

**Submission to the
Law Commission of Ontario**

Concerning:

THE LAW AS IT AFFECTS OLDER ADULTS

Submitted By:

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**Response of the Advocacy Centre for the Elderly
to the Law Commission of Ontario's Consultation Paper:
*The Law As It Affects Older Adults***

The Advocacy Centre for the Elderly (ACE) is pleased that the Law Commission of Ontario (LCO) has chosen to embark on a multi-year project to develop a new framework to analyze and understand the impact of law on older persons. In order to focus its work, the LCO is conducting a preliminary consultation and inviting stakeholders to comment on its paper entitled *The Law As It Affects Older Adults*. This is our reply to that document. After providing a brief introduction about ACE, we will answer the eight sets of questions posed in the LCO's paper. Our responses are not recommendations; our intent is to raise issues and facilitate discussion. We would be happy to participate in any further LCO consultations or discussions about the law and older persons.

Advocacy Centre for the Elderly

ACE is a specialty community legal clinic that was established to provide a range of legal services to low income seniors in Ontario. The legal services include individual and group client advice and representation, public legal education, community development, and law reform activities. ACE has been operating since 1984 and it is the first and oldest legal clinic in Canada with a specific mandate and expertise in legal issues of the older population.

The individual client services are in areas of law that have a particular impact on older adults. These include but are not limited to the law related to:

- capacity, substitute decision-making and health care consent;
- end-of-life care;
- supportive housing and retirement home tenancies;
- long-term care homes;
- patients' rights in hospitals;
- consumer law;
- elder abuse;
- long-term care community services (home care);
- public pensions;
- other income support issues.

ACE receives, on average, over 2,500 client intake inquiries a year. These calls are primarily from the Greater Toronto Area but approximately 20% are from outside this region, and may come from any part of the province, as well as from out of province.

Public legal education programs are directed to seniors and their families, as well as health professionals and other service providers working with seniors. These presentations and workshops may be on any topic of law within ACE's practice. ACE also produces written educational material, such as booklets and pamphlets on seniors' legal issues in partnership with Community Legal Education Ontario.

ACE staff also produce papers for continuing legal education programs and engage in other writing on elder law. For example, ACE has produced an extensive manual on long-term care law, *Long-Term Care Facilities in Ontario: The Advocate's Manual*. This manual is an effort to assist other advocates (both lay advocates and lawyers), as well as seniors and their families engaging in advocacy on seniors' issues. Now in its third edition, this manual is over 600 pages and also includes chapters on retirement homes, home care, and other issues such as substitute decision-making, powers of attorney, and advocacy.

As part of its law reform mandate, ACE staff frequently participate in government consultations as stakeholder representatives for the seniors' community. We also prepare written briefs for policy makers and make submissions to legislative committees when new legislation or legislative amendments on seniors' legal issues are proposed. For example, ACE has drafted submissions on various long-term care consultations, including a major brief on the new long-term care home legislation.

Consultation Questions

1. What aspects of diversity should any approach to the law affecting older persons take into account?

A. Diversity

Canada is a multicultural and diverse society where older persons experience life differently due to numerous factors, including one's gender, colour, income, level of education, ethnicity or place of origin, place of residence, marital status, sexual orientation, family status and health. Older adults are not a homogenous group.

As with all laws, not just those pertaining to older persons, ACE expects all aspects of diversity to be considered when drafting laws and that they are made in accordance with human rights legislation.

In reality, older persons are often discriminated against due to their age. Discrimination is often compounded for older adults due to the intersection of age with other aspects of their identity.

B. Immigrants

While the LCO paper notes that a significant percentage of older persons are immigrants and it lists some of the barriers to services experienced by this group, it fails to mention that they often experience economic insecurity. Studies indicate that the percentage of older persons living on lower incomes is much higher for recent immigrants than non-immigrants or immigrants who have been living for a longer period of time in Canada.¹

¹ Sandra Elgersma, Library of Parliament, Political and Social Affairs Division, *Immigrant Seniors' Economic Security and International Social Security Agreements*, PRB 07-45E (6 December 2007).

One of the reasons for the disparity is due to the ten year residency requirement for a pension which requires individuals to have lived in Canada for ten years before collecting the Old Age Security Pension and the Guaranteed Income Supplement.² Immigrants from countries with which Canada has reciprocal international security agreements may benefit from pensions from their country of origin and may use periods of residency there to qualify earlier for Old Age Security. A private member's bill before the House of Commons is attempting to reduce the residency requirement from ten to three years for entitlement to these financial supports.³

Admission to a long-term care home is also an issue for seniors who are under sponsorship. As earlier stated, a new immigrant is not entitled to Old Age Security or the Guaranteed Income Supplement until he or she has been in Canada for ten years. Therefore, unless the person receives a foreign pension or the country of origin has a reciprocal agreement with the Canadian government, they will not be receiving any old age pensions. The sponsor agrees to provide them with "food, clothing, shelter, fuel, utilities, household supplies, personal requirements, and other goods and services, including dental care, eye care, and other health needs not provided by public health care." They also promise that the sponsored person will not need to apply for social assistance. In most cases, the senior will live with his sponsor. However, if the senior becomes ill, for example has a stroke, a fall, or has Alzheimer's disease, they may have more care needs than the person can meet in their home. This necessitates admission to a long-term care home. The accommodation rate associated with this is usually beyond the means of the sponsor. The result is either that the person is not admitted, or they are admitted and the home applies for social assistance on their behalf. If social assistance is granted, which it usually is, any amounts paid out will be charged back to the sponsor. This will mean that they can be sued for the outstanding amounts, can have any tax refunds seized, and will be prevented from sponsoring any other family members. This causes the sponsor to refuse admission or to discharge the person back to their home, because they are usually also the substitute decision-maker. This results in the senior not receiving the health care to which they are entitled (as the payment is for accommodation only), and puts them at risk.

ACE does not yet have a position as to whether the private member's bill to reduce the residency requirement for eligibility for the Canadian pensions is the best approach to this issue. However, we encourage the LCO to look at this issue, as well as other instances where new older immigrants face challenges due to lack of economic security. In particular, the LCO should research the impact of the lack of pensions and the sponsorship agreements on seniors who are not only permanent residents in Canada but in many cases are Canadian citizens, but who, because of their immigration status, age and disability, are unable to access guaranteed health care services.

² Section 1 of the *Old Age Security Act*, R.S., 1985, c. O-9 defines a "specially qualified individual" as a person "who has not resided in Canada after attaining eighteen years of age for an aggregate period of ten or more years other than such a person to whom a pension or allowance was payable."

³ Bill C-362, An Act to amend the *Old Age Security Act* (residency requirement), Colleen Beaumier (Brampton West), 1st session, 39th Parliament.

2. What principles and goals should guide the law as it affects older persons?

It is the opinion of ACE that the overarching principle that should guide the law as it affects older adults is that seniors are people. They are presumed to be capable of making decisions and they have the right to make foolish decisions, if they so choose. The government must be careful not to create laws, in its overzealousness to protect so-called vulnerable older adults, which actually limit their rights. By way of illustration, ACE is concerned about proposals to create a Seniors Charter of Rights.⁴ It is unlikely to guarantee any protections that do not already exist and it has the potential to take rights away from older adults if interpreted narrowly to say older persons do not have any rights outside of this document.

ACE agrees it is valuable to utilize a framework for the purposes of designing and reviewing laws and programs to ensure they are not detrimental to older adults. Dignity, independence and participation – principles found in both the *National Framework on Aging* and the United Nations *Principles for Older Persons* – are paramount.

The principle of fairness contained in the *National Framework on Aging* suggests intergenerational struggles for access to scarce resources, in which the rights of older adults have to be balanced against the competing interests of other generations. This is a limitation of rights to which the *Principles for Older Persons* does not subscribe and it should not be one of Canada's guiding principles when dealing with older adults.

The notion of security in the *National Framework on Aging* is a good concept that resembles care in the *Principles for Older Persons*. Unlike the United Nations document, there is no entitlement to services which ensure security of the person, such as health care, institutional care or specialized care. The principle of security could be strengthened if it was expanded to include access to legal and social services, as well as legal definitions of program eligibility for health care and community based long-term care services, such that a person who meets the eligibility criteria is entitled to fully participate in the program regardless of competition for scarce resources. That being said, our concern about using the word care is that it is sometimes negatively equated with best interests.

ACE encourages the LCO to make recommendations that any legal framework supports the rights of seniors as adults because they are individuals with the same rights as adults of other ages. One way to do so is by incorporating and strengthening the principle of security to by addressing possible vulnerabilities of older adults, whether short term or long- term, without discounting the principles of dignity, independence and participation. The LCO is discouraged from recommending a framework based on the notion of vulnerability and a perception that older adults lack capacity and need protection.

⁴ A motion was passed by a majority in the House of Commons on June 20, 2006 that, in the opinion of the House, the federal government should create a Seniors Charter of Rights. To date, the federal government has not made any attempts to enact such a Charter.

3. Do negative attitudes or stereotypes about the characteristics, capacities or contributions of older adults affect the law or the administration of the law? Does the law adequately take into account the needs and experiences of older persons? Are there specific issues or areas of concern?

It is an unfortunate reality that negative attitudes and stereotypes are pervasive in Canadian society. These harmful views, in turn, are manifested in both our legislation and the administration of law.

A. Good Law, Bad Practice

ACE has identified a common theme with respect to the administration of the law as it applies to older adults, particularly in the health sector. In a number of areas of law, the law is good but the practice is bad. Therefore, law reform *per se* would not be necessary but research on why the law is not being followed could be very useful since it has a negative impact on older adults and their rights. Good laws should not be changed merely because there is resistance to comply.

One area where non-compliance with the law is rampant is that of capacity, substitute decision-making and health care consent. Ontario has comprehensive legislation, namely the *Health Care Consent Act, 1996*⁵ and *Substitute Decisions Act, 1992*,⁶ respecting decision-making for all people in the province, including older adults. The law sets out a positive framework but it is repeatedly misapplied, usually in a paternalistic fashion. In other words, the law is good but the practice is bad.

The right to consent to treatment by individuals who are capable, or to have treatment consented to by a substitute decision-maker if incapable, continues to be ignored and is one of the issues about which ACE receives a great number of complaints.

We are frequently contacted when substitute decision-makers discover that a mentally incapable person has been receiving treatment with medication, about which the substitute decision-maker knew nothing. Usually, but not always, the complaints are about anti-psychotic drugs, which have the potential for serious side effects. It is often not until the substitute decision-maker calls us that they learn of the health practitioner's legal obligation to obtain consent prior to commencing treatment.

In one such case, ACE represented a substitute decision-maker where a physician at a long-term care home prescribed an anti-psychotic to a resident without obtaining consent. The physician claimed it was standard practice in nursing homes throughout Canada to make treatment decisions and to let the staff at the home inform the family of any changes after the fact. A complaint was made to the Complaints Committee at the College of Physicians and Surgeons of Ontario and later appealed to the Health Professions Appeal and Review Board. The Committee submitted expert evidence confirming "it is a long-standing practice for physicians to give orders for patients' medications, and for families, if they have concerns, to discuss these with the attending physician (albeit after the fact of the medication having been prescribed)." Neither the

⁵ S.O. 1992, c. 30.

⁶ S.O. 1996, c. 2, Sched. A.

Committee nor the Board disagreed with the actions of the doctor. Therefore, it can be concluded that even regulatory colleges and administrative tribunals may not promote compliance or enforce the existing law.⁷ However it must be emphasized that this case should not stand for the proposition that the requirement for consent should be changed. Instead, it flags the need to look at how the regulatory Colleges ensure compliance with the law, how basic requirements for consent are being operationalized within health facilities and whether the lack of compliance within settings, such as long-term care homes, are reflective of institutionalized discrimination on the basis of age and disability.

There are many other examples of this same problem. Many long-term care homes routinely fail to obtain consent at all. Other homes attempt to obtain “blanket” consents at the time of admission to apply to all treatments that might be prescribed during the course of their stay. This in no way can meet the definition of “informed” consent required by law. Some homes commence treatment and some time thereafter a staff member will contact the substitute decision-maker to “advise” them that the resident is not taking the medication, leaving no option open for “consent.”

As illustrated above, if a capable person or their substitute decision-maker wishes to hold the health care practitioner accountable for their failure to obtain proper consent, their legal remedies are limited. A complaint may be made to the regulated profession responsible for overseeing the particular health profession but the process is lengthy and, if legal counsel is retained, expensive. Some of our clients opt not to make a complaint because it will take too long to address a problem that needs to be addressed immediately. We encourage the LCO to consider a review of the *Regulated Health Professions Act* to determine if an alternate summary procedure can be established with regards to addressing complaints about the failure to obtain consent. Such a process would be a short-cut to traditional disciplinary procedures and address the problem in a timely fashion.

We have observed that the provincial government itself may inadvertently encourage people to misapply the law by requiring health facilities to use assessment tools, such as the MDS-RAI (Minimum Data Set – Resident Assessment Instruments), which contain misstatements of the provincial law on health care consent. This assessment tool is intended to provide health practitioners with a common measure to determine a patient's health needs to develop a plan of treatment. The common tool also allows data to be collected on health needs that can be used to determine funding and allocate resources across the health system. The Ministry of Health and Long-Term Care piloted a version of this tool in long-term care homes and recently started to implement this tool in all homes across the province. One of the ACE staff attended an education program for long-term care home administrators on this tool and discovered that it contained misinformation on the list of health substitute decision-makers and on advance care planning. We contacted Ministry staff about this problem and they have indicated their willingness to discuss possible changes so that it properly reflects the *Health Care Consent Act*. Ministry staff confirmed that long-term care home administrators believed, due to the tick box component of the tool respecting advance care planning, that it was a requirement that all residents in long-term care were required to have a written “advance

⁷ *K.P. v. C. P.* (April 15, 2004) File No. 7690, Health Professions Appeal and Review Board.

directive.” This is not a requirement of Ontario law. Please find attached a separate paper entitled “Advance Care Planning in Ontario” at Tab 1 that will explain this issue in greater detail. This incident is yet another illustration that bad forms drive bad practice that does not comply with the law, thereby reducing and restricting patients’ rights.

This is only one example where facility forms and practices and provincial assessment tools or standards may not comply with Ontario law which then has a negative impact on older adults. We encourage the LCO to look at this issue in health care and its impact on older adults as part of any work it may pursue on “good law, bad practice.” We could provide the LCO with other examples, if so requested.

While it is laudable for the provincial government to make funding announcements about new initiatives, they must be supported by political will and with adequate resources. For instance, we are supportive of the government’s zero policy respecting elder abuse but we find that compliance advisors in long-term care homes are not properly trained to understand and detect elder abuse.

Due to the misapplication of the law, the LCO should investigate working with professional faculties (such as medicine, nursing and social work) to better prepare their graduates about the applicable law and to work with older persons in a more supportive manner, without stereotypes. Not only should best practices begin in school, but the LCO should look into the feasibility of ongoing training and educational opportunities for professionals once they are in the workforce to ensure their compliance with the law.

The theme of the misapplication or the misunderstanding of Ontario’s laws as it pertains to older adults will be reiterated throughout our response to the LCO’s consultation paper.

B. Health Care

Older adults are over often viewed as sickly and erroneously blamed for increases in costs of health care. It has been suggested that such stereotypes support policies to reduce social programs for care. Also, these negative assumptions may send the message that older adults are not entitled to services and discourages them from seeking assistance.⁸

Finding a physician for an older adult who does not have one is difficult. One possible explanation is the shortage of health care professionals who are knowledgeable about the aging process. In 2005, there were only 191 geriatricians in Canada, as compared to the 538 that were estimated to be needed in 2006.⁹ Minimal amounts of teaching time are allocated to the issues of aging and dementia in Ontario medical schools, suggesting there will be future barriers for older adults in terms of not only accessing

⁸ See, for example, Jane Aronson and Sheila H. Neysmith, “Manufacturing social exclusion in the home care market” (2001) 27 Can. Pub. Pol’y 2 151-164.

⁹ Canada, Special Senate Committee on Aging, *Embracing the Challenge of Aging: First Interim Report* by The Honourable Sharon Carstairs and The Honourable Wilbert Joseph Keon (Ottawa: March 2007) at 72.

appropriate care but in receiving quality care.¹⁰ Another explanation for the difficulties in finding a doctor is that some physicians “normalize” concerns of older persons, often assuming them to be related to the aging process and, consequently, provide inadequate assessment and follow-up.¹¹

For these reasons, the LCO should examine several aspects of the medical profession, including: reviewing medical school curriculum to investigate if there any barriers to working with older persons; studying compensation criteria to determine the feasibility of changing the payment schedule to encourage more physicians to work with older persons; and considering whether the *Regulated Health Professions Act* can be amended to encourage on-going education and training.

Negative attitudes towards older persons are exemplified by calling those patients who are waiting in hospital for a bed to become available a long-term care facility “bed-blockers.” It infers that patients who are legitimately in need of long-term care beds are partially responsible for the shortage of emergency room beds. This issue will be discussed in more detail later in our submission.

C. Misconceptions about Adult Protection Law

Canada has three broad models of legislation respecting the mistreatment of older adults.¹² The Atlantic provinces’ model involves the enactment of special adult protection legislation supported by adult protection services or assigned adult protection personnel. This regime is similar to child protection legislation. The Ontario model involves the enactment of adult protection provisions within adult guardianship application legislation where the responsibility for the investigation of adult protection cases is conducted by the provincial Office of the Public Guardian and Trustee. The British Columbia model is a hybrid approach. Their legislation provides for interventions in cases of abuse or neglect, including self-neglect, as an alternative to court-ordered guardianship. Existing health and social service agencies have a mandate to investigate and intervene when abuse or neglect are reported.

Many people, including health practitioners, social service agencies and policymakers, do not understand that Ontario does not have adult protection legislation similar to the model in the Atlantic provinces. Due to their misconceptions, they often purport to act in the best interests of a vulnerable adult but they actually restrict the person’s right of autonomy and self-determination. Instead of working with the senior who may be “vulnerable” due to the abuse or offering options to the senior and ensuring that the senior is in control of the response, they may breach privacy, take action with which the senior does not agree, or treat the senior as incapable, removing their authority as decision-maker.

¹⁰ Ontario Human Rights Commission, *Time for Action: Advancing Human Rights for Older Ontarians* (Toronto: June 2001) at 57.

¹¹ *Ibid.* at 61.

¹² Robert M. Gordon, “Adult Protection Legislation in Canada: Models, Issues and Problems” (2001) 24 *Int’l J. L. & Psychiatry* 70-93.

ACE has always opposed adult protection legislation of the type in place in Nova Scotia,¹³ on the basis that such legislation: (a) limits the *Charter* values of liberty and security of the person without providing the same substantive rights and procedural safeguards that would be found in alternative criminal justice and mental health legal procedures; and (b) marginalizes already disadvantaged adults, often without providing anything constructive in the way of rights or resources that might assist them in overcoming neglect and abuse.

It is expected that various sectors will advocate for mandatory reporting legislation of abuse and changes to privacy legislation to legitimize the actions of service providers in acting in what they perceive to be in the best interests of the older person. It is recommended that the LCO undertake research on elder abuse and appropriate legislative models of response. This issue will also be discussed later in our submission.

4. Should the use of age-based criteria in laws and programs affecting older adults be re-examined? Are there specific aged-based criteria that warrant the attention of the LCO?

The use of age as criteria for purposes of eligibility provides policymakers with a simple, cost efficient and seemingly objective standard. However, “categories lead to comparisons and encourage people to emphasize differences between age groups; this can lead to stereotypes and incorrect assumptions.”¹⁴ Underlying many age-based laws and policies is the concept that “age is being used as a substitute for dependency...which is variously associated with illness, lack of ability, insufficient income and lack of maturity or capacity to be responsible or make decisions.”¹⁵ While age should not be the basis of adverse discrimination, it is appropriate as a criterion for affirmative action programs and the conferral of benefits (e.g., pension plans).

The provisions referring to the age of drivers in the *Highway Traffic Act*¹⁶ is the subject of contentious debate. Drivers of 70 years of age or older who are involved in a collision and convicted of a moving offence are required to complete a three-part exam consisting of a vision test, written test and road test.¹⁷ Drivers who are 80 years of age or older must participate in the Senior Driver Renewal Program which requires complete testing and participation in a group education session every two years.¹⁸

ACE represented Canadian Pensioners Concerned at the inquest into the death of Elizabeth Kidnie, who was struck by a car operated by an 84 year old woman. The overwhelming evidence at the inquest was that, on a per-driver basis, older drivers age 65 and over are safe drivers. Older drivers have the lowest crash rate per licensed driver of any age group. Based on this and other evidence, the coroner's jury

¹³ *Adult Protection Act*, R.S.N.S. 1989, c. 2.

¹⁴ Law Commission of Canada, *Does Age Matter?: Laws and Relationships Between Generations* (Toronto: 2004) at 22.

¹⁵ *Ibid.* at 17.

¹⁶ R.S.O. 1990, c. H.8.

¹⁷ O. Reg. 340/94, s. 16(b).

¹⁸ O. Reg. 340/94, s. 16(a).

recommended that the screening and evaluation of medically-impaired drivers should focus on medical condition without regard to age.¹⁹

The LCO is urged to review the restrictions on older drivers to determine if the current laws are justifiable and whether there should be enhanced road safety regulations for every driver, regardless of age, who is convicted of a moving offence. More generally, the LCO should examine age-based criteria laws and programs to determine if they are discriminatory and examine whether individualized assessments are more appropriate.

5. Do current legal frameworks adequately support access and participation for older adults? Are there any aspects of the relationships of older adults that have not been adequately addressed by current legal frameworks?

A. Access to Justice

Access to justice is a huge obstacle in the administration of both civil and criminal justice for older persons. All of the barriers to access to justice listed by the LCO in its paper must be addressed, in addition to financial barriers, the insufficient number of lawyers practicing elder law, lengthy court proceedings and the lack of rights advice for residents of long-term care facilities.

i) Financial Barriers

The most significant impediment to access to justice for older persons is money. The private bar model of law is prohibitively expensive for the majority of Ontarians.

Legal Aid Ontario does provide a limited number of services to older adults if they satisfy the financial requirements but they are so low that only the poorest members of society are eligible. Many older persons are precluded from receiving legal assistance for issues affecting security of the person because Legal Aid Ontario does not provide certificates for most civil claims. For example, there are no funds available for representation in the following areas: elder abuse, violation of consent and claims against long-term care homes.

As noted by the LCO, many older adults are “house-rich but cash poor.” Legal Aid Ontario will often require individuals to put a lien against their house in order to receive legal assistance but many older adults are hesitant to enter into such agreements as they are worried that they could potentially lose their home.²⁰ The LCO should consider examining the *Legal Aid Services Act, 1998*²¹ and whether it has a negative impact on access to justice, and whether Legal Aid Ontario has created policies respecting

¹⁹ Office of the Chief Coroner, Jury Recommendations into the Death of Elizabeth Kidnie (Inquest dates: March 4 – March 15, 2002), online: <http://www.mcscs.jus.gov.on.ca/english/pub_safety/office_coroner/verdicts_and_recs/2002%20Inquests/KIDNIE%20Recommendations.pdf>.

²⁰ It should be noted that ACE exempts the client's principal family residence in arriving at the total value of assets.

²¹ S.O. 1998, c. 26.

financial guidelines and permissible exemptions and scope for coverage that reflects the provisions of the *Legal Aid Services Act*.

An extra disincentive for older persons in seeking access to justice is the lack of monetary awards for successful cases. ACE generally does not recommend that older adults commence lawsuits if there are seeking primarily financial compensation because very few types of damages options are available. Older persons usually cannot claim damages for loss of income because they are no longer working, while the courts have narrowly interpreted damages for loss of companionship. In a British Columbia case where a 77-year old woman died due to the negligence of an aide in a nursing home, the court refused to award any damages to the woman's children because "their mother had long ceased to be a companion for she had been physically, mentally and emotionally incapacitated for a considerable time before her death."²² This judgment is alarming as it infers that a person can harm an older person with impunity and not held accountable by the civil justice system. Accordingly, the LCO should investigate ways in which to overcome this barrier. The LCO may wish to consider different mechanisms, which are not based in litigation, to compensate older persons (e.g., creating regulations which address injuries in long-term care facilities).

ii) Lack of Competent Legal Representation

At present, only a small proportion of the bar directly advises or represents the older adults themselves in the types of legal problems that have a specific impact on the older population, such as issues in retirement homes, public and private home care, long-term care, defence of guardianship applications, health consent, and elder abuse.

Even when lawyers do agree to assist a person with an elder law issue, ACE has received complaints where lawyers have breached their own *Rules of Professional Conduct*.²³ Some lawyers fail to consult with the older person who is their client; instead they obtain instructions from the older adult's friend or family member. In doing so, lawyers are putting themselves in a potential, if not actual, conflict of interest position.²⁴ Other lawyers who are not familiar with particular elder law issues have provided incompetent representation to the older person by not understanding the applicable law.²⁵

For the aforementioned reasons, there is a demonstrated need for specialized legal services, including the work of ACE, to stimulate discussion about these important issues. We appreciate this consultation by the LCO as it is acting as a stimulus to raise awareness about the particular legal issues faced by seniors and the way seniors are treated within the legal system.

²² *McDonnell Estate v. Royal Arch Masonic Homes Society*, [1998] 5 W.W.R. 268.

²³ Law Society of Upper Canada, *Rules of Professional Conduct* (Toronto: 2000).

²⁴ Rule 2.04(1) refers to the definition of a conflict of interest while Rules 2.04(2) and (3) refer to the avoidance of a conflict of interest.

²⁵ The commentary for Rule 2.01(1) says: "As a member of the legal profession, a lawyer is held out as knowledgeable, skilled, and capable in the practice of law. Accordingly, the client is entitled to assume that the lawyer has the ability and capacity to deal adequately with legal matters to be undertaken on the client's behalf."

iii) Lengthy Court Proceedings

Another reason why older adults do not have access to the justice system is the amount of time it takes to resolve a court case. Many older adults choose not to initiate legal proceedings, even if their case appears to be meritorious, because it may take many years and there is the possibility that they may die before a resolution is reached.

The LCO may wish to examine civil procedures and whether existing procedures may be changed to facilitate speedier resolution of matters. We recognize that this is an ongoing priority in a number of the courts but research by the LCO would complement that work.

iv) Guardianship Applications

The rights of incapable persons are well protected pursuant to Ontario laws and recourse can be made to the courts to become a person's guardian of the person or property. Guardianship applications are based on an adversarial model which requires legal representation. Due to the potential loss of liberty and autonomy in these proceedings, the court may direct that legal representation be appointed for a person whose capacity is at issue.²⁶

The LCO should consider whether it is necessary to amend the *Substitute Decisions Act* to make the requirement that legal representation be appointed mandatory.

v) Misuse of Powers of Attorney

One of the topics which ACE receives the most questions is powers of attorney, particularly the issue of abuse. While the framework of the *Substitute Decisions Act* provides mechanisms for individuals to challenge a "rogue" attorney who is not fulfilling their functions or who is taking advantage of the grantor, it is not very accessible as it is court-based. For example, an individual can apply to the court for a passing of accounts or seek guardianship of property and/or the person for an incapable person but the costs are prohibitive.

The LCO may wish to consider alternatives within the current legislative framework to make it easier for individuals to challenge the authority of an attorney who is not acting diligently and honestly for the grantor's benefit.

vi) Rights Advice

Rights advice is a process where an individual is informed of their rights by a rights adviser when their legal status has changed. The rights adviser cannot be a person involved in the direct clinical care of the person to whom the rights advice is given. There are currently eight mandatory rights advice situations, most of which only affect patients in psychiatric facilities.²⁷ The rights adviser has the responsibility to explain the

²⁶ *Substitute Decisions Act*, s. 3.

²⁷ Pursuant to the *Mental Health Act* and R.R.O. 1990, Reg. 741, the following eight situations require mandatory rights advice: a physician's decision that the patient's status in a psychiatric facility must change to

significance of the legal situation to the individual and, if requested to do so, assist that person to apply for a hearing to challenge the finding before the Consent and Capacity Board, obtain a lawyer, and apply for financial assistance from Legal Aid Ontario. Prescribed government forms must be completed to verify that rights advice was given. The lack of, or untimely, rights advice can invalidate a finding of capacity. For these reasons, rights advice is viewed as a legal protection for individuals.

Currently, the law does not provide for mandatory rights advice to individuals found incapable of consenting to treatment or property where they are not a patient in a psychiatric facility. Rights advice is also not mandatory if a person is found to be incapable of consenting to admission to a care facility.

For persons deemed to be treatment incapable outside a psychiatric facility, they are not afforded rights advice but rights information. Health care practitioners have an obligation to provide information to the incapable person in accordance with their profession's governing body.²⁸ Rights information does not require any specific paperwork to be completed. Unfortunately, many health care practitioners fail to satisfy the minimal requirement of providing rights information to individuals meaning they are unaware of their statutory rights and the procedures necessary to exercise these rights.

There are also problems with the policies respecting rights information of the various health Colleges. In 1995, the government proclaimed the *Consent to Treatment Act*,²⁹ the *Substitute Decisions Act* and the *Advocacy Act*³⁰ and the number of rights advice situations increased from 8 to 29. The situations were a combination of mandatory rights advice and rights advice at the request of the person impacted by the loss of decision-making authority.

The Ontario Advocacy Commission was created and one of its functions was to provide rights advice. However, when the *Consent to Treatment Act* and *Advocacy Act* were repealed in 1996, and the *Health Care Consent Act* was introduced, the rights advice requirements changed. Instead of rights advice being provided by rights advisers from the Advocacy Commission, it is our understanding that health practitioners would provide rights information and the Colleges would introduce rights information policies that would still ensure that patients found incapable in respect to treatment had access to the full information for purposes of due process. By requiring health practitioners to follow the policies of their Colleges, they could be subject to discipline proceedings if they failed to provide rights information. However, the policies of the Colleges did not necessarily ensure that the patient would have the information for the purpose of due process. As well, it is questioned whether the Colleges enforce this requirement for the

involuntary; a physician's decision that the patient's involuntary status must continue; a physician's decision that the patient is incapable to manage property; a physician's decision that the patient's incapacity to manage property must continue; a physician's decision that the patient is incapable to consent to treatment for a mental disorder; a determination that the patient is incapable of consenting to the collection, use or disclosure of personal health information; when a twelve to fifteen year old is admitted to a psychiatric facility as an informal patient, and every three months thereafter; before issuing or renewing a community treatment order, a physician must be satisfied that the person who will be subject to the order (and their substitute decision-maker, if any) has consulted with a rights adviser and have been advised of their legal rights.

²⁸ *Health Care Consent Act*, s. 17.

²⁹ S.O. 1992, c. 31, repealed by S.O. 1996, c. 2, s. 2.

³⁰ S.O. 1992, c. 26, repealed by S.O. 1996, c. 2, s. 1.

rights information and discipline practitioners who fail to comply.

One illustration of this problem is the policy on rights information of the College of Physicians and Surgeons. The College of Physicians and Surgeons of Ontario directs physicians to inform the incapable person that a substitute decision-maker is responsible for making treatment decisions.³¹ Where the patient disagrees with the need for a substitute decision-maker or disagrees with the involvement of the present substitute, the physician “must advise the patient of his or her options” which “include finding another substitute of the same or more senior rank, and/or applying to the Consent and Capacity Board for a review of the finding of incapacity.” A physician has a duty to “reasonably” assist the patient if he or she expresses a wish to exercise these options. The policy is narrow as it suggests that the physician does not have a duty to provide patients with information about their rights before the Board if they disagree with the finding of incapacity (as opposed to having a substitute decision-maker) or if they do not explicitly voice their disagreement. This policy does not ensure that the patient is informed of the process to challenge the finding of incapacity.

The *Health Care Consent Act* does not require evaluators, which are various types of health practitioners, to provide rights information to the individuals they find incapable of consenting to admission a care home. The practice of most evaluators is to give a rights information sheet to incapable individuals but the information may be unclear and misleading and the person may not be assisted by the evaluator to contact legal assistance or the Consent and Capacity Board to initiate the process to challenge the finding of incapacity.

We encourage the LCO to examine the statutory requirements for rights advice (or lack thereof) and how it impacts on older adults that are affected by the *Health Care Consent Act* and *Substitute Decisions Act*, particularly when their authority for decision-making is challenged.

B. Accessibility

i) Mobility Devices

Mobility devices can pose significant problems for individuals either seeking admission to long-term care facilities and or seeking to rent accommodation in retirement homes.

With respect to mobility aids in retirement homes, ACE has been informed by its clients about the following practices which are inconsistent with the duty to accommodate older persons:

- residents who need mobility devices (such as wheelchairs or scooters) are not welcome in the communal dining areas;
- if residents cannot enter the dining area on their own (or with a walker), they must eat their meals in their room or they must pay an extra fee for “tray service” for these meals to be delivered;

³¹ College of Physicians and Surgeons of Ontario, *Consent to Medical Treatment*, Policy Statement #4-05 (January/ February 2006).

- there are policies limiting access within the home as they say no motorized vehicles are permitted in the common areas of a retirement home; and
- these policies are applied even if the resident is able to demonstrate that he or she is able to safely operate a motorized vehicle.

In long-term care facilities, some residents are not permitted to use scooters or electronic wheelchairs for both legitimate and illegitimate concerns. An example of a legitimate reason for not allowing specific mobility devices is that the physical structure of some older homes are not large enough for specific devices. An example of an illegitimate reason is where “difficult” residents have their mobility devices confiscated if they fail to act, in the opinion of staff members, properly.

In light of these obstacles, the LCO should review ways in which the needs and rights of persons with mobility devices can be facilitated and protected by the law.

6. What are the key legal issues with respect to the relationships of older adults? Are there aspects of the relationships of older adults that have not been adequately addressed by current legal frameworks?

A. Elder Care and Older Adults as Caregivers

Before addressing some of the issues pertaining to elder care and older adults as caregivers, ACE would like to note that it is our opinion these topics are misplaced in the LCO’s consultation paper under the category of relationships. The problems associated with elder care and care giving has very little to do with the relationships between the older adult and other individuals. Instead, it has to do with the lack of legally defined program eligibility criteria for home care, hospital care and other scarce resources.

Elder care is largely provided in the community by family members. Not only does it facilitate “aging in place” but it saves public resources. Regrettably, the services in place to support family caregivers are extremely limited resulting in an “all or nothing” system where families feel they have no choice but to put their loved one into a long-term care facility. For example, in the case of an older couple where the husband requires a high level of care at home but the wife is becoming overwhelmed with her caregiving duties, they could apply for a short-stay respite whereby her husband could go to a long-term care home for a maximum of 90 days so she could have a well-deserved break. The obstacle to the couple is the daily co-payment fee of \$33.75. They are in receipt of social assistance so they can not afford this extra expense and, unlike other programs, there is no rate reduction.

As noted by the Ontario Human Rights Commission, “workplace structures and expectations have not adjusted to the changed situation of families” whereby “caregiving responsibilities tend to be viewed as individual ‘personal problems’ rather than as a systemic issue.”³² Persons with caregiving responsibilities, consequently, are incorrectly perceived to be less capable and less committed than their colleagues.

³² Ontario Human Rights Commission, *The Cost of Caring: Report on the Consultation on Discrimination on the Basis of Family Status* (Toronto: 2007) at 29.

Although some jurisdictions are considering the repeal of parental support provisions that require adult children to provide financial support to their parents under certain conditions, it should be pointed out that they represent a useful tool for some older adults, particularly immigrants, who are unable to obtain financial assistance from other resources.

The LCO is encouraged to examine the inadequacy of supports in place to assist caregivers and possible solutions to this problem, such as respite, increased financial assistance, and providing social assistance to family members who give up employment opportunities to stay at home with older persons.

B. Elder Abuse

As discussed earlier in this paper, Canada has three broad models of legislation respecting the mistreatment of older adults. The Ontario model is reinforced by recourse to several provisions in the *Criminal Code of Canada* in cases of possible abuse of older adults, including, but not limited to: theft; theft by person holding power of attorney; criminal breach of trust; extortion; forgery; fraud; failure to provide the necessities of life; criminal negligence causing bodily harm; assault; sexual assault; forcible confinement; criminal harassment; uttering threats; intimidation; and harassing phone calls.

Critics of the Ontario model who believe there is a need to protect older people contend that the current system inadequately addresses elder abuse and support the introduction of mandatory reporting of abuse. ACE disagrees because the *Substitute Decisions Act* effectively balances both the autonomy and safety of older adults. Arguments against mandatory reporting include:

- Older persons are not children. Mandatory reporting is appropriate for children as they are vulnerable because of their age, may not be able to make their own decisions about safety and well-being, many not be able to remove themselves from an abusive environment and are usually dependent on the abuser;
- Violation of autonomy as a mentally capable person's right to make decisions about their own lives is taken away;
- Unequal treatment of older persons since there is no mandatory reporting for younger adults who are capable;
- Client confidentiality is breached, which may discourage individuals from voluntarily seeking assistance;
- Encouraging isolation of older persons as they may choose to have no social contacts in order to avoid being the subject of mandatory reporting;
- Reporting does not necessarily lead to solutions; and
- The cost of mandatory reporting systems. They often deflect resources away from efforts to prevent abuse at both the individual and societal level.³³

³³ Many of these arguments were taken from *Abuse Education, Prevention and Response: A Community Training Manual for those who want to address the Issue of the Abuse of Older Adults in their Community* by Joanne Preston and Judith Wahl, 3rd ed., (December 2002) Advocacy Centre for the Elderly at 27-29, online, <<http://www.advocacycentreelderly.org/elder/pubs.htm>> and the work of the Canadian Network for the Prevention of Elder Abuse, Mandatory Reporting, online: <http://www.cnpea.ca/mandatory_reporting.htm>.

As stated in Question 3 of this submission, it is expected that various sectors will advocate for mandatory reporting legislation of abuse and changes to privacy legislation to legitimize the actions of service providers in acting in what they perceive to be in the best interests of the senior. It is recommended that the LCO undertake research on elder abuse and appropriate legislative models of response.

7. What are the key legal issues related to the living environments of older adults?

A. The Community

The majority of older persons want to remain in their own home and the concept of aging in place is paramount to fulfilling this wish. In order for “aging in place” to be realized, affordable and accessible housing options and in-home supports must be available. Insufficient funding of community-based care has been identified as an obstacle for older persons seeking access to the health care system.

The *Long-Term Care Act, 1994*³⁴ sets out much of the legal framework for the delivery of in-home services in Ontario. Section 11 says multi-service agencies are given the responsibility to provide and ensure the provision of community support services, homemaking services, personal support services and professional services.³⁵ Overall, the statute is good law as it confers benefits on those who need assistance at home. Unfortunately, it is extremely difficult for individuals to access the services. The statute says that the criteria for community based long-term care services will be set out in the regulations³⁶ but the only regulations that have been made limit eligibility by stating that services are not available under certain circumstances or beyond certain maximums. Moreover, specific eligibility requirements are not known to the public. This is the opposite of a demand driven system and is the root of the problem.

A further restriction of this statute pertains to the funding envelopes provided to Community Care Access Centres. Each Community Care Access Centre is provided with a fixed amount of money each year. Due to shortfalls in the annual funding envelopes or budgeting decisions, Community Care Access Centres may not be able to provide services. Therefore, contrary to the law, mandatory services are not provided. While there is a right of appeal regarding eligibility decisions, the Community Care Access Centres control the initial stages of the review process and ACE is aware that individuals are frequently not advised of their rights and how to exercise them.

We encourage the LCO to review the requirements for services to be provided by the Community Care Access Centres as mandated by the *Long-Term Care Act*, the lack of regulations in respect to the criteria for access and eligibility to the various services, the

³⁴ S.O. 1994, c. 26.

³⁵ Community Care Access Centres are responsible for determining who is eligible for publicly funded in-home services and for arranging the delivery of these services. However, the definition of Community Care Access Centres in section 1 of O. Reg. 33/02 only requires them to provide services in homemaking, personal support and professional services – not community support services.

³⁶ *Long-Term Care Act*, ss. 17 and 18.

funding agreements between the Local Health Integration Networks and Community Care Access Centres, whether these support the obligations of the Community Care Access Centre to provide the mandatory services as listed in the *Long-Term Care Act* and to find out whether individuals are obtaining the full benefit of the law.

B. Long-Term Care Homes

i) First Available Bed Policies

An increasingly large number of older persons or their families contact ACE with respect to first available bed policies. Due to the prevalence of this issue, as well as its legal complexities, we feel it is important to thoroughly canvass the issue for the LCO. For a more detailed analysis, please find attached at Tab 2 a paper entitled “Discharge to a Long-Term Care Home from Hospital.”

In Ontario, because of years of cut-backs and bed closings, many hospitals complain of beds being taken up by those awaiting placement in long-term care homes.³⁷ These patients are often referred to as “bed-blockers,” a pejorative description of seniors who, through no fault of their own, are awaiting placement in long-term care while occupying an acute care hospital bed. These patients are perceived as taking away beds from more deserving patients who have arrived at the hospital’s emergency room or need surgery but for whom there are no available beds. While the needs of those patients are not to be denigrated, the assumption that the solution to this problem should be placed on the seniors is misplaced. While everyone recognizes the needs of those who are awaiting the beds, few understand why those occupying them still need them: it is assumed that they should accede to others and move to wherever the system has determined is necessary. This is not only an incorrect assumption, but an unlawful one.

The process for placement is that a person or their substitute decision-maker applies for long-term care through the local Community Care Access Centre. Employees of the Community Care Access Centre are legally responsible for the placement process for those in hospital.

The Community Care Access Centre staff in some instances do the discharge planning directly at the hospital but in most instances the hospital also has a social worker or discharge planner who is the person’s primary contact regarding placement. However, one must understand that they are hospital employees and are therefore required to enforce hospital policy, whether or not it is lawful, and are not neutral when it comes to the placement issue.

Generally, a decision will be made by the patient’s care team that the person requires long-term care. Once a patient is “designated” by the physician as requiring long-term care (often referred to as “alternate level of care” or “ALC”), the hospital will attempt to have the person moved as quickly as possible. At some point, the patient or their

³⁷ Placement in a long-term care home in Ontario is regulated by the three pieces of legislation, the *Homes for the Aged and Rest Homes Act*, R.S.O. 1990, c. H.13, the *Nursing Homes Act*, R.S.O. 1990, c. N.7 and the *Charitable Institutions Act*, R.S.O. 1990, c. C.9 and specifically by their regulations. All three pieces of legislation are identical with respect to placement and therefore for the purpose of this paper, we will reference only the *Nursing Homes Act*.

substitute decision-maker will be advised of the hospital policy regarding the acceptance of the “first available bed” although such a policy is not legal. Many hospitals give a copy of their policy to the patient or their substitute decision-maker, advising them that they must accept the first bed available in the designated area, or they must choose beds from a “short list” of beds which are in homes that have short or no waiting lists. (In some cases, this is given to the patient upon admission to the hospital.) In other cases, when a bed becomes available, they will be told that they have to take it. Some hospitals will require the patient or their substitute decision-maker to sign a “contract” indicating that they “agree” with this policy. In no case should patients or their substitute decision-makers ever sign such a contract or agreement.

The hospital policy may include “choices.” These may include: accept the first available bed; return home to wait for their facility choice; go to a retirement home to await their facility choice; or pay the uninsured “daily rate” for the hospital bed. ACE is of the view that none of these choices is legal.

The application process requires the person or their substitute decision-maker to apply for up to three homes.³⁸ As set out in the *Health Care Consent Act*, valid consent is required prior to placing the person on a waiting list. As there is no specific section regarding consent to admission to a care facility, one must look to the section pertaining to “treatment” and modify it for placement.³⁹

Hospital policies often indicate that it is the physician or treatment team which will determine whether these beds are appropriate for the person. But, it is clear from the *Health Care Consent Act* that the decision belongs to the person or their substitute decision-maker, if the person is incapable, to choose the home that they believe is appropriate. Where there is a substitute decision-maker, this is further supported by their duties as set out in section 42 the *Health Care Consent Act*.⁴⁰ Nowhere in the *Nursing Homes Act*, its regulations, nor the *Health Care Consent Act*, is there any discussion of there being a requirement that the choice is to include anything other than the **person’s** own choice, or what is in their **best interest**. Therefore, based upon the legislation, the person is free to choose whatever long-term care homes they like. Placement into homes which are not of their choosing can be detrimental to their health. Often these homes are far from families and other support systems – the deleterious effects on both the person and their families can be quite great, even leading to the death of the person transferred. It has to be recognized that the home in which they are being admitted is their home and that there is a likelihood that they will die there. Separating the person from their family and other social supports is unacceptable. As well, it can be argued that the reason that some of these homes have available beds is because the homes are themselves unsatisfactory in some way. People should not be required to accept below-standard care, because there are no beds in appropriate homes.

³⁸ R.R.O. 1990, Reg. 832, s. 140.

³⁹ Section 11 outlines the elements required for consent to treatment, what constitutes informed consent, and that consent may be express or implied.

⁴⁰ Substitute decision-makers must obey the incapable person’s most recently expressed prior capable wish respecting admission to a care facility. If the substitute decision-maker does not know of a wish applicable to the circumstances that the incapable person expressed while capable and after attaining 16 years of age, or if it is impossible to comply with the wish, the person shall act in the incapable person’s best interests.

The question then becomes whether the hospital is required to keep the person while they wait for their choice. Many homes have multi-year waiting lists. Does the hospital have to keep the person until their choice arises?

The *Public Hospitals Act* contains a regulation making provision, stating that the Minister may make regulations regarding the “the admission, treatment, care, conduct, control and discharge of patients or any class of patients.”⁴¹ The regulations regarding discharge are as follows:

16(1) If a patient is no longer in need of treatment in the hospital, one of the following persons shall make an order that the patient be discharged and communicate the order to the patient:

1. The attending physician or midwife or, if the attending dentist is an oral and maxillofacial surgeon, the attending dentist.
2. A member of the medical, dental or midwifery staff designated by a person referred to in paragraph 1.

(2) Where an order has been made with respect to the discharge of a patient, the hospital shall discharge the patient and the patient shall leave the hospital on the date set out in the discharge order.

(3) Despite subsection (2), the administrator may grant permission for a patient to remain in the hospital for a period of up to twenty-four hours after the date set out in the discharge order.⁴²

Based upon this section, it would appear that as soon as a patient no longer requires treatment, they must be discharged from hospital, the only exception being a 24 hour grace period. The hospital can either choose to enforce this section, meaning **everyone** who requires long-term care will be discharged, whether a bed is available or not, or not to enforce it with respect to those awaiting long-term care. Hospitals are presently picking and choosing when to rely on this regulation, contrary to the rules of natural justice.

However, the hospital owes a duty to the person, meaning that they cannot be forcibly discharged to the community when they are unable to live there safely. This is the same argument that one can make regarding discharge to a retirement home: people cannot be forced to “wait” placement from there when they are entitled to care. Retirement homes are not part of the health system and are not regulated in the same way as long-term care homes so one cannot be forced into one as an alternative to waiting for a bed while in hospital. Retirement homes are not regulated in the same ways as long-term care, the health care provided therein is not part of the health care system, and therefore is private pay, and safety cannot be assured.

Those in the hospital who, in the opinion of the physician, are more or less permanent residents of a hospital or other institution, can be charged the “chronic care co-payment” pursuant to the *Health Insurance Act*.⁴³ This allowed the physician to designate a patient as being “alternative level of care” (ALC), allowing them to stay in

⁴¹ R.S.O. 1990, c. P.40, s. 32(1).

⁴² R.R.O. 1990, Reg. 965, s. 16.

⁴³ R.R.O. 1990, Reg. 552, s. 10.

hospital to await admission to a chronic care hospital or long-term care home, while charging them the same rate as they would pay in one of those institutions.⁴⁴

Not only does the chronic care co-payment and the designation of ALC indicate that those needing long-term care can stay in hospital pending placement, it also disallows the hospital from charging the person more than that rate. Therefore, the argument that the “daily rate” can be charged is contrary to the *Health Insurance Act*. Having said that, this does not mean that the person can simply wait in hospital for a specific long-term care home where it is clearly unreasonable to do so. For instance, it would be unreasonable to insist on going to a home with a three-year waiting list, unless it can be proven that that home is the only one which can meet the person’s needs. In addition, staying in hospital may not, in fact, be in the best interest of the person, given the rise of communicable diseases and antibiotic resistant illnesses. One must weigh all of these issues when making a placement decision.

As there is no case law on this important issue and the practices of hospitals and Community Care Access Centres vary across the province. We encourage the LCO to pursue research in the area of hospital policies and the rights of patients in respect of discharges.

ii) Admission Contracts

Upon admission into a long-term care home, the resident, their substitute decision-maker or family member is provided with a contract to sign. They are usually advised that this is a mandatory document and often the contract itself will state that there can be no admission to the long-term care home without the document being signed. This is not true. Long-term care is part of the health care system and admission cannot be barred on this basis.

Legislation governing long-term care homes deems there to be a contract between the home and the resident containing the Resident's Bill of Rights, but is otherwise silent as to an agreement. However, the *Long-Term Care Facility Program Manual*, published by the Ministry of Health and Long-Term Care, requires that long-term care homes have a “facility specific written admission agreement in place to delineate the accommodation, care, services, programs, and goods that will be provided to the resident and, the obligations of the resident with respect to their responsibilities and payment for service.” Nevertheless, there is no requirement for the resident or anyone on their behalf to actually sign the document and the Ministry has consistently supported us in this matter.

The reason that one would not sign the document is that it is not in the best interest of the person. Often, the agreement requires someone to sign as a “responsible party” so that if there are any payment issues, they can have someone to sue. These documents may also attempt to extract a blanket consent for treatment, have the person agree that their public pensions can be garnisheed (which is contrary to the legislation), and agree that they are not liable for harm or loss in most situations.

⁴⁴ Ministry of Health and Long-Term Care, *Complex Continuing Care Copayment Fact Sheet* (Toronto: 2008) online: <http://www.health.gov.on.ca/english/public/pub/chronic/pdf/chronic_20080618.pdf>.

The only documents that a resident or their substitute decision-maker must sign are with respect to optional payments or rate reductions. These are:

1. A written agreement to pay a bed-holding fee to hold a bed for up to five days prior to the person actually being admitted to the home;
2. A bed-holding fee to extend medical or psychiatric absences in hospital;
3. Semi-private or private accommodation rate agreements;
4. Unfunded service agreements (e.g., telephone, cable);
5. A rate reduction; and
6. Exceptional circumstances reductions.

If the resident does not want any of the above, they do not have to sign any agreements. This does not mean, however, that the person does not have to pay the basic accommodation rate: there is a deemed contract in the legislation.

Homes often include care agreements in the admission contract, and specifically “levels of care” documents which purport to be a type of advance directive, but in reality do not comply with the law in this area. (For a further discussion about levels of care documents, please see Question 8.)

We believe that the law regarding long-term care home admission contracts is one that should be examined by the LCO. The vulnerability of the client and their family at the time of admission means that many people sign documents they do not understand, that they would not otherwise sign except for the fact that they are told they are “required” to do so. A clear direction would be of assistance, especially as we go into the new era of the *Long-Term Care Homes Act, 2007*.⁴⁵

iii) Detention

At the present time, the legality of secure units is questionable. There is no authority for homes to restrain or detain residents, except under very narrow circumstances.⁴⁶ Nevertheless, secure units exist and many people are detained.

Under the common law, persons can only be restrained in an emergency where immediate action is required to prevent serious bodily harm to the person or to others, and only for so long as the emergency continues. The common law duty does not apply in situations where it might be “reasonably foreseeable” that a person might harm themselves or others. However, many residents are presently detained or restrained illegally, or by inappropriate means, due to the lack of appropriate legislative framework.

ACE has had numerous clients who have been prevented from leaving a long-term care home. This can occur when they are locked on a secure unit or prevented from leaving the building by the use of environmental restraints. There are two general categories of detained persons.

⁴⁵ S.O. 2007, c. 8 (not yet proclaimed).

⁴⁶ The only persons who may have authority to consent to a person being detained or restrained are guardians of the person, or attorneys for personal care where the power of attorney contains a special “Ulysses” clause.

The first category are those who are mentally incapable of making decisions and are detained to prevent them from coming to harm, such as wandering into traffic, getting lost or being assaulted by others. At present, there is a conflict because of the duty of care the home owe to these residents who cannot make decisions versus the absence of a law which allows them to be detained. In most cases the reason for detention is legitimate, unless a complaint is brought to us by the resident or their substitute decision-maker, these are not pursued.

The second category is all other persons. These residents may be capable or incapable, but it is the reason for the detention that is problematic. ACE has heard a variety of purported rationales for this type of detention, including:

- the home has a “policy” preventing **all** residents from leaving without an escort;
- a family member or attorney for personal care directs the home not to allow the person to leave despite the fact that the health practitioners in the home believe the person to be capable and, even if the person were mentally incapable, the family member or attorney has no legal authority to do so; and
- the home prevents the person from leaving because they might, for example, fall, get hurt or drink alcohol, even though the person is mentally capable of making such decisions.

While some matters can be resolved by legal counsel pointing out to the home that its actions are illegal, at other times it can be quite difficult where the home believes it is in the person’s “best interest” for them to be prevented from leaving. As there is no process other than an application to court, it can be a very difficult issue to resolve, particularly given that the resident usually has no other option but to stay in that home. It is often hard for the resident to move to another long-term care home or alternative accommodation, due to limited availability of long-term care home beds in most communities, as well as limited home care resources.

The *Long-Term Care Homes Act* creates new rights for residents facing transfer or admission to a secure unit in a long-term care home. Residents found incapable of consenting to their admission or transfer where substitute consent has been obtained can apply to the Consent and Capacity Board to determine whether a substitute decision-maker complied with the principles of giving or refusing consent under the *Health Care Consent Act*. This new protection, however, does not guarantee that homes will stop detaining residents who are not on a secure unit. Details regarding restraint will be found in the as yet undrafted regulations. While there is a definition of secure unit in the new statute, it is quite general and it is unknown how it will be interpreted in practice and by the courts.

ACE urges the LCO to consider how the current laws are used to restrain residents of long-term care homes and the legal mechanisms available to residents to challenge the imposition of restraint.

iv) Restraint

At present, there is very little regulation of restraint in long-term care. The Residents Rights, contained in all three pieces of legislation governing long-term care homes, guarantees the person who is being considered for restraints the right to be fully informed about the procedures and the consequences of receiving or refusing them.⁴⁷ While this sounds appropriate, it is rarely followed. Further, there is no “appeal” process, so that even if a resident or their substitute decision-maker does not consent, they may be used anyway.

The regulations for the actual use of the restraints are different for all three types of facilities and are rarely complied with. For example, under the regulations to the *Charitable Institutions Act*, no restraint can be used that has not been approved by the Ministry of Health and Long-Term Care. To date, even though this regulation has been in place for many years, no restraint has ever been approved for use by the Ministry.

The new *Long-Term Care Homes Act* sets out guidelines with the goal of minimizing restraint and a procedure to obtain consent to use restraint from the resident or the substitute decision-maker where the resident is incapable of providing consent. It does not, however, identify who makes the finding of incapacity, what it is the person is incapable of, and if there is an appeal process to that finding.

The LCO should examine the legislative gaps in the new legislation and determine whether amendments are needed. Examples of possible changes include: permitting persons found mentally incapable of consenting to restraints to challenge that finding to the Consent and Capacity Board; and allowing the Consent and Capacity Board to issue special orders to restrict the use of restraint if it is no longer necessary either during the Board hearing or during any further appeals of the Board’s decision.

v) Access to Medical Care

In most cases, the compliance program of the Ministry of Health and Long-Term Care will not review the actions of physicians providing care in long-term care homes. Patients must use the complaint process at the College of Physicians and Surgeons, which is complex, slow-moving, and unresponsive to the needs of those residing in long-term care. For example, while 24-hour coverage by physicians in long-term care is promised, our experience is that the reality is that often much less coverage is provided. In some homes, physicians attend once a week and see only as many residents as they can within a set time period, leaving patients requiring treatment unseen until the following week. Nurses are reluctant to contact physicians outside of their set hours, even in emergencies, as these contacts are not welcome by the physicians. The result is that many residents’ health decline because they are not being seen by the physicians to whom their care has been entrusted.

We encourage the LCO to examine the compliance program at the Ministry of Health and Long-Term Care and its jurisdiction to determine if legislative reform is necessary to address this issue.

⁴⁷ *Nursing Homes Act*, s. 2(2)8.

vi) Substandard Homes

The Ministry of Health and Long-Term Care conducts regular annual reviews of all long-term care homes, in addition to ongoing inspections and investigations of individual complaints. These inspections are carried out by compliance advisors. Although the legislation is silent about the qualifications of these advisors, the Ministry has decided to appoint registered nurses to this position, as opposed to trained investigators.⁴⁸

ACE regularly receives complaints from clients about the failure of the Ministry to investigate allegations of unmet standards and substantiate claims, or if an investigation is conducted, their inability to conduct a proper investigation, the inconsistent quality of work of compliance advisors, and the inability to make a determination of the complaint. (It should also be understood that most complainants do not receive detailed results of the investigation, usually simply whether the complaint was verified, not verified or unable to verify and perhaps a little information about what may have been done to correct the issue. To obtain a copy of the detailed report, one must make a request under privacy legislation.)

The Ministry makes it mandatory for long-term care homes to post their inspection reports in a public place. The Ministry posts information about those reports on its website and encourages those considering admission to a long-term care home to check the reports. Many people are not made aware of the existence of the website, nor are they advised that the information is only a snapshot at the point in time when the investigation was conducted. While potential residents and their families are entitled to receive a copy of the inspection report from the home upon request, they often met with resistance in exercising this right. The Ministry also strongly urges potential residents and their families to visit homes prior to choosing them.

However, according to information from the Ministry itself, there is “considerable evidence that the current compliance system is not meeting public expectations for ensuring safety and well-being of our seniors.”⁴⁹ Potential residents and families often find homes with lengthy lists of unmet standards and criteria, citations under the legislation, and verified complaints. A recent study by the Canadian Press analyzed inspection reports from April 2007 to March 2008 and found that almost three-quarters of homes are not meeting provincial standards.⁵⁰ At one home, it was reported that there 16 residents who had restraints applied incorrectly.

It is suggested that the LCO review the factors that contribute to substandard homes. For instance, the LCO could examine the appropriate skill-sets necessary to be a compliance advisor, the benefits of continued and ongoing training and whether the

⁴⁸ Both the *Nursing Homes Act* (s. 23) and the *Long-Term Care Homes Act* (s. 141) merely say that the Minister “may appoint inspectors.”

⁴⁹ Ministry of Health and Long-Term Care, Prepared by Monique Smith, *Commitment to Care: A Plan for Long-Term Care in Ontario* (Spring 2004) at 21.

⁵⁰ China Puxley, “Majority of Ontario nursing homes fail some basic standards” *Globe and Mail* (2 July 2008), online: <http://www.theglobeandmail.com/servlet/story/RTGAM.20080702.wnursinghomes0702/BNStory/National/home> >.

powers of compliance advisors should be expanded to ensure they are able to be effective.

vii) Difficult to Place Applicants

An issue which desperately needs a solution is the “difficult to place applicant” for long-term care. These people usually end up in hospital as there is nowhere else for them to go. They often require high complex care, due to behavioural issues stemming from dementia, psychiatric illness, or other neurological issues. Psychiatric facilities will not accept them, as they repeatedly state that they only provide short-term assessment and not long-term housing. While these individuals are technically “eligible” for long-term care homes, few homes will take them. Those homes that will accept them are often the least able to care for them, but who will admit them to fill their bed quotas. These people fall between the cracks and often stay in hospital as there are no alternatives. At the El Roubi/Lopez (Casa Verde) inquest in 2006, several recommendations were made about the need for specialized homes and units for this population.⁵¹

The LCO should conduct research into the number of difficult to place applicants in the province, the availability of resources for this group, the feasibility of implementing the recommendations from the El Roubi/Lopez inquest and the potential liabilities for institutions and the government, if any, for failing to assist this vulnerable group.

viii) Reporting Deaths to the Coroner

The *Coroners Act*⁵² contains mandatory reporting provisions in section 10(1) for every person who has reason to believe that a deceased person died in the following circumstances: as a result of violence, negligence, misconduct or malpractice; by unfair means; suddenly and unexpectedly; from disease or sickness which he or she was not treated by a medical practitioner; from any cause other than disease; or under such circumstances as may require investigation. In the context of long-term care homes, section 10(2.1) states that where a resident of a home dies, the person in charge of the home shall immediately give notice of the death to a coroner and, if as a result of the investigation he or she is of the opinion that an inquest ought to be held, the coroner shall hold an inquest.

In 1995, the Office of the Chief Coroner of Ontario issued a memorandum to long-term care homes across the province. It directed homes to maintain a patient/client registry documenting all deaths.⁵³ Homes were directed merely to file a completed death record with the Coroner’s Office within 48 hours, as opposed to immediately contacting a coroner, if the death did not immediately fall into one of the following three categories: (1) the requirements as set out in section 10(1) of the *Coroners Act* or if the family of the deceased or the staff expresses concerns about the care provided at the home; (2) a

⁵¹ Recommendations 22 through 25 deals with specialized facilities and units, Office of the Chief Coroner, Recommendations from the Inquest into the Deaths of Ezzeldine El Roubi and Pedro Lopez (Inquest Dates: January 31 – April 18, 2005), online: <http://www.mcscs.jus.gov.on.ca/english/pub_safety/office_coroner/verdicts_and_recs/2005%20Inquests/CASA%20VERDE%20ElRoubi-Lopez%20Recs.pdf>.

⁵² R.S.O. 1990, c. C.37.

⁵³ Office of the Chief Coroner, Memorandum #629 (January 31, 1995).

potential cluster death incident; or (3) a threshold case (control cases designed to ensure a random review of deaths occurring in each institution). Although ACE is not aware of any formal document or announcement stating the specific number required for a threshold case, the commonly accepted number appeared to be ten. The practice developed where many homes interpreted this policy to mean that they only need to contact the coroner after every tenth death, regardless if whether a death satisfied other statutory criteria. A consequence of this policy was the destruction of evidence – if the coroner needed to investigate one of the previous nine deaths, the majority of the evidence would have been destroyed.

The Office of the Chief Coroner recently issued a new memorandum emphasizing that the legislation requires every death in a home to be reported to the coroner and each death requires the completion and submission of an Institutional Death Record.⁵⁴ However, it does not appear that this is being followed. A recent death was reported in the media where a resident was dropped from a lift, sent to hospital where he died, and the death was not reported to the Coroner's office.⁵⁵

Based on the foregoing information, the LCO should review the policies of the Office of the Chief Coroner to verify their compliance with the law and to determine whether education programs and enforcement mechanisms are in place to ensure that deaths are being lawfully reported by long-term care facilities.

The *Coroners Act* is silent about deaths occurring in retirement homes. Despite the fact that many retirement homes have locked units and are being used as long-term care facilities, deaths of residents do not need to be reported to the coroner. The LCO should explore the requirements of other jurisdictions and whether Ontario's legislation needs to be amended with respect to deaths in retirement homes.

ix) Sexuality

Sexual expression is a normal part of a healthy life. People that live in long-term care homes should be able to engage in and participate in "normal" living which includes the right to sexual expression.

Mentally capable residents in long-term care who so consent have the right to engage in sexual expression, including intimate sexual relationships. The law does not allow people to "preconsent" to sexual activity. A person must give consent at the time of the activity. Therefore, it is not possible to express in a power of attorney for personal care that if a person should become mentally incapable to give consent to sexual intimacy, he or she would still want to engage in such activities. Likewise, a "substitute decision-maker," such as an attorney named in a power of attorney for personal care or a family member who is the health decision-maker for an incapable person by reason of the *Health Care Consent Act*, cannot "consent" on behalf of the resident to sexual activity by that resident.

⁵⁴ Office of the Chief Coroner, Memorandum #07-02 (February 16, 2007).

⁵⁵ Moira Walsh, "Coroner probes 2nd nursing home death" *The Toronto Star* (8, May 2008), online: <<http://www.thestar.com/News/GTA/article/422813>>.

It is clear that home operators have a duty of care to its residents, which includes keeping residents safe from sexual exploitation, sexual assault and sexual abuse. As the new *Long-Term Care Homes Act* specifically defines “abuse” as including sexual abuse and places obligations on operators to develop written policies on abuse prevention, sexuality will surely be a contentious topic in the coming years.⁵⁶

The challenge is how to support normal sexuality in this type of group living environment, yet ensure protection for residents from unwanted activities, since a large proportion of the residents have a degree of dementia and may or may not be able to provide consent. There are many unanswered questions which the LCO should try to address, including:

- As consent is required, what is mental capacity to consent to sexual activity? Who determines this capacity? How is capacity determined? When does someone have the obligation to determine capacity for this purpose? Is there an obligation to determine capacity for sexuality in the long-term care home and why?
- As a large number of people living in long-term care homes have dementia, can they consent to intimate sexual activity? Just because a person has dementia does not mean that person is “mentally incapable” for all purposes or at all times. How does this impact on intimacy and, from a legal perspective, on consent?
- What are the obligations of staff in long-term care homes to foster or discourage the sexuality of residents? When and how should staff intervene to support a relationship by providing privacy for two residents? How can staff divert incapable residents into safe expressions of sexuality or stop residents from particular sexual activities if they lack capacity to consent?
- What is the legal framework related to sexuality that will ensure that those persons that can consent to engage in intimate sexual relationships are provided the privacy and appropriate support while those persons that cannot consent are protected from sexual exploitation and abuse?

B. Retirement Homes

Retirement homes are not part of our health care system. Retirement homes are tenancies, regulated as “care homes” under the *Residential Tenancies Act*.⁵⁷ While retirement homes may make available some care services pursuant to a contract with the tenant, the care services provided are neither funded nor regulated by the Ministry of Health and Long-Term Care, or any other government Ministry. Although “nursing” care may be offered by the retirement home, it is up to the individual retirement home operator to decide whether this care will be provided by or under the supervision of a regulated health professional: it is perfectly legal to provide what is advertised as “nursing” care by unregulated, unsupervised workers.

⁵⁶ Section 2(1).

⁵⁷ S.O. 2006, c. 17.

The quality of care in retirement homes cannot be guaranteed. There is little or no oversight of these care services because there are no regulated standards. There are no inspections from an appropriate third party, like the Ministry of Health and Long-Term Care.

In 2007, the Ontario Seniors Secretariat released a Consultation Document proposing a “third-party regulatory model” for retirement homes. Under this model, the government would create an agency that would come up with standards and monitor its member organizations to ensure they are complying with these standards. The government itself would not be responsible for creating any minimum standards, conducting inspections, or penalizing for non-compliance. This is the type of regulatory body the government has set up for participants in industries like travel agencies, real estate agencies, and motor vehicle dealerships.

ACE believes that the third-party regulatory model is not an acceptable model to apply to an ongoing relationship of providing accommodation and care to members of a vulnerable consumer group. Instead, ACE has proposed a government-operated licensing system with grades (or classes) of license that a home would have to earn if it wished to provide certain classes of service. Consumers would then be aware of what services they can expect in any particular home, and could be assured that such services meet agreed-upon standards for safety, care, and quality of service.

As a general outline, for example, the basic class of license could be granted to homes demonstrating that they can meet agreed-upon standards concerning meals and nutrition, linen service, and programming for tenants. An intermediate class of license could be granted to homes that can demonstrate competence in all of the basic features, and also be able to meet agreed-upon standards concerning things like administering medications, assisting with activities of daily living, providing some nursing care, and helping residents transfer from bed to chair. A holder of the highest level of license would have to prove competence in all the items mentioned above, and would also be able to demonstrate it can meet agreed-upon standards on caring for frail persons including those with mid- to late-stage dementia.

With this type of graded licensing system, consumers would know in advance what levels of care or assistance they are entitled to expect, and what standards they can expect their licensee to meet. In tandem with a meaningful system of complaint resolution, which would have to be developed, this type of regulatory model would provide an important level of consumer protection. Please find a copy of ACE’s submission to the Ontario Seniors Secretariat at Tab 3.

There may be more effective ways of regulating the retirement sector than that proposed by ACE. We encourage the LCO to do research on this sector of “accommodation with care” to make recommendations on appropriate models of regulation.

8. Are there themes or issues other than those identified in this paper that the LCO should examine as part of this project?

A. Advance Care Planning

Advance care planning is a generic term that applies to the process of preparing for a time when a person is not mentally capable to make personal care decisions, and in particular health decisions. Although advance care planning can be done in Ontario, and is legally recognized, the term "advance care planning" does not appear in either the *Health Care Consent Act* or the *Substitute Decisions Act*; the legislation only uses the word "wishes."⁵⁸ The word "wishes" was deliberately used in the legislation rather than "decisions" as a patient is only "wishing" when advance care planning and is not giving or refusing consent. He or she does not always have all the information required to give an informed "consent" when he or she is wishing. These wishes are interpreted by the person's substitute decision-maker when the substitute is called upon to give or refuse consent to treatment or to make other health care decisions for the now incapable person.

This model of decision-making, we submit, provides an appropriate balance by ensuring an opportunity for patients to express wishes about future care but also enabling substitute decision-makers to interpret and apply the wishes when the substitute must give or refuse consent once the substitute has all the information about the patient's present health condition. This gives authority for decision-making to either a person that the patient has chosen to act for him or her or to a person that is likely to act for him or her when incapable, such as a family member, who knows the patient and can interpret the wishes in the way the patient intended. This model of health consent and advance care planning contrasts with the model in some other jurisdictions where the patient's advance care plan is a direction directly to the treating health practitioners who do not need to obtain consent from a substitute decision-maker when an advance directive exists. The difficulty with this model is that it gives authority to health practitioners to determine the applicability of the wishes to the treatment proposed and to interpret the patients' intent in the wish. This often means that health practitioners that have only a passing contact with the patient are given authority to give or refuse consent for the treatments that they are themselves proposing for patients with only the written directive as their guide. We submit that this is one of the reasons why the Ontario legislation was based on the substitute decision-maker model, not the advance directive model, to ensure that patients had the right to choose their own substitute decision-maker and have someone that is not their health practitioners having responsibility for consent or refusal of consent and responsibility to apply their wishes in context.

What we have observed is that many health providers mistakenly believe that the advance directions "speak" to them directly and that they need not get directions from the patient or the patient's substitute decision-maker if the patient had previously executed an advance directive or living will. Even if such a document exists, the health provider must still get a consent or refusal of consent from the patient, if capable, or from their substitute if the patient is not capable. The directive is intended as a guide or communication to the substitute, to assist him or her in making treatment decisions for

⁵⁸ *Health Care Consent Act*, s. 5(1).

the incapable person. The health provider is required to call upon the substitute to “interpret” the directive, if any such written directive exists, as it is the substitute that must give or refuse consent to treatment if the patient is incapable.

Some long-term care facilities and hospitals treat advance care planning as a “mandatory” part of the admission process when in fact it is a voluntary process. Frequently substitute decision-makers are asked by facility staff to sign facility advance directives forms as a condition of admission of their relative, who is not mentally capable. This is a bad practice because substitute decisions makers cannot advance care plan for the incapable person for whom they make substitute health decisions. Substitutes may only give or refuse consent to treatment for the incapable person after they receive the necessary information relevant to making such a decision. No facility may require a person or their substitute to sign an advance directive as a condition of admission nor can a facility have a blanket “do not resuscitate” (DNR) policy that requires each resident to sign a DNR form prior to admission.⁵⁹

The LCO is encouraged to research the differences between the various advance care planning regimes to understand if Ontario’s “substitute decisions” scheme is preferable to a traditional “advance care directives” system, in addition to learning how to address the misconceptions of health care providers to ensure compliance with Ontario law if that continues to be the recommended model.

B. Levels of Care Forms

A “Levels of Care” form is a very general type of advance care directive. Some facilities require that patients/residents or their substitutes execute levels of care forms that describe what degree of intervention that the person would want if health problems arise. The forms usually set out four levels of care, from no intervention through to hospital transfer. These forms may be very useful to health care providers in discussions with patients or their substitutes about care options. But, health care providers must realize that these forms are not consents to treatment and cannot be required as a condition of admission to a facility.

There are many problems with levels of care forms. The levels of care forms usually do not indicate that the levels as outlined are arbitrary. People signing the forms should understand that their choices for future care are not limited to the three or four levels outlined but tailored to the actual medical condition of the resident. As well, these forms are often signed by patients and their families without information on what the levels of care mean in reality. For example, a resident of a nursing home may indicate that they would prefer to remain at the nursing home rather than be transferred to a hospital in a crisis situation. However, this decision may have been made without the benefit of information about the differences in care, particularly palliative care and pain management that may be available at the hospital as opposed to the nursing home.

⁵⁹ The Ministry of Health and Long-Term Care has issued a policy directive to all long-term care facilities confirming that facilities cannot require residents to sign a DNR directive as a condition of admission or to have a blanket DNR policy stating that no resuscitation will be available for any resident.

Levels of care forms are not replacements for proper health care consent. Consent must be specific to the care needs of the resident and must be informed. These forms lack the specificity necessary for proper consent.

The LCO should examine the prevalence of levels of care forms and the legal remedies to hold long-term care homes accountable for using unlawful forms.

C. Access to Older Persons

Presently, there is no comprehensive legislation dealing with the issue of access to older adults. ACE gets calls from individuals complaining that they are unable to access a parent, spouse or friend because a caregiver or other individual is prohibiting access.

The capacity to decide what visitors or what contact an older person may wish to have is a capacity that may remain in tact long after other types of capacity have been lost. A senior may continue to enjoy contact with relatives and acquaintances long after the senior has stopped being able to manage property, to make treatment decisions or to retain recent memory. The comfort derived from human contact is a very basic comfort which can have a large impact on an individual's quality of life. However, persons who are competent to decide who they want to visit may have trouble exercising this right. They may have mental or physical limitations, such as the inability to use a telephone or the inability to ambulate.

An older person's place and type of residence plays an important role, especially where access is controlled by another individual. In long-term care homes or private care homes, it is not uncommon for access to be prohibited by the care providers on the instructions of the attorney for property or personal care or on the instructions of another individual who controls the older person's finances. On occasion, the care providers prohibit or limit access to a vulnerable adult because the visitor is deemed to be too demanding, troublesome or interfering. Access may also be limited because of legitimate concerns such as elder abuse.

An older person may live in a home owned or rented by a child or by some other care provider. Access problems in this type of setting may be the most intractable, as the owner of the home may simply issue a no trespass order against visitors. The older adult may be extremely vulnerable in the setting, as the care provider may in fact be the abuser who controls all contact with the outside world.

Even where an older adult is living independently in their own home, there may be limits on access. For example, an older person who is dependent for care on a child or a live-in care provider may face problems where the care provider limits access to the older person.

As previously stated, there is no comprehensive legislation dealing with access to vulnerable adults. Three statutes refer, indirectly, to access to older persons. Section 32 of the *Family Law Act*⁶⁰ deals with support of a parent as follows: "Every child who is not

⁶⁰ R.S.O. 1990, c. F.3.

a minor has an obligation to provide support, in accordance with need, for his or her parent who has cared for or provided support for the child, to the extent that the child is capable of doing so.”

Access to children is governed by *the Children’s Law Reform Act*,⁶¹ specifically section 21, which says: “A parent of a child or any other person may apply to a court for an order respecting custody of or access to the child or determining any aspect of the incidence of custody of the child.”

The guardianship investigation provisions of the *Substitute Decisions Act, 1992* gives the Office of the Public Guardian and Trustee the authority to investigate allegations where a person is incapable and may be suffering from serious adverse effects. Section 62(1) defines serious adverse effects as: “serious illness or injury, or deprivation of liberty or personal security and are serious adverse effects for the purposes of this section.”

Due to a limited legal framework dealing with access issues, the LCO may wish to consider amending our current legislation to grant authority to forums besides the courts to address these matters (e.g., expanding the jurisdiction of an administrative tribunal) or expanding the authority of the Office of the Public Guardian and Trustee.

D. Capacity of Substitute Decision-Makers

In order to act as a substitute decision-maker for a treatment incapable individual, the substitute decision-maker must meet certain requirements, including being capable with respect to treatment.⁶² The legislation does not provide any guidance as to how a health care practitioner can assess or make a determination about the potential substitute’s capacity, nor is there any right to appeal the health practitioner’s decision to the Consent and Capacity Board, or any other administrative body. Older adults are negatively impacted by this legislative gap as they are regularly found to be incapable if they try to act as a substitute decision-maker.

The LCO should review the potential benefits and obstacles of amending the *Health Care Consent Act* to delineate a process for health practitioners to make findings of capacity for substitute decision-makers and establishing a right of appeal for incapable substitute decision-makers.

E. Oversight by the Ombudsman

Ontario is the only province in Canada where the provincial Ombudsman does not have jurisdiction over the health care sector. The LCO should examine whether it is necessary for the Ombudsman could provide additional oversight, both individually and systemically, into the hospital and long-term care sectors.

⁶¹ R.S.O. 1990, c. C.12.

⁶² *Health Care Consent Act*, s. 20(2).

F. The Role of the Public Guardian and Trustee

According to its website, the Office of the Public Guardian and Trustee “delivers a unique and diverse range of services that safeguard the legal, personal and financial interests of private individuals and estates.”⁶³

Included within its responsibilities is a statutory duty to investigate any allegations that a mentally incapable adult is suffering, or at risk of suffering, serious adverse effects.⁶⁴ It has been ACE’s experience, however, that the Public and Guardian and Trustee has interpreted its duties very narrowly and does not intervene often enough. Friends, family members and health practitioners, concerned about the welfare of an older person, often call us in frustration after being told by the Public Guardian and Trustee that an investigation will not be completed. These people often feel powerless to help the older person because one of their only legal options is to make a court application for guardianship. As previously discussed, this is a lengthy and expensive process which is inaccessible for the average person.

One of the shortcomings of the *Substitute Decisions Act* is the lack of a mechanism to create a statutory guardianship for personal care decisions. As a result, ACE has heard complaints that the Public Guardian and Trustee will use its authority as either a person’s statutory guardian for property or a substitute decision-maker for health care to make personal care decisions.

The LCO should review the powers granted to the Public Guardian and Trustee, if they are using their powers appropriately and whether the legislation should be amended to clarify or broaden their jurisdiction.

G. Capacity Assessors

The *Substitute Decisions Act* provides for persons called “capacity assessors.” Despite this misleading title, capacity assessors are not required to be used for capacity assessments unless the statute so requires. A capacity assessor’s opinion is required in the following situations: to property to trigger a statutory guardianship; guardianship applications before the court; to activate powers of attorney where the grantor has specified that their incapacity must be proven before the power of attorney can be used but the document is silent about how incapacity is to be proven.

It goes without saying that an assessment on incapacity can have a profound effect on a person’s life. It has been ACE’s experience, however, that many capacity assessors do not adequately understand the law pertaining to capacity and are not well-trained. Furthermore, many professionals in the health sector do not understand the role of capacity assessors.

⁶³ Office of the Public Guardian and Trustee, *The Role of the Office of the Public Guardian and Trustee*, online: <<http://www.attorneygeneral.jus.gov.on.ca/english/family/pgt/overview.asp>>.

⁶⁴ *Substitute Decisions Act*, ss. 27 and 62.

Capacity assessors may charge fees for the assessments that they undertake. These fees may range anywhere from \$300 to fairly substantial sums, depending on the time necessary to the assessment and the complexity of the assessment. These fees are not covered by provincial health insurance. The person requesting the assessment is usually responsible for the payment for the assessment although requestors may ask for reimbursement from the person's estate if the person is found incapable and a statutory guardian is created, and there are sufficient funds in the incapable person's estate to pay for the assessment. There is also a Financial Assistance Plan to cover the costs of an assessment where an individual makes this request and cannot afford to pay the fees.

Originally, the Capacity Assessment Office⁶⁵ and the system that oversaw these assessors were more extensive. It had been intended to create a more comprehensive system that would include standards for assessors, peer review, various quality assurance practices, discipline procedures, continuing education and a code of ethics. Prior to proclamation of the legislation, there was not enough time to set up this complete system. The discussions about the appropriate oversight for assessors included discussions about the establishment of a "College" of assessors or a similar body. The hope was that by committing resources to this work that capacity assessment would be improved and that research on assessment in the legal context would be an outcome. Unfortunately, as the provincial government changed shortly after the proclamation of this legislation, within a year, the legislation was amended and parts of the legislative package were repealed.

Designated capacity assessors are required to conduct assessments in the manner and form as described in the "Guidelines for Conducting Assessments of Capacity" dated May 2005.⁶⁶ These Guidelines were originally developed in 1995. However, the requirement to follow the Guidelines, to have the quality of the assessments reviewed, to have mandatory continuing education, and to do a minimum number of assessments to retain designation only came into effect in December 2005.⁶⁷ It is hoped that the quality of assessments will improve; to date, any improvements have appeared to be minimal.

The LCO should monitor the effects of the recent changes to the regulations to the *Substitute Decisions Act* to see if the quality of assessments carried out by capacity assessors are sufficient.

⁶⁵ The Capacity Assessment Office, operated by the Ministry of the Attorney General, trains eligible health professionals to be capacity assessors, in addition to maintaining a roster of qualified assessors and operating a Financial Assistance Plan.

⁶⁶ Ministry of the Attorney General, Capacity Assessment Office, *Guidelines for Conducting Assessments of Capacity* (May 2005), online: <<http://www.attorneygeneral.jus.gov.on.ca/english/family/pgt/capacity/2005-06/guide-0505.pdf>>.

⁶⁷ O. Reg 460/05.

H. Evaluators

Pursuant to the *Health Care Consent Act*, an evaluator is responsible for determining whether a person is capable of giving consent to admission to a care facility. An evaluator is someone defined in the legislation as being a member of a specified health or social work college.⁶⁸ They are not required to receive any training in conducting evaluations.

The majority of evaluators use an “evaluator’s questionnaire” to test a person’s capacity. This questionnaire, consisting of five questions, has come under a great deal of criticism as it is overly simplistic. Some evaluators use it in a narrow way, asking only these questions to form an opinion of capacity of the person being assessed. This approach is inadequate and will likely result in incorrect assessments which can easily be challenged if the person applies to the Consent and Capacity Board for a review. Instead, evaluators should use the questionnaire as a tool while “probing and verifying;”⁶⁹ in other words, asking questions to determine the thought process of the person being assessed.

Admission decisions are of utmost importance as they affect a person’s liberty by determining where that person will live. Consequently, any admission to a home based on an improper evaluation violates the person’s rights and is illegal. Yet, both the Consent and Capacity Board and the court have found that many evaluators are ill-informed about how to execute an evaluation and the test of incapacity. Since only a small percentage of individuals challenge an admission decision to the Consent and Capacity Board, the actual number of unlawful evaluations is unknown.

A detailed discussion about evaluators can be found at Tab 4 in an article written by Jane Meadus called “Admission to Long-Term Care Homes: Are Evaluators of Capacity Being Conducted in Accordance with the Law?”

In light of the widespread concern about evaluations, the LCO should review whether the law needs to be amended to require initial and ongoing training for evaluators and whether new tools should be developed to assist evaluators in their duties.

⁶⁸ *Health Care Consent Act*, s. 2(1).

⁶⁹ *Re Koch* (1997) 3 O.R. (3d) 5.