

# Timiskaming Resource Manual

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# Introduction

In June 1999, the OACCAC mandated all CCACs to address the issue of Elder Abuse. As a result, an Elder Abuse Committee was created by the district of Timiskaming with 12 members. These members represented local hospitals, long term care facilities and Community Care Access Centre Timiskaming CASC. The name of the committee was changed to The Timiskaming Elder Abuse Task Force in September 1999. Membership has steadily increased and in 2002 membership is now at 45 members and represents a large variety of community agencies. Two sub-committees have addressed public awareness, with a month long media blitz, and the ongoing education of Task Force members.

OACCAC's Elder Abuse Training Initiative in June 2000, prompted CCACs to examine their existing methods of dealing with Elder Abuse. Locally, an Elder Abuse Resource Team was established. Headed by Colette Wright, the team included Lise Ethier, Placement Coordinator, Lisa Campbell, Occupational Therapist and Nancy Pedersen, Case Manager. A series of on-line surveys and questionnaires were completed to identify needs within each CCAC. The team then decided that a Resource Manual would be useful for our staff. Information was gathered from several CCACs who had manuals in place and the Elder Abuse Resources Manual was created.

The Resource Manual includes general information including the description Resource Team's Role, Philosophy and Guiding Principles, Definitions, Characteristics of Victims and Abusers, Precipitating Factors and Indicators of Elder Abuse.

A section on Intervention and Strategies includes Risk Management and Decision Trees to guide the reader through four different scenarios. An education section includes safety strategies, guidelines for conducting assessments and reference material.

The Resource Manual concludes with an Appendix with information on provincial and federal legislation, the Office of the Public Guardian and Trustee and local community information.

The Resource Manual is a work in progress. After implementing its use, the goal is to periodically review and change the tool to best suit the needs of its users. Compiling information a cases are handled will be important to the education of those using the Manual.

Currently, the CCAC Timiskaming CASC Elder Abuse Resource Team includes Lise Ethier and Nancy Pedersen.

## Role of the Elder Abuse Resource Team

1. To receive and organize information related to Elder Abuse.
2. To provide education to staff and outside service providers.
3. To provide resource information to clients and service providers.
4. To be available to all staff when abuse is suspected and /or identified to help direct investigation or intervention if help needed.
5. To debrief staff as needed if they are involved in a case of abuse.
6. To liaise with:
  - Timiskaming Elder Abuse Task Force;
  - Police;
  - Other agencies.

# Philosophy and Guiding Principles for the CCAC Timiskaming CASC Elder Abuse Manual

The purpose of the Guidelines for the Elder at Risk Protocol is:

- To provide a resource to help in identification of those who may be at risk for abuse.
- To provide direction when elder abuse is suspected, confirmed or witnessed.

1. As with all adults, elderly persons have the right to:

- Self-determination – the right to live their lives as they wish and to make decisions about themselves provided that their actions are not contrary to the law or that they do not infringe upon the rights and safety of others. Clients who are not found to be cognitively capable of making competent decisions in some areas of their lives need the professional to consult with the client's Substitute Decision Maker. In areas of clients' lives where they remain capable, clients need to be allowed to make their own choices.
- The basic requirements of life – food, shelter, clothing, medical attention and social contact;
- Protection – from physical, emotional, financial, sexual and medication abuse; from violation of their civil and legal rights and from neglect;
- Right of refusal – to refuse assistance, intervention or medical treatment;
- Privacy – to share only what they wish to share. This includes choice on access to a person, the person's body, conversations, bodily functions, or objects immediately associated with the person;
- Confidentiality – whatever information they choose to share or whatever information becomes known about them will remain confidential to the extent that is possible, within the requirements of agency practices and the law;

2. Each case of suspected abuse or neglect must be considered individually to achieve the appropriate balance of interests. The nature of the abuse, its severity and the implications to the person(s) involved will dictate the degree of intervention warranted.

3. In an apparent case of abuse, intervention should be:

- Based on a skilled assessment of the person and their environment (identifying the type and degree of risk posed to the person);
- Respectful of the elderly person's/family's right to confidentiality and to give consent for further investigation;
- The least intrusive or restrictive intervention possible, appropriate to the circumstances and determined by the degree of risk assessed;
- Aimed at maximizing the elderly person's/family choices;
- Based on the elderly person's/family's strengths and abilities for positive action;

# Philosophy and Guiding Principles for the CCAC Timiskaming CASC Elder Abuse Manual (cont'd)

- Undertaken with the voluntary and informed consent of the elderly person whenever and to whatever degree that is possible;
  - Sensitive to and addressing the following areas: cultural diversity, language, religious beliefs, lifestyle choices, poverty, disabilities, and educational background.
4. Certain types of behavior directed towards elderly persons can be considered criminal activity. Sexual and physical abuse, uttering threats to cause harm or to kill, theft, fraud, and neglect are all examples of situations where the perpetrator of such activity can be charged criminally. In these cases, staff will recommend to the client that the Police should be called to deal with complaints or instances of alleged criminal behavior.
5. Ending elder abuse is everyone's responsibility. Social change must occur through education and action, and includes prevention. It is the belief of the CCAC Timiskaming CASC that to help end elder abuse we must be involved in the following areas as a agency:

**Primary prevention** which includes:

Legislation: To establish legislative measures and policies, which will protect the rights of elderly persons;  
To provide health and social services, which will maintain the independence of the elderly within the community and care facility.

Advocacy: To represent the views of the elderly  
To articulate their special needs  
To foster an appreciation of the developmental stages of the elderly

Education: To increase public and professional awareness of the abuse problem  
To further an understanding of the aging process

**Secondary prevention** which includes:

- Use of screening tools for the identification of elder abuse
- Medical intervention for treatment of injuries
- Development of a plan of intervention to address elder abuse
- Coordination of the community support system to ensure quality continuum of care
- Teaching and supporting effective care-taking roles using a problem solving process

**Tertiary prevention** which includes:

- Rehabilitation: assisting the elder person to achieve their optimum level of health and safety. This may involve a permanent change to create a more supportive environment.

## Bill of Rights for the Older Person

- ? I have the right to have the basic requirements of life – food, clothing, shelter, and social contact.
- ? I have the right to live free from physical, emotional, financial, sexual, and medication abuse, and from neglect.
- ? I have the right to be informed about my civil and legal rights.
- ? I have the right to live my life as I wish providing I do not infringe upon the rights and safety of others.
- ? I have the right to be treated as an adult.
- ? I have the right to participate in making decisions.
- ? I have the right not to be perfect.
- ? I have the right to refuse assistance.

# Definitions

## **Elder Abuse**

- Is defined as any action/inaction that jeopardizes the health or well-being of an elderly person. It may include:

## **Physical Abuse**

- Any violent act(s) or rough treatment directed towards an elderly person whether or not actual physical injury results.
- May include the use of restraints.
- Any sexual behaviour directed toward an elderly person without that person's consent, or where consent is obtained by taking advantage of the elderly person's circumstances.  
Such behaviour would include sexual assault, sexual harassment, or any act designed to use the elderly person for the perpetrator's sexual gratification.

## **Psychological/Emotional Abuse**

- Any act, including social isolation, verbal assault, harassment, humiliation, intimidation, infantilization, or any treatment which may diminish the elderly person's sense of identity, dignity and self-worth.

## **Financial Abuse**

- The misuse of an elderly person's funds and assets including: theft, fraud and misappropriation of property.
- The misuse of funds through a Power of Attorney
- The misuse of bank accounts
- The use of coercion to obtain property or funds owned by another person without their informed consent.

## **Neglect**

### **Active Neglect**

- The deliberate withholding of basic necessities and/or care.

### **Passive Neglect**

- The non-deliberate, non-malicious withholding of basic necessities and/or care. This may be due to a lack of experience, information or ability.

## **Violation of Civil/Human Rights**

- Unlawful or unreasonable denial of fundamental rights and freedoms normally enjoyed by adults.

This may include:

- denial of information, privacy, visitors, religious worship; denial of informed consent to medical treatment; interference of mail; restriction of liberty; unwarranted confinement in a hospital or institution.

# Possible Indicators of Elder Abuse

## Physical Abuse

| Form   | Possible Indicators  |
|--|--|
| <ul style="list-style-type: none"> <li>• Assault<br/>e.g. slapping,<br/>pushing,<br/>burning,<br/>pulling hair,<br/>shaking,<br/>forced feeding</li> </ul> | <ul style="list-style-type: none"> <li>• Unexplained or explanation inconsistent with:                             <ul style="list-style-type: none"> <li>○ falls, abrasions,</li> <li>○ bruises,</li> <li>○ contusions,</li> <li>○ hematomas,</li> <li>○ grip marks,</li> <li>○ fractures,</li> <li>○ lacerations,</li> <li>○ restricted movement,</li> <li>○ ulcers,</li> <li>○ welts,</li> <li>○ tenderness,</li> <li>○ guarding injured area</li> </ul> </li> <li>• Delays in seeking medical treatment;</li> <li>• Denial in view of obvious injury;</li> <li>• Reports of similar injury.</li> </ul> |
| <ul style="list-style-type: none"> <li>• Sexual assault</li> <br/> <li>• Hypothermia</li> </ul>  | <ul style="list-style-type: none"> <li>• Pain, bruising, bleeding in genital areas ;</li> <li>• See Indicators for Psychological Abuse.</li> <br/> <li>• Inappropriate clothing/bedding;</li> <li>• Shivering;</li> <li>• Cyanosis;</li> <li>• Low body temperature;</li> <li>• Lack of heat in home.</li> </ul>   |
| <ul style="list-style-type: none"> <li>• Physical restraint</li> </ul>   | <ul style="list-style-type: none"> <li>• Rope/restraint marks;</li> <li>• Incontinence.</li> </ul>   |

## Possible Indicators of Elder Abuse (cont'd)

### Psychological Abuse

| Form  | Possible Indicators  |
|---|--|
| <ul style="list-style-type: none"> <li>• Threatening:<br/>e.g. abandonment<br/>institutionalization<br/>physical abuse<br/>withdrawal of care</li> <li>• Humiliation;</li> <li>• Intimidation/provoking fear;</li> <li>• Shouting;</li> <li>• Insulting;</li> <li>• Scolding;</li> <li>• Name calling;</li> <li>• Imposed social isolation;</li> <li>• Removal of elder's right to make decisions;</li> <li>• Infantilization.</li> </ul> | <ul style="list-style-type: none"> <li>• Shame;</li> <li>• Invalid guilt;</li> <li>• Passive;</li> <li>• Withdrawn;</li> <li>• Overly compliant or submissive;</li> <li>• Elder recoils from touch;</li> <li>• Sad;</li> <li>• Helpless;</li> <li>• Hopeless/depressed;</li> <li>• Loss of self-determination;</li> <li>• Excluded from family gatherings;</li> <li>• Not permitted to have friends or visitors ;</li> <li>• Not permitted to go to community outings (ie. church);</li> <li>• Tearfulness;</li> <li>• Significant weight loss;</li> <li>• Caregiver speaks for elder;</li> <li>• Caregiver is excessively involved with the elder;</li> <li>• Caregiver ignores the rights of the elder</li> <li>• Elder avoids eye contact;</li> <li>• Inappropriate clothing or hairstyles e.g. childish ribbons in hair;</li> <li>• Caregiver reluctant to leave elder alone with service provider.</li> </ul> |

## Possible Indicators of Elder Abuse (cont'd)

### Financial Abuse

| Form   | Possible Indicators  |
|--|--|
| <ul style="list-style-type: none"> <li>• Fraud;</li> <li>• Misuse of elder's money/property;</li> <li>• Theft of elder's money/property;</li> <li>• Withholding funds;</li> <li>• Coercion.</li> </ul> | <ul style="list-style-type: none"> <li>• Illegal use of elder's possessions/property/investments/ P.O.A./will for profit or personal gain;</li> <li>• Overcharging elder for expenses such as home repairs;</li> <li>• Elder forced to change will or sell possessions (ie. house);</li> <li>• Elder has no food, clothes, money;</li> <li>• Inadequate living environment;</li> <li>• Elder unable to afford social activities;</li> <li>• Disappearance of possessions;</li> <li>• Absence of required aids ;</li> <li>• Unexplained or sudden inability to pay bills;</li> <li>• Unexplained or sudden withdrawal of money from bank accounts;</li> </ul> |

## Possible Indicators of Elder Abuse (cont'd)

### Neglect – Passive & Active

| Form  | Possible Indicators   |
|---|---|
| <ul style="list-style-type: none"> <li>Withholding required food/fluids</li> </ul>          | <ul style="list-style-type: none"> <li>malnourishment</li> <li>emaciated</li> <li>mouth sores</li> <li>dehydration</li> <li>confusion</li> <li>ill-fitting or lack of dentures</li> </ul>   |
| <ul style="list-style-type: none"> <li>Inadequate hygiene or personal care</li> </ul>       | <ul style="list-style-type: none"> <li>decubitus ulcers</li> <li>poor skin hygiene</li> <li>soiled linens</li> <li>urine burns</li> <li>rashes</li> <li>unkept appearance</li> <li>odours</li> </ul>  |
| <ul style="list-style-type: none"> <li>Inadequate clothing</li> </ul>                       | <ul style="list-style-type: none"> <li>clothes in poor repair</li> <li>inappropriate for season</li> </ul>  |
| <ul style="list-style-type: none"> <li>Over-medication<br/>ie. drugs<br/>alcohol</li> </ul> | <ul style="list-style-type: none"> <li>over-sedation</li> <li>reduced physical/mental activity</li> <li>falls</li> </ul>  |
| <ul style="list-style-type: none"> <li>Under-medication</li> </ul>                          | <ul style="list-style-type: none"> <li>reduced/absence of therapeutic response</li> </ul>   |
| <ul style="list-style-type: none"> <li>Sensory deprivation</li> </ul>                       | <ul style="list-style-type: none"> <li>no glasses/hearing aid</li> <li>lack of independent access to social activities</li> <li>lack of independent access to social stimulation</li> <li>isolation</li> <li>lack of personal belongings</li> </ul> |
| <ul style="list-style-type: none"> <li>Lack of safety precautions</li> </ul>                | <ul style="list-style-type: none"> <li>dangerous environment</li> <li>lack of aids to facilitate safety and independence</li> </ul>   |
| <ul style="list-style-type: none"> <li>Lack of supervision</li> </ul>                       | <ul style="list-style-type: none"> <li>unattended</li> <li>restraints</li> <li>incontinence</li> </ul>  |
| <ul style="list-style-type: none"> <li>Withholding medical services</li> </ul>              | <ul style="list-style-type: none"> <li>no regular visits to doctor, dentist etc.</li> </ul>   |
| <ul style="list-style-type: none"> <li>Unjustified use of restraints</li> </ul>             | <ul style="list-style-type: none"> <li>contractures</li> <li>weakness</li> <li>immobility</li> <li>incontinence</li> <li>living in worse conditions than others in home</li> </ul>  |
| <ul style="list-style-type: none"> <li>Abandonment</li> </ul>                               | <ul style="list-style-type: none"> <li>financial or physical abandonment</li> </ul>   |
| <ul style="list-style-type: none"> <li>Forced entry into an institution</li> </ul>          |   |

# Characteristics of Elder Abuse Victims and Abusers

## Victims

Advanced age  
Female/single/ widow  
Progressive physical & cognitive impairment  
Emotional difficulties  
Low self esteem  
Takes on the role of a child  
Marital/family conflict  
Denies abuse/reluctant to report  
Financial dependency  
Alcohol/drugs/medications problems  
No regular doctors  
Suspicious falls/injuries  
Lack of understanding of medical condition  
Lack of social support/ isolation  
Confined to the house  
Has provoking behavior/ problems  
Unrealistic expectations  
Seen as a stress to caregiver  
Past abuse/may feel abuse is deserved  
May have been abusive parent

## Abusers

Middle age  
Son/daughter of victim  
Resents role reversal with parent  
Poor past relationship  
Increased demand of care taking  
Lack of family/social support  
Lack of understanding of medical condition/effect of aging  
Low self-esteem  
Senile/ demented/ abused as a child  
Alcohol /drugs /medication dependent  
Unsympathetic  
Hypercritical  
Persistent liar  
Blamer  
Unrealistic expectations  
Stress:

- Caregiving inexperience
- Role depletes family resources
- Economically troubled and dependent on victim
- medical problems
- marital conflicts
- unemployed

# Precipitating Risk Factors for Elder Abuse

## **Familial**

- Caregiver's lack of knowledge re:
  - Aging process;
  - Caregiving duties;
  - Services and resources;
  - Commitment.
  
- Age, psychological, physical health of the caregiver.
  
- Psychological and physical impairments of the elder.
  
- Potential for caregiver stress.
  
- Caregiver pressured into care-taking role:
  - Guilt;
  - Financial reasons.
  
- Caregiver has other dependents.
  
- Lack of support from others in the home/community:
  - Reduced interaction with others;
  - Lack of privacy;
  - Over-crowding;
  - Marital conflict.
  
- Poor family inter-relationships.
  
- Elder experiencing recent loss:
  - Bereavement;
  - Loss of independence;
  - Loss of mobility.
  
- Social isolation of caregiver.
  
- Family history of violence/abuse.
  
- Caregiver has poor impulse control.

## Precipitating Risk Factors for Elder Abuse (cont'd)

- Unreasonable expectations:
  - Elder of caregiver;
  - Caregiver of elder.
- Substance abuse by either elder or caregiver.
- Altered lifestyle of caregiver.
- Refusal of elder and caregiver to accept help.
- Elder who internalizes blame and is therefore vulnerable through self-depreciating behaviour and failure to acknowledge that abuse is the fault of the abuser.
- Excessive loyalty:
  - Not reporting as of fear consequences by abuser;
  - Unknown future without abuser.
- Stoicism may cause elder to accept troubles without seeking help.

### **Societal/Environmental**

- General lack of societal concern for the elderly;
- Lack of understanding of the aging process;
- Stereotyping of the elderly; ageism;
- Inadequate resources, social services, community support;
- Poverty of women, financial stress, lack of reimbursement for caring for the elderly at home;
- Poor/lack of housing;
- Unemployment of the caregiver to remain home to care for elder;
- Fear of crime;
- Lack of alternatives for elders other than institutions;
- Lack of definition of abuse;
- Lack of public awareness of the abuse problems and interventions;
- Learned behaviour in abusers that is difficult to break.

# Risk Assessment Screening Tool

|  |            | ASSESSMENT |   |   |   |   |   | REASSESSMENTS |   |   |   |   |   |   |   |   |
|--|------------|------------|---|---|---|---|---|---------------|---|---|---|---|---|---|---|---|
| Date of Visit  | Home Hosp. |            |   |   |   |   |   |               |   |   |   |   |   |   |   |   |
| Risks  |            | R          | A | U | R | A | U | R             | A | U | R | A | U | R | A | U |
| <b>Socioeconomic</b>   |            |            |   |   |   |   |   |               |   |   |   |   |   |   |   |   |
| No/inconsistent support from family/friends                    |            |            |   |   |   |   |   |               |   |   |   |   |   |   |   |   |
| Caregiver burden (inexperience, stress, fatigue, frustrations) |            |            |   |   |   |   |   |               |   |   |   |   |   |   |   |   |
| Pattern of family violence or conflict                         |            |            |   |   |   |   |   |               |   |   |   |   |   |   |   |   |
| Apparent inability to afford food, clothing, housing           |            |            |   |   |   |   |   |               |   |   |   |   |   |   |   |   |
| Dependent on others for funds                                  |            |            |   |   |   |   |   |               |   |   |   |   |   |   |   |   |
| Finances managed by others                                     |            |            |   |   |   |   |   |               |   |   |   |   |   |   |   |   |
| Questionable use of client's possessions, property, funds      |            |            |   |   |   |   |   |               |   |   |   |   |   |   |   |   |
| Lifestyles factors- Careless smoking                           |            |            |   |   |   |   |   |               |   |   |   |   |   |   |   |   |
| Use of O <sub>2</sub>  |            |            |   |   |   |   |   |               |   |   |   |   |   |   |   |   |
| Questionable driving skills                                    |            |            |   |   |   |   |   |               |   |   |   |   |   |   |   |   |
| Substance Abuse by client                                      |            |            |   |   |   |   |   |               |   |   |   |   |   |   |   |   |
| Causing poor judgment  |            |            |   |   |   |   |   |               |   |   |   |   |   |   |   |   |
| Causing unacceptable behavior                                  |            |            |   |   |   |   |   |               |   |   |   |   |   |   |   |   |
| Substance Abuse by caregiver                                   |            |            |   |   |   |   |   |               |   |   |   |   |   |   |   |   |
| Causing poor judgment  |            |            |   |   |   |   |   |               |   |   |   |   |   |   |   |   |
| Causing unacceptable behavior                                  |            |            |   |   |   |   |   |               |   |   |   |   |   |   |   |   |
| Social isolation   |            |            |   |   |   |   |   |               |   |   |   |   |   |   |   |   |
| Restricted access to telephone, food, bathroom, family         |            |            |   |   |   |   |   |               |   |   |   |   |   |   |   |   |
| Major losses- Death  |            |            |   |   |   |   |   |               |   |   |   |   |   |   |   |   |
| Separation from family/friends                                 |            |            |   |   |   |   |   |               |   |   |   |   |   |   |   |   |
| Divorce  |            |            |   |   |   |   |   |               |   |   |   |   |   |   |   |   |
| Deterioration of health  |            |            |   |   |   |   |   |               |   |   |   |   |   |   |   |   |
| Loss of home   |            |            |   |   |   |   |   |               |   |   |   |   |   |   |   |   |
| Loss of independence   |            |            |   |   |   |   |   |               |   |   |   |   |   |   |   |   |
| Presence of significant other who poses a risk                 |            |            |   |   |   |   |   |               |   |   |   |   |   |   |   |   |
| Caregiver demonstrates - Verbal aggression                     |            |            |   |   |   |   |   |               |   |   |   |   |   |   |   |   |
| Physical aggression  |            |            |   |   |   |   |   |               |   |   |   |   |   |   |   |   |
| <b>Environment/Hazards</b>                                     |            |            |   |   |   |   |   |               |   |   |   |   |   |   |   |   |
| Presence of pets/animals                                       |            |            |   |   |   |   |   |               |   |   |   |   |   |   |   |   |
| Communicable disease   |            |            |   |   |   |   |   |               |   |   |   |   |   |   |   |   |
| Antibiotic resistant VRE MRSA                                  |            |            |   |   |   |   |   |               |   |   |   |   |   |   |   |   |
| Unsafe housing- Poor/no access to exit                         |            |            |   |   |   |   |   |               |   |   |   |   |   |   |   |   |
| Unsafe stairs, ramp  |            |            |   |   |   |   |   |               |   |   |   |   |   |   |   |   |
| Absence of heat, water, cooking facilities, phone              |            |            |   |   |   |   |   |               |   |   |   |   |   |   |   |   |
| Fire hazards   |            |            |   |   |   |   |   |               |   |   |   |   |   |   |   |   |
| Presence of weapons  |            |            |   |   |   |   |   |               |   |   |   |   |   |   |   |   |
| <b>Physical Status</b>   |            |            |   |   |   |   |   |               |   |   |   |   |   |   |   |   |
| Rate of physical deterioration                                 |            |            |   |   |   |   |   |               |   |   |   |   |   |   |   |   |
| Physical limitations - Mobility                                |            |            |   |   |   |   |   |               |   |   |   |   |   |   |   |   |
| No Change:   |            |            |   |   |   |   |   |               |   |   |   |   |   |   |   |   |
| Initials   |            |            |   |   |   |   |   |               |   |   |   |   |   |   |   |   |

R=Risk

A=Acceptable

U=Unacceptable

## Risk Assessment Screening Tool (cont'd)

| Date of Visit  | ASSESSMENT |   |   |   |   |   |   |   |   |   |   |   | REASSESSMENTS |   |   |  |  |  |
|--|------------|---|---|---|---|---|---|---|---|---|---|---|---------------|---|---|--|--|--|
|  | Home Hosp. |   |   |   |   |   |   |   |   |   |   |   |               |   |   |  |  |  |
| Risks  | R          | A | U | R | A | U | R | A | U | R | A | U | R             | A | U |  |  |  |
| <b>Physical Status cont'd:</b>                                   |            |   |   |   |   |   |   |   |   |   |   |   |               |   |   |  |  |  |
| Vision   |            |   |   |   |   |   |   |   |   |   |   |   |               |   |   |  |  |  |
| Hearing  |            |   |   |   |   |   |   |   |   |   |   |   |               |   |   |  |  |  |
| Speech   |            |   |   |   |   |   |   |   |   |   |   |   |               |   |   |  |  |  |
| Swallowing   |            |   |   |   |   |   |   |   |   |   |   |   |               |   |   |  |  |  |
| Nutritional deficiencies   |            |   |   |   |   |   |   |   |   |   |   |   |               |   |   |  |  |  |
| Reports of falling   |            |   |   |   |   |   |   |   |   |   |   |   |               |   |   |  |  |  |
| Physical/Chemical restraints                                     |            |   |   |   |   |   |   |   |   |   |   |   |               |   |   |  |  |  |
| Presence of physical injury (bruises, cuts, swelling)            |            |   |   |   |   |   |   |   |   |   |   |   |               |   |   |  |  |  |
| ADL dependence   |            |   |   |   |   |   |   |   |   |   |   |   |               |   |   |  |  |  |
| Signs of sexual abuse  |            |   |   |   |   |   |   |   |   |   |   |   |               |   |   |  |  |  |
| <b>Psychological/ Cognitive Status</b>                           |            |   |   |   |   |   |   |   |   |   |   |   |               |   |   |  |  |  |
| Cognitive Impairment - Confused                                  |            |   |   |   |   |   |   |   |   |   |   |   |               |   |   |  |  |  |
| Some memory loss   |            |   |   |   |   |   |   |   |   |   |   |   |               |   |   |  |  |  |
| Poor judgment  |            |   |   |   |   |   |   |   |   |   |   |   |               |   |   |  |  |  |
| Diagnosis of Dementia  |            |   |   |   |   |   |   |   |   |   |   |   |               |   |   |  |  |  |
| Mental health issues - Depression                                |            |   |   |   |   |   |   |   |   |   |   |   |               |   |   |  |  |  |
| Anxiety  |            |   |   |   |   |   |   |   |   |   |   |   |               |   |   |  |  |  |
| Paranoia   |            |   |   |   |   |   |   |   |   |   |   |   |               |   |   |  |  |  |
| Psychiatric diagnosis  |            |   |   |   |   |   |   |   |   |   |   |   |               |   |   |  |  |  |
| Suicidal risk  |            |   |   |   |   |   |   |   |   |   |   |   |               |   |   |  |  |  |
| Behaviour – Fearful  |            |   |   |   |   |   |   |   |   |   |   |   |               |   |   |  |  |  |
| Withdrawn, passive, overly compliant                             |            |   |   |   |   |   |   |   |   |   |   |   |               |   |   |  |  |  |
| Helpless, hopeless, sad  |            |   |   |   |   |   |   |   |   |   |   |   |               |   |   |  |  |  |
| Physically aggressive  |            |   |   |   |   |   |   |   |   |   |   |   |               |   |   |  |  |  |
| Verbally aggressive  |            |   |   |   |   |   |   |   |   |   |   |   |               |   |   |  |  |  |
| Agitated   |            |   |   |   |   |   |   |   |   |   |   |   |               |   |   |  |  |  |
| Wandering  |            |   |   |   |   |   |   |   |   |   |   |   |               |   |   |  |  |  |
| <b>Neglect</b>   |            |   |   |   |   |   |   |   |   |   |   |   |               |   |   |  |  |  |
| Malnourishment   |            |   |   |   |   |   |   |   |   |   |   |   |               |   |   |  |  |  |
| Dehydration  |            |   |   |   |   |   |   |   |   |   |   |   |               |   |   |  |  |  |
| Poor hygiene   |            |   |   |   |   |   |   |   |   |   |   |   |               |   |   |  |  |  |
| Inappropriate clothing/hairstyle                                 |            |   |   |   |   |   |   |   |   |   |   |   |               |   |   |  |  |  |
| Unsuitable living conditions                                     |            |   |   |   |   |   |   |   |   |   |   |   |               |   |   |  |  |  |
| Inadequate attention to health care needs                        |            |   |   |   |   |   |   |   |   |   |   |   |               |   |   |  |  |  |
| <b>Incongruity</b>   |            |   |   |   |   |   |   |   |   |   |   |   |               |   |   |  |  |  |
| Client information differs from service provider's observations. |            |   |   |   |   |   |   |   |   |   |   |   |               |   |   |  |  |  |
| Discrepancies between client and caregiver's perceptions.        |            |   |   |   |   |   |   |   |   |   |   |   |               |   |   |  |  |  |
| No Change:   |            |   |   |   |   |   |   |   |   |   |   |   |               |   |   |  |  |  |
| Initials   |            |   |   |   |   |   |   |   |   |   |   |   |               |   |   |  |  |  |

R=Risk

A=Acceptable

U=Unacceptable

# Interventions / Strategies

## RISK ASSESSMENT SCREENING TOOL

### Purpose

To help CCAC Timiskaming CASC staff to identify problems and determine which interventions/strategies apply in various situations involving potential/suspected/actual abuse.

### Procedure for Determining Risk

- A Risk Assessment will be completed by Case Managers on all admissions except clients admitted to 501 program unless the Case Manager deems this to be necessary on assessment.
- If risk has been identified, one of the following models may be used as a strategy to reduce/eliminate risk.

Visual diagrams called decision trees have been included re:

- Basic Model;
  - The Resistant Victim;
  - Financial Abuse;
  - Basic Model with Concurrent Police/Legal Action.
- The Case Manager and the team will respect the rights of the vulnerable adult/elderly.

## DECISION TREES

*Individuals have the right to self-determination. Access is at their discretion and any intervention depends on their acceptance.*

**There is no standard formula for intervening in cases of physical, psychological and financial abuse and/or infringement of basic rights involving capable and incapable people. Decision trees, however, can be used as general reference points in developing plans of action. Although the particular steps used and their sequence may vary depending on the circumstances of each case, trees can guide the decision-making process and possibly provide some focus in complex circumstances.**

# Interventions / Strategies

## **RISK MANAGEMENT OF VULNERABLE ADULT / ELDERLY AT RISK PROTOCOL**

### **Procedure for Client/Caregiver Disclosures with Permission to Take Action :**

The Case Manager will consult with the client/caregiver/service providers/workers of other agencies involved with client to gather information regarding:

- The situation;
- The client's support system;
- The family relationships;
- The level of risk;
- The client's strengths, perceptions and feelings;
- The client's ability to cope;
- The competency of the client.

The Case Manager will consult with the Director, Client Services and/or CCAC Timiskaming CASC Resource Team. The Case Manager will develop strategies for risk reduction, which may include:

- a) Support the client/caregiver's decision-making;
- b) Provide options on the use of laws, enforcement agencies and legal recourse, women's shelter, public guardian and trustee;
- c) Referral for provision of basic needs of food, clothing, shelter, finances;
- d) Offer respite care;
- e) Medical intervention;
- f) Referral to social work;
- g) Provide a list of resources and emergency numbers if the elderly refuses assistance.

The Case Manager may arrange a case conference, to review all the facts, within two working days to discuss appropriate risk reduction strategies with all team members, including the client whenever possible. The following issues will be addressed at the case conference:

- a) Type and frequency of services required;
- b) Medical supplies and equipment as they impact care;
- c) Need for social work or other intervention;
- d) Need for police or other persons to be notified with client's consent if capable;
- e) CCAC Timiskaming CASC goals with timeframes.

The team will develop a care plan to meet the client's needs. The Case Manager will record the case conference proceedings and file it in the client's chart.

The Case Manager will schedule another case conference within one month or sooner if the need arises. The Case Manager will establish clear expectations to the service providers regarding what observations should be communicated back to the Case Manager for further action.

The Case Manager will document the situation on a Desk Note and will submit it to the Director, Client Services.

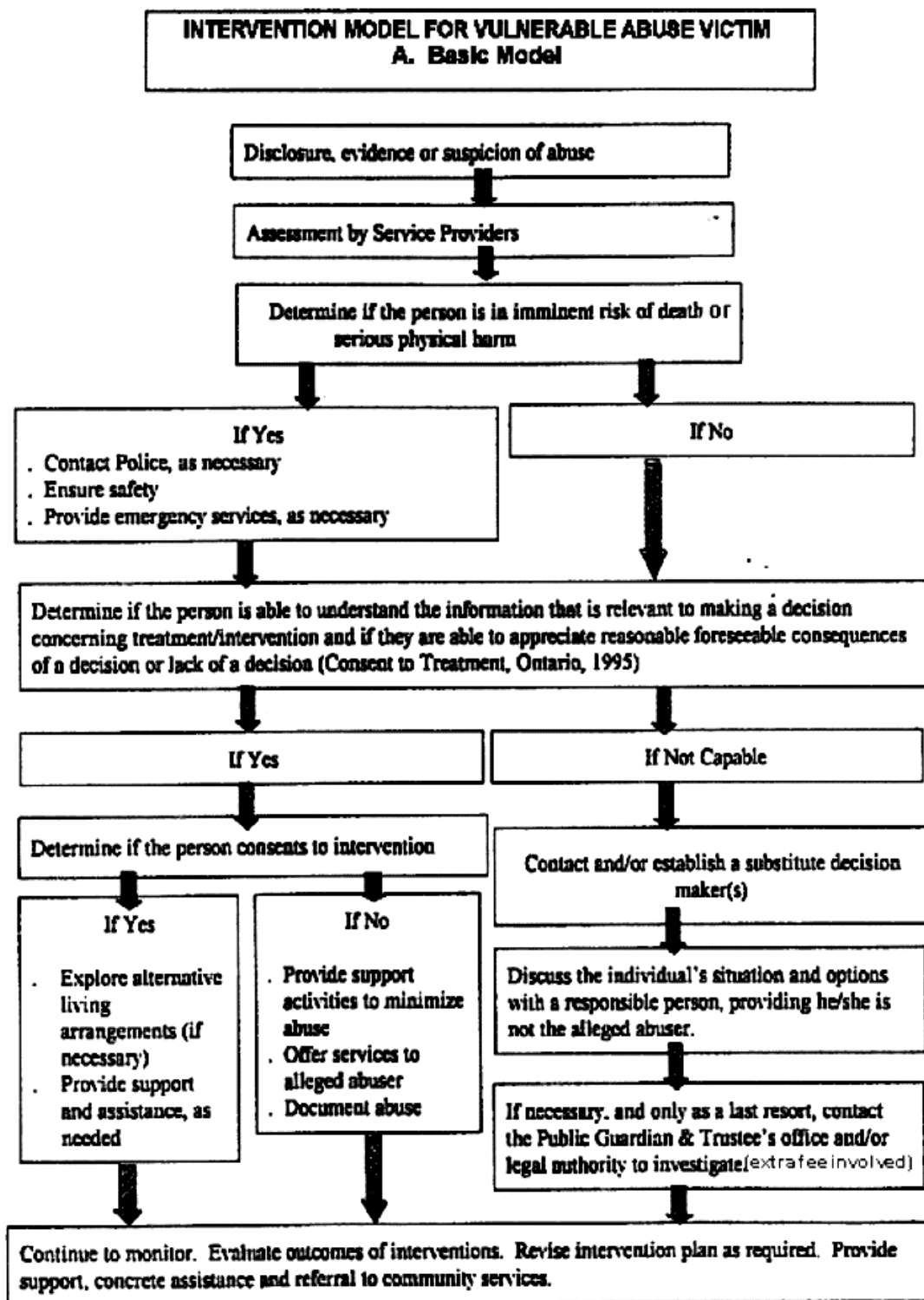
# Interventions / Strategies

## **RISK MANAGEMENT OF VULNERABLE ADULT / ELDERLY AT RISK PROTOCOL (Cont'd)**

The Director, Client Services will complete a **Service Occurrence Report**, which will include the following information:

- a) Client related occurrence
- b) Possible contributing factors
- c) Action taken
- d) Client outcome

The **Service Occurrence Report** is used for statistical purposes.



*Intervention Models adapted from An Elder Abuse Resource and Intervention Guide developed by the Council on Aging of Ottawa Carleton.*

**INTERVENTION MODEL FOR USE WITH VULNERABLE ABUSE VICTIM  
B. Intervention Concerning the Resistant Victim**

Evidence or suspicion of abuse

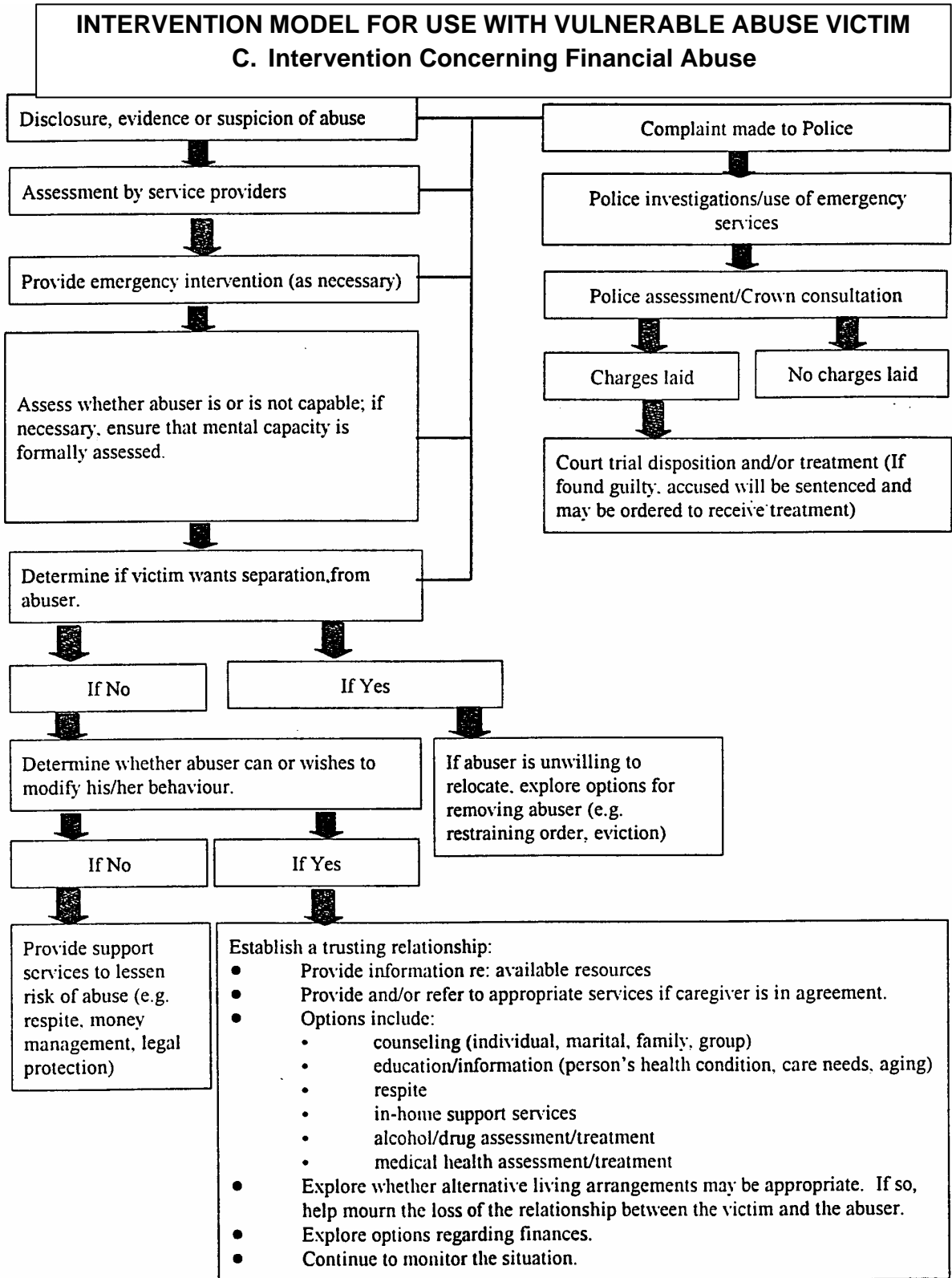
Person resists assessment by service provider(s) and/or refuses help

Provide emergency intervention, as necessary.  
(Victims generally are willing to access emergency medical care)

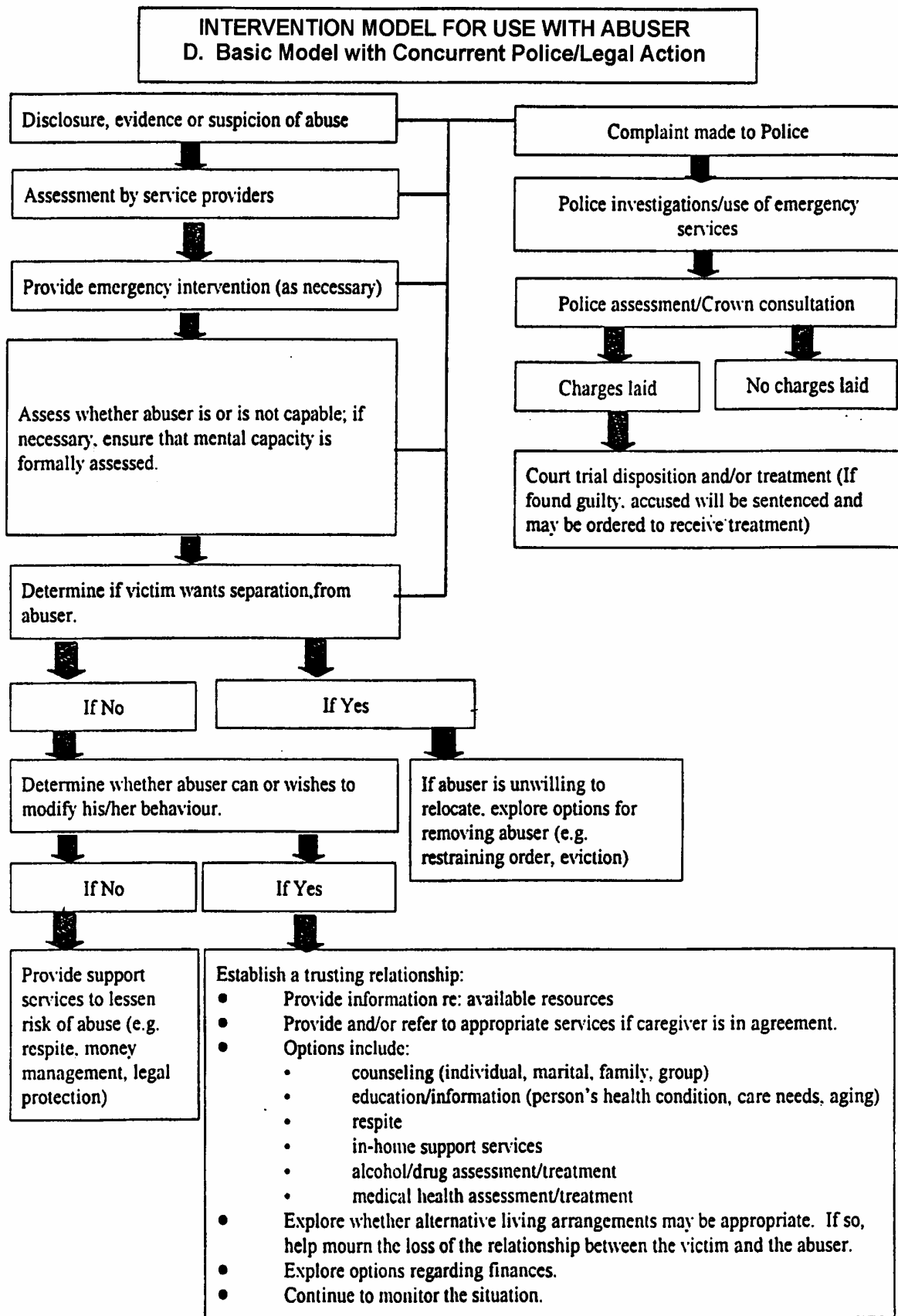
- Maintain an ongoing telephone or in-person contact to further assess the situation, to diminish the fear and anxiety of the vulnerable person and to establish a trusting relationship.
- Use active listening, support and encouragement. Proceed at a pace which is comfortable for the vulnerable person.
- Document details of the situation.
- Suggest meeting in a neutral place, if appropriate.
- Communicate generalized information about the abuse in a matter-of-fact way (e.g. that abuse tends to increase in frequency and severity over time).
- Communicate enough information about alternatives so that the person can make informed choices. Help the person concentrate on possible solutions rather than on feeling helpless.
- Offer concrete help, if appropriate.
- Attempt to engage other friends, neighbours or relatives to support the person, providing the individual consents.
- Establish a plan of action in the event of an emergency. Provide a list of emergency contacts and telephone numbers.
- Let the abused person know of your availability when he/she decides to act.
- Monitor and follow the person until the problem is resolved.

This process may last a few weeks, months or even years. Cases can be monitored and followed by trained volunteers, professionals or para-professionals.

*Intervention Models adapted from An Elder Abuse Resource and Intervention Guide developed by the Council on Aging of Ottawa Carleton.*



*Intervention Models adapted from An Elder Abuse Resource and Intervention Guide developed by the Council on Aging of Ottawa Carleton.*



# Education

## Education of Staff on Elder Abuse

It is the intent of this section of the Elder Abuse Manual to begin providing a resource for CCAC Timiskaming CASC staff to learn about Elder Abuse and how to respond. The education section will be an evolving section and will expand as new information is added.

This section includes:

- Staff Safety Protocols
- Guidelines for Conducting Elder Abuse Assessments
- Considerations for In-Home Assessment
- Police Protocol for Case Manager's Reference

# Education

## Staff Safety Protocols

### **Risk Management Guidelines for Personal Safety when dealing with Clients:**

CCAC Timiskaming CASC recognizes the right of the employee to a safe work environment as supported by the Occupational Health and Safety Act, Section 236: "A worker may refuse to work or to do particular work where he has reason to believe that the physical condition of the work place or the part thereof in which he works or is to work is likely to endanger himself". CCAC Timiskaming CASC strives to provide services with the least possible risk to clients, caregivers, CCAC Timiskaming CASC personnel and purchased service staff.

Personnel are responsible for identifying risk factors and/or threatening situations which undermine their safety and security. These risk factors are to be reported by personnel to their manager and to the client's case manager. Examples include harassment (sexual, verbal, physical), threatening phone calls, verbal abuse, and physical abuse experienced, witnessed or disclosed. This will ensure that the rights of other staff who interact with this client will be protected.

Management is responsible to investigate concerns of staff and to consider options. Managers will offer staff appropriate advice, information, support and action as required.

### **Determine Risk Factors to Staff in Suspected Abuse Situations:**

- The Case Manager obtains as much information as possible from the referral source, client/caregiver, service providers, physicians, other agencies, etc. as soon as risk is identified.
- Document risk factors.
- Notify all service providers of documented risk factors.

### **Things to Consider in Planning the Home Visit Where Suspected Abuse May Be Present:**

- Review current status of risk factors with Case Manager.
- Make decision with case manager as to when the visit should be made and whether it should be made alone, or made jointly with a co-worker, Manager, family member, Community Crisis Team, police escort, or not at all.
- Call ahead to client to assess the situation before visiting. Do not proceed with contact or enter dwelling if you assess danger objectively or instinctively.
- Leave location of the visit, with the estimated time and duration, with someone in the office who may be told to call and verify your safety. Pre-arrange a code with this person to alert them of your need for immediate assistance (e.g. "I need to speak to Dr. Black".)
- Notify the CCAC Timiskaming CASC office when the visit is over.
- Familiarize yourself with the area, and township name before visit (street map).
- Know the telephone numbers of police and emergency services (bring emergency card).

# Education

## **Staff Safety Protocols (cont'd)**

- Visit early in the day.
- Meet the family or client outside of the dwelling or in the CCAC Timiskaming CASC office.
- Dress appropriately and avoid wearing jewelry.
- Wear walking shoes with a solid base.
- Carry only what is necessary (briefcase, no purse or wallet) and keep your keys on your immediate person at all times.
- Wear name tag with discretion if personal safety is threatened.
- Leave purse and wallet locked out of sight in your vehicle.
- Consider bringing along a cellular telephone, especially if the client has no telephone.

## **Things to Consider During the Visit:**

- Introduce yourself at the door by agency and title before entering.
- Do not enter a dwelling if your instinct tells you not to go.
- Exercise judgment in using stairs, elevators, halls, etc..
- When entering the home, note the location of the telephone and obstacles that would hinder or prevent a quick exit.
- Check for household objects that could be used as weapons.
- Appear calm and in control.
- Sit between client and the doorway to the outside.
- Avoid being cornered or turning your back to the client.
- Leave the room if the client is agitated and be prepared to leave the dwelling.
- Do not give a verbal response to verbally assaultive behavior.
- Record notes with discretion, especially if the client is uneasy.
- Telephone the office during the visit if you are anxious about your safety or arrange in advance to have the office call you at the client's home.
- Call the office after you have left the client's home to ensure them of your safety.

## **Exiting from the Visit :**

In any situation that has potential for risk, do not feel obligated to remain when you feel unsafe.

- Keep an exit route open whenever possible.
- Leave immediately if you feel threatened. If necessary, explain to the client this is not a good time to visit, and then leave.
- If you need help immediately, and are in an area where other may hear you and be able to help, try shouting "fire".
- Do not antagonize.
- If you are told to leave, leave immediately.
- Do not stay if you are being threatened by someone.
- Be aware that weapons can appear from anywhere (e.g. hot coffee, cane).
- Call the police if necessary; assault constitutes a criminal offence.
- Notify your manager as soon as possible.

# Education

## **Staff Safety Protocols (cont'd)**

### **Report of Incident:**

- Staff will report incidents to their manager as soon as possible and document the incident in the client's chart.
- The manager will ensure that the incident is reported to other services involved to make sure their rights will be fully protected.
- The manager will evaluate the details of the incident and inform staff of their personal responsibility to call police and lay charges if desired by staff member. (This is a personal responsibility and cannot be done by the employer).
- The incident may be reported to the police by the victimized employee. The police will assess whether charges can be laid. If there is insufficient evidence or grounds to lay charges then police may encourage the individual to file an information report.
- The manager, in consultation with the case manager, will document the incident. This report is forwarded to the Occupational Health and Safety Committee (confidentiality of employee is protected by omitting their name).
- Manager will report the incident to the Executive Director of CCAC Timiskaming CASC, if appropriate.

### **Evaluation of Risk Factors and Revising the Client Service Plan:**

- The case manager /service provider(s) identifies all risk factors and recommends strategies for risk reduction.
- Document risk factors identified and actions planned on the client record.
- The case manager will advise all service providers.
- Services may be put on hold and a case conference may be held as soon as possible to determine whether services will be reinstated and under what conditions.
- An action plan may be negotiated with the client/family and a Letter of Agreement/Contract may be prepared and signed to indicate agreement and commitment to reduce/eliminate risk factors.
- If the client/family does not abide by the terms of agreement, eligibility for continuing services will be assessed by Case Manager.
- If the client remains eligible and present service providers have withdrawn, the case manager is responsible for seeking alternative service providers and ensuring that they are fully informed of all events. New service providers have the right to refuse the referral and should be supported in this decision. The client/family is made fully aware of the reasons service was withdrawn. If there are no service providers willing to service this client, the case manager, in consultation with Manager, will discharge the client from the program and advise the client/family, in writing, of the decision.

# Education

## Guidelines for Conducting Elder Abuse Assessments

Assessment involves both dialogue and observation, and is an on-going process in the client-worker relationship. Sensitivity to language and cultural differences is important in information gathering. It is also necessary to be aware of vision, hearing, or speech deficits. The assessment interview is most effective when conducted in a relaxed, non-judgmental, supportive manner.

### Suggestions for Conducting Assessment Interviews:

- Home assessment interviews should be arranged by appointment with the client.
- If the client and the alleged abuser are both to be interviewed, the client and the alleged abuser should be interviewed **separately** as soon as possible following the reporting of the abuse episode.
- The client (suspected victim) should be interviewed **first**, and then the alleged abuser.
- Privacy is essential to the interview process, therefore, the interview setting should be a place where there is little chance of being overheard or interrupted.
- The worker must be sensitive to and aware of ethno-cultural as well as religious values and traditions, especially as they related to gender/family role expectations or the acceptance of outside help.
- The interview should be conducted in a calm, unhurried manner and should consist of open-ended questions in order to allow the client the freedom to express feelings, provide descriptions, and share perceptions.
- The worker should refrain from making assumptions or drawing conclusions before all the facts are known.
- Particular attention should be paid to any discrepancies and inconsistencies in the accounts of abuse obtained from the client, the alleged abuser, and other information sources.
- Without compromising client confidentiality, the worker should obtain the client's permission to contact other involved service agencies, family members, or friends for collateral information.

### Documentation:

- In situations of suspected abuse, clearly and accurately record the size, pattern, age, description and location of all visible injuries on a body diagram.
- Record all non-physical signs of abuse such as torn clothing, damaged jewelry, broken eyeglasses, or dentures, etc.
- Record verbatim the client's explanation of injuries by prefacing each remark with "The client stated that...".
- Avoid subjective data, lengthy descriptions or client statements, which are unrelated to the incident.
- If the client denies being abused, document the client's exact explanation of the injuries as well as your own observation of the client's condition.

# Education

## **Guidelines for Conducting Elder Abuse Assessments (cont'd)**

- Determine whether any arrests were made or any charges were laid.
- In all situations of suspected abuse or neglect, record the dates and times of all contacts, home visits and telephone calls.

# Education

## Considerations for In-Home Assessment

Assessment within the client's home setting can provide the worker with valuable information about the client's situation. Whenever possible, assessments should be conducted in the client's home.

### Worker Safety

Worker safety and access to the client are issues of **primary concern** when planning a home assessment interview.

Worker safety within the client's home may be jeopardized by the presence of:

- Individuals with a history of unpredictable, explosive, or violent behavior;
- Firearms or other weapons;
- Dangerous animals such as guard dogs;
- Individuals with a history of drug and alcohol abuse.

### Access to Clients:

The worker has no authority to gain access without the property owner's consent. It is helpful for the worker to identify any barriers to access that may exist, e.g.:

- If the suspected abuser lives with the client and is likely to restrict or deny access to the client;
- If the suspected abuser is likely to screen or withhold telephone calls or mail from the client;
- If attempts at access have been made earlier by home visit, telephone or mail, and how these attempts were thwarted by the suspected abuser.

In order to gain access to the client, it may be necessary for the worker to enlist the aid of the referral agent.

To ensure worker safety as well as access to the client, it may be necessary to conduct the home assessment in the presence of another formal care provider such as visiting nurse, co-worker, or police officer.

If it is perceived that there are language or cultural barriers, the worker should ensure that a qualified and trusted interpreter is present to assist with the assessment interview in the client's primary language.

Assessment interviews may be conducted in other settings such as the worker's offices, a senior center, day hospital, or any other place that ensures client privacy and freedom from intimidation as well as worker safety.

# Education

## Considerations for In-Home Assessment (cont'd)

### Telephone Assessments

- When conducting an assessment over the telephone, ask direct, simple, open-ended questions in a calm, sensitive manner.
- Obtain as much basic information as possible from the client in order to determine if the situation is an emergency.
- If the situation is an emergency, follow the procedures outlined for dealing with emergency situations.
- If the situation is not an emergency, obtain:

|                     |           |
|---------------------|-----------|
| • The client's name | • Age     |
| • Telephone number  | • History |
| • Address           |           |

- Record:

|                            |  |
|----------------------------|--|
| • The date                 | • Time of the call                                     |
| • Type and extent of abuse | • The names of any other agencies providing assistance |

- Determine if the client would be receptive to a home visit by the worker.
- If the client is not receptive to a home visit at this time, determine how the client would like to proceed.

#### In responding to emergency calls, it is important to:

1. Assess immediate danger to the client:
  - Where is the client?
  - Where is the alleged abuser?
  - Are there any weapons present?
  - Does the alleged abuser have a weapon?
2. Assess the need for medical attention and access to resources.
  - Has the client sustained any injuries?
  - Does the client need transportation to a medical facility or shelter?
  - Can the client contact the police or other emergency services on his own?
3. Assess the need for emergency housing:
  - Does the client wish to go to a shelter, or have friends or other family who could provide temporary accommodation?

# Education

## Considerations for In-Home Assessment (cont'd)

### **If the client is unwilling to leave the abusive situation, and is in no immediate danger:**

- Provide the client with the number to emergency shelter, police and other agency services; have the client repeat these numbers back to you.
- Stress to the client that abusive behaviors tend to increase in frequency and intensity over time.
- Stress to the client the need to develop a safety/protection plan.
- Negotiate with the client a means of maintaining ongoing contact with you.

### **Procedure for Handling Self-Referral Emergency Telephone Call:**

1. Obtain the client's **address** first in case the call is lost, and then obtain their **telephone number** and **name**.
2. In a crisis situation, obtain the client's permission to conference call #911 or other emergency numbers in order to secure police protection and or emergency services such as an ambulance.
3. After placing the call, tell the dispatcher that the client is still on the line.
4. Stay on the line with the client until the police/ambulance have obtained the necessary information and agree to respond to the call or until the police/ambulance arrives, unless directed to do otherwise by the Police Communications Officer.
5. Obtain permission from the client to follow up with the police.
6. Advise the police dispatcher that the agency would like to be made aware of the disposition of the case.
7. Provide the police with the agency name and telephone number and request that the attending officers call back with dispositional information to keep the agency informed of the outcome.

### **If the client prefers to call emergency services directly:**

1. Strongly encourage the client to do so immediately to ensure emergency assistance.
2. Obtain the client's permission to follow up.

# Education

## Considerations for In-Home Assessment (cont'd)

### **Suggestions for Follow-Up of Self-Referred Emergency Calls:**

1. Contact the client within 1 working day of the emergency call for follow-up.
2. If the client cannot be reached, contact the police within 1 working day of the initial emergency to obtain information regarding their intervention.
3. Maintain contact with the client until an assessment determines that the agencies' services are no longer considered necessary or until the client requests that the agency discontinue contact.

### **Procedure for Handling a Call Being Placed on Behalf of the Client:**

1. Determine whether the client is aware of the call and agrees to being contacted by the agency.
2. If the referral agency is another professional:
  - Determine whether the caller desires feedback, and
  - Obtain the client's permission before sharing any information relating to the case.
3. If the caller is a concerned friend, relative, or neighbour:
  - Provide assurance that the agency will respond to the referral,
  - Do not disclose any additional information concerning the situation.

# Education

## Police Protocol for Case Manager's Reference

### POLICE

#### **What is the role and responsibility of the police upon receiving a complaint of abuse?**

- Safety of victim is number one priority – obtain information about the suspect regarding his/her whereabouts, and relationship to the victim. Also it should be determined whether or not the suspect is under the influence of alcohol, drugs, and whether or not firearms are in the residence or involved in the incident, or if there have been any previous incidents and whether or not a current peace bond or restraining order exists.
- Determine the necessity of emergency services ( ambulance)
- Attendance at the scene in order to collect any possible evidence (photographs, clothing, etc.)
- Interview the victim to obtain details of offence – (once again, collection of evidence may be necessary – photographs of victim, seizing of clothing, etc.)
- All members of the police service should be aware of components of spousal assault which include: physical assault, sexual assault, psychological abuse, stalking, threats of physical assault, directed by a spouse against his/her partner with whom there is or has been a relationship, whether or not that relationship has received legal sanction as a marriage and includes assaults in or outside the home (it does not matter that at the time of the assault, the people did not live together).
- If determined to be spousal assault – charges *must* be laid where there are reasonable grounds to do so.
- If other criminal code violations are identified, the incident should be investigated fully and applicable charges should be laid where there are reasonable grounds to do so.
- If determined to be financial abuse, the incident should be investigated fully, and applicable charges should be laid where there are reasonable grounds to do so.
- If the victim is fearful for safety, and no evidence of violations of the criminal code has been obtained, legal options regarding obtaining a restraining order, or exclusive possession order should be explained. Victim should be advised to seek legal advice.
- As per sections 103 (1) and (2) of the Criminal Code, police officers may seize firearms, other offensive weapons, firearm acquisition certificates, etc., in the interests of the safety of the individual or any other person.
- When this service becomes available, the victim may be taken to the Domestic Assault Center at the hospital for treatment of injuries, collection of evidence and referral to victim services.
- Police must remain with the victim until they are satisfied that there is no further immediate threat to the victim.

# Education

## Police Protocol for Case Manager's Reference (cont'd)

- If the suspect is the victim's sole caregiver, and his/her arrest and removal from the residence will put the victim at physical risk, officers will contact, on advice of the victim or advocate, appropriate resources such as family and/or community services for care.
- If there are language barriers, police will make every effort to obtain an interpreter.
- In Cases where there is a communication barrier as a result of physical, cognitive or developmental disability, police will make all reasonable efforts to contact appropriate community resources to render assistance, including suitable transportation, care and shelter.
- If immigration status is a consideration, the victim must be advised as to his/her rights in Canada, and advised to obtain independent legal advice as to immigration status in Canada.
- Police should arrange for transportation to a shelter or safe place as necessary. The location shall remain confidential unless disclosure is authorized by a Crown Attorney.
- Referrals must be made to victim's services available in the region.
- If an arrest has been made as the result of the investigation, the officer in charge should consider the following factors in determining whether it is in the public interest to detain or release the accused:
  - Seriousness of the crime
  - Use of or threat to use weapons
  - Past history of violence
  - Substance abuse by the accused
  - Other factors observed by officers at the scene that they believe are important in the exercise of their discretion
- The victim must be kept informed regarding the status of the investigation.
- If an arrest has been made and bail has been granted, the victim must be informed of any conditions of release.
- The victim should be invited to fill out a Victim Impact Statement
- Contacts should be maintained with the victim up to court, and the victim should have proper representation prior to court date. This can be accomplished with the assistance of the Victim Witness Assistance Plan and the Crown Attorney's office.

**Community Resource List**



**Emergency Services**

**Telephone Numbers**









**Police:**

|                     |   |                            |
|---------------------|---|----------------------------|
| New Liskeard .....  |  | <u>911 or 705-647-4388</u> |
| Kirkland Lake ..... |  | <u>705-567-5355</u>        |
| O.P.P .....         |  | <u>1-888-310-1122</u>      |

**Hospital:**

|                     |   |                     |
|---------------------|---|---------------------|
| New Liskeard .....  |  | <u>705-647-8121</u> |
| Englehart .....     |  | <u>705-544-2301</u> |
| Kirkland Lake ..... |  | <u>705-567-5251</u> |

**Ambulance:**

|                     |   |  |
|---------------------|---|--|
| Haileybury .....    |  | <u>705-672-3133</u>                          |
| Englehart .....     |  | <u>705-544-7777</u>                          |
| Kirkland Lake ..... |  | <u>705-567-4357</u>                          |
| Temagami .....      |  | <u>705-569-3434</u>                          |
| Matachewan.....     |  | <u>call KL- 1-705-567-4357</u>               |
| Larder Lake.....    |  | <u>0 for operator- ask for zenith 90,000</u> |
| Virginiatown.....   |  | <u>0 for operator- ask for zenith 90,000</u> |
| Latchford.....      |  | <u>call Haileybury 1-705-672-3133</u>        |

|                                   |   |  |
|-----------------------------------|---|--|
| <b>CCAC Timiskaming CASC.....</b> |  | <u>Tri-Towns: 1-888-546-2222</u><br><u>Kirkland Lake: 1-888-602-2222</u> |
|-----------------------------------|---|--|

|                            |   |                             |
|----------------------------|---|-----------------------------|
| <b>Crime Stoppers.....</b> |  | <u>1-800-222-TIPS(8477)</u> |
|----------------------------|---|-----------------------------|

|   |   |                       |
|---|---|-----------------------|
| <b>Timiskaming Crisis Response System</b> |  | <u>1-888-665-8888</u> |
|---|---|-----------------------|

|   |   |                       |
|---|---|-----------------------|
| <b>Seniors Help Line (24 Hours)</b> ..... |  | <u>1-888-871-9090</u> |
|---|---|-----------------------|

|                            |   |                       |
|----------------------------|---|-----------------------|
| <b>Phone Busters</b> ..... |  | <u>1-888-495-8501</u> |
|----------------------------|---|-----------------------|

## THE OFFICE OF THE PUBLIC GUARDIAN &amp; TRUSTEE

**Northern Region**

Client services at 199 Larch St., Suite 602, Sudbury, ON P3E 5P9  
Telephone (705) 564-3185 Fax (705) 564-3193 Toll Free (800) 891-0503

Area Managers (for Thunder Bay Office also)  
Robert Ducharme (613) 241-1202  
Toll Free (800) 891-0506

Team Leader (for Thunder Bay Office also)  
Diane Lafond (705) 564-3191

Senior Client Representative  
Ann Contini (705) 564-3196  
For all files ending in "407"

Client Representative Assistant to 407  
Colleen Sparks (705) 564-3148

Dan Skwarok (705) 564-3189  
For all files ending in "404"

Client Representative Assistant to 404  
Gerry Regimbal (705) 564-3190

Roxanne Mayer Varcoe (705) 564-3187  
For all files ending in "402"

Client Representative Assistant to 402

Client Representative  
Suzanne Lachance (705) 564-3145  
For all files ending in "406"

Legal Counsel (for Thunder Bay Office also)  
Vani F. Santi (705) 564-3134

Legal Counsel (for Thunder Bay Office also)  
Lise Paillé (705) 564-3135

Client Services at 189 River Road, Suite 10, Thunder Bay, ON P7B 1A2  
Toll Free (800) 891-0503 Fax (807) 343-7242

Senior Client Representatives  
Valerie Pleard (807) 343-7241  
For all files ending in "405"

Client Representative Assistant to 405  
Cathy Sheare (807) 343-7242

Elizabeth Bode (807) 343-7237  
For all files ending in "408"

Client Representative Assistant to 408  
Sherry Britton (807) 343-7227

**TREATMENT DECISIONS UNIT**

8:00 AM TO 6:00 pm, 7 days/week  
Weekends and Holidays (800) 891-0503

**Treatment Decisions Consultant**

Lynn Heroux – Ottawa Office (613) 241-1524

**OTHER SERVICES AND IMPORTANT CONTACTS****Office of the Public Guardian and Trustee**

Telephone (416) 314-2800  
Toll Free (800) 366-0335

**Power of Attorney Booklets/Kits**

Telephone (416) 314-2803  
Toll Free (800) 366-0335

<http://www.attorneygeneral.jus.gov.on.ca> - click on "Protecting Vulnerable Persons"

**Intake Unit/PGT**

General Inquiries (416) 327-6683  
Abuse of Guardianship/POA (800) 366-0335

**Guardianship Investigation**

Telephone (416) 327-6348  
Toll Free (800) 366-0335

**Capacity Assessment Office**

List of Capacity Assessors (416) 327-6766

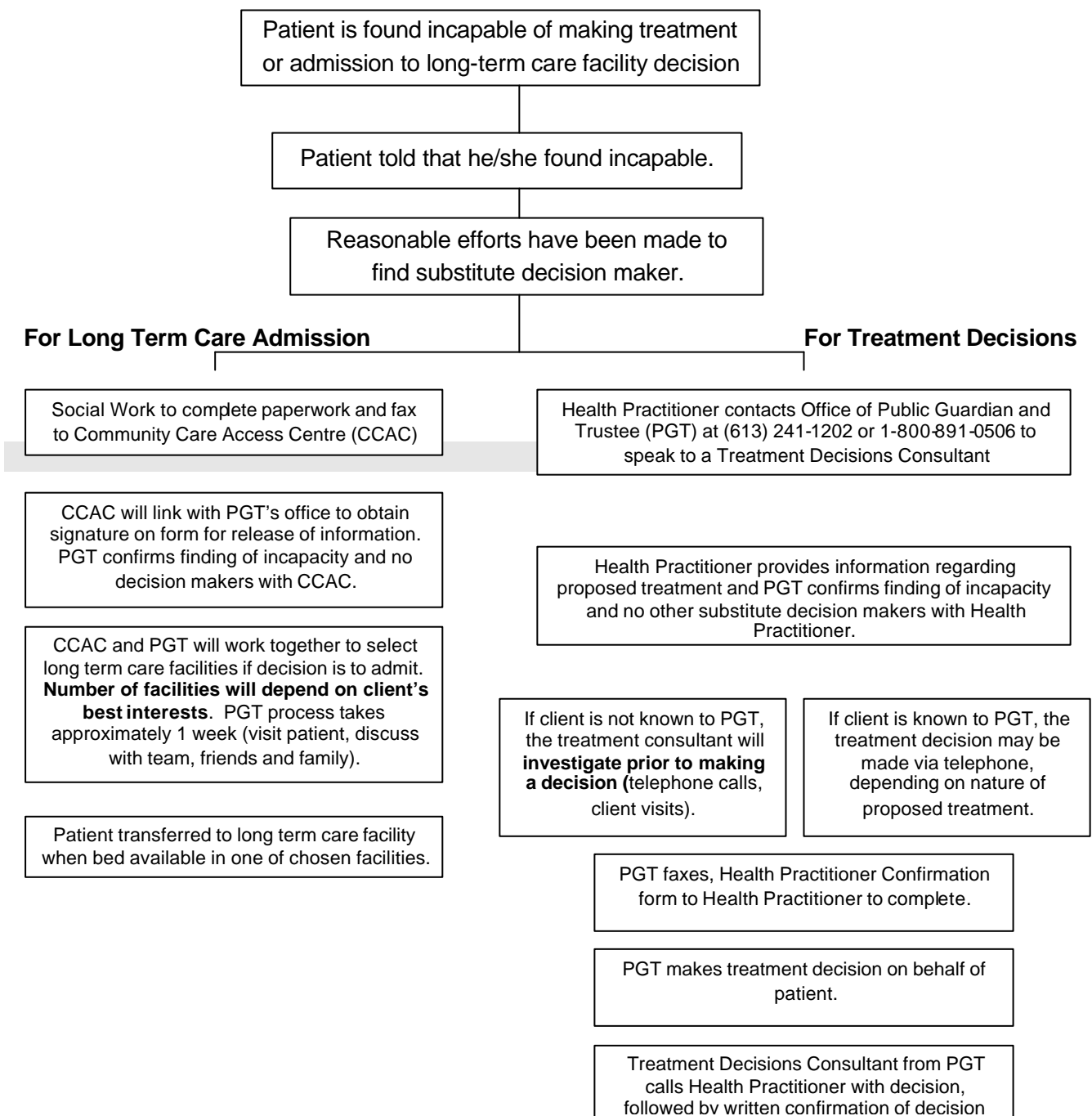
**Consent & Capacity Board**

North Bay (705) 474-1220  
Sudbury (705) 674-6441  
Thunder Bay (807) 623-4442

Copies of the Health Care Consent Act, Substitute Decision Act, <http://www.gov.on.ca>

**THE OFFICE OF THE PUBLIC GUARDIAN & TRUSTEE**

**Process for Involvement of Public Guardian and Trustee  
Under the Health Care Consent Act**



**THE OFFICE OF THE PUBLIC GUARDIAN & TRUSTEE****WHAT KIND OF DECISIONS NEED TO BE MADE FOR YOUR CLIENT?**

- Treatment?
- Admission to a long term care facility?
- Move to a group home?
- Managing finances?

**WHO ASSESSES CAPACITY FOR WHAT?**

- Property (statutory guardianship):
  - Inpatient in a Schedule 1 psychiatric facility: physician;
  - All other settings: capacity assessor
- Treatment :
  - health practitioners listed in Health Care Consent Act (HCCA);
- LTC admission:
  - Evaluator (social worker, registered nurse, occupational therapist, psychologist, physician, speech-language pathologist)
- Clients have the right to appeal the capacity determination to the Consent and Capacity Board.

**HEALTH CARE CONSENT ACT :**

- Codifies common law of consent;
- Recognizes 3 separate areas of decision making:
  - Treatment
  - Admission to a long-term care facility
  - Personal Assistance Services
- Determines who can assess capacity for decisions in these areas;
- Determines when a health care practitioner or agency needs consent;
- Provides a list of substitute decision makers;
- Health practitioner determines capacity for treatment decisions;
- Evaluator determines capacity for placement decision.

**PGT AS DECISION MAKER WHEN:**

- Person is incapable:
  - making treatment decision;
  - making admission decision

**and**
- no other higher ranked substitute capable, available and willing

**or**

- guardian for personal care

**or**

- two equally ranked substitute decision makers disagree

**TREATMENT DECISIONS UNIT**

- Regional Offices
- 8 AM to 6 PM, 7 days a week
- 1-800-387-2127
- Lay person standard

**THE OFFICE OF THE PUBLIC GUARDIAN & TRUSTEE (cont'd)**

**WHO RANKS ABOVE THE PGT?**

- Personal care guardian
- Attorney for personal care
- Board appointed representative
- Spouse or partner
- Child or parent
- Parent with right of access
- Brother or sister
- Any other relative
- Public guardian & trustee

**INFORMATION FOR INFORMED CONSENT**

- The nature of the treatment
- The expected benefits of the treatment
- The material risks of the treatment
- The material side effects of the treatment
- Alternative courses of action
- The likely consequences of not having the treatment

**PRINCIPLES FOR GIVING/REFUSING CONSENT**

- Any substitute decision maker must make decisions based either on:
  1. Prior capable wishes;
  - or
  2. Best interests (if not known prior capable wishes)

**TREATMENT**

“Treatment” means anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other health-related purpose and includes a course of treatment or plan of treatment, but does not include:

- The Assessment of person’s capacity regarding treatment, admission or personal assistance services or property management or personal care decision-making.

**CONSENT FOR TREATMENT IS NOT REQUIRED FOR...**

- General health assessment or examination
- Taking health history
- The admission of a person to a hospital or other facility
- A personal assistance service
- The treatment is such that the circumstances poses little or no risk or harm to the person

**EMERGENCY PROVISIONS**

- Treatment without consent to incapable person if:
  - There is an emergency (there is an emergency if the person for whom the treatment is proposed is apparently experiencing severe suffering or is at risk, if the treatment is not administered promptly, or sustaining serious bodily harm);
  - The delay required to obtain a consent or refusal on the person’s behalf will prolong the suffering that the person is apparently experiencing or will put the person at risk of sustaining serious bodily harm.

## THE OFFICE OF THE PUBLIC GUARDIAN &amp; TRUSTEE

## ***Decision-Maker of Last Resort Under the Health Care Consent Act (HCCAC)***

### **Role as Decision-Maker under the HCCAC**

The Public Guardian and Trustee (PGT) makes decisions for incapable persons:

- When there is no one available, willing or capable of making decisions about treatment or admission to a regulated long-term care facility;
- As a court-appointed guardian of the person for personal care;
- When two equally ranked decision makers such as siblings disagree about giving/refusing consent to treatment or admission.

### **Public Guardian and Trustee Decision Making**

#### **Jurisdiction**

For the Public Guardian and Trustee to make a decision:

- a person must be found incapable with respect to the treatment or admission as defined in the HCCA;
- There must be no other higher ranked substitute decision-maker available; and
- Where the decision relates to treatment, it must be proposed by a health practitioner as defined by the Act.

#### **Process**

- The Health Care Consent Act sets out the principles for giving or refusing consent on behalf of an incapable person. The Office of the Public Guardian and Trustee (OPGT) staff must take into account the person's prior capable wishes where known. If prior capable wishes were known. If prior

capable wishes are not known, staff must make the decision in the person's best interests. The HCCA sets out the factors to be considered when making a decision in their person's best interests.

- When health practitioners or Placement Coordination Services (PCS) coordinators require decisions from the OPGT, they should call the nearest OPGT regional office.
- The OPGT staff person will ask for the name and date of birth of the person for whom the substitute decision is being sought.
- He/she will check the OPGT's computerized register to see if the person has a guardian of the person. If so, this information will be given to the health practitioner or PCS coordinator.
- If not, the health practitioner or PCS coordinator will be connected with the appropriate OPGT staff person, and will be given the staff person's telephone number for future reference.
- When the health practitioner or PCS coordinator is connected to the staff member, he/she will verify the person's name, date of birth and address again, and ask for the caller's name, telephone number and health discipline (e.g. doctor, nurse).
- Once this information has been obtained, the staff person will be required to establish jurisdiction (i.e. determine whether the OPGT should be making the decision). The OPGT staff person will then ask the caller to describe the proposed treatment or admission, and will ask a series of questions that a reasonable person in the same circumstances as the incapable person might ask in order to make a decision.

These questions include, but are not limited to, information regarding risks, benefits and alternatives. OPGT staff will complete a questionnaire when obtaining the information on the telephone from health practitioners or PCS coordinators.

- OPGT staff will indicate when they will call back with the decision and will ask the health practitioner or PCS coordinator to complete the Health Practitioner Confirmation/PCS Confirmation form and fax/send it to the OPGT regional office as soon as possible.
- The staff person will confirm the decision in writing.

## Health Practitioners

The Public Guardian and Trustee may only make treatment decisions that are proposed by health practitioners under the HCCA. The health practitioner must ensure that the information which is necessary for a person or substitute decision-maker to make an informed decision is provided to that person or the substitute decision-maker.

## Admission Decision

The PGT may only make decisions if an evaluator finds the person incapable of making an admission decision, and the admission is to a regulated long term care facility, as defined by the HCCA.

## Emergencies

Under the HCCA, a health practitioner may provide treatment without consent if all of these conditions are present:

1. The person is mentally incapable of making the treatment decision.
2. The person is apparently experiencing severe suffering, or it at risk of serious bodily harm if treatment isn't given promptly.
3. It is not reasonable possible to get consent from a substitute decision-maker, or the delay in doing so will prolong the suffering that the person is apparently experiencing, or put the person at risk of serious bodily harm.
4. Under HCCA, a Placement Coordination Service may admit an incapable person to a regulated long term care facility without consent in a crisis situation.

**Federal Legislation****FEDERAL LEGISLATION RELEVANT TO ABUSE OF ADULTS***(taken from the Grey-Bruce CCAC Elder Abuse Resource Manual)*

In most cases of abused adults, including all forms (physical, psychological, financial and neglect), a crime has been committed and may be punishable under the criminal code (CC). In order for the client to be made aware of this, the service provider must be aware of the criminal code in order to provide the client with accurate information when presenting the option of taking legal route in the case. The following are the highlights of the offences under the **Criminal Code of Canada**:

a) **PHYSICAL ABUSE AND SEXUAL ABUSE**1. **Assault cc. 265**

A person commits an assault when:

- Without the consent of another person, applies force intentionally to the other person
- Attempts or threatens to apply force to another, or causes the other person to believe upon reasonable ground that he has the ability to do so

2. **Assault with a weapon or causing bodily harm cc. 267**

A person committing an assault carries or uses or threatens to use a weapon or an imitation thereof causing bodily harm.

3. **Aggravated assault cc. 268**

A person who wounds, maims, disfigures or endangers the life of another

4. **Sexual assault cc. 271**

Sexual assault is an assault of a sexual nature such that the sexual integrity of the victim is violated

5. **Sexual assault with a weapon, threats to a third party or causing bodily harm cc. 272**

- When committing a sexual assault carries or uses or threatens to use a weapon or an imitation thereof or threatens to cause bodily harm to a person other than the complainant
- Causes bodily harm to the complainant
- Is a party to the offense with any other person

6. **Forcible Confinement cc. 279**

Anyone who, without lawful authority, confines, imprisons or forcibly seizes another person

7. **Murder cc. 229**

- When a person causes the death of a human being
- Means to cause his death, or
- Means to cause him bodily harm that he knows is likely to cause his death

**Federal Legislation (cont'd)**

8. **Manslaughter cc. 234**
  - Based on intent
  - If there is a reasonable doubt that there was intent to commit murder

**b) ACTIVE NEGLECT**

1. **Criminal negligence causing bodily harm or death cc. 220, 221**
  - Causes the death of another person, showing reckless disregard for the lives and safety of others
  - Causes bodily harm to another
2. **Breach of duty to provide necessities cc. 215**
  - Everyone is under the legal duty to provide the necessities of life for the person under his charge due to detention, age, illness, mental disorder or other cause
  - Necessities of life – to preserve life

**c) PSYCHOLOGICAL ABUSE**

1. **Intimidation cc. 423**
  - Anyone who for the purpose of compelling another person to abstain from doing anything that he has a lawful right to do or has a lawful right to abstain from doing
  - Uses violence or threats of violence to a person or his spouse or children or injures his property
  - Uses violence or threats of violence to intimidate that person or a relative by threats of violence or injury to self or property
  - Follows that person from place to place
  - Hides property owned or used by that person
  - Watches the place where that person resides, works or carries on business or happens to be
2. **Uttering Threats cc. 264**  
 Everyone who knowingly utters, conveys or causes any person to receive a threat:
  - To cause death or bodily harm to a person
  - To burn, destroy or damage real or personal property
  - To kill, poison or injure an animal or bird that is the property of any person
3. **Harassing Telephone Calls cc. 372.3**  
 Every person who without lawful excuse and with intent to harass any person, makes or causes to be made, repeated telephone calls to another person

**Federal Legislation (cont'd)****d) FINANCIAL ABUSE****1. Theft cc. 322**

Everyone commits theft who fraudulently converts to his use or to the use of another person, a possession owned by another person. The intent may be to:

- Deprive, temporarily or absolutely, the owner of the possession
- To pledge it or deposit the possession as security
- To deal with it in such a manner that the possession cannot be restored in the condition it was at the time the possession was taken

**2. Theft by person holding Power of Attorney cc. 331**

Anyone commits theft who, being entrusted, whether solely or jointly with another person, with the Power of Attorney for the sale, mortgage, pledge or other disposition of real or personal property, and fraudulently sells, mortgages, pledges or otherwise disposes of the property or any part of it, or fraudulently converts the proceeds of a sale, mortgage, pledge or other disposition of the property or any part of the proceeds, to a purpose other than that for which it was entrusted.

**3. Stopping Mail with Intent cc. 245**

- Anyone who stops a mail conveyance with intent to rob or search is guilty of an indictable offense and liable to imprisonment for life
- Mail conveyance – any physical, electronic, optical or other means used to transit mail

**4. Extortion cc. 346**

Anyone who without reasonable justification or excuse, with intent to obtain anything by threats, accusations or violence, attempts to make another do anything or cause anything to be done

**5. Fraud cc. 380**

Anyone by deceit, falsehood or other fraudulent means, attempts to defraud any person of any property, money or valuable security

**6. Forgery cc. 366**

- Anyone who makes a false document, knowing it to be false with intent
- This may include: altering a genuine document by adding to an original a false date, seal etc. or erasure or removal

## Provincial Legislation Relevant to Abuse of Adults

### **Mental Health Act:**

This act allows for:

- Involuntary removal of a person from their home to a psychiatric facility for up to 72 hours for a psychiatric assessment
- Assessment of the person for mental competence

**A physician can make an application for a psychiatric assessment (Form 1) when, as stated in the act:** "...a physician examines a person and has reasonable cause to believe that the person:

- Has threatened or attempted or is threatening or attempting to cause bodily harm to himself
- Has behaved or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him
- Has shown or is showing a lack of competence to care for himself"

And if the physician "is of the opinion that the person is apparently suffering from mental disorder of a nature or quality that likely will result in:

- Serious bodily harm to the person
- Serious bodily harm to another person
- Imminent and serious physical impairment of the person"

Based on the results of the assessment, the facility may admit the person as an informal (applies only to children ages 12 – 15) voluntary or involuntary patient or release the person if he/she is not in need of psychiatric treatment.

### **Mental Competence** (sub category to Mental Health Act):

There are four main kinds of mental competence described in this act:

- To consent to treatment
- To permit disclosure of the patient's clinical record
- To gain access to the patient's clinical record
- To manage one's estate

A client may be competent in one or more areas, but not in others.

If the physician finds this person is incapable of managing her/his finances, the physician must fill out and immediately send a Form 21 to the Office of the Public Trustee. The Public Trustee assumes the responsibility of managing the estate unless the person has appointed an "Attorney" under a Power of Attorney which applies following a declaration of incompetency.

### **Role of the Justice of the Peace** (sub category to Mental Health Act):

The Justice of the Peace can order a psychiatric examination of a person by a physician (Form 2) on the basis of sworn information, contained in an affidavit. Relatives or others who have not been able to have a physician sign the Application for Assessment have this option, if a person is in need of psychiatric care.

**Provincial Legislation Relevant to Abuse of Adults (cont'd)****Role of the Police** (sub category to Mental Health Act):

The police may be involved in three ways:

- To assist with transportation to a psychiatric facility
- To take an individual to an appropriate place for assessment on an order from the Justice of the Peace
- To take an individual to a facility for assessment if an officer "...observes a person who acts in a manner that in a normal person would be disorderly" and has reasonable cause to believe that the person fits the same criteria outlined for physicians on previous page, and in addition that it would be dangerous to delay apprehension.

The Mental Health Act was never intended to provide a legal remedy for victims of adult abuse. It has no impact on situations where neither the victim or perpetrator have a mental disorder. It does, however, allow entry to a residence without consent in cases of suspected adult abuse where either the victim or abuser meets the above criteria. The act may be helpful, then, in cases where the perpetrator or victim has a psychiatric illness.

**Regulated Health Professions Act:**

- Defines sexual abuse of a patient by a member of a regulated health profession. Outlines actions including reprimand or revocation of certificate of registration if discipline panel finds that member has committed an act of professional misconduct by sexually abusing a patient Sections 1(3) & 51 (5)

Requires mandatory filing of written report with Registrar of College of the member who is the subject of a report when member filing report "has reasonable grounds obtained in the course of practicing the profession to believe that another member of the same or a different College has sexually abused a patient" Section 85(1).

**Health Protection and Promotion Act:**

Police may be asked to assist a Medical Officer of Health acting on a warrant under this act to enter a home without consent if the conditions of the premises pose a health hazard. This act does not permit the police or a Medical Health Officer to forcibly enter a residence to investigate a suspected medical emergency eg. An elderly victim of abuse who is in danger of physical harm.

**Nursing Homes Act, Charitable Institutions Act, Homes for the Aged Act:**

There is a mandatory reporting requirement in cases of abuse, neglect or improper treatment of residents in long-term care facilities. No one who reports abuse may be reprimanded or dismissed from her/his employment.

Anyone who is mentally capable of understanding the nature and consequences of giving a power of attorney may give one to a trusted relative, friend, or, if there is no one else, the public trustee. This enables the "Attorney" to manage the person's financial and property matters but does not allow the "Attorney" to make personal decisions for the donor.

**Provincial Legislation Relevant to Abuse of Adults**

**Health Care Consent Act (1996 – replaced Consent to Treatment Act):**

The Act defines “treatment” and “capable” with respect to giving consent to treatment. It outlines the process required to obtain consent to treatment. The Health Care Consent Act allows for a hierarchy of substitute decision makers if the person is incapable to give consent.

**Substitute Decisions Act (amended in 1996):**

The Act respects people’s choices by giving them the opportunity of appointing someone in advance to make decisions about their finances and personal care if they eventually become unable to make those decisions themselves.

**Advocacy Act (repealed in 1996)**

The Act clarifies the right of adults believed to be mentally incapable and the rights and responsibilities of substitute decision makers. It limits public guardianship to those situations where there are no other suitable alternatives.

**KEY POINTS TO CONSIDER**

It is important to note that there may be a strong preference for a **SOCIAL** rather than a **LEGAL** approach to adult abuse (particularly in reference to the elderly) for the following reasons:

- Most providers perceive the problem as a family issue requiring family service, rather than a legal intervention.
- The frequent denial on the part of the victims and the refusal to lay charges has made it difficult to use the legal system for capable clients.
- The strong fear of having to go to court because of lack of familiarity with the system and concern that court cases go on for extended periods of time.
- Past experiences with the legal system which has only provided short, non-punitive sentences and therefore no protection for the client
- The lack of a clear mandate has hampered the police from responding to cases unless the action is covered by the criminal code
- The lack of sufficient documentation has hindered legal investigations and therefore has increased the investigators’ reluctance to pursue future cases

The Crime Stoppers’ Hotline could be utilized and would not necessitate identification of the caller.

**NOTE: The police must be notified in the case where the life, personal security or property of an individual is threatened. Security of the individual supersedes the maintenance of confidentiality.**