

Position Paper on Mandatory reporting of older adult victims of abuse and neglect in residential settings.

Presented by Seniors Action Quebec in collaboration with NDG Community Committee on Elder Abuse

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Introduction

This paper will present the pros and cons of enforcing mandatory reporting laws and systems in the province of Quebec. The background and context will first be presented followed by lessons learned from three case examples which illustrate our position on this serious and important issue. Finally we will present our position and conclude with our brief recommendations and suggestions for its implementation. The paper is bilingual, representing the two official languages of our clientele who are mainly Anglophone and allophone.

The NDG Community Committee on Elder Abuse (NDGCCEA) serves the territory of the CSSS Cavendish and beyond to the west end of Montreal. It is one of the only community organizations whose mission is the prevention of elder abuse in this area, and was therefore asked to collaborate on this position paper. A recent report has also highlighted that English speaking seniors are particularly vulnerable as many of their families have moved away in the past decades, making their family supports and networks extremely limited as they grow older and are in need of more long-term care (Pocock, 2012, McDonald et al. 2012).

Background and context

Several reports have noted the changing demographics in Canada and Quebec resulting in the increase in the proportions of the population of seniors to youth which is expected to continue into the next decades (McDonald et al, 2012, Stats Canada, 2011). In 2011, census data shows that in the Atlantic Provinces, Quebec and British Columbia, the proportion of seniors over the age of 65 was the highest. In Quebec, between 2006 and 2011, the numbers increased by 15.9 percent. It is the proportion of seniors over the age of 80 which will almost double in 2026 and it is those over the age of 85 years who constitute the largest age group in long-term care settings. Approximately 7% of all seniors are in institutions and approximately 20-30% of seniors will likely end their lives in a residential care setting. Finally most of these are women as women currently live longer than men.

Currently, we have little scientific evidence about the incidence and prevalence of abuse and neglect among seniors in residences in Quebec. However, it has been observed that residents in long-term care settings are often frail and more dependent on others to provide care and are more likely to suffer from cognitive impairments and disabling conditions; consequently, they are more vulnerable to abuse and neglect. Several types of abuse and neglect have been noted, including physical, psychological, financial/material and neglect, as well as sexual abuse and systemic abuse which are mentioned less often. There are few scientific studies which have validated causes and signs of abuse and neglect in institutional settings, but some studies have stated that causes of abuse and neglect are often interactional and therefore difficult to understand, measure and prevent. Some studies speak of poor communication issues because of the different language and cultural backgrounds of many workers and residents, leading to misunderstandings. Others point to denial of abuse and neglect as a major issue and acceptance of abuse and neglect as part of institutional life. Structural factors are also noted such as inadequate staffing, undertrained staff, burn-out and problems in the organizational environment with regards to regulations.

Public Policy for Seniors

“Seniors” is a generic term seemingly representing a monolithic group with common interests. However, this is not the case and a very misleading approach which obscures the complexity of seniors’ lives. Seniors are far from being a homogenous group; they are as varied and diverse as the population in general: their ages vary, their situations are not identical and their needs are not uniform. The status also is not constant but dynamic and like other segments, change over the years. With time or circumstance many will shift from perfect functionality to a loss of physical or mental autonomy and many will transition from one to the other. All have problems and needs specific to them, and any public policy must take into account all their individuality and diversity. Obligatory disclosure may apply differently depending on the condition and needs, and any policy has to be adapted to extend to all seniors and, paradoxically, cover all their particularities.

Overall, the laws and the institutions in place are plentiful but the design is not adapted to the specific needs of seniors. The existing processes are too cumbersome and slow, and they are not adapted for the particular situation of aged people who do not have as the waiting time as do younger victims nor the same stamina and recuperative powers in stressful scenarios where health and autonomy can decline rapidly. Also, the application and enforcement are inadequate because the administrative leadership and political will to make them effective in this domain have been lax.

Having already addressed the situation of seniors that are capable, our focus here will be on the particular condition of seniors that are incapable, and, among them, we will consider those that are under a regime of public protection.

Frail Seniors

There are vigorous and independent seniors who may find themselves victims of abuse and, depending on personal circumstances and conditions, may or may not be able to cope on their own with the dilemma. Others are frail but are characterized in differing ways which is exemplified by the application of public policy set in place for some public institutions. In the health and social services sector for treatment, care and residential placement, seniors will be differentiated according to their “autonomy”. For the Office of Handicapped People, the primary criterion is whether a person has a “handicap”. The Commission des droits de la personne et des droits de la jeunesse will activate Charter measures against exploitation where the senior is “vulnerable”. The Public Curator has jurisdiction to intervene if a senior is “inapt”. When eligibility criteria vary from one organization/institution to another, it is unclear which organization/institution has jurisdiction and which one to address. The current fragmented maze of standards makes the adoption and application of a uniform mandatory reporting policy a challenge, unless clarified and rationalized.

With impaired faculties and often without insight into their own deficits and limitations, inapt individuals, by definition, cannot deal with problems on their own and it is unrealistic to count on them to act on their own. In such circumstances, they need outside help to detect abuse and alert authorities but confidentiality serves as an obstacle.

In order to avoid any appearance of conflict of interest, mandatory reporting should not be exercised by the same agencies or personnel that provide other services. Confidence will be enhanced and the reporting reliable and effective if it is exercised independently of agencies or personnel of service-providers; otherwise it would put in question the dedication and reliability of the report and damage the integrity of any system.

The Case for mandatory reporting laws and systems

Mandatory reporting has been discussed and debated in the province of Quebec for over 30 years, beginning with the first Quebec government report on elder abuse entitled “Viellir en toute liberte” commissioned under the Minister of Health and Social Affairs, the honourable Therese Lavoie Roux. The reason the laws and systems have never been passed and implemented is that seniors and senior organizations argued that they did not need to be protected like children, and implementing such laws and systems would infantilize them and violate their rights to decide. Since then, the discussion has continued, in particular with regards to “inapt” seniors and how to protect them against abuse and neglect in residential settings in both the public and private sectors. These discussions usually become more active following high-profile cases in the media about severe cases of abuse and neglect.

The following three case examples will state the pros and cons relating to our organization’s perspective on the need for mandatory reporting laws in Quebec at this time.

Case example 1 : Public Curator Wards

One specific area of concern for mandatory disclosure policy that we wish to bring to attention is that of abuse by the very organizations and institutions set up to protect impaired seniors; they are unseen abusers disguised by virtue of their title or mission and above suspicion as part of the State apparatus.

A majority of Public Curator wards are seniors, and their number will be growing with the aging of the population. If they are inapt, that is, unable to look after themselves and to manage their affairs, they are attributed legal representatives for that purpose. For 13,000 incapable Quebecers their legal representative is the Public Curator. The Public Curator does not follow the incapable person and is not continually on the scene to detect and report mistreatment, neglect, disrespect, lack of services or privation of services. And, most wards are under public curatorship because they have no family or friends and cannot count on anyone else to observe and denounce abuse. In that respect, these seniors are the most vulnerable of the vulnerable.

Besides the absence of the Public Curator from day-to-day activities, we have noted operational deficiencies. The Public Curator rarely consults its wards for decision-making as required by law. The Public Curator, by law, does not have custody of its incapable wards and leaves them to stay at home or, if unable, places them in public or private residences. It institutionalizes wards instead of providing home care services contrary to Minister of Health and Social Services priorities. It visits them at most once a year and many not all. The ward is abandoned to the mercy of the residence for care and residences bill for products and services sometimes never supplied. Residences are delegated by Public Curator to administer monthly allowance money. It doesn't inventory property as required by law and there is no annual accounting of its administration to anybody. Valuable real estate is disposed against the will of wards and family.

When the Public Curator slips up there is no other resource to protect the incapable ward and when in the rare event that a relative or friend does appear, the Public Curator uses its internal firm of lawyers to defend itself against anyone acting for the benefit of the ward and legal fees are incurred by the good Samaritan. In the last six years we alone have assisted five people to get released from wrongful placement under regimes of protection and deprivation of the exercise of their civil rights. The Public Curator often wages war against wards and their families when its own law provides for the primacy of relatives.

Structural flaws are also inherent diminishing principles of good governance. There is a lack of transparency by misuse of confidentiality and effective accountability is neutralized by lack of any independent external oversight.

Massive abuse by the Public Curator in its administration of incapable people was exposed in 1997 by the Protecteur du citoyen and in 1998 by the Vérificateur general. And, once again, in the chapter on the administration of the reparation program for victims that had sustained

financial loss as a result of poor management by the Public Curator was reported in the 2003 – 2004 annual report of the Protecteur du citoyen. More recently, a secret brief submitted in 2008 by the then Minister of Relations with Citizens to the cabinet established that the large-scale abuse has still not been resolved. In all instances, investigation was left to organisms that submitted reports to the Assemblée nationale but they had no ability, instruments or powers to promptly implement corrective, punitive or disciplinary measures.

Wards of the Public Curator are unable to act and speak for themselves and when they are victimized they still have to turn to a representative to act for them but that is illusory when the sole representative is the Public Curator. In addition, their personal and financial information held by the Public Curator is deemed confidential and shrouded in a veil of secrecy and inaccessible which serves as an obstruction for obtaining information on abuse and alerting authorities.

For seniors who are incapable of making decisions and unable to handle their affairs on their own, the need for mandatory reporting of abuse is particularly compelling and indispensable. If we support the advisability of establishing a specialized official or organism dedicated to the protection of seniors against abuse, the need applies more compellingly and urgently to the category of seniors who are incapable.

Moreover, to be effective, any system of obligatory disclosure of abuse must enable access to information to what are now confidential files.

Case example 2 :

Barrières systémiques à la dénonciation obligatoire de la maltraitance en milieu d'hébergement : l'affaire Saint-Charles-Borromée

Malgré le fait que nous n'avons pas au Québec, une loi dictant la dénonciation obligatoire de la maltraitance envers les aînées en milieu d'hébergement, il est important de souligner qu'au fil des ans, plusieurs organismes de protection ont déjà brisé la consigne du silence en dévoilant publiquement des informations alarmantes sur le sort réservé aux personnes vulnérables hébergées en CHSLD, pour en nommer que quelques-unes:¹

- Vérificateur général du Québec (1993-94) : un seul bain par semaine, port de culottes d'incontinence forcé, limites de sorties et d'activités récréatives;
- Protecteur du citoyen (1997) : absence de consentement aux soins, projets d'expérimentation sans contrôles adéquats, méthodes aversives, usage élevé des contentions auprès des personnes incaptes;

¹Rumak, Hélène et Ravenda, Johanne, « Conditions indignes dans les CHSLD du Québec, Handicap-Vie-Dignité outré par les propos du Ministre Couillard » Communiqué de presse de Handicap-Vie-Dignité au ministre de la santé Philippe Couillard, le 26 octobre 2005, extraits, <http://webperso.mediom.qc.ca/~merette/hvd05.pdf>

- Ordre professionnel des diététistes du Québec (1999) : 25 à 65% des patients souffrant de malnutrition pouvant entraîner perte de poids, plaies de lit, affaiblissement du système immunitaire et morbidité;
- Association des centres d'hébergement et de soins de longue durée(1999): personnel soignant ne répondant qu'aux deux tiers des besoins de soins et d'assistance ;
- Ordre des infirmières et infirmiers du Québec (1995-1999) : inspections dans 49 CHSLD ainsi que 38 résidences privées dévoilant l'insuffisance de soins, le manque de respect de la vie privée et de la dignité de la personne, et la violence physique et verbale incluant gifles, menaces, intimidation, touchers et mobilisations brusques;
- Commission des droits de la personne et des droits de la jeunesse du Québec (2000) : 117 mémoires de la part d'organismes et d'individus du milieu dénonçant l'exploitation et l'abus des personnes âgées....
- Bureau du coroner (2003) : 414 morts violentes depuis 1990,
- Ministère de la santé et des services sociaux (2004): selon les rapports de « Visites d'appréciation » pour contrôler la qualité des services offerts en CHSLD: manque d'hygiène (bains peu fréquents, culottes d'incontinence non remplacées), appels à l'aide ignorés, attitude infantilissante de certains employés, organisation trop rigide de l'horaire (pour les repas, les visites à la toilette); résidents laissés à eux-mêmes (demeurent dans leur lit, ne sont pas habillés), manque d'intimité, l'usage mal encadré, voire abusif, des contentions, etc.

Plus particulièrement, nous ne pouvons passer sous silence le rapport Francoeur, suite à la création d'un comité ministériel du MSSS au début des années 2000, qui, dans un effort de «... passer d'une culture de silence à une culture de transparence... » afin de mieux s'occuper des victimes, a obligé les établissements de soins de longue durée à adopter des politiques de gestion de déclaration obligatoire des accidents et incidents i.e. chutes, les erreurs de médication, les erreurs liées aux traitements, les situations d'abus, d'agression et de harcèlement – afin de créer un registre national de ces incidents et accidents survenus lors de la prestation de soins de santé et de services sociaux (RNIASSSS)²

Or, comment se fait-il que 20 ans après les premières dénonciations systémiques, ainsi que tous ces efforts collectifs pour prévenir la maltraitance auprès de nos personnes vulnérables « sans voix » en CHSLD, sommes-nous- « *les gens du terrain qui accompagnent dans leur quotidien ces personnes vulnérables afin qu'elles soient traitées avec respect et dignité* »- à considérer la dénonciation obligatoire de la maltraitance en milieu d'hébergement enchâssée dans une nouvelle loi, comme il se fait dans d'autres provinces canadiennes et ailleurs?

L'histoire de la résidence Saint-Charles-Borromée, un établissement public de soins de longue durée, qui avait pourtant le mandat légal de protéger ses résidents de toute forme d'abus et de négligence, est un exemple flagrant du besoin d'une telle législation.

Rappelons dans un premier temps les faits suivants.

² Ministère de la santé et des services sociaux, Gouvernement du Québec. « *Rapport semestriel des incidents et accidents survenus lors de la prestation des soins et services de santé au Québec- période du 1 avril au 30 septembre 2011* », 2011. <http://publications.msss.gouv.qc.ca/acrobat/f/documentation/2011/11-735-01W.pdf>

Dans les années 1970, alors qu'il n'y avait aucune loi en ce temps, monsieur Claude Brunet, un résident de Saint-Charles-Borromée, après de multiples efforts pour faire corriger la situation, fût le premier à dénoncer dans les médias les conditions de vie indignes qui régnaient dans cette institution³.

Puis entre 1991-1995, l'association Handicap-Vie-Dignité (HVD)⁴, témoin oculaire aussi de tant de souffrances et de violation des droits fondamentaux des résidents les plus vulnérables, alerte et interpelle différentes instances afin de les inciter à intervenir dans leur mission de protection: direction générale de l'époque, Ordre des infirmières et infirmiers du Québec, Curateur Public, Comité des usagers, Comité Provincial des Malades, Ministère de la santé et des services sociaux, Commissaire aux plaintes, etc.⁵

En 1995, insatisfait, à leur tour, des résultats de leur efforts pour améliorer le sort de ses résidents « sans voix », HVD décide de s'adresser aux médias afin de dénoncer publiquement la situation en espérant d'inciter les divers acteurs en autorité à prendre les mesures qui s'imposent pour faire corriger la situation...⁶

Or, depuis 1993 plusieurs instances étaient aussi au courant de la problématique systémique, ayant eux même rédigé des rapports très sévères, mais protégés par le sceau de la confidentialité : le Conseil canadien des agréments des services de santé, l'Ordre professionnelle des infirmières et infirmiers du Québec, le Collège des médecins, l'Ordre professionnelle des Pharmaciens du Québec, etc.

Puis en 1998, devant la situation qui persiste, malgré les efforts des instances en autorité pour corriger la situation, cette même association s'adresse au Tribunal afin d'obtenir l'autorisation d'intenter un recours collectif au nom des résidents. Ce n'est qu'en 1999, après de multiples efforts par l'établissement de nier le sérieux des allégations invoquées, que le Tribunal leur donnera la permission d'intenter ce recours.⁷

Malgré tout cela, envers et contre tous, HVD continu de veiller au grain, déterminé plus que jamais, à faire respecter les droits fondamentaux de cette clientèle captive.

³ Brunet, Claude et le *Comité des malades*, Nous les oubliés, Les Éditions Œil de feu, 1983

⁴autrefois connu sur le nom « *Fondation Lise T- pour le respect du droit à la vie et à la dignité des personnes lourdement handicapées* »

⁵Jacoby, Daniel, Protecteur du Citoyen, « *Les personnes vulnérables en institution : Le temps est venu d'éliminer les barrières* » ,Actes du congrès « Brisons le Silence : Dévoiler les mauvais traitements infligés dans les institutions – Intervention en faveur des droits des personnes ayant des incapacités » organisé par *Handicap-Vie-Dignité* en collaboration avec *Le consortium de Montréal pour la défense des droits Humains de Montréal, École de service social, Université McGill* , p. 16-17.

⁶NOËL, André. « *L'hôpital Saint-Charles-Borromée ne répondrait pas aux normes – Le conseil canadien des services de santé lui a refusé l'agrément* », Journal *La Presse*, le 7 janvier 1995, page A1-A2.

NOËL, André. « *Traité de ...- petite merde- Un patient de St Charles Borromée aurait été maltraité par un gardien*», Journal *La Presse*, le 8 janvier 1995, page A1-A2.

NOËL, André. « *Un préposé de Saint-Charles-Borromée est accusé d'avoir violé une patiente*», Journal *La Presse*, le 9 janvier 1995, page A3.

⁷BISHOP, John, l'honorable, J.C.S.Jugement No: 500-05-003602-958,*Handicap-Vie-Dignité* et al. c. *Hôpital Saint-Charles-Borromée, Cour supérieure*, District de Montréal, le 24 novembre 1999, pp. 1-27.

Puis en 2003, par un concours de circonstances, HVD collabore à rendre public des extraits d'enregistrements sonores, fait par une famille à l'insu du personnel, qui témoignent de façon évidente d'abus psychologiques à caractère sexuel, de brusqueries, de propos méprisants, voire menaçants, et de négligence au niveau de l'hygiène, commis par certains membres du personnel soignant à l'égard d'une résidente vulnérable de SCB.⁸

Suite à cette nouvelle vague médiatique qui est comme « une bombe dans le réseau de la santé » comme dirait plusieurs, le ministre de l'époque mets SCB sous tutelle, un geste sans précédent pour un CHSLD public. De nouveaux rapports accablants viennent s'ajouter aux rapports précédents. La reconnaissance de la maltraitance, qui était établie en système, ne peut plus être nié, ni à l'interne, ni à l'externe. C'est le début d'une nouvelle ère.

Malgré cela, ce ne sera que vers 2006, après un changement de cap de la nouvelle direction de SCB déterminée à créer une nouvelle culture de soins de qualité dans un milieu sécuritaire et respectueux des droits fondamentaux, et ce après des années de non- reconnaissance de la problématique de l'abus et la négligence systémique dont étaient victimes les résidents de cette institution, que des négociations de règlement hors cours sont entamées.

Sept ans plus tard, soit en 2013, un règlement «historique» de \$8, 500,000 est finalement convenu entre les parties afin de dédommager les victimes qui ont subis des années de maltraitance en plus de donner des outils innovateurs pour tenter de prévenir qu'un tel scénario ne se reproduise plus.⁹

Commentaires et trois leçons à retenir

Est-ce qu'une loi de dénonciation obligatoire aurait pu prévenir qu'une situation si triste perdure pendant des décennies?

La réponse est bien sur mitigé car il existait déjà plusieurs lois qui devaient pourtant assurer une protection minimale aux résidents de SCB et qui ont failli à la tâche, les personnes n'étant pas en mesure d'exercer leurs droits individuels, d'une part, et d'autre part, une association, comme HVD, n'ayant aucune autorité « légale » pour intervenir en leur nom, ce qui ne leur a pas empêché d'intervenir au niveau « moral » à l'égard de ces personnes.

Ceci étant dit, voici quelques leçons à retenir et qui devraient être considérés dans l'élaboration d'une loi de dénonciation obligatoire.

Premièrement, contrairement à celui qui dénonce, il faut souligner que toutes les instances déjà prévu dans nos systèmes de protection actuels, sont soumis à des règles de confidentialités sévères malgré le fait qu'ils ont accès à des informations privilégiées qui, pour le commun des mortels ne sont pas accessibles.

À titre d'exemple, HVD a dû faire une cinquantaine de représentations devant la Commission d'accès à l'information, afin de sustenter leurs inquiétudes observées auprès des résidents, de

⁸NOËL, André. « *Mauvais traitements à l'Hôpital Saint-Charles-Borromée -Des employés piégés par un magnétophone* », Journal *La Presse*, le 24 novembre 2003, p. A1.

⁹ Daoust- Boisvert, Amélie, « *Saint-Charles-Borromée –Tourner la page – Québec signe une entente de 8.5 millions avec les victimes* » Journal *Le Devoir*, le 20-21 avril 2013, p. A3.

façon collective. i.e. "Si monsieur ou madame x est abusé(e) ou négligé(e), se pourrait-il qu'il ou qu'elle soit plusieurs à partager le même sort?"

Une loi de dénonciation obligatoire, devrait permettre aux institutions, aux corporations professionnelles, ainsi que toute instance qui produit des rapports qui impliquent des données concernant des « indicateurs de la qualité des soins et services offerts aux résidents vulnérables », de rendre public ou accessible tous rapports à toute personne qui en fait la demande selon la Loi d'accès à l'information. Car, n'oublions pas, tout rapport, dans la loi actuel, peut être « dénominalisé » afin de protéger la confidentialité de certaines informations telles l'identité des résidents, etc.

Deuxièmement, il faut souligner que toutes les instances actuelles de protection et qui peuvent fournir des rapports pouvant permettre aux instances décisionnelles de prendre des mesures correctrices et préventives, n'ont pas de liens privilégiés avec les victimes étant des instances administratives. Ce faisant, elles ne sont pas soumises « personnellement » à des mesures de représailles.

À contrario, notons que les personnes parlant au nom de HVD et des victimes, ont été soumis à diverses représailles personnelles et professionnelles: injonction et poursuite en dommages et intérêts; mise-en-demeures avec menaces de poursuites judiciaires; plainte pour avoir porté atteinte au respect du secret professionnel; menaces d'expulsion de l'établissement; recours judiciaires pour les obliger à se taire publiquement ; menaces de transférer « leur protégée » vers une autre institution; dénonciations publiques par le Comité des résidents, le syndicat, des familles quant à la crédibilité de leurs dénonciations; recours pour interdire toutes demandes d'accès à l'information sur des informations pourtant d'ordre publique, etc.

Une loi devrait absolument fournir une protection aux organismes et personnes qui sonnent l'alarme. Il faut arrêter de permettre aux institutions d'utiliser les fonds publics pour défendre leur réputation au détriment des résidents qu'ils doivent protéger en premier lieu.

Troisièmement, il faut savoir qu'aucune des instances impliquées, n'a été en mesure d'agir rapidement, la lourdeur de la boîte administrative étant trop lente à réagir.

À contrario, HVD, libre de tout conflit d'intérêt, n'étant pas soumis aux mêmes exigences administratives, pouvait agir rapidement pour tenter de faire cesser un abus, mais ce sans pour autant avoir les pouvoirs légaux pour intervenir, agissant plutôt par obligation morale.

Or, afin que la dénonciation obligatoire par toute personne ou instance témoin de maltraitance auprès de résidents vulnérables soit efficace, il faut absolument qu'une instance extérieure neutre, libre de tout conflit d'intérêt, puisse réagir et agir rapidement, avoir accès à la personne négligée ou abusée, ainsi qu'avoir accès aux informations confidentielles la concernant, et ce afin de faire cesser, le plus rapidement possible, la situation qui met la sécurité et la santé de la personne à risque.

En guise de conclusion, il n'existera jamais de lois assez fortes pour enrayer le problème de la maltraitance en institution, ce problème étant avant tout un problème d'ordre moral, de choix de société à l'égard de ses membres les plus vulnérables comme en fait foi l'histoire de SCB, qui pour plusieurs ne représente que la pointe d'un iceberg encore plus grand.

En même temps, l'ajout d'une loi spécifique à la dénonciation, pourrait à tout le moins, dans le meilleur des mondes, resserrer le filet de sécurité autour de cette clientèle silencieuse et captive.

Case Example 3 :

Lessons learned from implementing an elder abuse policy in a Long Term Care Institution

A consultant from NDGCCEA was hired over a period of three years to design, implement and evaluate the elder abuse policy and procedures in a CHSLD in Montreal. Over the three years all personnel employed in the establishment were trained to understand the concepts of elder abuse and the policy and processes involved in implementing the policy. The bilingual training program consisted of interactive workshops , including presentations of information, discussions with exercises and role plays, and DVDs. Reporting cases was a big issue noted in the training sessions by staff, who were reluctant to report on their colleagues and also felt they were often not supported by the administration if they wanted to report. Confidentiality was a major problem.

After evaluating the training program, the problems which were raised in the implementation of this policy were brought to the attention of the administration with recommendations. It was decided that the main problems and abuse incidents were partially linked to a lack of understanding by the personnel about dementia, other mental health problems and the behaviors resulting from these conditions. Thus, a second series of training programs were offered to cover these issues and to provide and practice alternative approaches to use when confronted by difficult behaviors. Another problem presented to the consultant was the absence of good case management systems in place which would help workers on any of the shifts to better understand the issues and get the support they needed for a consistent approach and plan to be made for the individuals, whose behavior they considered difficult to deal with.

These workshops were found to be successful and useful to the personnel. However, there is such a turnover in staff that the training program needs to be repeated often for new staff, and followed up though an evaluation system to see whether the abuse was reduced and stopped.

Observations from lessons learned through this exercise are that even if mandatory reporting laws are introduced there is much to do at the level of the residence itself.

- An elder abuse policy needs to exist in each senior residence, however large or small, in the public and private sectors
- The policy needs to be properly implemented and enforced, not merely exist as a document on a shelf
- Interactive training programs about elder abuse, the elder abuse policy and the procedures need to be put in place on a regular basis to ensure that all personnel and residents and families in the case of those who are “inapt” are aware of and understand them

- Mechanisms need to be in place to deal with incidents, reporting of abuse and procedures to be followed. These include an outside body of objective interdisciplinary professionals to whom the victims, families or abusers could lodge a complaint and information about whom to appeal to if the complaints are not dealt with appropriately from their perspectives
- Case management processes need to be in place with appropriate training programs
- A yearly evaluation needs to be done to monitor the outcomes of the training programs
- Evaluations need to systematically and objectively assess the mechanisms in place to resolve the abuse and neglect incidents.

Pros and cons of mandatory reporting in relation to this case

Benefits

The residents who are most at risk of abuse and neglect are those with mental health and behavior problems and/or suffer from cognitive impairments where they have been deemed inapt. These persons would be targeted for protection by mandatory reporting laws as they have been assessed as not able to defend their own rights. The other residents with the appropriate information sessions and training and mechanisms in place could make their own decisions about reporting.

Protection and support needs to be in place for whistle blowers. Many cases are not reported or followed up or dealt with appropriately, making the case for mandatory reporting laws necessary as this will increase the numbers of reported cases.

It is also clear that operators and managers of residences have legal and contractual responsibilities to provide quality care to residents. These are often displayed on posters or flyers; however, these responsibilities must also be reinforced by strong mandatory reporting laws and structured mechanisms to ensure protection for all those concerned.

Disadvantages

The problems inherent in mandatory reporting laws and mechanisms are the cost and structuring of the mechanisms and resources required. Many people and organizations think the present laws are adequate to ensure the protection of those who are abused. However if many cases of abuse and neglect are not being reported as is the case, the laws are not being applied. As well, many residences are small, with few staff members to implement and enforce the steps and procedures needed for adequate follow up of cases, appropriate case management systems, etc. The effectiveness of reporting systems depends on upholding strictly confidentiality rules and regulations which are often not applied. Finally, abuse and neglect cases are extremely complex and multi-faceted, as well as time-consuming to resolve appropriately.

In spite of the difficulties, the benefits to those who are unable to defend their own rights outweigh the disadvantages, and since abuse and neglect are a social problem and often a

crime, we have a social responsibility to enforce mandatory reporting laws for those who need protection.

Conclusions and recommendations

We conclude that much needs to be done by the government and by policy makers to stop and reduce the abuse and neglect experienced by the most vulnerable people in our society. We therefore make the following recommendations:

1. To complete the social safety net, a system of mandatory disclosure would be advisable.
2. The senior should be informed and consulted and his/her wishes should be respected if decision-making ability is intact and not in a vulnerable relationship with respect to any perpetrator.
3. To promote confidence and avoid any appearance of conflict of interest, mandatory reporting should not be exercised by the same agencies or personnel that provide other services, but by an independent agency/organization.
4. The disclosure ought not to be merely statistical and passive, but must be pro-active with concrete policies and procedures. The recipient of the mandatory disclosure should be equipped with investigative and remedial powers.
5. Participants in the process should be exempt from restrictions of confidentiality.
6. The structure could be similar to that of youth protection as abuse is a social problem. However, multi- and inter-disciplinary teams should be involved in the treatment programs as elder abuse is also multifaceted and complex.
7. Finally since prevention is better than cure, we suggest that funds be allocated to community organizations to set up, recruit and train volunteers to advocate for vulnerable residents and to train personnel in approaches to use when confronted with difficult behaviors from dementia and/or mental health problems.

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