ACE
Advocacy Centre for the Elderly

2 Carlton Street, Suite 701
Toronto, Ontario M5B 1J3
Tel: (416) 598-2656
Fax: (416) 598-7924
www.acelaw.ca

SUBMISSION OF THE ADVOCACY CENTRE FOR THE ELDERLY TO THE STANDING COMMITTEE ON SOCIAL POLICY

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The Advocacy Centre for the Elderly ("ACE") is pleased to provide comments on Bill 148, *Protection of Vulnerable Seniors in the Community Act, 2015* ("Bill 148"), based upon our extensive experience advocating for older adults in Ontario and our expertise in the areas of elder law and substitute decision-making.

After a brief introduction to ACE, we will examine the following concerns raised by Bill 148 as they affect older adults:

- The current regime for the reporting of "elder abuse";
- The problem of protection legislation as it applies to capable adults;
- The broad definition of abuse and the low threshold for reporting;
- The impact of mandatory reporting on the relationship between health practitioners and older adults; and,
- The lack of remedy for abuse or neglect under the proposed legislation.

We thank you for the opportunity to provide our submissions in this regard. ACE would be happy to participate in any further consultations or discussions with the Committee.

The Advocacy Centre for the Elderly (ACE)

Established in 1984, ACE is the first and oldest legal clinic in Canada with a specific mandate to provide a range of legal services to low-income older adults in Ontario. ACE's legal services include individual and group client advice and representation, public legal education, community development and law reform activities.

On average, ACE receives more than 3,000 client intake inquiries each year. Most of the telephone inquiries come from the Greater Toronto Area with approximately 20% originating from other areas of the province. From time to time, ACE also receives inquiries from outside of Ontario. The individual client services provided are in areas of law that particularly impact older adults. These include, but are not limited to, elder abuse, capacity, substitute decision-making and health care consent; end-of-life care; supportive housing and retirement home tenancies; long-term care homes; and patients' rights while in hospital.

As part of its law reform mandate, ACE has been involved in many of the law, policy and education initiatives related to elder abuse and consent, capacity and decision-making that have taken place in Ontario over the last 30 years. These have included participation on the following committees:

- O'Sullivan Committee, which was a review of advocacy for vulnerable adults in Ontario undertaken in 1987;
- Fram Committee, the work of which resulted in the passage of the *Consent to Treatment Act, 1992,* subsequently replaced by the *Health Care Consent Act, 1996*;[1]
- Expert Roundtable on Elder Abuse convened by the Human Resources and Social Development Canada (HRSDC) in Ottawa in June 2008;
- Retirement Home Expert Roundtable convened by the Ontario Seniors Secretariat in 2010;

[1] *Health Care Consent Act*, *1996*, S.O. 1996, c. 2, Sched. A (*HCCA*)

- Fact Finding Working Group on Prevention and Awareness of the Abuse of Older Adults with Disabilities convened by the HRSDC from 2009 to 2010;
- Elder Health Coalition Elder Abuse Working Group convened by the Ontario Seniors Secretariat from 2006 to 2012; and,
- Best Practice Guideline Panel convened by the Registered Nurses Association of Ontario on Elder Abuse Awareness: Prevention, Identification and Intervention from 2013 to 2014.

In addition to participation on these committees, ACE has:

- Trained police officers in the Ontario Police College Training Programme on Elder Abuse Response and Prevention for Police Services from 2004 to date;
- Organized the First National Conference on Elder Abuse and Crime in 1990 with Ryerson Polytechnical Institute (as it then was) and the HRSDC,;
- Assisted in organizing and facilitating two Federal-Provincial-Territorial Working Group Consultations on elder abuse in Vancouver in November 2007 and in Ottawa in June 2008;
- Co-organizing the Canadian Conference on Elder Law (with Law Commission of Ontario and Canadian Centre for Elder Law) in Toronto in 2010;
- Making submissions to the Senate as part of the Consultation on Elder Abuse in 2010 and the Federal Standing Committee on Status of Women, Abuse of Older Women Consultation in 2011;
- Making submissions to the Ontario Human Rights Commission on its Policy and Guidelines on Disability and the Duty to Accommodate; and,
- Co-authoring (with the law firm of Dykeman Dewhirst O'Brien LLP) a major research paper on health care consent and advance care planning for the Law Commission of Ontario.[2]

[2] Judith Wahl, Mary Jane Dykeman and Brendan Gray, *Health Care Consent and Advance Care Planning in Ontario: Legal Capacity, Decision-Making in Guardianship,* Law Commission of Ontario: January 2014, online: <http://www.lco-cdo.org/capacity-guardianship-commissioned-paper-ace-ddo.pdf>

I. Overview

Of the estimated two million seniors residing in Ontario, between two and ten percent are expected to experience abuse. This translates to between 40,000 and 200,000 people over the age of 65 in Ontario who have been, or will be, abused.[3] Given the magnitude of this problem, ACE welcomes new measures that seek to address elder abuse. Nevertheless, ACE does not believe that mandatory reporting in the manner envisioned by Bill 148 will be effective in addressing this problem.

During the legislative debates, Soo Wong, the member for Scarborough-Agincourt, stated that if passed, Bill 148 would "ensure that all seniors living in the community have protection and support by requiring regulated health professionals to report elder abuse or neglect."[4] It is not clear, however, that mandatory reporting of elder abuse can have the effect of supporting and protecting all seniors in the community.

In Ontario, decisional capacity is presumed unless there is reasonable cause to believe otherwise.[5] Bill 148 upends this presumption, and instead presumes that all adults over the age of 65 are incapable. This reversed presumption reflects a prejudice long held in our society that to be old is to be feeble or demented, and treats older adults as if they were children. Mandatory reporting regimes for elder abuse are modeled on child protection legislation and not on the more analogous situation of domestic violence. For example, we are unlikely to see legislation making the reporting of domestic abuse mandatory. Rather, the decision to charge in domestic violence contexts has been made mandatory,[6] which is not an option canvassed under Bill 148. Even mandatory charging

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[3] *What is Elder Abuse?* online: <www.elderabuseontario.com>
[4] Ontario Legislative Assembly, *Official Report of Debates (Hansard),* 41st Parl, 1st Sess, No 134 (10 December 2015) at 7238 (Soo Wong).
[5] For example, see Laura Cardiff (ed)., *Whaley Estate Litigation on Guardianship,*(Whaley Estate Litigation, 2015), p.23, see *HCCA, supra,* note 1, s. 4(2) for treatment, admission to a care facility and personal assistance services; see also *Substitute Decisions Act*, S.O. 1992, c. 30 (SDA), s.2(2) for personal care decisions and s.2(1) for contracts; See also Knox v. Burton, 2004 CanLII 35099 (ON SC), online: <http://canlii.ca/t/1gsck>
[6] See "Mandatory Charging", *Ontario Women's Justice Network,* online:<http://www.owjn.org/owjn_2009/legal-information/criminal-law/271-mandatory-charging>

has been criticised by the Ontario Women's Justice Network as potentially leading to reluctance to call the police.[7]

Victims of domestic violence who wish to ameliorate their situations are offered referrals to a wide variety of services that are in keeping with the complexity of abuse situations. These services are offered with the understanding that capable adults may have reasons compelling them to either stay or to leave an abusive situation.

In the course of her remarks, Ms. Wong listed several reasons why a senior might not report elder abuse: "Victims are often reluctant to report elder abuse due to fear of repercussions; a feeling of shame or guilt associated with reporting the abuser, who may be a relative; financial or emotional dependence on the abuser; fear of loss of contact with the abuser; and fear or reluctance to relocate to an unfamiliar environment."[8] These are all valid reasons why one may choose not to report. ACE submits that mandatory reporting of suspected elder abuse by health practitioners removes the choice of whether to report without addressing these underlying reasons. The remainder of these submissions will discuss ACE's concerns in greater detail. The next section, however, will outline the current legal framework for protecting older adults who are experiencing abuse or neglect.

II. Existing Mechanisms to Protect Older Adults in Cases of Abuse or Neglect

Under the current regime, any person, including health care providers, *may* report suspected cases of abuse or neglect; however, reporting is not mandated except where the older adult is a resident of a Long-Term Care Home (LTCH) or a tenant in a retirement home. In addition, health care providers must report any suspected sexual abuse by another health care provider, no matter the setting. Should any person suspect abuse of an older adult, they may contact the police if the senior is capable, and either the

[7] *Ibid.*
[8] Ontario Legislative Assembly, *supra,* note 4

police or the Office of the Public Guardian and Trustee (OPGT), if the senior is, or is suspected of being, incapable.

i. Mandatory Reporting: Long-Term Care Homes and Retirement Homes

LTCHs are health care facilities licensed by the Ministry of Health and Long-Term Care to provide long-term care services to eligible persons. LTCHs are required to provide specific care and services including 24-hour nursing care, restorative care, recreational and social activities, medical services and dietary services.[9]

The *Long-Term Care Homes Act, 2007* (*LTCHA*) provides that:

> A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
>
> 1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
> 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.
> 3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
> 4. Misuse or misappropriation of a resident's money.
> 5. Misuse or misappropriation of funding provided to a licensee under this Act or the *Local Health System Integration Act, 2006*.[10]

While this requirement applies only to residents of a LTCH; it applies even when the resident is not physically present in the LTCH. For example, if a resident of a LTCH is receiving treatment in hospital, staff are required to report any suspected abuse or neglect to the Director. The duty to report abuse or neglect applies to all persons who have reasonable grounds to suspect abuse, and is not restricted to health practitioners.

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[9] *LTCHA,* 2007, S.O. 2007, c. 8, ss. 8 – 12.
[10] *Ibid.,* s. 24(1)

The only exception is for other residents, who may make a report, but are not required to do so.[11] Failure to report is an offence under the *LTCHA*.[12] Lawyers are also protected from reporting in certain cases by solicitor-client privilege.[13]

Abuse under the *LTCHA* is defined as physical, sexual, emotional, verbal or financial abuse. The regulations provide the following definitions:

> "emotional abuse" means,
>
> > (a) any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident, or
> >
> > (b) any threatening or intimidating gestures, actions, behaviour or remarks by a resident that causes alarm or fear to another resident where the resident performing the gestures, actions, behaviour or remarks understands and appreciates their consequences;
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> "financial abuse" means any misappropriation or misuse of a resident's money or property;
>
> "physical abuse" means, subject to subsection (2),
>
> > (a) the use of physical force by anyone other than a resident that causes physical injury or pain,
> >
> > (b) administering or withholding a drug for an inappropriate purpose, or
> >
> > (c) the use of physical force by a resident that causes physical injury to another resident;
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> "sexual abuse" means,
>
> > (a) subject to subsection (3), any consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a licensee or staff member, or

[11] *Ibid.,* s. 24(3)
[12] *Ibid.,* s. 25(5)
[13] *Ibid.,* s. 24(7)

(b) any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member;

"verbal abuse" means,

(a) any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident, or

(b) any form of verbal communication of a threatening or intimidating nature made by a resident that leads another resident to fear for his or her safety where the resident making the communication understands and appreciates its consequences.[14]

Reports are made to the Director, who is appointed by the Minister of Health and Long-Term Care.[15] The Director is required to conduct an inspection in order to determine compliance with the *LTCHA*.[16] This inspection must be conducted immediately in certain instances, including where there is "harm or a risk of harm to the resident."[17]

The licensee of a LTCH must notify the resident's substitute decision-maker if the resident is incapable of making personal care decisions either immediately or within 12 hours depending on the gravity of the incident and its effect on the resident (unless the substitute decision-maker is the alleged abuser).[18] The licensee must also notify the police if the abuse or neglect might constitute a criminal offence.[19]

There is a duty to report abuse or neglect in retirement homes, too. Retirement homes are residential complexes occupied by at least six persons who are over the age of 65 and who are unrelated to the operator of the home, and where at least two care services

[14] O. Reg. 79/10, s. 2(1)
[15] *LTCHA, supra,* note 9, s. 175(1)
[16] *Ibid.,* s. 25(1)
[17] *Ibid.,* s. 25(1) and s. 25(2)
[18] *LTCHA, supra,* note 14, s. 97(1)
[19] *Ibid.,* s. 98

are made available.[20] Ontario law does not prohibit retirement homes from offering the same level of care that a LTCH may provide.

While the duty to report in the *Retirement Homes Act* is similar to the duty imposed by the *Long-Term Care Homes Act*, the licensing and regulatory oversight of retirement homes differs greatly. Reports of suspected abuse are made to the Registrar of the Retirement Homes Regulatory Authority (RHRA), rather than to a Ministry of the Government of Ontario.[21] Any person who "has reasonable grounds to suspect":

(1) improper or incompetent treatment or care of a resident;
(2) abuse of resident by anyone or neglect of a resident by the licensee or staff of a retirement home;
(3) unlawful conduct that resulted in harm or a risk of harm to the resident; or
(4) misuse or misappropriation of a resident's money

must report to the Registrar.[22] The duty to report also applies where the retirement home tenant is away from the retirement home.

Both retirement homes and LTCHs are congregate settings in which their operators have an unusually high level of control over residents'/tenants' day-to-day activities. The mandates of these homes touch on most aspects of their residents' lives, including care provision, medical assistance, food and nutrition, financial dealings and social activities. Dependence on the operators of these homes for assistance with the activities of daily living, as well as the insular nature of these homes, render residents more vulnerable to abuse or neglect. This distinguishes these settings from other places where older adults may reside. In this context, mandatory reporting of abuse to the prescribed regulatory authority is an appropriate protection.

[20] *Retirement Homes Act, 2010,* S.O. 2010, c. 11, s. 1
[21] *Ibid.,* s. 75(1)
[22] *Ibid.*

It is important to note that reports of abuse or neglect in LTCHs and retirement homes are made to a regulatory authority, which then uses the information to assess the licensee's compliance with the enacting legislation by conducting inspections. The capacity of the tenant/resident is not at issue in these cases, nor would there be outcomes to these inspections that would result in the tenant's/resident's capacity being challenged. Only where the abuse or neglect possibly constitutes a crime would a report be made to the police.

ii. Voluntary Reporting under the Substitute Decisions Act or the Criminal Code

In other settings, there is no mandatory abuse reporting requirement. The *Substitute Decisions Act, 1992* (*SDA*), which details the law on mental capacity, powers of attorney, guardianship and substitute decision-making, includes voluntary reporting to the Office of the Public Guardian and Trustee (OPGT). The OPGT is part of the Ministry of the Attorney General, and its role includes protecting the rights and interests of mentally incapable adults.

The *SDA* defines two types of incapacity: incapacity to manage property and incapacity to make personal care decisions, and includes a presumption of capacity in certain contexts.[23] As defined in the legislation, "A person is incapable of managing property if the person is not able to understand information that is relevant to making a decision in the management of his or her property, or is not able to appreciate the reasonably foreseeable consequences of a decision or lack of decision."[24]

A person is incapable of making a personal care decision, "if the person is not able to understand information that is relevant to making a decision concerning his or her own health care, nutrition, shelter, clothing, hygiene or safety, or is not able to appreciate the reasonably foreseeable consequences of a decision or lack of decision."[25]

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[23] See note 5.
[24] *SDA, supra,* note 5, s. 6
[25] *Ibid*., s. 45

Where a report is made that an incapable adult is at risk of suffering serious financial or personal adverse effects, the OPGT has a duty to investigate.[26] Serious adverse effects with respect to property include, "Loss of a significant part of a person's property, or a person's failure to provide necessities of life for himself or herself or for dependents."[27] Circumstances that constitute financial abuse, such as a person's family members using their pension funds for their own benefit rather than the benefit of the older adult, may be included in this category. Serious adverse effects with respect to personal care include, "Serious illness or injury, or deprivation of liberty or personal security."[28] These effects would include physical abuse or neglect.

As the law stands today, reporting to the OPGT can only result in a guardianship investigation, and only if the suspected victim is incapable.

A guardianship investigation is very invasive. During the course of an investigation, the OPGT may look into a person's financial, medical and other personal records. They may interview anyone, "who may have knowledge about the person's situation including – family members, health professionals, neighbours, bank staff, caregivers, service providers and landlords,"[29] exposing one's whole life to scrutiny.

Following an investigation, the OPGT may take steps to become that person's guardian on a temporary basis.[30]

In addition, there are many forms of elder abuse that constitute crimes under the *Criminal Code*. These include assault,[31] assault with a weapon or causing bodily harm,[32] sexual

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[26] *Ibid*., s. 27(2) and s. 62(2)
[27] *Ibid.,* s. 27(1)
[28] *Ibid.,* s. 62(1)
[29] Office of the Public Guardian and Trustee, *Guardianship Investigations: The Role of the Public Guardian and Trustee*, online: Ministry of the Attorney General, online: < https://www.attorneygeneral.jus.gov.on.ca>.
[30] *SDA, supra,* note 5, s. 27(3.1) and s. 62(3.1)
[31] *Criminal Code, R*.S.C., 1985, c. C-46, s. 265
[32] *Ibid.,* s. 267

assault,[33] forcible confinement,[34] breach of duty to provide necessaries of life,[35] uttering threats,[36] intimidation,[37] theft,[38] theft by a person holding a power of attorney,[39] fraud,[40] extortion,[41] stopping mail with intent[42] or forgery.[43] These crimes can be reported to the police but a police report is not mandatory.

iii. Other Reporting Obligations

The obligation to report elder abuse may also appear in a contract for services. An example of this would be a policy that personal support workers must report suspicions of elder abuse to a supervisor as part of an employment contract.

Reporting may be a professional responsibility. For example, regulated health professionals have a responsibility to report sexual abuse perpetrated by another regulated health professional.[44] The health professional's college would then investigate and, depending on the results, may discipline the health professional.

Ontario already has a regime of laws addressing elder abuse. These laws seek to balance protection of individuals against the autonomy of the individual. Where the older adult is incapable, the law has a process by which decisions can be made to protect them from abuse or neglect. While some law reform may be necessary, Bill 148 goes too far. It proposes to protect capable adults, and, in doing so strips them of their autonomy. As such, ACE questions the necessity of such a law.

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[33] *Ibid.,* s. 271
[34] *Ibid.,* s. 279(1)
[35] *Ibid.,* s. 215
[36] *Ibid.,* s. 264.1
[37] *Ibid.,* s. 423
[38] *Ibid.,* s. 322
[39] *Ibid.,* s. 331
[40] *Ibid.,* s. 380
[41] *Ibid.,* s. 346
[42] *Ibid.,* s. 345
[43] *Ibid.,* s. 366
[44] *Health Professions Procedural Code, Schedule 2, Regulated Health Professions Act, 1991,* S.O. 1991, c. 18, s. 85.1

III. Specific Concerns regarding Bill 148

i. Capable Seniors as the Subject of the Legislation

Bill 148 proposes mandatory reporting of any suspected abuse of "seniors" by regulated health practitioners. "Senior" is defined in the Bill as a person who is 65 years of age or older. Nowhere in the reporting requirements does it indicate that the person reporting must have reasonable grounds to suspect the older adult is incapable of managing their property or making personal care decisions. The Bill would apply to all persons over 65, regardless of capacity.

As discussed above, reporting of abuse without the older adult's consent is a gross invasion of privacy. Such reports should only be made where an adult is incapable of making decisions for himself or herself. To require health practitioners to report suspected abuse of a capable senior denies the senior their agency, and undermines one of the fundamental tenets of our society — that capable persons may make decisions for themselves, including the decision to tolerate behaviour that others consider abusive. As such, the legislation is overbroad, capturing persons who are capable, and capable of consenting to disagreeable situations.

On second reading of the Bill, the proposed legislation was compared to Newfoundland's *Adult Protection Act*. However, the *Adult Protection Act* defines an adult in need of protective intervention to mean, "an adult who lacks capacity" *and* who "is incapable of caring for himself or herself, or who refuses, delays or is unable to make provision for adequate care and attention for himself or herself," or "is abused or neglected."[45] In Ontario, the OPGT is already required to investigate instances of suspected abuse or neglect where the victim is thought to be incapable.

[45] *Adult Protection Act*, SNL 2011 c. A-4.01, s. 5

Furthermore, the decision to make those over 65 the subject of this Bill is arbitrary. It is unclear why a person aged 64 is any less vulnerable than a person aged 65. Newfoundland's *Adult Protection Act* applies equally to all adults, regardless of age. Without principled reasons for this differentiation, the law could be seen as discriminatory.

Most troubling of all, the proposed legislation provides no role for the senior in question. The onus is on the health practitioner to report, and the police or the OPGT to take action. *There is no requirement that the health practitioner speak to the senior* before reporting, or for the OPGT to speak to the senior prior to investigating. There is no requirement to ask the senior how they feel about the "abuse" or "neglect" or whether they would like assistance. The senior would not necessarily be advised of the reporting, placing them in a position that is untenable at best and dangerous at worst. Lack of consultation with the senior may deny them the opportunity to make a plan to leave the home safely, or find alternate accommodations. They may not have time to arrange for emotional support or take any of the other steps to ensure the least amount of disruption to their lives.

Bill 148 presumes that all seniors are in need of protection. As noted in the introductory section, poverty, dependence, and discrimination in the older adult population do contribute to vulnerability. However, vulnerable capable adults should be offered assistive, not protective, services.

ii. Possible Over-Reporting Pursuant to Bill 148

The definition of abuse in the Bill is expansive. It is defined as, "physical, sexual, emotional, verbal, financial or systemic abuse of [that] senior." As can be observed from the *LTCHA* regulations, abuse can include a range of actions, from sexual assault to name-calling. Name-calling may be upsetting to an older adult and can be an affront to a person's dignity. Should the OPGT respond to an incident of name-calling with a guardianship investigation? Is this proportionate? While all forms of abuse should be addressed, investigation with an eye to guardianship of the victim is not always the

appropriate response. Guardianship investigations may be heavy-handed where the abuse does not have serious adverse effects.

Furthermore, the threshold for mandatory reporting by health care practitioners is as low as the definition of abuse is wide. In reviewing the Hansard transcripts of the Bill's second reading, it is clear that Ontario's legislators do not mean to capture such minor issues. However, the low threshold for mandatory reporting—"reasonable grounds to suspect"—would require the health practitioner who suspects their patient has been called an unpleasant name to make a report to the OPGT, and the OPGT would be required to investigate.

It should also be noted health practitioners may not be able to reasonably assess for all forms of abuse. They are not, for example, trained to spot the signs of financial abuse. It is not appropriate to place a mandatory reporting requirement on health practitioners in domains where they have no training.

iii. Effects of Mandatory Reporting on Relationships with Health Practitioners

Requiring health practitioners to report suspected abuse would have a dramatic impact on seniors' relationships with their health practitioners. Older adults experiencing difficulties may not feel comfortable discussing their concerns with health practitioners, for fear their concerns may lead to an OPGT investigation. Those who might otherwise disclose abuse may choose not to, rendering inaccessible the help that would otherwise be available to them.

Health practitioners are aware of this paradox. One study of California physicians found that in spite of mandatory reporting of suspected elder abuse by physicians, many still used their discretion when deciding whether to report. "Some physicians noted that suspicion is often a subjective judgment, and the expected loss of rapport caused by reporting raised the level of evidence they believed was necessary to suspect abuse,

thereby inhibiting reporting."[46] Others described a process of deciding whether to report as a "cost-benefit evaluation of the contradictory effects of reporting."[47]

Where this relationship involves psychiatry, psychology or counselling, mandatory reporting may interfere with the therapeutic process.

The present law in Ontario allows health practitioners to use their discretion when deciding whether to report suspected abuse, enabling the health practitioner, in conjunction with the older adult, to assess the risks and benefits of reporting abuse.

iv. Availability of a Remedy for Abuse or Neglect

Bill 148 states that once a mandatory report is made, the OPGT must investigate the incident or incidents. Where abuse is determined to have occurred, the OPGT's only remedy is to seek guardianship of a person's property or person in the Ontario Superior Court of Justice. However, this option is only available where a person is incapable.

Under the terms of the Bill as written, when a report is made about a capable older adult, there is no remedy available. The legislation in fact offers no new solution to the problem of elder abuse.

Mandatory reporting gives the (in this case false) impression that Bill 148 offers a remedy to the abused senior. However, the Bill does not require victims of elder abuse to be referred to services, or that any steps be taken to discuss the abuse or neglect with the abuser. A person who is experiencing abuse may have safety, financial, shelter, health care or legal needs that the proposed legislation offers no way to meet. Furthermore, the mere fact of reporting may make the matter worse, without offering an effective solution.

[46] Michael A. Rodriguez *et al*., "Mandatory Reporting of Elder Abuse: Between a Rock and a Hard Place" (2006) 4(5) Annals of Family Medicine 403-409
[47] *Ibid.*

Conclusion

ACE remains extremely concerned about elder abuse in Ontario. Elder abuse can take many forms and can be difficult to detect: it is a complex problem which requires solutions in a myriad different arenas. The solution may lie in offering more services to capable older adults seeking to leave abusive situations. It may lie in properly implementing existing laws, for example, recommending that the OPGT broadly interpret its jurisdiction to investigate abuse where there are serious adverse effects. The solution may lie in granting additional powers to an administrative body to address cases that the OPGT does not have the mandate to investigate, as recommended by the Law Commission of Ontario in its interim report, *Legal Capacity, Decision-making and Guardianship*.[48]

However, Bill 148's mandatory reporting requirement for health care professionals does not offer solutions to the problems it seeks to resolve. As noted above, reporting in and of itself does not necessarily stop the abuse or solve the problems that lead to the abuse. Reporting is not a guarantee that the abuse will be confirmed, resolved or stopped. This legislation ends the obligations of the person making the report after the report is made, but does not offer any guidance regarding the assistance that can be provided to a person. Other than guardianship, no remedy to the abuse is offered, nor is any assistance to the victim of the abuse suggested.

[48] See Law Commission, *Interim Report: Legal Capacity, Decision-making and Guardianship*, online:<http://lco-cdo.org/en/capacity-guardianship-interim-report>, Draft recommendation 27 at p. 220

Ontario deserves a solution that is not overly broad, intrusive and that has proof of effectiveness. Ontario deserves a solution that actually improves the situation of those experiencing elder abuse, rather than worsening a difficult situation.

SUBMITTED ON BEHALF OF THE ADVOCACY CENTRE FOR THE ELDERLY

Judith Wahl
Executive Director
Barrister and Solicitor

Bernadette Maheandiran
Staff Lawyer

Terri Stein
Law Clerk