

A Commentary on the Protection for Persons in Care Act

I. Rationale

It is a fundamental expectation both in law and ethics that patients¹ should not be abused or neglected. The *parens patriae* jurisdiction has historically enabled the courts to protect vulnerable persons.² Recently, statutory protection has also been introduced in Canadian jurisdictions. Adult protection legislation came into force in Alberta on January 5, 1998, with proclamation of the *Protection For Persons In Care Act*.³ The purpose of this Act is to protect adults in care by requiring criminal record checks for employees and volunteers, mandatory reporting of abuse, and investigation of complaints. The good intentions of this legislation are obvious, but a review of the details in this legislation reveals some concerns.

II. Overview of the Law

This section will outline the legislation in Alberta. Adult protection legislation in other jurisdictions and related legislation will also be canvassed.

A. Protection for Persons in Care Act

This Act requires every individual or service provider who “has reasonable and probable grounds to believe and believes that there is or has been abuse against a client”⁴ to report the abuse to the Minister of Community Development or as specified. A client is defined as any adult who receives services from an agency.⁵ The duty to report exists even if the information is confidential and disclosure is prohibited under other legislation but does not extend to information covered by solicitor-client privilege.⁶ Complainants are protected, as agencies may receive a fine up to \$25,000 and individuals may receive a fine of up to \$5,000 for discontinuing or threatening to discontinue services or for adverse employment action.⁷ Failure to report as well as false complaints are offences punishable with a maximum fine of \$2,000 and in default, a maximum of six months imprisonment.⁸ The Minister must also advise the governing

body of a person registered under a professional or occupational statute who fails to report.⁹

The definition of abuse in the Act is:

- (i) intentionally causing bodily harm
- (ii) intentionally causing emotional harm, including but not limited to, threatening, intimidating, humiliating, harassing, coercing or restricting from appropriate social contact,
- (iii) intentionally administering or prescribing medication for an inappropriate purpose,
- (iv) subjecting to non-consensual sexual contact, activity or behaviour,
- (v) intentionally misappropriating or improperly or illegally converting money or other valuable possessions, or
- (vi) intentionally failing to provide adequate nutrition, adequate medical attention or other necessity of life without a valid consent;¹⁰

This definition only explicitly uses the word “abuse” but arguably this definition also covers neglect, as the last subsection includes the failure to provide necessities of life. Only abuse which occurs after the Act comes into force is reportable.¹¹ It remains to be seen how these provisions will be interpreted in situations involving aggressive or violent patients who are cognitively impaired¹² or in emergency departments and mental health settings. Medications prescribed for confused patients, in end-of-life situations and in conjunction with use of restraints may be controversial. For example, due to the variety of approaches in the use of restraints,¹³ could the use of chemical restraints be construed as administering or prescribing medication for an inappropriate purpose?

The agencies covered by the Act include publicly funded agencies or institutional settings such as hospitals, lodges, nursing homes, facilities under the *Social Care Facilities Review Committee Act*,¹⁴ and institutions or organizations designated by regulation.¹⁵ Agencies have the obligation to make this Act available to service providers, employees and clients.¹⁶ This obligation has resource implications for

agencies. A criminal records check is required for successful applicants for employment and new volunteers.¹⁷

The report of abuse may be made directly to an entity with authority to investigate such as to the police or to the Minister of Community Development.¹⁸ The Department of Community Development must refer the report to the appropriate Minister who must appoint a person to investigate as quickly as possible.¹⁹ The investigator is entitled to enter an agency at any reasonable hour and may inspect and copy records of the agency.²⁰ An investigator may obtain a court order for access when refused entry or records.²¹ Records available to the investigator do not include financial operational records or medical records unless the person or guardian consents to release of the medical record.²²

The investigator must prepare a final report to the Minister responsible for the agency involved, and may make recommendations including agency review or alteration to funding for Crown agencies, disciplinary action for employees or service providers, dismissal of the complaint, or any other appropriate recommendation.²³ Legal action may not be taken against the investigator for anything done in good faith under the legislation.²⁴

The responsible Minister may approve the recommendations in whole or part, reject the recommendations, order further investigation, or take any other action that the Minister deems appropriate.²⁵ The decision of the Minister is binding.²⁶ The Minister must provide a copy of the decision to the person reporting and to the agency involved.²⁷

B. Adult Protection Legislation in Other Canadian Jurisdictions

Adult protection legislation is in place in many American states²⁸ and in a number of Canadian jurisdictions. Adult protection legislation varies a great deal in regard to which groups are protected, whether reporting is voluntary or mandatory, and the obligations which arise for the responsible entity. The following provides an overview of adult protection legislation in other Canadian jurisdictions.

The Atlantic provinces were the first Canadian jurisdictions to enact dedicated adult protection legislation. In 1973 Newfoundland passed the *Neglected Adults Welfare Act*,²⁹ which created a mandatory reporting obligation for “any person who has information which leads him to believe that an adult is a neglected adult...”.³⁰ A “neglected adult” is defined as an adult that is incapable of properly caring for himself due to physical or mental infirmity, is not covered by the mental health legislation, not receiving proper care

and attention, and refuses or is unable to care for himself.³¹ It is interesting to note that the Newfoundland statute encompasses neglect but does not explicitly include abuse of adults.

Later legislation in the Atlantic provinces covers both neglect and abuse of adult persons. In 1980 New Brunswick followed with the *Child and Family Services and Family Relations Act*,³² which addresses child and adult welfare and includes disabled³³ and elderly adults.³⁴ A neglected adult includes a disabled or elderly person who is incapable of caring properly for himself and is not receiving proper care and attention, or who refuses or is unable to make provision for proper care and attention.³⁵ An abused adult includes a disabled or elderly person who is a victim or is in danger of being a victim of physical abuse, sexual abuse, or mental cruelty.³⁶

The next Atlantic province to legislate in this area was Nova Scotia, which enacted the *Adult Protection Act*,³⁷ and created a mandatory reporting duty for “every person who has information...indicating that an adult is in need of protection.”³⁸ An adult is defined as a person sixteen years or older.³⁹ An adult “in need of protection”⁴⁰ is defined to include the categories of persons covered by the definitions of neglected and abused adults in the New Brunswick legislation.

In 1988 Prince Edward Island enacted the *Adult Protection Act*,⁴¹ which enables voluntary reporting when “a person is, or is at serious risk of being, in need of assistance or protection.”⁴² An adult person “in need of protection” means “requiring legally authorized protective intervention in order to preserve essential security and well-being...owing to physical or mental infirmity or disability or other incapacity... i) is a victim of abuse or neglect by, or otherwise put in danger by behaviour or way of life... (ii) is incapable of fending for himself and is unable to make provision for necessary care, aid, or attention, or (iii) refuses, delays or fails to arrange for or comply with necessary care, aid or attention.”⁴³ This legislation enables reporting at an earlier stage, for persons “in need of assistance,” defined to include persons at “serious risk of falling into need of protection.”⁴⁴

A different approach is evident in the adult protection legislation which has been enacted in both Ontario and Manitoba. The 1992 Ontario legislation⁴⁵ applies to vulnerable persons sixteen years of age or older, and defines a vulnerable person as one “who because of a moderate to severe mental or physical disability, illness or infirmity,... (a) is unable to express or act on his or her wishes or to ascertain or exercise his or her rights, or (b) has difficulty in

expressing or acting on his or her wishes or in ascertaining or exercising his or her rights.”⁴⁶ This Act makes extensive provision for the assistance of vulnerable persons, access to records, and disclosures, procedural fairness and due process.⁴⁷

Manitoba enacted adult protection legislation in 1993⁴⁸ which created a mandatory reporting obligation for “a service provider, substitute decision maker or committee who believes on reasonable grounds that the vulnerable person... is or is likely to be abused or neglected...”⁴⁹ A vulnerable person is defined as an “adult living with a mental disability who is in need of assistance to meet his or her basic needs with regard to personal care or management of his or her property.”⁵⁰ Neglect means “an act or omission whether intentional or unintentional, that is reasonably likely to cause death or that causes or is reasonably likely to cause serious physical or psychological harm...or significant loss to his or her property.”⁵¹ Abuse means “mistreatment, whether physical, sexual, mental, emotional, financial or a combination thereof, that is reasonably likely to cause serious physical or psychological harm to a vulnerable person, or significant loss to his or her property.”⁵² This legislation is similar to that of Ontario with regard to the extensive attention to assistance for the vulnerable adult and to procedural fairness and due process requirements.

Other provinces with adult protection legislation address the obligation to investigate following knowledge of the alleged abuse or neglect.⁵³ Extensive powers are given to access information, make decisions, and communicate decisions.⁵⁴ Most of the statutes make extensive provision for intervention and support of the abused or neglected adult and explicitly outline obligations to vulnerable persons.⁵⁵

The legislation in Ontario and Manitoba is comprehensive and extensively addresses issues such as due process.⁵⁶ The legislation in New Brunswick, Newfoundland, Nova Scotia and Prince Edward Island also makes provision for due process,⁵⁷ but to a lesser extent than Ontario and Manitoba. However, the Ontario and Manitoba provisions are lengthy. Service providers and agencies responsible for implementation may find these statutes convoluted and cumbersome. In contrast, the Alberta legislation is concise and relatively straightforward.

C. Other Relevant Legislation

Although the focus of this discussion is adult protection legislation, such legislation does not exist in isolation. Other provincial legislation touches upon related issues such as mental health, family violence, dependent adults or trusteeship and guardianship, health professions, civil rights,

and financial and personal directive legislation.⁵⁸ It is important to keep related legislation in mind to complete the picture of adult protection. This legislation may be addressed in consequential amendments to adult protection legislation to clarify which legislation is paramount.

It should also be noted that protection exists for other age groups in other legislation. For example, in Alberta, children or persons under 18 years of age in need of protection are covered under the *Child Welfare Act*.⁵⁹ A child engaging, or attempting to engage, in prostitution is also a child in need of protection under the new *Protection of Children Involved In Prostitution Act*.⁶⁰

Before the *Protection for Persons in Care Act* came into force, various legislative provisions existed that provided some protection to persons receiving institutional care. For example, the Alberta Health Facilities Review Committee existed pursuant to the *Health Facilities Review Committee Act*⁶¹, with authority to investigate complaints against health facilities⁶² and to make recommendations. The Minister of Health and Wellness (formerly the Minister of Health) or designate has the authority to conduct inquiries and investigations and take action in various health care settings.⁶³

Residents in Alberta nursing homes had some legislative protection from financial abuse in the safeguards which existed for the care of residents’ property and money, such as the provision which precludes an operator from any dealings with a resident’s money unless written authorization is given by the resident or the legal representative of the resident.⁶⁴

Federal legislation such as the *Canadian Charter of Rights and Freedoms*⁶⁵ and the *Criminal Code*⁶⁶ of Canada must also be kept in mind. The *Charter* enshrines rights such as the right to life, liberty and security of the person,⁶⁷ the right to be secure against unreasonable search and seizure,⁶⁸ the right not to be arbitrarily detained or imprisoned,⁶⁹ the right not to be subjected to any cruel and unusual treatment or punishment,⁷⁰ and the right to be treated equally and without discrimination based on physical or mental disability or age. The *Criminal Code* has many offences which could relate to adult protection in extreme cases,⁷¹ such as criminal negligence causing bodily harm or causing death where there has been a “wanton or reckless disregard for the lives or safety of other persons.”⁷² Criminal charges could also be laid for the failure to provide the necessities of life to a person under one’s charge⁷³ in a situation of extreme abuse or neglect of an adult.

The common law or judge-made law must also be considered in adult protection issues. Canadian courts have shown little tolerance for health care providers who have abused or neglected persons in their care, as the cases which have been litigated in this area have consistently found that providers are held to high standards of conduct and that staff abuse of clients is not tolerated,⁷⁴ even in the most trying of circumstances. Similarly, health care facilities have been liable for the failure to take reasonable care to protect one resident from another,⁷⁵ due to the high duty imposed to provide a safe environment for vulnerable persons in institutions.⁷⁶

Ideally the common law needs to achieve the appropriate balance between the rights of employees and the rights of patients. Civil actions including actions in negligence, assault and battery, breach of contract, defamation, and false imprisonment are available to address specific issues which could arise in adult protection situations. However, legal remedies are seldom sought by or on behalf of abused adults for many reasons including the desire to avoid publicity and the ineffectiveness of these remedies for situations of abuse.⁷⁷

III. Analysis of the Protection for Persons in Care Act

A. The First Eighteen Months: Reporting Statistics

The experience in Alberta with the Act being in force for eighteen months (January 5, 1998 to June 30, 1999),⁷⁸ is that a total of 1,176 reports have been made under this legislation. A total of 799 of these reports fell under the authority of the (then) Minister of Health, 260 fell under the (then) Minister of Family and Social Services, and 117 fell under the Minister of Municipal Affairs. Recent governmental organizational changes have altered some of the areas of responsibility of these ministers, so future statistical comparisons must be made with caution.

The highest incidence of alleged abuse by type was emotional abuse (775), followed by physical abuse (613). The two highest incidences by category of abuser were abuse by staff (593) and abuse by residents (510).

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Note that earlier reports included cognitively impaired residents as alleged abusers, but this type of allegation is no longer included in the reports. Third party financial abuse is now reported to the police. These differences in the data recorded may result in the appearance that the percentage of reports involving staff are

increasing, when this may not be correct. One situation of reported abuse may involve more than one type of alleged abuse and more than one category of alleged abuser.

Within Alberta Health and Wellness (then Alberta Health) 91% of the allegations relate to long term care facilities. Forty-three percent (43%) of the reports were made against facility staff. The allegations against facility staff included 110 professional staff (e.g. physicians, registered nurses, registered psychiatric nurses, licensed practical nurses and social workers) and 237 non-professional staff (e.g. nursing attendants or aides, housekeeping and trades personnel). Allegations were also made against other residents, family members and third parties such as trustees.

The *Protection For Persons in Care Act* in Alberta will now be analysed, with a particular focus on reporting requirements and criminal records checks.

B. Reporting

The Alberta legislation requires all situations of abuse against a client to be reported. The definition of abuse⁷⁹ is narrow in the Alberta legislation, as only intentional behaviour is covered even under the section which appears to be addressing neglect.⁸⁰ Neglect is often defined to include both intentional and unintentional behaviour. It is logical that both aspects would be included in the definition as the adult in need of protection may be injured to the same degree, regardless of the existence or lack of intent, for example when causing bodily harm. It may be particularly difficult for investigators to ascertain that intention existed in a particular case, without which an abuser cannot be held accountable under this legislation.

Although the legal definition of abuse may appear clear, the difficulty of defining and identifying abuse in a standardized manner in the clinical setting should not be underestimated, even with improved assessment criteria.⁸¹ Substantial penalties and sanctions exist in the Alberta legislation for the failure to report. Health care professionals could, however, be concerned about complying with these reporting

requirements in view of the uncertainties when identifying abuse in the clinical setting and when considering the serious consequences for the alleged abuser.

The obligation to report abuse applies to every individual and service provider. A service provider means “a person who provides services to a client and is employed by or provides the services on behalf of an agency.”⁸² This part of the Act may apply to physicians, students, volunteers, and independent contractors in addition to employees. It is not clear whether other individuals or groups such as researchers or persons not providing services to clients are covered.

It is interesting to note that the definition of agency in this legislation does not include the Regional Health Authorities, Alberta Mental Health Board and the Alberta Cancer Board, although these entities operate agencies which are covered under this definition such as hospitals. A piecemeal approach is evident as regional services such as public health and home care services not provided in hospital are not covered in the definition of agency. Personal care homes and family care homes where care is provided in the home are also not covered. It is unclear whether private facilities and agencies contracted to agencies as defined in the Act are covered by the legislation.

The obligation to report abuse applies to all individuals and “service providers”. However, criminal record checks must be conducted by an “agency” for all successful applicants for employment and all new volunteers. The difference in the definition of “service provider” and “agency” creates two different groups with different obligations under this legislation.

One concern is that the legislation could be misused as a potent weapon by special interest groups or persons with an axe to grind where the real issue may be something other than abuse, such as complaints about access to services. Upon receipt of a complaint the appropriate minister must appoint an individual to investigate and prepare a final report for the appropriate Minister. It should be emphasized that after completing the investigation, the investigator may recommend a variety of options including dismissal of the complaint. However, it is recognized that even when a complaint is eventually dismissed, a large amount of time, anxiety, and resources may be invested by the agency in responding to the allegations. It should be remembered that it is an offence to make a complaint knowing it to be false, and that a complainant is not protected against an action

when a complaint is made maliciously or without reasonable and probable grounds. However, these remedies may not be possible for anonymous complaints.

It may be difficult for a complainant to determine the appropriate entity to contact when reporting abuse, particularly with the recent government reorganization with

major changes to ministerial titles and areas of responsibility. The report is to be made “to the Minister of Community Development or a police service or a committee, body or person authorized under another enactment to

investigate such an abuse.”⁸³ The Minister of Community Development has overall responsibility for this legislation. However, complaints may involve other government departments responsible for the entities described in the definition of agency such as hospitals and nursing homes, lodges and facilities defined in the *Social Care Facilities Review Committee Act*.

A toll free number is available during business hours for reporting non-crisis situations (1-888-357-9339). A Government of Alberta brochure indicates that the police or an ambulance should be called when a person’s life or well-being are in immediate danger.⁸⁴

The entity with the authority to receive and refer a complaint may be different from the entity with the authority to investigate a complaint. All entities appear to have the authority to refer a complaint on as appropriate. The obligation of the Minister of Community Development appears to be to make the appropriate referral.⁸⁵ Leaving the question as to whether this Minister would ever have authority to investigate a complaint of abuse. In contrast, the Minister responsible for a particular area may have the responsibility to refer as well as to investigate due to powers under specific legislation. For example the Minister of Health and Wellness has the authority to investigate agencies covered by this legislation and within his jurisdiction such as hospitals and nursing homes.

This legislation may lead to duplication of investigations, as agency policy may require an immediate internal response and investigation of all allegations of patient abuse. Even before this new legislation one situation or complaint may have necessitated a number of investigations each with a different focus. For example: internal review, peer review, professional disciplinary body, and various other forms of

The legislation does not provide the option of informal resolution regardless of circumstances or the wishes of the abused person.

administrative tribunal review, Health Facilities Review Committee, and other committees and review by the police. Each of these reviews could consume considerable resources⁸⁶ without providing any additional protection to the abused person or society.

Duplication is also a concern due to repeated questioning which may be required with regard to a sensitive and confidential issue for the patient and family. The legislation does not provide the option of informal resolution regardless of circumstances or the wishes of the abused person. A formal approach is mandated, for example the Minister must appoint an investigator and reports must be prepared for the Minister every 30 days until the investigation is completed. This could result in the external investigation providing a slower response than the internal investigation, with decisions being internally implemented before the results of the external investigation are communicated to the agency. It might have been more reasonable to legislate a discretionary authority for the Minister or responsible entity to conduct an investigation when needed in the circumstances.

A further issue which arises is whether the information gathered under this legislation is privileged, that is, protected from subsequent disclosure even in legal proceedings. Solicitor-client privilege is preserved in the Act for reporting purposes,⁸⁷ as solicitor-client privilege appears to be the only exception to the reporting requirement. However, once a situation has been reported under the Act, investigation and reporting are required and a copy of the decision of the Minister must be provided to the complainant and the agency. It seems unlikely that solicitor-client privilege would apply to information gathered pursuant to this legislative requirement. However, the question of whether or not privilege could exist in specific situations should be further explored.

The Alberta adult protection legislation is sparse on issues such as due process and procedural fairness, which other jurisdictions such as Ontario and Manitoba address at length. Notification of the allegation to entities such as the regional health authority responsible for the agency involved is not required. This is a concern due to the variety of relationships which exist between regional health authorities and agencies including independently operated agencies. Recommendations may be made which may have a substantive impact including review and alteration in funding. The potential effect upon the region such as damage to reputation and the possibility of subsequent legal proceedings against the region are serious considerations.

Notification of the alleged abuser is not even addressed within this legislation. The *Charter* requires that persons charged with an offence have the right to be informed of the specific offence without unreasonable delay.⁸⁸ Allegations of abuse create a potentially serious situation for the person accused. Whether or not a complaint is found to be substantiated by the investigator, the allegation alone may have a marked effect upon an individual's career. The legislation requires the Minister to provide a copy of the decision to the person who reported the abuse and to the agency. However, there is no requirement to provide a copy of the decision to the alleged abuser. Similarly, there is no requirement to provide a copy of the decision to the person who has allegedly been abused.

One of the major difficulties with this legislation is the loss of autonomy of competent adults. Many of the adults covered by this Act are mentally competent persons making their own decisions, pursuant to their right to self-determination and autonomy. This Act covers all adults receiving services from an agency, in contrast to other jurisdictions where adult protection applies to adults who are unable to properly care for themselves. The service received may be as fleeting as a minor laboratory or radiographic procedure or a clinic visit at a hospital. It is acknowledged that the literature indicates that a variety of factors influence abused persons who may choose not to report the abuse or seek help.⁸⁹ However, it is argued by the writer that particularly when the client is competent, the ultimate decision should be left with the client to determine what is in their best interest.

The right to autonomy of a mentally competent patient has long been protected by principles of ethics⁹⁰ as well as law. The most insignificant medical procedure could not be done without first obtaining informed consent from the client.⁹¹ The mentally competent client has the legally protected right to refuse unwanted medical treatment, even where refusal may result in death.⁹² Clients have increasing control over their lives with new legislation which creates the legal ability to appoint enduring powers of attorney for financial and personal matters and to enforce living wills.⁹³ Ironically, control over the disclosure of such sensitive information as reporting abuse has been taken away without any requirement for client consent, consultation or other involvement.

Competent clients may resent this intrusion in their lives. For instance an individual, particularly a prominent or public figure, may wish to choose when and to whom information about a spousal assault is disclosed. Once the information is disclosed, for example to the police, criminal charges may be laid and public legal proceedings begun.

The client must face the consequences of disclosure. Disclosure may be harmful for the client; for example, reputation and career opportunities may be jeopardized. The argument can be made that the competent client should remain the decision maker in regard to when and to whom the information is disclosed.

When the abuser provides financial support for the person abused as well as other dependents, financial hardship may result from the disclosure. It is interesting to note that although a mandatory reporting requirement exists, the legislation does not establish an explicit obligation upon the Minister of Community Development to advocate for or protect or assist the abused person. In contrast, other jurisdictions such as Manitoba and Ontario have extensive provisions setting out responsibilities to assist the abused adult.⁹⁴

The client who returns to the community after abuse is reported may be in serious danger, where protections such as restraining orders may be inadequate. Review of bail procedures and availability of restraining orders are currently being discussed in relation to other legislation in Alberta. However, these measures are clearly not a sufficient response. Client danger may be escalated by the mandatory reporting of abuse, and yet the legislation does not establish a parallel obligation to protect the abused person.

The client may not have participated in the disclosure of information and may not have had the opportunity to make alternate plans. Although abuse cannot be condoned, the right of the client to make the decision to temporarily stay in an abusive situation or to choose the time of disclosure may be an important component in achieving the psychological strength and developing the support system needed to make a successful change.

Another difficulty with this legislation is the erosion of privacy and confidentiality of health information. Clients disclose information to health care professionals with the expectation that the information will be kept confidential and used to provide appropriate health care services, and that disclosures to third parties will be made only with patient permission.⁹⁵ Clients do not expect health information to be used for a different purpose than the purpose for which it was disclosed, especially identifiable information. This legislation was proclaimed in force when Bill 30, the proposed provincial health protection legislation, was under intense discussion. Erosion of privacy of health information in new legislation may create distrust of future initiatives.

Clients do not regard health care professionals as an extension of law enforcement agencies. When competent clients wish a situation to be reported to the police, professional disciplinary body, or the Health Facilities Review Committee, they may take this step on their own. In the opinion of the writer, clients expect health care professionals to encourage them to take appropriate steps, and to assist them for example with support services, resources, or referrals to appropriate professional services.

Mandatory reporting of abuse may be viewed by the client as yet another invasion of privacy and loss of control over the release of health information, particularly when reported against the express objection of the client. These situations may create ethical conflicts between legislative obligations and agency policies, and long standing values and codes of ethics of health care professionals.

Patients may have no idea when they release information to a service provider or an agency, that their physician or nurse has a mandatory duty to report abuse even in situations where the client expressly states that the information is not to be disclosed. Others may refuse medical treatment to avoid unwanted disclosure of health information, for example in situations involving allegations of criminal sexual assault where health information could be compelled by the alleged abuser. Will clients avoid necessary health care to avoid disclosure of abuse against their wishes?

C. Criminal Records Check

This requirement is commendable as this step may provide an extra measure of safety for clients by ensuring that persons with unsuitable backgrounds are screened out and precluded from providing services to clients. Alberta legislation requires agencies to ensure that a criminal records check is provided by every successful applicant for employment and every new volunteer.⁹⁶ A similar requirement was not located in any of the provincial adult protection legislation which has been described earlier. However, similar provisions do exist in some jurisdictions for day care settings, volunteers and for license renewals by professional licensing bodies. It is interesting to note that no penalty exists in this legislation for the failure to comply with this requirement. However, consequences could arise in civil or criminal litigation against agencies failing to meet this legislative standard.

One of the practical issues which arises in the interpretation of the categories of persons who must provide criminal records checks. Does an "applicant for employment" include persons who are not usually considered employees such as physicians, students researchers, and contractors? Similarly,



do the words “volunteer” include all members of Boards of Directors, foundations, auxiliaries and every high school student that helps to organize a raffle? With the focus on individual facilities, must he check be completed again for an employee or volunteer who transfers within a health region? These provisions are left for interpretation and definition at the discretion of each agency.

Some important groups have been excluded from the criminal records check requirement. Physicians are not usually employees in agencies in Alberta, and therefore will not usually be subject to this requirement. It is inconsistent that a new physician who applies to be an employee requires a criminal records check, but a colleague (or the same physician applying at another agency) who is making an initial application for hospital privileges and may be doing identical work, is not required to provide a criminal records check. A health care worker who is a successful applicant for employment in a hospital must provide the criminal records check, but the same individual who is a successful applicant for employment in home care or public health in the same region does not have this requirement.

Similarly, records checks are not required for persons who are current employees or volunteers, although they may be transferring to different areas, sites and facilities of the same agency. It appears that employees or volunteers moving from one hospital to another are required to provide a criminal records check as this requirement applies to every agency. In contrast, if regional health authorities were defined as agencies, employees and volunteers could move within these entities without this requirement.

One of the drawbacks is that criminal records checks may become false security, and result in less attention being paid to other hiring and selection tools such as interviews and references. A clear record could become misinterpreted as an indication that the candidate is suitable for the position. However, a “hit” may mean a variety of things, including a similar or identical name belonging to a different individual than the new applicant for employment or volunteer. A criminal record can be expunged or cleared after a certain length of time based upon the application of the convicted person. It must be emphasised that the records check only indicates convictions. Therefore in cases where persons facing serious criminal charges were not convicted, the criminal record would be clear.

Different law enforcement jurisdictions may provide varying levels of detail, for example whether a person has been repeatedly charged but not convicted of a relevant offence. Databases are not completely current, as data may be backlogged awaiting entry. A person who has moved from

jurisdiction to jurisdiction, may not have a complete record in the jurisdiction of their present residence, or may involve extensive delays. This could create an unfair competitive edge for persons able to produce their criminal records searches with less difficulty. This may decrease the ability to utilize the global market for needed talent and skills. A declining pool of applicants may result which could become problematic with the predicted shortage of certain health care providers, in conjunction with critical staffing levels. The benefit gained in increased patient safety must be balanced against the costs of obtaining criminal records checks. Increased time and resources in processing applications are evident when delays of 10 to 14 days for routine applications are experienced. Even where the cost of the criminal records check is waived by police services for individuals applying as volunteers, the cost of this service is born by the taxpayer. As the risk of patient harm is lowest among persons with little or no access to patients, perhaps persons without direct patient contact could be excluded from future legislative requirements with little increase in risk to patients.

A further practical difficulty once the criminal records check is obtained, is determining the relevance and weight to give the information received. Difficult judgments may need to be made. Where information is misinterpreted or where a difference of opinion exists as to the significance of the information, the applicant for employment may disagree with the assessment made and seek compensation for losses incurred.

Other considerations include the possibility of a “window of opportunity” being lost, for volunteers who may become discouraged and lose interest after a certain amount of aggravation has been experienced and time has passed since they applied. Employees bound by this legislation may have difficulty competing for new applicants for employment when applicants are in short supply and can readily choose other agencies, for example in food and housekeeping service areas.

One of the consequences of this new legislative requirement is the cost of implementation including analysis and planning, development of policy and procedure, staff education, communication, and the cost of labour and resources even where the cost of time required to obtain the criminal records check is passed along to applicants. The cost of any new initiative is an important consideration at this time when the health care system is facing serious resource allocation and cost constraint issues. Ironically, at a time when government is pushing initiatives for deregulation with less red tape and bureaucracy, this legislation establishes further requirements for agencies.

IV. Conclusion

In conclusion, the good intentions of this legislation must be recognized as this step has been taken to protect adults in care from abuse. The very existence of this legislation emphasizes that abuse is unacceptable. However, major differences are evident when it is compared with legislation in other provinces. Application to adults who are mentally competent and generally able to care for themselves, is markedly different from the approach taken in other provinces.

Mandatory reporting of abuse is a blunt instrument which creates troublesome issues such as in the area of confidentiality of health information. The writer would argue in favour of voluntary reporting with client consent and involvement where the client is mentally competent. Mandatory reporting is consistent with the *parens patriae* jurisdiction and is more appropriate where the client is not mentally competent and unable to care for himself. Alternatively, clients could be defined under the Act as persons unable to care for themselves, removing mentally competent adults from this legislation altogether.

The writer would also argue in favour of less emphasis upon reporting of abuse, and greater emphasis upon assisting adults in need of protection. Legislative provision creating legal obligations to provide advocacy services, resources, and support systems for abused adults are essential to enable real change and progress.⁹⁷

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1. The word "patients" herein includes reference to residents and clients.

2. E. Picard & G.B. Robertson, *Legal Liability of Doctors and Hospitals in Canada*, 3d ed. (Scarborough, Ont: Carswell, 1996) at 64; *Re D (S)* (1983), 42 B.C.L.R. 153 (Prov. Ct.) rev'd (1983) 42 B.C.L.R. (S.C.).

3. S.A. 1995, Ch. P-19.5, as am.; Refer to L. Hardingham, "Protecting Vulnerable Persons in Care" (1995) 55:1 Alberta RN 12, for an interesting discussion about the development and introduction of this legislation.

4. *Ibid.* s. 2(1).

5. *Ibid.* s. 1(c).

6. *Ibid.* s. 2(2)(3).

7. *Ibid.* s. 4.

8. *Ibid.* ss. 2(5) & 11.1.

9. *Ibid.* s. 2(4).

10. *Ibid.* s. 1(a).

11. *Ibid.* s. 2(6).

12. J. Thomson, "Acting Upon Alberta's Protection for Persons in Care Act" (1998) 9:2 Health Ethics Today 6.

13. J. Hirdes, L. Mitchell & G. Ljunggren, "International and Regional Variations in Restraint Use: Implications for Selecting Benchmarks" (1999) 15:2 Can. J. Quality in Health Care 19.

14. S.A. 1980 c. S-15.

15. *Supra* note 3 at s.1(a.1).

16. *Ibid.* s. 5(2).

17. *Ibid.* s. 5(3).

18. *Ibid.* s. 2(1).

19. *Ibid.* s. 6.

20. *Ibid.* s. 7(1)(2).

21. *Ibid.* s. 7(3).

22. *Ibid.* s. 7(5).

23. *Ibid.* s. 8(3).

24. *Ibid.* s. 11.

25. *Ibid.* s. 8(4).

26. *Ibid.* s. 8(5).

27. *Ibid.* s. 8(6).

28. W. Roach, "Legal Review" (1989) Sept. Topics in Health Record Management 71.

29. *An Act Respecting The Welfare of Neglected Adults*, S.N. 1973 No. 81.

30. *Ibid.* s.4(1).

31. *Ibid.* s. 2(i).

32. S.N.B. 1980, c. C-2.1.

33. *Ibid.* s.1, defined as one who because of physical or mental impairment suffers absence or reduction of functional competence which substantially limits the ability to carry out normal daily activities.

34. *Ibid.* defined as one who has reached the age of 65 years.

35. *Ibid.* s. 34(1).

36. *Ibid.* s. 34(2)

37. *An Act To Provide For Protection Of Adults From Abuse And Neglect*, S.N.S. 1980, c.2.

38. *An Act To Provide For Protection Of Adults From Abuse And Neglect*, R.S.N.S. 1089, c. 2, s.5(1).

39. *Ibid.* s. 3(a).

40. *Ibid.* s. 3(b).

41. *Adult Protection Act*, R.S.P.E.I. 1988, c. A-5.

42. *Ibid.* s. 4(1).

43. *Ibid.* s.1 (i).

44. *Ibid.* s. 1(h).

45. *An Act Representing the Provision of Advocacy Services to Vulnerable Persons*, S.O. 1992, c.26.

46. *Ibid.* s. 2.

47. *Ibid.*

48. *The Vulnerable Persons Living With A Mental Disability Act*, S.M. 1993, c. V90.

49. *Ibid.* s. 21(1).

50. *Ibid.* s. 1(1).

51. *Ibid.*

52.*Ibid.*

53.*Supra* note 48 at s. 22; *supra* at 45 at ss. 17b & c; *supra* note 30 at s. 35; *supra* note 29, s. 5; *supra* note 37 at s.6; and *supra* note 39 at ss.6-7.

54.*Supra* note 48 at ss.23, 29-56; *supra* note 45 at ss. 21-23; *supra* note 29 at ss. 35 & 36; *supra* note 36 at ss. 6-9 and *supra* note 39 at ss. 6-8.

55.*Supra* note 48, Part 2 Support Services, Part 3 Protection and Emergency Intervention, Part 4 Substitute Decision Making; *supra* note 45 at ss. 1, 5-19; *supra* note 30 at ss.37-39; *supra* note 28 ss. 8 & 10, *supra* note 36, ss.. 10-15; *supra* note 39 at 9-17, 23-24

56.*Supra* note 45 and 48.

57.*Supra* note 28, 30, 36 & 39.

58.For example, see the *Dependent Adults Act*, R.S.A. 1980, c. D-32; *Health Disciplines Act* R.S.A. 1980, c. H-3.5; *Human Rights, Citizenship and Multiculturalism Act*, R.S.A 1980, H-11.7; *Mental Health Act*, S.A. 1988, c. M-13; *Nursing Profession Act*, S.A. 1983, c. N-14.5; *Personal Directives Act*, S.A. 1996, c. P-4.03; *Powers of Attorney Act*, S.A. 1991, c. P-13.5; *Protection Against Family Violence Act*, S.A. 1998, c. P-19.2; *Trustee Act*, R.S.A. 1980, c. T-10. Other provinces have legislative provisions in these areas.

59.S.A. 1984, c. C-8.1.

60.S.A. 1998, c. P-19.3, which was proclaimed in force on February 1, 1999.

61.R.S.A. 1980, c. H-4, s. 2.

62.*Ibid.* ss. 7 & 8.

63.*Ambulance Services Act*, S.A. 1990, c. A-40.5, s. 27; *Hospitals Act*, R.S.A. 1980, c. H-11, ss. 42, 43 & 45; *Nursing Homes Act*, S.A. 1985, c. N-14.1, s. 19; *Patient Advocate Regulation*, Alta. Reg. 310/89, ss. 3-5; *Public Health Act*, S.A. 1984, c. P-27.1, s. 30; and *Regional Health Authorities Act*, S.A. 1994, c. R-9.07, s. 19.

64.*Nursing Homes Operation Regulation*, Alta. Reg. 258/85, s.8(5), as am. Ontario also provides special protection for residents in nursing homes with a Resident's Bill of rights and mandatory reporting requirement for health care professionals where a resident has or may suffer harm due to unlawful conduct or improper or incompetent treatment or care or neglect in *An Act to Amend the Nursing Homes Act*, S.O. 1987, s. 17a(1) (5).

65.*Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c. 11 [hereinafter the *Charter*].

66.R.S.C. 1985, c. C-46, am. 1995, c. 39.

67.*Supra* note 65 at s. 7.

68.*Ibid.* s. 8.

69.*Ibid.* s. 9.

70.*Ibid.* s. 12.

71.*Ibid.* s. 15.

72.*Supra* note 66, ss. 219(1), 220-221.

73.*Ibid.* s. 215(1).

74.*Re Province of Alberta and Alberta Union of Provincial Employees* (1987) 29 L.A.C. (3d) 109 at 122 (Alta.), and K. Feehan & T. Bailey, "Patient and Staff Abuse: Rights Expectations, Options and Policies" (1994) 14:3 Health L. Can. 74.

75.*Stewart v. Extencicare* (1986) 4 W.W.R. 559 (Sask. Q.B.).

76.*Bazley v. Curry* [1999] S.J.C. No. 35 (Q.L.). In this case, the S.C.C. held that the Children's Foundation in Vancouver was not negligent but was nevertheless vicariously liable for sexual abuse of children residing in a residential care facility.

77.V. Boyack, *Golden Years - Hidden Fears Elder Abuse* (Calgary, Alta: Kerby Centre, 1997) at 23.

78.E. Baraniecki, Alberta Health, Protection for Persons in Care, Issues Management, Corporate Services, personal communication.

79.*Supra* note 3 at s. 1(a).

80.*Ibid.* s. 1 (a)(vi).

81.J. Ashley & T. Fulmer, "No Simple Way To Determine Elder Abuse" (1988) 9:5 Geriatric Nursing 286; M. Sengstock *et al.* "Identification of Elder Abuse in Institutional Settings: Required Changes in Existing Protocols" (1990) 2:1/2 J. Elder Abuse & Neglect 31; L. Phillips, "Elder Abuse - What Is It? Who Says So?" (1993) May/June Geriatric Nursing 167.

82.*Supra* note 3 at s. 1(f).

83.*Supra* note 3 at s. 2(1).

84.Government of Alberta, *Protecting People in Care*, July 1999.

85.*Supra* note 3 at s. 6(1).

86.L. Hardingham, "Protecting Vulnerable Persons in Care, Part II: Alberta Nurses and the Act" (1998) 55:2 Alberta RN 32.

87.*Supra* note 3 at s. 2(3).

88.*Supra* note 65 at s. 11(a).

89.*Supra* note 77 at 21 and Roach, *supra* note 28 at 71.

90.J.L. Storch, *Patients' Rights: Ethical and Legal Issues in Health Care and Nursing* (Toronto: McGraw-Hill Ryerson, 1982) at 22; J.K. Mason & R.A. McCall Smith, *Law and Medical Ethics*, 2d ed. (London: Butterworths, 1987) at 140.

91.*Schloendorff v. Society of New York Hospital* 105 NE 92 (NY, 1914); Mason & McCall Smith, *ibid.* at 141; Picard & Robertson, *supra* note 2 at 41.

92.Generally, see Picard & Robertson, *ibid.* At 40-45. See also, *Nancy B. v. Hotel-Dieu de Québec* (1992), 86 D.L.R. (4th) 385 (Que. S.C.).

93.*Powers of Attorney Act* S.A. 1991, c. P-13.5; *Personal Directives Act*, S.A. 1996, c. P-4-03.

94.*Supra* notes 48 & 45.

95. Storch, *supra* note 90 at 74; Picard and Robertson, *supra* note 2 at 14-17; J. Bruce, *Privacy and Confidentiality of Health Care Information*, 2d ed. (Chicago: American Hospital Publishing, 1988) at 1.

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97. E. Pittaway & E. Gallagher, *A Guide to Enhancing Services for Abused Older Canadians*. (Family Violence Prevention Division, Health Canada) 1995; National Clearinghouse on Family Violence, Elder Abuse: *It's Time We Did Something About It* by E. Podnieks (Ottawa: National Clearinghouse on Family Violence: Health and Welfare Canada, 1989); R.S. Breckman & R.D. Adelman, *Strategies for Helping Victims of Elder Mistreatment* (Newbury Park: Sage Publications, 1988).