Seniors at Risk
Guelph Wellington

Guidebook for Service Providers

This guidebook was developed and validated by a working group of the Guelph Wellington Seniors at Risk Network with funding from the Ministry for Seniors and Accessibility, Seniors Community Grant Program and with support from the Canadian Mental Health Association Waterloo Wellington.

gwseniorsatrisk.ca

Funded by:

Canadian Mental Health Association Waterloo Wellington

Ontario

Table of Contents

Acknowledgments 4

Preface 5

Executive Summary 7

- Suicide, Social, Substance 7
- Abuse & Neglect 7
- Functional 7
- Environmental 7
- Support by Sector 8
- Other Considerations 8

Chapter 1: Suicide, Social, Substance 10

- Depression 10
- Suicide 11
- Social 12
- Substance 14

Chapter 2: Abuse & Neglect 19

- Financial 20
- Physical 23
- Psychological/Emotional 27
- Sexual 29
- Neglect 31
- Safety Planning Resources 33
- Support Is Available 33

Chapter 3: Functional 34
Self-Neglect 35
Falls 36
Delirium 39
Living Safely with Dementia 41
Polypharmacy 42
Chapter 4: Environmental 44
Living Safely with Dementia 44
Diogenes Syndrome 47
Chapter 5: Support by Sector 49
Justice 49
Home and Community 54
Health Care 58
Crisis Services 62
Social Services 64
Chapter 6: Privacy & Reporting 68
Privacy 68
Reporting and Your Client's Privacy 69
More on Mandatory Reporting 71
Chapter 7: Consent & Capacity 73
Legislation 74
Powers of Attorney 76
Capacity Assessments 77
Advance Care Planning 81
References 82

Acknowledgments

The Guelph Wellington Seniors at Risk Network would like to express gratitude to the members, older adults and organizations who contributed their in-kind time, knowledge and experience to creating this guide for service providers. The hours and service provided by individuals dedicated to supporting older adults at risk in Guelph Wellington is an invaluable contribution to our community.

The Guelph Wellington Seniors at Risk Network is a collaborative of cross-sectoral service providers that has been in existence for more than 15 years and works to ensure there is a coordinated community response to supporting older adults living at risk in Guelph Wellington.

Tiffany Smith	Vulnerable Seniors Lead, CMHA WW – Project Lead
Laura Sullivan	Seniors at Risk Clinical Consultant, CMHA WW
Birgit Niggebaum-Purvis	Senior Counsellor, Transitional Housing and Support Program Guelph Wellington Women in Crisis
Jaclyn Van Der Kraak	Geriatric Emergency Management Nurse, Guelph General Hospital
Janine Murrell	Senior Support Team Consultant, WWLHIN
Detective Constable Brian Gemin	Seniors at Risk Coordinator, Guelph Police Services
Police Constable Chris Biondi	Mental Health Liaison, Wellington County OPP
Gail Roth	Manager of Programs and Services, Alzheimer Society Waterloo Wellington
Wendy Awrey	Geriatric Nurse Clinician, Specialized Geriatric Services, WWLHIN and St. Joseph's Health Centre Guelph
Aleah Wagner	Manager – IMPACT and Mental Health and Justice, CMHA WW
Audrey Devitt	WW BSO Lead, St. Joseph's Health Centre Guelph
Cathy Sturdy Smith	Manager, Seniors Services, CMHA WW
Emily Gibson	WG Hoarding Response Coordinator, Dunara Homes for Recovery
Samantha Kim	Clinical Resource Worker Lead, St. Joseph's Health Centre Guelph
Mary Shkoury	Central West Regional Consultant, Elder Abuse Prevention Ontario

Preface

The proportion of our senior population is steadily on the rise, and there is an increasing need for and demand on community services, home care services, and family caregivers to provide a degree of support that ensures older adults can remain safe and well in their homes for as long as possible. As people age we can predict that at some point their health and social situations are going to change. Increasingly, there is a need to address the issue of vulnerable older adults who live at risk in the community. Many have significant cognitive, mental health, and physical problems yet may not seek assistance. Support and intervention requires an interdisciplinary approach to care (Culo, S., 2011).

18%

of Guelph Wellington residents are currently adults aged 65+.
(stats Canada, 2016 census)

> For the purposes of this guidebook, a "senior at risk" is defined as an older adult whose situation is having a negative impact on their independence, personal well-being and overall quality of life. Their situation could be a result of their own challenges in caring for themselves or challenges resulting from their trust or dependence on someone else.

Geriatric specialists are frequently called upon to assess and manage vulnerable at risk older adults. Opinions regarding capability, capacity and safety are often needed. The older adult at risk may ignore recommendations from medical or health service providers, refuse long term care placement, experience abuse, neglect or discrimination, suffer from self-neglect, drive dangerously, or live in an unsuitable or unsafe environment. These situations are compounded by complexity with health, legal, social and ethical issues and offer challenges for community service providers supporting the older adult at risk (Culo, S., 2011).

The Guelph Wellington Seniors at Risk: *Guidebook for Service Providers* was informed through a series of consultations and working group meetings with experts from across sectors including older adults. The guidebook outlines dimensions of risk using the SAFE (Suicide, Social, Substance; Abuse and Neglect; Functional; Environmental) acronym that was developed during the content development phase.

34%

of all City of Guelph residents will be adults aged 55 years and older by 2031.

(OAS Guelph, 2018)

This guidebook provides a hard copy of the content that is displayed on the Guelph Wellington Seniors at Risk website (gwseniorsatrisk.ca) is intended to work alongside the Is it SAFE? Tool as a companion for reviewing different aspects of risk and considerations for capacity, privacy, legislation, and reporting. It offers providers appropriate resources for further assessment, safety planning, intervention and community referrals. Content provided in this guidebook is referenced from credible sources and offers providers direct links to need to know legislation and best practice.

Resources are highlighted in boxes throughout this guidebook

Executive Summary

As this guidebook explores the many dimensions of vulnerability a short acronym (SAFE) was developed to assist service providers in guiding their assessment of risk. Each dimension will provide reference to further assessment and screening tools if applicable, as well as general best practice resources and considerations.

Suicide, Social, Substance

Although this section is broad with respect to each of the three sub-dimensions, consideration should be given to how each may impact one another. In this section we will explore depression, suicide, social isolation, inclusion and diversity, and how substance misuse or dependence can lead to increased risk and vulnerability.

Abuse & Neglect

In addition to the types of Elder Abuse, this section provides further insight into topics such as intimate partner violence, the importance of risk assessments, and navigating the justice sector.

Functional

This section reviews how changes in both physical and cognitive abilities can lead to challenges with self-neglect, falls, delirium, driving, wandering and the risks associated with polypharmacy.

Environmental

Access to safe, affordable and stable housing is a strong social determinant of health. This section explores the need for Long Term Care and the risks associated with unstable or inappropriate housing for older adults including additional challenges with hoarding and/or squalor.

Support by Sector

One of the foundational principles of supporting older adults at risk is that risk is a shared responsibility of the community as a whole. This guidebook was developed in partnership with a variety of sectors that support older adults at risk in unique ways. This section offers an overview of many programs and services across sectors that may be helpful for service providers when determining your response. The sectors highlighted in this section include:

- Justice
- Community
- Health Care
- Crisis
- Social Service

Other Considerations

When determining your support plan as a service provider, consideration should be given to the impact of risk (severity and probability of harm) and the vulnerability of the older adult. It should be noted that there are some key considerations that should be a part of every risk assessment.

Privacy & Reporting

It is important to familiarize yourself with privacy legislation, including 'circle of care' so that you are familiar with how a risk assessment of imminent harm can impact a health care provider's response to support. This section also covers what you might need to know about mandatory reporting.

Consent & Capacity

Consent and capacity are important considerations when determining your plan of support. It highlights necessary legislation, defines Powers of Attorney and links to resources for capacity assessment. It also reviews why Advance Care Planning is so important.

Interpretation Services

Select health system partners and providers now have access to free professional interpretation services for clients. These services are available to clients wherever they live in Guelph Wellington and are available in person or over the phone. Funding for this initiative is being provided by the Waterloo Wellington LHIN; and, services will be arranged through the KW Multicultural Centre in partnership with Immigrant Services Guelph Wellington and Access Alliance Language Services. To access services, family physicians or clinicians will simply need to contact the Kitchener-Waterloo Multicultural Centre at 519-745-2593 to arrange interpretation services for their patients.

Chapter 1: Suicide, Social, Substance

As a service provider it is important to understand how depression, suicidal thoughts and plans, social isolation, inclusion and diversity, and substance misuse can all uniquely lead to increased risk and vulnerability.

Depression

Depression and suicide are both significant public health issues for older adults. Many older adults are affected by depression, however it should be noted that this is not necessarily a part of normal aging. It is important to consider how recent changes and losses associated with one's independence (i.e removal of a driver's license) can have a significant effect on their emotional well-being.

As symptoms can often present similarly, it is also important to distinguish depression from other conditions such as dementia or delirium in order to properly identify treatment. For more information on delirium and dementia, refer to Chapter 3: Functional.

Primary care providers play a critical role in the assessment, treatment and monitoring of depression. If you are concerned about an older adult experiencing depression, it is important to work with their primary care provider and if possible offer collateral information to assist in their clinical assessment.

Screening tools for depression with older adults include:

- Geriatric Depression Scale
- Cornell Scale for Depression in Dementia
- Clinical: Tool on Depression: Assessment and Treatment for Older Adults (NICE + CCSMH)
- Clinical: Are my older patients at higher risk for depression? (NICE + CCSMH)

Suicide

Older adults, particularly men have the highest rates of suicide (WHO, 2019)

So why older adults?

- Often times they tend to talk about suicide less
- Many live alone so there is less of a chance of survival if an attempt is made
- Evidence suggests they tend to use more lethal means (ie firearms) (Centre for Suicide Prevention, 1998)

Older adults at higher risk include those (CCSMH, 2017)

- With a personal history (self or family) of suicidality
- Who have experienced a suicide loss
- Experiencing social isolation
- With physical and/or mental health concerns (including depression)
- Experiencing negative life events and transitions
- Recent losses (health, relational, independence)
- Major life changes (environmental, financial)

As service providers we need to be aware of and attentive to possible warning signs (WHO, 2020), screening and prevention practices:

- Suicide: Assessment and Prevention for Older Adults (CCSMH, 2017)
- The Columbia Lighthouse Project
- Suicide Prevention Resource Centre – Safety Planning Guide
- HERE 24/7: 1-844-HERE 247

Additional training regarding mental health and suicide assessment and intervention for service providers is available:

- Living Works : ASIST (Applied Suicide Intervention Skills Training)
- Living Works: safeTALK
- Mental Health First Aid Canada (Seniors)

Social

Social Isolation

In addition to seeing social isolation listed as a risk factor above for suicide, socially isolated seniors are more at risk of other negative health behaviours including drinking, smoking, being sedentary and not eating well; have a higher likelihood of falls; and, have a four-to-five times greater risk of hospitalization (Nicholson, N.R, 2012).

Social isolation is also considered a risk factor for elder abuse.

For information on social or community programs in Guelph Wellington for your clients, please visit www.wwhealthline.ca.

It is estimated that

16%

of seniors experience social isolation.

(Stats Canada, 2010)

Caregiver Burnout

Caregiver burnout is a "state of physical, emotional, and mental exhaustion that may be accompanied by a change in attitude – from positive and caring to negative and unconcerned" (Ontario Caregiver, 2020). Burnout can occur when caregivers don't get the help they need, or if they try to do more than they are able – either physically or financially.

As service providers we need to be aware that if left unsupported and unaddressed, the effects of a burnt out caregiver may adversely impact their ability to care for a vulnerable older adult.

Here are some caregiver burden screening tools and resources available to you and the caregivers you work with:

- Agape Hospice Caregiver Stress Test
- The Zarit Burden Interview
- The Ontario Caregiver Association and Caregiver HelpLine: 1-833-416-2273 (CARE)

Inclusion and Diversity

Every older adult ages differently and 'senior' is no longer defined by a specific age (i.e. historically defined as age 65). For this reason, it is important to note that older adults experience their 'senior' years differently depending on many factors. Consider how the intersections of race, culture, gender, disability, sexual orientation, income, and religion play key roles in our lives, affecting our experiences in many ways.

Local Resources:

- Aging with Pride Waterloo Wellington
- Guelph Welcoming Streets Initiative – Community Health Centre
- Legal Clinic Guelph Wellington
- Immigrant Services Guelph Wellington

Other Resources:

- Ministry of Children, Community and Social Services: Guidelines for Supporting Adults with a Developmental Disability to/in Long Term Care
- If you have additional questions about your service and health equity, resources for Health Equity Impact Assessments are available through the Ministry of Health and Ministry of Long Term Care.

Substance

It is important for service providers to distinguish between substance use and misuse.

- **Substance use** may be more casual in nature and may not ever lead to misuse.
- **Substance misuse** on the other hand is when someone continues to use even when it causes problems (i.e. with health or family).
- **Substance dependence** is an addiction where one may be unable to stop using and have physical withdrawal symptoms when they try to quit.

With many older adults taking sometimes complicated regimens of multiple prescribed medications each day, substance misuse is common. Due to physiological changes, older adults are much more vulnerable to the negative effects of substance use and misuse (CCSMH, 2017).

If you are working with an older adult who would like assistance with their substance dependence, local support is available:

- **Rapid Access Addiction Clinic:** Physicians and/or Nurse Practitioners, Addictions Counsellors and Peer Support Workers are all available to provide assistance to everyone – regardless of substance used.
- **Community Addictions Services:** Homewood's Community Addiction Services (CADS) provides outpatient addiction treatment for residents in our local community coping with the devastating effects of alcohol, drug and gambling issues.
- **Behaviour Supports Ontario – Geriatric Addictions:** The Community Responsive Behaviour Team in Waterloo Wellington includes a Geriatric Addictions Clinician who provides assessment (with respect to the addiction and responsive behaviours), care planning, and support during transitions for older adults with substance misuse.
- **Specialized Outreach Services (SOS) and Addiction Support Coordination:** Stonehenge Therapeutic Community offers Specialized Medical, Addiction and Mental Health Outreach services to homeless individuals with addiction, mental health, or concurrent issues by providing supportive nursing and counselling, connections to primary care, and referrals to other community services. Addiction Support Coordination (ASC) is also available for older adults living with addiction issues.

The Canadian Coalition for Seniors Mental Health has recently released **Clinical Guidelines on Substance Use Disorders Among Older Adults.** These include guidelines on:

- Alcohol
- Cannabis
- Opioids
- Benzodiazepines

Alcohol

Alcohol is the most commonly used and misused substance among older adults (Kuerbis et al., 2014). Alcohol Use Disorder (AUD) and risky alcohol consumption is common among older adults, with reported problem drinking rates ranging from 1–22% (Woodruff et al., 2009).

Supporting older adults with alcohol use disorder requires a continuum of care approach that matches any concurrent issues, severity of impact and life changes/transitions that they may be experiencing. The topic of alcohol use in the senior population is often associated with stigma, which may elicit denial and defensiveness.

6-10%

of older adults who drink will experience problems.
(CAMH, 2008)

Q: What does "living at risk" mean to you?

A: "An erosion of quality of life."

– Older Adult

72% of Canadians aged 65 years or older drank alcohol in the past 12 months (CCSA, 2020).

Low Risk Drinking Guidelines recommend no more than two standard drinks on any one day and no more than fourteen drinks per week for men and 9 drinks per week for women (NICE, 2020).

Screening and Management of Alcohol Use Disorder in Older Adults:

- **The Senior Alcohol Misuse Indicator (SAMI)** is a brief, senior-specific screening tool designed to start a gentle, non-threatening conversation about alcohol consumption. This approach may be helpful for services that provide outreach care in seniors' homes and whose first priority is establishing and maintaining rapport. Please note: follow up by a skilled clinician for diagnostic and treatment purposes is required.
- **2019 Canadian Guidelines for Alcohol use Disorder among Older Adults** (CCSMH, 2019)
- **National Initiative for the Care of the Elderly (NICE):** screening for alcohol related issues and older adults.

Cannabis

Evidence is limited with regard to the potential benefits and harms of cannabis use, especially among older adults. Physiological changes that impact sleep, mobility, diet, exercise, and overall quality of life, along with issues such as polypharmacy and cognitive decline are all confounding factors in the effects and response of cannabis use in this population (CCSMH, 2019).

2019 Canadian Guidelines for Cannabis Use Disorder Among Older Adults (CCSMH, 2019)

Behaviour Supports Ontario: **Cannabis and Older Adults: Know the Facts!**

Opioids

Globally, according to the World Health Organization people over the age of 50 accounted for 27% of deaths from drug use disorders in 2000, a figure that rose to 39% by 2015. Of those deaths in older adults (age ≥ 65), approximately 75% were linked to the use of opioids (Degenhardt & Hall, 2012; UNODC, 2018).

2019 Canadian Guidelines on Opioid Use Disorder Among Older Adults (CCSMH, 2019)

Benzodiazepine Receptor Agonist (BZRAs)

As noted in the release of the 2019 Canadian Guidelines on BZRA Use Disorder, clinicians continue to frequently prescribe these medications despite recommendations that they be avoided whenever possible in older adults. The guidelines highlight several recommendations and strategies for minimizing BZRA use and preventing BZRA Use Disorder.

2019 Canadian Guidelines on Benzodiazepine Receptor Agonist Use Disorder Among Older Adults (CCSMH, 2019)

National Initiative for the Care of the Elderly (NICE) also has 'pocket guide' available for "Opioids, Benzodiazepines and the Elderly".

Q: What does "living at risk" mean to you?

A: "It means being at the mercy of someone else and not having any control"

– Older Adult

Smoking Cessation

Older adults have the highest percentage of people who smoke. According to Statistics Canada, 2018:

- About 18% of all people between the age of 50 and 64
- About 9% of everyone 65 and up

Oxygen Therapy and Smoking Cigarettes

Smoking around oxygen is extremely dangerous and may cause clothing and hair to catch fire and burn much more vigorously than in air. For your clients: never smoke or allow someone else to smoke nearby whilst using oxygen equipment.

Smoking with Dementia

When a person experiences memory loss, smoking may mean an increased fire risk. Some people with dementia may simply forget about smoking if cigarettes and ashtrays are removed from sight, however, if the person stops smoking, they may present with increased anxiety, tension and irritability. There are also ethical considerations around the person's right to continue to enjoy something that they have enjoyed their whole life even if its bad for them (as could be the case with another substance).

If you are working with an older adult who is interested in smoking cessation, resources are available:

Ontario – Support to quit smoking

Chapter 2: Abuse & Neglect

Elder abuse is defined as "a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person. This type of violence constitutes a violation of human rights and includes physical, sexual, psychological, and emotional abuse; financial and material abuse; abandonment; neglect; and serious loss of dignity and respect." (WHO, 2020)

Identifying abuse can be difficult. It is important to note that abuse can happen to any older adult, at any time, anywhere.

Around

1 in 6

people 60 years and older experienced some form of abuse in community settings during the past year.

(WHO, 2020)

There are several factors that place older adults at risk (WHO, 2020):

1. **Individual** – poor physical, mental health; gender
2. **Relationship** – shared living arrangements; dependency
3. **Community** – social isolation; lack of social support
4. **Socio-Cultural** – ageist stereotypes; lack of funds; systems of inheritance and land rights;

Service providers working with older adults in potentially abusive situations need to be sensitive to cultural differences and intervene accordingly. Formulating culturally sensitive prevention and intervention efforts requires an understanding of roles and responsibilities within the family. Certain cultural values, beliefs and traditions influence family dynamics, intergenerational relationships and ways in which families define their roles and responsibilities and respond to daily challenges. These differences make some situations difficult to distinguish from abuse or neglect (EAPON, 2020).

This section aims to increase awareness of the possible indicators of abuse and how service providers can better screen for and provide support. Information provided in

this section has been adapted from the Elder Abuse Prevention Ontario resources available at eapon.ca.

Additional resources are available:

- For Your Clients: **Seniors Safety Line: 1-866-299-1011**
- **National Initiative for the Care of the Eldery (NICE)** has developed an Assessment and Intervention Reference Guide for Elder Abuse
- NICE Elder Abuse Reference Guide

Financial

The most common form of elder abuse, financial abuse, is defined as any improper conduct, done with or without the informed consent of the senior that results in a monetary or personal gain to the abuser and/or monetary or personal loss for the older adult (EAPON, 2020).

Financial abuse of an older adult can include (EAPON, 2020):

- Misusing property and/or funds, Power of Attorney
- Theft, forgery
- Sharing their home without paying a fair share of the expenses
- Unexplained disappearance of personal belongings, such as clothes or jewellery
- Unduly pressuring an older adult to relinquish property, sign legal documents without understanding, give money to relatives/caregivers

Possible Indicators of Financial Abuse (EAPON, 2020):

Banking/Legal

- Unexplained or sudden withdrawal of money from accounts
- Suspicious or forged signatures on cheques or other documents
- The older adult is not receiving bank statements
- Transfer or withdrawal of funds without prior permission

- Denial to access or control finances such as credit cards, cheques

Living Status

- Notice of eviction or discontinuation of utilities
- Older adult is unable to pay bills, buy food or pay rent
- Standard of living not in keeping with the older adult's income or assets
- The older adult's home is unexpectedly sold
- Power of Attorney refuses to consider moving an older adult to Long-Term Care or Retirement Home in order to gain or retain access to their finances

Financial abuse can be a difficult subject to broach with a family member or older adult. The following are sample questions adapted from Elder Abuse Prevention Ontario's Guide: **Financial Abuse of Older Adults: An Intervention Guide for Service Providers and Partners in Care** (EAPON, 2018) that may assist service providers in starting the conversation. Follow your professional standards when conducting investigative interviews and obtaining client consent.

Questions (EAPON, 2018):

- Is there something that you would like to share with me?
- Has there been a recent incident causing you concern?
- Do you make decisions for yourself or does someone else make them for you?
- Does your caregiver depend on you, for shelter or financial support?
- Have you ever felt taken advantage of?
- Do you have any concerns about your money/belongings/property/valuables?
- Has anyone ever asked you to sign papers that you did not understand?
- Does anyone ever take things from you or use your money without your permission?
- Do you manage your own money?
- Has anyone taken anything from your purse/wallet?
- Has anyone taken money from your bank account?

- Have you been pressured to change your Power of Attorney?
- Has anyone pressured you to change your Will?
- Would you like some help with…?

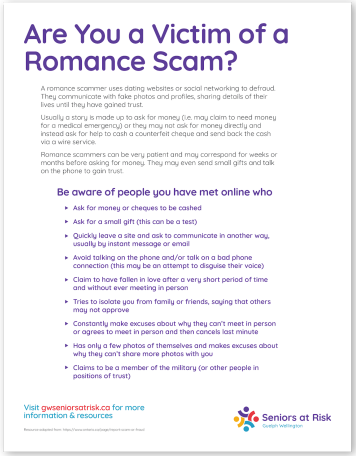
Additional Resources on Fraud and Scams:

- Canadian Anti-Fraud Centre
- Consumer Protection Ontario – Report a Scam or Fraud
- Little Black Book of Scams (Competition Bureau Canada, 2012)

Romance Scams

The Seniors at Risk Network of Guelph Wellington has seen an anecdotal increase in reporting of romance scams with older adults. As such, we have adapted information from Consumer Protection Ontario (2020) as a downloadable tipsheet "Are You a Victim of a Romance Scam" for you to support the conversation with your clients.

Are You a Victim of a Romance Scam?


Are You a Victim of a Romance Scam?

A romance scammer uses dating websites or social networking to defraud. They communicate with fake photos and profiles, sharing details of their lives until they have gained trust.

Usually a story is made up to ask for money (i.e. may claim to need money for a medical emergency) or they may not ask for money directly and instead ask for help to cash a counterfeit cheque and send back the cash via a wire service.

Romance scammers can be very patient and may correspond for weeks or months before asking for money. They may even send small gifts and talk on the phone to gain trust.

Be aware of people you have met online who

- Ask for money or cheques to be cashed
- Ask for a small gift (this can be a test)
- Quickly leave a site and ask to communicate in another way, usually by instant message or email
- Avoid talking on the phone and/or talk on a bad phone connection (this may be an attempt to disguise their voice)
- Claim to have fallen in love after a very short period of time and without ever meeting in person
- Tries to isolate you from family or friends, saying that others may not approve
- Constantly make excuses about why they can't meet in person or agrees to meet in person and then cancels last minute
- Has only a few photos of themselves and makes excuses about why they can't share more photos with you
- Claims to be a member of the military (or other people in positions of trust)

Visit gwseniorsatrisk.ca for more information & resources

Seniors at Risk Guelph Wellington

Romance scammers can be very patient and may correspond for weeks or months before asking for money. They may even send small gifts and talk on the phone to gain trust.

Be aware of people you have met online who

- Ask for money or cheques to be cashed
- Ask for a small gift (this can be a test)
- Quickly leave a site and ask to communicate in another way, usually by instant message or email
- Avoid talking on the phone and/or talk on a bad phone connection (this may be an attempt to disguise their voice)
- Claim to have fallen in love after a very short period of time and without ever meeting in person
- Tries to isolate you from family or friends, saying that others may not approve
- Constantly make excuses about why they can't meet in person or agrees to meet in person and then cancels last minute
- Has only a few photos of themselves and makes excuses about why they can't share more photos with you
- Claims to be a member of the military (or other people in positions of trust)

Physical

Physical abuse is defined as any act of violence or rough handling that may or may not result in physical injury but causes physical discomfort or pain (EAPON, 2020).

Physical abuse may include (EAPON, 2020):

- Physical assault – hitting, shoving, slapping, rough handling
- Pushing, pulling, kicking, beating, twisting, shaking
- Pulling hair, biting, pinching, spitting at someone
- Confinement, inappropriate restraint use
- Overmedicating, withholding necessary medications

Possible Indicators of Physical Abuse (EAPON, 2020):

Physical

- Unexplained injuries such as broken bones, bruises, bumps, cuts, grip marks, welts, lacerations, swelling, fractures
- Internal injuries
- Head or neck injuries
- Signs of being restrained
- Unusual patterns of injuries
- Immobility
- Broken eyeglasses
- Unkempt
- Signs of lethargy, memory problems (under/over medication)

Behavioural

- Discomfort or nervousness around family, friends, caregiver or others
- Unusual withdrawal from family and friends
- Depression
- Discrepancies between injury and explanation from the older adult
- Seen by many different doctors or hospitals
- Reluctance to talk openly; uncommunicative; unresponsive
- Avoidance of physical or eye contact with caregiver and/or health care provider
- Sleep problems
- Self-harming
- Changes in eating patterns

Physical abuse can be a difficult subject to broach with a family member or older adult. It is important to conduct a thorough assessment to identify and intervene appropriately. The following are sample questions adapted from Elder Abuse Prevention Ontario's Guide: **Physical Abuse of Older Adults: An Intervention Guide**

for Service Providers and Partners in Care (EAPON, 2018) that may assist service providers in starting the conversation. Follow your professional standards when conducting investigative interviews and obtaining client consent.

Questions (EAPON, 2018):

- Is there something that you would like to share with me?
- Has there been a recent incident (with a family member, friend and/or caregiver) that is causing you concern?
- Is there anyone close to you that makes you feel uncomfortable?
- Is there anyone that you fear being left alone with?
- Are you afraid of any family members and/or caregivers?
- How do family members behave toward you?
- Does your caregiver and/or family member(s) always answer questions that are asked of you? Is there someone in your life who is mistreating/harming you?
- Have you ever been touched in any way you did not want?
- Do you have any bruises, cuts and/or pain in your body that you cannot explain?
- Have you ever experienced physical abuse in the past?
- Are you alone a lot?
- Does your family member/caregiver take you to see a doctor when you have pain or an injury of any sort?
- Do you see different doctors/hospitals every time you are injured?
- Does your family member or caregiver force you to see a different doctor or hospital when you are injured?
- Has anyone tried to harm you while under the influence of alcohol or any other substances?
- Have you ever been forced or tricked to take any substances that may impair your memory or judgment?

Intimate Partner Violence

As service providers, you should be aware of the laws on intimate partner violence and what it means for the older adult, partner and/or family when and if a charge is made. Please refer to the section on Support by Sector for more information about how intimate partner violence is defined and how the justice, health, social or other services may impact or support your client.

Intimate Partner Violence in later life may be a continuation of long-term partner abuse or may begin with retirement or the onset of a health condition that leads to a dependency.

If Intimate Partner Violence is a concern, a more comprehensive risk assessment of the situation is recommended. The Guelph-Wellington Community Protocol on Sexual Assault and Domestic Violence, 2017 has developed a Risk Assessment/ Screening Tool for Domestic Violence.

Q: What would you like a Service Provider to ask you?

A: "Do you feel safe? If not, why not?"

– Older Adult

Psychological/Emotional

Emotional and Psychological abuse is any action, verbal or non-verbal, that lessens a person's sense of identity, dignity and self-worth (EAPON, 2020).

Emotional Abuse may present as the following (EAPON, 2020):

- Words that are hurtful make the older adult feel unworthy
- Not considering a person's wishes. Removal of decision-making powers
- Not respecting a person's belongings or pets
- Threatening an older adult
- Stalking behaviour
- Treating an older adult like a child
- Shunning, ignoring or lack of acknowledgement
- Verbal intimidation, being forced into making decisions against their will
- Threats of institutionalization
- Not allowing the older adult to socialize, including access to telephone, friends, neighbours, or attending social gatherings
- Withholding of affection, such as refusing access to grandchildren

Possible Indicators of Psychological Abuse (EAPON, 2020):

- Low self-esteem, withdrawal
- Tearfulness
- Lack of eye contact with health care providers
- Fearfulness – Nervous around caregiver or other persons
- Reluctance to talk openly, waits for caregiver to respond to questions asked of them
- Helplessness
- Insomnia/sleep deprivation/fatigue, listlessness

Emotional abuse can be a difficult subject to broach with a family member or older adult. It is important to conduct a thorough assessment to identify and intervene appropriately. The following are sample questions adapted from Elder Abuse Prevention Ontario's Guide: **Emotional Abuse of Older Adults: An Intervention Guide for Service Providers and Partners in Care** (EAPON, 2018) that may assist service providers in starting the conversation. Follow your professional standards when conducting investigative interviews and obtaining client consent.

Questions (EAPON, 2018):

- Is there anyone close to you that makes you feel uncomfortable?
- Is there anyone that you fear being left alone with?
- Are you afraid of family members and/or caregivers?
- How do family members behave towards you? Are they verbally abusive?
- Do your caregiver and/or family member(s) always answer questions that are asked of you?
- Can you tell me about a time recently when someone talked to or yelled at you in a way that made you feel bad about yourself?
- Does anyone ever scold or threaten you? Can you give me an example?
- Does anyone ever tell you that you're sick when you know you aren't? Can you give me an example?
- When was the last time you got to see relatives or friends?
- Do you have any access to a telephone? If not, why not?
- Are you by yourself a lot?

Sexual

Sexual abuse is any sexual behaviour directed toward an older adult without that person's full knowledge and consent; it includes coercing an older person through force, trickery, threats or other means into unwanted sexual activity (EAPON, 2020)..

Sexual abuse also includes sexual contact with seniors who are unable to grant consent and unwanted sexual contact between service providers and their elderly clients. Sexual abuse can be very difficult to identify as embarrassment and shame may prevent the issue from being talked about or reported (EAPON, 2020).

Sexual abuse can include (EAPON, 2020):

- Unwanted sexual contact such as touching, sexualized kissing
- Making sexual remarks and/or suggestions to another person
- Forcing a person to perform a sexual act
- Inappropriate touching
- Fondling a confused senior
- Forced intercourse/rape
- Coerced nudity and sexually explicit photographing

Possible Indicators of Sexual Abuse (EAPON, 2020):

- Bruising around the breasts, inner thighs or genital area
- Unexplained venereal disease or genital infections
- Torn, stained, or bloody underclothing
- Difficulty in walking or sitting
- Inappropriate sexual comments

Sexual abuse can be a difficult subject to broach with a family member or older adult. It is important to conduct a thorough assessment to identify and intervene appropriately. The following are sample questions adapted from Elder Abuse Prevention Ontario's Guide: **Sexual Abuse of Older Adults: An Intervention Guide for Service Providers and Partners in Care** (EAPON, 2018) that may assist service providers in starting the conversation. Follow your professional standards when conducting investigative interviews and obtaining client consent.

Questions (EAPON, 2018):

- Is there anyone close to you that makes you feel uncomfortable?
- Does anyone speak to you in a sexual nature that makes you feel uncomfortable?
- Has your partner ever made inappropriate or aggressive sexual remarks towards you?
- Is there anyone that you fear being left alone with?
- Have you ever been touched in any way you did not want?
- Has anyone forced you to watch pornographic material or pictures?
- Have you ever been forced to watch someone else take part in any sexual act without your consent?
- Have you ever felt pressured to take part in a sexual act with your partner because they threatened you?
- Do you feel coerced to participate in sexual acts with your partner for fear of physical harm being done to you if you do not?
- Has anyone forced you to touch them?
- Have you experienced sexual abuse or any other type of abuse in the past?
- Has a family member tried to harm you while under the influence of alcohol or drugs?
- Does your partner force you to take any substances which may impair your memory or judgment?
- Have you been forced or tricked to take any substances that may impair your memory or judgment?

Sexual assault and harassment are a crime in Canada. Even when you are married, it is a crime to force any sexual conduct on another person. If a sexual act is committed while the victim is physically or mentally unable to consent, that is sexual assault (EAPON, 2020)..

Reporting instances of sexual abuse is mandatory in Long Term Care and Retirement Homes, for more information refer to the section of this guidebook on Privacy and Reporting.

Neglect

Neglect is not meeting the basic needs of the older person and can include (EAPON, 2020):

1. **Active** (intentional) neglect: the deliberate withholding of care or the basic necessities of life to an older adult for whom they are caring
2. **Passive** (unintentional) neglect: the failure to provide proper care to an older adult due to lack of knowledge, experience /ability or unaware of how to access local resources

Neglect can be (EAPON, 2020):

- Withholding care or denying access to necessary services (home care, nursing) or medical attention
- Leaving a person in an unsafe place
- Improper use of medication – over/under medicating
- Not providing food or liquids, proper clothing or hygiene
- Failure to assist with activities of daily living
- Abandonment
- Denial of a senior's basic rights

Possible Indicators of Neglect (EAPON, 2020):

- Signs of malnourishment
- Missing or broken dentures, walkers, hearing aids, glasses
- Unsafe and/or unclean living conditions
- Non-compliance/withholding of medical prescriptions and/or treatments
- Insect and pest infestation
- Presence of urine and/or fecal smell
- Being left alone/isolated and/or unattended for long periods of time
- Unkempt appearance (unshaven, matted hair) or dirty clothing
- Soiled bedding and linens
- Inappropriate or inadequate clothing for weather/season
- Lack of contact with healthcare practitioners such as doctor/dentist
- Untreated pressure ulcers (EAO)

Considerations (EAPON, 2020):

- Caregiving for mental or physical impairments is highly stressful and families are not trained for the job. Unintentional though it may be, abuse and neglect is sometimes perpetrated by people who had previously acted loving, supportive and caring. For more information about screening for caregiver burnout refer to the section on Social.
- The likelihood of abuse and neglect increases with age. As people get older, especially those more dependent, the likelihood of being taken advantage of increases.

Victims of neglect may feel ashamed of their experiences. Those who consider reporting often choose not to because, in the majority of cases, they are abused by a family member, loved one, or trusted caregiver. It can be extremely difficult to tell others that someone you trust and love is abusing or neglecting you. Consider how your communication strategies impact your assessment of the facts. It is important to conduct a thorough assessment to identify and intervene appropriately (EAPON, 2018).

The following are sample questions adapted from Elder Abuse Prevention Ontario's Guide: **Neglect of Older Adults: An Intervention Guide for Service Providers and Partners in Care** (EAPON, 2018) that may assist service providers in starting the conversation. Follow your professional standards when conducting investigative interviews and obtaining client consent.

Questions (EAPON, 2018):

- Do you have anyone who spends time with you, takes you shopping or to the doctor?
- Is there someone who helps you with personal needs such as taking medicine, getting to the bathroom, getting out of bed, getting dressed or getting food?
- Can you take your own medication or get around by yourself?
- Who makes decisions about your life – how you should live or where you should live?
- Do you have enough privacy at home?
- Do you trust most of the people in your family?
- Are you uncomfortable with or afraid of anyone in your life?
- Are you sad and lonely often?

- Do you feel like no one wants you around?
- Does anyone in your family drink a lot?
- Does someone in your family make you stay in bed or tell you are sick when you are not?
- Has anyone taken things that belong to you, without your approval?
- Does anyone tell you that doing things for you is too much trouble?
- Has anyone close to you tried to hurt you or harm you in any way?

Safety Planning Resources

As with many forms of risk and abuse, it may be necessary to complete a safety plan with your client - Safety Planning Guide for Older Adults – Keeping Safe in Unhealthy Relationships.

SAFE PATHWAYS: A safety plan specific to dementia and the justice system, where a potential for intimate partner violence exists is also available for service providers to download via the Alzheimer Society Waterloo Wellington.

Support Is Available

Please refer to the section on Support by Sector for more information about what services are available to support your client within the justice, home and community, health, or social services sectors.

Q: What would you like a Service Provider to ask you?

A: "Ask me questions about bullying."

– Older Adult

Chapter 3: Functional

This section defines functional decline as the loss of one's physical and/or cognitive abilities. If functional decline is a result of aging it can be referred to as "age-related functional decline."

There are many types of common age-related functional decline:

- Changes in vision (macular degeneration, cataracts, and glaucoma)
- Hearing difficulty
- Issues with balance and gait
- Memory problems, including dementia
- Frailty or bone weakness (osteoporosis)

Functional decline can take place slowly over time or very rapidly (for example due to a hospitalization) and unfortunately leave the older adult unable to complete either basic Activities of Daily Living (like bathing, dressing) or Instrumental Activities of Daily Living (driving, banking, shopping). As functional decline worsens older adults may become more dependent on family, friends, or the healthcare system.

Next we review five risks associated with physical or cognitive decline:

1. **Self-Neglect**
2. **Falls**
3. **Delirium**
4. **Living Safely with Dementia**
5. **Polypharmacy**

Self-Neglect

Self-neglect occurs when an older adult is unable or unwilling to effectively meet his or her own needs for food, clothing, shelter, medical care, safety, and personal hygiene, and lacks the insight into the consequences or harm that can subsequently result. Older adults who neglect themselves typically live in conditions of extreme isolation, filth, and squalor. They often hoard and have rodent, insect infestations and may possibly risk eviction as a result of safety hazards and complaints from neighbours (Culo, S., 2011).

An interdisciplinary approach is useful in managing situations of self-neglect. Often there is a question of cognitive and functional decline and capacity assessments specific for areas of personal care and shelter may be required (Refer to the section on Consent and Capacity for more information). Additionally, some older adults do not have the social support, finances or ability to seek assistance from other services which may lead to self-neglect. Clinicians frequently debate whether self-neglect represents a medical or social concern, particularly if dementia or severe mental illness is not present. If an older adult who is at risk as a result of self-neglect is incapable and ill, it would be negligent for health professionals not to intervene (Culo, S. 2011).

The goals of intervention in cases of vulnerability are to promote autonomy, ensure safety, reduce morbidity and mortality, maximize function, and improve quality of life (Pavlou M., Lachs M., 2008). Individuals should be offered support and assistance such as home care, day programs, ongoing medical follow-up, housekeeping, meal delivery, and transportation programs. Hospitalization and facility placement may be required, depending on the needs of the individual. The least invasive measures should always be used in accordance with the individual's previously expressed wishes and values. Service providers should include the older adult in decision making as much as possible (Culo, S. 2011).

Falls

Falls are one of the leading causes of hospitalizations among older adults and also the main reason older adults lose their independence. It is important that as service providers we are screening older adults for changes in balance, gait and mobility and engaging them in the conversation (Stats Canada, 2014).

1 in 5

people (20%) over the age of 65 living in the community report having a fall, with a higher prevalence among older seniors (over 80 years).
(Statistics Canada, 2010)

Resources for your clients at risk of falling:

- Waterloo Wellington Healthline – A screener: Am I at Risk for Falls?
- The Public Health Agency of Canada – Falls Prevention Brochure

Risk Factors:

Most falls occur as a result of compounding factors that combine and overwhelm an older person's ability to maintain or regain their balance. Risk factors typically represent a complex interaction of the following conditions (Public Health Agency of Canada, 2014):

- **Biological**: acute illness, balance and gait deficits, chronic conditions, cognitive impairments, low vision, reduced physical fitness
- **Behavioural**: assistive devices, fear of falling, footwear and clothing, excessive alcohol, previous falls, diet, medications
- **Environmental**: living environment; community hazards, weather and climate
- **Social and Economic:** social networks, socio-economic status

Understanding what puts an older adult at risk of falling is a critical step in reducing falls and fall-related injuries among older adults (Public Health Agency of Canada, 2014).

The Role of Occupational Therapy

Occupational Therapists work with older adults and their caregivers to assess the home environment for hazards and evaluate the older adult for limitations that can contribute to falls. Recommendations can include improving physical abilities to manage daily tasks, modifying the home and suggesting changes in activity. Consider how a referral for an Occupational Therapist can help.

The Role of Physiotherapy

Physiotherapists are integral to interprofessional falls prevention programs and rehabilitation services for older adults who have experienced a fall. Physiotherapy effectively improves strength, motor function and balance in older adults at risk of falling and those with fall-related injuries. Physiotherapists assess individuals to screen for risk of falls and manage falls prevention programs. Physiotherapists prescribe specific exercises, activities and interventions, and provide advice on managing environmental risks (Physio Can Help, 2020).

Refer to the section on Support by Sector for information on how Home and Community Care support services can help.

Medications and Falls

Certain medications can make older adults more likely to fall, causing injuries which could lead to hospitalizations. Effects can include balance problems, drowsiness, dizziness or changes in blood pressure. If you have concerns about your client's medications and falls please contact their primary care provider to discuss.

Resources:

- Regional Geriatric Programs of Ontario – Assessment and Management Tool: Common Medications and Falls Risk
- The Canadian Deprescribing Network "Medication and Falls"

Low Vision and Falls

Changes to vision are associated with aging and increase the risk of falls. Older adults with low vision are more likely to fall than older adults without visual deficits. Learn how services can help – visit Vision Loss Rehabilitation Ontario.

Resources:

- VON SMART exercises and Fall Prevention
- Lifeline: AutoAlert Fall Detection

Q: What would you like a Service Provider to ask you?

A: "Do you feel like you have lost control of your life?"

– Older Adult

Delirium

In order to determine if a risk of delirium is presenting, it is important to understand the difference between delirium, dementia and depression (3 D's). The 3 D's are different from one another, but it can be hard to distinguish between them because their signs and symptoms may be alike and sometimes an older adult can have more than one of these conditions at the same time (RNAO, 2016).

Delirium is a condition that comes on quickly (within hours or days) and affects the brain. It is usually temporary, lasting one-to-seven days, but should be treated right away. Most times delirium is caused by a combination of factors. Delirium is an acute disturbance in mental abilities that results in confused thinking and reduced awareness of the environment (RNAO, 2016).

Dementia is a disorder of the brain that can affect learning, memory, mood and behaviour. Dementia develops slowly, over several months or years. Dementia affects different people in different ways. Aging does not cause dementia but it is more common among older adults. One of the most common types of dementia is Alzheimer's disease (RNAO, 2016).

Depression is a medical illness. Having depression does not mean someone is weak. Many people have depression throughout their lives, while others suffer from depression as a result of a major change in their life, including (RNAO, 2016):

- death of a loved one
- loss of independence (e.g. moving to a long-term care home)
- developing dementia or an illness

Causes of Delirium

Delirium may be caused by (Delirium Toolkit, 2019)**:**

- having an illness
- staying in bed too long
- being in a noisy or confusing environment
- having pain

Signs and Symptoms of Delirium

Assess older adults at risk for recent (within hours or days) changes or fluctuations in behaviour. These may be reported by the person at risk, or a carer or relative. These behaviour changes may affect (Delirium Toolkit, 2019):

- **Thinking Skills:** Poor recent memory; Being disoriented to time and place; Difficulty in comprehending speech, reading, and writing
- **Perception of Environment:** lack of concentration and getting distracted easily; Not being able to respond to a question by getting stuck on a thought or an opinion
- **Behaviour:** Hallucination (seeing things that do not exist) Delayed response and movement Significant changes in sleep habits
- **Emotions:** Rapid and unpredictable mood changes Feeling depressed or euphoric without reason

These signs can fluctuate throughout the day and come and go. If any of these behaviour changes are present, a healthcare professional who is trained and competent in diagnosing delirium should carry out a clinical assessment to confirm the diagnosis. Delirium is a serious illness and needs to be treated right away (Delirium Toolkit, 2019).

Resources:

- Regional Geriatric Program of Toronto: Senior Friendly Care – Delirium Toolkit
- Regional Geriatric Program of Toronto: Senior Friendly Hospital – Delirium Toolkit
- Regional Geriatric Program of Toronto: Delirium Prevention Poster
- National Institute for Health and Care Excellent – Delirium: prevention, diagnosis and management

Living Safely with Dementia

Wandering

For older adults living with dementia, wandering is a common behaviour. As a result, people living with dementia may not be able to find their way back home and become lost. Wandering can lead to safety concerns (i.e. may lead the person with dementia outdoors, which can expose them to dangers such as traffic or dangerous weather conditions).

Whether or not a person living with dementia wanders, it is a good idea to take proactive steps to understand this particular behaviour and reduce the risk of the older adult becoming lost (Finding Your Way, 2020).

60%

of people with dementia-related memory problems become lost at some point.

(Finding Your Way, 2020)

Resources:

- Alzheimer Society of Ontario – Finding Your Way: Living Safely with Dementia
    - Identification Kit
- Project Lifesaver Guelph Wellington: GPS Tracking Device
- Vulnerable Persons Registry
- MedicAlert Safely Home

Driving

People living with early dementia may still be able to drive however there may come a point when it is no longer safe to do so. Primary Care Providers may be helpful when making this determination for your clients – refer to the section on Reporting for more information about the role of physicians in mandatory reporting. Please note that driving must be stopped immediately if the safety of the older adult or others on the road is at risk.

Resources:

- Driving Rehabilitation Program – St. Joseph's Health Centre Guelph
- DriveABLE

Polypharmacy

How many medications are older adults taking?

66% take 5+

27% take 10+

(CIHI, 2016)

It is important to identify when the medications used by older adults may be inappropriate and may place the person at increased risk of adverse events and poor health outcomes (Polypharmacy Toolkit, 2019):

- >5 medications
- >12 doses a day
- medications prescribed by multiple healthcare providers

If you are concerned about polypharmacy, ensure that accurate and complete medication information is available. This is especially important when there is a transition in care such as being admitted to or discharged from hospital.

Adverse Drug Reactions (ADRs) in Older Adults – Risk Factors (Polypharmacy Toolkit, 2019)**:**

- Recent changes in medication
- Taking more than 5 medications
- Age-related functional decline
- Ethnicity and gender
- Chronic health conditions
- Social habits (i.e. substance use)

Help older adults to be aware of signs and symptoms of adverse drug reactions. Offer to identify out-of-date medications and dispose of them.

Pharmacists

As medication experts, pharmacists are perfectly positioned to work with older adults, their doctors, and their caregivers to prevent medication problems, monitor for potential drug interactions, adapt packaging to the individual's needs and help people manage their health and get the most benefit from their medications.

GeriMedRisk: A resource for Physicians, Nurse Practitioners and Pharmacists

GeriMedRisk connects physicians, nurse practitioners and pharmacists through telephone and eConsult to an interdisciplinary team to troubleshoot complex physical and mental health conditions in older adults. A team of specialists from geriatric psychiatry, geriatric medicine, clinical pharmacology, and geriatric pharmacy work collaboratively to answer clinicians' questions about medications, physical and mental health conditions.

Additional Resources:

- Regional Geriatric Program of Toronto – Senior Friendly Care: Polypharmacy Toolkit
- Lifeline Medication Dispensing Service
- Deprescribing Guidelines

Chapter 4: Environmental

Different types of environments may either support or inhibit a person's function and health. Older adults should have a living environment that is safe and helps them to live as comfortably and independently as possible. As age-related functional decline occurs and other possible conditions arise an individual's ability to interact with or even make sense of their environment may be impacted (Dementia: Care for People Living in the Community, 2018).

Providers should establish a connection with appropriate supports who can help ensure that housing is safe and meets the needs of the older adult and their caregivers.

Living Safely with Dementia

Over the course of a person's dementia, living environments need to be modified to help the person navigate their surroundings, support their independence, and reduce their feelings of confusion and stress. Design modifications may include non-slip floor coverings, handrails in the shower and beside the toilet to provide support and balance, heat and smoke sensors, and memory cues.

When people living with dementia are no longer able to live safely and independently in their home, they may consider moving to a more supported care setting, such as a supportive or assisted living facility, a retirement home, or a long-term care home.

Long Term Care

In order to be admitted to a long term care home, the person must consent to the admission. If the person is incapable of consenting, then the Substitute Decision Maker, as determined by Section 20 of the Health Care Consent Act, must consent on their behalf.

The Local Health Integration Network Home and Community Care is responsible for access, eligibility and evaluation for Long Term Care.

Unstable Housing

The rural area of Wellington County presents different issues for older adults accessing social services in comparison to the City of Guelph. Low population density in rural areas means that it is not financially viable to establish emergency shelters, and so the majority of homelessness support services are located in Guelph. It is also important to note that the current shelters available may not be suitable and/or accessible for the older adults you support (A Place to Call Home, 2019).

Resource:

- Legal Clinic of Guelph Wellington: Housing Law

Housing Stability Programs

In general, the demand for subsidized housing greatly outweighs the supply, as a result there is a large waiting list for social housing units.

The County of Wellington currently offers a range of Housing Stability Programmes, including referrals to financial assistance, rent banks and emergency energy funds; landlord education and information on tenant rights and responsibilities; and Housing Community Support Workers who provide outreach. In addition, the County has begun working on an Eviction Prevention Policy which will introduce strategies to support tenants at risk of eviction from becoming homeless (A Place to Call Home, 2019).

Resources:

- **Wellington County Affordable Housing**
- **Drop In Centre Guelph:** Community space in downtown Guelph that offers a multitude of services, especially for those living on a limited income. It provides a place to meet with friends and have a meal, access shelter if needed, and connect with support services
- **Retirement Home Subsidy:** The County of Wellington currently has formal service agreements with Retirement Homes in the City of Guelph and throughout Wellington County. A Supportive Housing Caseworker will meet with older adults applying for financial support in order to determine initial and ongoing eligibility.
    - For information on which formal service agreements exist with Retirement Homes in the City of Guelph and throughout Wellington County visit: www.wellington.ca
- **Thresholds Homes and Supports: Crisis Respite**
    - May not be suitable for all older adults (review for suitability and accessibility)
- **Guelph Wellington Women in Crisis: Transitional and Housing Support**

Local Housing Strategies

- 10 Year Housing and Homelessness Plan for Guelph-Wellington – Five Year Update, 2019
- City of Guelph Affordable Housing Strategy

Diogenes Syndrome

Diogenes syndrome (DS) is a behavioral disorder of the elderly. Symptoms include living in domestic squalor, extreme self-neglect, and unhygienic conditions. This is accompanied by a self-imposed isolation, the refusal of external help, lack of shame and a tendency to accumulate unusual objects (Cipriani, G et al., 2012; and Irvine, J., & Nwachukwu, K., 2014).

A diagnosis of Diogenes Syndrome can be difficult as no one set of symptoms has been established. Additionally, management can be difficult, as individuals often deny that there is a problem, may refuse any help, and can present late to medical attention, often in crisis (Irvine, J., & Nwachukwu, K., 2014).

Domestic Squalor

Squalor is different from hoarding in that there is no intentional saving or acquiring of items. Build-up is instead due to neglect or inability to remove the items. The individual's home is generally in a state of disrepair, may look unclean or unkempt. The state of the home may or may not cause distress, however it does present to have a negative impact on the health and wellbeing of the individuals who reside there (WGHR, 2019).

Hoarding

The word “hoarding” is often used to describe a person’s home that has such a large number of items that the livable spaces in their home are significantly reduced.

For some people, these items make their space feel homey and inviting, for others, they make the space feel distracting and chaotic. With age-related functional decline, it is important to consider how living environments with a large number of items can create safety concerns.

The Wellington Guelph Hoarding Response (WGHR) represents a committed group of organizations in Guelph Wellington that have come together to provide support and resources for persons with hoarding challenges.

Resources:

- HOMES assessment – A multi-disciplinary risk assessment used for assessing home safety
- Clutter Image Rating Scale – A quick reference to help identify the volume of possessions in a person’s home

Chapter 5: Support by Sector

It is important to recognize that many sectors provide services to older adults living at risk. Each sector is guided by different legislation and mandates which results in unique responses. The information provided here highlights the different roles and possible responses to supporting older adults at risk across sectors.

For ease of this guidebook, mental health services are embedded in each of the applicable sectors below:

- **Justice**
- **Home and Community**
- **Health Care**
- **Crisis Services**
- **Social Services**

Justice

- Police
- Crown Attorney
- Court Support
- Victim Services
- Victim Witness Assistance Program
- Legal Support
- Elder Mediation

Resource:

Ontario's Human Services and Justice Coordinating Committee has developed: *Older Adults and the Justice System: A navigational guidebook for caregivers and service providers* outlining a variety of age-related conditions and presents strategies for working with or caring for these populations. Best practices for engaging with the police and the courts are explored, with detailed summaries of the criminal and mental health law systems. Finally, challenges and available services in correctional facilities are described, including supportive housing options.

Police

As a service provider, it is important that you are aware of how involving police services may impact your client/family and when/how to initiate a call for support. We split this category into 4 areas:

- Guelph Police Services – Seniors at Risk Officer
- Ontario Provincial Police – Wellington County
- IMPACT
- Intimate Partner Violence

Guelph Police Services – Seniors at Risk Officer

The Seniors at Risk Officer (attached to the domestic violence unit) fully investigates all elder abuse cases, works with community partners to mitigate risk, supports safety planning, and ensures the appropriate victim services are provided. The Seniors at Risk Officer acts as a secondary response unit; As uniformed officers respond to calls and identify older adults at risk, the information is forwarded to the Seniors at Risk Officer for follow up.

Ontario Provincial Police – Wellington County

The Ontario Provincial Police values the aging population and has developed the "Resource Guide to Living Well Aging Well" to provide seniors, loved ones and caregivers with information and resources available to assist them in maintaining their safety and wellness in a variety of situations.

Wellington County O.P.P. continues to commit to supporting older adults at risk by working collaboratively with community partners to support social development initiatives to minimize risk to seniors and increase community safety through safety-focussed consultation.

IMPACT

Consists of specially-trained clinicians to mental health + addictions related calls alongside police officers. This is a regional partnership and includes both Guelph Police and Wellington County OPP. Referrals to IMPACT are initiated through police

dispatch. IMPACT clinicians assist in liaising with acute care, making appropriate referrals to community services and support the transition between those services.

Intimate Partner Violence

A few helpful definitions:

- ***Domestic incident –*** *Any incident that the police have been called to investigate, between persons who have been or are presently involved in an intimate relationship regardless of whether a criminal offence has occurred.*
- ***Intimate partner violence*** *(domestic violence) – Any use of physical force, actual or threatened, or threatening/harassing behaviour between persons who are or have been involved in an intimate relationship. Intimate partner violence can be a pattern of abuse or a single act*
- ***Intimate Partner*** *= Include those between opposite-sex and same-sex partners, including current and former dating, common-law or married couples or in instances where one party feels like they are in a relationship, regardless of whether or not there has been sexual activity.*

If an instance of intimate partner violence is reported to the police and a charge has been laid, the process that unfolds is directed by the justice system. At times, a spouse/partner of a senior living at risk, particularly in situations of intimate partner violence, may be reluctant to contact police. This is because once charges are laid there is a complex set of rules and procedures that must be followed. It is important that caregivers clearly understand that if they report a criminal offence to the police, the police will investigate. Once the police have knowledge that a crime has been committed, the police are obligated to lay a charge in cases of intimate partner violence. Police can arrange contact with Victim Services if the caregiver/partner wants the support of this resource.

> **Tip:** Encourage caregivers to ask for the officer's business card so that they can contact him or her with any information or questions.

Resources:

- **Project Lifesaver Guelph Wellington:** helps families protect members who may wander in Guelph and Wellington County. Typically these are people living with Alzheimer's, autism, Down's Syndrome, acquired brain injury or other types of cognitive impairment. These individuals can be equipped with a 1 ounce wrist transmitter that sends a radio signal which can be tracked up to a 2 kilometer radius. The system operates all day, every day of the year.
- **Interpretative Services:** The Ministry of Citizenship and Immigration offers free interpretative services for victims of DV, sexual violence or human trafficking.
- **Safe Pathways: supporting dementia in the justice system** is a collaborative community approach, to support and guide individuals with dementia and their care partners away from and/or through the Guelph and Wellington County Judicial System while maintaining dignity and respect. A caregiver/family safety plan is available for service providers.
- **Vulnerable Persons Registry – Guelph Police**

Crown Attorney

Once charges are laid, the Crown Attorney is the person who determines how to proceed with a legal case and whether charges are prosecuted. They will proceed with screening all files, notifying Family and Children's Services if appropriate, meet with the victim (caregiver/partner), seek appropriate conditions to protect the victim, witnesses and the public should the senior be released, and request reports and/or psychiatric assessment, where appropriate.

If you are a healthcare provider and you have questions about supporting your client with respect to privacy legislation, please refer to the section on privacy (link here) and speak with your privacy officer.

Court Support

Mental Health Court: Support Coordinators provide bail, diversion and non-diversion support to address needs such as housing, treatment, crisis planning and court support. These services are available for youth and adults depending on the region.

Mental Health and Justice Services – CMHA WW

CMHA Mental Health and Justice Services helps people who are experiencing mental health concerns (whether diagnosed or symptoms suggesting a major mental illness) who are also charged with a criminal offense in Waterloo or Wellington region. They offer advocacy and individual assistance in accessing services and community resources for adults 18+. Referrals are made through Here 24/7 (1-844-HERE 247). The MH&J team is also available for consultation.

Guelph-Wellington Women in Crisis

Women In Crisis also offers a Family Court Support Program for women who have experienced abuse and are currently involved in or about to enter the Family Court process.

Court Support can enable easier navigation through the justice system and connect individuals with community service providers to address their concerns.

Victim Services Wellington

Victim Services Wellington is responsible for providing on-site emotional and practical support to victims of crime and tragic circumstances throughout Guelph and Wellington County. There are a number of other programs and services available.

Victim/Witness Assistance Program

The Victim/Witness Assistance Program is offered through the Ontario Victim Services Secretariat within the Ministry of the Attorney General. The program's mandate is to provide information, assistance and support to victims of crime throughout the criminal court process in order to increase their understanding of, and participation in, the criminal court process.

Once a criminal charge has been laid, services are offered on a priority basis to victims of sexualt assault, intimate partner violence, hate crimes, families of homicide victims or traffic fatalities, vulnerable victims with special needs and older adult victims.

Legal Support

Advocacy Centre for the Elderly (ACE)

ACE provides direct legal services to low-income seniors, public legal education, and engages in law reform activities. ACE services and activities are in relation to areas of law of special importance to the seniors' population. ACE is funded through Legal Aid Ontario.

Legal Clinical of Guelph and Wellington County

The Legal Clinic of Guelph and Wellington County provides free legal services for low-income people in Guelph and Wellington County.

Elder Mediation

Community Justice Initiative (CJI)

Community Justice Initiative (CJI) utilizes a restorative justice approach to provide conflict resolution for seniors who are friends, family members, and neighbours in Waterloo Wellington. They also work with victims and offenders. During a mediation, trained facilitators ensure that everyone has a chance to speak and listen. Participants discuss how a situation impacted them and ask questions. All are encouraged to take responsibility for their actions and repair harm. Participants leave with a mutually acceptable plan to move forward.

Home and Community

For the purposes of this guide, we have included the following programs/services within the Home and Community sector:

- Guelph Wellington Seniors at Risk
- Elder Abuse Prevention Ontario
- LHIN Home and Community Care
- Community Support Services
- Behaviour Supports Ontario
- Wellington Guelph Hoarding Response Network

Guelph Wellington Seniors at Risk

Seniors at Risk Clinical Consultant – CMHA WW

The clinical consultant provides support and consultation regarding vulnerable older adults and their families in Guelph and Wellington County. This role functions as a part of the broader Specialized Geriatric Services and HERE 24/7 team and works to build capacity of service providers to support their older adult clients with mitigating and minimizing risks. Access to emergency shelter in Guelph Wellington is also available. Referrals are directed through HERE 24/7 at 1-844-437-3247.

Seniors at Risk Network/Consultation Team

Guelph Wellington Seniors at Risk Consultation Team is a network of service providers working to ensure there is a coordinated community response to supporting older adults living at risk using a collaborative, multi-disciplinary approach across health and social services, legal and police services. The purpose of the consultation team is to advise service providers who are dealing with complex situations involving vulnerable older adults on available options to improve each agency's response for support. For more information, contact the Vulnerable Seniors Lead 519-821-8089 x2105.

Elder Abuse Prevention Ontario

Elder Abuse Prevention Ontario (EAPO) is a provincial, registered charitable organization responsible for implementing the Ontario Strategy to Combat Elder Abuse. The framework of the strategy focuses on three priorities – community service coordination, building local capacity of front-line workers/caregivers/ community networks and service professionals through training and through public education forums raising overall awareness about the complexities of elder abuse.

A Regional Consultant with EAPO is a member of the Guelph Wellington Seniors at Risk Network and supports local community services and other initiatives as required/appropriate. For more information, contact: centralwest@elderabuseontario.com

LHIN Home and Community Care

Care Coordinators with the Local Health Integration Network (LHIN) are regulated health professionals who are based in the community and/or local hospitals. They

conduct eligibility and service needs assessments. In collaboration with clients and families/caregivers, they develop, initiate and coordinate individualized care plans to achieve mutual goals. They also provide ongoing case management, system navigation, future planning and discharge planning to supportive settings as required.

LHIN Care Coordinators are evaluators of capacity for Long Term Care. Capacity evaluation for admission to a long-term care home involves an important and complex assessment with significant consequences for those being assessed. If a person is deemed capable, he/she retains the right to decide where they will live, including whether or not they will move to a long-term care home. If declared incapable, the individual loses that autonomy, and someone else will make the decision on their behalf.

Community Support Services

Community Support Services (CSS) are not-for-profit agencies committed to providing a continuum of services ranging from prevention to end of life care. Services benefit a full range of clients, including seniors, people of all ages with disabilities or chronic illness, and their caregivers. Funding for services are often through a combination of sources including: LHIN, client fees, private donations and/or other grant programs. For the purpose of this guide, we review local Adult Day Services, Overnight Respite and the Alzheimer Society in further detail below. For more information on additional CSS visit: wwhealthline.ca.

Adult Day Services and Overnight Respite

Adult Day Services offer full-day opportunities for clients to participate in a social/recreational program while providing respite to caregivers and families. Additionally, some programs offer direct support and health system navigation to families/caregivers. Programs can offer a full-day of support and a safe place for an older adult at risk while caregivers, family members and/or community partners work together to develop a safety plan. Referrals are made via the LHIN Home and Community Care.

Programs are offered through:

- St. Joseph's Health Centre Guelph (Programs in Guelph/Fergus)
- VON Day Program – Mount Forest
- East Wellington Community Services

Short-term overnight respite services are also available through the Regional Overnight Stay Program (a collaborative model between St Joseph's Health Centre Guelph and Sunnyside Seniors Services) . This service can provide an older adult at risk temporary safe shelter to allow caregivers, family members and/or community partners time to plan for a more permanent or longer term housing solution. This is an opportunity to remove the client from the identified risk environment, while providing supervision and ensuring the client's basic needs are met. Contact the programs directly for consultation to determine suitability and availability.

Alzheimer Society Waterloo Wellington (ASWW)

ASWW works with care partners and people who are living with dementia to identify possible risks with memory related changes that impact one's ability to function in their home and to develop safety plans that help the person living with dementia to live safely in the community. We might do this through an education session, telephone support, care partner support groups or through individual or family counselling.

Behaviour Supports Ontario

In Waterloo Wellington, BSO is hosted by St. Joseph's Health Centre Guelph and is an integrated extension of Specialized Geriatric Services (SGS) working closely with the primary care practitioner or geriatric specialist. It is preferred that a thorough geriatric assessment is completed and pharmacotherapy reviewed/optimized, prior to BSO involvement.

Community Responsive Behaviour Team (CRBT)

A multi-disciplinary team of clinicians who assess older adults with cognitive impairment for specific responsive behaviours arising from dementia, mental health and/or addictions. The clinicians work collaboratively with identified caregivers on strategies to manage the behaviour and/or associated risk.

Behaviour Supports Ontario (BSO) Transition Team

A multi-disciplinary team of clinicians who provide assessment on specific responsive behaviours arising from dementia, mental health and/or addictions in order to facilitate a positive and successful transition across sectors (i.e. from Community to Long Term Care or Hospital to Community).

Referrals can be made by healthcare professionals via the Specialized Geriatric Services Referral Form.

Wellington Guelph Hoarding Response

The Wellington Guelph Hoarding Response (WGHR) represents a committed group of organizations in Guelph Wellington that have come together to provide support and resources for persons with hoarding challenges. Together they continue to build capacity to support each other and situations where home safety is compromised due to clutter. A coordinator is available for consultation.

Health Care

This section includes the following programs and services as part of the older adult's health care team:

- Primary Care
- Specialized Geriatric Services
- Community Paramedicine
- Acute Care
- Sexual Assault/Domestic Violence Treatment Centres

Primary Care

Primary care is the day-to-day healthcare given by a health care provider. Typically this provider acts as the first contact and principal point of continuing care for patients within a healthcare system, and coordinates other specialist care that the patient may need. Primary care is seen as a "gatekeeper" and as a patient's medical "home", helping patients navigate throughout their whole care journey. Primary care could be seen as the best place within the health system to identify, provide and coordinate care for at-risk older adults.

Specialized Geriatric Services (Medicine/Psychiatry)

Specialized Geriatric Services (SGS) is a community based network of interdisciplinary teams (geriatricians, geriatric psychiatrists, specialized nurses and social workers). SGS completes a comprehensive, holistic assessment of a client

which promotes improved health/wellbeing, improved function and decreased risk. Ongoing assessments, treatments, monitoring as well as support and education are available to clients and their families. A physicians' referral is required using the SGS Referral Form.

Intensive Geriatric Service Worker (IGSW) Program

As an extension of Specialized Geriatric Services (SGS) in the community, the IGSW Program provides follow-up and intensive service coordination for older adults with complex geriatric issues. The IGSWs work with the broader health care system and community to support older adults who may be isolated, with limited resources. Team members build rapport with clients in order to best support them where they are, and work closely with the senior's network to promote independence and self-directed care through the coordination of appropriate services and support for the senior. **Note**: This service is accessed through designated Specialized Geriatric System referral sources only.

GeriMedRisk

A resource for Physicians, Nurse Practitioners and Pharmacists:

GeriMedRisk connects physicians, nurse practitioners and pharmacists through telephone and eConsult to an interdisciplinary team to troubleshoot complex physical and mental health conditions in older adults. A team of specialists from geriatric psychiatry, geriatric medicine, clinical pharmacology, and geriatric pharmacy work collaboratively to answer clinicians' questions about medications, physical and mental health conditions.

Community Paramedicine – Guelph Wellington Paramedic Service

Community paramedicine is an evolving model of community-based health care in which paramedics function outside of their traditional emergency response and transport roles. The program aims to support individuals to access collaborative resources in order to reduce dependency on 911 and possible transports to the local emergency department.

Paramedic Referrals: Frontline Paramedics can refer directly to the LHIN Home and Community Care or HERE 24/7 advising when an older adult could benefit from additional support and intervention.

Paramedic Home Visits: For clients with frequent calls to 911, the community paramedics can provide home visits to determine an alternate support plan for the individual (i.e. supported referrals).

Community Health Assessment Program (CHAP): Paramedics also offer health monitoring clinics in Wellington County Housing buildings. Monitoring includes social determinants, food security, blood pressure monitoring, blood sugar checks, and falls risk assessment.

Remote Patient Monitoring: People that suffer from congestive heart failure (CHF), diabetes (DM) and/or chronic obstructive pulmonary disease (COPD) will be monitored remotely through technology to recognize exacerbations and trends to improve patients health awareness and decrease dependency on emergency services and hospitals admissions. Paramedics work collaboratively with LHIN Rapid Response Nurses and Primary Care to provide wrap around care for unstable patients.

For more information about access and referrals to the Community Paramedicine Program, contact the Coordinator at 519-822-1260 x3379.

Acute Care

Geriatric Emergency Management Nurses

Care for older adults at risk often begins with a Geriatric Emergency Management (GEM) nurse assessment in the Emergency Department. A GEM nurse is a specially trained nurse in geriatric medicine and can assess older adults for geriatric syndromes. GEM nurses work in collaboration with Specialized Geriatric Services (link to section) to create comprehensive treatment plans and liaise with community supports to allow for community based follow up to further address safety concerns for seniors at risk.

Acute Inpatient Units

Treatment for older adult patients while residing in hospital is based on a multidisciplinary approach to care. A team of physicians, allied health professionals (social work, therapy), nurse practitioners, specialists (i.e. geriatricians, psychiatry) work to create comprehensive assessments and treatment plans during the stay as well as contributing to safety plans as necessary when older adult living at risk are returning back to reside in the community.

Specialized Inpatient Units

Homewood Health Centre

The Program for Older Adults supports those dealing with depression, anxiety, dementia, or other mental health needs through a multidisciplinary clinical team, led by physicians and offers three treatment streams to meet the diverse needs of patients. All three streams provide a comprehensive assessment, individualized treatment and recommendations for the continued management of care after discharge.

Grand River Hospital

Both the Geriatric Assessment Unit (GAU) and Neurobehavioural Unit (NBU) are located in the Grand River Terrace Building at the Freeport Campus. The Geriatric assessment unit inpatient service is designed for frail seniors who need an inpatient admission. They have a number of health professionals working together to give patients comprehensive geriatric assessment and treatment. The neurobehavioural unit offers specialized assessment and treatment for adults living with age-related conditions that may include dementia.

There is also a specialized mental health unit for seniors who have a cognitive impairment typically related to dementia. Patients may have responsive behaviours such as aggression, wandering, physical resistance or agitation. The behaviour is termed “responsive” because the person is responding to something negative, frustrating, or confusing in his or her environment.

Psychogeriatric Resource Consultant (PRC)

The PRC provides consultation, education and training to Long Term Care (LTC) Homes and Acute Care settings regarding older adults who exhibit complex responsive behaviours associated with physical and mental health needs. PRCs collaborate to bring together the right people and resources to meet the changing needs of clients. If you are supporting an older adult at risk with an upcoming transition to LTC or hospital, consider how a referral to the PRC can support the staff in the new setting as they prepare for the arrival of your client. The Guelph and Wellington PRC role is hosted by the Canadian Mental Health Association WW in partnership with Home and Community Care.

Sexual Assault/Domestic Violence Treatment Centres

Sexual Assault/Domestic Violence Treatment Centres (SADVTC) are 35 hospital-based centres that provide 24/7 emergency care to women, children and men who have been sexually assaulted or who are victims or survivors of domestic violence by an intimate partner.

Services include:

- Emergency medical/ nursing care
- Crisis intervention
- Collection of forensic evidence
- Follow-up and counselling
- Referral to community resources
- Safety planning

Resource:

- Let's Stop Sexual Harassment and Violence
- Find a sexual assault centre near you

Crisis Services

For the purposes of this guide for service providers, crisis resources include:

- Crisis Call Centres
- Emergency Shelter
- Treatment Centres

If your client is experiencing a medical or mental health crisis with imminent risk of harm, consider calling 911.

Crisis Call Centres

HERE 24/7

Here 24/7 is the front door to the addictions, mental health and crisis services provided by partner agencies across Waterloo – Wellington. A HERE 24/7 staff members completes crisis intervention, intake, mental health/addictions assessment, referral, and brief support functions.

Guelph Wellington Women in Crisis

The Crisis Line is a 24-hour telephone and TTY support and referral line in Guelph and Wellington County offering support to those who have experienced or are experiencing physical, sexual, emotional or financial abuse and/or stalking. They also speak to concerned friends and family members of abused women, service providers and other professionals in contact with abused women.

Support Services for Male Survivors of Sexual Abuse

The Support Services for Male Survivors of Sexual Abuse program provides help for male survivors of sexual abuse, both recent and historical. The program is the first of its kind in Canada and is delivered by agencies across the province. Survivors also have access to a 24-hour, multilingual, toll-free phone line for immediate crisis and referral services at 1-866-887-0015.

Emergency Shelter

Retirement Home Placement Program

Three Retirement Homes located in Guelph and Wellington County agree to provide temporary, emergency placement for older adults who are victims of abuse. Abuse can include financial, emotional, physical and sexual mistreatment as well as neglect. Accommodation will be provided for a minimum period of 48 hours with additional provision to be determined in consultation with the Wellington County Special Services Unit. Note that for this purpose emergency placement is intended to be of short term duration and that a follow-up case conference and a housing plan will be required within one week of the placement. To access this service, any requests are

to be directed to the seniors at risk clinical consultant, vulnerable seniors lead, or via the supportive housing caseworker with the County of Wellington.

Marianne's Place – GW Women in Crisis

Marianne's Place is an accessible emergency shelter where all women and their children who are experiencing physical, sexual, emotional or financial abuse and/or stalking are welcome. Staff provide support and information so the individual can make informed choices about their safety. All services are free and interpreters can be arranged when necessary. You can contact the shelter by calling the 24-hour Crisis Line at 1-800-265-7233 for immediate and confidential support.

Drop In Centre – Shelter Program

The Drop In Centre's shelter programs provide homeless individuals with a shelter bed and access to basic needs, such as meals, hygiene items, and showers. These emergency shelters offer individuals a safe place to stay as they search for housing and pursue their goals. Many of the shelters may not be suitable or accessible for your older adult client, contact the Drop In Centre for more information. Note: all shelter residents are encouraged to utilize The Drop In Centre during the day, when the shelter is closed. Meals are provided twice daily at the Drop In Centre and are free of charge to anyone utilizing the shelter program.

Treatment Centres

Sexual Assault/Domestic Violence Treatment Centres

Sexual Assault/Domestic Violence Treatment Centres (SADVTC) are 35 hospital-based centres that provide 24/7 emergency care to women, children and men who have been sexually assaulted or who are victims or survivors of domestic violence by an intimate partner.

Social Services

County of Wellington – Social Services

The central offices of the County of Wellington, Social Services Department are located in downtown Guelph. An Ontario Works and Settlement Services office

located in Fergus provides full support for these programmes, and appointments can be made for other social services in Fergus as well as in Mount Forest.

Social Services: May include support with housing and social assistance programs. Financial assistance may be available to assist Social Assistance recipients (Ontario Works and/or Ontario Disability Support Program) who are homeless obtain housing, or who are at risk of becoming homeless remain housed. The emergency housing and energy supports available through the Housing Stability program can assist with last month's rent deposits, hydro arrears and moving costs.

Housing services: All applications for Rent-Geared-to-Income (RGI) assistance for subsidized housing located in GuelphWellington are managed by the County of Wellington through the Centralized Waiting List. This "one-stop" centralized approach means applicants only need to complete one application form to apply to multiple housing providers for RGI assistance.

Settlement Services: This programme is funded through Immigration, Refugees and Citizenship Canada (IRCC). The mandate of this programme is to assist newcomers to Canada access community services and adjust to life in their new community. All services are available at no cost to those with Permanent Resident, Convention Refugee, or Live-In Caregiver status in the County of Wellington and City of Guelph.

Lutherwood

Lutherwood is a progressive, not-for-profit health and social service organization that strengthens people's lives in our community by providing mental health, employment and housing services in Waterloo Region and Wellington County. Lutherwood's housing services support clients in the search to find permanent, safe and affordable housing.

Drop In Centre Guelph

The Drop In Centre (also called The Welcome In Drop In Centre) is a community space in downtown Guelph that offers a multitude of services, especially for those living on a limited income. It provides a place to meet with friends and have a meal, access shelter if needed, and connect with support services to improve quality of life. The Centre welcomes all individuals, offering a sense of community, friendship, happiness and hope to everyone who walks in the door. The Drop In Centre is a place for everyone — regardless of gender, socioeconomic status, sexual orientation,

or any other factor. Supports available include meals, emergency pantry, financial assistance, as well as access and referral to outreach, emergency shelter, mental health and addictions supports, medical assessment, housing and legal services.

Women in Crisis

Guelph-Wellington Women in Crisis (G-W WIC) supports seniors affected by domestic or sexual violence through safe shelter, crisis line response, individual and group counselling, accompaniments, advocacy, risk assessment and safety planning. Additionally, G-W WIC offers community consultation on incidents involving seniors at risk and elder abuse.

Developmental Services

Developmental Services Ontario

Developmental Services Ontario is the central access point for all adult developmental services in Ontario. They determine eligibility for ministry funded services that may be available in Guelph Wellington.

Community Networks of Specialized Care – Health Care Facilitator

The refreshed mandate of the Community Networks of Specialized Care (CNSC) is to improve access to healthcare for individuals with a developmental disability that have High Support and Complex Care Needs. Referrals can be made from community or residential services. The Health Care Facilitators support and educate primary health care providers and non-developmental services agencies about people with complex and multiple needs and develop linkages between health care professionals and share knowledge with the existing developmental services community. For more information on programs in the Central West Region, visit the Central West Specialized Developmental Services.

Resources:

- When To Refer to a Health Care Facilitator
- Combined CNSC Referral Form

Family and Children's Services

Family and Children's Services is mandated to protect children in our community. If a person has reasonable grounds to suspect that a child is or may be in need of protection, the person must promptly report the suspicion and the information to Family and Children's Services.

The duty to report is an ongoing obligation and cannot be delegated to someone else. If a person has made a previous report about a child and has additional grounds to suspect that the child is or is likely to suffer harm, that person must make another report. For more information visit the section on privacy and reporting.

If you are uncertain about reporting you can contact Family and Children's Services at 1-800-265-8300 to discuss the questions and concerns to determine if it is reportable.

Chapter 6: Privacy & Reporting

Some of the Information provided in this section is taken directly from the Canadian Mental Health Association Waterloo Wellington's Policy on Disclosure of Information Permitted in Emergency or Urgent Circumstances and Mandatory Reporting Situations and it should be noted that although the content is based on legislation, services may apply it differently at the discretion of the organization's Privacy Officer.

Privacy

Defining Privacy Acronyms:

- PHIPA – Personal Health Information Protection Act
- FIPPA – Freedom of Information and Protection of Privacy Act
- PHI – Personal Health Information is any identifying information about clients that is in verbal, written or electronic form.
- HIC – Health Information Custodian
- Circle of Care – The term "circle of care" is not a defined term in the Personal Health Information Protection Act, 2004 (PHIPA). It is a term commonly used to describe the ability of certain health information custodians to assume an individual's implied consent to collect, use or disclose personal health information for the purpose of providing health care, in circumstances defined in PHIPA

For Health Care Providers:

Ontario Privacy legislation (PHIPA/FIPPA) and the Regulated Health Professions Act (RHPA) do not prevent the rapid sharing of Personal Health Information (PHI) in certain situations. It is a given that personal information is protected by Ontario's privacy and access laws, but it is imperative to know that these protections are not intended to stand in the way of disclosure of "need to know" vital information in emergency or other situations and in some cases, life-saving.

Subsection 40(1) of PHIPA (Personal Health Information and Protection of Privacy Act) provides that a health information custodian **"may disclose personal health**

information about an individual if the custodian believes on reasonable grounds that the disclosure is necessary for the purpose of eliminating or reducing a significant risk of serious bodily harm to a person or group of persons". This provision may be relied on when health information custodians are considering disclosing personal health information to the police.

Reporting and Your Client's Privacy

Disclosure of Information in Emergency or Urgent Circumstances

In emergency and limited other situations, personal information, including personal health information, may need to be disclosed in a timely fashion, even if the person's consent has not been obtained.

The provider who encounters a situation or circumstance that includes emergency or critical situation affecting a person receiving services or public health and safety needs to understand what is permitted in certain circumstances and should consult with their Privacy Officer or delegate as time permits.

It is important to document in the clients' health record the circumstances of the situation, what was disclosed, to whom, at what day and time and for what reason(s) the information was disclosed and why consent was not obtained.

Here are a few potential circumstances of disclosure of PHI without expressed consent:

1. **Providing Health Care:** When consent cannot be obtained in a timely manner and disclosure is reasonably necessary for the provision of health care, personal health information may be disclosed to certain other health care providers *(unless a person has pro-actively forbidden disclosure of the relevant personal health information).*

2. **Disclosure Related to Risk – Health and Safety of an Individual/Risk of Serious Harm to Person or Group:** It is permissible to disclose personal health information about an individual if there is a belief that on reasonable grounds, that the disclosure is necessary to eliminate or reduce a significant risk of serious bodily harm to a person or group of persons. The disclosure may be made to police, and in some instances, to the intended victim(s). Even if the individual gave express instructions not to disclose the relevant personal

health information, the disclosure may be made. Providers are expected to use their best judgment in these situations; however, are advised to consult with management and/or privacy officers to ensure that the disclosure is appropriate. When appropriate, the client is advised of the decision to disclose the relevant information.

3. **Child Abuse/Neglect:** Under the Child and Family Services Act (CFSA) "a child in need of protection includes a child who has suffered, or is at risk of suffering abuse, neglect, or emotional harm" (section 72(1) of CFSA. Individuals who have reasonable grounds to suspect a child is in need of protection must report directly to Family and Children's Services (F&CS), however, are not obligated to report suspicion of abuse to the Police. If information provided to F&CS alleges that a criminal offence has been perpetrated against a child, F&CS will immediately inform the police and work with them according to established protocols for investigations.

4. **Impaired Driving Ability:** The Highway Traffic Act requires that physicians report every individual 16 years of age or older that they serve, who, in the opinion of the physician is suffering from a condition that may make it dangerous to operate a motor vehicle. Reports are sent to the Registrar of Motor Vehicles, and include the name and address of the individual, as well as the medical condition that affects their ability to drive. While it is not necessary to obtain a patient's consent before making a report under the Highway Traffic Act, the College of Physicians and Surgeons encourages that physicians inform the client in advance of doing so and where it was not possible to inform client beforehand, the College recommends that physicians do so after the report has been made. A report by a physician under the Highway Traffic Act will not automatically result in the suspension or downgrading of the client's licence. Upon receipt, the Ministry of Transportation will review information received in accordance with the Highway Traffic Act and national medical standards. Other providers who encounter situations whereby the person they serve appears to be suffering from a condition that may impact their ability to safely operate a motor vehicle are encouraged to facilitate a medical appointment with the person's family physician and/or arrange for the assessment through interdisciplinary team consultation.

5. **Compassionate Circumstances:** PHIPA allows a health information custodian to disclose personal health information without consent in order to contact a relative, friend or potential substitute decision maker if an individual is injured,

incapacitated or ill and unable to consent. It is also permissible to disclose personal health information about a deceased person or a person suspected of being deceased (cause of death, or identifying information) to spouse, partner, sibling or child if it is reasonably required to enable these persons to make decisions about their own health care or about the health care of their children. PHIPA allows a HIC to disclose PHI without consent about a deceased individual or one who is suspected of being deceased for the purpose of identifying the individual.

Duties and expectations vary with respect to reporting among professionals so each provider and clinician must consider their particular obligations.

Liability Protection

Executive Directors, Health Information Custodians and individuals acting on their behalf are protected from actions or proceedings if they act in good faith and do what is **reasonable** under the circumstances. This protection may relate to:

1. Disclosure (or non-disclosure) of information
2. Giving of a required notice, if that person took reasonable care to give the required notice.

More on Mandatory Reporting

The Long-Term Care Homes Act and Retirement Homes Act state that any staff member that has reasonable grounds to suspect that a resident from a long-term care or retirement home has or may be harmed or put at risk of harm at the home has a duty to report their concerns. A report must also be made if there is a suspicion on reasonable grounds that a home has or may misuse or misappropriate a resident's money.

Long Term Care ACTION Line: If you suspect or have evidence that elder abuse is taking place in the Long-Term Care Home it is mandatory to report it with the exception of residents themselves (who have a choice in the matter). The Long-Term Care Homes Act (s.24) states if a person who has reasonable grounds to suspect abuse has occurred or may occur shall immediately report the suspicion and the information to the Ministry of Health and Long-Term Care Director.

Tel: 1-866-434-0144 (7 days a week, 8:30a.m.-7:00 p.m.)

Retirement Home Regulatory Authority (RHRA): You must report elder abuse immediately to the RHRA if you see or suspect harm or risk of harm to a resident resulting from: Improper or incompetent treatment or care, abuse of a resident by anyone or neglect of a resident by staff of the retirement home, unlawful conduct, or misuse or misappropriation of a resident's money.

Tel: 1-855-ASK-RHRA (1-855-275-7472)

The Director or the Registrar must look into all reports of abuse, and must send an inspector to the home immediately if the report is about harm or risk of harm. The operator of the home, whether a Long-Term Care or a Retirement Home, is also required to immediately contact the police if there is an alleged, suspected, or witnessed incident of abuse or neglect of a resident which may be a crime.

Crime Stoppers: If you suspect an older adult is being abused and/or a criminal act has taken place you can report anonymously to the police through Crime Stoppers.

Tel: 1-800-222-TIPS (8477)

Office of the Public Guardian and Trustee (OPGT): is responsible for protecting mentally incapable people; other responsibilities include protecting the public's interest in charities, searching for heirs, investing perpetual care funds, and dealing with dissolved corporations.

In cases of financial or personal abuse, the OPGT can apply to the court to become the abused senior's guardian on a temporary basis. The OPGT can also help the person get access to other services. They can intervene only if the person is believed to be mentally incapable and is at risk of harm or experiencing harm. There must be evidence/reason to believe that the person is incapable before the OPGT will investigate.

The Guardian Investigation Unit: 1-800-366-0335 or 416-327-6348

Visit Elder Abuse Prevention Ontario for more information on Legislation and Reporting.

Chapter 7: Consent & Capacity

The ability of a person to make their own decisions is called having capacity. Having capacity means the person is able to make "informed decisions." According to the Health Care Consent Act, a person is said to have capacity when they:

- Understand all of the information relevant to the decision they are making.
- Appreciate the reasonably foreseeable consequences of a decision or lack of decision.

It is important to note that the capacity to make decisions should not be confused with judgement. The issue is not whether a person is making a "good" decision, but whether they are able to make an informed decision after carefully weighing the pros and cons of the options available (Conversations About Decision Making, 2019).

There is no such thing as "global incapacity": incapacity is determined on an issue by issue basis. For example, you may be capable to consent to one type of treatment, and not another, or be capable of treatment, but not capable to consent to admission to long-term care, and vice-versa. Further, capacity can fluctuate over time (Meadus, J, 2010).

Questions you might ask: (EAPON, 2017):

- Has anyone told you that you are incapable of making decisions? If so, have you been assessed by a physician or capacity assessor?
- Do you have a Substitute Decision Maker or legal guardian?
- Have you prepared a Power of Attorney (POA) for Property and/or Power of Attorney for Personal Care?
- Do you have access to the documents?
- When was the last time you reviewed and/or updated your POA?

Resources:

- National Initiative for the Care of the Elderly (NICE): Tool on Consent and Capacity

The information presented below is divided into four broad areas:

- **Legislation**
- **Powers of Attorney**
- **Capacity Assessments**
- **Advance Care Planning**

Legislation

When working in the social and health services sector there will be times when you will have questions around consent and capacity. it is important that you have working knowledge of the following legislative Acts:

- Health Care Consent Act (HCCA)
- Substitute Decisions Act (SDA)
    - Regulation 460/05 – Capacity Assessment
- Powers of Attorney Act
- Mental Health Act

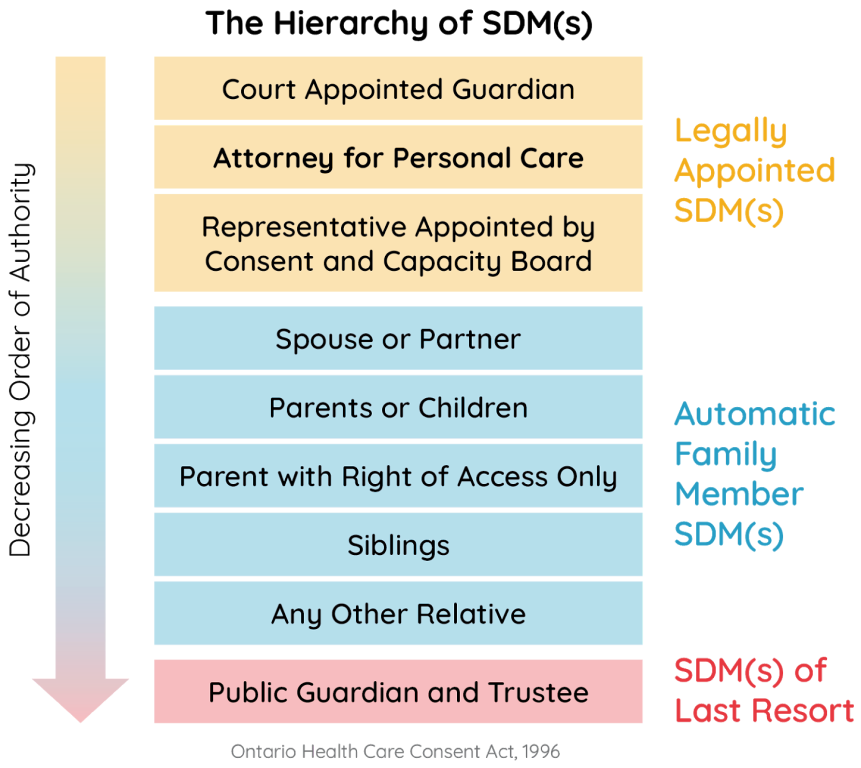
Q: What does “living at risk” mean to you?

A: “For me it was living with a spouse with Alzheimer’s”

– Older Adult

Substitute Decision Makers:

Everyone in Ontario has a Substitute Decision Maker (SDM) even if they have never prepared a Power of Attorney for Personal Care appointing someone to act in that role. The Health Care Consent Act includes a hierarchy of SDMs.



Ontario Health Care Consent Act, 1996

Resources:

- 25 Common Misconceptions About the Substitute Decisions Act and Health Care Consent Act
- Hierarchy of Substitute Decision Makers (SDMs) in the Health Care Consent Act
- A Guide to the Substitute Decisions Act
- Speak Up: Substitute Decision Maker Hierarchy in Ontario
- Advance Care Planning: Introducing the Substitute Decision Maker

Powers of Attorney

A Power of Attorney is a legal document that an individual can use to appoint another person (called an attorney) to make decisions on the individual's behalf (Older Adults and the Justice System, 2020).

- **Continuing Power of Attorney for Property** is a legal document that gives the attorney the legal authority to make decisions about an individual's finances, home and possessions. A continuing power of attorney for property typically comes into force as soon as it is signed and witnessed. However, the older adult can also state in the power of attorney that it will come into effect at a later date. For example, when a designated capacity assessor makes a finding that the older adult is incapable of managing their own property (Older Adults and the Justice System, 2020).
    - Did you know? Anyone can ask a court to review whether an attorney is mismanaging an incapable person's property
- **Power of Attorney for Personal Care** is a legal document that gives the attorney the legal authority to make personal care and treatment decisions for the individual if the individual becomes mentally incapable of making these decisions independently. Personal care decisions include decisions about the individual's health care, medical treatment, diet, housing, clothing, hygiene and safety (Older Adults and the Justice System, 2020).

Resources:

- **Office of the Public Guardian and Trustee** – Powers of Attorney: Questions and Answers
- **Advocacy Centre for the Elderly** – Powers of Attorney – FAQs
- **Attorney General:** Duties and Powers of a Guardian of Property
- **Advance Care Planning Waterloo Wellington** – Power of Attorney 101
- **Power of Attorney for Personal Care (CLEO)**

Capacity Assessments

Capacity Assessment is the formal assessment of a person's mental capacity to make decisions about property and personal care (Ministry of the Attorney General, 2019).

If a person does not have a power of attorney and cannot make personal or financial decisions, another person may have to be given special legal authority to make decisions on their behalf. This authority is called guardianship. Before this authority is given, it must be determined that the person is mentally incapable. In certain circumstances which are detailed in the Substitute Decisions Act, a designated capacity assessor is the only professional authorized by law to make this decision.

An assessment of mental capacity for anything other than what is in the *Substitute Decisions Act* does not need to be performed by a designated capacity assessor. For example, many health care decisions fall under the *Health Care Consent Act* and can be made by a spouse, relative or other appointed person (Ministry of the Attorney General, 2019).

Before requesting any assessment – whether from a capacity assessor or other professional – it is important to be clear about the purpose of the capacity assessment, and whether it is actually necessary. To check whether the assessment required should be done by a designated capacity assessor, you can contact the Capacity Assessment Office: Ministry of the Attorney General: 416-327-6424

Resources:

- **Advocacy Centre for the Elderly:** Who Assesses Capacity Under What Circumstances
- **Attorney General: Capacity Assessment Office:** Questions and Answers
- **Attorney General: List of Capacity Assessors by County**
- **Consult Geri:** Decision Making and Dementia
- **Alzheimer Society of Canada:** Decision Making: Respecting Individual Choice

Assessing Capacity for Admission to a Long Term Care Home

Capacity Evaluation is the process of determining a person's ability to make his/her own decision about admission to a long-term care home. It includes asking the person questions related to admission. It may be supplemented by tests or procedures to measure cognitive ability, but these are not the determinants of capacity (Cole J., Dawe, N, 2010).

The Local Health Integration Network (LHIN), Home and Community Care MUST do the evaluation of capacity of a person making the decision about Admission to Long Term Care. Do not seek a capacity assessor to overturn this decision. Do seek a higher ranked assessor or administrator within the LHIN to re-assess and provide reasons (Cole J., Dawe, N, 2010). .

Resources:

- **Advocacy Centre for the Elderly – Admission to LTC Homes:** Are Evaluations of Capacity Being Conducted in Accordance with the Law?

Consent and Capacity Board

The Consent and Capacity Board (CCB) is an independent body created by the provincial government of Ontario under the Health Care Consent Act. It conducts hearings under the Mental Health Act, the Health Care Consent Act, the Personal Health Information Protection Act, the Substitute Decisions Act and the Mandatory Blood Testing Act (CCB, 2012-15).

With respect to the Health Care Consent Act, the CCB has the authority to hold hearings to deal with a review of capacity to consent to treatment, admission to a care facility or personal assistance service; a review of decision to admit an incapable person to a hospital, psychiatric facility or long term care home for the purpose of treatment; a review of an SDMs compliance with the rules for substitute decision making, among many others.

Resource for Health Practitioners:

If a health practitioner thinks the older adult's substitute decision-maker is not making decisions in the individual's best interest, the health practitioner can apply to the Consent and Capacity Board (CCB) with a Form G. If the CCB decides the substitute decision-maker is not making decisions in the older adult's best interest, the CCB will tell the substitute decision-maker how to make decisions in the individual's best interest (Ibid at ss. 37(4) and 37(5)). If the substitute decision-maker does not follow these directions, the CCB may remove that person from being a substitute decision-maker (Ibid at s. 20(2)) (Older Adults and the Justice System, 2020).

- **Form G** – Applying to Determine Whether or Not the Substitute Decision Maker has Complied with the Rules for Substitute Decision Making

Office of the Public Guardian and Trustee

The Office of the Public Guardian and Trustee (OPGT) is part of Ontario's Ministry of the Attorney General.

Making Decisions About Personal Care, Treatment and Admission to Long Term Care:

Very occasionally the court will order the OPGT to make decisions of a personal nature for an incapable person in order to protect him or her from extreme physical risk.

The OPGT is also responsible for making decisions on behalf of incapable people when either medical treatment or admission to a long-term care facility is proposed and it is not possible to obtain informed consent from another authorized person, such as a relative who are available, capable and willing to do so (Ministry of the Attorney General 2019).

Investigations

The OPGT will conduct an investigation when it receives information that an individual may be incapable and at risk of suffering serious financial or personal harm and no alternative solution is available. An investigation may result in the OPGT asking the court for authority to make decisions on the person's behalf on a temporary basis (Ministry of the Attorney General, 2019).

Resources:

- **Attorney General – Guardianship Investigations:** The Role of the Office of the Public Guardian and Trustee
- **Attorney General: Making Substitute Health Care Decisions:** The Role of the Office of the Public Guardian and Trustee

Advance Care Planning

When working with your older adult clients, it is important to make Advance Care Planning a part of your work.

How Do I Describe Advance Care Planning to My Clients?

There are two parts to Advance Care Planning:

1. Deciding who will make future health care decisions for you if you are unable to. This will be your Substitute Decision Maker (SDM).
    - *Review with the older adult who their automatic SDM will be based on the hierarchy – a ranking list in the HCCA. If they do not wish to have their SDM based on the hierarchy, they will need to choose someone else by preparing a Power of Attorney for Personal Care.*
2. Having conversations with your SDM to share information about what's important to you, your wishes, values and beliefs. This helps guide your SDM to make healthcare decisions that are based on what you would want (ACPWW, 2015).

In Ontario, as health care professionals you are required to obtain informed consent before providing any treatment or care. Consent must come from your client or from their SDM if the person is not mentally capable. Advance Care Planning conversations can help your clients and their loved ones be better prepared for making health care decisions in the future (ACPWW, 2015).

Resources:

- **Advance Care Planning Waterloo Wellington**
- **Speak Up Ontario:** Advance Care Planning Workbook

References

1. A Place to Call Home (2019). A 10-year Housing and Homelessness Plan for Guelph-Wellington. Five Year Update. County of Wellington. Received from: https://www.wellington.ca/en/social-services/resources/Housing/A-Place-to-Call-Home_Five-Year-Update-Final.pdf
2. ACPWW (2015). Received From: http://acpww.ca/
3. Alexis Kuerbis, LCSW, PhD,a,* Paul Sacco, PhD, LCSW,b Dan G. Blazer, MD, PhD,c and Alison A. Moore, MD, MPHd. (2014). Clin Geriatr Med. 2014 Aug; 30(3): 629–654. Received from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4146436/
4. CAMH (2008). Received from: https://www.camh.ca/en/health-info/guides-and-publications/alcohol-use-in-older-adults
5. Canadian Coalition for Seniors Mental Health (2017). Received from: https://ccsmh.ca/
6. CCB (2012-15). Received From: http://www.ccboard.on.ca/scripts/english/index.asp
7. CCSA (2020). Received from: https://ccsa.ca/canadas-low-risk-alcohol-drinking-guidelines-brochure
8. Centre for Suicide Prevention (1998). Received from: https://www.suicideinfo.ca/
9. Child and Family Services Act (1990). R.S.O. 1990 c. C.11 Received from: https://www.ontario.ca/laws/statute/90c11
10. CIHI – Canadian Institute for Health Information (2016). CIHI's Annual Report 2015-2016. Charting a New Course. Received from: https://secure.cihi.ca/free_products/2016_AnnualReport_EN-web.pdf
11. Cipriani, G., Lucetti, C., Vedovello, M., Nuti, A. (2012). Diogenese syndrome in patients suffering from dementia. Dialogues Clinical Neuroscience. 2012 Dec; 14(4): 455–460. Received from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3553571/
12. Cole J., Dawe, N. (2010). Assessing Capacity for Admission to Long-Term Care Homes. A Training Manual for Evaluators: Received from: https://www.collegeofdietitians.org/resources/scope-of-practice/acting-as-an-evaluator/assessing-capacity-for-admission-to-long-term-car.aspx
13. Competition Bureau Canada (2012). Received from: https://www.competitionbureau.gc.ca/eic/site/cb-bc.nsf/vwapj/lbbs-web-2017-eng.pdf/$file/lbbs-web-2017-eng.pdf
14. Consumer Protection Ontario (2020) Report a Scam or Fraud. Received from: https://www.ontario.ca/page/report-scam-or-fraud
15. Conversations About Decision Making (2019). Alzheimer Society, Decision Making: Respecting Individual Choice. Received From: https://alzheimer.ca/sites/default/files/files/national/brochures-conversations/conversations_decision-making.pdf)
16. CSMH (2019): National Best Practice Guidelines for Substance Use Disorder. Received from: https://ccsmh.ca/substance-use-addiction/intro/
17. Culo, Sandi (2011). Risk Assessment and Intervention for Vulnerable Older Adults. BC Medical Journal. Vol 53. No. 8; 421-425. Received from: https://www.bcmj.org/articles/risk-assessment-and-intervention-vulnerable-older-adults
18. Degenhardt L, Hall W. 2012. "Extent of Illicit Drug Use and Dependence, and Their Contribution to the Global Burden of Disease." The Lancet 379 (9810): 55–70
19. Delirium Toolkit (2019). SfCare – Senior Friendly Care 7t. Regional Geriatric Program of Toronto. Received from: https://www.rgptoronto.ca/wp-content/uploads/2018/11/SF7-Toolkit-Delirium.pdf
20. Dementia. Care for People Living in the Community. (2018). Health Quality Ontario – Health Standards. Received from: https://www.hqontario.ca/Evidence-to-Improve-Care/Quality-Standards/View-all-Quality-Standards/Dementia/Quality-Statement-9-Safe-Living-Environment
21. EAPON (2018). Intervention Tools. Received from: http://www.eapon.ca/training-education/training/intervention-tools/
22. EAPON (2020). Elder Abuse Prevention Ontario. Received from: http://www.eapon.ca/
23. Finding Your Way (2020). Alzheimer Society of Ontario. Received from: http://findingyourwayontario.ca/living-safely-with-dementia/
24. Freedom of Information and Protection of Privacy Act (1990). R.S.O. 1990. c. F. 31 Received from: https://www.ontario.ca/laws/statute/90f31
25. Health Care Consent Act (1996) S.O. 1996, c. 2, Sched. A. Received from: https://www.ontario.ca/laws/statute/96h02

26. Highway Traffic Act (1990). R.S.O. 1990, c. H.8 Received from: https://www.ontario.ca/laws/statute/90h08
27. Irvine, J., & Nwachukwu, K., (2014). Recognizing Diogenes syndrome: a case report. BMC Res Notes. 2014; 7: 276. Received from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4016666/
28. Meadus, J. (2010). ADMISSION TO LONG-TERM CARE HOMES: ARE EVALUATIONS OF CAPACITY BEING CONDUCTED IN ACCORDANCE WITH THE LAW?. Advocacy Centre for the Elderly. Received from: http://www.acelaw.ca/appimages/file/Are_Evaluations_being_Conducted_in_Accordance_with_the_Law_-_2010.pdf
29. Mental Health Act (1990). R. S. O. 1990. c. M. 7 Received from: https://www.ontario.ca/laws/statute/90m07
30. Mezey, M. (2016). Decision Making in Dementia. Best Practices in Nursing Care to Older Adults with dementia. The Hartford Institute for Geriatric Nursing, New York University, College of Nursing, and the Alzheimer's Association. Issue No D9
31. Ministry of the Attorney General. (2019). Received from: https://www.attorneygeneral.jus.gov.on.ca/
32. NICE (2020). Received from: http://www.nicenet.ca/tools-introduction-to-older-adults-and-substance-use
33. Nicholson, N.R. (2012). A Review of Social Isolation: An Important but Underassessed Condition in Older Adults. Journal of Primary Prevention. 33 (2-3), 137-152.
34. OAS Guelph (2018). City of Guelph Older Adult Strategy. Received from: https://guelph.ca/plans-and-strategies/older-adult-strategy/
35. Older Adults and The Justice System (2020). A navigational guidebook for caregivers and service providers. Human Services and Justice Coordinating Committee. Received from: https://hsjcc.on.ca/wp-content/uploads/Older-Adults-and-the-Justice-System-A-navigational-guidebook-for-caregivers-and-service-providers-Feb-2020.pdf
36. Ontario Caregiver Organization (2020). Received from: https://ontariocaregiver.ca/
37. Pavlou, Maria P., Lachs, Mark S. (2008). Self-neglect in Older Adults: a Primer for Clinicians. J Gen Intern Med. 23(11): 1841–1846. Received from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2585676/
38. Personal Health Information Protection Act (2004). S.O. 2004 c. 3 Sched. A. Received from: https://www.ontario.ca/laws/statute/04p03
39. PhysioCanHelp. (2020). Received From: https://physiocanhelp.ca/blog/the-value-of-physiotherapy-falls
40. Polypharmacy Toolkit (2019). (2019). SfCare – Senior Friendly Care 7t. Regional Geriatric Program of Toronto. Received from: https://www.rgptoronto.ca/wp-content/uploads/2018/11/SF7-Toolkit-Polypharmacy.pdf
41. Public Health Agency of Canada (2014). Senior's Falls in Canada – Second Report. Received from: https://www.canada.ca/content/dam/phac-aspc/migration/phac-aspc/seniors-aines/publications/public/injury-blessure/seniors_falls-chutes_aines/assets/pdf/seniors_falls-chutes_aines-eng.pdf)
42. RNAO (2016). Delirium, Dementia, and Depression in Older Adults: Assessment and Care, Second Edition. Received From: https://rnao.ca/bpg/guidelines/assessment-and-care-older-adults-delirium-dementia-and-depression
43. Statistics Canada (2010). Canadian Community Health Survey – Healthy Aging. Received from: https://www23.statcan.gc.ca/imdb/p2SV.pl?Function=getSurvey&SDDS=5146&Item_Id=47962&lang=en
44. Stats Canada (2010). Received from: https://www150.statcan.gc.ca/n1/pub/11-402-x/11-402-x2010000-eng.htm
45. Stats Canada (2015). Understanding seniors' risk of falling and their perception of risk. Received from: https://www150.statcan.gc.ca/n1/pub/82-624-x/2014001/article/14010-eng.htm
46. Substitute Decisions Act (1992) S.O. 1992. C. 30. Received from: https://www.ontario.ca/laws/statute/92s30
47. UNODC (2018). Received from: https://www.unodc.org/unodc/en/frontpage/2018/June/responding-to-global-opioid-crisis--unodc-launches-strategy-to-protect-public-health.html
48. WGHR (2019). Received from: www.wghoardingresponse.ca
49. World Health Organization (2020). Received from: https://www.who.int/