

STRATEGIES FOR INTERPROFESSIONAL HEALTH CARE PROVIDERS TO ADDRESS ELDER ABUSE/MISTREATMENT

PREPARED BY:
CANADIAN ASSOCIATION OF OCCUPATIONAL THERAPISTS
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WARNING

This material contains information and guidance for practice. The information is not legal advice. Abuse or neglect of older adults can have serious consequences. In many instances it will be your obligation to ensure that an older adult gets legal advice as soon as possible. Legal advice will help protect your client. It can also protect you and your employer from a lawsuit. The law is always changing. All material provided is up to date as of August 31, 2013. Any changes to the law after August 31, 2013 are not reflected in these materials.

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PREAMBLE:

Because they are frequently in close contact with clients and families, health care providers are often in a position to be entrusted with information about abuse/mistreatment of elders. This inter-professional project started with occupational therapists who felt they needed more information on their responsibilities in such instances and on potential strategies for intervention and came to the Canadian Association of Occupational Therapists (CAOT), their national professional association for advice.

CAOT, striving to provide its members with the necessary tools to achieve excellence in their professional practice, applied to Human Resources and Skills Development Canada (HRSDC) for funding to create a document to build capacity and confidence to help occupational therapists intervene when faced with elder abuse in their practice. Understanding the signs of abuse/mistreatment and knowing the barriers to disclosure can increase the ability of health care providers to empower and support the vulnerable elder. This project spread over 3 years and led to the publications of the 2011 ***Strategies for occupational therapists to address elder Abuse/mistreatment*** which provides information regarding elder abuse including primary indicators, prevention, assessment, intervention protocols, relevant legislation, regulatory requirements and resources for older adults.

Building on the success of this publication amongst occupational therapists and feedback received, CAOT believes the strategy documents created have relevant application to other health providers including physiotherapists, speech language pathologists as well as support workers (Rehabilitation assistants) across all provinces and territories in Canada. CAOT values interprofessional collaboration and education to develop a strong health human resource to provide effective delivery of services to support the health of Canadians. Thus, CAOT sought and received further funding to build capacity for managing situations of elder abuse among interprofessional health care providers. Building on the ***Strategies for occupational therapists to address elder abuse/mistreatment***, this project aims to develop a curriculum for health care providers to learn about indicators of elder abuse, prevention, assessment and intervention protocols, relevant legislation and available resources. The curriculum will be delivered in face- face workshops (with teleconference/video link option for those remote) in various regions across Canada. The expected outcome of the training workshops is to have participants knowledgeable and skilled to deliver interdisciplinary educational sessions in their regions. CAOT is proud to be a leader in building capacity for managing situations of elder abuse and to share this information with other health care professionals across Canada.

1. OVERVIEW & INDICATORS

1.1 BACKGROUND

1.1.1 Who is this document for?

- The strategies are designed to address the needs of with health care providers across Canada, and will help with issues in practice arising when either suspect elder abuse/mistreatment is noted, or a person has disclosed that they are being abused.
- This document draws heavily on materials provided by Human Resources and Skills Development Canada (HRSDC), with input from the Canadian Centre for Elder Law (CCEL), and in consultation with a legal researcher and advisory committee. This document is revised based on an original document created for the Canadian Association of Occupational Therapists. An inter-professional advisory committee made changes to allow the content to provide information for an inter-professional audience such as, but not exclusively; physical therapy, nursing, occupational therapy and social work.
- The overall goal of this resource is to provide information and help direct health care providers to further resources online or in their local community. Individual therapists or groups of therapists wishing to discuss the issue can use these resources. This document cannot advise a definite plan of action, but offers a strong educational tool for those dealing with issues of abuse and mistreatment.

1.1.2 What is elder abuse and mistreatment?

- The World Health Organization¹ defines abuse as a single, or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust that causes harm or distress to an older person.
- There can be a wide range in severity of abuse. What might be considered a “minor incident” may in fact be an important indicator of abuse, as abuse is often repeated and rarely constitutes a single act.
- Statistics on elder abuse indicate that between two and 10 per cent of older adults will experience elder abuse (Lachs & Pillemer, 2004)². As much of the data is based on self-report interviews, it is suspected that there are more cases than reported. Older adults are often reluctant to disclose abuse for various reasons including lack of knowledge about what constitutes abuse or not wanting to lose contact with the perpetrator.
- Although older adults are mistreated by strangers and con artists, elder abuse and mistreatment often occurs in the context of a relationship. In some circumstances, abusers might intentionally target an older adult because of a mistaken belief that all older adults are more vulnerable than other members of society. However, most abusers personally know the victim in some way.
- Abuse can be intentional or unintentional harm.
- Social factors and relationship dynamics can contribute to the abuse. Social isolation can make an adult more vulnerable to abuse or make it harder to access assistance. Older adults are sometimes abused by people they rely on for assistance, or who are dependent on them financially or emotionally.
- Sometimes, elder abuse and neglect is a form of domestic violence, such as spousal assault.

Frances has been married to Harry for over 40 years. Harry has physically and psychologically abused Frances for most of their relationship. When Harry takes early retirement due to his decreasing mobility, his violent behaviour escalates.

Who is an elder?

In this resource, “elder abuse” refers to mistreatment of persons who are older in age. Sometimes, the term “elder” is also used to refer to older members of Aboriginal communities. For the purpose of this resource, the term “elder” refers to all older adults, regardless of culture or First Nations affiliation.

¹ World Health Organization. (2002). The Toronto declaration. Retrieved from: http://www.who.int/ageing/projects/elder_abuse/alc_toronto_declaration_en.pdf

² Lachs, M.S. & Pillemer, K. (2004). Elder Abuse, *The Lancet*, 364(9441), 1192–1269.

1.1.3 Why are inter-professional health care providers important in addressing elder abuse?

- Quite often a health care provider is one of the key people who is helping an older adult maintain daily living function. The health care provider may be in a unique position for the older adult to disclose mistreatment because of development of intimate knowledge of the daily life of an older adult. Also, the provider may be able to detect abuse. For example, an assessment may involve assessing cognitive abilities and household finances. Another example is through a physical assessment or dressing assessment that may allow the provider to view body parts normally covered by clothing. While talking with the older adult about health and wellness, the provider may be able to provide education and advocacy. The provider can be a needed link between the vulnerable older adult and existing community resources. These vital roles were also recognized by the funder of this project, a national body for elder abuse education – Human Resources and Skills Development Canada (HRSDC). Health care providers can also find themselves in the role of general citizen, and elder abuse is a public health concern that can be addressed by any citizen.

Potential roles for health care providers in managing abuse:

- as a citizen or as a professional
- identification and detection
- reporting
- support and advocacy
- liaison with community resources.

- Mandatory reporting laws in other jurisdictions have not been found to be effective in discouraging the abuser or decreasing abuse. It is understood that it is more effective to support the vulnerable person (HRSDC)³
- Therefore, it is important to support vulnerable persons.

Abuse rarely stops without intervention and an important strategy is for vulnerable older adults to receive support from people around them to promote choice and well-being.

The overall guiding principle for this document is to support health care providers so they can increase their own skill and confidence. Increased skill aids in recognizing mistreatment, educating and supporting the vulnerable person, and timely, appropriate referrals to community supports. Barriers to reporting of abuse often include fear on behalf of the vulnerable older adult, because of the need for support or care from the abuser. Health care providers can increase their own skills in ways to support the older adult, which in turn can empower clients to take action against being abused.

1.1.4 Responding to elder abuse and neglect: Guiding principles

The following principles were developed by the Canadian Centre for Elder Law (CCEL) to help professionals and volunteers understand and effectively respond to the rights of older adults who are abused, neglected or at risk:

- **Respect personal values –**
Respect the personal values, priorities, goals and lifestyle choices of an older adult. Identify support networks and solutions that suit the older adult's individuality.
- **Recognize the right to make decisions –**
Mentally capable older adults have the right to make decisions, including choices others might consider risky or unwise.
- **Seek consent or permission –**
In most situations, you must get consent from an older adult before taking action or disclosing personal or health information.

³ Government of Canada. (2008). Elder Abuse Awareness. Ottawa: Human Resources and Skills Development Canada

- **Avoid ageism –**

Prevent ageist assumptions or discriminatory thinking based on age from affecting your judgment. Avoid stereotypes or stereotypical language about older people and show respect for the inherent dignity of all human beings, regardless of age.

- **Know that abuse and neglect can happen anywhere –**

Be aware that abuse and neglect of older adults can occur in a variety of circumstances from home care to family violence.

- **Involve the older adult in problem solving and decision-making –**

Ask questions. Responses to abuse, neglect, and risk of abuse or neglect should involve the older adult's views and concerns.

- **Place high value on independence and autonomy –**

Choose the least intrusive way to provide support or assistance to an older adult.

- **Respond appropriately –**

An appropriate response to abuse, neglect, or risk of abuse or neglect should respect the legal rights of the older adult, while addressing the need for support, assistance, or protection in practical ways. Educate yourself: ignorance of the law is not an excuse for inaction when someone's safety is at stake.

1.2 TYPES OF ABUSE/MISTREATMENT

These include:

- physical/sexual;
- psychological, emotional and verbal;
- financial;
- neglect; and
- denial of entitlements protected by law.

An older adult might experience more than one type of abuse and neglect by the same person. For example,

William, who had a number of physical health problems and a diagnosis of dementia, hired a young man, Elliot, to provide him with assistance with household tasks, medication management, accompaniment to appointments and banking. Elliot used his position to convince William to give him a great deal of additional money to spend on his own interests and also withdrew funds from William's accounts without consent. Neighbours found William alone in his home in a state of extreme malnourishment and dehydration, and with no access to his medication.

Elliot's behaviour represents both financial abuse and neglect.

1.3 DEFINITIONS AND INDICATORS (SIGNS) OF ABUSE/MISTREATMENT

The following definitions for each type of abuse are provided by HRSDC⁴:

1.3.1 Physical or sexual abuse

Physical abuse is defined as the use of physical force that may result in bodily injury, physical pain or impairment. Physical abuse often amounts to assault. Physical abuse may include one or more of the following, but is not limited to:

- pushing, shoving;
- hitting, slapping, poking;

⁴ Human Resources and Skills Development Canada (HRSDC). (2010). Elder abuse awareness information materials: Module 1. Ottawa, ON: HRSDC.

- pulling hair, biting, pinching;
- spitting at someone; or
- confining or restraining a person inappropriately.

Signs of possible physical abuse may include one or more of the following:

- depression;
- fear and paranoia;
- discomfort, anxiety or complete silence (or stupor/catatonia) in the presence of particular people;
- visible scratches, bruises, cuts, swellings or burns; and
- vague or illogical explanations for injuries.

Often the alleged abuser will try to keep the abuse hidden. Therefore, signs of physical abuse may be quite subtle or covered by clothing. Grip marks or bruises on the older person's forearms may indicate abuse.

Statistics Canada⁵ indicates that 68 per cent of older adults who reported physical abuse stated that a family member physically assaulted them.

Examples:

- **physical assault:**
Martha regularly dressed and fed her husband in the mornings. Sometimes frustrated with his lack of mobility, Martha would grab his right arm and forcefully pull him from the bedroom to the kitchen.
- **over-medicating a person** (i.e., give medication that is not needed, administering too much medication):
Apama increased her mother's medication, without consulting a doctor or her mother. The extra medication has severely limited her mother's alertness and agility, confining her to bed. She sleeps for longer periods of the day, is often incontinent and no longer has visitors.
- **withholding medication** (i.e., refusing to pay for a prescription, rationing or limiting the dosage of medication):
Peter's heart medication is expensive. Without consulting a doctor, Peter's son began rationing the pills, cutting the dosage in half. Peter did not know about or consent to the change in dosage.
- **unlawful confinement** (i.e., locking someone in a vehicle, room or building, using restraints to keep someone in bed or in a chair):
Flora often scratches or picks her skin until it bleeds. Hoping to prevent her from causing more damage to herself, her son and daughter made her wear gloves. When Flora insisted on removing the gloves, her son tied her arms down to a chair.

Sexual abuse is defined as any sexual behaviour directed toward another person without that person's full knowledge and consent.

It includes coercing an older person through force, trickery, threats or other means into unwanted sexual activity. Sexual abuse also encompasses sexual contact with older adults who are unable to grant consent (including unwanted sexual contact between service providers and their older adult clients).

Sexual abuse can include rape, incest, ritual abuse, marital or partner rape, sexual exploitation, unwanted sexual contact, sexual harassment, exposure and voyeurism. Unwanted sexual activity, such as verbal or suggestive behaviour, fondling or a lack of personal privacy is also sexual abuse.

Signs of possible sexual abuse may include one or more of the following:

- physical symptoms, including pain, bruises and bleeding in genital area, sexually transmitted disease and infections;
- disclosures of strange encounters with known or unknown individuals, and strong reactions to sexual abuse as a subject matter.

⁵ Statistics Canada. (2000). Abuse and Neglect of Older Adults: A Discussion Paper. Ottawa, ON: Author.

Older adults who have previously been sexually abused may experience especially strong reactions to:

- major life changes such as moving to a long-term care home; and
- being in a situation where they feel they have little or no control.

Example:

Non-consensual sexual contact (i.e., forcing someone to participate in sexual activity or making inappropriate sexual comments).

A nurse would often make inappropriate comments to Walter, particularly when dressing him in the morning and prior to bathing. Walter complained about the comments to another staff member, saying he felt degraded.

1.3.2 Psychological, emotional and verbal abuse

Psychological, emotional and verbal abuse is defined as any action, verbal or non-verbal, which lessens a person's sense of identity, dignity and self-worth. These forms of abuse may include one or more of the following actions:

- words or actions that put an older adult down, are hurtful, make the person feel unworthy;
- not considering an older adult's wishes;
- not respecting an older adult's belongings or pets;
- inappropriate control of activities (i.e., denying access to grandchildren or friends);
- threatening an older adult (e.g., telling the older adult you will put them in a 'home');
- treating an older adult like a child;
- removal of decision-making power while the older adult is still competent;
- withholding affection; and
- verbal aggression, humiliation, isolation, intimidation, name-calling.

According to the World Health Organization, many older adults report psychological, emotional and/or verbal abuse as the most harmful forms of abuse. Many older adults reported that physical scars could heal but psychological hurts were emotionally destructive and damaging to their self-worth and sense of self.

Such abuse can easily affect the mental health of older adults, which can also have an impact on their physical health and level of self-care. Depression can sometimes lead to isolation and/or self-neglect or to situations of increased risk of further abuse.

Signs of possible psychological, emotional or verbal abuse may include:

- fear;
- withdrawal;
- low self-esteem;
- extreme passivity or lethargy;
- nervousness and being uncomfortable around a particular individual;
- depression and anxiety; and
- increased isolation.

Examples:

- **invading privacy** (i.e., opening someone else's mail or emails, accessing personal information).

Gabrielle opens her mother's bank statements and checks her bank balance online. Gabriel says that "someone needs to check on how her money is being spent." But her mother has not given her permission to do this, and Gabrielle is not a power of attorney. Her mother is able to make financial decisions on her own.

- **causing social isolation** (i.e., refusing to allow visitors, refusing to allow someone to attend religious or social gatherings).

Sam's mother regularly played bridge on Wednesday mornings. After she fell and broke her hip, Sam prevented her from going to play bridge. He refused to drive her. He also lied to her friends, saying she needed to be left alone to recover.

- **preventing an older adult from practicing a faith** (i.e., refusing to allow someone to attend religious services, removing personal property associated with someone's faith).

Emile refused to allow his father, who had been a devout churchgoer for several years, to attend church events. Emile

would lock his father's bedroom door on Sunday mornings. When friends from the congregation would call, Emile would say that his father was not home. Although this is not what his father wanted, Emile felt that he was protecting his father from "money grabbers."

- **threats of harm** (i.e., saying or doing something that causes fear).
Alek would often tell his mother that one day he would "teach her a lesson," "get rid of her" or "lock her away for the rest of her life."
- **harassment** (i.e., intimidating or threatening someone, bullying, degrading comments).
Katya regularly told her father that he was "just a stupid old man" and threatened to prevent the grandchildren from visiting him.

1.3.3 Financial abuse

Financial abuse is defined as any improper conduct, done with or without the informed consent of the older adult, which results in a monetary or personal gain for the abuser and/or a monetary or personal loss for the older adult. The misuse of another individual's funds or property through fraud, trickery or force is financial abuse.

*The National Survey on Abuse of the Elderly in Canada: The Ryerson Study (1990)*⁶ found that financial abuse was the most prevalent type of elder abuse reported. Further, it was found that those who were most likely to financially abuse older adults were relatives, friends or neighbours, rather than close family members. Those older adults found to be financially abused were typically single, somewhat isolated, and with health problems.

Financial abuse may include one or more of the following:

- misusing an older person's property and/or funds;
- theft, forgery or fraud;
- refusing to move out of the older person's home when asked;
- sharing the older adult's home without paying a fair share of the expenses;
- unduly pressuring an older adult to:
 - buy alcohol or drugs;
 - make or change a will;
 - give money to relatives or caregivers;
 - engage in paid work to bring in extra money; or
 - care for children or grandchildren;
- over-charging for room and board or for small services;
- trying to persuade older adults to give up control over their finances;
- trying to persuade older adults to sign over their home;
- selling a older adult's home or furnishings without permission and/or at below market value; or
- tricking older adults into signing something that they do not understand.

Signs of possible financial abuse may include one or more of the following:

- changes in a bank account or banking practices;
- unauthorized ATM withdrawals;
- a person showing unusual interest in the senior's financial affairs;
- changes to a will or to other financial documents;
- inability to meet expenses;
- transfer or disappearance of assets; or
- suspicious-looking signatures on cheques and documents.

Examples:

- **Fraudulently gaining access to a person's money** (i.e., theft; stealing personal banking information, coercing a person

⁶ National survey on abuse of the elderly in Canada (1990). Podnieks, E., Pillemer, K., Nicholson, J.P., Shillington, T., Frizzel, A., . Ryerson Polytechnical Institute: Toronto, Canada.

to open a joint bank account, receiving payment for repair work that has not been done). *Ethan persuaded his aunt to open a joint bank account. Ethan said that the joint account “would be easier for everyone.” All the money that went into the account belonged to his aunt. She did not realize that opening a joint account would mean that the other person named on the account could spend all her money. Once the account was set up, Ethan used some of the money to buy a car.*

- **Misusing funds** (i.e., spending money that belongs to someone else, coercing someone to make a financial decision, where there is a power of attorney, not spending money according to the donor’s values and needs, selling property for financial gain). *In a power of attorney document, Jane wrote that she wanted to continue making monthly donations to the Canadian Cancer Society and People for the Ethical Treatment of Animals (PETA) from a special savings account. She continued to have sufficient funds for her own care plus this donation. The attorney refused to make the monthly donations, saying it was a waste of her money.*

1.3.4 Neglect

Neglect is defined as the intentional or unintentional failure to provide for the needs of the older adult. This can be distinguished from self-neglect which includes the adults failing to care for themselves adequately. Self-neglect may make a person more vulnerable to abuse and certain conditions may contribute to self-neglect (e.g. addictions, mental health, poverty,)

Neglect is divided into two categories:

Active neglect – the deliberate or intentional withholding of care or the basic necessities of life.

Passive neglect – the failure to provide proper care due to lack of knowledge, information, experience or ability.

Caregivers who passively neglect an older adult may be doing their best to provide care for a loved one, but they may not have the knowledge, skills or resources to provide adequate care, or they may be unaware of how to access local resources and information. In addition, caregivers who passively neglect may be misguided by inaccurate or outdated information.

Neglect may include one or more of the following:

- inadequate provision of food, liquids, clothing or shelter;
- failure to attend to other health and personal care needs, such as washing, dressing and bodily functions;
- failure to provide social companionship, both within the family and with peers;
- leaving a person in an unsafe place; and
- abandonment.

Signs of possible neglect may include:

- malnourishment, dehydration;
- missing dentures, glasses, hearing aid(s);
- an older adult left unattended for long periods of time;
- unkempt appearance, dirty or inappropriate clothing; and
- untreated medical problems.

Example:

Neglecting a person’s basic needs (i.e., not providing necessary care, such as food, clothing, shelter and health care needs).

While recovering from surgery, Mark lives with his son and daughter-in-law. He has limited mobility and is unable to drive. Mark asks his daughter-in-law to pick up his prescription medication while she is buying groceries. The daughter-in-law bought the groceries, but did not fill the prescriptions. She said it was too expensive and she will get them next week. Mark became quite ill from an infection that developed when he did not take his medication.

1.3.5 Denial of entitlements protected by law

A **denial of entitlements protected by law** is defined primarily as the denial of a person’s fundamental rights according to the Canadian Charter of Rights and Freedoms or the United Nations’ Universal Declaration of Human Rights.

Conduct that denies an older adult’s rights may include one or more of the following:

- censoring or interfering with a person's mail;
- withholding information to which the person is entitled;
- restricting liberties, not letting the older adults go out and/or socialize; and
- denying privacy, visitors, phone calls or religious worship and spiritual practice.

Signs of possible violation of rights may include:

- difficulty visiting, calling or otherwise contacting an older adult; and
- excuses made by an older adult to explain their social isolation enforced by others.

2. FIRST STEPS

2.1 RECOGNIZING ELDER ABUSE

The following clinical scenarios are designed to trigger further assessment regarding the possibility of elder mistreatment.

The health care provider working in home care is seeing a child to provide therapy in the home. The provider is working with the child in the living room every week. Every week, the provider notices that the grandmother of the family is in the kitchen. One gate blocks the kitchen from the living room and another blocks the kitchen from the other rooms to the house. The grandmother is seated in a chair against the wall and does not do any activity. The family walks around her and does not address her. Twice when she needed to go to the toilet, she called out several times and the gate is opened for her to walk alone to the washroom.

Reflective questions:

- 1) Why might this situation cause some concern?
- 2) Is this scenario necessarily indicative of abuse or could there be other explanations for the family's actions?
- 3) If there is abuse/mistreatment occurring, how do your observations relate to the definitions of abuse? How do they relate to the signs/indicators of abuse?

Responses to consider:

- It is concerning because the grandmother is confined to one room of the house for most of day, not participating in activities.
- Query dementia and the perceived need to ensure the safety of the grandmother, query another reason regarding safety.
- Does the activity observed relate to the indicators of neglect?

The health care provider working in the acute-care unit of a hospital is seeing for the first time Mrs. M., who is admitted with a hip fracture. Mrs. M. is frail but cognitively alert. The provider talks with health care team members who state that Mrs. M. had the fracture for five days prior to coming to emergency. The other team members do not have concerns about her discharge except that she needs the standard devices. The provider, asks Mrs. M.'s who states that her husband refused to let her call the ambulance because of the cost, and he wants her home to cook. Mrs M. also is reluctant to either rent or purchase any ADL equipment for discharge. The health care provider wonders if the husband is a supportive caregiver, but is aware that the system and team are pressing for discharge soon.

Reflective questions:

- 1) How can we be certain that this represents an abusive situation, or might other explanations be plausible?
- 2) If there is abuse/mistreatment occurring, how do your observations relate to the definitions of abuse? How do they relate to the signs/indicators of abuse?
- 3) If the provider suspects abuse or neglect, at this early stage of detection, what discussions might the provider have?

Responses to consider:

- Perhaps the husband lacks awareness in general? Perhaps Mrs M. minimized her situation for various reasons? Is there possible financial strain?
- This situation relates to the indicators of neglect, but may also relate to the indicators of physical abuse.
- It is suggested that the provider discuss the suspicion of abuse / neglect with team members. It is possible that the discharge plan needs to be changed which may ultimately involve several team members (see document section on “next steps”). If other team members disagree that suspicion of abuse/neglect is not warranted the provider should at least document, and be sensitive to their suspicion when planning discharge and recommending follow up services. It is important to note the red flags, and start making inquiries. At this very beginning (detection) stage, and in a team environment, the provider would want to seek support and information. Likewise, if one has another team member approach with a suspicion, it is important to be sensitive to the concerns of that team member.

The health care provider, who is consulting in a long-term care home, has been seeing Mr. J. weekly. He recently has become very withdrawn, with no change in his medical status and he is oriented to person, place and time. He appears anxious and told his nurse yesterday that he wants to sell his home to be able to make payments for a semi-private room for himself at the nursing home. He said that his daughter lives in the house and is refusing to help him sell it.

Reflective questions:

- 1) Why might this situation cause some concern?
- 2) If there is abuse/mistreatment occurring, how do your observations relate to the definitions of abuse? How do they relate to the signs/indicators of abuse?
- 3) It is possible that his daughter is not aware that she is a possible perpetrator of abuse/mistreatment. How can the definitions of abuse/mistreatment help in this scenario?

Responses to consider:

- It is concerning because Mr. J. seems to have decreased control over his finances and his daughter seems to be playing a part in this. Is there a valid reason for Mr. J. to have to sell his home? Has there been a decrease in his financial status and does his family have anything to do with that? Is there any change in his mental status?
- Does this scenario relate to the definitions/indicators of financial abuse?
- The definition includes refusing to move when asked, pressure to make financial decisions in one particular way. Educate Mr J and his daughter about what could be considered against the law. Assuming Mr J remains capable of making financial decisions, he has right to make final decision about selling his home.

Summary to consolidate skills:

Signs of abuse/mistreatment may come through either the disclosure by the vulnerable person or observations of such indicators as the living environment, financial circumstances, family relationships or the older adult's communication with others. Two important questions that are central in helping to recognize situations of possible abuse are:

- Why is this situation causing me concern? (Listen and watch for red flags.)
- What am I observing? (Get facts, reflect on the situation and how it fits with the definitions of abuse/mistreatment.)

After completing this section, the following is an overall reflective question:

Have there been situations like this that have caused you some concern in your practice?

2.2 BARRIERS TO DISCLOSURE

Why is elder abuse kept secret? Disclosing the abuse experienced may be difficult because the older adult:

- **does not recognize the situation as abusive.**

People who have lived in abusive circumstances over a period of time may stop recognizing abuse because it is a regular occurrence.

- **does not know where to get help.**

Older adults may not be aware of agencies or individuals who can assist; they may have tried to get help in the past and were unsuccessful.

- **fears it will escalate.**

Older adults may be afraid that if they say something or complain, the alleged abuser will find out and the abuse will get worse. Older adults are often at greater risk when the abuse is brought out into the open.

- **worries about what will happen if the abuse becomes known.**

Older adults may worry that the person abusing them will be arrested, and they often do not know that this may be an avenue for the perpetrator to get badly needed help. They may also worry about where they will live and not want to leave their own homes. They may be fearful of having to move into a facility, which the person abusing them may have been threatening.

- **feels humiliated.**

Older adults may feel humiliated because they mistakenly believe that they should be able to control or stop the abuse.

- **takes blame for the abuse.**

Older adults who are abused may feel that they deserve the abuse because they 'chose the wrong spouse' or perhaps feel guilty about how they functioned as parents.

- **fears a loss of connection.**

Older adults may no longer have siblings, relatives or a spouse still alive. The alleged abusers may be the only people with whom the older adults connect personally or is their only conduit to the outside world. Many alleged abusers threaten their victims with ending contact with loved ones such as grandchildren.

- **believes that family honour is at stake.**

Older adults who are abused may believe that disclosing abuse will bring shame and dishonour to the entire family. In some communities, the family unit is considered more important than the individual; the older adult may feel a duty to suffer in silence rather than bring adversity or shame to the whole family.

- **believes that privacy is at stake.**

Older adults who are abused may believe that they should be able to solve their own problems (and not "air dirty laundry in public," for example).

- **has a history of abuse.**

Older adults who are abused may have had previous experience in disclosing an incident of abuse and had a poor or unpleasant outcome.

- **lack of evidence:** The older adult may believe that lack of evidence means they will not be taken seriously, or that reporting will be a waste of time

Content from the above section obtained from:

Government of Canada. (2008). *Recognizing Elder Abuse*. Ottawa: Human Resources and Skills Development Canada

Clinical scenario and reflective questions:

Health care providers can often be in a position to empower the older adult to overcome some of the barriers to disclosure. How does awareness of the barriers to disclosure increase the skill of a therapist to support the older adult?

Consider the following clinical scenario:

Mrs. S. has Parkinson's disease and lives with her son and daughter-in-law. The health care provider has noticed that she is frail and unkempt, smells of urine and is unable to recall her medical history. On speaking with the family, they say that she is requiring more help and they would like homemaking but they want to take care of her at home. Mrs. S.'s son calls the provider on his own and states that he didn't want to say anything during the visit but his wife has started yelling at his mother, and discourages her from coming out of her room to eat with the family. She says she'll "put her in a home," but when he has talked with his wife she denies being frustrated. He is worried that his wife is "too stressed" but wants his mother's income to keep their own household running.

Reflective questions:

- 1) Why might this situation cause concern?
- 2) Mrs. S.'s son overcame barriers to disclose his concerns, and is putting some trust in the therapist. What other barriers might he still be facing?
- 3) Knowing he may face more barriers, how might you consider supporting and empowering him?

Responses to consider

- It is concerning because Mrs. S. may not be well cared for by family, there is possible caregiver stress relating to her daughter-in-law and/or any other family members. Seek information about caregiver stress.
- The son may have difficulty talking to his mother or wife about the situation, may have caregiver stress himself and difficult to acknowledge, financial or other strains may be a barrier to changes, may not be aware of supports or other solutions.
- Acknowledge that it may be difficult to discuss, recognize the good decision to talk about it, acknowledge importance of mother's care to the son, ask about best place/time to talk further, acknowledge seriousness of situation (i.e., mother's care is important, possibly educate about signs of neglect & ask about signs of physical abuse).

Providing information about caregiver stress might be very important in this scenario. Links to information about caregiver stress:

Canadian Caregiver Coalition: <http://www.ccc-ccan.ca/index.php>

Canadian Association of Occupational Therapists: "Quick Tips" section: <http://www.caot.ca/default.asp?pageid=3696>

Alzheimer Society: <http://www.alzheimer.ca/>

Summary remarks: Health care providers because they often are in close contact with clients and families, are in a position to be entrusted with information about abuse/mistreatment. Understanding first the signs of abuse/mistreatment and knowing the barriers to disclosure can increase the ability of the therapist to empower and support the vulnerable adult.

2.3 TYPES OF INFORMATION NEEDED DURING IDENTIFICATION OF ABUSE/MISTREATMENT

Two types of information are needed as soon after abuse/mistreatment is suspected. Even if abuse is not confirmed, this information is important for choosing supports and actions in later on with the older adult.

- *Determine risk of harm/urgency:* Is this an emergency? Focus on the risk of imminent harm, and consider the immediate safety of the older adult. Call 911 or your community's emergency number if it is a life-threatening emergency situation and stay with the person for support until help arrives. People who can help must remain alert and non-judgmental, and do not jump to conclusions or ignore danger signs. If it is an emergency and it is safe to do so, it is valuable to determine the immediate supports for the vulnerable person (ie which family or friends are supportive?) and communicate this to the emergency providers.
- *Determine cognitive ability:* Is the older adult oriented to person, place and time? Do they recall events with accuracy? Do they have an understanding of the risk of harm to themselves? Whether the older adult is cognitively capable of understanding the situation influences the direction of the next steps. It may be possible that cognitive impairment may not be apparent, especially if the abuser is with the person during each visit. A structured evaluation may be of some help to understand the cognitive status.

Below are two suggested resources that outline steps to address a situation of possible elder abuse. Each serves as a guide to use alongside knowledge of the legal requirements within each province. These guides can be useful quick references for systematically sorting through difficult situations using ethical reflection for decision-making. Both are designed specifically with health and social service providers in mind.

IN-HAND: An ethical decision-making framework by Dr. Marie Beaulieu. Available through: National Initiative for the Care of the Elderly (NICE). This tool is accompanied by an overview in short video clips. (Dr Beaulieu requests that the video clips be reviewed prior to using the tool.) The video clips can be accessed at www.nicenet.ca and input “In Hand” in search field.

DECISION TREE: Senior’s Resource Centre Association of Newfoundland and Labrador (2004), Looking beyond the hurt: A service provider’s guide to elder abuse, pp 50-53. This can be accessed online at www.seniorsresource.ca

2.4 MENTAL CAPACITY AND CONSENT

The Canadian Centre on Elder Law has prepared the following frequently asked questions for health care providers nationally to use when considering cognitive ability:

What is mental capacity?

Capacity, also called mental capacity, is an individual’s ability to make decisions that may have legal or other consequences. Legal definitions of capacity vary depending on the province or territory. In general, a capable adult must be able to understand information and appreciate the consequences of decisions. In most jurisdictions, laws applying to guardianship and health care consent state that every adult is presumed to be capable of making decisions.⁷ In some jurisdictions (e.g. New Brunswick), the term competency is used instead of capacity to refer to the ability to make decisions.

How does capacity relate to elder abuse and neglect?

A lack of capacity could affect a person’s ability to access support or assistance. Capacity is also relevant to whether a person can provide informed consent to supportive interventions. Some forms of elder abuse are connected to disregarding mental capacity or disregarding a lack of capacity.

Jill has lost her verbal communication skills and her hearing since her stroke. Although she remains cognitively sharp, she has been having trouble making her wishes known and often does not notice decisions that are made on her behalf until the damage has been done. Her grandson, who has a power of attorney for property, arranges for her home to be sold and wants her admitted to a care facility. He is the only person who knows these decisions go against her previously expressed wishes.

When is someone legally incapable?

In the context of day to day practice, practitioners must determine whether an adult to whom they are providing or offering services or care is capable of making decisions to direct their own care. However, an adult may be incapable even if no formal process has been initiated to appoint a substitute decision-maker for the adult. Health care practitioners deal with capacity issues as a regular aspect of their practice.

A judge can declare that an adult is incapable, based on evidence. This can result in the appointment of a guardian as a legal

⁷ See for example, Adult Guardianship Act, R.S.B.C. 1996, c. 6, s. 3; Representation Agreement Act, R.S.B.C. 1996, c. 405, s. 3; Health Care (Consent) and Care Facility Admission Act, R.S.B.C. 1996, c. 181, s. 3; Adult Guardianship and Trusteeship Act, S.A. 2008, c. A-4.2, s. 2(a); Adult Guardianship and Co-decision-making Act, S.S. 2000, c. A-5.3, s. 3(b); Vulnerable Persons Living with a Mental Disability Act, C.C.S.M. c. V90, Preamble; The Health Care Directives Act, C.C.S.M. c. H27, s. 4; Substitute Decisions Act, 1992, S.O. 1992, c. 30, s. 2; Health Care Consent Act, 1996, S.O. 1996, c. 2, Schedule A, s. 4(2); Code civil du Québec, L.R.Q., c. C-1991, s. 154; Consent to Treatment and Health Care Directives Act, R.S.P.E.I. 1988, c. C-17.2, s. 3; Hospitals Act, R.S.N.S. 1989, c. 208, s. 52; Advance Health Care Directives Act, S.N.L. 1995, c. A-4.1, s. 7; Guardianship and Trusteeship Act, S.N.W.T. 1994, c. 29, s. 1.1; Guardianship and Trusteeship Act, S.N.W.T. (Nu.) 1994, c. 29, s. 1.1; Adult Protection and Decision-Making Act, Schedule A, S.Y. 2003, c. 21, Sch. A, s. 3.

substitute decision-maker for the adult. A person may be incapable of some decisions or types of decisions. For example, a finding of incapacity may be limited only to financial matters or a particular subset of personal care decisions. A guardianship order will set out what decisions the substitute decision-maker has authority to make.

If a practitioner does not think the adult is capable then the practitioner should be getting consent from the person appointed by the adult in a previously drafted document, such as a representative agreement or a power of attorney for personal care, if such a document exists. Otherwise, the practitioner must get consent from the appropriate “default” health care decision-maker under the laws of that province or territory. Everyone has a substitute decision-maker for health whose authority kicks in in the event of incapacity, where a person has not chosen their own substitute decision-maker in advance.

Practitioners should also be alert to signs that an adult is incapable and might benefit from access to additional support or assistance. For health care practitioners, assessing capacity is a regular part of practice, even when he or she is not participating in a formal capacity assessment or legal process relating to determining capacity.

What is the impact of becoming legally incapable?

An incapable adult may lose the right to make certain decisions in relation to health care, personal matters or finances. A guardian or substitute decision-maker might be appointed to make decisions according to the incapable adult’s values and needs. Alternatively, in some provinces or territories, an adult who has incapacity issues might agree to or designate a formal assistant or supported decision-maker if they are able to make decisions with support or assistance. However, this option is not available in every province or territory. Note, a supported decision-maker is not simply someone an adult consults or asks for help from with respect to decision-making, but rather a legal supported decision-maker appointed or agreed to in accordance with laws of that province or territory.

The consequences of losing the right to make decisions can be very serious. The ability to make decisions is a fundamental human right and the loss of this right can be devastating.

Does capacity change?

Individuals with capacity limitations may experience fluctuations in capacity throughout the day or go through longer episodes of reduced or improved capacity. This may depend on factors such as time of day, a medical condition, or situational stressors (e.g. grief from loss of a spouse, financial stress). You may be able to enhance the ability of a client or patient to participate in decision-making by adapting your practice (e.g., by carefully choosing the time of day to meet with an individual with capacity issues or by choosing a meeting place or supports with whom the person will feel most calm).

Can an older adult make unwise or risky decisions?

All adults have the right to make unwise or risky decisions. The tendency to make damaging choices does not make an older adult incapable. For example, adults who have been habitual gamblers should not be considered incapable simply because they are older and prone to taking financial risks. All adults retain the right to make choices. Adults with capacity can choose the people with whom they live or associate, including people who may be abusive, unless a judge has granted an applicant a protection order such as a no contact order.

What is consent?

Consent means giving someone permission to do something that impacts you. The adult who is giving consent must have the mental capacity to understand and appreciate the consequences of their decision. If an adult is legally incapable, then consent must be obtained from the guardian or substitute decision-maker. Otherwise, consent is not valid.

How can consent be given?

Consent can be expressed verbally or in writing. It can also be implied in a person’s behaviour.

When is it necessary to seek consent?

Consent is required each time a provider wishes to initiate services or treatment, except in emergencies or where the law prescribes otherwise. As the services or treatment evolve, or as new information becomes available, consent may need to be reaffirmed. Consent can be required to share an adult's personal information.

Can an older adult refuse or withdraw consent?

An older adult with mental capacity has the right to refuse services or treatment. A mentally capable older adult may also withdraw consent at any time.

Suggested resource pamphlet: Access online from Canadian Centre for Elder Law, click on "Publications", "2011", "Counterpoint Mental Capacity and Consent"

Link: http://bcli.org/sites/default/files/Counterpoint_Brochure_Mental_Capacity.pdf

2.5 STRATEGIES FOR APPROACHING A DISCUSSION WITH A VULNERABLE OLDER ADULT

2.5.1 Therapeutic environment

Whether the person who is disclosing is the older adult themselves or a person who knows them well, it is important to ensure a therapeutic environment that enables a supportive relationship grounded in confidentiality and respect. Health care providers will want to consider:

- Promoting an environment where the person is comfortable and at ease. If talking on the phone, attempt to be in an environment that minimizes the chance of being overheard or interrupted;
- Providing empathy, summary statements about the person's situation and reflect feelings;
- Gathering information in a calm, non-judgmental, supportive manner, with consideration of cultural and spiritual factors; and
- Avoiding comments that may seem like putting down the alleged or suspected abuser.

2.5.2 Possible interview questions

Open-ended questions will allow the older adult to share information, and the examples below can be used as a tool to get the conversation going:

- How is everything going at home?
- Has anyone at home ever hurt you?
- Do you feel safe? Is there something that you would like to share with me?
- Has there been a recent incident causing you concern? Tell me about it.
- Has anyone ever tried to take advantage of you?
- Has anyone ever pressured or forced you to do things you didn't want to do?
- Do you make decisions for yourself or does someone else make decisions about your life, like how or where you should live?
- Are you alone a lot? Has anyone ever failed to help you take care of yourself when you needed help?
- Are you afraid of anyone?
- Would you like some help with...?
- It must be hard for you to look after...?

What to note:

- Are there any inconsistencies (i.e., vague explanations)?
- What are the person's wishes, what do they understand and appreciate about what is happening?
- Is any important information missing (i.e., frequency of abuse, duration, urgency, need for physical examination)?

Content for above section obtained through;
Advocacy Centre for the Elderly (ACE) (2010)
Government of Canada (2008): Elder Abuse Awareness. Ottawa: Human Resources and Skills Development Canada

2.5.3 Resources for standardized assessment

The following are resources for standardized assessment tools designed to assess whether a person is abused/mistreated. The items in the tool have been generated by an expert panel and may help with coverage of appropriate domains to consider. Data about the accuracy of the tool in identifying those who are abused/mistreated was not available at the time of writing. One tool was developed by an interprofessional team and is designed to help in the determination of risk: (access at “Taking Charge elder abuse” website, click on “Tools for Professionals”) link: <http://www.prendreencharge.com/en/tools-for-professionals/>

Two more tools are available through National Initiative for Care of the Elderly (NICE): one is called the *Elder Abuse Suspicion Index* (EASI) and the other is the *Brief Abuse Screen for the Elderly* (BASE). The format is a pocket card for easy use. Please refer to the citation at the bottom of the tool for information about its development and use. The tools can be accessed at link: www.nicenet.ca (from home page go to: “Tools”, “Elder Abuse”)

2.6 CLINICAL SCENARIOS AND REFLECTIVE QUESTIONS

Clinical scenario #1

A vulnerable older adult is reluctant to talk about a situation of abuse/mistreatment. At this point, the health care provider is focusing on talking about the situation before taking any actions.

Mrs. R. lives in an apartment and the home care provider has been seeing her to address her concerns with her multiple sclerosis. She uses a wheelchair and has been independent with directing her care. When the provider arrives she seems agitated. The provider asks if there is anything causing her concern. She says she isn't sure she should say anything. The provider says that there is some time to talk, and ensures that they are in a quiet area. Mrs. R. says, “Someone in my family, I won't say who, came a couple of months ago to talk about my banking and I signed a form. I think. I didn't think much of it, but now I can't find any bank statements in my drawers.”

Reflective questions:

- 1) Why might this situation cause you concern?
- 2) What two types of information would the health care provider have in mind to try to gather while talking with Mrs. R.?
- 3) How can the therapist promote the physical environment for talking and help Mrs. R. feel supported to talk about the situation?

For example:

- What might be the barriers Mrs. R. faces to disclosing and how might the health care provider begin to acknowledge these?
- What are some open-ended questions and/or statements of empathy that the provider can consider?
- How might you consider incorporating questions or information about abuse/mistreatment into the usual practice in your setting? (For example, could information be gathered during screening, client intake or the initial assessment process?)

Responses to consider:

- 1) It is concerning because there may be possible financial abuse.
- 2) a) Whether the person is aware of situation, and b) whether there is immediate danger of harm to person.
- 3) The setting (e.g., policies, procedures, screening on intake or initial assessment, discussion of case concerns or ethical issues with colleagues). The older adult may be worried about implications for losing care from family, isolation, values giving money to family, wants to be helpful. Asking the question, such as “What is the most important concern for you?”

Clinical scenario #2

The following is a scenario in which the health care provider needs to consider what information to gather.

Mrs. K. is 75 years old and living in her own home with her cousin and his wife. The health care professional (e.g. nurse, physical or occupational therapist) has a referral to see her through home care. On their first visit the professional speaks with Mrs. K., who seems unkempt. Her cousin, although in the home, does not talk with the professional. There are open places on the walls where paintings have recently been removed. The professional makes an appointment to see Mrs. K. for follow-up but her cousin calls to cancel the appointment, stating Mrs. K. has a cold and he will call the therapist when they are ready. The professional consults with the social worker who also suspects financial abuse based on recent information about Mrs. K.'s banking. The social worker and professional go to the home together and find Mrs. K. locked out of the house in the back yard in extremely hot weather. She is very thirsty, appears confused, winces from pain when getting up, and has blood coming from her nose. The professional checks the home, which is locked, nobody appears to be there and the cousin's car is not in the driveway.

Reflective questions:

- 1) Why might this situation cause concern? What type(s) of abuse might be occurring?
- 2) What two types of information should the health care provider gather?
- 3) Is this an emergency situation? If so, what action should the professional and social worker take?
- 4) If Mrs. K.'s cousin arrives while the professional and social worker are with her in the back yard, what action can the therapist take?
- 5) In considering this as an inter-professional interaction between the professional and social worker, what are some thoughts about strengthening this partnership for future work?

Responses to consider:

- 1) It is concerning because of suspected financial abuse, but being locked out of house may be neglect, and most importantly, pain upon getting up and bloody nose are signs of physical abuse.
- 2) a) Whether the person is aware of situation (determine orientation to person, place & time and if she recalls events of the day, what happened to cause her to be locked out) (Note that she may have delirium at this stage because of heat/dehydration.) b) Whether there is immediate danger of harm to person. Can she be left alone? Is she in immediate danger of deterioration? (Yes, this is likely because of the heat and her pain and bloody nose.)
- 3) Yes, this is an emergency situation. Call emergency services (e.g., 911), and stay with her until help arrives. Depending on the jurisdiction, the police and/or ambulance services will arrive and she will likely need to go to a hospital for assessment.
- 4) If her cousin arrives, it is possible that the professional and social worker may feel or be in immediate danger themselves. In this case, if police have not yet arrived, call emergency services again. The professional and social worker can leave if they are in immediate danger to themselves.
- 5) Some inter professional teams may choose to have debriefings after difficult casework, if it cannot be incorporated into regular meetings. It can be valuable for each provider to discuss impressions of their own strengths and areas for improvement related to the case. A supportive environment ensuring self-reflection would be an initial step to supporting team effectiveness. If this is present, the ability to give and receive feedback may also be valuable. For more resources on interprofessional team work please refer to the Canadian Interprofessional Health Collaborative: <http://www.cihc.ca/>

2.7 DOCUMENTATION

- It is important to document your interaction with the older adult following documentation standards for the professional regulatory college.
- Notably, the documentation should include objective observations. It would include physical signs, observations of the person's health status and behaviour. Comments made by the person should be recorded verbatim whenever possible (e.g., "Mrs. R. stated 'I think it's my daughter who withdrew the money,' rather than "Mrs. R's daughter withdrew the money").
- Make a note of the provider's impression regarding the two key types of information: risk for harm (was it deemed an emergency?) and cognitive ability (cognitively capable of understanding the current situation?)

- Clearly state any actions taken including discussion with colleagues, referral to resources, and provision of information to the person. Also state any plans for further action or follow-up.

The Canadian Centre for Elder Law has created a documentation tool, that can be used in combination with the NICE tools. It can be accessed online at Canadian Centre for Elder Law, click on “Publications” “2011”, “Counterpoint documentation sheet”: http://bcli.org/sites/default/files/Counterpoint_Charting_Sheet_11-04-20.pdf

2.8 INTERACTING WITH THE SUSPECTED ABUSER

- A primary prevention strategy involves providing education to families and caregivers. Some may not be aware of what is against the law. Providing education to them about responsibilities for caregiving and powers of attorney is important. Some examples (CNPEA, 2011)⁸ of statements to approach families are included:
 - “I wonder if I could give you some more information about power of attorney?”
 - “Is it possible that the type of power of attorney you have can’t be used for health care decisions?”
 - “Were you aware that a power of attorney has to be used for the older adult’s benefit, and not other people’s?”
 - “Did you know that what you are suggesting might be considered against the law?” or “One would wonder if a situation of abuse or mistreatment might arise if something like that were to occur.”

Suggested resources:

Caregiver support groups: check with a local seniors’ centre, government pages in telephone book, or for dementia caregivers, check with the local Alzheimer’s Society www.alzheimer.ca.

In some regions, telephone buddy programs or online supports may be available for caregivers. Consider increasing respite services and referral to day programs.

Reflective questions:

- Is there a person (i.e., caregiver, family member) you can think of who has benefitted or may benefit from some information about responsibilities for caregiving or power of attorney?
- If they needed more detailed information, can you direct them to some useful resources.

3. TAKING ACTION AGAINST ELDER ABUSE/ MISTREATMENT

3.1 CONSENT IS AN IMPORTANT CONSIDERATION

Inter-professional health care providers are aware of the professional standard to seek consent to contact others. The following are some additional considerations when addressing a situation of a vulnerable adult giving consent:

- Note that often a person needs to trust before they can agree to receive help. They need to trust that help is available and that you will follow through with any offers of help.
- Your role likely would be as part of a team of service providers. You will need to give information about who else will be able to provide support and linking with the broader community.
- If the person does not consent, maintain contact with them to try to provide education and a plan for safety (see point 3.3 “Safety plan”).

⁸ Canadian Network for the Prevention of Elder Abuse (CNPEA) (2011). Improving access to justice. Retrieved March, 2011 from: http://www.cnpea.ca/improving_access_to_justice.htm

3.2 REPORTING

- It is important to know that there are certain legal requirements to report that differ in regions across Canada.
- Regulated health care professionals are bound by regulatory requirements of provincial professional colleges of to report abuse in certain circumstances.

3.2.1 Disclosure of information and professional confidentiality:

What is professional confidentiality?

- Professional confidentiality refers to the legal obligation of a professional, employee or volunteer to keep the personal and health information of a client confidential.
- Confidentiality ensures that vital information is kept private. Privacy laws across Canada say that confidential information can only be shared in limited circumstances. Many professional bodies also address confidentiality in their *Code of Conduct* or *Code of Ethics*.
- The general rule is that disclosure of a person's confidential information requires the person's consent. This section discusses exceptions to that rule. See Section 3.2.2, Elder abuse in your region, for the rules and exceptions that apply in the province or territory in which you practice.

When can confidential information be disclosed without consent?

Before discussing exceptions to the requirement to get consent it is worth noting that even if you are not required to get consent, it may still be best practice to get consent. Often a client or patient will give you permission to share their personal information with a third party if you go over the circumstances and your concerns with them and ask for their permission. The best form of help is almost always something the older person identifies as helpful. Abuse takes away a person's sense of power and control. Be conscious that your response serves to empower the older person rather than take more personal power away.

- According to the law, confidential information may be disclosed without consent under limited exceptions created by provincial, territorial and federal laws. Some laws that apply to adult protection state that the obligation or option to report abuse or neglect applies to confidential information, and so information may (or in some circumstances must) be disclosed without the vulnerable adult's consent, without breaking the law. Personal information law also creates exceptions. This section highlights exceptions of particular relevance to elder abuse and neglect.
- In terms of responding to elder abuse and neglect, there are essentially four exceptions to the requirement to get consent that apply in all provinces and territories. Be aware that the precise language used in each law to set out an exception varies in each province or territory. To appreciate your obligations you must be informed of the specifics of the law that applies in the jurisdiction in which you practice. This summary is intended to review general concepts found in personal information law. We encourage you to consult a supervisor and review policy interpreting obligations under personal information law before you share a client or patient's personal information without their consent.

Generally speaking, disclosure is permitted where the disclosure is:

1. Authorized or required by another law;
2. Provided to assist with a police investigation, or where the police produce a warrant or production order;
3. Consistent with the purpose of collection; or
4. Required for health and safety reasons.

Disclosure authorized or required by another law

- Disclosure of information by a person without an older adult's consent is permitted in all provinces and territories where disclosure is authorized or required by another law. Therefore, in any jurisdiction where there is legislation allowing or requiring an individual to respond to abuse or neglect of an older adult, it will not be a violation of privacy or confidentiality to disclose the confidential information for the purpose of responding to the abuse or neglect.

- Other jurisdictions require disclosure when requested by certain agencies investigating allegations of abuse. For example, in Saskatchewan, any person must provide any information requested by the Public Guardian and Trustee investigating an allegation of financial abuse.⁹

Disclosure to assist with a police investigation

- All provinces and territories allow disclosure of confidential information in certain circumstances where you are assisting with a police investigation, in some instances even before charges have been laid or a court order or warrant produced. If a practitioner is requested to provide personal information without first getting consent then it is important to be aware of the specific wording of the exception contained in the law that applies in your province or territory of practice.

Disclosure consistent with the purpose of collection

- **If the reason that confidential information has been collected requires information to be shared, then disclosure to fulfill that purpose is allowed.** For example, if a health care worker collects personal information for the purpose of delivering a health care service and the information must be shared with a medical professional in order to effectively deliver the health care service, then disclosure to the medical professional is allowed.

Disclosure required for health and safety reasons

- Disclosure may be allowed for health and safety reasons. This is one of the most complex exceptions to the need to keep information confidential. Each province and territory deals with this exception differently. Refer to Section 3.2.2., Elder abuse in your region, for more detailed information about privacy rights in your province or territory.
- Some jurisdictions contain a health and safety-related exception but require consultation with the head of the public body before disclosure occurs. In other jurisdictions, the front-line health care or social service practitioner has the legal authority to make the decision.
- The circumstances under which a health care practitioner may disclose personal information without consent for health reasons is slightly different in each province and territory. The various statutes refer to:
 - a health emergency
 - a health urgency
 - imminent danger to health or safety
 - necessary medical treatment
 - serious harm, or
 - compelling health or safety circumstances

In some statutes the language refers to the slightly lower standards of:

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

Who decides whether or not to disclose information?

- In most contexts, the health care provider will need to decide whether or not it is appropriate to disclose personal or health information. In some provinces and territories, the provider will need to receive permission from the head of a public body or someone in a position of authority (e.g., the director of a hospital).
- Disclosing someone's personal information is a significant decision. It is usually a good idea to consult a co-worker or supervisor about the appropriate steps you should take.
- In all provinces and territories, each place of employment should have practical guidelines for employees to follow. Policies and guidelines do not override the law, however. If the law requires you to report abuse or neglect then a policy stating otherwise should be disregarded.

Suggested resource/brochure: Confidential patient privacy rights: accessed online at Canadian Centre for Elder Law , click on

⁹ The Public Guardian and Trustee Act, S.S. 1983, c. P-36.3, s. 40.7(3).

“Publications”, “2011”, “Counterpoint confidential-patient privacy rights”.

Link: http://bcli.org/sites/default/files/Counterpoint_Brochure_Confidential-Patient_Privacy_Rights_11-04-20.pdf

3.2.2 Elder abuse in your region

a) Background

Many laws apply to elder abuse. The federal government has created some laws and the provinces and territories have passed others. Criminal laws relevant to elder abuse and neglect, which are mentioned in provincial legal information appendices of this resource, are federal. Most laws that apply to health, social services and adult guardianship are provincial and territorial.

Each province and territory takes a unique approach. Some jurisdictions have domestic violence laws that apply to certain circumstances of elder abuse. In a few provinces there is legislation that creates obligations to respond to abuse of adults receiving services from a care facility. Newfoundland and Labrador has neglect legislation. Québec addresses elder abuse in its Charter of Human Rights and Freedoms. Some laws apply to adults at risk; other laws apply only when abuse or neglect has already happened.

A small number of jurisdictions have broad adult protection laws that apply to adults who meet a definition of an “adult in need of protection,” regardless of the age of the vulnerable adult and where the adult lives. But even these adult protection laws vary in terms of the relative value they place on intervening to protect the vulnerable adult versus respecting the autonomy and independence of a person who might be in need of protection, and so among these limited jurisdictions the legal obligation to respond to abuse will vary.

Canadian law is not grounded in a single definition of elder abuse or neglect. Some laws that apply to elder abuse do not define abuse. Most definitions reference harm or mistreatment and provide a list and description of categories of abuse that generally includes the core types of physical, financial, psychological (also called mental or emotional) abuse, and sometimes also sexual assault, withholding medication or overmedication a person, abandonment, neglect or forced confinement.

In most jurisdictions a number of laws apply to abuse and neglect. The overall options and obligations to respond to or report elder abuse and neglect depend on the relationship between the various laws and the specific circumstances of abuse or neglect involved in each case.

The links for each region in the “Key legal information” document contain snapshots of the law in each province and territory in relation to elder abuse and neglect. Each snapshot identifies key legislation in the jurisdiction and outlines aspects of each law that are most relevant to responding to elder abuse, neglect and risk of abuse and neglect, such as definitions of abuse and neglect, the duty to respond or report abuse, and protections afforded to individuals who file a report of abuse based on an honest belief that an older adult has been mistreated or is at risk of harm. Each provides a plain language summary rather than the law verbatim, and gives key information without describing all statutes (e.g. Substitute Decision Maker’s Act in Ontario).

These snapshots distill key features from the perspective of regulated health professionals practicing across Canada, in addition to discussing adult protection and domestic violence law, each snapshot identifies any obligation to respond to abuse arising out of laws governing the various professions mentioned above. Obligations of other individuals or agencies, such as the Ministry that responds to reports of abuse under the law, or other non-regulated professionals are not covered in this legal resource. Each snapshot contains a section that identifies laws in each jurisdiction that impact on the confidentiality obligations of health professionals.

Note: The tables provide information about key legislation. It is not up to the health care provider to identify the person’s (suspected abuser’s) intention or whether the incident falls under the exact specifics of the law. The agency or department responsible for reports will make that decision.

b) Mandatory reporting of elder abuse

Is there a legal obligation to notify someone?

You may be legally required to notify a designated person, organization or government authority about concerns of elder abuse, neglect or risk. Whether or not you have a legal duty to notify someone will depend upon a number of factors, including:

- What is the province or territory that the older adult lives in?
- What is your employer or the agency through which you are delivering services?
- Is the older adult living in the general community or in a care facility?
- Is the older adult in need of support or assistance, or unable to care for themselves?
- Is the issue risk or has abuse already occurred?
- Has a criminal act occurred?

Table 1 contains information on your obligations in each jurisdiction.

How should you respond when an older adult is at risk?

“At risk” means that an incident of abuse or neglect has not happened but circumstances indicate that a person is likely to become abused or neglected. In some provinces, you may be legally required to notify the appropriate authorities that an older adult is at risk of abuse or neglect in certain situations. Refer to Section 3.2.2 to determine whether you have an obligation to report risk in the province or territory in which you practice.

Can an older adult be allowed to keep living at risk?

Mentally capable older adults have the right to make choices. As long as an adult is capable, she may make risky or unwise choices. You must respect the right of the older adult to choose the people with whom to live or associate, including people who may be abusive. However, you can also offer resources in a respectful manner. A person in an abusive relationship may require access to support and assistance in order to be comfortable with leaving an abusive relationship.

c) Community or long term care

Abuse, neglect, or self-neglect occurring in the community: If a health care provider suspects that an older client is being (or may be) abused or neglected, it is important to understand that they may not be able to seek help on his or her own because of a physical or mental condition, and therefore is often referred to as a “vulnerable adult” or “adult in need of protection.” There may be special laws and resources in your jurisdiction to help you support this population.

If an older person living in the community is being abused or neglected and is not a vulnerable adult, then health care providers may want to seek out more information to help the person access appropriate community resources. Or with the older adult’s consent, they may want to make a referral to family violence or victim services, law enforcement, or other important resources in the community.

Abuse or neglect happening in long-term care: Many provinces and territories have specific reporting requirements if the abused or neglected person lives in a licensed long-term care facility or certain other facilities that provide care and assistance. Health care providers working in these settings are usually expected to report abuse or neglect incidents they witness. They must be aware of whom to contact (e.g., their immediate supervisor, the facility manager, or director of care) so that the incident can be properly addressed and reported to the necessary authorities or parties.

In **long-term care** there can be three types of perpetrators: a) staff, volunteers or others in the setting; b) family members; and c) other residents. Depending on the type of care setting, the type of harm, the level of seriousness, the type of person causing harm, and sometimes the type of abuse, the licensees or operators of facilities usually have a responsibility to report the incident to outside authorities. They may also have a responsibility to keep a record of other ‘not reportable’ serious incidents. If the suspected perpetrator is a member of a regulated health profession (e.g., medicine, nursing, physical or occupational therapy), there is a mandatory obligation to report certain types of abuse (e.g., sexual abuse) and to contact the respective provincial College for specific information.

Long-term care home operators cannot safeguard residents or fulfil their legal duty if they do not know about the incident. It is important that all staff report incidents promptly to the appropriate person(s) so that the incident can be properly addressed and reported to the necessary authorities or parties.

Table 1: Responding to elder abuse & neglect: Highlights of the law in each province & territory. Consult “Key legal information” document for more details for each jurisdiction.

The information is not legal advice. The law is always changing and this is a summary of key legislation only. All material provided is up to date as of August 31, 2013

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

MB	<p><i>Protection for Persons in Care Act, C.C.S.M. c. 144.</i></p> <p><i>Vulnerable Persons Living with a Mental Disability Act, C.C.S.M. c. V90.</i></p>	<p>Adult is a resident, in-patient or person receiving respite care in a health facility.</p> <p>Adult has had a mental disability since childhood and is in need of assistance to meet basic needs.</p>	<p>A resident, in-patient or person receiving respite care in a health facility is being abused, or is likely to be abused.</p> <p>An adult who has had a mental disability since childhood is being abused or neglected, or is likely to be abused or neglected.</p>	<p>Employee or service provider at a health facility must promptly report to the Minister via the Office of the Vulnerable Person's Commissioner.</p> <p>A person who provides care, support services or related assistance, substitute decision maker, or committee must report to the executive director appointed by the Minister, via the Office of the Vulnerable Person's Commissioner.</p>
ON	<p><i>Long Term Care Homes Act 2007, S.O. 2007, c. 8.</i></p> <p><i>Retirement Homes Act, SO 2010, c 11</i></p>	<p>Adult is residing in a long-term care home.</p> <p>Adult is residing in a retirement home home.</p>	<p>Harm, abuse or neglect has occurred or may occur.</p> <p>Any of the following has occurred or may occur: abuse; improper treatment; neglect; unlawful conduct causing harm to a resident; misappropriation of the resident's money.</p>	<p>A staff member, any person who provides professional services (i.e., health, social services) and licensee must report to the Director appointed by the Minister.</p> <p>Any person must report to the Registrar of the Retirement Homes Regulatory Authority.</p>
QC	<p><i>Chartre des droits et libertés de la personne, L.R.Q., c. C-12.</i></p>	<p>Adult is living anywhere.</p>	<p>Older adult is the victim of exploitation.</p>	<p>Victims, group of victims, or advocacy organization may apply to Commission des droits de la personne et des droits de la jeunesse. Commission may initiate investigation.</p>
NB	<p><i>Family Services Act, S.N.B. 1980, c. F-2.2</i></p>	<p>Adult is living anywhere.</p>	<p>Adult is being abused or is at risk of abuse.</p>	<p>Professional person (i.e., care worker, physician, nurse, or other health or mental health professional, social worker) may report to the Minister via the Adult Protection Program.</p>
NS	<p><i>Protection for Persons in Care Act, S.N.S. 2004, c. 33.</i></p> <p><i>Adult Protection Act, R.S., c. 2.</i></p>	<p>Adult is a patient of a hospital or a resident of a health facility (i.e., special care home).</p> <p>Adult is living anywhere.</p>	<p>Adult is being abused or is likely to be abused.</p> <p>Adult is the victim of abuse or not receiving adequate care, is incapable of protecting himself/herself and refuses, delays or is unable to protect himself/herself.</p>	<p>Employees and service providers of a health facility must promptly report to the Minister (via the Adult Protection Program).</p> <p>Any person must report to the Minister of Community Services (via the Adult Protection Program).</p>

PEI	<i>Adult Protection Act</i> , R.S.P.E.I. 1988, c. A-5.	Adult is living anywhere.	Adult is in need of assistance or protection, or is at serious risk.	Any person may report to the Minister of Health and Wellness (Adult Protection Program).
NL	<i>Neglected Adults Welfare Act</i> , R.S.N.L. 1990, c. N-3.	Adult is living anywhere (except a mental health facility).	An adult is incapable of caring properly for himself or herself, not suitable to be in a mental health facility, not receiving proper care and attention and refuses, delays or is unable to make provision for proper care and attention for himself or herself.	Any person must give information to Director of Neglected Adults, or to a social worker (who must report the matter to the Director).
NU	<i>Family Abuse Intervention Act</i> , S.Nu. 2006, c. 18.	Adult is living in the community (i.e., not in care).	Family abuse has occurred.	The following people may apply to the court for a protection order with the older person's consent: family members or friends; lawyers; police; safe house or shelter workers; Community Justice Outreach workers
NWT	<i>Protection Against Family Violence Act</i> , S.N.W.T. 2003, c. 24.	Adult is living in the community (i.e., not in care).	Family violence has occurred.	The following people may apply to the court for an emergency protection order: the victim; an RCMP officer or victim services worker, with consent from the victim; any other person, with leave of the court.
YT	<i>Adult Protection and Decision Making Act</i> , S.Y. 2003, c. 21, Sch. A.	Adult is living anywhere (except a prison).	An adult is abused or neglected and unable to seek support or assistance.	Any person may report to the Seniors' Services/Adult Protection Unit, currently the only designated agency in the Yukon.

Operators are usually required to have written policies and protocols on abuse. This practice helps all staff and others working or volunteering at the facility to know their responsibilities, and to whom they should be making a report.

Reflective questions:

- On the home page for this document, access the “Key Legal Information” pdf file. What are the reporting laws pertaining to your area of practice?
- Using the table in the “Key Legal Information” file for your region, to which body would a health care provider report suspected abuse in a long term care home in your region?

3.2.3 Clinical scenarios:

Mrs. T. is a resident in a nursing home and she has severe dementia. Her room-mate tells the health care provider that she was making unusual noises after one staff member washed her. The provider sees that there are bruises on her upper and lower torso and you suspect there may have been sexual abuse.

Reflective questions:

- 1) According to the legal information tool, does this require mandatory reporting and to whom? What if any additional information may need to be gathered prior to reporting?

Mr. H. lives in a senior’s apartment complex and receives home care services. Mr. H. says he wants to complain that a home care worker (not a member of a regulatory college) has been hitting him if he takes too long to wash.

Reflective question:

- 1) According to the legal information tool, is there mandatory reporting in this scenario and who would the regulated health professional report to?

The following is a scenario that may be more common but may or may not constitute abuse:

Mrs. W. lives in a long-term care home, has moderate dementia, and has been deemed incapable of medical decision-making. The regulated health professional with an assistant, works daily in the home. The assistant notices a decline in her alertness, balance and ambulation after having seen her a few times. Since admission she has demonstrated paranoid thinking, believing people have been stealing things from her and she frequently calls out at night wondering if there are shadows in her room. A staff member received an order for several new sleeping and anti-psychosis medications to administer as needed, which is when the assistant noted the changes.

Reflective questions:

- 1) Why might this situation cause some concern?
- 2) What are at least two courses of action that could be taken?

Responses to consider:

(Note: the responses in this section will be specific for region. Refer to Table I for specific regional information in the legal information tool. Note this tool provides plain language summary and a snapshot of key legislation)

- Mrs. T.: If she was living in her own home, there is suspected sexual abuse from a family caregiver, and she is not capable, there is no mandatory reporting law. Health professionals must also consider codes of ethics and regulatory requirements of practice. If there is no mandatory reporting law, the regulated health care professional would consider a decision making framework to decide to take action and report the abuse. (See NICE ethical decision making framework.)
- Mr. H.: Professional confidentiality legislation would not be a barrier to reporting because Mr. H. is at risk for harm.
- Mrs. W.: There is concern because over-medication can be a sign of physical abuse and it is not clear how necessary the medication is in this case.

Possible course of action:

A) Speak directly with the staff member who requested the order to ask about the rationale and any other measures that had been explored to deal with the behaviors of calling out about the “shadows.” Problem solve with the staff to avoid use of medication and implement new strategies (e.g., night light to reduce shadows, use of a volunteer during day to increase activity, involvement of family in some way).

B) Depending on how many other residents with whom you have addressed this similar care plan with, health care providers may need to discuss with staff and/or supervisor and problem solve as above. If there are mandatory reporting laws that apply, the health professional is obligated to report possible abuse/mistreatment.

C) Consider mandatory reporting of abuse as per the legal information tool for your region. Also consider, if regulated staff is involved, reporting to the regulatory college for that staff person. Also note that if the health provider knows that a particular senior lives facility, even if they are receiving current care in another setting, the mandatory duty to report continues to apply (e.g. a healthcare worker at a hospital who has concerns about a senior who is temporarily in hospital for treatment although lives in a long term care home; the duty to report continues to apply to healthcare workers at that hospital).

3.3 INTERVENTION AND SUPPORT

Determine the most important concerns of the person and provide information and support for those needs first. Provide the person with some vision about multiple possibilities to address the situation.

1. Client-centred, problem-solving approach:

- a. Identify most important issue.
- b. Identify (brainstorm) several possible solutions, Have the older adult generate their own and suggest some if needed.
- c. Examine each solution and, together with the older adult, chose the best one to try first.

2. Making effective referrals and interventions to help older adults how to address and respond to the abuse.

3. Resources specific to region: The main web page has clickable links for resources specific to your region that are easily printable for your desktop.

- a. Know the resources in your community. These may include: Victim Services, Shelter, Seniors Organization, Information/Crisis/Abuse Line, Legal Services/Legal Aid, Healthcare/Home Care Provider, Mental Health, Government Pensions, Immigration/Language Services, Public Guardian/Trustee/Curator.
- b. Create a binder or poster from your own local information and programs.
- c. Create your own network to support you.
- d. The National Initiative for Care of the Elderly is developing easy to use resources for health care professionals and also for vulnerable older adults. For example: Assessment and Intervention Reference Guide (NICE) (www.nicenet.ca, from the home page go to: "Tools", "Elder abuse")
- e. Consider facility policies: Are contact information and resources listed in policy documents? Include elder abuser resources on a list of facility resources to be updated annually or semi-annually

Checklist for creating a safety plan

A safety plan may be needed if there is possible future danger. This would involve a change to: a) the environment to remove the context of the abuse or b) the relationship with the potential abuser to eliminate the role of the abuser. Access this resource at ONPEA.org (from home page go to: "About Elder Abuse", "Help for Seniors," scroll to bottom for "Safety Planning".)

Here are important considerations for developing a safety plan:

Issues to consider:

- Planning must be done in conjunction with the adult and their support network – obtain permission to expand it
- Removing the adult from their home should only be done in cases of high risk and after careful consideration
- Risk may escalate once the abuser realizes they are losing control.
- Compromised or fluctuating capacity requires more detailed planning
- The older adult may become nervous when interacting with the abuser – walk them through scenarios and practice words and actions they can use to neutralize the situation

Review:

- Living situation (how can they leave, where would they go to, is it possible they can visit someone else for a short time until the situation stabilizes)
- Financial resources (maintain income, seek other benefits, how will debts be managed)
- Health Considerations (medications, aides, possibly notifying health care professionals and ensuring appointments are kept)
- Security (of the home, other family, pets and sentimental articles)
- Legal Measures (protective orders, substitute decision makers, location of important papers)
- Security (line of life, cell phone, regular check ins)

Remember:

- Documentation is critical
- Take time, listen and remain patient
- The older adult may experience extreme guilt/remorse and the stress could trigger a delirium
- Maintain confidentiality and respect their wishes

3.4 ONLINE RESOURCES FOR VULNERABLE OLDER ADULTS

The Ontario Network for the Prevention of Elder Abuse has printable fact sheets for older adults, for example “What you need to know fact sheet” (ONPEA.org from home page go to: “About Elder Abuse”, “Help for Seniors,” scroll to bottom for “What you need to know”

Seniors Canada printable fact pamphlets about various types of financial abuse designed for older adults and families: www.seniors.gc.ca (from home page go to “Elder Abuse”, scroll down for “resources on Elder Abuse”

3.5 PUTTING IT ALL TOGETHER

The following clinical scenario is intended for health care providers to use in putting the resources and skills together. The numbers in brackets represent the sections of the guideline to consider for each reflective question.

Mrs. G. lives in an apartment and pays for weekly nursing services through a private agency. She is referred by her daughter to home care services because her daughter is concerned that the nurse is “too friendly” with Mrs. G. Her daughter states that Mrs. G. has given the nurse money to use for food and rent, and Mrs. G. has freely told her daughter about this. Her daughter is concerned because Mrs. G. has mild dementia, although she still manages her own finances. The home care service provider asks Mrs. G., who states that she has given gifts of money to the nurse, but thinks her daughter is meddling in her business.

Reflective questions:

- 1) Why might this situation cause concern? (See section 1.3 definition & signs of financial abuse.)
- 2) What might be some barriers for Mrs. G. to disclose a feeling of being vulnerable or abused? (See section 2.3.)
- 3) What are two types of information the provider needs to determine during the interview? (See section 2.3 First steps during identification of abuse/mistreatment.)
- 4) How might one approach the conversation to support and empower Mrs. G.? (See sections 2.5.1 [therapeutic environment] and 2.5.2 [possible interview questions].)
- 5) What are the reporting laws that apply to this situation in your region of the country? (See section 3.2.)
- 6) How can the provider initiate a problem-solving process with Mrs. G. and her daughter about this situation? (See section 3.3 intervention & support.)
- 7) What are some educational resources the provider can provide to Mrs. G. and her daughter? (See section 3.3 intervention & support-links.)

