Legislative Frameworks and Service Provision Regarding Abuse and/or Neglect of Older Adults in Manitoba

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EXECUTIVE SUMMARY OF REPORT

This report is a summarized version providing highlights of a longer 116 page report.

The recommendations section includes suggestions for proposals in order to work towards revising related Manitoba legislative frameworks, improved service provision, and, developing new future research. Part One of this review includes a statement of the goal of this work followed by this study’s primary objectives. An introduction of selected research follows which demonstrates key themes in the literature regarding elder abuse and/or neglect. Data collected by the Manitoba Seniors and Healthy Aging Secretariat and by the Protection for Persons in Care Office, on each of their services to Manitobans, is subsequently analyzed. Next, data provided to Research and Education for Solutions to Violence and Abuse (RESOLVE) from the Family Violence Court, as well as existing data from Statistics Canada, is summarized and reviewed. The conclusion drawn is that abuse and/or neglect of older adults is under-reported, and that little is known about the range of types of abuse and/or neglect.

Part Two outlines the methodology. In total, nineteen interviews were completed: ten with older adults and nine with professionals working in the field. One focus group with professionals was held via conference call. One new survey was developed and implemented at five sites; it was distributed to 522 potential respondents, with a response rate of 168. It was found that mandatory reporting is supported in cases where an older adult is known to have a diagnosis of incompetence and is known to be living at risk. In all other cases, where older adults may experience some confusion or may be considered healthy, mandatory reporting was not always supported. Support was inversely related to age and degree of contact with older adults. It was also found that awareness of legislative frameworks and related issues is low in the general population. More education, care provision, and media visibility were suggested.

Part Three includes a discussion of legislative frameworks relevant in Manitoba and action items identified for each legislation.
RECOMMENDATIONS

Legislative framework

It is suggested that the Manitoba Seniors and Healthy Aging Secretariat consider developing a working group, in order to review the Yukon and British Columbia legislative frameworks, for the purposes of recommending amendments to relevant legislation in Manitoba. Priority areas for consideration include i. mandatory and voluntary reporting, ii. mandatory investigation.

Service Provision

It is suggested that the Manitoba Seniors and Healthy Aging Secretariat consider producing a position paper towards the development of a full-time Seniors’ Advocate delineating reporting structure, location, and their focus of responsibility regarding services to older adults living at risk. It is recommended that a team of professionals trained in gerontology and issues of abuse and/or neglect be established along with the development of associated services. In particular, developing accessible and affordable legal services, as well as advocacy for older adults living at risk, should be considered.

Public and Professional Education

It is suggested that the Manitoba Seniors and Healthy Aging Secretariat work with government and other community partners to increase the level of visibility of this issue for the public, and the type of education programs available about abuse and/or neglect of older adults. As well, emphasis should be placed on more training for police officers and Crown Attorneys.

Research

It is suggested that the Manitoba Seniors and Healthy Aging Secretariat consider maintaining a budget with which to facilitate data collection and analysis in the area of elder abuse to further inform policy and program development.
List of Terms

“Abuse” of older adults refers to actions that harm an older person or jeopardize the person's health or welfare. Abuse of older adults is also known as elder abuse. According to the World Health Organization (Bain and Spencer, 2006), abuse and neglect of older adults can be a single or a repeated act. It can occur in any relationship where there is an expectation of trust or where the abuser is in a position of power or authority. Abuse can be physical (e.g. hitting), emotional, verbal (e.g. name calling), financial (e.g. taking money or property), sexual, spiritual, or, it may include neglect. Some types of abuse of older adults involve violation of their rights. Financial abuse is considered the most common form of abuse of older adults. Neglect is when your caregiver or somebody else you trust withholds care, food and/or emotional support, and it may be intentional or unintentional. Sometimes those we trust to provide care do not have the necessary knowledge, experience or ability (Bain et al.).

“Older Adult” is the term selected for use in this report. The terms ‘senior’ and ‘elder’ are used when they occur as part of proper titles, as stated in existing reports, or, as they were used originally in the research instruments. The term ‘older adult’ was selected as most appropriate during the writing of this report, since senior organizations provide services to the older adult who may be over 50 and not yet 65. It was also found that older participants in our interviews, and older respondents in the survey, may not have considered themselves a ‘senior’ even if they fit in this age group. Furthermore, finding enough seniors as participants over 65 proved difficult, thus, suggesting that inclusion of the category ‘older adult’ would reap more participation. There is also a concern that using the term ‘elder’ may be too confusing given the Aboriginal communities’ use of the term ‘Elder’.
Part 1

BACKGROUND

Elderly people aren’t dumb; they’ve worked hard their whole lives [and] they know what goes on. My mother is 94 and she knows what goes on.

Older Adult Interview Participant

Goal of Review

The goal of this review, as requested by the Manitoba Seniors and Healthy Aging Secretariat, is first, to seek out public attitudes and awareness of abuse and/or neglect of older adults and related legislative frameworks in Manitoba. Second, the review aims to highlight key strengths and weaknesses in existing legislations and service provision regarding abuse and/or neglect of older adults in Manitoba and across Canada. A third goal is to summarize existing themes about abuse and/or neglect of older adults in literature and research, and, finally, to make recommendations for future development regarding Manitoba-based legislative frameworks and service provision for older adults.

Introduction to Themes

Novak and Campbell (2006) project that the population of persons aged 65 to 74 will more than double between 1998 and 2041. The 85 and over group will increase almost fourfold by 2041 and constitute 17.6% of the older population. Surprisingly, abuse and/or neglect of older adults remains poorly understood, despite the fact it was first referenced in the academic literature over 30 years ago (Manitoba Law Reform Commission, 1999). Since that time, significant advances have occurred in our understanding of violence against children and women, leading to reforms in criminal law and policy in the 1980s (Ursel, 1992). Effective legislative frameworks that protect older adults are now more critical than ever before.

Primary areas of concern for abuse and neglect of older adults includes (a) physical, emotional, sexual, and financial abuse; and (b) active and passive neglect. In the first category, the following behaviours may be witnessed: physical or verbal intimidation or aggression, shaking or inappropriate handling, and unwanted sexual touching. Examples of financial abuse include the withholding of money, misuse of power of attorney, and/or controlling an older person’s finances. In the second category, neglect implies an omission of care and a failure to attend to the basic necessities of an older adult. This most commonly includes neglect in the area of meals and food provision, medical or physical care.

No single definition of abuse and/or neglect of older adults exists. Some individuals define abuse as primarily physical in nature, while others extend the definition to include such behaviours as limiting access to grandchildren or over-medicating. At a February 2007
workshop (hosted by the Public Health Agency of Canada and the Manitoba Seniors and Healthy Aging Secretariat, in partnership with the World Health Organization), another form of neglect was identified. It was noted that older adults are often the first victims of natural disasters, that they are more likely to die in such instances, that evacuation is often most difficult for them due to mobility issues, and that they are often the poorest members of a community. As stated at the workshop, this combination may result in older adults being neglected in the case of a natural disaster.

The general ambiguity of what abuse and/or neglect is and how to define its severity makes investigation and reporting of suspected cases difficult. Little attention has been paid to the physical abuse and/or neglect of older adults, and even less attention has been paid to defining the range of non-physical ways in which older adults may be at risk of abuse and/or neglect. This oversight results in a general lack of understanding and awareness of what risk may even look like, how much is too much, and who is most likely to be at risk.

There are several hypotheses regarding the occurrence of abuse of older adults. In some cases, such abuse is thought to be a continuation of previous and long-term existing abuse against a person who has become an older adult; it is also understood that sometimes this is a result of caregiver stress (Hawranik and McKeen, 2004). Abuse may be a transfer of abusive behaviours to an older adult parent, learned by a child who was abused by that person (Statistics Canada, 2005); or, it may be a sign of temporary age and stage-specific intergenerational conflicts. Contrary to popular belief, financial dependence on an older adult has been found to lead to abuse by the dependent younger family member (Novak and Campbell, 2006). As in other forms of abuse, addiction is often involved in the abuse and/or neglect of older adults.

**Manitoba Resources: Calls for Information and Data Collection**

Current data on the number and type of calls occurring to the Seniors’ Abuse Line (SAL) and the Protection for Person’s in Care Office (PPCO) is presented first, illustrating that increasingly, calls are being made in Manitoba by the public seeking information on abuse and/or neglect of older adults. Data will be presented next from RESOLVE demonstrating that reporting rates and actual arrests regarding abuse and/or neglect of older adults are particularly low, suggesting such abuse and/or neglect may be severely under-reported. These numbers confirm that there is growing concern about the issue of abuse and/or neglect of older adults in our community. However, it is still unclear how this concern gets translated into action.

**Manitoba Seniors and Healthy Aging Secretariat**

The Seniors’ Abuse Line has collected data regarding the type of person making the predominant number of calls to this line including older adults calling on behalf of
themselves, third party callers on behalf of an older adult living at risk, and information calls only.

Figure 1. Type of Caller to Seniors’ Abuse Line

Figure 1 illustrates that 31% of the calls to the SAL were by older adults about themselves, yet, 64% were third party calls. This disparity reflects the difficulty older adults may be having in acknowledging that abuse and/or neglect is occurring, or, in overcoming fears they may have in reaching out for help. Such a high rate (64%) of third-party calls indicates that concern about older adults is being experienced by other community or family members. Data provided by the Manitoba Seniors and Healthy Aging Secretariat suggests that there was a significant increase in the number of calls to the Seniors’ Abuse Line between 2000 and 2006. The fourth year demonstrated the highest increase of any year with 100 more calls. The Seniors’ Abuse Line has also collected data regarding the types of questions people call about with questions about emotional and financial issues at first and second place. The type of questions were predominately related to financial (34%) and emotional (28%) abuse. Several calls included questions about both financial and emotional abuse (19%). Future analysis of the way in which this service is promoted, and to whom, will contribute towards a better understanding of this focus.

Protection for Person in Care Office (PPCO)

The Protection for Persons in Care Office (Manitoba) began to collect preliminary data on calls to their office since the implementation of the Protection for Persons in Care Act in 2001 (P. Lamoureux, personal communication, PowerPoint Presentation for the Protection for Person’s in Care Office, February 27, 2007). The number of calls to the PPCO rose significantly from 417 to 1091 between 2001 and 2005. This increase in calls, coupled with the data derived from the Manitoba Seniors and Healthy Aging Secretariat, demonstrates the growing demand for a service that provides information on such abuse and/or neglect. It is interesting to note that the majority of calls are about older adults, although the office serves
all adults. In total, 2674 (not including those under 60) calls were made about or by older adults aged 60 to 100. Given this total, it is evident that the dominant age of the alleged older adult victim aged 60 to 100 was 80 to 90 (43%) years old. The second largest group of alleged victims was older adults between 70 and 80 (26%), and the third, between 90 and 100 (20%).

**Data on Incidence of Abuse and/or Neglect of Older Adults**

There are three sources of information on interventions in such abuse cases available and all are from the Justice System -- national crime statistics published by Statistics Canada; data on cases regarding abuse of older adults from the Winnipeg Family Violence Court (FVC); and data on Protection Order applications in Winnipeg. This summary will focus on the data available from the Winnipeg Family Violence Court, and data on Protection Order applications in Winnipeg.

*Winnipeg Family Violence Court.*

The Winnipeg Family Violence Court (FVC) Monitoring Project conducted by RESOLVE collects data on abuse cases related to older adults processed in that court. Data has been collected from this court since its opening in 1990, and it is the only longitudinal court study of its kind in North America. RESOLVE collects and codes data on all cases and this represents a complete population of family violence criminal cases rather than a sample. In the ten year period 1992-2002, Table I describes that there were 526 older adult abuse cases heard before the court which constitutes approximately 2.5% of the overall FVC caseload. The data includes 314 spousal abuse cases, 100 intergenerational abuse (see definition below), and a category defined as “Other” including 112 cases involving a variety of relationships and/or multiple victim or multiple accused dynamics. In the remaining four cases, the accused died before the court case was completed. Such cases demand further investigation in particular also as to the reasons why they were not investigated further after death. The characteristics of these cases are identified below in Table 1.
Table 1

Older Adult Abuse Case Characteristics

Winnipeg Family Violence Court 1992 – 2002

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>%</th>
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<tbody>
<tr>
<td><strong>Type of Abuse</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spouse</td>
<td>314</td>
<td>60%</td>
</tr>
<tr>
<td>Intergenerational**</td>
<td>100</td>
<td>19%</td>
</tr>
<tr>
<td>Other***</td>
<td>112</td>
<td>21%</td>
</tr>
<tr>
<td><strong>Gender of Accused</strong></td>
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<td></td>
</tr>
<tr>
<td>Male</td>
<td>403</td>
<td>77%</td>
</tr>
<tr>
<td>Female</td>
<td>115</td>
<td>22%</td>
</tr>
<tr>
<td>Male &amp; Female</td>
<td>8</td>
<td>1%</td>
</tr>
<tr>
<td><strong>Gender of Victim</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>119</td>
<td>23%</td>
</tr>
<tr>
<td>Female</td>
<td>336</td>
<td>64%</td>
</tr>
<tr>
<td>Male &amp; Female</td>
<td>71</td>
<td>13%</td>
</tr>
</tbody>
</table>

* Denominators for each category have been adjusted to account for missing information.

** Intergenerational is defined by relationship (i.e. mother/son) or a 20 year age difference between the adult accused and the Older Adult Victim.

*** OTHER includes acquaintances and friends and cases of multiple victims and accused.

Similar to the national data the most frequent form of violence is common assault, however, the Winnipeg FVC data provides further information on all assaults which add up to a disturbing pattern of violence against older adults.

It is important to note that 28% of all cases involved a serious physical assault and 26% of all cases involved an assault with a weapon. Further, evidence of the older adult’s vulnerability in these cases is the fact that 63% of the accused had a history of prior arrests. This suggests that police are most likely to be called when serious harm could or did result from the incident. This may explain the extreme difference in who calls help lines and who calls police. One of the interesting statistics from the Senior Abuse Line is that only (31%) of their calls are from older adults at risk while 80% of calls to police are made by the older adult victim. Our data would suggest that older adults at risk seldom call for help unless they are in extreme danger and then they call police. These findings give credence to the general concern expressed by professionals and the community at large that older adult abuse is dramatically under-reported, and that intermediate interventions must be developed prior to the occurrence of a ‘most extreme’ case.

For the purposes of understanding court outcome and sentencing patterns we will compare the older adult spousal abuse cases with the intergenerational cases. The other category involves such complex relationships and complex multiple victims, multiple accused dynamics that it is beyond the scope of this report. When we compare older adult spousal abuse and intergenerational abuse of older adults there are some interesting differences in how these cases fare in the justice system.
Intergenerational cases of such abuse are one and a half times more likely to end in a conviction than a spousal abuse case. Which raises the question of whether this difference expresses a community standard that perceives the assault of an older adult by a young adult as more harmful and serious than the assault of an older adult by their spouse? Perhaps there are other factors at play that are in need of investigation. Are spousal abuse victims less likely to testify against their accused than those victims who have been abused by their child or younger relative? Clearly, these questions merit further exploration.

Another source of information from the Justice system on such abuse comes from the RESOLVE collection of data on applications for Protection Orders in Winnipeg. This data is extremely limited because the information in the files coded by RESOLVE almost never has the age of the applicant included. Out of thousands of cases analyzed over the past five years, only 29 applications indicated that an older adult had applied for a Protection Order. However, we only had information on age in a couple of hundred cases. Thus, these statistics represent less than 5% of all cases and so they must be read with a great deal of caution.

Out of 29 applications, 20 applications (69%) were taken out against the intimate partners and ex-partners of the applicants, whereas 6 applications (21%) were taken out against children, grandchildren, or siblings; and, 3 applications (10%) were against neighbours, caregivers, co-workers or landlords. Fourteen of the 29 cases (48%) were described as involving emotional or psychological types of abuse, including unwanted communication (e.g. stalking). Six of the 29 applications (21%) appear to be due to physical abuse. Only 1 of the 29 applications (3%) also included a call to the police. In this case, the victim was a female older adult (aged 75) whose walker was being pulled away from her by her grandson (aged 41). He was charged.

The majority of protection orders requested by older male applicants were directed against women who were listed as ex-spouses. It appears that not a single male who applied for a protection order had an application granted.

There may be a wealth of information within the application files for Protection Orders, however, there needs to be some means of identifying the applicants age. RESOLVE was informed that the information sheet containing particulars of the applicant and the respondent are removed from the files before we code them to ensure anonymity. If this is the case there may be a procedure for identifying older adult applicants, by the staff of the Department of Justice pulling those files for RESOLVE to code. If this is, in fact, possible, it would be beneficial for the Manitoba Seniors and Healthy Aging Secretariat to negotiate this arrangement with the Department of Justice and RESOLVE.
Part 2

PUBLIC AND PROFESSIONAL KNOWLEDGE AND ATTITUDES ON ABUSE AND/OR NEGLECT OF OLDER ADULTS

Section A - Methods

Qualitative and quantitative methods were selected for this study. Qualitative methods were selected to seek new data as these best allow for the investigation of little known views in new areas of research. Little work has been done to better understand the views of Manitobans on questions related to mandatory reporting, legislative development, and abuse and/or neglect. It was decided that interviews with older adults and professionals, and focus groups with the same, could effectively establish rich qualitative data. The development of a new survey occurred in order to collect and analyze more general views in Manitoba on this topic and since few appropriate existing surveys on this topic were found. Other research was archival in nature in order to review, summarize and analyze existing documents (see bibliography). An ethics protocol was approved by the Psychology / Sociology Research Ethics Board at the University of Manitoba in January 2007.

Due to the time constraints associated with this five month project, some important areas were not able to be reviewed. For example, it was not possible to fully explore how differing communities (e.g. ethnic, disabled, rural) may define, understand, and respond to such abuse and/or neglect, or what they would prefer regarding protective legislative frameworks. Another limitation is that the data that emerged from the interviews and the survey can still be mined for further analysis. Future studies may refine questions for each. The focus group for older adult interview participants was not implemented due to the season and time constraints. Some of the legislation had not yet been put into practice, and so it is too early to assess their practical implementation.

Caution is recommended in generalizing this data to a broader audience, as the sample size of participants was quite small.

Section B - Summary of Findings from Survey

The survey responses from the three designated sites were summarized and analyzed. For the purpose of this discussion, the responses are clustered into three age categories: 113 young adult responses (age 29 and younger), 27 adult responses (age 30 - 49), and 27 older adult responses (age 50+). Clearly, the highest number of people in any age group was people age 29 and younger (67%). Women (82%), people with higher levels of education (75% - University), and single people (67%) dominated in this sample. This is not a representative sample, thus, the data is derived from populations we could easily access for this survey.

Older adults who responded to the survey have significantly more awareness of the topic of such abuse and/or neglect than younger adults who responded. Where 5% of older adults were
very high and 38% of older adults were quite high in awareness (totaling 43%), the remaining 57% are average, somewhat low, or, very low in awareness. Only 4% of younger adults were very high, and 12% were quite high in awareness (totaling 16%). Adult responses demonstrate a higher awareness than young adults and a lower awareness than older adults. Further, young adults dominated the lower end of the awareness scale with 47% having average awareness, 24% somewhat low, and 13% very low. This level of awareness must be considered when analyzing the views on mandatory reporting. To what extent does one take into account views on mandatory reporting by an age group that reflects average to low awareness on this issue?

Only 27% of older adult respondents and 9% of adult respondents knew of legislative framework that might protect older adults. This is similar to what was found in the individual interviews with older adults, where very few older adults were aware of any legislative framework they could apply to protect themselves. It is clear that young adults lag far behind older adults in their awareness of legislative framework with 92% saying they had little knowledge of such legislative framework. Similarly, 88% of the adults stated they knew little on this topic. Again, this data raises caution in translating into action the views of a group whose knowledge and awareness is low not only on the issue of abuse but also regarding related legislative framework. The survey sought to determine whether respondents thought that older adult’s rights would be restricted in the case of mandatory reporting.

*Figure 1. Belief that Mandatory Reporting Would Restrict Rights by Age of Respondent*

Few people stated that they strongly agreed. Older Adults were more likely to hesitate on the subject of mandatory reporting than younger adults: 50% of older adult respondents agreed that mandatory reporting would restrict the rights of older adults, while 22% stated they neither agreed nor disagreed, and 22% stated they disagreed somewhat. Adults appeared equally
ambivalent in their predominant responses which clustered as follows: “somewhat agree” (21%), “neither agree nor disagree” (30%), and “disagree somewhat” (25%). Even young adults clustered around responses that appear ambivalent: 24% somewhat agreed, 29% neither disagreed nor agreed, and 30% disagreed somewhat.

As illustrated above, support for mandatory reporting varies according to the age of the respondent, with younger respondents more strongly in favor of mandatory reporting. Adults were somewhat in favor compared with younger adults, and older adults were most likely to appear ambivalent. Due to the strong youthful bias in the sample (the highest number of respondents were under 30), it was important to seek out other ways to establish the knowledge and attitudes regarding abuse and/or neglect of older adults and mandatory reporting.

As the following figure demonstrates, 46% of the respondents with regular contact with older adults (N=77) supported mandatory reporting, and, 54% of respondents with little contact with older adults (N=90) supported mandatory reporting. The results are striking.

![Figure 2. Support for Mandatory Reporting on Behalf of Older Adult by Level of Contact](image)

Respondents with little contact with older adults are much more likely to respond in favour of mandatory reporting (80%) than respondents with regular contact with older adults (53%). Those with more regular contact appear more ambivalent to mandatory reporting. This is again mirrored in the “not sure” response, where respondents with more contact with older adults are more likely to be unsure (30%) than those who have less contact with older adults, and appear more certain about mandatory reporting (17%).
On a further question regarding who should definitely be supported by legislative frameworks, the following results merged. If an older adult has been diagnosed as incompetent and is living at risk, most respondents stated this older adult should unequivocally be supported through mandatory reporting. Here, those with more regular contact with older adults (90%) and those with less regular contact (80%) predominantly agreed that mandatory reporting should occur. In fact, people with more regular contact with older adults are less divided on this question than they were on any other previous questions. Very few people stated “no”. Views become more ambivalent when the health status of the older adult does not include a diagnosis of incompetence. An older adult who is experiencing some confusion should be protected through mandatory reporting, according to 70% of those with little contact with older adults and 71% of those with regular contact with older adults (compared with 80 and 90% stated above). Even more ambivalence emerged regarding mandatory reporting on behalf of the healthy older adult living independently in community but living at risk.

In conclusion, the survey responses suggest that respondents were not always in support of mandatory reporting in all situations. In cases where a diagnosis of incompetence has occurred, and an older adult is clearly living at risk, mandatory reporting is unequivocally supported. Otherwise, support for mandatory reporting varied according to the age of the respondent and the degree of contact they had with older adults. For example, older respondents with more regular contact with older adults were more ambivalent about mandatory reporting. Interesting to note are the low levels of awareness of older adult abuse and/or neglect in younger adults, the low assessment of one’s own risk when one is over 60 in any age group, the lack of general knowledge regarding legislative framework, and the lack of knowledge regarding whom to call on this topic.

Section C - Summary of Findings from Older Adult and Professional Interviews

“I would never expect a senior to navigate through this, [that is] totally unreal. It is exasperating and [is currently] not [set up] to the benefit of the senior.”

Older Adult Interview Participant

Older Adult Interviews

Eight of the ten older adult participants interviewed stated that they did not really consider themselves a “senior”, since a senior was someone who was fragile and older, and some participants did not view themselves as such, despite their age. Most older adult participants stated they had not experienced abuse firsthand, but knew about it only through the media. As the interviews progressed, some participants stated they had heard “about a woman on their street having difficulties”. This was removed from their own personal experience, according to these interviews.

Three participants knew about organizations such as Age and Opportunity and the Manitoba Seniors and Healthy Aging Secretariat. Seven out of ten participants stated that they did not know about any seniors’ organizations in the city except those that were culturally specific
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(e.g. Italian Club). It was felt that if one did not belong to a given cultural group, that one had no access to that kind of centre or inherent supports.

By majority, older adult participants did not know of any specific legislative framework that might protect or support them if they were at risk. Certainly then, older adult participants were not aware of gaps or benefits of any particular legislative framework, although they readily referred to the police and their duty to protect. As one participant stated, “I can’t answer most of these questions because I don’t really know what policy or the relationship to abuse is, and as far as mandatory reporting goes, I don’t know what exists or where, and what the terms are.”

Mandated reporting was feared by some as it could force older adults to report even if they were too scared, or if they chose to stay in their situations for complex reasons. Another participant agreed, “We should have some kind of legislation without being aggressive about it. Like just something to make people aware that it is there and that the people [who want it] can seek help and get protected.”

One comment about legislating intervention went as follows:

Hmmm, it [the abuse] would have to be very serious I think. Yeah, I really have an issue about people meddling in people’s lives where they shouldn’t. How do you draw a clear line because what one professional may perceive of what the time [is that] I would have to step in there: another professional might say, “oh no, no, no, no, it isn’t there yet you know”. It has to be about life, the risk of life.

One participant stated clearly that we should have legislative framework that protects older adults in the same manner that we do for children, but she was not aware of any specific existing legislation that might protect her. Again, another participant was hesitant about the power of legislative frameworks. She stated, “A law isn’t going to make people do it. It is just going to be there as a working tool for, you know, society”. The role of mandatory reporting was queried by one well-informed participant, who demonstrated some hesitation as to how this might effectively occur:

See, this is what is so hard. Once you are a professional [it is hard] to get into the life of a person. It’s like I said, it is privacy, and that’s the one thing; people are private no matter who they are. If they want to talk about it they will, but if they don’t and it’s personal, and you assume that if you are a representative from the government, that’s just one thing . . . If you are from the province or something like that it puts them off right away. You got to be very careful how you approach them.

For this reason, including the older adult was considered by some participants to be a critical element in all discussions on protection. As one participant stated:

The senior should always be the priority when that happens. There is a concern of the family, there is a concern of the community, there is a concern from the medical
people. So, you have all of these views regarding the senior, but what the senior thinks most and wants to do is very important.

Older Adult participants stated that another challenge for them in reporting abuse was that professionals often changed their jobs – someone they had come to know with a particular title may not be in that position especially when they may need help. Trusting and knowing a professional was viewed as very important when discussing abuse with anyone. Again, shedding more light on why older adults may not report abuse and/or neglect can contribute towards better service provision, and legislative development.

All participants stated that their direct communities had to become more involved with older adults in general, in order to provide improved safety for older adults at risk. As well, older adults should always be included in decisions that were being made on their own behalf.

Professional Interviews and Focus Group

First, there was unequivocal support that if an older adult had been diagnosed as incompetent and was clearly living at risk, the police should be mandated to step in and protect that older adult. As one professional participant stated, “we should not let that older adult rot in their own risk”. This mirrors the survey responses as well as the view of older adults in the interviews, who stated that if an older adult were in immediate physical danger the police should step in. The type of risk could include physical violence, but other abuses stated by professionals included financial abuse, any type of neglect, or, any kind of medical or chemical restraint that prevented that older adult from seeking help on their own behalf. The view was also held by the majority of professional participants that in cases where older adults (a) appeared to be at risk of abuse and/or neglect and (b) were clearly either competent or predominantly competent, that these older adults must be allowed to choose whether or not to live with risk, as they were adults able to make their own decisions. In such cases, it appeared that program development and improved policies were preferred.

The second predominant theme was that in cases where there was no diagnosis of incompetence, and an older adult appeared to be living at risk, that a “response” by the Regional Health Authority, Registered Social Workers, or, other Certified Professionals was favored over a police visit and a formal report. A response would include: information, referrals to relevant agencies, counseling, and developing a safety plan. It may include calling the police, but was generally seen as a preliminary visit. Professionals stated in the interviews that Regional Health Authority and/or Registered Social Workers should have the authority to enter any premise if they had good reason (not necessarily evidence) to believe a person’s life was at risk. A psychosocial (not clinical) assessment of capabilities was preferred by professional participants in the case of someone who appeared to be somewhat confused, but still retained their competence in many areas. This could help to identify whether incompetence in an older adult may be due to dehydration or medical interactions (and not dementia).
Developing a relationship of trust with the older adult was seen as a key step towards future “response” interventions. It was believed by the majority of respondents that a series of “responses” could bring about important change for the older adult in the future leading that older adult or another family member to make a formal report down the road.

Police were seen as strong allies who should always be involved in a report or a “response”, but the type and degree of this involvement varied according to the situation, and according to participants. The older adult interviews similarly suggested that while police should be available in cases where risk and incompetence was clear, they may not always be viewed as supports by older adults. Police presence in some cases (except in the most serious case where incompetence and risk was present) might act as a deterrent to an open conversation with a frightened older adult. As used in the Yukon, a “memorandum of understanding” could be drawn up that would clarify the role of communication between the police and social services, so that police would be notified about every call but need not always go on an initial visit, except if violence were clearly occurring. Strategies were intended to be ‘most effective, least intrusive’.

Significant concern arose regarding possible financial abuses and health care abuses. Statistics on such cases were not being collected (or made public) by relevant organizations, so very little can be analyzed in this regard. It was stated that if a power of attorney, a primary care provider, or a substitute decision-maker was suspected of also being a perpetrator, a Public Trustee should be allowed to immediately freeze the accounts of the older adult and protect their property from sale or transfer of ownership. If the suspected abuses were of a health care nature, it was felt that all restrictions regarding the privacy of health information should be lifted for a specific set of professionals who would be investigating the report. A more user-friendly definition of over- and under-medication was hoped for by all professional participants. Computer systems were seen as helpful in tracking medical and other health care abuses. It was suggested that transportation systems must be improved so older adults who cannot drive can seek help. Police were not always seen as the most ideal resource (although valuable) in such cases. More explicit legislative frameworks regarding reporting of financial and health care abuses was seen as favorable.

A unified response network was suggested. This meant two things. Reciprocal reinforcement across provinces should be developed, so that provinces have the right to reinforce other provincial legislation. A similar approach might function between employment sites as well, where a registry would allow a new employer to seek out the status of a potential new employee. These strategies would help to sustain a unified response network between professionals and older adults at risk across Canada.

Professionals suggested that a specific team of professionals should be designated for older Manitobans. Each member would be well versed in gerontology and older adult abuse and/or neglect. This team may include the Public Trustee, a member of the Geriatric Program Assessment Team (GPAT), clergy, a police officer, a physician, a social worker/mental health worker, and, an older adult volunteer from the community. As part of this team, a full-time
“Seniors’ Advocate” could be made available. This person would be trained in gerontology and specific issues related to abuse and/or neglect and they would be tasked as advocates to speak on behalf of older adults who requested their services. Advocacy would reflect inviting older adults into decision-making processes that involved them, and, ensuring that their voices are heard and considered in those decisions. The Seniors’ Advocate would develop regional and provincial educational programs for the community at large and for older adults more specifically, they would support policy development in local and provincial organizations, and, they could make recommendations to government regarding relevant legislative development.

Some professional participants stated that new ‘monitors’ should be trained to assess and analyze how reporting processes were working. This monitor would also be able to assess whether a substitute decision-maker and a power of attorney were abusive or neglectful. The collection of data could be utilized by researchers in the field. Home care workers should be certified so that (a) they could both be held accountable if they were the abusers, and (b) they could have a refined method for reporting on abuses within the daily context of their work. Further, there is no tracking of the cases that are effectively resolved or remain unresolved, so that “lessons learned” are currently communicated through word of mouth, rather than documented knowledge.

Five options were provided to professional participants in the interview process to prioritize in the event that future funding became available. The options were education, legislative development, research, care provision, and counseling. Education and care provision were selected as first and second priorities.

**Education** for all relevant parties was seen as a strong priority including: professionals and family, community members, lawyers and police, doctors and financial planners, as well as real estate agents, clergy and all First Nations People, and, pharmacists and emergency teams in hospitals. As the survey results similarly stated, accessible information, more education and much more media attention is being requested. It was seen as important to reduce the stigma of being an older adult through such education, a strategy thought to help increase reports of abuse by older adults. Practical information about dementia and confusion was needed for professionals and family members. As well, several professionals wanted more education on disabilities in general. Improving the legal knowledge and financial skills of older adults was seen as valuable. Education for older adults about the internet, online sales, and snail mail lotteries was discussed.

Some educational material on abuse and/or neglect of older adults was available, but professionals stated this was not sufficient given language needs in northern communities. Language was deemed key when English was not the predominant language among older adults; it was also noted that some English terms are regionally specific, as in the example where Elders refers to the leaders of First Nations people. The suggestion was made to use the term “older adults” across Canada instead.
Care provision was seen as a second priority of the five options presented, but care provision could mean different things. In one case, it was suggested that older adults at risk should be allowed to stay in their home and more formal care provided to them there, while the abuser would be taken from the home. Safe housing was also discussed. In another case, improving care provision meant providing professionals and staff already doing this work with significantly more administrative supports. In some cases, improved care provision meant more care supports for the non-abusive care provider in the home.

Part 3

SUMMARY OF LEGISLATIVE FRAMEWORK PROVIDING PROTECTION TO OLDER ADULTS

Manitoba Legislative Frameworks

The following Table summarizes eight Manitoba Acts selected given the criteria stated above. Each of these legislative frameworks has strengths and gaps that can be applied to protect older adults at risk. Some Acts may be applicable in existing form, but the limited resources could hinder its application for these purposes. For this reason, each of the Acts summarized are followed by a statement of a single action item. This action item acts as a recommendation towards increased service provision given existing strengths of that Act. Other Acts were reviewed in chart form also as presented in the longer version of this report: British Columbia (7), Yukon (6), Saskatchewan (6), New Brunswick (4).
Manitoba Report: Abuse of Older Adults

<table>
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<tr>
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| Domestic Violence and Stalking Act, C.C.S.M., c. D93 | Domestic Violence: an act or omission that causes or has a reasonable fear of causing bodily harm or property damage; conduct that constitutes psychological or emotional abuse; forced confinement; sexual abuse. Stalking: repeated harassment that causes the person to reasonably fear for their safety. | Voluntary (onus on victim to seek prevention or protection order) | - Broad application (includes family members regardless of cohabitation)²  
- Evidence can be given by telecommunication and acted upon immediately by a JP⁷  
- Defines tort (personal injury) of stalking⁴  
Types of Protection:  
- Protection Order⁵  
- Prevention Order⁶ which can include a driver’s licence suspension⁷ | - Does not deal with financial abuse  
- Does not refer specifically to elder abuse  
- Applies only to acts committed by those with a direct connection to the victim (e.g. cohabitation, family member). For example, it would not include an act encouraged by family member against victim through a third party | - No definition of capacity  
- Mental incompetence referred to as reason for disbelieving reasonable fear of stalking⁸ |

**ACTION RELEVANT TO OLDER ADULTS:** Consider providing more training in community-based organizations so that staff can better act as advocates on behalf of older adults in the event of violence and stalking. Age and Opportunity does have two trained professionals, called Protection Order Designates, who can act as a resource for expanding training in this area to other community based organizations.

¹ Section 2, *Domestic Violence and Stalking Act.*  
### Manitoba Report: Abuse of Older Adults

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| **Health Care Directives Act, C.C.S.M., c. H27** | Focus of Act on designation of health care decision-making power by directive or proxy for use when incapacitated regarding treatment options. Abuse component of Act focuses on misconduct by proxy of authority relating to medical care. | Review of conduct of proxy by application only (voluntary). | • This Act provides some assurance that a “living will” will be respected by family and medical practitioners  
• Approach to capacity and competence is flexible, depending on circumstance\(^9\)  
• Express limitation on scope of proxy’s authority (e.g., no consent to treatment for medical research; sterilization; removal of tissue while living).\(^10\)  
Misconduct by proxy can result in suspension or termination of authority\(^11\), or substitution of decision by court\(^12\). Strong penalties for “any person who, without the maker’s consent, willfully conceals, cancels, obliterates, damages, alters, falsifies or forges a directive or a revocation of a directive is guilty of an offence”\(^13\)  
| • Does not deal with abuse of older adults specifically  
• Applies only in serious circumstances (e.g., maintenance of life support)  
• Can be written quickly, by anyone, with no witness or confirmation of proxy | Capacity to make health care decisions defined if one is able to understand the information that is relevant to making a decision and able to appreciate the reasonable consequences of a decision.\(^14\)  
Capacity to make decisions can change with time and treatment.\(^15\) Strong penalties proscribed (fine $2000 and/or 6 months imprisonment)\(^16\) |

**ACTION RELEVANT TO OLDER ADULTS:** Consider tracking the assignment of and agreements made with proxies. Consider an assessment of their competence, and whether they have a Protection Order against them. A clearer definition of abuse and/or neglect of older adults would be helpful.

\(^9\) Section 6, *Ibid.* “A person may have capacity respecting some treatments and not others and respecting a treatment at one time and not at another”.


\(^12\) Section 17, *Ibid*.

\(^13\) Section 27, *Ibid*.

\(^14\) Section 2, *Ibid*.

\(^15\) Section 6(2), *Ibid*.

\(^16\) Section 27, *Ibid*. 
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| Personal Health Information Act, C.C.S.M., c. P33.5 | Personal | Voluntary. May share information with outside agency (without consent) if necessary to prevent serious harm.¹⁷ | • Restriction on use of information only for purpose for which it was collected.¹⁸  
• It is an offence to disclose personal health information by employees of trustees¹⁹ | • Possible to share personal health information without patient’s consent²⁰ for purposes of: health care; to lessen or prevent a serious or immediate threat; public safety  
• No reference to older adults  
• Applies only to personal health information  
• Capacity considered only in cases of minors²¹ | • Capacity only in reference to minors |

**ACTION RELEVANT TO OLDER ADULTS:** Consider protocols that specify who should have access to personal health information when older adults are at risk.

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¹⁸ Section 21, *Personal Health Information Act.*  
²¹ Section 60(e), *Ibid.*
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| Protection for Persons in Care Act, C.C.S.M., c. P144 | Mistreatment, whether physical, sexual, mental, emotional, financial that causes or is reasonably likely to cause death or serious physical or psychological harm to a person or significant loss to property. | Mandatory<sup>23</sup>  
  - Service provider or person with reasonable grounds must report abuse to the Minister or the Minister’s delegate<sup>24</sup>  
  - Patient may report<sup>25</sup> |  
  - Patient autonomy to be considered (to an extent)<sup>26</sup>  
  - Provides for mandatory reporting<sup>27</sup>, powers of investigation<sup>28</sup>, protective action<sup>29</sup> and a mechanism for appeal  
  - Definition includes possibility of causing death (enabling urgent intervention)  
  - Protects “whistleblowers”<sup>30</sup> from liability, including adverse employment action, if make a report of abuse in good faith |  
  - *Act* doesn’t apply to a person who is living independently.  
  - Personal health information can be disclosed during investigation without consent of older resident<sup>31</sup> | No reference to capacity or competence |

**ACTION RELEVANT TO OLDER ADULTS:** Consider the possibility of expanding reporting duties designated in this Act, and protection for whistleblowers, beyond institutional care.

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<sup>22</sup> Section 1, *Protection for Persons in Care Act.*  
<sup>23</sup> Section 3, *Ibid.*: Reports of abuse to Minister or Ministers delegate.  
<sup>26</sup> “When making a report, the investigator shall try, to the fullest extent, to involve the patient and to determine and accommodate the patient’s wishes.” Section 7, *Supra* Note 26.  
<sup>29</sup> Section 11-12, *Ibid.*  
<sup>31</sup> Section 6, *Ibid.*
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| Powers of Attorney Act, C.C.S.M., c. P97 | Focus of Act is on person with power of attorney who will not be liable if they act in good faith. | Voluntary any time after execution of power of attorney on review by court | - Covers financial abuse  
- Positive duty to take action on behalf of the grantor to protect the grantor’s interests when unable to make reasonable judgments  
- Attorney will be held liable for any loss to grantor where attorney failed to act.  
- Duty to account on demand or annually | - Attorney’s can avoid this duty by not commencing any action and not indicating acceptance of appointment  
- Mental incompetence is the inability of a person to manage his or her affairs by reason of mental infirmity arising from age or a disease, addiction or other cause. Capacity at issue when power executed. | Mental incompetence is the inability of a person to manage his or her affairs by reason of mental infirmity arising from age or a disease, addiction or other cause. Capacity at issue when power executed. |

**ACTION RELEVANT TO OLDER ADULTS:** A definition of abuse and/or neglect of older adults would be helpful to clarify actions and inactions taken in accordance with this Act, and protocols that regulate the same.

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34 Section 24 (1), *Powers of Attorney Act*  
### Legislation

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| Public Trustee Act, C.C.S.M., c. P225. |               | The Public Trustee is the official guardian in Manitoba. There is an annual report to Minister of Justice following audit by Auditor General\(^{38}\) | • Administers small estates\(^{39}\)  
• Annual audit of estates\(^{40}\)  
• Liability of trustee for losses assessed on same basis as if a personal liability to discharge, and paid out of Consolidated Fund\(^{41}\) | • Does not deal with older persons specifically | No reference to capacity or competence |

### ACTION RELEVANT TO OLDER ADULTS:

Consider the gaps to interventions possible by the Public Trustee in the case of an older adult who is experiencing some confusion, is living in the community, and may be living at risk. Clarify how consent is sought regarding decisions made by older adults living with some confusion but with no diagnosis of incompetence.

\(^{38}\) Section 19, *The Public Trustee Act.*


\(^{40}\) Section 17, *Ibid.*

### Manitoba Report: Abuse of Older Adults

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| Vulnerable Persons Living with a Mental Disability Act, C.C.S.M., c. V90 | Abuse means mistreatment, whether physical, sexual, mental, emotional, financial that is reasonably likely to cause death or serious physical or psychological harm to a vulnerable person, or significant loss to their property. Also includes neglect. | Mandatory. Duty to report by service provider to Executive Director who after investigation may take certain action, which could include “requesting an investigation by a law enforcement agency with jurisdiction respecting the matter”. | • Capacity to retain legal counsel is presumed.<sup>45</sup>  
• Executive Director given power of emergency intervention where abuse or neglect and immediate danger or serious harm or deterioration to physical and mental health of vulnerable person<sup>46</sup>  
• Extensive framework for substitute decision-making, including vulnerable persons commissioner<sup>47</sup>, vulnerable person entitled to be present<sup>48</sup>  
• Substitute decision maker granted broad powers (max. 5 years)<sup>49</sup> with set conditions, only for areas where vulnerable person unable to make a decision alone or with support network. Can include issues relating to health care, place of residence<sup>50</sup> (including apprehension order) and/or financial matters<sup>51</sup> (fiduciary duty<sup>52</sup>)  
• Prevents fraud for administration of property by substitute decision maker<sup>53</sup> | • Limited applicability. Does not apply to those whose impairment resulted from accident or illness after the age of 18, to patients in psychiatric facilities, or to those who suffer from other forms of mental disorder.  
• No specific reference to abuse of older adults | • “Capable” refers to mentally capable<sup>54</sup> A vulnerable person is defined as an adult living with a mental disability who is in need of assistance to meet his or her basic needs with regard to personal care or management of his or her property. |

**ACTION RELEVANT TO SENIORS:** Consider the inclusion of seniors with a diagnosis of incompetence in this Act, and, provide training for staff in community-based organizations on elder abuse and/or neglect.

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<sup>42</sup> Section 1(1), *The Vulnerable Persons Living with a Mental Disability Act.*  
<sup>44</sup> Section 25(b), *Ibid.*  
<sup>46</sup> Section 26, *Ibid.*  
<sup>49</sup> Section 57(4), *Ibid.*  
<sup>51</sup> Section 82, *Ibid.*
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| Mental Health Act, C.C.S.M., c. M110. | No definition of abuse or neglect. Focus of Act on mental competence or incapacity for personal care of by individual. E.g., POLICE officer can intervene where reasonable grounds to believe that the person has threatened bodily harm or behaved violently to self or others or shown lack of competence to care for self; or believes suffering from mental illness that will result in serious harm to self or another person. Also, emergency intervention by Public Trustee permitted where abuse or neglect (not Admission to care can be voluntary or involuntary. Police officer and Public Trustee mandatory reporting requirements. Where involuntary admission, reporting requirements only internal to medical facility, information is protected by patient confidentiality considerations. Report of allegations or concerns of any abuse is voluntary and at discretion of Medical Director with consent of patient or patient’s proxy. | • Permits appointment of Committee to manage the adult’s affairs, personal or financial or both  
• Public Trustee may be appointed without a court order  
• Public Trustee can intervene in emergency situations of abuse or neglect  
• Any person may apply for a termination, replacement or variation of an appointment  
• Cannot override a Health Care Directive  
• Allows police intervention at risk | • The approach to competence is problematic (an all-or-nothing approach)                                                                 | Mental disorder is a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgement, behaviour, capacity to recognize reality or ability to meet ordinary demands of life, but does not include a disorder due to exclusively a mental disability as defined in the Vulnerable Persons Living with a Mental Disability Act.  
Capacity to consent to voluntary admission is determined by psychiatrist based on person’s understanding of the nature and purpose of admission; whether... |
Mental Health Act continued

ACTION RELEVANT TO OLDER ADULTS: Consider how consent is sought from older adults with a diagnosis of incompetence (early stages). Provide training to professionals on the distinction between assessing capacity versus requesting diagnosis for competence. A clearer definition of abuse and/or neglect of older adults would be helpful to clarify how professionals may take action in accordance with this Act.

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58 Section 8, *Ibid.* applies only to admission to psychiatric care, report filed with Medical Director (s.18); no requirement to report of nature of abuse to relevant (external) authorities. Part 5 (s.32-39) deals with Information and Records. Consent of patient required to disclose medical records (s.36).

59 Section 36(2)(e), *Ibid.* Section 36(2)(e) states that the medical director may disclose such information to “any person, if the medical director reasonably believes that the disclosure is necessary to prevent or lessen a serious and immediate threat to the mental or physical health or the safety of the patient or another person” with the patient’s consent.

60 See Part 8 which gives Public Trustee same powers as a private committee, *Ibid.*


References


