FAIRE'S PERSPECTIVES

ON THE

LEGISLATIVE REVIEW COMMITTEE'S REPORT
ON THE
PROTECTION FOR PERSONS IN CARE ACT

RESPECTFULLY SUBMITTED TO THE
HONOURABLE GENE ZWOZDESKY
MINISTER OF COMMUNITY DEVELOPMENT

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PERSPECTIVES

PART ONE: BACKGROUND

1. Government Powers Under the *Protection for Persons In Care Act (PPCA)*

The *PPCA* gives the Alberta government the power to act as *intake officer, investigator, and "quasi judge and jury" in cases of alleged abuse and neglect of vulnerable adults in government-funded care settings, including long-term care facilities. [* receives and screens reports of abuse allegations]

Discussion

In the 2001-2002 fiscal year, two-thirds (66%) of the 542 reports of alleged abuse were dismissed and only 5.1% of these cases were referred to the police for investigation. However, according to lawyer/researcher, Charmaine Spencer, over 57% of the reports involved allegations that potentially held some criminal law elements. The high rate of dismissed cases and the low rate of referred cases to the police suggest alleged victims in these settings may not be receiving the protection and benefit of the law. In turn, this suggests the *Act* may be sufficiently flawed to violate the victim's rights of equality under the *Canadian Charter of Rights and Freedoms.*

Canadian Charter of Rights and Freedoms

Section *15: Every individual is equal before and under the law and has the right to equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.*

The following examples represent flaws in the *Act* that, in FAIRE's view, could result in the unanticipated violation of victims' rights entitlements under the *Charter.*

i. Section 8(2) of the *PPCA* requires the appropriate Minister or the investigator to refer a complaint to the police, if, in their opinion the complaint could constitute an offence under the Canada Criminal Code. This raises important questions.

- Should not all alleged abuses be reported to the police by victims, their families and witnesses to determine which cases constitute a criminal offence?
- If the Minister or the investigator does not have the proper knowledge and expertise to determine what constitutes a criminal offence, what is the likelihood that the victim's abuse will be reported to the police?
- If there are no safeguards to ensure that crimes are being recognized at the Ministry level, and the investigative and facility levels, does this not increase the likelihood that offences will be overlooked and go unreported to the police?

ii. Section 5(1) of the Act states: "E*very agency shall have the duty to protect the clients it serves from abuse …*" However, the *Act* has no mechanism to hold agencies accountable when they breach their lawful duty. Does this not protect the offending agency from being sanctioned? And does this not increase the likelihood of re-victimization?

iii. The Department of Community Development defers allegations of abuse by health care professionals to their respective bodies for internal investigation and recommendations. Will this not jeopardize the victim's right to a proper and impartial investigation?

iv. Under the *Act*, there is no requirement for contracted investigators to have the skills, knowledge and expertise required to conduct a proper investigation. Does this not impinge on the victim's right to an effective investigative and resolution process?

2. Public Perception

In theory, the *Act* recognizes residents' right to abuse and neglect protection. However, in practice (as suggested previously), the *Act* may function in a way that inadvertently violates residents' *Charter* rights of equal protection and benefit of the law. The general public and legal community have not had the opportunity to engage in discussions and debate about this potential effect or other rights impingements. As a result, there is a naïve inclination to view and support the *Act* as an added protection and benefit, despite the lack of evidence to that effect.

3. Redundant Mandates

The mandates of government-contracted investigators under the *PPCA* and government-appointed investigators under the *Health Facilities Review Committee Act* are almost identical. In FAIRE's view, this creates redundancy which suggests an inefficient use of taxpayer dollars.

4. Restricted Composition of the Review Panel

The appointed review panel consists of three government MLAs and four high profile long term care owners/operators. In the April 2002 government news release and the Committee's report, industry representatives are presented as "*public*" members. FAIRE argues the industry is a misrepresentation of the "true" public. We also argue that the composition of the panel disregards the need for:

- safeguards at the review table to prevent industry and government from using their positions for their own vested interests and gain;
- diverse representation, views, experiences and expertise at the review table to ensure broad debate, constructive dialogue and sound decision-making.

5. Consultation Sessions

Participants were mainly long-term care owners/operators, regional health authority representatives and government bureaucrats. Participation by the general public required an invitation by government. Input was restricted to opinions on areas of the *Act* predetermined by the review committee. Participants were not required to substantiate their opinions. No effort was made to determine consensus. No discourse, dialogue, information sharing, debate was allowed. In FAIRE's view, the restrictions that dominated these sessions seriously compromised the value, fairness and credibility of the input derived from these sessions and, ultimately, the Committee's report.

PART TWO: THE REPORT'S RECOMMENDATIONS

Recommendation 1.1

The PPCA should include a strong statement of guiding principles and objectives to reflect the educative and preventive nature of the legislation.

The nature of the *Act* is NOT stated in the legislation. Rather, it has evolved external to the *Act* apparently at the Alberta Community Development level. Since the educative-preventative approach has proven inadequate to deterring or preventing abuse, what is the justification for recommending that it persist? We also question why the educative and preventive nature of the Act is recommended over the residents' right to protection and security, and equal access to and benefit of the law.

Recommendation 2.1

The PPCA should be expanded to apply to all adults in care who receive services from agencies or bodies that receive funding from the Government of Alberta.

Since the *Act* has no power to protect persons in care from abuse or to provide victims access to justice, why subject MORE vulnerable people to its impotence? If a larger population came under the *Act*, isn't it likely that MORE victims will be robbed of their right to justice and due process? Is a greater application of this *Act* a prudent use of taxpayer dollars? Would Albertans not get more value for their money if government targeted funding toward:

- creating specialized detective units and a dedicated court to deal with the issue?
- expanding the mandate of the provincial ombudsman to include long-term care?
- establishing/supporting autonomous family councils in long-term care facilities?
- establishing community initiatives dedicated to tackling elder abuse?

Recommendation 3.1

The definition of abuse should focus on the impact or ***harm*** *to the alleged victim and the requirement of "intent" should be removed. Abuse should include actions that have the potential to cause, or are reasonably likely to cause, serious harm.* ***Abuse should not be defined to include systemic quality of care issues.*** [Emphasis added]

i. Actions or inactions that cause actual or potential harm, or premature death could constitute a criminal offence. Presumably, these actions would obligate the Minister, the investigator, the facility, the witness and other informed persons, including families to refer such allegations to the police. FAIRE suggests that shifting the focus to "harm" would require a punitive consequence which conflicts with recommendation 1.1. proposing the *Act* remain non-punitive ("*educative and preventive*"). We also suggest the "harm" criteria is beyond the mandate of Community Development and would obligate the Alberta government to move the *Act* under the Ministry of Justice.

ii. The second part of this recommendation **rejects** the inclusion of **systemic abuse and neglect** in the definition. **Systemic abuse and neglect** is defined as "*harmful situations*

iii. *created, permitted or facilitated by procedures and processes within institutions*" [Spencer, C.]. Such harmful situations in Alberta's long-term care facilities are many and obvious. They include low staff-to-patient ratios; a workforce hampered and stressed by inadequate skills, knowledge and training, and; ineffective inspection and enforcement systems. These situations exist because the Alberta government persistently refrains from addressing them in regulation. As a result, increasing numbers of residents are paying the price, sometimes with their health and lives. So why was this critical piece rejected? Given the composition of the review panel, one could reasonably argue the exclusion is related to self-protecting interests.

It is also important to examine why * **neglect** and ** **the violation of human and civil rights** were omitted from the definition. The exclusion may reflect an oversight in the review process. It may just as easily represent a lack of effort or will to consider expanding the definition to include these acts .
[* *the failure to meet the needs of a resident unable to meet them herself or himself* - Spencer, C.]
[** *the denial of an older adult's basic rights (according to the Canadian Charter of Rights and Freedoms, the United Nations Declaration of Human Rights and the United Nations Declaration of the Rights of Older Persons*" - Spencer, C.]

Recommendation 3.2

The term "alleged abuser" should be defined to include: ***other clients****, health care professionals and other service providers, employees, contractors, family members, volunteers and any other third-party individuals.* [Emphasis added]

- Including "**other clients**" would potentially victimize the very people the *Act* was meant to protect. Facilities have an obligation to monitor residents with behavioral problems and to assess for, and address risk factors that contribute to the occurrence of resident-to-resident abuse. This recommendation would wrongly allow facilities to abdicate their responsibility by shifting the "blame' onto persons entrusted to their care.

- Excluding "the facility" or "owner/operator" in the definition of alleged abuser is cause for concern and it is important to consider what the reasons are. It could reflect an oversight in the review process, or a narrow view of what the definition should encompass. However, it could just as easily represent self-serving motives of the industry.

Following are brief comments on some of the remaining recommendations.

Recommendation	Comments
4.1 proposes *"agencies as generally conducting initial investigations of alleged abuse .."* with government *investigating "only as a last resort or in special circumstances."*	What is the likelihood of: • an impartial investigation? • the incident being trivialized or swept under the rug? • victims' best interests prevailing over other interests?
5.4 proposes "*agencies, alleged victims and guardians/agents should be notified of the commencement of investigation and outcomes*".	• "Notified" how? In writing? • Notification should extend to the family and substitute decision-maker. • Investigations can take place days or weeks after an alleged incident. Families of victims should be notified upon recognizing that abuse <u>may have occurred</u>.
Discussion (page 13) proposes *"Participation of witnesses and alleged abusers in the investigation should remain voluntary. Witnesses and/or alleged abusers should not be compelled to provide information during an investigation."* *"Current legislation provides no discretion to address the merits of individual complaints."*	• What is the likelihood that this approach would be tolerated in a court of law? • Would this approach not result in automatic and perhaps unwarranted dismissal of the allegation? • How does this approach serve the best interests of the victim? If agencies are authorized to decide the merits of a complaint, what is the likelihood of: • impartial decision-making? • the complaint being trivialized or swept under the rug? • the victim's interests prevailing over other interests?
Discussion relating to recommendation 7.1 *"The Committee suggests that recommendations arising from investigations should be primarily oriented to prevention…"* *"Ministerial approval or rejection of recommendations is not binding on agencies …"*	• If recommendations are oriented toward "prevention" – yet the recommendations are not binding on the agency – how will abuse be prevented? • Since an investigation results in recommendations that are not binding on the agency, what is the purpose or value of an investigation – or indeed, the *Act* itself? • Since costly investigations result in recommendations that are not binding on the agency, what value are taxpayers getting for the money spent on investigations?

FAIRE's POSITION

From FAIRE's perspective, the *Act* and the recommendations for reform are sufficiently flawed to inadvertently jeopardize or violate the victim's right to equal protection and equal benefit of the law as set out in the *Canadian Charter of Rights and Freedoms.* We also believe that the many deficiencies of the *Act* have rendered it powerless to protect persons in care from abuse and neglect or victims from being re-victimized. For these reasons, FAIRE does not support the *Protection for Persons In Care Act* or the recommendations in the report.

PROPOSAL

FAIRE proposes the *Protection for Persons In Care Act* be revoked and replaced by legislation that establishes a Vulnerable Adults Protection Commission. This Commission would be modeled after the Massachusetts Disabled Persons Protection Commission created in 1987 as an **independent** state agency. It was established because crimes committed against persons with disabilities were not being recognized or reported to the appropriate authorities. We believe the same can be said of many cases under the PPCA system.

The following highlights some key differences between Alberta's *Protection for Persons In Care Act (PPCA)* and the Massachusetts' *Disabled Persons Protection Commission (DPPC):*

Alberta's PPCA	Massachusetts DPPC
Abuse/neglect allegations are reported to government.	Abuse/neglect allegations are reported to a State Police Detective Unit within the Commission.
The government or the investigator determines which cases, in their opinion, constitute criminal activity.	The State Police Detective Unit determines which cases constitute criminal activity
There is no investigative oversight or protective services for victims.	The Commission's Oversight Unit monitors each case. Oversight officers ensure the victim is safe, the report is timely, the investigation is thorough, and that protective services are provided when abuse is substantiated. To confirm that necessary protective services are implemented, Oversight Officers monitor cases until all risk of harm to the victim is eliminated.
There is no indication that the government's database is analyzed for these purposes.	Information in the Commission's database is analyzed continually in an effort to identify potential preventative measures to be implemented and/or systemic challenges needing attention.
There is no provision in the Act to receive and screen reports of deaths of persons in government-funded care settings.	The Commission receives and screens reports of all deaths, when an individual has died while in the care of a state or private service provider.

CONCLUSION

FAIRE encourages the Minister of Community Development to look upon this submission as an opportunity to analyze the *PPCA* and the Committee's recommendations from a broader perspective. We also recommend that future deliberations and decision-making concerning the protection of Alberta's citizens in care be based on the principles set out in th*e Canadian Charter of Rights and Freedoms, the United Nations Declaration of Human Rights and the United Nations Declaration of the Rights of Older Persons*. At this time, we wish to thank the Honourable Minister for inviting our comments and perspectives on the report by the Legislative Review Committee.