
**Protecting Vulnerable Adults:
Lessons from the Past,
Recommendations for the Future**

**Prepared By:
Craig Shields
Human Services Consultants**

November 2008

DEDICATION



Tiffany Pinckney
March 22, 1982 – April 2, 2005

This work and report is dedicated to the memory of Tiffany Pinckney.

May our honouring of the past and our memory of Tiffany assist us to humbly look to a future where we can together live with greater connectedness, safety and hope.

CONTENTS

	<u>Page</u>
DEDICATION	2
EXECUTIVE SUMMARY	4
INTRODUCTION	
◦ Circumstances Surrounding the Death of Tiffany Pinckney	6
◦ The Project on Protecting Vulnerable Adults	6
PHASE 1: PEEL SERVICE COMMUNITY MEETING	
◦ Overview of the Event	7
◦ Timelines and Agency Involvement Related to Tiffany	7
◦ Efforts by Others to Support Tiffany	9
◦ Summary of Outcomes	9
- Opportunities to Engage / Intervene Differently	9
- Lessons Learned	10
- Additional Comments	10
PHASE 2: BROADER COMMUNITY MEETINGS	
◦ Overview of the Event	11
◦ Summary of Ideas from Other Sectors and Jurisdictions	11
- Overview of Legislation and Issues across Canada	11
- Adult Protection in New Brunswick	12
- The Alberta Protocols	12
◦ Developing a Framework of Understanding about Vulnerability	13
- Personal Characteristics	13
- Contextual Factors	14
- Previous Life Experience	15
◦ Effective Practices	15
◦ Principles to Guide Practice	16
- Principles Related to Identification	16
- Principles Related to Protection	16
- Principles in Conflict	17
◦ Summary of Recommendations	17
- Increasing Public & Professional Awareness: Building on What Exists	18
- Increasing Public & Professional Awareness: Introducing Something New	18
- Strengthening Identification and Protection: Building on What Exists	18
- Strengthening Identification and Protection: Introducing Something New	19
◦ Next Steps	19
Appendices	
A. Participants at Peel Service Community Meeting, September 23, 2008	21
B. Peel Regional Police: Definitions and Reporting	22
C. Participants at Broader Community Meetings, October 27 & 28, 2008	23
D. Presentation Notes: Ken Pike	25
E. Presentation Notes: Dr. Sheila Mansell	30
F. Reference Materials for Community Discussion Process	46
G. Timelines for Tiffany Pinckney	48

EXECUTIVE SUMMARY

Introduction

This report summarizes a community discussion process focused on the protection of adults who are vulnerable to abuse and neglect. The process was initiated following the death of Tiffany Pinckney, a young woman with autism, who died of starvation in Mississauga in 2005. As a result of this tragedy, key stakeholders were brought together to discuss ways to increase safety for adults who are vulnerable to abuse and neglect. This report summarizes the outcomes from the community discussion process.

Circumstances Surrounding the Death of Tiffany Pinckney:

Tiffany Pinckney lived with her mother and sister in Mississauga, Ontario. Tiffany was quite vulnerable in that she was reliant on others to assist her with all areas of personal care, meal preparation, communication, and advocacy. Following their mother's death, Tiffany's older sister assumed responsibility for Tiffany's care and for liaising on her behalf with community support agencies. Over time Tiffany became increasingly isolated; she graduated from school at age 21, the family moved to a new neighborhood, and her sister began to systematically disengage from social services. In April 2005, Tiffany was found deceased in the basement of her sister's home in conditions described by the Superior Court judge as appalling. The court ruled that Tiffany died of chronic malnutrition. Tiffany's brother-in-law pleaded guilty to criminal negligence causing death. Tiffany's sister was found guilty of manslaughter, criminal negligence causing death, and failure to provide the necessities of life. She was convicted on the manslaughter charge and sentenced to 9 years in penitentiary.

The Project on Protecting Vulnerable Adults:

Tiffany Pinckney's death and the subsequent revelations regarding the last years of her life raised troubling questions for the disability community. People felt that it was important to try to learn from Tiffany's tragic death in order to bring greater safety to others who are vulnerable to abuse / neglect. Following the criminal trial proceedings and a debriefing session with Peel Regional Police and the Peel Crown Attorney Office, a two-phase community discussion process occurred in the fall of 2008.

Phase 1 – Peel Service Community Meeting:

The Peel service community met in September 2008 with participation from agencies within Peel who either had involvement with Tiffany Pinckney, or had the potential to have had involvement, along with representatives from Peel Regional Police and the Office of Public Guardian and Trustee. The group identified a number of lessons learned which in future situations might provide opportunities for service providers to engage or intervene differently with a family.

Phase 2 – Broader Community Meetings:

Phase 2 of the community discussions involved a two-day event with participation from local Peel service providers and representatives from the broader community, including representatives from provincial groups. Several self-advocates participated in the process, as did representatives from other sectors such as justice, education, and health. This event built on the lessons learned from Tiffany's death, but also provided an opportunity to learn from other jurisdictions and sectors. The group had the opportunity to hear from three

presenters sharing their experience and insight regarding the issues surrounding protection of adults who are vulnerable: Mr. Orville Endicott, legal counsel for Community Living Ontario, Mr. Ken Pike, Director of Social Policy for New Brunswick Association for Community Living, and Dr. Sheila Mansell, Registered Psychologist in private practice in Alberta.

Over the two days small groups tackled a number of assignments intended to inform the development of recommendations. The assignments included developing frameworks of understanding about vulnerability, identifying effective practices for reducing risk, and identifying principles to guide practice. With regard to principles, **the groups overwhelmingly identified that the safety of the individual should be paramount, and where the principles of the responsibility to keep safe come in conflict with other principles, the principle to keep safe should prevail.** In other words, where there is greater risk there is greater need to intervene. The groups then developed specific recommendations related to increasing public and professional awareness, strengthening the identification of abuse / neglect, and providing protection when abuse / neglect is identified.

Recommendations and Next Steps:

The process generated a wide range of recommendations, some of which are within the reach of local communities and others which would require a provincial approach. Copies of this report are being provided to Peel Planning Group, Ministry of Community and Social Services – Central West Region Office, and all participants in the process. It is hoped that local communities will be able to use these recommendations to develop regional strategies for increasing the safety of adults who are vulnerable in their respective communities. It is also hoped that those groups that have provincial affiliations will also be able to work together to promote change at a provincial level.

Deep gratitude is acknowledged to all those who participated in such a thoughtful and careful manner, struggling with the complex issues of providing safety in a manner that is respectful and in keeping with our Canadian Charter of Rights and Freedoms. Thank you for constantly reinforcing the dignity and value of the life of Tiffany Pinckney and keeping her in the forefront in our minds throughout the discussions.

INTRODUCTION

Circumstances Surrounding the Death of Tiffany Pinckney

Tiffany Pinckney was a gentle woman, with a great sense of humour, who enjoyed food, music and outings to the park. She communicated primarily by gestures and by leading others to what she wanted. When frustrated with her circumstances or when having difficulty communicating her needs, Tiffany would at times grab at others. She needed assistance in personal care and preparing meals, and supervision for safety in both the home and community.

On April 2, 2005, at age 23, Tiffany was found dead in the unfinished basement of her sister's home in suburban Mississauga. Subsequent court testimony would establish that she died of chronic malnutrition. Medical experts at the trial suggested that Tiffany had been deprived of food for some time, perhaps a year or longer. Medical evidence also indicated that she had been deprived of fluids. The prosecutor would argue that her sister, Allison, deliberately starved her to death because she stood to gain financially if Tiffany died before her, according to the conditions of their late mother's will. Allison was charged with, and found guilty of manslaughter, criminal negligence causing death, and failure to provide the necessities of life. She was convicted on the manslaughter charge and sentenced to 9 years in penitentiary. In addition, Allison's husband Orlando pleaded guilty to the charge of criminal negligence causing death and was sentenced to 2 years house arrest.

Tiffany was born on the first day of spring, March 22, in 1982. At two years of age she was diagnosed as having a developmental delay and autism. A year later, Tiffany's mother died and she was adopted by Margaret Cox, who raised Tiffany until she died of cancer in January of 1998. Before her death, Margaret arranged for Tiffany's sister Allison (eight years her senior) to assume full responsibility for Tiffany's care after she was gone.

At the time of her adopted mother's death, Tiffany, then age 15, was attending a special education high school and the family was involved with six community agencies that provided funding and support to assist with the care of Tiffany. Following Margaret's death, Allison and her husband gradually disengaged from these community supports. Tiffany finished school at age 21 in June 2003, the family moved to a new home in August 2004, and by the end of the year the family had totally disengaged from any agency supports.

The Project on Protecting Vulnerable Adults

Tiffany's death and the subsequent revelations regarding the circumstances of the last few years of her life raised some troubling questions for the Peel service community and the broader disability community. Kerry's Place Autism Services, along with other service provider and disability advocacy groups, felt that it was important to try to learn from this tragic death in order to reduce the likelihood of something similar happening again. The Central West Region of the Ministry of Community and Social Services shared this view and provided some one-time funding to facilitate the bringing together of interested parties to see what can be learned from Tiffany's death and to explore how we might improve safeguards for adults who are vulnerable to abuse and neglect. This resulted in two events: a one-day meeting with the Peel agencies that provided (or might have provided) services to Tiffany and

her family, in order to review what happened and identify any lessons that might be learned; and a two-day event with a broader group of participants to learn what is being done in other sectors and jurisdictions, and to develop recommendations for the protection of vulnerable adults.

This report summarizes the outcomes from these two events.

PHASE 1: PEEL SERVICE COMMUNITY MEETING

Overview of the Event

The Peel Service Community meeting was held on Tuesday September 23, 2008 from 9:30 – 3:00. Representatives from 16 organizations attended the session (see Appendix A for a list of participants).

The event was organized to allow the Peel service community to come together to review what had happened with regard to the involvement of agencies with Tiffany and her family, and to see what could be learned from it. The session began with an overview of timelines describing key milestones in Tiffany's life and her family's involvement with various service organizations. Next, each of the organizations briefly described the nature of their involvement with Tiffany and her family.

With the timelines and descriptions of agency involvement as a foundation, the group then explored whether there were any opportunities to do things differently. Lastly, the group discussed what could be learned from this tragic event; particularly any lessons that might change the way agencies in Peel respond to similar situations in the future.

Timelines and Agency Involvement Related to Tiffany

Tiffany's biographical milestones and the family's history of engagement with services and supports were summarized on a timeline ranging from the date of her birth to the date of her death (see Appendix G). The timeline was created in part to situate events in time and in part to see whether the visual representation suggested any interesting patterns. In fact, the timeline did reveal two interesting patterns: the mobilization of community resources by Margaret Cox between the time she fell ill and the time of her death, and the sudden decline in the use of those resources after Allison and Orlando wed and began to have children of their own.

The following agencies or organizations provided services and supports to Tiffany and her family between 1992 and 2004—the year before Tiffany died.

- Peel District School Board (? – 2003)
Tiffany attended Applewood Acres Secondary School, a special education high school, until she “graduated” at age 21 in June of 2003. A teacher's assistant had concerns about Tiffany's well-being in the last year of school due to weight loss, coming to school without lunches and a generally unkempt appearance. An educational social worker made a number of attempts to contact the family towards the end of the 2003 school year,

because Tiffany missed three weeks of school in May 2003 (and apparently did not attend the graduation ceremony). The social worker was unable to connect with the family prior to Tiffany's last day of school.

- Ministry of Community and Social Services (ODSP & SSAH)
The Ministry cannot comment on the use of either Special Services At Home (SSAH) or the Ontario Disability Support Program (ODSP) due to privacy and confidentiality requirements. It was noted, however, that a family's failure to renew its SSAH funding would normally be a cause for concern and there would be some effort made to engage with the family. If the efforts are unsuccessful the SSAH funding is discontinued.
- Peel Behaviour Services (1992 – 1993, 1997 – 1998)
Peel Behaviour Services uses a goal-oriented, mediator model approach, which means that they work with the family unit, and not just the person with the behavioural needs. After Margaret Cox's death, Allison withdrew from service and the file was closed.
- Community Living Mississauga (1993 – 2003)
Community Living Mississauga provided service coordination and respite funding from 1993 to 2003. It also provided summer programs between 1993 and approximately 2001. The summer programs and respite funding require reapplication each year, and the family stopped applying for both in 2001. With regard to service coordination, the agency was unable to contact the family via mail, telephone, alternate contacts or other agencies. The agency finally closed its file in May 2003 given the family's lack of responsiveness.
- Kerry's Place Autism Services (1996 - 2002)
Kerry's Place initially had used a vacancy at a group home to provide respite between 1996 (when Margaret Cox first became ill) and 2000, when the vacancy was filled and respite was no longer available at that site. At the same time the agency shifted from providing respite services to providing respite funding. Funding was allocated to the family and staff assistance was offered repeatedly to assist the family in finding, screening, and utilizing private respite workers. The funding allocated to the family was unused for 4 consecutive years (1999 – 2002). In-Home Consultation also was provided to assist Tiffany and Allison in addressing areas of their concern and identified goals. This support is based on a mediator model whereby the Kerry's Place staff works with the family in supporting their family member. Initial consultation services revolved around helping Allison develop ways to assist Tiffany in the grief she was experiencing following her mother's death, and in communication strategies. This support was stopped by Allison. After numerous unsuccessful attempts to contact the family by phone, letter, and registered mail the file was closed in May 2002.
- Community Care Access Centre (1997 - 2004)
While the Community Care Access Centre was involved with the family, a CCAC representative was unable to attend the September 23rd meeting, and therefore the details of its involvement are unavailable at this time.
- Victorian Order of Nurses (1998 - 2004)

Similarly, the Victorian Order of Nurses was involved with the family, but a representative was unable to attend the September 23rd meeting, and no details of its involvement are available at this time.

Efforts by Others to Support Tiffany

Evidence presented at the trial indicated that there were also attempts by individuals to provide informal support to Tiffany. Aisha Klass, Orlando's sister had provided respite support for Tiffany. When she saw Tiffany for the last time in September 2004 she was concerned about Tiffany's weight loss and raised these concerns with Orlando. The concerns were dismissed and Aisha was not invited back to the house. In addition to Aisha's concerns, a previous school teacher had reached out to Allison encouraging her involvement with Community Living but was told by Allison that it would be too much bother.

Summary Of Outcomes

The review of timelines and agency involvement provided everyone with a common understanding of events, and laid a foundation for the discussions that followed.

Participants were asked to address two questions. The first was, Knowing what you now know about Tiffany and the circumstances leading to her death, is there anything you might have done differently? The second was, What lessons might be learned from this specific case that could be applied to safeguard other vulnerable adults?

Opportunities to Engage / Intervene Differently

The group discussed the challenges of monitoring Tiffany's well-being, particularly once she finished school, the family moved, and the family dis-engaged from all social services. Over the course of the discussion it became apparent that strategies were needed for monitoring two types of situation.

The first was where there was suspected maltreatment, and the group identified two things that might have been done differently in Tiffany's case. One was to contact the Peel Regional Police, which in emergency situations can do "well-being checks" on behalf of vulnerable adults (see Appendix B for definitions and reporting). The other was to contact the Office of the Public Guardian and Trustee (OPGT), which has the authority to carry out investigations where a person is deemed incapable and at risk in certain areas. The OPGT is only able to take action when there is an issue of guardianship involved, although the office can be consulted on other situations not involving guardianship.

The second type of situation was where there was vulnerability due to risk factors such as isolation but no known maltreatment, and here the group felt that certain safeguards could be put in place that would reduce the likelihood of neglect or abuse. These potential safeguards included:

1. Promoting the development of circles of support
2. Inviting social service agencies to attend transition planning meetings hosted by schools and exploring the possibility of having a service coordinator at each transition meeting

3. Asking families to identify other agencies that they are involved with, and where more than one agency is involved, holding an inter-agency case conference with the identification of a lead agency that would have primary responsibility for linking with the family (NB would require the consent of families)
4. Revising agency disengagement and follow-up practices to ensure some monitoring of the person with the disability once they have left services
5. Exploration into the use of a multi-agency consent for release of information, to be used to facilitate interagency communication while adhering to principles of right to privacy

Lessons Learned

The discussion of lessons learned from the Tiffany Pinckney experience was intentionally open-ended, and resulted in suggestions ranging from the very general to the very specific. Among the lessons identified were the following:

1. The need for a common definition of maltreatment, including descriptions of both neglect and abuse
2. The need for a common protocol among service agencies to be used when there is suspected or actual maltreatment
3. The need for public awareness and education in spotting suspected maltreatment and in knowing how to report it
4. The need for better coordination and information-sharing where multiple agencies are involved with the same individual or family, including:
 - the identification of other involved agencies at the point of intake
 - consent to share information across agencies
 - coordinated case conferencing with the identification of a lead agency
5. The need to try to prevent maltreatment using strategies such as:
 - providing information and support for good estate planning, including the safeguard of using co-trustees rather than a single trustee
 - the introduction of better tracking systems
 - awareness and sensitivity to various cultural practices
6. The need to make greater use of technology such as video-conferencing for education and training purposes
7. The need for someone to have a face-to-face meeting with the vulnerable adult on an annual basis

Additional Comments

A few individuals were unable to attend the September 23rd meeting but participated in the process through telephone interviews. They reiterated many of the points made at the meeting, as well as added some other lessons learned:

1. The need to have the time and resources to build relationships with families and other service providers and sectors (e.g. education)
2. The need to address potential disincentives for families to fully disclose their involvement with other agencies because of a fear that resources might be taken away
3. The need to clarify who is responsible for assessing the level of risk (as opposed to level of need) of a vulnerable adult, and to develop the tools to carry out the assessment
4. The need for web-mounted resource materials to assist in the detection and reporting of suspected maltreatment of vulnerable adults, for whatever reasons.

PHASE 2: BROADER COMMUNITY MEETINGS

Overview of the Event

The second phase of the project consisted of a two-day event that took place on October 27 and 28, 2008. This event allowed the broader community to join in the discussions of what could be learned by Tiffany's death.

More than 50 people attended the two-day Community meetings (see Appendix C for a list of participants). The meetings began with the Project Coordinator, Gail Jones, providing an overview of the Vulnerable Adults Project, including the circumstances of Tiffany's death, and a description of the process since then. The Facilitator for the two days, Craig Shields, then reviewed the desired outcomes for the session, including:

- To identify factors that increase vulnerability, and good community practices that offset these factors
- To identify principles that should guide practice
- To develop recommendations for increasing public and professional awareness
- To develop recommendations for identifying and responding to suspected abuse or neglect

The format for the two days was to build upon a shared foundation of information beginning with the insights from the Peel service community discussions (see "Summary of Outcomes" above), and followed by presentations on approaches and issues from other Canadian jurisdictions. The remainder of the event was essentially a day-and-a-half working session, with small groups tackling each of the desired outcomes and then reporting back to the group of the whole.

Summary of Ideas from Other Sectors and Jurisdictions

Overview of Legislation and Issues across Canada

Orville Endicott, legal counsel for Community Living Ontario, led off the presentations with an overview of legislation and issues across Canada. He began by suggesting that laws don't protect people; instead people protect people and laws sometimes assist people to protect people. He noted that there are three areas of legislation that are relevant to adults who are vulnerable to neglect and abuse. The first two are by definition always too late: the Criminal Code and Coroner's Inquests. Both are necessary, however; the Criminal Code for the purposes of deterrence and the expression of society's abhorrence towards certain acts; and the Coroner's Inquest for the purposes of reviewing a death and learning from it so that similar deaths become less likely in the future.

The third area of legislation falls between the first two, and consists of comprehensive Adult Protective Legislation. He noted that much of this legislation is modelled after child protection legislation, and he expressed the concern that if such legislation equates the vulnerable adult to a child, then it denies the adult the right to self-determination. A better alternative for keeping vulnerable adults safe might be something like the Adult Protective Service Worker (APSW) program in Ontario. Many APSWs do an excellent job but the program generally

serves a narrow population, primarily those who live on their own or have the potential to do so.

Orville noted that Ontario has passed, but not yet proclaimed, a new piece of legislation that puts emphasis upon supporting the social inclusion of people with developmental disabilities. The new Act, Bill 77, The Social Inclusion Act, contains provisions for the development of “person-directed plans” at the outset of service. He suggested that the development of a person-directed plan should be more than just an option. There should be an agreement at the outset of service that a person-directed plan is to be an ongoing tool to support the inclusion of the person with a disability.

Adult Protection in New Brunswick

The second presenter was Ken Pike, Director of Social Policy for the New Brunswick Association for Community Living. Ken provided an overview of the approach to adult protection in New Brunswick (see Appendix D for the presentation notes). There are four main components to the New Brunswick approach:

- Legislation (including powers of investigation and response)
- Policies
- Standards and guidelines
- Interdepartmental protocols

Adult protection services are provided by regional adult protection workers, which are overseen by a provincial adult protection consultant. Ken reviewed the principles that guide adult protection, including the principle that an adult is competent and capable unless legally declared incompetent or certified incapable, and should be supported to make their own decision whenever they are able. He also highlighted aspects of the legislation, including reporting (which is not mandatory) and investigations. The New Brunswick legislation protects both adults with a disability and “elderly persons” who are victims—or in danger of being victims—of neglect or abuse. He also provided some illustrations of how the approach works in terms of possible responses.

Ken concluded his presentation by suggesting some considerations for improvement, including a continued focus on training, development of specialized regional teams, mandatory reporting, and development of a good risk assessment tool that differentiates between persons with disabilities and seniors. He also posed the question of how to avoid having to determine competency in order to have an effective intervention strategy when abuse or neglect has been confirmed. Ken noted that adult protection systems such as New Brunswick’s depend upon having good information about people and their situations of vulnerability; they can only work when we know what is happening in people’s lives.

The Alberta Protocols

The final presenter was Dr. Sheila Mansell, a registered psychologist in private practice from Calgary, who provided an overview of the approach to vulnerable adults in Alberta (see Appendix E for the presentation notes).

Sheila began by noting that adults with disabilities are 2 to 4 more times more likely to be abused than members of the general population. There are many different and complex reasons for this heightened risk, including:

- Socialization practices that promote and reward compliance and obedience
- Limited social skills
- Limited access to relationships and friendships
- Limited opportunities for social engagement
- Limited knowledge about body and sexuality
- Limited experience with, or success using assertiveness
- Receiving intimate care and services in isolated settings

She went on to define and provide possible indicators of different kinds of mistreatment including inappropriate use of restraint, physical abuse, sexual abuse, and emotional abuse.

She then described the Alberta Abuse Prevention and Response Protocol, which provides a provincial policy framework for processes and accountability measures related to abuse prevention and response. Adherence to the protocol is mandatory for all parties who are paid or receive funding through the Persons with Developmental Disabilities (PDD) Program under the Ministry of Seniors and Community Supports. This includes all service providing organizations and families or others that hire privately.

The Protocol and training packages were released in 2000 and updated in 2004. The Provincial Board supported a strategic plan for addressing abuse in 2002. This resulted in the Persons with Developmental Disabilities Program focusing more on the prevention of abuse, and strengthening accountability, reporting, and the on-going review of the Protocol.

The presentations were followed by discussion periods where people were able to ask questions and/or comment on what they had heard.

Developing a Framework of Understanding about Vulnerability

Following the presentations, the focus shifted to a discussion of the complex interaction of factors that place individuals with developmental disabilities at risk of mistreatment. Participants were organized into five small groups and asked to develop a “framework of understanding” for abuse and neglect that took into consideration characteristics of the individual, the circumstances in which they are living, and previous life experience. This exercise was a prelude to the next day’s discussion of recommendations, intended to get people thinking creatively about the contributors to neglect and abuse and therefore potential points of intervention. The groups also discussed how these factors frequently interacted to increase vulnerability and risk of abuse.

Personal Characteristics

The small groups identified a number of personal characteristics that they felt could contribute to the risk of abuse and neglect. These included:

- The type and severity of disability
- The presence of more than one disability
- Level of physical ability to defend oneself

- Difficulties in communication due to limitations in verbal ability or language barriers
- Difficulties with behaviours due to communication challenges
- Wearing a “cloak of confidence / competence” to avoid being identified as having a disability
- Limited social skills, social boundaries, and knowing who to trust
- Lack of self-esteem and self-awareness; desire to please
- Limited reasoning ability; difficulty with judgement and decision-making
- Dependency; reliance on others for personal care
- Isolation
- Desiring social contact at any price
- Insufficient resources; poverty
- Lack of opportunity to make own decisions
- Vulnerability due to an increase of financial assets

Contextual Factors

The contextual factors identified by the small groups included:

- Issues related to **personal supports and caregivers** such as
 - Lack of competency or capacity of caregiver
 - Lack of capacity (e.g. aging parent)
 - Insufficient amount of support (e.g. number of hours for Supported Independent Living)
 - Number of caregivers (either too few or too many who don't communicate among themselves)
 - Frequent turnover of caregiver
 - Exploitation by family, friends and service providers
 - People can be both hurt and helped by people closest to them; greatest harm and greatest benefit
- Issues related to **agency supports** such as
 - Lengthy wait lists; uncertainty of eventual support; strain on family
 - Insufficient amount of available service and support
 - Number of providers of services and supports
 - Insufficient communication and coordination of effort where multiple service providers
 - Frequent turnover of support staff
 - Lack of access to mainstream community services (e.g. counsellors, police, lawyers, doctors)
 - No system in place to report concerns related to abuse and neglect of adults
 - People are devalued; not seen as victim – seen as clients and service only
- Issues related to **access to information & services**
 - Access to information in plain language
 - Lack of understanding of sources of help
 - Access to mainstream community services; police, lawyers, counselling, etc
- Issues related to **financial resources** such as
 - Financial dependency & lack of choices
 - Financial exploitation
 - Limits of choice due to poverty
 - Resources not provided for advocacy and self advocacy
- Issues related to **isolation** due to
 - Difficulty making / sustaining personal relationships

- Limited opportunities for social inclusion
- Limited social networks / introducing relationship circles
- Communications limitations
- Geography
- Aging caregiver(s)
- Access to transportation
- Poverty
- Under-developed / funded self-advocacy networks
- Issues related to **accessible living** due to
 - Lack of accessible living options / choices
 - Assumptions favouring dependent living arrangements (e.g. family) versus more independent living arrangements
- Issues related to **transition planning** including
 - Inadequate planning related to developmental transitions (e.g. child to adult, family home to community living)
 - Inadequate long-term planning (e.g. estate, trustee)
 - Transitions from school
- Issues related to **monitoring well-being** of vulnerable adults including
 - No system in place to monitor well-being of vulnerable adults
 - Unresolved conflicts between need to ensure safety and right of privacy
 - Unclear expectations where multiple agencies serving same individual / family
 - Inconsistent protections for “whistle-blowers”
- Issues related to **societal attitudes** such as
 - Stigmatizing and devaluing people with disabilities
 - Using labels to pigeon-hole individuals
 - Cultural values / practices that ostracize or hide people with disabilities

Previous Life Experience

The risk factors related to the individual’s previous life experience identified by the small groups included:

- Learned submissiveness, helplessness
- Frequent moves
- History of being segregated; limited opportunity to form relationships
- Previous victimization
- Family upheaval / breakdown
- Loss of loved one / primary caregiver
- Previous institutionalization
- Living in an environment where assaults / inappropriate interactions are common
- Prior abuse, bullying or neglect
- Lack of education in areas of relationships / sex / human rights
- Limited life experience and context
- Limited experience in making choices / decisions

Effective Practices

As part of the discussion of a framework of understanding, the small groups were asked to identify practices that might offset the factors that contribute to abuse and neglect, or that

otherwise reduce risk. Their suggestions included the following:

- Increase both social inclusion and societal awareness
- Increased education of people with disabilities, public, caregivers, service providers
- Easier reporting and faster response when abuse or neglect is identified
- Provide a legislative base for adult protection and “whistleblower” protection
- Develop best practices in areas such as:
 - Identifying suspected or actual abuse or neglect
 - Tracking the well-being of vulnerable adults / potential database (to flag situations such as withdraw from services / isolation/ school transition)
 - Requiring an annual face to face visit if individual / family is receiving any public funds in context of safeguards / wellness checks
 - Reporting and responding to abuse or neglect
 - Improved interagency communication / Coordinating multiple agency involvement and identifying a lead agency
 - Strengthening supports for developmental transitions (e.g. child to adult)
 - Development of circles of support

Principles to Guide Practice

On the morning of the second day, participants again formed five small groups. Their first task was to identify the principles that should guide the identification and protection of vulnerable adults. They were further asked to determine whether any of the principles were in conflict with one another, and if so, which should prevail. Their responses were as follows:

Principles Related to Identification

Individual Rights

- Protection and freedom from harm
- Privacy
- Canadian Charter of Rights and Freedoms – right to life, security of person, liberty
- Self-determination and choice
- Involvement in decisions that affect oneself
- Access to an advocate / person of their choice
- Access to augmentative communication
- Emphasis on prevention and early identification
- Anonymity in reporting suspected mistreatment

Protocols and Communications

- Common definitions and protocols for service providers
- Good communication between service providers
- Best interest of the individual in decisions regarding sharing of information

Principles Related to Protection

Individual Rights

- Right to basic necessities of life / quality of life
- Protection and freedom from harm
- Life-long social inclusion
- Principle of do no harm – respect and dignity required
- Protection should not mean institutionalization

- Citizenship and inclusion
- Self-determination and choice, including choice of living situation
- Recognition of uniqueness; respected and valued as a person
- Privacy and informed consent
- Access to emergency shelter / safe place
- Fair and equitable access to the justice system

Person-Centred Action

- Appropriate intervention designed to meet individual circumstances / needs
- Person directed / focused planning

Community and Services

- Community responsibility to ensure people are safe
- Emphasis on prevention and early identification of high risk situations
- Availability of a continuum of services and supports throughout life span
- Universal responsibility to report suspected mistreatment
- Safety is first priority
- The greater the risk to safety the more important that intervention occur
- All who report in good faith should be protected from liability

Principles in Conflict

Participants identified a number of situations where two principles might come into conflict. Many of these were variations on the theme of the principle of self-determination and privacy coming into conflict with an individual's safety and well-being. This conflict expressed itself in different ways, sometimes in terms of self-determination coming into conflict with risky or self-injurious behaviour, and sometimes in terms of societal responsibility to protect coming into conflict with the individual's right to privacy. In most instances, the small groups appeared to feel **that the safety of the individual should be paramount, and that where principles of the responsibility to keep safe come into conflict with other principles, the principle to keep safe should prevail.** As one group noted, the greater the risk, the greater the grounds to over-ride individual decisions.

Summary of Recommendations

Having heard about the lessons learned in Peel and the practices in other jurisdictions, and having developed a framework of understanding and identified principles to guide practice, participants were asked to turn their attention to recommendations. Specifically, they were asked to develop recommendations for increasing public and professional awareness related to vulnerable adults, and for strengthening identification and protection. They also were asked to think in terms of strategies that would build on things that already exist in Ontario, and strategies that would require the introduction of something new.

There was no consensus-building exercise to prioritize the recommendations developed by the small groups, nor does their inclusion below indicate that all participants agreed on the recommendations. They are presented here, in no particular order, to illustrate the range of ideas that people felt were worth considering or pursuing. It should be noted, that the small groups often developed more detailed recommendations within the themes described below.

Recommendations for Increasing Public & Professional Awareness: Building on What Exists

- Develop a core message: people are at risk, people have the right to live in the community, you have a responsibility to act
- Use existing media (print, radio, TV) to educate regarding the potential for abuse and neglect of vulnerable adults
- Expand existing help-lines to include vulnerable adults
- Use existing settings for awareness campaigns (e.g. community centres, schools, libraries, doctor's offices, hospitals, malls, faith settings, drop-in centres, long-term care settings, etc)
- Educate existing neighbourhood groups to potential for abuse and neglect of vulnerable adults (e.g. Neighbourhood Watch, Block Parents, Crime Stoppers)
- Promote / support self-advocate groups to speak to professionals and the public
- Improve communication between service providers and between service sectors
- Increase training of professionals in this area; increase rights training
- Include a section on vulnerable adults in all developmental services worker (DSW) training courses and other relevant training courses (e.g. nursing, doctors, fire, police, emergency services)
- Make better use of videoconferencing for awareness and training
- Expand the role of Adult Protective Service Workers (APSW)
- Increase awareness of the role of the Office of the Public Guardian and Trustee
- Provide public awareness materials / messages in a wide range of languages

Recommendations for Increasing Public & Professional Awareness: Introducing Something New

- Create a telephone information line to provide information on potential abuse and neglect of vulnerable adults (i.e. one number to call)
- Create a website to provide information on potential abuse and neglect of vulnerable adults
- Introduce mandatory and ongoing training of front-line staff and volunteers
- Develop resource materials on how to identify suspected abuse/neglect and what to do about it
- Create a collaborative public awareness campaign sponsored by provincial organizations and the Ministry of Community and Social Services

Recommendations for Strengthening Identification & Protection: Building on What Exists

- Add information about neglect and abuse to agency websites
- Expand existing databases (for example ODSP) to help identify at-risk vulnerable adults via flagging significant transitions such as leaving school, move, disengagement from services, death of caregiver etc.
- Strengthen the transition planning and hand-off between the children's sector (particularly schools) and the adult's sector
- Put emphasis on creating and promoting support groups for families caring for a vulnerable adult
- Put emphasis on providing respite to families caring for a vulnerable adult
- Use of media to build public and professional awareness

- Develop a protocol for identifying a lead agency when multiple agencies are involved with the same individual / family
- Develop a common consent form to enable agencies to share information on a timely basis
- Expand the role of the Office of the Public Guardian and Trustee in relation to vulnerable adults
- Require a person-directed plan at the initiation of service or funding that becomes a living document and ongoing process and addresses what would happen if services were no longer engaged
- Require exit interviews when families are withdrawing from services, and otherwise strengthen disengagement process

Recommendations for Strengthening Identification & Protection: Introducing Something New

- Require annual face-to-face visits with vulnerable adults by people who know what to look for in terms of abuse and neglect
- Develop protocols across agencies and sectors that contain definitions and signs of neglect and abuse, and expectations with regards to reporting
- Development of protocols for disengagement of services that requires visit and wellness check
- Promote / assist in the development of on-line support groups
- Create a “friendly caller / visitor” program
- Create a service that would telephone individuals regularly to chat and check on their well-being (similar to Life Line)
- Develop and apply risk assessment tools to identify vulnerable adults (along the lines of that used in Alberta)
- Develop a vulnerable persons registry (along the lines of that used in York Region)
- Create inter-sectorial networks that share concerns about vulnerable adults (e.g. developmental disabilities, mental health, seniors, violence against women) to address the issues of prevention, identification and protection
- Create adult protection legislation to clarify expectations with regard to identifying, reporting and responding to abuse / neglect of vulnerable adults
- Introduce a mandatory requirement to report suspected abuse or neglect of adults
- Develop a trained multi-disciplinary team to respond to situations of abuse and neglect and to collaborate with police

Next Steps

The broader community meetings conclude the formal part of this project. This report will be forwarded to the co-sponsors: Peel Planning Group and Central West Region of the Ministry of Community and Social Services. The report also will be distributed to all those who participated in the project.

Some of the recommendations contained in this report are more within the reach of local communities, while others would require a provincial approach. It is anticipated that the Peel service community will continue to consider how to strengthen its approach to identifying and protecting vulnerable adults. It is hoped that other participants in the process will take the ideas developed over the course of this project and promote them in their respective

jurisdictions, including those individuals and organizations that might be able to promote change at the provincial level.

In conclusion, a heart-felt thank you to all those who gave so freely of their time and expertise so that we might collectively learn from the sad death of Tiffany Pinckney.

Appendix A
Participants at Peel Service Community Meeting
September 23, 2008

Name	Agency / Affiliation
Jill Carlyle	Centre for Addiction and Mental Health
Nicole Christie	Peel Crisis Capacity Network
Sharon Dam	Christian Horizons
Keith Dee	Brampton Caledon Community Living
Terry Elliott	Mary Centre
Susan Furman	Office of the Public Guardian and Trustee (OPGT)
Jon Greenaway	Erinoak Kids
Patricia Hood MacNicol	Infant and Child Development Services Peel
Kristie Hannahson	Peel Behaviour Services
Gail Jones	Kerry's Place Autism Services
Heidie Kazman	Peel District School Board
Leanne Mione	Peel Case Management
Riva MacNeil	Child Development Resource Connection Peel
Jim Preston	Kerry's Place Autism Services
Susan Ross	Ministry of Community & Social Services
Fiona Thivierge	Peel Regional Police
Jannett Thompson	Family Services Peel
Craig Shields	Facilitator

Unable to attend, but participated through telephone interviews

Name	Agency / Affiliation
Helen McAlpine	Community Living Mississauga
John Roloson	Peel Service Resolution
Nancy Stafford	Community Living Mississauga

Appendix B Peel Regional Police Definitions and Reporting

Definitions

Vulnerable person means a person who depends upon others to meet their everyday needs due to mental illness and/or developmental disabilities, or requires long-term or indefinite care due to their age or medical condition.

Vulnerable person abuse means any act or behavior that harms or threatens to harm the health or well-being of an elderly or vulnerable adult. The abuse is caused by someone in a position of trust or authority that the elderly/vulnerable adult relies upon for their basic needs. Forms of abuse include, but are not limited to physical, sexual, financial and psychological abuse and neglect, whether active or passive.

Reporting

The above definition encompasses the criteria that could be used by someone when deciding to contact the police. The decision as to whether to contact the police depends upon the complainant's perception of level of harm, which is subjective on their part. One person may decide to involve the police while the second person may not see it as a serious situation.

To report suspected neglect or abuse, dial the main police number at (905) 453-3311 and indicate the reason for calling. Unfortunately, there aren't currently specialized vulnerable adult investigators. Instead, front line officers take the initial report and then forward it onto the appropriate investigative bureau, quite often the divisional criminal investigations bureau. Of course, if the situation is deemed to be an emergency, the use of 911 would be most appropriate. However, keep in mind that if the vulnerable person is a child, then the Special Victims Unit would investigate.

Appendix C
Participants at Broader Community Meetings
October 27 & 28, 2008

Name	Agency / Affiliation
Leslie Atkinson	Safeguards
Lori Betts	Peel Regional Police
Patty Bingham	Ministry of Community & Social Services, SSAH
Jill Carlyle	Centre for Addiction and Mental Health
Angie Case-Macintosh	Community Living London
Nicole Christie	Peel Crisis Capacity Network
Barbara Collier	Augmentative Communication Community Partnerships, Canada
Peggy Corrigan-Dench	Freedom From Harm / Regional Support Associates
Sharon Dam	Christian Horizons
Keith Dee	Brampton Caledon Community Living
Allan Devlin	Ministry of Community & Social Services, Policy Br.
Terry Elliott	Mary Centre
Orville Endicott (Presenter)	Community Living Ontario
Barb Fowke	Freedom From Harm
Susan Furman	Office of the Public Guardian and Trustee (OPGT)
Sandy Garnham	Freedom From Harm; Community Living London
Camelia Girodat	Freedom From Harm
Jon Greenaway	Erinoak Kids
Kristie Hannahson	Peel Behavioural Services
Tyler Hnatuk	Community Living Ontario
Janis Jaffe-White	Family Alliance
Gail Jones (Project Coord.)	Kerry's Place Autism Services
Bruce Kappel	People First / Concerned Citizen
Heidie Kazman	Peel District School Board
Lana Kerzner	ARCH Disability Law Centre
Elisha Kroeker	Mary Centre
Lisette Lanthier	Freedom From Harm
Jennifer Leblanc	Freedom From Harm
Patricia Hood MacNicol	Infant and Child Development Services Peel
Janice May	Ministry of Community & Social Services
Leanne Mione	Peel Case Management
Riva MacNeil	Child Development Resource Connection Peel
Sheila Mansell (Presenter)	Registered Psychologist Private Practice in Alberta
Ken Pike (Presenter)	Community Living New Brunswick
Nancy Plater	Kerry's Place Autism Services
Olga Plesko	Community Care Access Centre
Jim Preston	Kerry's Place Autism Services
Ravi Nivedita	Community Living Ontario
Maureen Robinson	Central West Specialized Developmental Services
John Roloson	Peel Service Resolution
Susan Ross	Ministry of Community & Social Services
Arran Rowles	Community Network For Specialized Care – Central

	West Region
Craig Shields (Facilitator)	Human Services Consultants
Marg Spoelstra	Autism Ontario
Fiona Thivierge	Peel Regional Police
Jannett Thompson	Family Services Peel
Nancy Wallace-Gero	Freedom From Harm; Community Living Essex

Regrets

Name	Agency / Affiliation
Jose De La Barrera	Thistleton TRE-ADD
Laura Correa	Ministry of Community & Social Services, OSDP
Teri Gordon	Peel Wraparound
Gerry Harnden	Peel Regional Police
John Kovac	Peter Fonseca MPP Office
Gordon Kyle	Community Living Ontario
Alan McWhorter	Community Living Kingston
Nadia Mustillo	Ministry of Community & Social Services, OSDP
John Raftery	Peel Crown Attorney Office
Keith Tansley	Community Living Mississauga
Brigitte Wentlandt	Peel Children's Aid Society

Appendix D Presentation Notes: Mr. Ken Pike

Adult Protection

The New Brunswick Example

Adult Protection in N.B.

- 4 main components
 - Legislation (includes powers of investigation and response)
 - Policies
 - Standards and Guidelines
 - Interdepartmental Protocols
- Adult protection services are provided by regional adult protection workers (investigators and “case managers”) and overseen by a provincial adult protection consultant

Adult Protection Principles

- Adults have basic rights and fundamental freedoms, including legal rights, a right to security of the person, a right to be protected from exploitation of their property and a right to accept or reject assistance, intervention or medical treatment.
- Adults have a right to self determination and a right to choose the manner in which they wish to live, provided that the decision is voluntary . . .
- Adults have the right to the basic necessities of life.
- Adults are entitled to appropriate intervention and assistance designed to meet their specific needs.
- Adults are entitled to fair and equal access and participation in the criminal justice system.

Adult Protection Principles

- The abuse of and adult is a societal, as well as an individuals problem.
- Adults have a right to the least invasion of their privacy and interference with their freedom that is compatible with their own interests and those of society. The wishes of the adult are of primary importance.
- An adult is competent and capable unless legally declared incompetent or certified incapable. Adults should be supported to make their own decision whenever they are able.

Adult Protection Principles

- Competent adults have the right to provide their own instructions, make their own decisions and manage their own affairs. These directives are to be taken from the individuals themselves, rather than a family member or other person purporting to be acting for the adult.
- Adults should be supported in telling their own story to the extent possible, rather than having control taken over by a family member or other person purporting to be acting for the adult.

Adult Protection Legislation

- N. B. Legislation covers both neglect and abuse
- An abused adult is a person with a disability or "elderly person" who is a victim or is in danger of being a victim of physical or sexual abuse or mental cruelty (financial abuse is not covered)
- A neglected adult is a person with a disability or elderly person who is "incapable of caring for him or herself by reason of physical or mental infirmity and is not receiving proper care and attention" – or who "refuses, delays or is unable to make provision for his or her proper care and attention"

Adult Protection Legislation Reporting

- Reporting of neglect or abuse of adults covered by the legislation is not mandatory
- A professional person may disclose information about another person who he or she “has reason to believe” is a neglected or abused adult. This includes information acquired during the carrying out of the professional person’s duties or within a professional relationship.
- A professional person who reports suspected abuse or neglect is protected from liability if he or she acts in “good faith”
- The law outlines a long list of people who are considered to be “professionals” for the purpose of reporting

Adult Protection Reporting

- Adult residential facility standards require reporting by facility operators of “suspected” abuse of residents
- Government protocols of abuse of adults require employees who have “witnessed” mistreatment of elderly person or person with a disability or who suspects such a person has been abused to report this “immediately”

Adult Protection Investigations

- Where the Minister has a “reason to believe” that a person is an abused or neglected adult an investigation shall be conducted
- There is responsibility to investigate regardless of where the person is living or residing (residential facilities, hospitals or community)
- Where the reported abuse or neglect “appears to involve immediate or imminent danger” an investigation must be started immediately. Otherwise, an investigation must start within 16 working days from the date that the referral was received.
- An investigation can be conducted regardless of whether the person is believed to be “competent” or “incompetent”

Adult Protection Investigations

- If considered advisable, the Minister may request and authorize a medical examination of the person to report on the physical and mental condition of the person. This can be done without the person's consent.
- If an investigation is being obstructed, the Minister can ask a court for a warrant to authorize the investigation. This authorizes the police to help with the investigation and the use of force, if necessary, to enter a place to carry out an investigation.
- Investigations are carried out by people who are specially trained to conduct investigations – or by police – or by adult protection workers and police. Other people are not permitted to interview an abused adult.

Adult Protection Possible Responses

- If the Minister has reason to believe that a person is a neglected or abused adult because of the presence of any person, an application to a court for a warrant to remove the person can be sought.
- After an investigation, if the Minister is "satisfied" that an adult is neglected or abused, social services may be provided by the Ministry or a referral can be made to a community agency, another government department, a law enforcement agency, etc. If the adult is believed to be competent, they can refuse services.

Adult Protection Possible Responses

- If an adult is considered to be "mentally incompetent" (usually after a medical examination) the Minister may:
 - Put the person under "protective care" if the security of the person may be in danger and if the person has refused to accept services; or
 - Apply for a court order
 - Putting an adult under protective care allows the Ministry to take steps to remove a person from their current residence and, if necessary, arrange for medical treatment. Protective care status can last for 5 days. If further intervention is required, a court order must be sought.

Adult Protection Possible Responses

- Applications for a court order can include orders of supervision, protective intervention orders, orders for medical treatment, etc.

Adult Protection Considerations for Improvement

- A continued focus on training
- The development of specialized “teams” in each region to respond to adult protection situations (adult protection workers, physicians, police, etc.)
- The development and use of a good risk assessment tool (one that differentiates between persons with disabilities and seniors)
- Mandatory reporting???

Adult Protection A Final Word

- Adult protection systems such as New Brunswick’s depend on having good information about people and their situations of vulnerability. They can only react when we know what is happening in people’s lives.
- Other approaches to ensuring adequate safeguards are also critical.

Appendix E

Presentation Notes: Dr. Sheila Mansell

Recognizing and responding to abuse:
Alberta's experience with vulnerable
person's legislation and implementation of
abuse reporting protocol

Dr. Sheila Mansell
Registered Psychologist
Calgary, AB T3H5R7
(403) 503-0848

Presentation Content

- The Protection of Persons in Care Act
- The Alberta Abuse Reporting Protocol

Heightened vulnerability to abuse

- Children and adults with developmental and physical disabilities have a heightened risk for all varieties of maltreatment and abuse
- Most findings estimate 2 to 4 times the risk found in the general population
- There are many different and complex reasons for this heightened risk

Reasons for vulnerability

- Reasons center on a combination of both individual and social factors.
- Individual factors may include the specific constellation of a person's disabilities that may be attractive to perpetrators.
- Individual factors are multiple and complex.

Reasons for heightened vulnerability

- Socialization practices that promote and reward compliance and obedience
- Limited social skills
- Limited access to relationships and friendships
- Limited opportunities for social engagement

Reasons for heightened vulnerability

- Limited knowledge about body and sexuality
- Limited experience with or success using assertiveness (it is rarely reinforced) and even less experience with reinforcing personal boundaries
- Receiving intimate care and services in isolated settings (such as transportation)

Sources of vulnerability

- Limited affective and sexual vocabulary
- Disempowered and devalued
- Low self-esteem, feelings of inadequacy, and prolonged dependency
- Loneliness

Vulnerabilities

- Poor social discrimination and limited understanding of dangerous situations and risk (social and personal ambiguity)
- Limited experience with relationships, assertiveness, negotiating about one's needs, saying "no", and choice making

Sources of risk for abuse

- Sources of risk vary from those observed in the general population due to the systems in which people with developmental disabilities live and work
- Yet a consistent feature emerges within the affinity systems (i.e., the systems of people that surround and have closest access to the person)

Responses to these situations

- A range of different policy and legal initiatives have provided responses to these sources of heightened risk
- Adult protection legislation, mandatory employee screening, whistleblower protection, and reviews of policies and practices that had heightened vulnerability to abuse within the system have all been implemented to different degrees in different places

Risk reduction

- Risk reduction strategies include education for families, staff and school personnel, and for children with disabilities
- Education may focus specifically on abuse and exploitation prevention or may focus more on reducing risk vulnerability and improving skills in a range of areas

Risk reduction interventions

- Social skills
- Sexuality
- Boundaries
- Communication
- Assertiveness
- Coping skills
- Self-Esteem

Risk reduction necessities

- Abuse risk reduction needs to have some emphasis placed on enhancing communication, understanding abusive situations, reducing social isolation, promoting and practicing social skill development, making friends, establishing and maintaining boundaries, and learning about feelings and your body

According to PDD abuse is

- When a staff person misuses their authority by acting in a way that causes harm or potentially causes harm to individuals receiving PDD funded supports
- People use different terms to describe abuse
- PDD identifies six categories of abuse

Negligence

Failure to provide necessities (such as food, clothing, shelter, protection from hazardous environments, care or supervision appropriate to the person's age or development, hygiene and medical care).

Possible Indicators

- Health concerns that go ignored or untreated
- Loss of weight without a medical reason
- Always tired and falling asleep
- Frequent falls, injuries and reoccurring minor accidents

Exploitation

Taking advantage of a person, including but not limited to money and things, as well as persuasion to do things that are illegal or not in the individual's best interest.

Possible Indicators

- Using someone's treaty card to access benefits
- Borrowing money or objects without permission
- Convincing someone to give away personal possessions
- Convincing someone to do something they do not want to

Inappropriate use of restrictive procedures

Use of restrictive procedures that are outside the parameters of the Creating Excellence Together (CET) Certification Standards adopted by the PDD Boards

Possible Examples

- Withholding a person's possessions
- Using medications outside of the approved planned approach
- Using unnecessary restraint

Physical abuse

Physical acts of assault (or threats of) such as hitting, punching, kicking, biting, throwing, burning or violent shaking that cause, or could cause physical injury.

Possible Indicators

- Unexplained or unusual injuries
- Defensiveness in regards to injuries
- Sudden fear of physical contact
- Sudden inability to sleep at night

Sexual abuse

- Sexual Abuse
- Sexual assault (touching of a person's sexual features without consent) or
- Sexual harassment (any conduct, comment, gesture or contact of sexual nature likely to cause offence or humiliation to an individual).

Possible Indicators

- Pain or injury to genital areas
- Difficult time walking or sitting
- Sudden childlike actions (regression)
- Sudden sexual acting out

Emotional abuse

The rejecting, ignoring, criticizing, insulting, threatening, harassing, degrading, humiliating, intimidating or terrorizing of a person. Acts or omissions that cause or are likely to cause conduct, cognitive, affective or other mental disorders, emotional stress or mental suffering.

Possible Indicators

- Sudden onset of speech disorders
- Anxiety, anger and behavioural changes
- Constant apologies
- Nightmares or sleep disturbances

Abuse Prevention and Response Protocol

- Abuse Prevention and Response Protocol is a Provincial Operational Policy Framework.
- Adherence to the Protocol is mandatory for all parties who are paid to provide PDD funded supports – this includes all service providers organizations and families/others that hire privately.
- The purpose is to provide a policy framework that identifies processes and accountability measures related to abuse prevention and response.

Abuse Prevention and Response Protocol

- The Protocol and Training package was refined and released in January 2000 and updated in January 2004.
- Provincial Board supported a strategic plan for addressing abuse in February 2002.
- This resulted in PDD focusing more on the prevention of abuse and strengthening accountability, reporting, reviewing and follow up components of the Protocol.

Changes to Protocol

- An increased focus on abuse prevention and the use of a proactive rather than a reactive approach
- Strengthening the training package with a prevention focus and making it available to service provider organizations and families/others who hire privately.
- Seeking help from adults with developmental disabilities and their families, to consider what prevention information needs to be shared and strategies for doing this is part of the process.

Knowledge and Information

Individuals and staff need to be educated and informed on prevention

- Knowledge is power
- Boundaries around the ethics and use of touch
- Social and Sexual Behavior
- How to say “no”
- Opportunity for healthy relationships

Responsibility to take action

- Ethical Responsibility to Take Action
- Authority Related to Allegations

Levels of ethical responsibility

Situations of concern that are not receiving PDD funding

- Service provider organizations, families/others who hire privately and PDD have an ethical responsibility to do whatever is reasonable related to the individuals it supports, by influencing situations over which they have no jurisdiction or authority.
- PDD is committed to playing a role in educating and influencing such situations, as the need arises.
Example: Stress while visiting in the family home.

Levels of ethical responsibility

Situations that are receiving PDD funding

- Service provider organizations, families/others who hire privately and PDD all have an ethical responsibility to be proactive and take action to reduce the potential for harm. Examples:
Behavioral concerns with a fellow PDD funded roommate.
- Staffing practices or inaction creates the potential for putting the individual at risk of being harmed.

Levels of ethical responsibility

Authority Related to Allegations

- PDD has the authority to address allegations of abuse in situations where PDD provides funding.
- In community based service providers and families who hire privately this authority comes from a contractual agreement.
- In government operated facilities the authority comes from its basic duty to protect while being directly responsible for providing services to the individuals its supports.

Becoming aware of abuse

- Witnessing it
- Through physical evidence
- Through behavioural indicators
- Through a report from a third party, or
- Through a disclosure by the alleged victim

Guideline

- Recognizing changes in behavior and signs of distress
- Accessing appropriate professionals to investigate and knowing your limits
- Following protocols carefully and recognising your responsibilities and proceeding sensitively
- Ensuring person's protection and safety
- Providing support and ensuring access to treatment services
- Ensuring accountability to all appropriate stakeholders

Receiving a disclosure

- Do not promise to keep the information you are receiving a secret
- Be prepared to listen immediately to the allegation
- Do not ask questions of the individual specific to the allegation
- Assist the person to be as comfortable as possible
- Ensure the setting is private
- Remain calm
- Do not express anger towards the alleged abuser
- Do not photograph the alleged victim.

Receiving a disclosure

- Listen to the person
- Be non-judgemental – respect everything the person says to you without judgement.
- Go at a pace with which the person is comfortable.
- Allow the individual to use a communication system that is comfortable to them, pictures, sign language, etc.
- Do not ask questions of the individual specific to the allegation – at this time you are receiving information – if needed ask open ended questions like - “Tell me about your visit to the house”?
- Do not use leading questions.

Receiving a disclosure

- Ensure safety and support
- Safety will be ensured and support will be provided.
- The guardian will be informed (if there is a guardian and he/she is not implicated).
- Explain that it will be reported.
- Local police services will be informed if the allegation is perceived to be criminal in nature

Receiving a disclosure

If Medical Attention is Required

- Ensure that a support person of the alleged victim's choice accompanies him/her to the hospital or doctor's office.
- Ensure that the guardian is informed.

It is best if the individual:

- Does not change clothing (*for the purpose of a criminal investigation*)
- Does not shower (*for the purpose of a criminal investigation*)
- Understands why it is important to go to the hospital or doctor's office and what will occur.

Take Immediate Action

- If you witness abuse, stop it
- Ensure the safety of the alleged victim
- Seek medical assistance if required
- Report the abuse

Obligation to report

- If staff reasonably suspects or believes that an individual has been or is being abused, they are expected to immediately report the matter.

Reluctance to Report

- Participants may identify concerns with identifying abuse. For example, a staff person may fear losing his/her job. It is important to acknowledge those fears. However, as professionals, staff have a moral and ethical obligation to report abuse.
- The protocol states that when a person reports a matter, no action is to be taken against him/her by the service provider or PDD unless the report is made maliciously or without reasonable grounds. In addition, employees who have been dismissed have other options to address the issue.

Service Providers

- It is important that the Service Provider create an environment that supports reporting and encourages as well as creates opportunities for discussion within the organization around the reporting of abuse.
- If the allegation is believed to be criminal in nature contact the police.
- If unsure if the setting falls under the PPC Act, get clarification from your agency or phone PPC Act reporting line.

Service provider

- Reporter should only have to report once and then the responsibility for follow-up lies with the service provider organization or the family that hires privately.
- PDD will review all cases where a service provider fails to report or take action to follow-up on an allegation of abuse. If the service provider does not take appropriate action, each situation will be reviewed and acted upon, given the unique circumstances involved.

Reporting to PDD

- Service provider organizations or families/others who hire privately report all allegations of abuse to PDD
- Report allegations of abuse as they occur
- Provide preliminary report to PDD within one working day
- Community Boards forward this data to Provincial Board quarterly

Reviews

- Internal reviews
- External reviews
- Process considerations for reviews are outlined in the Protocol

Reviews

Internal reviews are conducted:

- By the service provider organization or family/other who hires privately or
- In conjunction with PDD or
- Through an agreement with a third party, at the request and responsibility of the service provider organization or family who hires privately

Reviews

External Reviews are conducted:

By PDD, PPCA office, and/or a police service, either by their employees or through a contract with a third party

Examples of why an external review would be necessary:

- The staff person doesn't trust the CEO or Board to act appropriately
- The alleged offender is a friend of the CEO or Board member
- A belief that the service provider is not handling an internal review appropriately
- The allegation appears to be criminal in nature
- The setting falls under the PPC Act

Follow-up

- Follow-up with interim or final report within 30 days
- Action plan implemented by service provider or family/other who hires privately
- PDD Community Board designate will monitor implementation of action plan

Complicated disclosures and trauma histories

- In some experiences during my practice I have occasionally encountered clearly unfounded accusations of sexual or physical assault made against a staff member.
- In some cases these unfounded reports were acts of retribution with little appreciation of the consequences for others.
- Some adults I have worked with misidentify individuals who could not have been their perpetrators however they may unwittingly trigger the person to re-experience their traumas.

Complicated disclosures and trauma histories

- In other cases no verbal report was available at all but significant evidence of other concerns associated with staff and clients raised enough concern about client safety that other actions were taken.
- In other circumstances with alleged “abuse” occurring between individuals receiving services disclosures become even more complicated. Some instances this kind of “abuse” is in fact consensual sex that is occurring furtively due to lack of appropriate sexual opportunities.

Complicated disclosures and trauma histories

- When individuals are “discovered” (given the history for most people involving punishment for sexual behaviour) no one will admit to having initiated the sexual contact. The situations are difficult to clarify and carefully examining longer term behaviour patterns will be important.
- In other cases that resemble this form abuse truly has taken place significant care must be used when examining these situations. It is sometimes the case that more information obtained over time will reveal the nature of these situations more accurately.

Appendix F

Reference Materials Provided to Participants in Community Discussion Process

If you have difficulty accessing these materials please contact Gail Jones – 905-457-1130 ext. 202 or gjones@kerrysplace.org

Alberta Seniors and Community Supports. Safeguards for Adults. Available on Alberta Seniors and Community Supports website:

http://www.seniors.gov.ab.ca/CSS/persons_in_care/AdultsSafeguards.pdf

Alberta Seniors and Community Supports. Protections for Persons in Care. Safeguarding Vulnerable Adults. Available on Alberta Seniors and Community Supports website:

http://www.seniors.gov.ab.ca/CSS/persons_in_care/PPIC_Brochure.pdf

Collier, Barbara. Pointing It Out. Safety for People Who Use Augmentative Communication. Toronto, Ontario: Augmentative Communication Community Partnerships – Canada, 2007. Resource can be ordered from www.accpc.ca

Hingsburger, Dave. Black Ink – Practical Advice & Clear Guidelines for Dealing with Reports of Sexual Abuse from People with Intellectual Disabilities. Mississauga, Ontario: Trillium Health Centre, 2006.

Hingsburger, Dave. Upping the Anti – Anti Abuse Policies: Handling Allegations of Sexual Abuse Within Organizations That Serve People With Intellectual Disabilities. Mississauga, Ontario: Trillium Health Centre, 2006.

Jones, Gail. Vulnerable Adults – What Are The Safety Checks? October 2007.

Available on Kerry's Place Autism Services website:

<http://www.kerrysplace.com/Reports/Safeguards%20for%20Vulnerable%20Adults%20Discussion%20Paper%20October%202007.pdf>

O'Brien, John, and O'Brien, Connie Lyle, and Swartz, David B. What Can We Count On To Make and Keep People Safe? Syracuse, New York: Responsive Systems Associates, Inc. / Centre on Human Policy, 2004.

Persons with Developmental Disabilities Alberta Provincial Board. Abuse Prevention and Response Protocol. August 2006.

Available on Persons with Developmental Disabilities website:

http://www.pdd.org/docs/prov/Protocol_Manual_Aug2006.pdf

Persons with Developmental Disabilities Alberta Provincial Board. Plain Language Brochure On Keeping Safe – I Feel Good About Me! Available on Persons with Developmental Disabilities website:

http://www.pdd.org/docs/prov/Abuse_Pamphlet.pdf

Persons with Developmental Disabilities Alberta Provincial Board. Preventing and Responding To Abuse... Everyone Has a Role. January 2004. Available on Persons with Developmental Disabilities website:
http://www.pdd.org/docs/prov/AbuseBrochure_Jan2004.pdf

Persons with Developmental Disabilities Alberta Provincial Board. Top 10 Things You Need To Know About The Abuse Prevention And Response Protocol. September 2005. Available on Persons with Developmental Disabilities website:
http://www.pdd.org/docs/prov/Top10_messages_forPDDstaff.pdf

Pike, Ken. Adult Protection in New Brunswick.

Ravi, Nivedita. Adult Protection Legislation. July 2008.

Self Advocates Council of Community Living Ontario. How to Support Me with Respect Brochure. Ontario, Community Living Ontario.

Self Advocates Council of Community Living Ontario. Reporting Abuse. A Guide for Caregivers Brochure. Ontario, Community Living Ontario.

Self Advocates Council of Community Living Ontario. Stop Abuse. What You Can Do To End The Hurt Brochure. Ontario, Community Living Ontario.

Self Advocates Council of Community Living Ontario. You Have Rights Brochure. Ontario, Community Living Ontario.

The Government of New Brunswick. Adult Victims of Abuse Protocols. Fredericton, New Brunswick: The Government of New Brunswick. Sept. 2005.

Appendix G Vulnerable Adults Project Timelines for Tiffany Pinckney

