not justify a service or system taking over the older adult's life and removing their right of choice - which the model of adult protection legislation usually does.

Adult protection legislation often focuses only on older adults, or adults with disabilities, and not on all abused adults. It would not apply to abused younger adult women. It may be asked then, if adult protection legislation is justifiable, why should it not also apply to these situations? The dynamic of wife assault/abuse is similar to that of abuse of older adults. However few people would find the interventions which occur in adult protection legislation as appropriate when applied to a mentally capable younger woman, even though she was a victim of abuse, as it would remove control of her life out of her hands and make others decision makers for her. So then why is it believed to be acceptable for older adults?

Adult protective legislation has also been called inappropriate because abuse of older adults is not a single issue or single problem and there is not one solution to all abuses. There are many different types of abuses, and the remedies and responses to assist an abused older adult are many and may come from a variety of sectors - adult protection services focus on **one** service responding.

But one service can't solve all the abuse problems. The assistance the older adult may need, may have to come from a lawyer if it's a legal problem (such as misappropriation of property) or a social worker if the abuse is rooted in family conflict and a history of abuse. Or some incidents of abuse are best responded to by police intervention. Or the abuser may need to get assistance through a drug or alcohol rehab programme There is a need to continue to develop a variety of responses and services to address abuse of older adults as it is impossible for a single service to meet all needs in this area.

Some people think that special legislation would increase resources to respond to abuse. But ironically, the creation of a special "abuse response" or adult protection service may reduce the response to an older adult rather than increase it. As soon as a service is specifically mandated to respond, the other services that don't have that particular mandate or specific funding, then drop out as a resource, referring the older adult to the special service. This may happen even if the older adult actually needs the help from that first contacted service. This just creates additional delay and steps that have to be taken before help is given.

It is more efficient and effective for all relevant services - whether labeled as abuse response services or not - whether a funded service, or volunteer group, or informal organization - to be aware of the network of services and response in a community so that when a senior makes contact with one service, he or she may be directly connected to other parts of that network without having to go through a specialized service and wait in line to just then be referred to the appropriate service. This networking and interconnection is one of the advantages of a community response network over an adult protection legislated service.

Reporting legislation does not create solutions to abuse problems - it is only a means of people referring to a particular service to investigate. It appears attractive to other service providers who

know that assisting a person who has been affected by abuse will take time and resources and/or who may feel that they lack the expertise to assist the older adult. Service providers may therefore prefer to pass on the matter to another person to deal with rather than help the older person themselves.

However, passing on the problem to another person doesn't mean the older person will be helped. The specialized services are usually overloaded and many times need to refer the older person back to the person who referred them as the help the older person needs is that available at the referring agency, not the specialized service. Also, in most cases, the specialized services focus on investigation and possibly the co-ordination of a response to the older adult, but do not directly provide service to the person.

General reporting legislation is a bandaid - its not a solution but a cover-up that makes it look like something is being done to help the older adult when in fact that's not the case. **Some help may be given but usually not the type to resolve the abuse.**

For an interesting discussion on the Nova Scotia Legislation read the report from the Dalhousie Health Law Institute - *Mistreating Elderly People: Questioning the Legal Response to Elder Abuse and Neglect* - Elder Abuse Legislation Research Team, Coughlan, Stephen et al, Halifax, Nova Scotia November 1995. Other provinces, such as Manitoba, have also rejected the introduction of adult protection legislation and supported alternative models that are more rights based.

In contrast, in long term care home legislation, there is a mandatory reporting provision in the *Nursing Homes Act*, section 25. That section states:

s25 . Reporting of harm to resident
A person other than a resident who has reasonable grounds to suspect that a resident has suffered or may suffer harm as a result of unlawful conduct, improper or incompetent treatment or care or neglect shall forthwith report the suspicion and the information upon which it is based to the Director.

The term "director" refers to a person at the Ministry of Health and Long Term Care.

Although a similar section is not in the *Homes for the Aged and Rest Homes Act* or the *Charitable Institutions Act,* the other two pieces of legislation that regulate long term care homes, the reporting requirement is part of the service agreements that homes for the aged and charitable homes have with the Ministry of Health and Long Term Care, Therefore the reporting requirements are deemed to apply also to those homes. In the new *Long Term Care Homes Act* that has been passed but not yet proclaimed (proclamation expected in spring 2010) the abuse reporting requirements have been continued and abuse prevention standards increased.

In contrast to mandatory reporting of abuse in the community, these abuse reporting are appropriate, like the provisions in the *Substitute Decisions Act*, because the majority of residents in long term care lack mental capacity and require a high level of care . They are often unable to make complaint about abuse because of incapacity or because the perpetrators are staff in the homes in which they reside. As such they are dependent of these staff for care and assistance with daily living making it very challenging, even if mentally capable, to make complaint for

fear of retribution. ACE supports the inclusion of mandatory reporting in long term care legislation for this reason.

When such reports are made. the Ministry of Health and Long Term care has the authority to investigate and take steps to address the abuse. As well, police services may be called in if the abuse in the home is a potential criminal matter.

Remedies in Elder Abuse Issues – What do you do and how can you help the senior?

In looking at elder abuse issues in a legal context, it is clear that elder abuse is not one thing but deals with many different types of legal problems for which there may be a range of remedies. This is another reason why special legislation is not appropriate as that type of legislation might limit response or take away existing remedies now available.

There are various remedies depending on the type of abuse. The specific remedy depends on the type of abuse and the circumstance of the particular case. Not all remedies are appropriate in all cases. Often before taking formal action, efforts to mediate a solution or to resolve a dispute by other than court action may be appropriate to follow. Also, before taking action or informing the abuser that a power of attorney is being revoked or that action is being started for recovery of funds or that the victim is moving or taking steps to put a stop to the personal abuse etc, it may be necessary and prudent to take steps to "safety plan" with the victim to keep him or her safe or to protect and safeguard property. Any steps taken depend on the specific case and the specific facts of that case.

Along with looking at the options, the person may need assistance to get to a place of safety, to get access to his or her own funds, to seize funds or property in the hands of third parties, to take steps to protect property pending resolution of any action (one example - filing of a notice on title to property that litigation is pending involving the property).

The capable person should have control over what is done in respect to the abuse and should be assisted and supported so that he or she can give this direction and determine what should be done.

One way to think about the various options that may be available to victims of abuse, is to look at the needs of the victims –
a. the need for SAFETY;
b. the need for SHELTER;
c. the need for CONTROL and ACCESS to FINANCES;
d. the need for EMOTIONAL AND PERSONAL SUPPORT;
e. the need for FOOD and BASIC LIVING needs

In looking at these various needs, various options may need to be pursued at the same to assist the victim. The victim may need help from a variety of resources. The victim may need help more urgently in respect to some needs and less urgently in respect to others. Every situation must be examined individually to determine the appropriate options.

Possible Options

This is by no means a comprehensive review of remedies. Originally this section of the paper was prepared as a "popular education" handout to help people think through some possible options to elder abuse problems and to prompt more specific examination of the particular type of abuse and most appropriate remedies. In setting out these possible approaches, it is assumed that steps would not be taken without the consent and agreement of the capable senior who has been victimized and that care is taken to ensure the safety of the senior going through the process of seeking a remedy.

Financial Abuse

1. Of an Older person mentally capable of financial decision making

TALK to the older person - what does he or she want to do? Is he or she even aware that abuse has occurred? It is very common that service providers call ACE, describe a situation in which they believe a senior is a victim of some sort of abuse but when asked if they have talked to the senior about the particular problem, answer that they have not raised their concerns to the senior. How can the senior address the abuse if they are not made aware of it or not told of the options that may be available to help from that service provider or made aware of other assistance (from other services) that may be available to help them address the problem?

Is it actually abuse or does it appear to be abuse when its not (ie money removed from a bank account with the agreement of the person with full consent and not with undue influence)? In some instances some form of abuse has occurred either without the knowledge of the senior or with knowledge but against the will of the senior. In some instances, the senior is not a victim and abuse has not taken place. In some instances, the situation is not exactly abuse, but is the result of a poor or bad choice/decision on the part of the senior, such as a bad investment.

The older person needs information on options open for him or her to pursue before he or she can make decision of whether to take action or not and what action to take. That older adult may need to speak to a lawyer or others to determine the options available.

Who are the best people to provide information on the options available? The person may need help from a variety of sources simultaneously to address the abuse - ie talk to a lawyer to seek legal options, talk to a financial advisor to get finances back in order, get counselling to assist the person in supporting self esteem and in having confidence to pursue remedies, get ongoing assistance from various services to prevent a reoccurrence of the abuse by reducing or eliminating the dependency or power of the abuser.

Some ideas:

a) If abuse by an attorney named in the person's continuing power of attorney for property, revoke the continuing power of attorney for property by signing a revocation of the

CPOAP, tear up the original CPOAP, get all copies if any of the CPOAP back , send notices of the revocation to all places (ie banks etc) where the attorney may have used the CPOAP and where the person has assets, take action if necessary against the attorney for an accounting and for the return of any assets misappropriated, possibly create a new CPOAP naming another person as attorney that the grantor can trust to properly manage his/her finances; report to police for investigation as to whether criminal offence committed (Abuse of Power of Attorney? Theft? Fraud?) See Substitute Decisions Act and Criminal Code.

b) If abuse of pension cheques (ie theft of cheques) – help older person get direct deposit of pension cheques into the person's own bank account not accessible by the abuser; take action against the abuser to recover misappropriated funds; report to police for possible criminal charges and process in criminal justice system

c) Return of property placed in name of abuser (ie on promise to provide care etc) - action against the abuser for return of property if undue influence, unjust enrichment, fraudulent transfer etc. Action for Restitution.

2. Of a person incapable of financial decision making

Can you talk to and communicate with this person? Although incapable for financial decision making is he or she still capable to participate in decision making as to a remedy? Remember capacity is issue specific

Is the substitute the abuser? If not, can you talk with the substitute decision maker as to the possible options? Would the substitute be the person who would need to pursue the options?

Some ideas:

a) Person incapable in respect to property but still capable to revoke a continuing power of attorney for property if the abuse is by the attorney named in the CPOAP - revoke CPOAP - same as in a) above

b) Person incapable and at risk of serious harm or serious harm is occurring to their property - contact OPGT under s. 27 of SDA for investigation . It is not a breach of the Personal Health Information Protection Act for a health information custodian to disclose personal health information without consent of the individual to the OPGT to enable them to carry out their statutory duties. [18]

c) Contact to the police - what can you say or not say? Think about rules about confidentiality and rules of professional conduct. The person contacting the police may want to get legal advice before releasing information as to appropriate action.

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18 Personal Health Information Protection Act, S.O. 2004, c.3 s. 43(1)

d) Substitute decision maker may be able to take action for recovery of funds, take steps to protect property as appropriate to the situation.

e) If no attorney, someone may apply to HRSDC Income support to become trustee to manage OAS and CPP cheques of the financially incapable person.

3. Personal Abuse of a person mentally capable of personal care decisions

What does the person who has been abused want to do? Does he or she know of the options available? Is the person at personal risk if no steps are taken to address the abuse? Is the person dependent on the abuser for care? Is abuse taking place or is the caregiver not providing good care unintentionally or doesn't know how to provide the care needed? Are there alternative options for the care and other ways of reducing or eliminating the dependency on the abuser? Does the person live with the abuser? Can the abuser be removed from the household? Does the victim want to move to alternative accommodation? Does the victim have control over his or her own money (This may extend the options available). Who is the abuser? A family member, a service provider, a paid caregiver, a health care professional? There will be different options depending on who is the abuser and the type of abuse committed. Depending on the abuse that was committed, this may change create special obligations on some persons who become aware of the abuse ie obligation on health professionals to report sexual abuse has been committed by another health professional

Some ideas:

a) Assist the person to make a complaint to a Professional College

b) Assist the person to make a complaint to the Ministry of Health and Long-Term Care if abuse in a Long-term care home

c) Action for damages for harm suffered

d) Eviction of abuser who is living with the victim from household by action under the *Residential Tenancies Act*

e) Application to the Criminal Injuries Compensation Fund for compensation for victims of crime

f) Assist the victim to find alternative care providers (alternative to the abuser), to find alternative accommodation, to get counselling and support

g) Assist the person to report the abuse to the police if the abuse was a criminal act

4. Of a person mentally incapable of personal care decisions

Can this person still participate in decision making about options to address the abuse? The person may lack some capacity and yet still be capable to give some directions? Is the substitute decision maker the abuser? How much at risk is the person? How quickly does this person need assistance? If the abuser is not the substitute, is the substitute aware of the abuse? Can the substitute take steps to address the abuse? Who does the victim and his/her substitute need to get advice from to address the abuse?

Some ideas:

a) Report to OPGT to do investigation under s. 62 of the SDA - incapable person at risk of serious harm/ experiencing serious harm to his or her person.

b) Report to the police of criminal offence

c) Report to Professional College of professional's misconduct

d) If no Guardian of the Person and no attorney named in a power of attorney for personal care, application to Consent and Capacity Board to be appointed as representative for the Person (the new substitute decision maker) if abuse related to existing substitute's failure to act as appropriate substitute for treatment, admission, or personal assistance services

e) Application by health practitioner (if treatment) or by Community Care Access Centre (Person authorizing admission) (if admission) to Consent and Capacity Board to determine compliance of substitute with the legislation if abuse related to substitute's failure to act as an appropriate SDM.

f) Report to the Ministry of Health and Long-Term Care of harm caused to a resident of a long-term care facility (see *Nursing Homes Act*)

Why do people refuse help?

1. They may not understand the options available to them.
2. They may think that they are no other options except to put up with the abuse.
3. They may not trust the person who is seeking to help them.
4. The person seeking to help may not know all the options or may be trying to impose a particular option on them that they don't want to pursue.
5. The person seeking to help may be setting up barriers unknowingly that prevents the person from agreeing to the help offered.
6. The person may need time to consider the options and may be willing to take help but at their own pace, a pace that is different than the person offering the help.

The person offering the help may have done things that cause the person needing help to distrust them ie. taking direction from an abusing caregiver instead of the victim or disclosing information to the abuser that the victim did not want to be disclosed

The experience at ACE in responding to abuse has lead us to the conclusion that no one service can be the only source of help to the older adult. There are many different types of abuse and wrong-doings that require a range of responses from a variety of sources, both formal and informal. Special legislation appears to do little to address the abuse and yet seems to give the appearance that "something" is being done to help older adults and thus may divert attention away from real sources of help that can not only bring immediate help but may help the senior address the problem in the long term.

Abuse response and remedies should be directed by the senior. Remember who is your client. In abuse situations, start by talking to the senior.

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ELDER ABUSE: FAILING TO PROVIDE THE NECESSARIES OF LIFE TO OLDER ADULTS IS A CRIME

By: Lisa Romano, Staff Lawyer

Section 215 of the *Criminal Code of Canada* says an offence is committed if an individual fails to provide necessaries of life to a person under his or her charge if that person is "unable, by reason of detention, age, illness, mental disorder or other cause, to withdraw himself from that charge, and is unable to provide himself with the necessaries of life."

This means it is a crime if you do not provide necessaries of life to someone in your care that cannot leave your care due to their age, illness or other impairment. Necessaries of life refer to those things necessary to preserve life, such as food, shelter, medical attention and protection from harm. Under Canadian criminal law, there are two types of offences: summary conviction and indictable offences. Generally, indictable offences are more serious than summary conviction offences and have harsher sentences. A person found guilty of a summary conviction offence for failing to provide the necessaries of life could be sentenced to imprisonment for a maximum of 18 months while a person found guilty of an indictable offence could be sentenced for up to five years of imprisonment. This article will briefly review the five reported cases where individuals were convicted of failing to provide the necessaries of life to older adults.

R. v. Chartrand [1]

Earlier this year, a paid caregiver by the name of Daniel Chartrand was sentenced to 12 months in jail after endangering the life of the older adult, Harry Matthews, under his care. Although the caregiver was paid very generously, he squandered much of Mr. Matthew's assets. Mr. Chartrand also failed to look after Mr. Matthews on a daily basis despite his declining health. The paramedics arrived at Mr. Matthew's apartment after receiving a call from a neighbour to find him on his back lying in his own urine and feces. Mr. Matthews was not suffering any physical injuries but the emergency room doctor testified that the senior was living in a life threatening situation. The judge ruled that Mr. Chartrand blatantly neglected and disregarded Mr. Matthew's needs. As Mr. Chartrand was keenly aware of the senior's needs, he knew or should have known that he was not meeting those needs and he was found guilty of failing to provide the necessaries of life.

R. v. Grant [2]

Margaret Grant called 911 and reported that her 78-year-old mother, Kathleen Grant, was not feeling well. Paramedics found Mrs. Grant malnourished, dirty and seated in a chair covered in urine and feces. She had been sitting in the chair for such a long period of time that the chair had taken the form of her body. She was suffering from multiple ulcers, profound malnutrition, sepsis, extensive gangrene and hydration. Four days after being admitted to hospital, Mrs. Grant died. The daughter pleaded guilty and was sentenced to four years incarceration. The court found that the daughter seriously abused her position of trust in relation to her mother, in addition to benefiting financially from keeping her mother with her. Even though the daughter had limited mental capabilities, she knew or ought to have known that her mother required medical

attention and the failure to provide her mother with the necessaries of life contributed to her death.

R. v. Nanfo [3]
Mary Nanfo always lived with and relied on her parents. After the death of her father, she became the primary caregiver for her mother, Maria Nanfo. Mrs. Nanfo was obese, almost blind, incontinent, suffered heart attacks and had been diagnosed with dementia. Especially towards the end of Mrs. Nanfo's life, her daughter provided little care of any kind. The house was unsanitary: human feces covered the floor, walls and bedding while garbage was piled high. Despite her serious medical conditions, Mrs. Nanfo had not seen a doctor for years. The daughter frequently left the home for long periods of time, leaving her mother home alone. When Mrs. Nanfo eventually died of a heart attack, her daughter waited more than 24 hours after her death to call the police because she wanted to try to clean up the house. The court sentenced Ms. Nanfo to imprisonment for one year to be served as a conditional sentence in the community. The court arrived at this sentence because it felt Ms. Nanfo loved her mother "in her own way." The court found that Ms. Nanfo had a lifelong dependence on her parents which resulted in her being only marginally capable of looking after herself and unable to care for a senior with great care needs. As the situation grew worse, it had become harder for her to handle and the situation may have been aggravated by depression.

R. v. Noseworthy [4]
Donald Noseworthy lived with his 78-year-old mother in her home. She developed rapid onset Alzheimer's disease and became incontinent and progressively cognitively impaired. Mr. Noseworthy admitted to assaulting his mother due to her lack of communication skills and because she would soil herself. He also permitted his mother to live in filth and with horrible personal hygiene. The floor of almost every room in the house (except the one belonging to Mr. Noseworthy) was covered in urine and feces. He would not help her to eat although she ate little and required assistance. In the days before her death, he left her lying motionless and did not call 911 for fear that his abuse of his mother would be discovered. Mr. Noseworthy was convicted and sentenced to seven years imprisonment for manslaughter and two years imprisonment for failing to provide the necessaries of life (to be served concurrently).

R. v. Peterson [5]
Dennis Peterson, his sister and 84-year-old father resided in the same building but the doors between the apartments were locked. Mr. Peterson lived on the second floor, the sister stayed on the third floor while the father stayed in the basement. The father's apartment and living conditions werenot sanitary: he did not have a working kitchen or toilet; the apartment was full of cockroaches; the dirt floor was covered in dog feces; and both his clothes and person were unwashed. Police found the father lost on the street and advised his son about community agencies that could help look after his father but none were contacted. Two days after being released from the hospital because he collapsed, a gas company employee found Mr. Peterson and a dead dog in the house. Mr. Peterson was then admitted to a long-term care home. The court found that Mr. Peterson controlled his father's living conditions and personal care. He kept his father in an unsafe environment and chose not to make decisions that would ensure that his father would be provided with the necessaries of life. Mr. Peterson was sentenced to six months imprisonment, two years probation and 100 hours of community service.

Conclusion

Section 215 of the *Criminal Code* has been underutilized in the past to prosecute elder abuse. However, these recent cases indicate that this offence will be used more frequently in the future as police and Crown attorneys become more familiar with it. Educational programs will hopefully increase awareness of the crime, as well as the responsibilities that individuals and families have towards their elderly parents. ACE would also like to see the courts make sentences which truly reflect the seriousness of this crime.

1. 2009 CanLII 20709 (ON S.C.).
2. 2009 NBPC 17 (CanLII).
3. 2008 ONCJ 313 (CanLII).
4. 2007 CarswellOnt 9604 (Ont. S.C.J.).
5. 2005 CanLII 37972 (ON C.A.).