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Discussion Paper on Assisted Living: Past, Present and Future Legal Trends in Canada

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Executive Summary

This Discussion Paper provides a starting point to engage in a national conversation about a critical “middle option” of health / housing in Canada. This middle option, called “supportive housing / assisted living” (SH / AL) in this project, lies at the centre of a seniors’ housing continuum. This continuum is bookended by independent living at one end, and high care long-term residential facilities at the other. While SH / AL varies in lexicon and substance across Canada, it is often broadly described as independent living that includes some form of personal and health care services.

SH / AL is already of significant concern to Canadians, and with the impending “age wave” will only be more so in the immediate future. It is clear that Canadians will need to find legislative and regulatory systems that make sense to users and providers of SH / AL. Such systems will need to address the entire “field” of issues, while at the same time staying true to the chosen philosophical underpinnings of SH / AL. This is not the case in Canada, today.

In order to achieve this, a more focussed discussion on the needs of residents and operators must begin. This Discussion Paper brings some past, current, and future trends in SH / AL together, in order to prompt discussion and to assist in creating a common understanding of challenges faced in regulating this area.

Currently, the laws and policies governing SH / AL in Canada are fragmented, jurisdictionally bound, and difficult to grasp for layperson and professional alike. A snapshot and analysis of key provincial and national legislative issues are provided in this paper.

This Discussion Paper starts by briefly reviewing some of the political and social evolution of seniors’ housing in Canada. While modern SH / AL is still a relatively novel concept, it has been evolving over the course of the last century. The paper maps social housing’s evolution through the depression, the disability rights movements of the 1970s and 80s, and up to the present day.

Second, it reviews some key elements of a comprehensive legislative scheme for SH / AL. This includes the discussion of a scenario that highlights some typical legal issues and concerns that may arise.

Third, this Discussion Paper reviews key legislative governance across Canada. This highly detailed analysis makes up the bulk of the paper. The legislative scheme in all 13 jurisdictions in Canada are examined with reference to the following criteria:

1. Main Legislation
2. Ancillary Legislation
3. Lexicon / Parameters of Care (Lesser Care / More Care / Most Care)
4. Residential Tenancy Legislation Applicability
5. Consumer Protection
6. Funding
7. Complaints / Dispute Resolution
8. Staffing Indicators
9. Entry / Exit Criteria

Fourth, an analysis of common themes across jurisdictions will be considered. These themes are identified and discussed by asking three important questions:

- A. Whose responsibility is it and who is providing services?
- B. Can old and new models exist harmoniously in the same jurisdiction?
- C. How does regulation and philosophy co-exist?

Fifth, some emergent future legal issues in SH / AL are suggested. Issues of growing importance such as smoking, gay, lesbian and bisexual issues, transgendered issues, physical or mental challenges, and alcohol and drug use are all discussed. The Discussion Paper will suggest a series of questions to prompt further consideration of these issues.

This Discussion Paper concludes by asking a series of questions, and inviting input and consultation on these questions. Consultation is also sought on the broad issue of SH / AL and legal issues in Canada. Participants are free to broadly provide input.

Some key discussion questions open for consultation include:

- 1) Should SH / AL have national definitions which are standardized?
- 2) Should the “field” of SH / AL be regulated by a single statute in each jurisdiction or should SH / AL be regulated by a variety of legislation (e.g. Residential Tenancy, health and food safety standards etc)?

- 3) How can consumer protection issues be best addressed by legislation or regulation (e.g. food quality, services not up to standards, but not a risk to health and safety)?
- 4) What complaint systems are preferable? (e.g. reports based by resident, inspection-based required by legislation, hotline?)?
- 5) How can that information on complaints or standards best be made public or used by the public (e.g. online reports, independent body's publications etc?)?
- 6) What should be the best entry and exit criteria for SH / AL in Canada?
- 7) What do you think some of the "hidden issues" not raised in this Discussion Paper are?
- 8) What are the biggest challenges for SH / AL residents now? In future?
- 9) What are the biggest challenges for SH / AL operators now? In future?

While the scope of this project is to identify issues and engage in comparative research, it does not extend to creating draft legislation. However, a next step in a broader project which might include considering draft legislation and law reform issues may be possible in future.

I. INTRODUCTION

Housing and care needs in some way shape every era of our lives. However, as the Canadian population ages rapidly, a stronger emphasis on housing needs of older adults is becoming increasingly important.

Canada is being swept up in the “age wave.” With the number of Canadian older adults growing rapidly, Canadian systems will need to be ready. However, this large demographic shift is not necessarily a negative shift; rather, its impacts are largely yet unknown. Despite the apocalyptic predictions¹ of many demographers, Canadians are living longer and healthier² than ever before. Canadian older adults are active economic and social contributors well into their “third age.”³ Ageist stereotypes of dependent older adults who predominately require institutional health care services persist, despite all evidence to the contrary. The overwhelming majority of older adults live independently and do not require assistance with daily tasks.⁴ Statistics Canada indicates that the percentage of older adults who reside in institutional care settings is as little as 7%.⁵

Indeed, Canadian older adults hold independence as a key social and cultural value. In 1998, Canada engaged in a broad initiative to create a principles-based framework in which to develop national policy for seniors. Older adults from across the country were engaged in a national consultation to determine what principles were most important to them as they aged. “Independence” ranked in the five most important and overarching themes.⁶ This desire for independence strongly informs their preferences for housing and care options.

-
1. For an excellent discussion of the existing discourse of cataclysmic impacts of population aging, see Ellen M. Gee & Gloria M. Gutman, eds., *The Overselling of Population Aging: Apocalyptic Demography, Intergenerational Challenges and Social Policy*, (Don Mills, ON: Oxford University Press, 2000).
 2. The Canadian Senate Special Committee on Aging, *Second Interim Report: Issues and Options for an Aging Population* (March 2008), online: Parliament of Canada <<http://www.parl.gc.ca/39/2/parlbus/commbus/senate/com-e/agei-e/rep-e/repfinmar08-e.pdf>> at 35 and 36.
 3. Health Canada, *Canada's Aging Population* (Ottawa: Minister of Public Works and Government Services, 2002) at 9 [Canada's Aging Population].
 4. Public Health Agency of Canada, Division on Aging and Seniors, *Canada's Seniors At a Glance* (Ottawa: Canadian Council on Social Development for the Division of Aging and Seniors, 2005) online: Public Health Agency of Canada <http://www.phac-aspc.gc.ca/seniors-aines/pubs/seniors_at_glance/poster1_e.html>.
 5. *Ibid.*
 6. Public Health Agency of Canada, Division on Aging and Seniors, *Principles on a National Framework on Aging: A Policy Guide*, (Ottawa: Minister of Public Works and Government

Numerous studies and surveys⁷ affirm that Canadians, on the whole, prefer to “age in place” as one means of expressing this independence. “Aging in place” can be understood as a model of housing along a care continuum, with the underlying philosophy emphasizing the importance of older adults remaining in their own private homes as long as possible. When and if it becomes necessary, aging in place principles strongly support having services brought to older adults in their own homes in order to allow them a maximum amount of housing freedom. Should the physical space or “built environment” become inappropriate due to physical challenges or other higher care needs, then aging in place principles would then indicate that the older adult should, where possible, largely remain within their neighbourhood, connected with their local social networks.

Informing and operationalizing the concept of aging in place is the concept of the health and housing continuum. At its most basic, this continuum commences with an older adult living independently in their owned or rented home. When supports are required to assist with activities of daily living such as cooking and cleaning, then some form of public or privately funded home support worker will be able to come to the older adult’s home and assist with those activities. As the older adult progresses along this continuum, some physical adaptations to the home (referred to in the literature as the “built environment”) may be required.

Eventually, however, it may become necessary for the older adult to move out of their own home to a more congregate setting where additional personal assistance services can be provided. This next stage along the health / housing continuum is known as “supportive housing” (SH) or “assisted living” (AL). The BC Office of the Assisted Living Registrar describes this genre of health / housing mix as being based on a philosophy of providing “housing with supports that enable residents to maintain an optimal level of independence. Services are responsive to residents’

Services, 1998) at 14. Independence was described as “being in control of one’s life, being able to do as much for oneself as possible and making one’s own choices e.g., decisions on daily matters; being responsible, to the extent possible and practical, for things that affect one; having freedom to make decisions about how one will live one’s life; enjoying access to a support system that enables freedom of choice and self-determination”. The other 4 key principles were “dignity”, “fairness”, “participation” and “security”.

7. There is a rich literature surrounding the discussion of aging in place. See for example: Gloria Gutman & Andrews Wister, eds., *Progressive accommodation for seniors: Interfacing shelter and services* (Vancouver: Gerontology Research Centre, Simon Fraser University, 1994); V. Doyle, & N. Gnaedinger, *Aging together, aging in place: Responding to seniors’ issues in housing co-operatives* (Coop Housing Federation of Canada, 1996); Gloria Gutman, “Migration of the elderly: An overview” in Gloria Gutman & N. Blackie, eds., *Aging in place: Housing adaptations and options for remaining in the community* (Vancouver: Gerontology Research Centre, Simon Fraser University, 1986) at 71.

preferences, needs and values, and promote maximum dignity, independence and individuality”.⁸ Many understand AL as being at the higher-care support end of the broader SH context; others consider it a different next stage in the continuum entirely.

Such a health / housing system may provide adequate supports for some older adults, but for those experiencing a health decline, the continuum moves generally into the area of more traditional nursing-based care, found most often in institutional residential care facilities.

This health / housing continuum is, however, not necessarily so linear, nor so smooth. Most older adults will need little in terms of supports outside their own homes, predominately until they reach into their 80s.⁹ Some older adults may suffer acute health crises which result in an immediate need of the highest possible level of institutional nursing / residential care. Older adults may have health gains, such that they need fewer supports and services than previously required. Some may decide to move in with family or friends, or remarry, thus veering off this somewhat artificial continuum. External relationships, lack of available housing, an overarching desire to stay in one’s own home and the care needs of others such as children or grandchildren can significantly impact health / housing choices for older Canadians.

A. Purpose and Scope of Discussion Paper

The Canadian Centre for Elder Law was asked by the Good Samaritan Society of Canada to consider some past, present, and future issues associated with law and SH / AL in Canada. This project will assist in providing a snapshot and analysis of key provincial and national legislative issues.

The Discussion Paper does not purport to cover all issues regarding SH / AL, which are myriad, and for which a vibrant literature already exists. Rather, the intent of this Discussion Paper is to raise awareness of the regulatory complexities, jurisdictional differences and emerging legal issues associated with SH / AL. Its goal is to prompt discussion, and where appropriate identify areas of potential reform.

8. *About Assisted Living in BC*, online: Office of the Assisted Living Registrar <<http://www.health.gov.bc.ca/assisted/about/index.html>>.

9. “More than one in four seniors face restrictions in their activities due to long-term health problems. Such limitations tend to increase with age. In 1996-97, activity limitations affected slightly more than one fifth of seniors aged 65 to 74, but nearly half of seniors aged 85 or more,” Canada’s Aging Population, *supra* note 3 at 15.

Specifically, this Discussion Paper does not cover issues of adult abuse and neglect. An excellent project, entitled “*A Way Forward: National Snapshot: Preventing Abuse and Neglect of Older Adults in Institutions*”¹⁰ has recently been released. “The Way Forward” is a national review of SH / AL and long-term or institutional care legislative models regarding adult abuse and neglect in institutions and covered off key aspects of this issue.

This Discussion Paper will first provide a brief overview of some of the political and social evolution of seniors’ housing in Canada. Second, it will review some key elements of a comprehensive legislative scheme for SH / AL. Third, this Discussion Paper will review key legislative governance in various jurisdictions across Canada. Fourth, an analysis of common themes across jurisdictions will be considered. Fifth, some emergent future legal issues in SH / AL are suggested. The Discussion Paper will suggest a series of questions to prompt further consideration of these issues.

A period of consultation will follow this Discussion Paper, undertaken by the Good Samaritan Society of Canada and the Canadian Centre for Elder Law. A Final Report will be issued in 2009.

B. Why is this Discussion Paper Needed?

Generally, the laws governing SH / AL in Canada are fragmented, jurisdictionally bound, and difficult to grasp. It is extremely challenging for older adults, their supporters, SH / AL operators, policy-makers, and lawyers to have a complete sense of how these important housing markets are governed, or what rights the respective parties have.¹¹ Some jurisdictions, like British Columbia, have legislated more in this area; however, more legislation does not necessarily mean more clarity.

Provincially and nationally, the laws governing SH / AL can at best be considered legislative patchwork. It is unclear to many if the less-than-comprehensive legislative governance of SH / AL is purposive, evolutionary, or simply neglected. This Discussion Paper will probe these issues and suggest possible responses.

10. This project, entitled: “A Way Forward: Promoting Promising Approaches to Abuse Prevention in Institutional Settings” was ongoing during the drafting of this Discussion Paper. The author of this Discussion Paper provided input into this project. The Way Forward project is current legislatively to May 2008. For more information on the project, please visit online: A Way Forward <<http://www.elderabuse.utoronto.ca/>>.

11. Charmaine Spencer, Judith Wahl & Laura Watts, “Three Strikes and You’re Out: Legislating Homelessness Along the Housing Continuum in Canada,” presentation at the 34th Annual Scientific and Education Meeting of the Canadian Association on Gerontology, Halifax, Nova Scotia (October 2005) [unpublished, archived with the Canadian Centre for Elder Law].

This Discussion Paper suggests that the apparent challenge in legislating SH / AL may be indicative of a larger, and predominately agreed upon, underlying issue. There is no consistent approach to SH /AL in Canada from a policy, organizational or even philosophical perspective.¹² Terms and definitions differ broadly across the country and within region, both in meaning (e.g.: SH meaning “X” in one jurisdiction and “Y” in another) and in lexicon. Beyond SH / AL some of the other terms used in Canada to describe this “middle option” include, but are not limited to:

- Seniors’ lodges (Alberta)
- Supportive living (BC)
- Retirement homes (various)
- Retirement villages (Ontario)
- Selected portions of a “campus of care” (various)
- Community care facilities (PEI)
- Personal care homes (NFLD)

Without a common lexicon or frames of reference, access to good information on these types of important housing becomes problematic.¹³ A recent Canadian Policy Research Network report on SH noted that “supportive housing definitions vary notably across Canada. Many policy documents and academic studies have pointed out that inconsistent definitions in the supportive housing field create uncertainties

12. For further discussion see: Karen Croucher, Leslie Hicks & Karen Jackson, *Housing with Care for Later Life: A Literature Review* (York, UK: Joseph Rowntree Foundation, 2006); Janet Lum, Simone Ruff & A. Paul Williams, *When Home is Community: Community Supportive Services and the Well-Being of Seniors in Supportive and Social Housing* (Toronto: Ryerson University, Neighbourhood Link / Senior Link and the University of Toronto, 2005); Diana Kucharska, *Seniors’ Health and Housing Crossroads: Exploring Alternatives to Long-Term Care Facilities* (Ontario Coalition of Senior Citizens’ Organizations, Health Canada Project Number 6796-15-2001-434001, 2004).

13. Canada Mortgage and Housing Corporation, External Research Program, *A Legal Framework for Supportive Housing for Seniors: Options for Canadian Policy Makers, Final Report* by Margaret Hall, (March 2005) at 37 [Hall]; It may also help to explain the very limited research literature and analysis on law and SH / AL issues on this important area. Significant Canadian literature exists on SH / AL in other fields, such as gerontology, social work and health care, which address functional issues in a more client-centred or built-environment approach. These aspects more readily lend themselves to thematic, rather than jurisdictional, research.

for seniors in need of services and amongst practitioners in the health care, community support services and housing sectors”.¹⁴

This Discussion paper will identify common themes and provide analysis about this patchwork and provide some options for discussion and consideration.

II. PAST TRENDS

SH / AL housing for older adults evolved from a variety of social conditions and government initiatives. A brief historical overview provides some context for Canada’s approach to SH / AL today.¹⁵

In Canada, and indeed in many international jurisdictions, the modern notion of SH / AL is still a relatively new phenomenon, dating back only to the 1980s and 90s.¹⁶ Its evolution, however, has taken nearly a century.

This form of housing evolved from the general move towards providing emergency housing around the turn of the 20th century,¹⁷ to a more concerted effort to create social or affordable housing in post-war eras. Significant strides in social housing were made in the 1940s – 1980s in Canada.

14. Allison Jones, *The Role of Supportive Housing for Low-Income Seniors in Ontario, December 2007* (Canadian Policy Research Networks Inc and Social Housing Services Corporation, 2007) at 7 [Jones]; See also Seniors Advisory Council for Alberta, *Supportive Living Framework* (March 2007), online: Alberta Seniors and Community Supports <http://www.seniors.gov.ab.ca/housing/continuingcare/standards_framework.pdf> [SL Framework].

15. For more in-depth historical discussion, see: John Herrick & Paul Stuart, eds., *Encyclopaedia of Social Welfare History in North America* (Thousand Oaks, CA: Sage Publications Inc., 2005) [Herrick]; It is beyond the scope of this paper to undertake a full review of housing initiatives in Canada. For an excellent and thorough review of these issues current up to 1997 see: Tom Carter, “Current Practices for Procuring Affordable Housing: The Canadian Context” 8:3 Housing Policy Debate 593.

16. See for instance: Paul M Baker & Michael J. Prince, *Supportive Housing Preferences Among the Elderly* (Philadelphia: Haworth Press, Inc. 1990); Andrew Wister, “Living Arrangement Choices Among the Elderly” 3:3 Canadian Journal on Aging 127; United Senior Citizens of Ontario, *Elderly Residents in Ontario: Their Current Housing Situation and Their Interest in Various Housing Options*, (Ontario Minister for Senior Citizens Affairs, 1985); M.P. Lawson, M. Moss & M. Grimes, “The Changing Service Needs of Older Tenants in Planned Housing” 25:3 The Gerontologist 258; Gloria Gutman & N. Blackie, *Innovations in Housing and Living Arrangements for Seniors* (Vancouver: Gerontology Research Centre, Simon Fraser University, 1985).

17. For example after the 1917 Halifax explosion 3,000 houses were repaired in the first seven weeks and by the following in January, temporary apartments were being constructed at the rate of one every hour. *Halifax Regional Municipality Community Archives*, online: Halifax Regional Municipality <<http://www.halifax.ca/Community/explode.html>>.

Concurrent with this more generalized drive to provide social housing opportunities came the move towards “Independent Living” for persons with disabilities, which had significant impact in the 1970s and 80s. The Canadian disabilities community drove discussions of de-institutionalization that impacted on the existing discourse of affordable social housing for seniors.

Also in this time, significant national discussion on the role of health care in Canada was underway. Gerontologists and health care providers were questioning how “lighter” health care needs of many older adults could be positively intersected with social housing needs.

The threads of affordable social housing, combined with the disability community’s movement towards de-institutionalization and a national discourse on health care needs of the population fostered a healthy basis for the development of SH / AL in the 1990s and into the 21st century.

A. Historical Overview – Development of Housing Legislation in Canada

While some post World War I housing was created for veterans and some public social housing was established in predominately urban areas, such as Toronto, Canadian government did not become strongly invested in the business of social housing until the Great Depression of the 1930s.¹⁸

Legislation governing the federal government’s responsibility for housing issues moved rapidly in this era. In 1935 the *Dominion Housing Act* (DHA)¹⁹ was passed, which provided for loan initiatives to spur only private development of housing, and was largely considered a temporary measure, rather than an active program of government. By 1938 the DHA was replaced by the *National Housing Act* (NHA),²⁰ which formalized housing initiatives. In 1940, Wartime Housing Limited, the first crown corporation for housing, was created to provide housing needed in urban centres.

18. The purpose of this section is to provide some basic legislative background within which to understand the modern legislative schemes and development in SH / AL in Canada. For a more complete historical review of the broader issues, see: John R. Miron, ed., *House, Home and Community: Progress in Housing Canadians, 1945-1986* (Ottawa: Canada Mortgage and Housing Corporation, 1989) last revised 1992; Jane A. McNiven, *More than Shelter: Housing Policy Kit for Seniors in Atlantic Canada*, (The Atlantic Seniors Health Promotion Network, 2004) at 21 [McNiven].

19. S.C. 1935, c. 58.

20. S.C. 1938, c. 49.

In the immediate wake of World War II, the Canadian government became focussed on developing comprehensive social and welfare programs to provide protection for citizens. In 1944 Prof. C.A. Curtis of Queen's University was asked to undertake a review of housing and community development on behalf of the federal Advisory Committee on Reconstruction.²¹ The resulting *Curtis Report* of 1944 described how the government could support the building of new homes and encourage the process of community planning. The possibility for individual self-reliance had been dramatically altered by urbanization and industrialization, and it was thought that not all citizens could rely on family members, charity, or the market to meet their needs.²²

As a result of this influential report, the governing NHA underwent significant amendment that same year.²³

In 1949, the NHA was amended again,²⁴ creating a federal-provincial partnership in housing, away from the direction of municipal-based social housing. The amendments also created the Central Mortgage and Housing Corporation (CMHC). This agency, later renamed the Canada Mortgage and Housing Corporation, remains a key player in the Canadian housing and policy landscape.

With these structures in place, Canada now had broadly based legislation supporting social housing and an important new institution, CMHC, to assist in the implementation of the work envisioned.

While it is beyond the scope of this Discussion Paper to delve into the historical details of the impacts of these new policies and structures, many resources exist which provide that level of review.²⁵

21. Professor C.A. Curtis, *The Curtis Report*, Advisory Committee on Reconstruction, Canada, 1944. See also: Richard Harris, *Creeping Conformity* (Toronto: University of Toronto Press, 2004) at 115.

22. Herrick, *supra* note 15 at 362.

23. S.C. 1944, c. 46.

24. S.C. 1949, c. 30.

25. For example, see: John C. Bachker, *Keeping to the Marketplace: An Evolution of Canadian Housing Policy* (Kingston: McGill-Queen's Press, 1993); Albert Rose, *Canadian Housing Policies (1935-1980)* (Toronto: Butterworths, 1980); Donald Grant Wetherell & Irene Kmet, *Homes in Alberta: Building, Trends, and Design, 1870-1967* (Edmonton: University of Alberta Press, 1991).

Of key importance in the development of SH / AL in Canada, was the emergence of social awareness in the 1960s-70s of the unique housing needs of low-income elderly populations.²⁶ Further 1964 NHA amendments²⁷ streamlined housing cost-sharing schemes between the provincial and federal governments, which made it significantly easier for the provinces to secure funding for public housing. Projects specifically addressing housing issues for seniors and other “vulnerable” groups were undertaken,²⁸ often resulting in the new construction of “senior citizens’ homes,” as they were then known.

The changes in the 1960s and 1970s also heralded an impending shift to provincial government responsibility for affordable housing for low-income families or individuals, including the elderly. And while the purview for appropriate housing became more the responsibility of the provincial government, the federal government of Canada still retained final authority in most policy decisions.²⁹

B. Disability Rights Movements – Impacting Seniors Housing

Concurrently with seniors-specific housing being developed (1960s-80s), the era of disability rights was also starting to flourish. Canadians played an important role in the worldwide movement towards de-institutionalization of disabled persons.³⁰ Wolf Wolfensberger, a German sociologist working for the Canadian National Institute on Mental Retardation in Toronto argued in 1972 that people with developmental disabilities should live in the most “normal” setting possible if they were expected to behave “normally”.³¹ This growing discourse was “radical for the time, suggesting that people with cognitive disabilities could be better served outside institutions”.³² The development of community-based housing for persons with challenges laid the philosophical foundations for SH / AL.

26. McNiven, *supra* note 18.

27. S.C. 1964, c. 15.

28. The federal government assumed 75% of the cost, with the provinces and municipalities paying the rest.

29. McNiven, *supra* note 18 at 22.

30. Kathy Martinez, "Independent Living in the U.S. & Canada," (2003) online: Independent Living Institute <<http://www.independentliving.org/docs6/martinez2003.html>>. In the forthcoming English version of: J. Vidal Garcia Alonso "El Movimiento de Vida Independiente, Experiencias Internacionales", 2003 [Martinez].

31. Wolf Wolfensberger, *The Principle of Normalization in Human Services*, National Institute on Mental Retardation, Canadian Association for the Mentally Retarded, 1972.

32. Martinez, *supra* note 30.

C. The Not-For-Profit “Third Sector” Enters

After 1973 the federal government began directly funding new social housing projects built by both non-profit societies and municipally created housing corporations. This was the time when many non-profit seniors’ buildings in existence today were created throughout Canada.³³

In particular, during the 1970s and early 1980s, federal housing policies created housing for seniors in the public and non-profit sectors. Federal funding also became available to fund programs that helped seniors remain in their homes, such as funded home maintenance and repair programs, or other home support services. Rent controls were created in this era to further support seniors living in rental tenancies. Programs such as New Horizons were established,³⁴ which promoted social and physical well-being for older persons in communities throughout Canada.³⁵

However, a shift in federal policy began in the 1980s. By the mid-1980s, almost \$2 billion was cut from federal housing programs.³⁶ These cuts led to a reorientation in federal thinking, which began devolving responsibility for social housing to the provinces. Indeed by 1996, the federal government transferred existing federal social housing programs to the provinces, which included purview over housing for seniors, and withdrew funds for supporting seniors in their homes and communities.³⁷

In response, provinces began connecting the need for seniors housing, and linking it with the emerging discourse around community living for persons with challenges. For example, BC’s Provincial Commission on Housing Options (PCOHO) observed the following:

The Commission noted an emerging need to address the housing needs of the frail elderly. Since the PCOHO consulted with British Columbia residents, local

33. McNiven, *supra* note 18 at 22-23.

34. New Horizons: A national program to help ensure “that seniors are able to benefit from and contribute to the quality of life in their communities through social participation and active living.” For further information, see online: Human Resources and Social Development Canada <http://www.hrsdc.gc.ca/en/community_partnerships/seniors/index.shtml>.

35. McNiven, *supra* note 18 at 26.

36. Michael Shapcott, *National Housing Day 2007: Despite promises, few new homes and scarce dollars* (November 2007) online: Wellesley Institute <<http://wellesleyinstitute.com/files/winationalhousingday2007.pdf>>.

37. McNiven, *supra* note 18 at 26; In 1993, all federal funding for new social housing was eliminated.

governments and community groups have sought provincial assistance in understanding the issues. In response, the Housing Policy Unit has been working with the Ministry of Health and people at the local level, with the goal of developing a policy and legislative framework that protects consumers living in supportive housing.³⁸

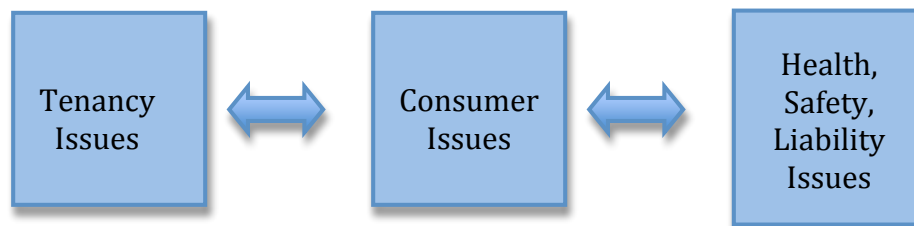
By the late 1990s, provinces saw the demand for SH / AL options outstripping its ability to create policy or law. The rise in the “middle option” housing for seniors grew significantly, in both for-profit and not-for-profit markets. This growth directly responded to a pressing need for alternatives to individual home living and institutional long-term care (LTC).

III. PRESENT TRENDS

In the twenty-first century SH / AL is widespread and provincially governed. This Discussion Paper seeks to map key aspects of legislative purview over these health / housing providers and to identify gaps or trends.

A. Mapping the Legal Themes

SH / AL are complex nodes of law. They include several genres of law that are central themes. This section will consider the three main theme areas of law found in SH / AL, which are: Tenancy, Consumer Services and Protection, and Health and Safety issues.



Below, this Discussion Paper will review the relevant legislation in each jurisdiction in Canada. However, this review needs to be understood within the broader context of the spectrum of legal issues which are embedded in SH / AL.

38. British Columbia, Housing Policy and Programs: Advances and Activities since the Provincial Commission on Housing Options, Office of Housing and Construction Standards.

SH / AL is many things to many people. To some it is a home. To others that home is a workplace. Rolled into this mix is the issue of service provision. In few other areas are the potential issues that need to be considered so varied and yet intertwined.

In order to put some of these issues in context, let's take the example of Martha and Jim to illustrate.³⁹

B. Jim and Martha at "The Cedars" – Scenario

Martha is 78. Her husband Jim is 81. They have been married for 40 years. They are both generally in good health but find that they were becoming isolated living in the rural community in which they had resided. They decided to move to town to a congregate housing type complex, which provided housing, some care services and a broad variety of social events and outings. A SH / AL building named "The Cedars" seemed expensive, but they were very taken with its individual apartments and the idea that they could get many services in one place. During the introduction, they were shown to the hairdressing salon onsite, which promised excellent hairstyles and other grooming services.

Martha and Jim were also very impressed with the range of social outings and clubs available; they had missed playing bridge very much and looked forward to engaging in the daily party bridge games advertised. Jim was also looking forward to using the health facilities including an outdoor heated pool. Food service was provided twice daily and the brochures noted that the meals were gourmet, healthy, and varied. The Cedars was marketed as very much one's "own home" with the added benefits of assistance with cleaning, personal care, and transportation on outings. Martha and Jim decided to move in.

On moving day, they were given a lot of forms to sign. Their daughter-in-law Susan came with them to help. The administrator gave them the "package" of forms. When Martha and Jim enquired as to what was in the forms, the administrator answered, "the usual – the agreement, the club information...you need to sign them all before you can move in". Martha and Jim were confused about the forms but, squinting at the type, tried to fill them in. They were having trouble reading the forms and were very tired from all the moving. The administrator noted that Susan could fill them in for the couple. One of the forms had the words "Levels of Care" on it. Martha was getting tired and wanted to go to her room. She signed the forms at the bottom where indicated, although the forms were not completely filled out. Susan said she'd fill in the rest while they took a break.

39. This is not an actual case, however, it is a fictional construction based on a mix of common issues arising in SH / AL.

After moving in, things did not go quite as smoothly as expected. Generally the building was good, but repairs started to the windows as part of a general building upgrade. Workers appeared at Martha and Jim's window without warning and started to bang heavily at 8:00 a.m. The noise was very difficult to live with. When they inquired to the administration, the manager noted that these were scheduled and important building upgrades that would take about two months to complete.

Two meals a day were provided, and Martha and Jim enjoyed the social aspect of the meals. However, the meals were not as varied as advertised, and the quality was dubious. There was nothing unhealthy or unsanitary about the food; rather, it was not the gourmet meals advertised and the food was largely unappetizing to Martha and Jim. Martha's in-house hairdresser quit and a new hairdresser was hired. This one was not very good and Martha was upset with the results. When she complained to the manager they said that they would take Martha's feedback into account and thanked her for providing input.

The bridge club shut down and bingo was introduced in its place. Martha and Jim are very disappointed. The outings that were planned for the upcoming season involved many craft shows, and few of the cultural events that Martha and Jim prefer.

Several months after moving into The Cedars, Martha was out walking in town. She slipped on some stairs and had a fall. Martha broke her hip and had to go to hospital for surgery and recovery for a period of time. When she was admitted to hospital, she overheard a nurse say "this patient signed a Levels of Care Advance Directive form from The Cedars so no CPR for her if something happens." Martha was very confused and upset. She had no idea what a Levels of Care form was, but she certainly did want CPR in case of an emergency.

When she returned back to The Cedars, Martha had increased care needs and her medications and general fatigue resulted in her becoming more easily confused. Jim started worrying that Martha might be developing some form of dementia.

While Martha was in the hospital, Jim noticed that two of the bathroom tiles in their suite had developed cracks. For Jim this was not really a problem. He just thought it looked ugly and ruined the aesthetic of the bathroom. Jim notified the building management who indicated that they would have someone come and look at it and replace the tile in due course. However, upon Martha's return from hospital, the cracked tiles presented a real risk to her and her newly mended hip. Jim mentioned this to The Cedars management who indicated that they were being diligent but

could not get someone to replace the tile for several weeks, due to the trouble finding trades people. Jim really worried that Martha would fall on these tiles and hurt herself during her unsteadiness as she recovering from her hip injury.

Jim had always smoked every day. He had been smoking for 60 years and had never been able to quit. He usually tried to smoke outside when he could, but the winter weather was turning very cold. Temperatures were hitting -30 degrees and it was becoming increasingly slippery and dangerous outside. Also, he did not want to leave Martha unattended – she had started wandering around and he could never seem to find someone to watch her when he needed a break. Jim started smoking more in his suite. He was served with a notice that as a workplace, smoking was not allowed. Jim was confused – he thought that this was his own home and that he could do what he liked in it. Besides, he could not just stop smoking – he’d tried to quit before, but at his age, he joked, he has few pleasures left. He admits that he is “hooked” on the nicotine. Smoking helps him relax and he’s been increasingly upset and worried over Martha.

The Cedars management has also been worried about Martha. Susan was called by the manager to “talk about your mother”. The manager told Susan that her mother would have to move out because of her “dementia”. The manager also said that Jim would have to move too – either to a smaller single room or leave the building. The building only has a limited number of 2 bedroom suites and the Cedars has a policy that these suites always have 2 occupants. Jim does not want Susan involved at all and is angry that the manager called her. Jim also does not want Martha to move – he notes that he can look after her well enough and he certainly does not want to move rooms. They have signed papers, he noted, for this particular 2-bedroom suite. Jim is very upset, Martha is in tears, and the building manager who is trying to do a good job for everyone is very frustrated as well.

C. Scenario Discussion

This scenario typifies the interconnected nature of the legal issues. Some of the issues raised include:

Tenancy

How does Jim deal with the unfixed tiles?

Who signed the tenancy contract – was it Susan or Jim and Martha?

Is the housing covered under residential tenancy laws?

Can the landlord make Jim move to a smaller suite?

Can Jim smoke in his suite?

Consumer Protection

What can be done about the fact that meals advertised are below the standard advertised?

How do they resolve the issue of the sub-standard hairdressing?

Social events advertised are not to their taste or what they were led to expect. Is this a legal issue or just unfortunate?

Was the inadequacy of the services enough to vitiate the contract?

Health & Safety and Liability

Can The Cedars ban Jim from smoking because it is a workplace?

What is the liability of The Cedars if Jim is hurt smoking outside?

Is the staffing adequate for The Cedars?

Is the food really just bland, or does it raise a health and safety issue?

Are the cracked tiles a health and safety risk to Martha while being only a tenancy issue to Jim?

Does Martha really meet the exit criteria, despite never having an evaluation?

Is Martha safe to live in The Cedars or are her care needs higher?

If Martha is not able to access residential care nearby, what will happen to her?

Other

Has The Cedars breached any privacy laws by contacting Susan?

Has The Cedars committed fraudulent misrepresentation by not specifically indicating a Levels of Care or advance directive?

What is the liability of The Cedars for breaching laws re: inclusion of Levels of Care form or Advance Directives?

D. Analysis

Many of these issues depend on the legislative regimes in the individual provinces. Where legislation is not “covering the field,” common law fills the void. Many of these issues might fall into the category of general contract, tort, privacy, and fiduciary law. Accessing justice, however, particularly in a rural area with little coverage for legal aid, can be significantly challenging. Complaining residents may worry about reprisals. Busy managers may not be able to fix problems appropriately (such as the challenge in fixing the tiles, due to shortage of trades people).

Another important piece in this scenario is that one set of facts can enter into various areas of law, depending on the individual point of view or personal set of

circumstances of the players. For Jim, the broken tile was merely ugly and he understood it to be a pure landlord – tenant issue requiring repair. For Martha, however, the broken tile presented a significant risk to her health and safety. Same suite. Same tile. Different impacts and legal arguments prevail.

No one in this scenario was ill intentioned. The manager was diligent and attentive. Jim and Martha were good residents. However, many significant legal issues arose, which crossed boundaries of law, and little of it was completely discrete in its application.

IV. PROVINCIAL LEGISLATION ON SH / AL ACROSS CANADA

Now that some context has been provided, this Discussion Paper will consider existing laws across Canada. As these regimes are so varied, distinct areas of comparison have been identified for cross-comparison.

The areas of comparison are as follows:

10. Main Legislation
11. Ancillary Legislation
12. Lexicon / Parameters of Care (Lesser Care / More Care / Most Care)
13. Residential Tenancy Legislation Applicability
14. Consumer Protection
15. Funding
16. Complaints / Dispute Resolution
17. Staffing Indicators
18. Entry / Exit Criteria

A. British Columbia

1. MAIN LEGISLATION

The primary source of legislation in BC is the *Community Care and Assisted Living Act*,⁴⁰ along with the *Adult Care Regulations*.⁴¹ This legislation is fairly specific compared to many other Canadian legislative schemes, and includes a rarity – a discrete legislative name and definition of SH / AL, and governance schemes covering many aspects of this health / housing mix. However, the legislation is still frequently criticized. Despite being quite modern and principle-based, the AL component only covers health and safety issues. The legislation has also been

40. S.B.C. 2002, c. 75 [CCA].

41. B.C. Reg. 278/2005 [ACR].

criticized for trying to regulate based on an inaccurate picture of who is actually in AL homes in BC.⁴²

2. ANCILLARY LEGISLATION

The *Residential Tenancy Act*⁴³ was amended in 2006 to include “supportive living” and AL. This is a departure from the previous legislation, which specifically excluded SH / AL from RTA coverage. These amendments, while passed, are not yet in force and at the time of writing, and it seems unlikely that they would be brought into force in the next year.

3. LEXICON / PARAMETERS OF CARE

In BC, *lesser care* is called “Supportive Housing.” This covers housing that may only have some hospitality services, which includes “meal services, housekeeping services, laundry services, social and recreational opportunities and a 24-hours emergency response system.”⁴⁴

BC Housing, a corporation established in 1967 to effect the province’s housing policy, provides modified rental homes to seniors with some services, such as 24-hour response, light housekeeping, meals, and social and recreational activities.⁴⁵ BC Housing notes the following on its website about its current SH programming:

Seniors’ Supportive Housing (SSH) – Launched on October 2007, the Seniors’ Supportive Housing program is being financed with the government’s Budget 2007 commitment of \$45 million over four years to upgrade or convert up to 750 subsidized housing units to supportive housing. The program provides specially modified rental homes, in selected subsidized housing developments, primarily to low-income seniors who need some assistance in order to continue to live independently. The outcome of the proposal call for approximately 300 units means that close to 800 housing units will be converted with the budget commitment.⁴⁶

42. Keith McBain, Master’s Thesis presentation to the World Study Group on Elder Law, November 2006. His comments noted that AL in BC was designed for a demographic group 15 years younger and more physically able than the actual residents of AL in BC, who tend to be older (80s) and more frail.

43. S.B.C. 2002, c.78 (as am. by Bill 27, *Tenancy Statutes Amendment Act, 2006*, 2d Sess., 38th Parl., British Columbia, 2006) [RTA].

44. CCA, *supra* note 40, s. 1.

45. *Seniors’ Supportive Housing Program Overview*, online: BC Housing <<http://www.bchousing.org/programs/SSH#SSHoverview>>.

46. *What we do*, online: BC Housing <<http://www.bchousing.org/aboutus/activities>>.

More care is provided through a specific “Assisted Living” framework. The legislation defines AL as “premises or part of a premises, other than a community care facility in which housing, hospitality services and at least one, but not more than two, prescribed services are provided by or through the operator to 3 or more adults who are not related by blood or marriage to the operator of the premises,”⁴⁷ or a place otherwise designated by the Lieutenant Governor in Council.

AL in BC is more commonly considered as providing “hospitality services and personal assistance services for adults who can live independently but need help with day-to-day activities.”⁴⁸ AL operators in BC offer meals, housekeeping, laundry, social and recreational activities, and a 24-hour response system.

Personal assistance services include: activities of daily living, medications, therapeutic diets, purchases or paying bills, psychosocial rehabilitation or intense physical rehabilitation, structured behavioural programs.⁴⁹

In BC, the terminology used to describe the type of housing with the *most care* is a “residential care facility”.⁵⁰ In the recent past, other words have been used, and the use of terminology to describe this type of care is still uneven. Past terms have included “complex care”, “institutional care”, and “long-term care”.

4. RESIDENTIAL TENANCY APPLICABILITY

As noted above, the RTA does not currently cover “supportive living” and AL, as the amendments that would bring them under these auspices are not yet in force.

5. CONSUMER PROTECTION

This is a significant gap in BC legislation. There are no specific consumer protection rights or coverage in BC’s SH / AL legislative scheme.

6. FUNDING

SH / AL is funded primarily through regional health authorities, in a mix of public and private funding. BC Housing is the provincial body which oversees and funds low-income SH / AL. Typically residents pay 70% of their after tax income. The

47. CCA, *supra* note 40, s. 1.

48. *Services Offered in Assisted Living Residences*, online: Office of the Assisted Living Registrar <<http://www.health.gov.bc.ca/assisted/about/services.html>>.

49. *Community Care and Assisted Living Regulation*, B.C. Reg. 6/2006, s. 2.

50. CCA, *supra* note 40, s. 1.

rates are between \$29.90 and \$71.80 a day depending on income.⁵¹ Funding and operations can exist within a public-private partnership.

In a 2004 media release BC Housing noted that:

with this partnership, private operators build and manage the developments, BC Housing subsidizes the rent, and regional health authorities fund personal care services and some of the hospitality costs to help seniors with daily activities like bathing and medications. About 1,000 rent supplements will be offered in assisted living developments throughout B.C., run by private operators with a solid track record managing seniors' housing. This partnership works especially well in rural areas where fewer subsidized units are required, and in communities with tremendous demand to open units quickly.⁵²

For-profit private pay AL does exist in BC, and rates in these facilities varies widely. In private-pay residences, charges may exist on a fixed rate package of services, or on a fee-for-service basis.⁵³

7. COMPLAINT / DISPUTE RESOLUTION⁵⁴

Generally, the philosophy of SH / AL in BC is that of less regulation, rather than more. Ironically, however, it is actually one of the highest "legislated" frameworks in the country.

However, to adhere to the philosophy, SH / AL's model is "complaints-based" rather than one of inspection. While a medical health officer can investigate complaints that a community care facility is not operating in compliance with the CCA,⁵⁵ the AL Registrar pursuant to the CCA, s. 25, conducts complaints or investigations on AL. This position does have some power, including the power to fine an operator, or to

51. *Fees for Services*, online: Ministry of Health <<http://www.health.gov.bc.ca/hcc/fees.html#residentialfees>>.

52. "Private sector helps make assisted living accessible", *The Future of Housing and Care Supplement* – December 2004 online: <<http://www.bchousing.org/news/Stories/private>>.

53. *Private Pay Assisted Living*, online: Office of the Assisted Living Registrar <<http://www.health.gov.bc.ca/assisted/about/types.html>>.

54. This section is more in-depth than some other jurisdictions, reflecting the fairly well developed scheme for complaints and reporting through the Office of the Assisted Living Registrar. Much of this content borrows heavily from public information of the complaints and investigation processes available online: Office of the Assisted Living Registrar <<http://www.health.gov.bc.ca/assisted/complaints.html>>. The authors would like to thank Susan Adams, Assisted Living Registrar of BC, for her assistance on the BC section.

55. CCA, *supra* note 40, s. 15.

cancel an operator's AL registration.⁵⁶ The AL Registrar does not have purview over SH residents, which leaves a gap in the complaints system.

While there are safeguards in the CCA pursuant to s. 22 preventing a complainant resident from having their tenure discontinued or otherwise threatened, some people maintain that those who complain may still justifiably fear reprisal. Further, in cases where their housing options are limited by geography and availability, complaining may seem a dangerous position to take for a resident.

A thorough information kit is available online at the Office of the Assisted Living Registrar about complaints. Some key points include, "complaints can be made: by a resident, a family member or friend of a resident, residence staff, health authority staff, or a member of the public, by phone, email, fax or in person."⁵⁷

The Office of the Assisted Living Registrar investigates complaints in a fair and transparent manner, and upon a complainant's request will maintain their confidentiality. The purpose of complaint investigation is remedial: to ensure that the residence operator complies with the Health and Safety Standards, or brings their facility into compliance. When investigating complaints the approach used is to ensure resident health and safety during the investigation, to promote good operating practices, and to intervene in the case of unacceptable practices. If the Office of the Assisted Living Registrar has purview and jurisdiction over the issue it will determine the best approach for investigating the complaint. Jurisdiction includes intervention in cases when:

- A facility is operating in a way that puts the health or safety of a resident at risk.
- A resident is unable to make decisions on his own behalf — the operator may be housing a resident who is unable to make the decisions needed to function safely in the semi-independent supportive environment of an assisted living residence.
- An unregistered assisted living residence is in operation.

The Registrar cannot investigate complaints related to:

56. *Ibid.*, s. 27.

57. The following section is an overview of more extensive information available online: Office of the Assisted Living Registrar <<http://www.health.gov.bc.ca/assisted/complaints.html>>.

- Tenancy issues — the OALR does not deal with complaints such as failure to refund damage deposits or increases in rent without notice. The OALR refers tenancy complaints to the Residential Tenancy Branch.
- Operating issues — the OALR is not authorized to deal with complaints about issues such as residence staff, management-staff relations, or services (e.g., dissatisfaction with meals) unless the complaint relates to the health or safety of a resident. These types of complaints must be resolved directly with the assisted living operator.
- Community care facilities — the OALR does not have authority to investigate complaints about community care facilities. Nor does the OALR have jurisdiction to investigate whether an assisted living operator is offering more than two prescribed services and is therefore operating an unlicensed community care facility contrary to the *Community Care and Assisted Living Act*. The OALR refers such complaints to the appropriate Community Care Facilities Licensing office.
- Case manager's assessments — the OALR does not deal with complaints about people who a case manager has assessed as being ineligible for publicly subsidized assisted living. The OALR refers complaints about case manager assessments to the regional health authority.

Responses may include education of the operator or complainant, the request of documents and / or an onsite inspection. If the operator is non-compliant, the progressive enforcement is used, which may include education, conditions to an operator's registration, changing the conditions of a registration and, in more dangerous situations, suspending or cancelling a registration. If the OALR finds that an operator is operating an unregistered assisted living residence and the operator either refuses to register the residence or applies to register but is unable to comply with the Health and Safety Standards, then the operator may be subject to fines.

The purpose of a site inspection is to ensure compliance with the Health and Safety Standards. The OALR may conduct a site inspection if it believes that an unregistered assisted living residence is being operated, or that the health or safety of a resident is at risk. Inspections may also take place when the OALR is processing an application for registration.

The Assisted Living Coordinator and a peer reviewer conduct the inspections. The inspectors:

- Make observations and collect information about whether the operator is complying with the standards. The process is transparent and intended to be educational for the operator.
- Review their observations with the site manager and highlight any areas of non-compliance.

If deficiencies are identified, the operator must bring the residence into compliance within an agreed-upon time. If the operator does not bring the residence into compliance, the OALR uses progressive enforcement.

8. STAFFING INDICATORS

While the *Adult Care Regulations*⁵⁸ (ACR) indicate no specific staffing levels, they require that staffing be “sufficient to meet hospitality service needs of residents and deliver the personal assistance services offered.”⁵⁹

Staff who provide personal assistant services are required to have a home support / care aide certification.⁶⁰ Section 6.1 of the ACR also requires that the operators ensure that staff have the “personality, ability and temperament,” and “training and experience necessary to carry out duties.”⁶¹ Staff must be “physically and mentally competent to carry out duties assigned.”⁶²

In order to ensure medication safety, an operator must have a supervising pharmacist on a medication and safety advisory committee.⁶³

9. ENTRY / EXIT CRITERIA

Protocols for entering a SH / AL facility depends on whether it is a private pay model or a one funded by government subsidies. A SH / AL resident moving into a private pay setting may do so on the basis of the private contract of the residence. If the client of SH / AL requires a subsidized funding space, then an interview for

58. ACR, *supra* note 41.

59. *Ibid.*, s. 6.8.

60. Ministry of Health, *Registrant Handbook: Health and Safety Standards* online: Office of the Assisted Living Registrar <http://www.health.gov.bc.ca/library/publications/year/2007/handbook_Health_and_Safety_Standards.pdf> at 15 [Registrant Handbook].

61. ACR, *supra* note 41, s. 6.1.

62. *Ibid.*

63. *Ibid.*, s. 8.1.

assessment will be conducted by a case manager representative of the prospective resident's health authority.

Foundational to AL in BC is the notion that residents must be able to make decisions on their own behalf.⁶⁴ The exception to this rule is if the incapable person is residing with a spouse who can make decisions for them.

As noted above, AL in BC was designed for a much younger and more able population than actually resides within its housing today. As such, the governing legislation is quite strict on exiting an AL if more than 2 prescribed services are needed by a resident. This requirement created a serious break in the health / housing continuum, as entry to residential care has a very high bar of need. In the interim, a policy has been extended allowing AL residents to use increased supports including outside sources of assistance while in a transitional phase from AL to another form of housing more appropriate to the resident's increased health care needs. Increased supports may also be sought and allowed during convalescence.⁶⁵

When the care needs exceed the capability of an AL residence to provide service, or when a resident loses the ability to make their own decisions (and does not reside with someone else who can), an exit plan must be created, in consultation with the resident, the doctor, family, support networks, and the health authority case manager.⁶⁶

B. Alberta

1. MAIN LEGISLATION

The main legislation in Alberta's regulation of SH / AL is the *Nursing Homes Act*⁶⁷ with its associated regulations, the *Nursing Homes General Regulation*⁶⁸ (NHR) and the *Nursing Homes Operation Regulation*⁶⁹ (NHOR). Alberta envisions SH / AL, which is known collectively as "supportive living" as the middle ground between "home living" and "facility living". Generally, the Alberta Seniors and Community Supports (ASCS) has purview over the government's role in providing accommodation

64. CCA, *supra* note 40, s. 26 (3).

65. *Frequently Asked Questions*, online: Office of the Assisted Living Registrar <http://www.health.gov.bc.ca/assisted/faq.html#e_e>.

66. Registrant Handbook, *supra* note 60 at 16.

67. R.S.A. 2000, c. N-7 [NHA AB].

68. Alta. Reg. 232/1985 [NHR].

69. Alta. Reg. 258/1985.

services including meals, housekeeping, and laundry. The ASCS has developed a framework of “accommodation standards”.⁷⁰

Alberta Health and Wellness has purview over publically funded health care services and has developed “Continuing Care Health Service Standards.”⁷¹

In Alberta, “supportive living” is licensed pursuant to the *Social Care Facilities Licensing Act*⁷² which requires compliance with the Supportive Living Accommodation Standards, which are divided into nine parts: physical environment, hospitality services, safety services, personal services, coordination and referral services, residential services, human resources, management, and administration.⁷³

The following relevant facilities are not licensed under the *Social Care Facilities Licensing Act*, however they are still required to follow the accommodation standards:⁷⁴

- Lodges as defined in the *Alberta Housing Act*⁷⁵
- Nursing homes under the *Nursing Homes Act*⁷⁶

Alberta has undergone significant policy analysis in the continuum of health / housing. The Broda Report entitled “Healthy Aging: New Directions in Care”⁷⁷ supported the goal of unbundling health, social services and housing services, with the goal of allowing people to make “choices about what they need regardless of where they live”.⁷⁸ The Auditor General also issued a key report in May 2005,

70. Government of Alberta, *Supportive Living Accommodation Standards* (March 2007) online: Seniors and Community Supports <<http://www.seniors.gov.ab.ca/housing/continuingcare/SLAS/default.asp#others> at 1> [AB Standards].

71. *Ibid.*

72. R.S.A. 2000, S-10.

73. AB Standards, *supra* note 70.

74. *Ibid.*

75. R.S.A. 1994, S-25.

76. NHA AB, *supra* note 67.

77. Policy Advisory Committee on Long Term Care, *Health Aging: New Directions for Care* (November 1999) online: Alberta Health and Wellness <http://www.health.alberta.ca/key/lt_aging.pdf> [Final Report AC].

78. *Ibid.* See also Seniors and Community Supports, *Supportive Living in Alberta*, presentation online:

entitled “Report of the Auditor General on Seniors Care and Programs”.⁷⁹ This report found that there was a “lack of updated standards to improve care in LTC facilities”; that seniors’ “lodge standards were out of date”; that there were “no supportive living standards” and a “lack of monitoring mechanisms of compliance”.⁸⁰ The Alberta government responded by forming a Task Force in May 2005 to conduct consultations, review quality of health and accommodations across the health / housing continuum, and to receive comments on a draft supportive living framework.⁸¹

In 2006, the government of Alberta approved the “Supportive Living and LTC Standards” and the “Supportive Living Framework.” In 2007, supportive living facilities began being licensed by the province, which included being monitored using Supportive Living and LTC Standards.⁸²

Supportive Living as a whole is conceptually divided in Alberta on the basis of resident need and services offered:⁸³

Residential Living – Level 1⁸⁴

Resident Need	Services Offered
Can arrange, manage and direct own care and is responsible for decisions about day-to-day activities.	<i>Meal Services</i> At least one meal per day is available.
Can manage most daily tasks independently.	<i>Housekeeping Services</i> Services are available.
Some supports/services are required	
All personal assistance can be scheduled.	<i>Personal Laundry</i> Personal laundry equipment is available.

Seniors Services Conference <http://www.seniors.gov.ab.ca/services_resources/workshop/supliving.pdf> [SL Slideshow].

79. Auditor General of Alberta, *Report of the Auditor General on Seniors Care and Programs* (May 2005).

80. *Supra* notes 78 & 79.

81. MLA Task Force on Continuing Care Health Service and Accommodation Standards, *Final Report: Achieving Excellence in Continuing Care* (November 2005). See also SL Slideshow, *supra* note 78.

82. AB Standards, *supra* note 70.

83. SL Framework, *supra* note 14, at 6.

84. This chart is largely mapped from the Supportive Housing Framework, *ibid.* at 6 and 7, in a slightly modified format.

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Resident Need	Services Offered
Primary needs housing for safety, security and socialization.	Personal laundry services may be available. Laundry and Linen Services Laundry and linen services may be available. Safety & Security 24-hour security is provided. Social, Leisure & Recreational Opportunities Services may be available. Coordination and Referral Services to Community Supports Guidance/Advocacy/Advisory role may be available. Assistance with accessing community services may be available. <i>May be Available</i> – Housing operators may or may not have the ability or capacity to co-ordinate this service with residents. <i>Is/Are Available</i> – The housing operator has the capacity to provide the service directly or arrange for its delivery by another source, if the resident needs or wants the service. <i>Provided</i> – These are the services that the housing operators supply to meet residents' needs.

Lodge Living – Level 2

Resident Need	Services Offered
Can arrange, manage and direct own care and is responsible for decisions about day-to-day activities.	Meal Services Full meal services are available (<i>2 meals if kitchenette in suite</i>).
Can manage some daily tasks independently.	
A basic set of supports/services is required.	Housekeeping Services Weekly services are available.

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Resident Need	Services Offered
All or most personal assistance can be scheduled. May require some assistance / encouragement to participate in social, recreational and rehabilitation programs.	<i>Personal Laundry</i> Personal laundry equipment is available. Personal laundry services may be available. <i>Laundry and Linen Services</i> Weekly laundry and linen services are available. <i>Safety & Security</i> 24-hour staff on site. Personal response system is provided. <i>Social, Leisure & Recreational Opportunities</i> Services are available. <i>Coordination and Referral Services to Community Supports</i> Guidance/Advocacy/Advisory role is provided Assistance with accessing community services is provided.

Assisted Living – Level 3

Resident Need	Services Offered
Has choices but may need assistance in making some decisions about day-to-day activities. Requires assistance with many daily tasks. Most personal assistance can be scheduled. The need for unscheduled personal assistance is infrequent. May require increased assistance to participate in social, recreational and rehabilitation programs.	<i>Meal Services</i> Full meal services are available. Some special dietary requirements can be met. <i>Housekeeping Services</i> More than weekly services are available. Additional sanitization as required. <i>Personal Laundry</i> Personal laundry equipment is available. Personal laundry services are available.

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Resident Need	Services Offered
	<i>Laundry and Linen Services</i> Weekly laundry and linen services are available. <i>Safety & Security</i> 24-staff on site. Routine checking of residents as required. Personal response system as provided. <i>Social, Leisure & Recreational Opportunities</i> Services are available. <i>Coordination and Referral Services to Community Supports</i> Guidance/Advocacy/Advisory role is provided Assistance with accessing community services is provided.

Enhanced Assisted Living – Level 4

Resident Need	Services Offered
Needs assistance in making decisions about day-to-day activities, but should still be given as many choices as possible. Requires assistance with most/all daily tasks. The need for unscheduled personal assistance is frequent. Requires enhanced assistance to participate in social, recreational and rehabilitation programs.	<i>Meal Services</i> Full meal services are provided. Most special dietary needs can be met. Food/nutrition intake monitored. <i>Housekeeping Services</i> Daily services are provided. Additional sanitization as required. <i>Personal Laundry</i> Personal laundry equipment is available. Personal laundry services are available. <i>Laundry and Linen Services</i> Weekly laundry and linen services are available.

Assisted Living: Past, Present and Future Legal Trends in Canada

Resident Need	Services Offered
	<i>Safety & Security</i> 24-staff on site. Routine checking of residents as required. Personal response system as provided. <i>Social, Leisure & Recreational Opportunities</i> Services are available. <i>Coordination and Referral Services to Community Supports</i> Guidance/Advocacy/Advisory role is provided Assistance with accessing community services is provided.

2. ANCILLARY LEGISLATION

*Social Housing Accommodation Regulation*⁸⁵ (SHAR) also governs this area of housing. The SHAR provides detailed governance on issues such as eligibility of social housing and gives definitions or parameters on such key terms as “senior household”, “functionally independent”, and “assets”. The SHAR has detailed information on how to apply for social housing accommodation, and how basic rent is set.

Part 3, sections 10 – 12⁸⁶ particularly govern issues associated with Seniors Lodge Accommodation, including eligibility, lodge rates (determined by the lodge annually), pro-rated refunds of the lodge rate if residents must leave the accommodation, and provisions allowing for lodges to charge for additional services.

Part 3, sections 13 (1-2) govern “Seniors Self-Contained Housing Accommodation” which includes any type of housing accommodation, with full services, intended to be used by one or more “senior households” (defined above).

85. Alta. Reg. 244/1994 [SHAR].

86. *Ibid.*

3. LEXICON / PARAMETERS OF CARE

(a) *Lesser Care*

Alberta has been quite diligent in providing specific definitions for the terms it uses. The following are taken directly from policy frameworks:

Supportive housing / lodge accommodation “combines accommodation or housing and hospitality services with other supports and care. Supportive living operators are responsible for coordinating and arranging hospitality services and may coordinate or provide personal care and other support services”.⁸⁷

There are many definitions of “Assisted living” and “Supportive Housing”. Neither of these terms is protected in Alberta and can be used by housing operators at their own discretion. In the broadest sense, they both refer to the combination of housing and services in a residential setting. The services that are included in the rent or are otherwise available for purchase vary from building to building.

Supportive Living means a philosophy and an approach for providing services within a housing environment. It provides a home-like setting where people can maintain control over their lives while also receiving the support they need. The building is specifically designed with common areas and features to allow individuals to “age in place”. Building features include private space and a safe, secure and barrier-free environment. Supportive living promotes residents’ independence and aging in place through the provision of services such as 24-hour monitoring, emergency response, security, meals, housekeeping, and life-enrichment activities. Publicly funded personal care and health services are provided to supportive living residents based on their assessed unmet needs.⁸⁸

A household or member must be functionally independent, meaning “physically and mental self-sufficient” to qualify for Lodge accommodation.⁸⁹

(b) *Most Care*

Nursing homes, sometimes described as Facility Living, “includes long-term care facilities (e.g. nursing homes and auxiliary hospitals) that provide care for individuals whose health needs are such that they are unable to remain at home or

87. SL slideshow, *supra* note 78.

88. SL Framework, *supra* note 14, at 9.

89. SHAR, *supra* note 85, ss. 1 & 10.

in a supportive living situation.”⁹⁰ Basic Care is defined by legislation to include “accommodation and meals, facilities services, necessary nursing services, personal services, therapeutic and special diets as required, routing and emergency drug and medicine, routine dressings, life enrichment services.”⁹¹

4. RESIDENTIAL TENANCY APPLICABILITY

The Supportive Living Framework notes “in most supportive living settings, residents apply directly to the housing operator for tenancy”.⁹² The word “tenancy” is used throughout Alberta materials to refer to this relationship.

Section 2 (2) (f) of the *Residential Tenancies Act*⁹³ (RTA) specifically excludes nursing homes as defined in the *Nursing Homes Act*. Section 2 (2) (g) of the RTA excludes lodge accommodation as defined in the *Alberta Housing Act* that is operated:

- (i) by a management body under a ministerial order under section 5 of that Act, or
- (ii) under an agreement with the Minister responsible for that Act.

Section s. 2 (2) (h) of the RTA excludes social care facilities licensed under the *Social Care Facilities Licensing Act*.

Despite these exclusions, the use of the language of tenancy otherwise throughout might allow for a challenge to these statutory exclusions.

5. CONSUMER PROTECTION

There are no special considerations for consumer protection issues for SH / AL in Alberta.

6. FUNDING

SH / AL costs are generally set by the management of the accommodation, and are reviewed annually.

90. SL slideshow, *supra* note 78.

91. NHR, *supra* note 68, s. 2.

92. SL Framework, *supra* note 14.

93. S.A. 2004, c. R-17.1.

Alberta works on a system of “unbundled costs,” which means that health costs are separated from accommodation costs. Typically a resident will pay the accommodation cost, and the government will pay the health costs. The services that fall under each category are determined by the province. Alberta also provides some low-income residents with income supports.⁹⁴

Currently in Alberta, the maximum fees for the accommodation portion of long term care are:

- Private room: \$54.25/day
- Semi-private: \$47.00/day
- Standard ward room: \$44.50/day⁹⁵

However, s. 12 of the SHAR allows for Seniors Lodges to charge additional costs for services or facilities. The attempted goal of the Alberta Seniors’ benefit is to ensure that each senior has \$265 per month in disposable income.⁹⁶

7. COMPLAINT / DISPUTE RESOLUTION

Alberta is working on a public reporting system for SH / AL.⁹⁷ Currently in supportive living environments, an operator must ensure that there is a “clearly documented process in place for concerns/complaints resolution.”⁹⁸

The Government of Alberta has launched a website that allows the public to see reports for inspection records.⁹⁹ Pursuant to s. 12 of the NHA, an inspector may ensure compliance with the governing legislation including issues of health, safety, and well-being.

There is no clear resolution for tenancy-type issues in Alberta. However, if an inspector identifies an area of concern outside of her mandate, she may “notify the

94. SL slideshow, *supra* note 78.

95. *Long-Term Care Accommodation Fees*, online: Alberta Seniors And Community Supports <<http://www.seniors.gov.ab.ca/housing/LTCare/index.asp>>.

96. *Ibid.*

97. Final Report AC, *supra* note 77.

98. AB Standards, *supra* note 70, Standard 25.3 at 19.

99. *Supportive Living Public Reporting*, online: Seniors and Community Supports <<http://asalreporting.gov.ab.ca/astral/>>.

appropriate regulatory body responsible for the area of concern, such as a municipal safety codes department, to inform them of the potential concern”.¹⁰⁰

8. STAFFING INDICATORS

In Alberta, supportive living staff must always have an employee trained in emergency first aid on site.¹⁰¹ Additionally, all employees, volunteers, and service providers must have criminal record checks.¹⁰²

In long-term care “facility living”, a facility must have a director of nursing who is a registered nurse or certified graduate nurse. Additionally a registered nurse or certified graduate nurse must be on duty or on call at all times. The facility must have at least two people on duty at a time, and each resident must get 1.90 paid hours of combined nursing and personal services per day. Sections 12 – 14 of the NHOR require that 22% of all paid hours be provided by nurses.

9. ENTRY / EXIT CRITERIA

(a) Entry

In Alberta, a supportive living operator must ensure that the residents meet eligibility requirements. Operators must have in place systems and policies associated with application, move-in and orientation, charge information, a list of optional personal services, notice of price increases, exit criteria, and a dispute resolution process.¹⁰³ Operators must assess new residents for ability, safety, and suitability.¹⁰⁴

For higher needs facility living institutions, an operator must provide resident with move-in orientation, monthly charges with a list of included services, personal service charges, notice period for any rate increases, policies and forms regarding resident’s expensive or sentimental objects, policies and forms relating to money held by operator, and the complaints / concerns resolution process.¹⁰⁵

100. *Supportive Living Public Reporting FAQs*, online: Seniors and Community Supports <<http://asalreporting.gov.ab.ca/astral/help.htm>>.

101. SL Standards, *supra* note 70, Standard 28.3 at 21.

102. *Ibid.*, Standard 30 at 21.

103. *Ibid.*, Standard 25.1 at 19.

104. *Ibid.*, Standard 26.1 at 20.

105. *Ibid.*, Standard 24 at 16-17.

(b) Exit

In supportive living, an operator must give exit criteria to residents when they enter.¹⁰⁶ As only persons able to “manage” both physically and mentally may enter Alberta supportive living, it appears that like BC, the higher care needs including mental incapability, will be central to exit criteria.

For higher needs facility living, residents may be discharged from a nursing home when they no longer need basic care. This is decided by attending physician and assessment committee. After discharge, the benefits will no longer be paid to home, and pursuant to s. 11 of the NHR, the resident will be liable for entire cost of nursing home care if they fail to leave the home.

C. Saskatchewan

1. MAIN LEGISLATION

The “middle option” of SH / AL in Saskatchewan is delivered through a combination of three options:

- privately owned and operated “personal care homes”
- assisted living, pursuant to the Saskatchewan Assisted Living Services Program (SALS)
- “enriched” assisted living (retirement living)

Saskatchewan does not have specific SH / AL legislation. In this province, the main legislation is the *Personal Care Homes Act*¹⁰⁷ and its *Personal Care Homes Regulations, 1996*¹⁰⁸. This governs personal care homes only, and does not govern the other two options (SALS or enriched AL/ Retirement living).

SALS is available in selected social housing projects for seniors in 70 communities throughout the province.¹⁰⁹ SALS is a public / private partnership that is narrowly prescribed and is available where offered for persons in subsidized housing requiring assistance.

106. *Ibid.*, Standard 25.1 at 19.

107. S.S. 1989-90, c. P-6.01.

108. R.R.S., c. P-6.01 Reg. 2 [PCHR].

109. Provincial Advisory Committee of Older Persons, *Housing Options for Saskatchewan Seniors* (Saskatchewan Health, January 2006) [Housing options for SK seniors].

SALS services may include: a maximum of one meal per day served in a common eating area; laundry and housekeeping services; a personal response service for unscheduled needs; and co-ordination of social/recreational, and other activities. All services are optional. SALS tenants choose which services they wish to receive and pay the direct cost of those services.¹¹⁰

Costs are kept affordable to low and moderate-income persons through administrative support from the Saskatchewan Housing Corporation and through co-ordination, co-operation, and bulk delivery at the local level.¹¹¹

The third option, which has only recently become available in Saskatchewan, is often referred to as “enriched” AL or “retirement living”. Private developers have built complexes where seniors live in individual suites, and which may include three meals per day, laundry, and housekeeping services as part of the rent. Additionally, other services may be provided depending on the complex. Amenity space is usually available for social/recreational activities, and scheduled transportation to local community shopping centres, etc. is usually provided.¹¹²

2. ANCILLARY LEGISLATION

Ancillary legislation in Saskatchewan includes the *Housing and Special-Care Homes Act*¹¹³ that governs nursing-type facility care, and its associated regulations, in specifically the *Special-care Homes Rates Regulations*,¹¹⁴ and the *Housing and Special-care Homes Regulations*.¹¹⁵

110. *Ibid.*

111. *Saskatchewan Assisted Living Services (SALS)*, online: Social Services <<http://www.socialservices.gov.sk.ca/Default.aspx?DN=b9bed0e1-12cd-4027-b7c1-9539fe66da8c>> [About SALS].

112. Charmaine Spencer, “Canadian Care and Protection Laws and Regulations: Saskatchewan” a part of *A Way Forward: Promoting Promising Approaches to Abuse Prevention in Institutional Settings* online: <<http://elderabuse.aging.utoronto.ca/>> at footnote 2 [Spencer SK].

113. R.S.S. 1978, c. H-13.

114. R.R.S., c. H-13 Reg. 2.

115. Sask. Reg. 34/66.

3. LEXICON / PARAMETERS OF CARE

(a) *Lesser Care*

Saskatchewan Assisted Living Services is a limited program run in subsidized housing for those with low incomes.¹¹⁶ SALS is run by local housing authorities. It is limited in scope and provides “lesser care” than personal care homes. SALS generally offers 5 options: up to one meal a day, laundry, housekeeping, personal response service for unscheduled needs, co-ordination of services and activities. All services are optional and tenants choose from a menu of services. (e.g., cost of meals – \$7.50 and housekeeping and laundry for \$11.50).

Use of the term “assisted living” in Saskatchewan connotes a lesser amount of care, rather than of being on the “upper end” of a SH health / housing continuum.

(b) *More Care*

“Personal Care Homes” (PCH) provide assistance or supervision with personal care, but do not offer the heavy health services of SCH.¹¹⁷ Included in the activities of daily living are help with activities such as eating, bathing, dressing, grooming, and participating in social and recreational activities.¹¹⁸ PCHs require a license but are privately owned and operated facilities. PCH residents do not usually require a high level of care; however, PCHs may be able to accommodate residents with higher care needs, more likely to be found in a special care home.

(c) *Most Care*

“Special Care Homes” are nursing-type residential care facilities for people with heavy care needs. This may include seniors but is not specifically limited to an age group. In general, “persons requiring higher levels of care use special-care home services. The primary role of the publically subsidized special-care home system is to meet the needs of individuals with heavy care needs that cannot be met through home care, housing or other community-based options”.¹¹⁹

116. About SALS, *supra* note 111.

117. Housing options for SK seniors, *supra* note 109 at 7.

118. PCHR, *supra* note 108, s. 2.

119. Housing options for SK seniors, *supra* note 109 at 5.

4. RESIDENTIAL TENANCY APPLICATION

Section 5 (d) (ii) of the *Residential Tenancies Act*¹²⁰ (RTA) specifically excludes personal care homes. The RTA's regulations¹²¹ also specifically excludes the following:

Non-application of Act

3 For the purposes of clause 5(f) [prescribed tenancy agreements, rental units or residential property] of the Act, the Act does not apply to: ...

(b) living accommodation that includes the provision of meals in the consideration paid by the tenant for the rental unit, but only if the rental unit is offered exclusively to tenants who are over 55 years of age.

However, the RTA will apply to SALS. SALS is essentially subsidized low-income housing with a few additional services.¹²² It appears likely that enriched assisted living / retirement villages also appear to fall within the RTA.

5. CONSUMER PROTECTION

There are no specific consumer protection provisions in place to cover this "middle ground" of health / housing in Saskatchewan.

6. FUNDING

SALS programs exist in subsidized housing only, where resident pay rent based on a percentage of the annual income of all individuals living in the suite. Residents must pay for cost of services used, although the coordination is free, and the services are all optional.¹²³ In January 2006, the sliding scale of rent was between 25% and 29%.¹²⁴

120. S.S. 2006, c. R-22.0001.

121. *Residential Tenancies Regulations, 2007*, R.R.S. c. R-22.0001 Reg. 1.

122. Hall, *supra* note 13 at 26.

123. About SALS, *supra* note 111.

124. Housing options for SK seniors, *supra* note 109 at 3.

PCHs are funded privately, and the related costs vary.¹²⁵

In SCHs “residents pay an income-tested charge based on annual income, plus earned interest. Personal assets such as land, houses, bank accounts etc are not taken into account.”¹²⁶

7. COMPLAINT / DISPUTE RESOLUTION

Pursuant to s. 11 of the PHCA, a PCH can be inspected. If there are reasonable grounds that the Act has been offended the inspector has increased investigatory power.

Typically the complaint investigation process is as follows:¹²⁷

- a. The complainant completes and submits the complaint form to the Personal Care Home Program
- b. A Personal Care Home Consultant reviews all of the information and conducts an investigation. Contact with other parties may be necessary
- c. If the complaint is founded, the Personal Care Home Consultant works with the Operator to gain compliance with the legislation
- d. The complainant is notified upon conclusion of the investigation.

It is notable that the available information specifically states that the investigation may take several months depending on the complexity of the complaint. The following is the warning on the standard complaint form:

Licensed personal care home operators are required to provide safe and adequate care to the residents in their home. The information you have provided will assist Saskatchewan Health officials in determining if the Licensee is providing safe and adequate care to their residents. While most complaint investigations are used to educate Licensees and staff to ensure they understand the requirements of the legislation, some investigations result in appropriate action being taken against a personal care licence, i.e., amendment, suspension or cancellation of the licence. Please be advised that every effort is being taken to keep your name confidential (if

125. *Personal Care Homes*, online: Saskatoon Health Region <http://www.saskatoonhealthregion.ca/your_health/ps_cpas_personal_care_homes.htm>.

126. Housing options for SK seniors, *supra* note 109 at 5. Fees ranged from \$956 to \$1,815 per month.

127. *Personal Care Homes Complaint Reporting Form*, online: Saskatchewan Health <<http://www.health.gov.sk.ca/personal-care-home-complaint>> [PCR Reporting Form]; This section follows the format found in Spencer SK, *supra* note 112 at 10.

this is your preference), however, during the course of the investigation, your identity may be assumed by or disclosed to the Licensee or their legal counsel in the interest of administrative fairness. By completing and signing this form, you are consenting to the release of your name and the details of your concerns to the Licensee or their legal counsel during the course of the investigation or follow-up enforcement, or any legal proceedings.¹²⁸

It is unclear as to how complaints are dealt with substantively within the SALS program or “enriched assisted living” / retirement living complexes. Standards are in place and there are responsibilities to uphold the standards; however, processes around complaints seem largely unregulated.

8. STAFFING INDICATORS

In PCHs, the licensee must provide the care to residents that are required to meet the individual needs of each resident. Where specialized care is required, s. 22 of the PCHR requires that the care be provided by a health care professional (L.P.N., R.N., or M.D.) or alternately be provided by a person *trained* by a health care professional.

IN PCHs there needs to be “sufficient care staff”. Facilities with between 21 and 30 residents require one or more care aides present not less than 5 days per week; those with more residents require one or more health care professional at least 5 days per week.¹²⁹

Details of staffing requirements at PCHs are prescribed in the PCH Handbook as follows:¹³⁰

When you hire staff, it is important to take the time to ensure that the applicant has the skills, character and ability to provide safe and adequate care to your residents. You can do this by interviewing the applicant, doing a criminal record check and contacting references. As the licensee, you must ensure that:

- Staff are on site at the personal care home 24 hours each day;
- There are sufficient care staff on duty at the home to meet the care needs of each resident at all times and to carry out all plans (e.g. evacuation plan or lost resident plan, etc.);

128. PCR Reporting Form, *supra* note 127.

129. PCHR, *supra* note 108, s. 24.

130. Community Care Branch, *Personal Care Homes Licensees' Handbook* (January 2005) online: <<http://www.health.gov.sk.ca/adx/asp/adxGetMedia.aspx?DocID=549,94,88,Documents&MediaID=1515&Filename=personal-care-home-licencees-handbook.pdf>> at 23 – 25 [Licensees' Handbook].

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- In homes with 10 or fewer residents, you or your staff must be available to aid the residents at night if the resident needs assistance (if using electronic monitoring of any kind you must ensure the residents' right to privacy is respected at all times);
- In homes with 11 or more residents, the staff must be awake at night;
- Only adult persons supervise or provide care to residents;
- No resident is designated to supervise or care for another resident;
- All staff of the home are in good health, free from communicable diseases, and physically and mentally capable of performing the services and duties assigned;

This is personal health information and must be kept confidential; however, it may be disclosed to your personal care home consultant. It may not be disclosed to anyone else except with the permission of the individual.

- The resident is comfortable with the gender of the caregiver giving intimate personal care;
- Staff can communicate effectively verbally and in writing; and
- All staff maintain a satisfactory criminal record check (CRC). You must obtain and screen a CRC: before hiring; if you believe a staff member has been arrested, charged or convicted of a criminal offence; and at least every 3 years.

b) How do you screen a criminal record check (CRC)?

The presence of a criminal record does not automatically disqualify a potential employee. You will need to consider the nature of the offence and its relevance to the position being sought.

Ensure the CRC is current and the information is complete. For example, if a potential employee has a criminal record, it must state what he was charged with.

You may consider employing a person with a criminal record once you have reviewed:

- The nature of the offence and its relevance to the safety of vulnerable adults;
- The length of time between the conviction and the time of the search result;
- The age of the applicant at the time of the offence;
- The details of the offence(s), the number of offences and any patterns of offences;
- Any steps taken by the applicant to rehabilitate or prevent reoccurrences;
- Employment history;
- The applicant's ability to live by the rules of the law and society since the conviction; and
- Any other information that is necessary.

Once you hire staff, they will need to sign a statement (see Appendix A – Employee Acknowledgement of Conditions of Employment Regarding Criminal Record Checks) indicating that they understand that they must:

- Maintain a satisfactory criminal record;
- Inform you within two days if they were arrested or charged with a criminal offence; and
- Submit a satisfactory CRC at least every 3 years.

In SCHs, an RN or RPsychN must be hired full time. SCHs require a 1:7 nurse to ancillary staff ratio pursuant to s. 4 of the HSCR.

9. ENTRY / EXIT CRITERIA

(a) *Entry*

SALS residents must be low-income social housing tenants and fall within the SALS guidelines.

In PCHs, residents must be reassessed every two years, pursuant to s. 14 of the PCHR. Also to comply with section 15 of the PCHR, a care plan must be created in the first seven days a resident is in a home. At entry, PCHs residents must be given a detailed admittance agreement that lays out details of the care, payments, terms and conditions of residency.¹³¹ The PCH handbook also requires that upon admission, residents be asked the “necessary questions” to ensure that the housing is appropriate and that it can provide safe and adequate care.¹³² The PCH handbook also requires that an operator talk to the resident, their supporters, the assessment agency, the previous caregivers or anyone else involved in the resident’s well-being to assist in determining in the new placement is appropriate.¹³³

Residents entering into the special-care system are assessed by their local regional health authority. The RHA will place applicants based on their needs.¹³⁴

(b) *Exit*

The PCH handbook has broad instructions and guidance regarding the dismissal of a resident, as follows:

If it is determined through an assessment that the resident is eligible for placement in a special care home, hospital or health centre for the purpose of receiving long term care:

131. PCHR, *supra* note 108, s. 17.

132. Licensees’ Handbook, *supra* note 130 at 29.

133. *Ibid.*

134. Housing options for SK seniors, *supra* note 109 at 5.

- the admission agreement ends on **the third day** following the day the resident moves all of his or her belongings from the room; and
- you must refund the resident from **the third day** following the day the resident's belongings are removed from their room until the end of the month if it is a monthly agreement or the last day of the week if it is a weekly or daily agreement.

o) When might a resident leave my home?

Residents will leave your home if:

- they decide they want to move to a different place;
- they get better and do not require assistance or supervision with personal care;
- they move to a special-care home or a bed in a hospital or health centre to receive long term care;
- they need more care than what you are able to provide;
- they pass away;
- you move or close your home; or
- your licence is cancelled or suspended, or is not renewed.¹³⁵

If a resident is leaving a PCH, pursuant to s.19 of the PCHR, a needs assessment must be undertaken for the resident.

D. Manitoba

1. MAIN LEGISLATION

Manitoba's "middle option" is a combination of five types of SH / AL. Manitoba has many options, but little governing law.

These different options are very well summarized in the Senior Access Resource Manual of Manitoba as follows:

1. Manitoba Housing Authority Senior 55 Plus Apartments¹³⁶ (Sometimes referred to as Elderly Persons Housing – EPH)

- Support services vary among facilities. They may include meals, housekeeping, transportation and recreation.
- Tenants must qualify based on the Housing Income Limit.
- Rent is based on individual's/couple's total gross income.
- At least one renter must be 55 years or older.
- Mostly studio or one-bedroom apartments.

135. Licensees' Handbook, *supra* note 130 at 33-36.

136. This type of housing is limited by geographic area. A full list of where this type of housing is available can be found *ibid.* at 44-45.

2. Assisted Living Facilities

- Combine independent living with a service package that may include meals, housekeeping, laundry, transportation or other services.
- Privately owned and operated facilities, so they are not licensed or government regulated.
- Government does not subsidize daily fees, but residents may qualify for the Manitoba Shelter Benefit Program. They may also access Home Care services.

3. Supportive Housing (Winnipeg, Brandon, Steinbach and Oakbank)

- Suitable for people who can no longer live independently, but are not ready for a personal care home.
- Provides 24 personal support and supervision in a secure group community setting.
- Residents must be assessed and admitted through the long- term care/home care case coordinator of the Regional Health Authority.
- Regional Health Authority monitors facilities to make sure they meet standards, and covers the cost of the health staff.
- Costs vary depending on the facility. Resident pays for the rent and service package.
- Residents may qualify for the Manitoba Shelter Benefit Program on the rent part of the fee.¹³⁷

4. Companion Care (Winnipeg Only)

- The Winnipeg Regional Health Authority selects and monitors Companion Care providers who house seniors in their homes and provide support in daily living.
- Services are similar to supportive housing.
- Residents must be assessed and admitted through the long term care/home care case coordinator of the Regional Health Authority.
- Cost is a subsidized daily fee based on income.

5. Personal Care Homes

- Provide professional nursing and personal care services to people who can no longer live independently.
- Manitoba Health subsidizes costs so a resident's daily rate depends on income.
- The Regional Health Authority co-ordinates application, assessment and admission.

There appears to be very little in terms of governing legislation for this “middle option” in Manitoba with the exception of the *Personal Care Homes Standards*

137. Manitoba Seniors and Healthy Aging Secretariat, *Senior Access Resource Manual – Housing Module* (March 2007) online: Province of Manitoba <<http://www.gov.mb.ca/shas/publications/index.html>> [Housing Module].

*Regulation*¹³⁸ and the *Personal Care Services Insurance and Administrative Regulation*.¹³⁹ Much of the regulation is done at a lower policy level.

2. ANCILLARY LEGISLATION

Like Alberta and Nova Scotia, Manitoba has a *Protection for Persons in Care Act*.¹⁴⁰ This legislation only governs the higher end of nursing home type care, including personal care homes. The function of this legislation is to prevent abuse of residents and to create a legislative framework around abuse issues.

The *Social Services Administration Act*¹⁴¹ governs “residential care.” The *Residential Care Facilities Licensing Regulations*¹⁴² provides the specific framework for residential care.

Charmaine Spencer, in *A Way Forward*, notes that:

Residential care is a housing option that provides congregate living accommodation with care and supervision at levels defined by Manitoba Family Services and Housing (“MFSH”). Residential care facilities are licensed through MFSH. Facilities may be profit or non-profit and operated by professional or non-professional staff.

These guest homes provide care and supervision to residents who do not need the type of personal care provided by a personal care or nursing home. Certain persons with disabilities or disorders may live in the facilities. Under Manitoba law, these may include people with (a) “a mental disorder”; (b) “mental retardation”; or (c) “infirmities of aging”. Services may include room and board and assistance with medication and bathing.

The regulations require all facilities providing services to three or more persons to have a license and, and those with one or two residents are required to have a letter of approval. The facilities are regulated by the Residential Care Facilities Licensing Regulations and licensing is done by the Residential Care Licensing Branch.¹⁴³

138. Man. Reg. 30/2005 [PCHR MB].

139. Man. Reg. 52/93 [PCR MB].

140. C.C.S.M. c. P144.

141. C.C.S.M. c. S165.

142. Man. Reg. 484/88 R.

143. Charmaine Spencer, “Canadian Care and Protection Laws and Regulations: Manitoba” a part of *A Way Forward: Promoting Promising Approaches to Abuse Prevention in Institutional Settings* online: <<http://elderabuse.aging.utoronto.ca/>> [Spencer MB].

3. LEXICON / PARAMETERS OF CARE

Please refer to part 1 of this section for a more complete breakdown of terms.

(a) *Lesser Care*

Manitoba Housing Authority 55 Plus Apartments: Studios and one-bedroom apartments. Support varies among facilities – may include meals, housekeeping, transport, and rec. For low-income seniors (55+) only. Rent is based on income.¹⁴⁴

Assisted Living Facilities: independent living with a service package that may include meals, housekeeping, laundry, transportation, and other services. Unlicensed, and not subsidized by the government, but residents may qualify for Manitoba Shelter Benefit Program.¹⁴⁵

(b) *More Care*

Supportive Housing: 24-hour personal support and supervision.

Companion Care service: in only Winnipeg and is a program in which seniors move into Care providers homes and given the same types of services as supportive housing.

(c) *Most Care*

Personal Care home: “provides nursing and personal care services for people who can no longer live independently.”¹⁴⁶ Personal care regulations establish a residents’ bill of rights, residents councils, specifics of care planning, residents’ rights to participate in care, a duty on operators to develop safeguards to protect residents from abuse, a process for achieving a least restrictive approach to restraints, along with basic requirements in nursing, physician and pharmacy services.¹⁴⁷

4. RESIDENTIAL TENANCY APPLICATION

Section 3 (1) (f) of the *Residential Tenancies Act*¹⁴⁸ (RTA) specifically excludes residential care facilities and personal care homes.¹⁴⁹ However, the RTA policy

144. Housing Module, *supra* note 137.

145. *Ibid.*

146. *Ibid.*

147. Spencer MB, *supra* note 143 at 6.

148. C.C.S.M. c. R119.

notes that in cases of unlicensed residential care facilities, which are not designated as personal care homes and are not licensed as residential care facilities the RT office may intervene. What constitutes an unlicensed “supportive housing” may be inferred by the services defined, which may include: meals, transportation, organized activities, housekeeping, linen service, 24-hour desk supervision, assistance to arrange nursing or medical care.¹⁵⁰

The RTA’s policy is as follows:

The Residential Tenancies Branch deals with only certain tenant and landlord questions and disputes about unlicensed residential care facilities. For example:

- If a landlord doesn’t do necessary repairs, a tenant may ask the Branch for help.
- If a tenant doesn’t pay their rent, a landlord may apply for an Order of Possession.
- If a landlord plans to stop providing a service, they must apply to the Branch.

The Residential Tenancies Branch does not deal with:

- 10) disagreements between tenants and landlords about meals. For example: If the tenants are not happy with the kind of meals or the amount of food the landlord is providing, the Branch won’t order the landlord to change their menu or provide more food.
- 11) disagreements between landlords and tenants about the quality of an activity the landlord organizes. For example: If the tenants are not happy with the types of social activities the landlord is providing, the Branch won’t order the landlord to schedule different activities.¹⁵¹

5. CONSUMER PROTECTION

Manitoba has no specific provisions which would provide for consumer protection in SH / AL.

149. *Residential Tenancies Branch*, online: Consumer and Corporate Affairs <www.gov.mb.ca/finance/cca/rtb/gbook/s1genissues_unlicensedfacilities16.html>.

150. *Ibid.*

151. *Ibid.*

6. FUNDING

In “55 Plus” program apartments, rental rates for a studio apartment are 25% gross income, and one-bedroom apartments are 27% gross income.¹⁵²

In Manitoba SH, the resident pays for rent and service package while the Regional Health Authority pays for health staff. The resident may be eligible for the Manitoba Shelter benefit program to help pay for these costs.

In personal care homes, Manitoba health subsidizes costs, but the rate will depend on the resident’s income.¹⁵³ The PCR rates are between \$29.70 and \$69.70 as of August 1st, 2008, pursuant to s. 6. Homes may charge an extra \$2.50 per day for a semi-private room, or \$5.00 for a private room.¹⁵⁴

7. COMPLAINT / DISPUTE RESOLUTION

For Manitoba SH, the regional health authority monitors the facility to make sure they meet standards. For PCHs, the regional health authority co-ordinates application, assessment and admission.¹⁵⁵ A PCH operator must develop a residents’ bill of rights in consultation with residents and post it prominently.¹⁵⁶

All PCHs must have a resident council to raise and discuss issues of concern including services provided in the care home. The operator must respond, or prepare a preliminary response to the council’s concerns before its next meeting.¹⁵⁷

A PCH operator must have a written policy process for complaints about the home’s care, services or environment, and to “post information on how to lodge a complaint in a prominent place so that people can easily see it. The operator is required to keep records on complaints received and provide the regional health authority with information about complaints received if requested.”¹⁵⁸

152. *Senior 55+ Accommodation and Support Services*, online: Manitoba Housing Authority <http://www.gov.mb.ca/fs/housing/mha_seniors.html#accommodations>.

153. Housing Module, *supra* note 137.

154. PCR MB, *supra* note 139, s. 7.

155. Housing Module, *supra* note 137.

156. PCHR MB, *supra* note 138, ss. 2-4.

157. *Ibid.*, ss. 5-6.

158. Spencer MB, *supra* note 147 at 9; PCHR MB, *ibid.*, ss. 39-42.

A PCH operator must also report to the regional health authority about “occurrences in or related to the personal care home that have resulted in actual or potential (a) loss of life, limb or function; (b) loss or damage to property; or (c) other harms or risks.”¹⁵⁹

8. STAFFING INDICATORS

A physician needs to be designated responsible for the overall condition of medical services for a PCH. Professional staff and residents must have access to a physician 24 hours a day to provide emergency care and consultation pursuant to sections. 19 – 20 of the PCHR. Nursing services must be “organized and available to meet residents’ nursing care needs in accordance with guidelines approved by the minister”.¹⁶⁰

An operator must ensure that all staff of the PCH has appropriate qualifications to carry out the responsibilities of their positions. It also requires the operator to provide an “an organized orientation and in-service education program” for all staff of the personal care home.¹⁶¹

This orientation includes a “responsibility to make available health-related resources, including books, journals and audio-visual materials, to staff and volunteers, and to evaluate orientation and in-service education programs being offered annually or more often to ensure that they are current and meet the learning needs of the staff”.¹⁶²

There are no legislated staffing indicators for the other SH / AL regimes.

9. ENTRY / EXIT CRITERIA

(a) Entry

Generally, the resident has a broad right to choose in Manitoba. There are qualifications embedded in the Senior 55 Plus apartments, which must be met, based on total gross income and an age requirement (one person minimum must be over 55). For AL facilities in Manitoba, residents must meet the individual requirements of the privately owned and operated facilities.

159. PCHR MB, *ibid.*

160. PCHR MB, *ibid.*, ss. 21-23.

161. Spencer MB, *supra* note 147 at 9; PCHR MB, *ibid.*, ss. 39-42.

162. PCHR MB, *ibid.*

For SH, and PCH, the entry must come via a long-term care/home care case coordinator of regional health authority.¹⁶³ A committee of Regional Health Authority professionals will decide the appropriate facility for a person after reviewing their application.¹⁶⁴

On entry, an operator must give the resident the bill of rights, philosophy and mission, ways in which the resident can participate in assessing, planning, providing, monitoring, and evaluating the resident's care, info on policies relating to complaints, abuse and restraints, financial info, and orientation.¹⁶⁵

(b) Exit

Generally, the language suggests that if the resident becomes incapable or higher care needs develop, the resident can move to a more appropriate level of health / housing service. However, no specific legislative framework exists for this at present.

E. Ontario

1. MAIN LEGISLATION

Governance of the “middle option” for health / housing issues in Ontario is primarily effected through the *Residential Tenancies Act*.¹⁶⁶ There are no legislative frameworks governing the provision of the care portions of the SH / AL. Generally the scheme in Ontario is based on a private pay system and the bulk of the SH / AL type housing is located within “retirement homes.” These are largely unregulated and are described as:

private businesses that sell to consumers various combinations of accommodation, support services and personal care. Retirement homes are nearly all for-profit facilities, and care and support services in these settings are neither funded nor regulated by the provincial government. Unlike long-term care facilities, the government does not subsidize retirement homes...Retirement homes vary widely in terms of care and services provided, amenities offered, types of accommodations, staffing patterns and physical structures. Prices vary widely in accordance with the type of accommodation and range of services selected.¹⁶⁷

163. Housing Module, *supra* note 137.

164. *Ibid*.

165. PCHR MB, *supra* note 138, s. 8.

166. S.O. 2006, c. 17 [RTA ON].

167. *A Guide to Programs and Services for Seniors in Ontario, Housing: 4.2 Housing Choices for Seniors* online: Ontario Seniors' Secretariat <<http://www.culture.gov.on.ca/seniors/english/programs/>>

Confusingly, the Ontario *Long-Term Care Act* (LTCA)¹⁶⁸ does not pertain to residential nursing home care, as might be suggested by its name. Rather, the LTCA actually governs home support services and care – support at the very early end of the spectrum, which does not enter truly into the SH/AL “middle option”.

Residential nursing-home care is currently governed through a trilogy of legislation, including the *Homes for the Aged and Rest Homes Act* (HARA)¹⁶⁹ the *Charitable Institutions Act* (CIA)¹⁷⁰ and the *Nursing Homes Act* (NHA),¹⁷¹ however, they will be repealed and replaced by *Long-Term Care Homes Act, 2007*¹⁷² (LTCHA). The LTCHA has been passed but not yet proclaimed. When the LTCHA is brought into force the confusingly named LTCA will be more aptly renamed the *Home Care and Community Services Act*.

2. ANCILLARY LEGISLATION

The *Provision of Community Services*¹⁷³ regulates specifics in the LTCA regarding home support service provision.

3. LEXICON / PARAMETERS OF CARE

(a) Lesser Care

Home support services are available in Ontario including visiting health professional services, personal care and support (bathing, eating, and dressing), homemaking services, and a community support program (meal delivery, transport, and social services). These services are allocated based on needs and regional availability. Many seniors will need to augment these services with privately funded care.¹⁷⁴

seniorsguide/housing.shtml> [ON Housing Choices for Seniors].

168. S.O. 1994, c. 26.

169. R.S.O. 1990, c. H.13.

170. R.S.O. 1990, c. 9; Note: these two acts are essentially the same and cover profit/non-profit homes, see Hall, *supra* note 13 at 31.

171. R.S.O. 1990, c. N.7.

172. S.O. 2007, c. 8.

173. O.Reg. 386/99.

174. Best in Care, *Long Term Care in Ontario*, online: Manulife Financial <[https://hermes.manulife.com/canada/repsrcfm-dir.nsf/Public/ThecostoflongtermcareinOntario/\\$File/ONTARIO_LTC_CostReport.pdf](https://hermes.manulife.com/canada/repsrcfm-dir.nsf/Public/ThecostoflongtermcareinOntario/$File/ONTARIO_LTC_CostReport.pdf)> at 3-4 [Best in Care ON].

(b) *More Care*

“Supportive Housing” in Ontario is typically a more limited level of care than in most other jurisdictions adopting this phrase. However, it can provide onsite “personal support services...designed to help people live independently in their own apartments...Services include personal support / attendant services, essential homemaking services, and staff available 24-hours a day to handle regular scheduled services and emergency needs.”¹⁷⁵ Supportive housing units are in shortage in some parts of Ontario, and almost non-existent in others.¹⁷⁶

Supportive housing services are available on a fee-per-use basis or can be provided by not-for-profit agencies, usually partially funded by the Ministry of Health and Long-Term Care (MOHLTC).¹⁷⁷

All tenants are responsible for paying their own rent, food, clothing and living allowances. The MOHLTC supportive housing can be selected units in mixed buildings, public housing apartment buildings, seniors’ only residences or congregate housing environments. Supportive housing providers can be charitable foundations (often ethnoculturally or religiously based), non-profit agencies, cooperatives or municipal social housing corporations.¹⁷⁸

“Retirement homes”, as noted above, are private enterprises in Ontario that operate on a for-profit fee-for-service basis. They vary widely in terms of offered services. Many facilities are a member of a self-regulating (but non-mandatory) Ontario Retirement Communities Association (ORCA). ORCA has accreditation standards that address issues of staff training, care services, safety control and more. Local bylaws also play a role in regulation of retirement homes.

“Assisted living” also exists in a limited way in Ontario, although it is unregulated. This form of housing, with significant services, operates pursuant to the RTA but is more directed at persons who are disabled.

(c) *Most Care*

Nursing-type long-term care homes offer 24-hour nursing care and supervision. These facilities provide the highest level of care and are government funded and regulated. However, there is an overlap between long-term care and the lesser

175. ON Housing Choices for Seniors, *supra* note 167.

176. Jones, *supra* note 14 at 3.

177. *Ibid.*

178. *Ibid* at 8.

forms of care. Some critics note that long-term care in Ontario can be a “dumping ground” for those who cannot afford lesser private pay care, or where there is no availability for subsidized supportive housing.¹⁷⁹

4. RESIDENTIAL TENANCY APPLICATION

Retirement homes, supportive housing, and the more nebulous “assisted living” arrangements are all covered by the Ontario RTA.¹⁸⁰ Pursuant to s. 139 of the RTA, a tenancy agreement must be in place. This genre of health / housing is referred to, globally, as “care homes” in this Act.

Notably, unlike other jurisdictions where residential tenancy purview is very weak or non-existent, Ontario’s provisions are very strong. Indeed, the “same rules that apply to any type of tenancy also apply to retirement home tenancies with some additional requirements. The [tenancy legislation] deals with residential tenancy issues but not standards of care.”¹⁸¹

Tenancy agreements in retirement homes have several special provisions and requirements. There are protections against unfair evictions, rent increases and poor maintenance.¹⁸² These agreements must also set out, in writing, the amount of the rent alone (without the costs of services), a list and pricing of the services the tenant must pay for, and the duration of the agreement. Tenants have the right to consult with others on the document and may cancel the tenancy agreement within 5 days of signing.

In Ontario issues relating to AL residency have produced a number of useful case authorities.¹⁸³ The leading case of *Grenadier (Tenants of) v. We-Care Retirement Homes of Canada Ltd.*¹⁸⁴ (“*Grenadier*”) arose from a protracted legal battle, within a variety of different tribunals and courts, and continued for approximately eight years. The final Ontario Court of Justice decision was delivered in 1993.¹⁸⁵

179. The author thanks the staff lawyers of the Advocacy Centre for the Elderly, a speciality clinic of Legal Aid Ontario, for their various perspectives and provision of contextual analysis for this section of the paper. See online: <<http://www.advocacycentreelderly.org>>.

180. Part IX, ss. 139-151.

181. ON Housing Choices for Seniors, *supra* note 167 at 3.

182. *Ibid.*

183. In Ontario, a term often used for AL is “retirement home.”

184. (1993) 63 O.A.C. 387 (Div. Ct.).

185. The Advocacy Centre for the Elderly, “Comings and Goings” (2006) 4 ACE Newsletter 1, online:

This case arose when 125 seniors living at the Grenadier Retirement Village complex asked the Ontario Ministry of Housing to order that the Ontario *Residential Rent Regulation Act, 1986*¹⁸⁶ (later superseded by the Ontario *Rent Control Act*)¹⁸⁷ applied to their four apartment towers.¹⁸⁸ The Grenadier was a privately owned and managed housing complex for older adults featuring bachelor, one-bedroom, and two-bedroom suites. Each suite contained a private kitchen, bathroom, and living quarters; every resident supplied their own furniture and dishes. Residents were given individualized nursing and housekeeping services for an additional fee, and were able to hire outside care services at their own option.¹⁸⁹ The Grenadier's rental agreement not only included the right to exclusively occupy one's own unit, but also included an individual meal plan.

The Grenadier's rental arrangement, however, included rent increases that far exceeded the limits set out in provincial rent review legislation.¹⁹⁰ From 1988 to 1991, the Grenadier complex issued cumulative rental increases of between 60% and 67%, despite Ontario's legislated cap of 20.7%.¹⁹¹ The issue before the court was whether the Grenadier should be exempted from the rent review limit pursuant to section 4 (1) (e) of Ontario's *Residential Rent Regulation Act*.¹⁹² That section provided that all living accommodations "occupied by a person for penal, correctional, rehabilitative or therapeutic purposes or for the purpose of receiving care" were exempt from the province's rent review legislation.¹⁹³ Despite the Grenadier residents' request, the Ontario Ministry of Health found that the complex fell within this statutory exemption.¹⁹⁴ The residents subsequently appealed to the Ontario Rent Review Hearings Board, which conversely decided in the residents'

Canadian Centre for Elder Law Studies <http://www.ccels.ca/resources/ACE_Newsletter_2006.pdf> at 12. The authors thank Judith Wahl, Jane Meadus and Graham Webb of the Advocacy Centre for the Elderly with their input on this portion of the paper. The Advocacy Centre for the Elderly represented the plaintiff tenants in this case.

186. S.O. 1986, c. 63 (since repealed) [RRRA].

187. S.O. 1992, c. 11 (since repealed) [RCA].

188. Lynda Russell, "Ont. 'retirement homes' subject to rent review process" 11 (20 December 1991) *The Lawyers Weekly* 32 (QL) at ¶23-27 [Russell].

189. *Ibid.* at ¶35-41.

190. In some cases, increases were reported to reach nearly 60% (Advocacy Centre for the Elderly).

191. Russell, *supra* note 188 at ¶3.

192. RRRA, *supra* note 186.

193. *Supra* note 188 at ¶7.

194. *Supra* note 185 at ¶27.

favour; that decision was later appealed by the Grenadier complex to the Ontario Court of Justice.

In 1993, the Ontario Court of Justice upheld the decision of the Rent Review Hearings Board, and found that the appellants' facility was indeed subject to Ontario's *Residential Rent Regulation Act*.¹⁹⁵ The court held that the effect of a section 4 (1) (e) exemption "would be to establish a class of accommodation, inevitably catering primarily to the elderly, in which neither cost nor quality would be regulated."¹⁹⁶ The court further found that "given the complex statutory framework establishing Ontario's regime for the care of the elderly, the result would be an anomalous one."¹⁹⁷ The correct test as to whether a particular facility is exempt from the Act was held to be "whether the 'accommodation with care' was primarily *housing* or primarily *care*."¹⁹⁸ Since the Rent Review Hearings Board found that the Grenadier was primarily *housing*, the complex was accordingly subject to Ontario's residential tenancy legislation.

Grenadier marked the first judicial decision in Canada to determine that the relationship between the seniors living in AL (or supportive housing) and the AL operator was a legal tenancy, and as such was subject to residential tenancy regimes. Subsequent changes to the Ontario residential tenancy legislation were, in part, prompted by the *Grenadier* decision. AL (and supportive housing-type) facilities were specifically included in the 1997 residential tenancy legislation entitled the *Tenant Protection Act*.¹⁹⁹ Other provincial governments have had to seriously consider their residential tenancy legislative schemes in the wake of the *Grenadier* decision, particularly with respect to supportive housing and AL.

5. CONSUMER PROTECTION

Ontario has some embedded consumer protection laws; some located in the RTA which appears to go beyond simple tenancy matters, others by virtue of application of other legislation, such as food safety or local bylaws. Consumer protection issues, however, do have to be read carefully and can be general in nature.

Care in supportive housing or retirement home settings is unregulated. However, ORCA runs a CRIS complaint hotline for all residential seniors' homes in the

195. *Supra* note 184 at ¶1.

196. *Ibid.*

197. *Ibid.* at ¶4.

198. *Ibid.* at ¶5 (emphasis added).

199. S.O. 1997, c. 24.

province. They handle issues such as: quality of resident care, safety and security, emergency planning, building and property maintenance, food and meal services, recreation opportunities, housekeeping and laundry and compliance with legislation. This organization will handle cases such as complaints about food, which is a common issue arising in consumer protection in SH / AL generally.

ORCA, however, does not have the ability to enforce issues. It is a non-mandatory organization. They can, however, forward concerns, contact operators, and publicly “name and shame” homes.²⁰⁰

6. FUNDING

Home care Community Care Access Centre-approved services are provided at no cost, but it is often inadequate and seniors may need to purchase additional services privately.²⁰¹

Supportive housing is predominately funded through the Ontario MOHLTC, via a not-for-profit operator. There may be no charge for some care services, but tenants are still responsible for their own rent, based on income.²⁰²

Retirement homes are entirely privately funded with no government subsidies available.²⁰³

Nursing home long-term care fees²⁰⁴ are set by the Ontario MOHLTC and are funded primarily through government,²⁰⁵ however, in some ways it is also a co-pay system. Residents living in long-term care must pay a share of the total cost along with additional fees if the resident is in a semi-private or private room. If an individual is unable to pay accommodation fees, the total monthly income of the resident minus \$100 will be put towards the cost and the Ontario MOHLTC will pay the remainder.²⁰⁶

200. Ontario Retirement Communities Association “Complaints Response and Information Service (CRIS) FAQs and information online: <http://www.orcahomes.com/cris_faq.html>.

201. Best in Care ON, *supra* note 174 at 3-4.

202. ON Housing Choices for Seniors, *supra* note 167 at 6.

203. Best in Care ON, *supra* note 201 at 3-4.

204. Jones, *supra* note 14 at 11.

205. Best in Care ON, *supra* note 201 at 1.

206. *Ibid.* at 2.

7. COMPLAINT / DISPUTE RESOLUTION

ORCA has a Complaints Response and Information Service toll free hotline funded by the Ontario government. This hotline accepts complaints in relation to all retirement residences in Ontario, not just ORCA members. Key areas of complaint that the ORCA hotline staff are trained to help with include concerns about the quality, nutrition, and adequacy of food served, cleanliness of the building, monitoring and delivery of medication, security and safety issues and attitude and behaviour of staff towards residents.²⁰⁷

Hotline operators are trained information officers. They can provide information to residents on how to deal with many challenges or can, if required, talk to an operator or administrator to the retirement home to try to reach a solution. ORCA can also inspect and report on conditions at residences.²⁰⁸ If a complaint cannot be resolved, the matter can be referred up to the Retirement Home Complaints Response and Information Services Review Committee. This committee can publicize the complaint via the ORCA website. The hotline is free to use and is funded by the Government of Ontario.

Additionally, all retirement homes must provide residents with a Care Home Information Package (CHIP) before the resident signs the tenancy agreement. "Internal procedures, if any, for dealing with complaints, including a statement as to whether tenants have any right to appeal an initial decision, or a statement that there is no internal procedure for dealing with complaints"²⁰⁹ must be included in the CHIP.

While not directly applicable, there are a number of safeguards in the trilogy of legislation currently governing long-term care. For example, residents in long-term care homes can complain if a home is non-compliant with standards and regulations. Residents must be provided with a "Bill of Rights".²¹⁰ An inspector may inspect homes to ensure compliance subject to HARA, s. 21, or CIA, s. 10.1. Residents' council can be created if requested by 3 persons, and the council may only be made up of residents pursuant to HARA, s. 30.6, CIA, s. 9.19, and NHA, s. 30. A council review financial statements, inspection reports, the operation of the home, and can

207. *Ibid.*

208. *Ibid.* at 3.

209. ON Housing Choices for Seniors, *supra* note 167 at 4.

210. *Seniors' Care: Maintaining Standards of Care in Long-Term Care Homes*, online: Ministry of Health and Long-Term Care <http://www.health.gov.on.ca/english/public/program/ltc/25_standards.html#5>.

attempt to mediate disputes and report concerns to the minister pursuant to CIA, s. 9.21. The unproclaimed new long-term care legislation also has many safeguards in place.

8. STAFFING INDICATORS

ORCA requires a written orientation program for new staff, a staff development program and a continuing education program.²¹¹ There must be a written policy and procedure in place for staff regarding resident abuse and aggressive behaviour, including definitions of abuse and neglect, procedures for staff to report, document, and investigate abuse and neglect, and staff training on resident abuse prevention at orientation and annually thereafter.²¹² If a mechanical lift is in use, an appropriate policy and procedure to ensure staff training on equipment, preventive maintenance of equipment and safe storage of equipment is required.²¹³ Staff who are engaged in food preparation and service also must be trained on food-handling practices and infection control, as part of their orientation and each year thereafter.²¹⁴

Minimum staffing levels and qualifications of staff must be included in the Care Home Information Package (CHIP), which must be provided to residents before a resident signs a tenancy agreement.²¹⁵

9. ENTRY / EXIT CRITERIA

(a) *Entry*

Community Care Access Centres are a “one stop” location for information and services for seniors in Ontario. They conduct needs assessments, and provide lists and information on home care, homes, services, and long-term care in Ontario.²¹⁶

However, most of the “middle option” in Ontario for health / housing is provided through retirement homes. Homes will have their own entry requirements and, as services vary, so will the level of care that can be provided to residents.

211. Ontario Retirement Communities Association, *Accreditation Requirements* (February 2007) online: <http://www.orca-homes.com/intranet/orca_information/documents/Accreditation_Document_Public_March2007.pdf>.

212. *Ibid* at 15.

213. *Ibid*.

214. *Ibid*.

215. ON Housing Choices for Seniors, *supra* note 167 at 4.

216. Best in Care ON, *supra* note 174 at 1.

(b) *Exit*

Tenants may leave a retirement home on 30 days written notice to an operator. An operator may transfer a resident from a retirement home if a tenant's care needs are too high or too low to be provided by landlord.²¹⁷

F. Quebec

Quebec has a civil law system rather than the common law system standard in all other Canadian jurisdictions. Due to this fact the legislative framework for seniors' housing is quite different than in the rest of Canada. As such this section is included to provide a general overview of how seniors' housing is organized in the province, rather than the in-depth summaries made for other provinces.

1. MAIN LEGISLATION

The general scheme is made up of private supportive housing and a combination of private and public long-term care facilities. Due to a widely perceived inadequacy in terms of regulation, the system has recently been tightened up, and supportive housing has had a licensing system imposed on it. There is a complaint mechanism in place with an ombudsman, and supportive housing residents are able to avail themselves of the residential tenancy sections of the civil code.

Centres d'Hebergement et de soins de longue duree (CHLSD), are public long-term care facilities, and are regulated by *An Act respecting Health Services and Social Services*²¹⁸ (HSS). Both CHLSDs and their private counterparts are regulated by the Act, although different sections may be applicable depending on the issue.²¹⁹

Residences for the elderly, known as Residences privees pour personnes agees (RPPA), is also regulated by the HSS via a registration system.²²⁰ *Regulation respecting the conditions for obtaining a certificate of compliance for a residence for the elderly*,²²¹ details the requirements for certification that include health, safety, and staffing.

217. RTA ON, *supra* note 166, s. 148.

218. R.S.Q. c. S-42 [HSS].

219. Charmaine Spencer, "Canadian Care and Protection Laws and Regulations: Quebec" a part of *A Way Forward: Promoting Promising Approaches to Abuse Prevention in Institutional Settings* online: <<http://elderabuse.aging.utoronto.ca/>> at 6 [Spencer QC].

220. HSS, *supra* note 218, art. 346.

221. R.Q. c. S-4.2, r.0.01.1 [RCOC].

2. ANCILLARY LEGISLATION

There is little legislation for RPPAs and CHSLDs, although in the province of Quebec, residential tenancy legislation contained in the civil code apply to RPPAs.

3. LEXICON/PARAMETERS OF CARE

(a) *Lesser Care*

RPPAs fall towards the supportive housing side of the spectrum. RPPAs must provide at least one of the following services: “regular meals; personal assistance in bathing or dressing; housekeeping / domestic help; leisure activities, transportation, security or surveillance; nursing care,” but most offer more than one service.²²² These services tend to be provided in independent-style housing. These services are provided on a needs based basis, so unfortunately they tend to house people with higher care needs than they were intended for.

CHSLDs were created to offer “...lodging, assistance, support and supervision services as well as rehabilitation, psychosocial and nursing care and pharmaceutical and medical services to adults...”.²²³ CHSLD services primarily serve seniors who require higher levels of care.²²⁴

4. RESIDENTIAL TENANCY LEGISLATION APPLICABILITY

RPPAs are regulated under the Civil Code provisions dealing with tenancy.²²⁵ The *Regulation respecting Mandatory lease forms and the particulars of a notice to a new lessee*²²⁶ requires that a person entering into a lease that includes care must have the details laid out in the agreement.²²⁷ This onus ensures that both the landlord and tenant put their mind to the services offered before entering into an agreement, and in theory this would give each party an adequate understanding of the terms of service.

5. CONSUMER PROTECTION

There is no consumer protection legislation in Quebec in regards to seniors’ homes.

222. Spencer QC, *supra* note 219 at 15.

223. HSS, *supra* note 218, art. 83.

224. Hall, *supra* note 13 at 29.

225. C.c.Q. art. 1982 – 1978.

226. R.Q. c. R-8.1, r. 1.02

227. *Ibid.*, s. 2.

6. FUNDING

RPPA funding is private, and the facility's operators are free to set their fees. There are three types of CHSLDs: public, private, and private with public financing. Residents moving into private facilities must pay for the entire costs, while those moving into public CHSLD may have their costs subsidized after an income asset test.²²⁸

The fees for CHSLDs are set annually by the Ministry of Health and Social Services: Rooms with three or more beds cost \$32.30 per day, semi-private rooms with two residents cost \$43.46 per day, and private rooms are \$51.99 per day.²²⁹ These fees cover part of the cost towards:

- room and board expense such as food, housekeeping, heating
- personal hygiene products such as incontinence products, soap, deodorant
- all other equipment necessary for therapeutic purposes²³⁰

RPPA Residents with rent related complaints may go to the Regie du logement, which may adjudicate on any resident / tenant issue. The Regie has no jurisdiction to deal with any dispute that relates to the cost of care.²³¹

7. COMPLAINT / DISPUTE RESOLUTION

Regional Health Boards have the authority to inspect RRP's if they receive a formal complaint from the human rights commission or pursuant to the HSS.²³² With the recent addition of the licensing system, it will be interesting to see how this affects the previously unregulated RPPAs as they adapt to the change in circumstances.

La Federation de l'Age d'Or du Quebec (FADOQ) has a "rose d'or" voluntary accreditation program, with specific standards for supportive housing.²³³ Residents who feel as if their homes are not satisfying the standards may take their concerns to them.

228. Spencer QC, *supra* note 219 at 8.

229. Best in Care, *Long Term Care in Quebec*, online: Manulife Financial <[https://hermes.manulife.com/canada/repsrcfm-dir.nsf/Public/ThecostoflongtermcareinQuebec/\\$File/QUEBEC_LTC_CostReport.pdf](https://hermes.manulife.com/canada/repsrcfm-dir.nsf/Public/ThecostoflongtermcareinQuebec/$File/QUEBEC_LTC_CostReport.pdf)> at 2.

230. *Ibid.*

231. Hall, *supra* note 13 at 21.

232. *Ibid.*

233. La Federation de l'Age d'Or du Quebec, online <<http://www.fadoq.ca>>.

As stated above RPPA tenants can request adjudication under the *Regie du logement* for the tenancy issues, although the body does not deal with any care-related complaints.²³⁴

Residents of CHSLDs have a chain of people to whom they may take concerns or complaints. The board members in charge of a CHSLD must select a person to act as a local service quality and complaints commissioner.²³⁵ This person must report to the board of complaints received, and the board members must ensure his independence.²³⁶ Residents who are unsatisfied with the resolution facilitated by the commissioner may take their complaint to a regional quality commissioner.²³⁷

Residents whose complaints are not resolved by the above processes may bring their concerns to the “*protecteur du citoyen*” (Quebec Ombudsman). The Ombudsman’s role, however, is mostly investigatory, and she can only provide recommendations to remedy or prevent infringement of residents’ rights.²³⁸ Thus the Ombudsman lacks the authority to issue fines that British Columbia’s Assisted Living Ombudsman has (see British Columbia section).

8. STAFFING INDICATORS

There are few requirements for staff members working in supportive housing in Quebec. RPPAs must have at least one employee present at the residence at all times, and this person must have training in moving patients safely, standard first aid, and CPR.²³⁹ This may be problematic as some critics charge that RPPAs are housing people with higher needs than the legislation intends.

CHSLD staffing standards are created at a lower policy level of administration. The number of physicians practicing in a CHSLD must be set by the organization plan of a

234. Hall, *supra* note 13 at 21.

235. HSS, *supra* note 218, ss. 29 – 40.

236. *Ibid.*, s. 31; The local service quality and complaints commissioner has many functions and duties that are set out in ss. 22 – 40 of the HSS. It would be inappropriate to go into further detail in this paper, but his role can generally be seen as an ombudsman-like facilitative role.

237. Spencer QC, *supra* note 219 at 13.

238. *Public Protector Act*, R.S.Q. c. P-32.

239. RCOC, *supra* note 221, s. 14.

local community service centre (LCSC), and it will be identified on the permit of the institution.²⁴⁰

9. ENTRY / EXIT CRITERIA

LCSCs are the gatekeepers to long-term care, and residents wishing to enter into care must have an assessment performed by them.²⁴¹

Residents of CHSLDs are protected from discharge unless they are well enough to return home, admitted into another institution, or be cared for by a family caregiver.²⁴²

As noted above, contracts to enter RPPAs are regulated by Quebec's residential tenancy law, which means that three months notice is required to move out. It has been noted that this can cause great hardship for residents who need to move quickly due to acute health problems.²⁴³

G. Nova Scotia

1. MAIN LEGISLATION

Nova Scotia has a fairly complex housing system that is regulated in various ways. "Community Based Options" are unlicensed, but if they are subject to the purview of the Ministry of Health, then they are inspected and approved by the Department of Health.

Nova Scotia has "residential care facilities" which are generally the "middle option" in this province, but which have a broad definition. They are subject to the *Homes for Special Care Act*,²⁴⁴ and its regulations. The *Homes for Special Care Regulations*²⁴⁵ notes that:

(4) A residential care facility shall include a community-based residential facility.

240. HSS, *supra* note 218, s. 186.

241. Spencer QC, *supra* note 219 at 8.

242. HSS, *supra* note 218, s. 14.

243. Spencer QC, *supra* note 219 at 15.

244. R.S.N.S. 1989, c. 203 [HSCA].

245. N.S. Reg. 127/77 [HSCR].

(5) The term “community based residential facility” means any building or place where persons receive supervisory care in a residential and family environment and the care is provided by persons who are not their parents.

2. ANCILLARY LEGISLATION

Nova Scotia, like Manitoba and Alberta, has a *Protection for Persons in Care Act*.²⁴⁶ This legislation specifically deals with issues of adult abuse and neglect, for persons in some form of institutional care.

3. LEXICON / PARAMETERS OF CARE

(a) Lesser Care

“Community Based Options” (CBOs) are unlicensed, but inspected and approved by the Department of Health. They provide accommodation, supervision, and non-nursing level personal care for 1-3 people. CBOs provide accommodation, minimal supervision and the development of self-care skills for three or less residents.²⁴⁷ CBOs are privately owned and operated by individuals or organizations. They may offer largely the same services that a residential care facility can, but to only 1-3 people.

Assisted Living Facilities are a for-profit option for those who seek housing with minimal supports. Assisted Living is sometimes also called “Enriched Living” and is defined by the Department of Health as including the following elements²⁴⁸:

a. A living arrangement where individuals, able to direct their own care, reside in separate, self contained units. (Individuals able to self direct their own care are cognitively capable and have the ability to make informed, voluntary decisions regarding care requirements and living arrangements or alternatively, are living with a spouse/partner able to do so.) The resident controls access to the unit.

b. An arrangement where some or all of the individual's needs, related to activities of daily living, are met through services which are provided as a formal part of the person's daily living, residential arrangement. (That is, the services are provided by the operator of the residence and are a mandatory part of the individual's monthly accommodation costs. This requirement may be incorporated in a lease/rental

246. S.N.S. 2004, c. 33.

247. *Entering Long Term Care Factsheet Spring 2006*, online: Nova Scotia Department of Health <http://www.gov.ns.ca/health/ccs/ltc/Entering_LTC_FactSheet.pdf> [LTC factsheet].

248. *Glossary of Continuing Care Terms*, online: Nova Scotia Department of Health <http://www.gov.ns.ca/health/ccs/glossary_cc_terms.pdf>.

agreement or in some form of a documented service plan negotiated between the resident and the operator.) This includes Enriched Housing units under the jurisdiction of the Department of Community Services, Housing Services branch.²⁴⁹

(b) More Care

Residential Care Facilities are licensed homes for people who need supervision and limited help with personal care.²⁵⁰

The Residential Care Fact Sheet notes:

Department of Health residential care facilities (RCFs) provide an important option for seniors who need housing and continuing care. When home care is not appropriate and nursing home care is not required, an RCF can provide people with personal care, supervision and accommodation in a safe and supportive environment. In Nova Scotia, RCFs operate either under the jurisdiction of the Department of Health or the Department of Community Services. Those under the Department of Health provide mainly care to seniors and are inspected by departmental staff to ensure they are operating in compliance with the *Homes for Special Care Act* and Regulations. RCFs are mostly owned and operated by private individuals or organizations. In Nova Scotia, there are 35 RCFs licensed by the Department of Health. They range in size from 6 beds to 85 beds.²⁵¹

(c) Most Care

“Nursing Homes / Homes for the Aged” provide personal and / or skilled nursing care in a residential setting to individuals who require the availability of a registered nurse on-site at all times.²⁵² Residents will be referred to this level of care if they: require assistance from an R.N., cannot ambulate on their own (with or without cane, wheelchair, walker), no physical/cognitive ability to evacuate independently or they need more than 1.5 hours of one-on-one care per day.²⁵³

249. Charmaine Spencer, “Canadian Care and Protection Laws and Regulations: Nova Scotia” a part of *A Way Forward: Promoting Promising Approaches to Abuse Prevention in Institutional Settings* online: <<http://elderabuse.aging.utoronto.ca/>> at 6 [Spencer NS].

250. LTC factsheet, *supra* note 247.

251. *Ibid.*

252. *Service Eligibility Policy* (last revised December 2006) online: Nova Scotia Department of Health <https://www.gov.ns.ca/health/ccs/ltc/policyManual/Service_Eligibility_Policy.pdf> at 2 [SEP].

253. *Ibid.* at 7 – 8.

4. RESIDENTIAL TENANCY APPLICATION

Section 2 (h) of the *Residential Tenancies Act*,²⁵⁴ excludes:

(iii) a nursing home to which the Homes for Special Care Act applies...

(v) a residential care facility licensed under the Homes for Special Care Act;

“Assisted” or “Enriched Living” is, in essence, a rental contract or lease agreement, and is not governed pursuant to the Homes for Special Care Act. The Nova Scotia RTA is silent on whether or not it is included or excluded from RTA coverage.

5. CONSUMER PROTECTION

There is no specific consumer protection for persons in SH / AL in Nova Scotia.

6. FUNDING

In NS, funding is generally “unbundled”. Health care costs, such as nursing, personal care, social work services, recreation therapy, physical, and occupational therapies, are paid by the government. The resident pays for accommodation and maintenance, dietary services, housekeeping, management and administration, capital, return on investment, and personal expenses such as clothes, glasses, hearing aids, dental services, funerals, pharmacare co-pay, transportation.²⁵⁵

The “standard fees” are as follows:

- Nursing home: \$79.00/day
- Residential Care Facilities: \$50.50/day
- Community Based Option: 46.50/day

Residents who cannot pay will be assessed, and will be allowed to retain 15% of their monthly income.²⁵⁶

Assisted living is a private pay enterprise. Funding for Enriched housing is supported by the Department of Community Services, Housing Services branch.

254. R.S.N.S. 1989, c. 401.

255. *Resident Charge Policy, August 2008*, online: Nova Scotia Department of Health <www.gov.ns.ca/health/ccs/ltc/policyManual/Resident_Charge_Policy.pdf>.

256. *Ibid.*

7. COMPLAINT / DISPUTE RESOLUTION

Generally, all “complaints about licensed facilities in Nova Scotia, including allegations of abuse and neglect, are referred to licensing and inspection staff in the respective departments.”²⁵⁷

The inspector has a right at any reasonable time to enter and inspect a nursing home,²⁵⁸ although, there is no such right or requirement to inspect residential care facilities. However, the operators of nursing homes and residential care facilities have a duty to permit an inspector at all reasonable times to enter and inspect the residential care facility, its records, and equipment, and if required to have any resident examined by a physician.²⁵⁹ Residential care facilities are to be inspected at least once a year, and nursing homes are to be inspected twice a year.²⁶⁰ The health inspector must inspect premises every year.²⁶¹

8. STAFFING INDICATORS

Residential Care facilities retain the services of a medical advisor. Residents may continue to be served by their family doctor.²⁶²

Every nursing home and home for the aged:

- with less than 30 residents must have one R.N. on duty at least 8 hours a day, and when that RN is absent there must be a person in home capable of providing emergency care
- with more than 30 an R.N. must be on duty at all times

Staff must be in good physical and mental health, pursuant to section s. 21, HSCR. A pharmacist must supervise receipt and storage of bulk pharmaceuticals.²⁶³ The scope of care that can be delivered by an L.P.N. is determined by the College of

257. *Adult Protection Act: A Discussion Paper, September 2004*, online: Nova Scotia Department of Health <http://www.gov.ns.ca/health/ccs/discussion_paper.pdf>. See also: Spencer NS, *supra* note 249 at 9.

258. HSCA, *supra* note 244, s.10 (3).

259. *Ibid.*, s. 10 (4); HSCR, *supra* note 245, s. 23 (2) (b).

260. HSCR, *supra* note 245, s. 23 (2) (b).

261. *Ibid.*, s. 29.

262. LTC factsheet, *supra* note 247.

263. HSCR, *supra* note 245, s. 37.

Licensed Practical Nurses of Nova Scotia. R.N.s follow standards of practice set by college of registered nurses.

9. ENTRY / EXIT CRITERIA

(a) Entry

At the time of entry into the system a functional assessment is made determining unmet needs and a care level recommendation is made. The Care Coordinator will decide which of the 3 levels of care is appropriate for a client.²⁶⁴ If a resident turns down a specific placement, due to a First Available Bed Policy, and if they are in a hospital, they will either be discharged or forced to pay a daily fee for their hospital care.²⁶⁵

Individuals are not eligible for any of the 3 care options if they have non-stabilized physical / mental illness, serious behavioural problems or are active substance users or are in acute withdrawal etc.²⁶⁶

(b) Exit

If the needs of a client change, then an assessment will be done and the resident will have to re-apply for a new care facility.²⁶⁷

H. New Brunswick

1. MAIN LEGISLATION

The province is run under a “single entry” system, which means that residents wishing to enter supportive housing or nursing home care must go through the same assessment and placement process.

Special Care Homes and Community Residences are regulated by the *Family Services Act*,²⁶⁸ and the *Community Placement Residential Facilities Regulation*.²⁶⁹ The Act requires these facilities to obtain “approval” from the Minister on a yearly basis,

264. SEP, *supra* note 252 at 4-5.

265. LTC factsheet, *supra* note 247.

266. SEP, *supra* note 252 at 6-7.

267. *Ibid.* at 9.

268. c. F-2.2 [FSA].

269. N.B. Reg. 83-77 [CPRFR].

which functions as a licensing system.²⁷⁰ The facilities are also subject to *Standards and Procedures for Adult Residential Facilities*,²⁷¹ which set out requirements for special care homes and community residences in detail.

Special Care homes and Community residences are sub-classified as a home (less than three residents), a residence (3-9 residents), or a residential centre, (10 or more residents).²⁷² These terms are used in the regulations, while the legislation uses the broader classification terms.

Nursing Homes in New Brunswick are governed by the *Nursing Homes Act*²⁷³ and the *General Regulation*²⁷⁴ created pursuant to it.

It is important to note that the government of New Brunswick recently released a long-term care strategy that might signal a shift in the provinces system.²⁷⁵

2. ANCILLARY LEGISLATION

The legislative scheme is mostly contained in the main legislative documents already discussed. The residential tenancy legislation is silent on the issue of supportive housing, although a case could be made that supportive housing falls under the tenancy legislation (see section 4 for more detail).

3. LEXICON / PARAMETERS OF CARE

Both Special Care homes and Community Residences provide 24-hour supervision and non-nursing support, although there are some differences between them.²⁷⁶

270. FSA, *supra* note 268, s. 26.

271. New Brunswick Department of Family and Community Services *Standards and Procedures for Adult Residential Facilities* "Introduction" at 1 online: <<http://www.gnb.ca/0017/Seniors/arfstandardsandprocedures-e.pdf>> [NB Standards].

272. *Ibid.*

273. S.N.B. 1982, c. N-11 [NHA].

274. N.B. Reg. 85-967 [NHR].

275. Province of New Brunswick, *Be independent. Longer.: New Brunswick's Long-Term Care Strategy* (February 2008) online: Government of New Brunswick <<http://www.gnb.ca/0017/LTC/seniorconsultation-e.asp>> [NB LTC Strategy].

276. Charmaine Spencer, "Canadian Care and Protection Laws and Regulations: New Brunswick" a part of *A Way Forward: Promoting Promising Approaches to Abuse Prevention in Institutional Settings* online: <<http://elderabuse.aging.utoronto.ca/>> at 6 [Spencer NB].

Special Care homes are usually privately owned and are for residents assessed at levels 1 and 2:

Level 1 – Clients are generally mobile but require the availability of supervision on a 24-hour basis related to their personal care.

Level 2 – Clients may require some assistance or supervision with mobility and require more individualized assistance or supervision on a 24-hour basis with personal care and their activities of daily living.²⁷⁷

Community Residences are generally not-for profit organizations, and offer level 3 to 4 services for residents similar to nursing home care.²⁷⁸ (see below)

Nursing Homes, with one exception, are private, not-for-profit facilities.²⁷⁹ They provide care for people requiring level 3 or 4 care:

Level 3 – Clients have a medically stable physical or mental health condition or functional limitation and require assistance and supervision on a 24-hour basis. These clients need a great deal of assistance with personal care and often require medical attention.

Level 4 – Clients have difficulties with cognition and/or behaviour requiring supervision and care on a 24-hour basis. Clients may display aggressive behaviour toward self and/or others. Most often they need maximum assistance with their personal care and activities of daily living. Often they also require medical care.²⁸⁰

4. RESIDENTIAL TENANCY LEGISLATION APPLICABILITY

New Brunswick's residential tenancy legislation, the *Residential Tenancies Act*,²⁸¹ is silent on the issue, but states that it covers "any house, dwelling, mobile home, apartment, flat, tenement or similar place that is occupied or may be occupied by an individual as a residence."²⁸² This may or may not include Special Care homes, Community Residences, and Nursing Home facilities.

277. NB LTC Strategy, *supra* note 275 at 8.

278. Spencer NB, *supra* note 276 at 6.

279. Health Canada, *Canada Health Act Annual Report 2006 – 2007*, online: Government of Canada <http://www.hc-sc.gc.ca/hcs-sss/alt_formats/hpb-dgps/pdf/pubs/chaar-ralcs-0607/chaar-ralcs-0607-eng.pdf> at 75 [CHAR].

280. NB LTC Strategy, *supra* note 275 at 8.

281. S.N.B. 1975, c. R-10.2.

282. *Ibid.*, s. 1 (1) (b).

5. CONSUMER PROTECTION

There is no consumer protection legislation in force in the province of New Brunswick.

6. FUNDING

When a resident is unable to pay for the full cost of any long-term care services (including supportive living), the government will assist with the cost of services based on an income test that does not take assets into account.²⁸³

The maximum amount that a resident can be charged for nursing home accommodation is \$70 per day.²⁸⁴

While low-income seniors must pay for supportive housing costs themselves, they may be eligible for designated public housing units, on an age and needs-based basis.²⁸⁵ The maximum subsidy for subsidized residents in special care homes is \$74 per day.²⁸⁶ Subsidized residents receive a monthly comfort and clothing allowance, the size of which is at the discretion of the facility.²⁸⁷

7. COMPLAINT / DISPUTE RESOLUTION

Special Care homes are inspected yearly as a part of the renewal of approval process. Inspectors have the right to enter the home, examine records, and interview employees. An inspector can act in a variety of ways, including suspension of approval if after a general inspection they find that the home is:

(a) operating without the Minister's approval;

(b) disregarding the criteria for admission to and discharge from the community placement resource or the program or physical requirements prescribed by the Minister or by regulation;

(c) of inadequate quality; or

283. NB LTC Strategy, *supra* note 275 at 9.

284. *Ibid.* at 10.

285. CHAR, *supra* note 279 at 76.

286. NB LTC Strategy, *supra* note 275 at 10.

287. Best in Care, *Long Term Care in New Brunswick*, online: Manulife Financial <[https://hermes.manulife.com/canada/repsrcfm-dir.nsf/Public/ThecostoflongtermcareinNewBrunswick/\\$File/NEWBRUNSWICK_LTC_CostReport.pdf](https://hermes.manulife.com/canada/repsrcfm-dir.nsf/Public/ThecostoflongtermcareinNewBrunswick/$File/NEWBRUNSWICK_LTC_CostReport.pdf)>.

(d) dangerous, destructive or damaging to the user of the community placement resource.²⁸⁸

Additionally, as a part of the renewal process a district medical officer, fire marshal, and ministry officials must confirm compliance with various health and safety regulations.²⁸⁹

According to *Standards and Procedures for Adult Residential Facilities*, operators should establish a regular written procedure for hearing concerns of residents, and the procedure should be accessible to residents, their relatives, and advocates. All concerns, investigations, and outcomes of those investigations should be recorded in a daybook.²⁹⁰

The *Nursing Home Act* requires operators to have procedure for dealing with complaints, and they must properly inform residents of the plan.²⁹¹ Nursing homes also have an inspection regime. In their inspections, inspectors must visually examine one or more residents to assess over-all health and to determine if the residents are getting adequate care.²⁹² Under the Act, the Minister has the power to take over administration of a nursing home due to severe violations of the Act, licence, or if the nursing home doesn't function effectively.²⁹³

8. STAFFING INDICATORS

Staff members at special care homes must have graduated from a "home support worker, special care worker, health care aid, human services or nursing assistant program."²⁹⁴ Special Care homes must maintain a ratio of 10 residents to one worker at all times, although two volunteers may replace a full time staff member if they meet certain criteria.²⁹⁵ Staff members must have:

288. FSA, *supra* note 268, s. 27.

289. CPRFR, *supra* note 269, s. 4 (2) (iii).

290. NB Standards, 2.21, *supra* note 271.

291. NHA, *supra* note 273, s. 13(d).

292. *Ibid.*, s. 40.1.

293. *Ibid.*, ss. 10-11.

294. NB Standards, *supra* note 271 at 18.

295. CPRFR, *supra* note 269, s. 19.

the personality, ability, and temperament to provide services in a community placement residential facility in a manner that will maintain the spirit, dignity and individuality of the residents.²⁹⁶

Due to the higher needs of residents at community residences, staff must have specialized knowledge to meet the needs of the residents, such as in the areas of behaviour management or mental illness.²⁹⁷

In Nursing Homes, care staff must be in attendance at all times in “appropriate ratios”²⁹⁸ Employees must have a criminal record check performed, and must have a physical examination to ensure they can provide appropriate care.²⁹⁹ Nursing homes with more than 30 beds must ensure that they have a registered nurse on duty at all times.³⁰⁰

9. ENTRY / EXIT CRITERIA

During the admittance process into either a nursing home or a special care home, potential residents are evaluated with a single comprehensive test.³⁰¹ The test evaluates the potential resident and evaluates their needs and abilities on a scale of 1 – 4 (see Section 3 above for more details). People with lower end needs are referred to special care homes, those with higher level needs will be referred to either a community residence or a nursing home.³⁰²

New Brunswick has adopted a first bed policy, which means that with some exceptions resident have to go to the first residence with an available space within 100 kilometres.³⁰³ Nursing homes with 30 or more residents will have an admissions committee that determines if an applicant’s needs fit with the home’s

296. *Ibid.*, s. 20 (4) (a).

297. NB Standards, *supra* note 271, 3.1.

298. NHR, *supra* note 274, s. 18.

299. *Ibid.*, s. 14.

300. *Ibid.*, 18 (b).

301. CHAR, *supra* note 279 at 76.

302. Spencer NB, *supra* note 276 at 6.

303. *Going to a Nursing Home* (Last Revised 2008) online: Public Legal Education and Information Service of New Brunswick <http://www.legal-info-legale.nb.ca/assets/pdf/Nursing_home_en_lr.pdf> [NB PLEI].

abilities.³⁰⁴ Residents entering a nursing home must be provided with written statement of services provided, additional services with their costs, and policies.³⁰⁵

The resident living in facilities may apply to transfer to other facilities if they wish.³⁰⁶ Except for situations in which the safety of a resident or care provider is at risk, residents of Special Care homes, Community Residences and Nursing homes who are discharged must be given 15 days notice.³⁰⁷

I. Prince Edward Island

1. MAIN LEGISLATION

Prince Edward Island's *Community Care Facilities and Nursing Home Act*³⁰⁸ regulates Community Care Facilities (CCF) and nursing homes in the province, which are facilities that provide assisted living services and traditional nursing home care respectively. The *Nursing Home Regulations*³⁰⁹ provide a framework for the administration of licensing, building construction, health, safety, social rights, and care in P.E.I.'s nursing homes. The *General Regulations*³¹⁰, which were enabled under 1974 legislation,³¹¹ runs parallel to the *Nursing Home Regulations* and broadly regulates both CCFs and nursing homes.

The *Community Care Facilities and Nursing Homes Act*³¹² sets out the regulatory framework for long-term care facilities in the province, while the *General Regulations* provide baseline standards for those facilities. Neither sets specific standards for CCFs that differ greatly from Nursing Home care, and the legislation is silent on CCF specific concerns such as landlord/tenant disputes, or consumer quality.

304. NHR, *supra* note 274, s. 7.

305. NHA, *supra* note 273, s. 13.

306. NB PLEI, *supra* note 303.

307. NHA, *supra* note 273, s. 17; CPRFR, *supra* note 269, s. 215.

308. R.S.P.E.I. 1988, c. C13 [CCFNHA].

309. P.E.I. Reg. EC10/88 [PEI NHR].

310. P.E.I. Reg. EC391/84 [NHGR].

311. *Community Care Facilities Act*, R.S.P.E.I. 1974, c. C-13.1. Despite the repeal of the statute, the regulations are still in effect under the *Community Care Facilities and Nursing Homes Act*.

312. CCFNHA, *supra*, note 308.

It is important to note that neither CCFs nor nursing homes with fewer than 5 residents are regulated by legislation.

2. ANCILLARY LEGISLATION

The main pieces of legislation broadly regulate seniors' homes in the province. As in many other jurisdictions in Canada, the P.E.I. residential tenancy legislation specifically exempts supportive housing from its scope (see section 4 for more information).

3. LEXICON / PARAMETERS OF CARE

In Prince Edward Island, lower level care is administered in Community Care Facilities, which are privately owned and operated. The facilities provide personal services such as "housekeeping, meals, assistance with grooming, and hygiene".³¹³ While twenty-four hour nursing care is not provided in these facilities, some CCFs are located within a larger facility that provides higher-level nursing home care.³¹⁴

Once a resident's needs grow to require more comprehensive care, the next level of care available is in nursing homes, or manors. These residences provide higher levels of care including "accommodation, supervisory care, personal care and nursing and medical services on a 24/7 basis."³¹⁵ There is both public and private nursing home care available.

4. RESIDENTIAL TENANCY LEGISLATION APPLICABILITY

The *General Regulations*³¹⁶ made pursuant to the *Rental of Residential Property Act*³¹⁷ specifically exempts all premises licensed under the *Community Care Facilities and Nursing Home Act*³¹⁸ from Prince Edward Island's residential tenancy legislation.

313. *Community Care Facilities*, online: Prince Edward Island Department of Health <<http://www.gov.pe.ca/health/index.php3?number=1020395&lang=E>> [CCF].

314. *Ibid.*

315. *Fact Sheet: Entering a Nursing Home* (March 2007) online: Prince Edward Island Department of Health, <http://www.gov.pe.ca/photos/original/hlth_ltc_fs1.pdf>.

316. P.E.I. Reg. EC10/89, s. 1 (b).

317. R.S.P.E.I. 1988, c. R-13.

318. CCFNHA, *supra*, note 308.

5. CONSUMER PROTECTION

There is no consumer protection legislation in relation to assisted living or nursing home care in Prince Edward Island.

6. FUNDING

CCFs are privately owned and operated, and generally the cost must be borne entirely by the resident.³¹⁹ A senior with limited means may be eligible to receive financial assistance under the *Social Assistance Act*,³²⁰ including funding for care, and a comfort allowance that provides seniors with funds to pay for out of pocket expenses.³²¹

Nursing home care is subsidized in the province, and an income-based assessment is made to determine the level of subsidy a resident will receive.³²² Accommodation rates as of March 2007 are a maximum of \$65 per day for self-paying residents living in public manors.³²³ This covers “nursing and personal care, incontinence and infection control measures and basic stock supplies for hygiene and grooming.”³²⁴ Expenses deemed personal such as “eyeglasses, hearing aids, dental service, internet/cable, telephone service, hairdressing, clothing, dry cleaning, personal equipment, ambulance service and general transportation” are not included.³²⁵ Nursing Home residents are also entitled to the aforementioned comfort allowance, which can be used to pay for such expenses.³²⁶

7. COMPLAINT / DISPUTE RESOLUTION

A board, created by the *Community Care Facilities and Nursing Homes Act*³²⁷ has power under a licensing scheme to ensure adherence to prescribed standards.³²⁸ An

319. CCF, *supra* note 313.

320. R.S.P.E.I. 1988, c. S-4.3; *General Regulations*, P.E.I. Reg. EC 396/03, s. 1 (4) (c) states that Community Care Facilities qualify as “residential institutions” under the Act.

321. *Social Assistance Act*, s. 1 (d.2), *ibid.*

322. *General Regulations*, P.E.I. Reg. EC615/05, s. 6.

323. *Fact Sheet: Paying for Long-term Nursing Care* (March 2007) online: Prince Edward Island Department of Health <http://www.gov.pe.ca/photos/original/HLTH_LTC_FS_5.pdf>.

324. *Fact Sheet: Explanation of Terms* (March 2007) online: Prince Edward Island Department of Health <http://www.gov.pe.ca/photos/original/HLTH_LTC_FS_3.pdf>.

325. *Ibid.*

326. *General Regulations*, *supra* note 322, s. 12.

327. CCFNHA, *supra*, note 308.

operator of a facility in Prince Edward Island who fails to comply with the Act, Regulations, or the license may be fined, or put out of business with a withdrawal of the licence.³²⁹

Other than the licensing system, there is no legislated process for complaint / dispute resolution.

8. STAFFING INDICATORS

Both Nursing Homes and Community Care Facilities must have enough staff on hand to effectively evacuate residents in case of fire.³³⁰ While nursing homes must have a Registered Nurse on duty at all times, CCFs may function without one as long as all staff have first-aid qualifications, with at least one member qualified and competent to perform CPR.³³¹

Operators of CCFs and Nursing homes must:

ensure that it is staffed sufficiently as determined by the Board with respect to numbers and capabilities and arrangement, so as to be able to carry out effective evacuation for all residents in case of fire or other emergency and to cope satisfactorily in case of personal emergencies among residents.³³²

9. ENTRY / EXIT CRITERIA

In Community Care Facilities admission is determined by the parties, although a care needs assessment will occur to determine if the facility is appropriate to the care needs of the potential resident.³³³

Entry into either a public or private nursing home in the province will occur after an assessment performed by “representatives from hospitals, home care, housing, and long-term care programs”, and these homes cater to seniors who need more intensive care.³³⁴

328. *Ibid*, ss. 2-8.

329. *Ibid*.

330. NHGR, *supra* note 310, s. 31.

331. PEI NHR, *supra* note 309, ss. 21 & 27.

332. NHGR, *supra* note 310, s. 31.

333. CHAR, *supra* note 279 at 41.

334. CCF, *supra* note 313.

J. Newfoundland and Labrador

1. MAIN LEGISLATION

The system in Newfoundland is one in which the costs of care and accommodation are unbundled. The province has both a single entry system for all seniors' residences, and has a first bed policy. Only homes with more than four residences are covered by legislation. Personal Care homes, which are in effect supportive care facilities, are governed by the *Health and Community Services Act*³³⁵, and the *Personal Care Home Regulations*.³³⁶ Special care homes are regulated under the *Homes for Special Care Act*,³³⁷ but detailed standards for all long-term care facilities in Newfoundland are located in the Long Term Care Operational Standards.³³⁸

2. ANCILLARY LEGISLATION

There is little legislation on this issue in the province, as the previously mentioned acts broadly regulate home care. Residential tenancy legislation does not apply to seniors' facilities in the province (see section 4 below)

3. LEXICON / PARAMETERS OF CARE

Lesser care in Newfoundland is provided in personal care homes, also known as community care residences. These homes are for older Canadians requiring minimal assistance with daily living activities and supervised care.³³⁹ Services provided may also include food preparation services and social activities.³⁴⁰ Residents who require constant, daily, on site professional care of a registered nurse or doctor are not permitted live in these facilities.³⁴¹

335. S.N.L. 1995, c. P-37.1.

336. N.L.R. 15/01 [PCHR NL].

337. R.S.N.L. 1990, c. H-5.

338. Department of Health and Community Services *Long Term Care Facilities in Newfoundland and Labrador Operational Standards* (November 2005) online: Province of Newfoundland and Labrador <<http://www.health.gov.nl.ca/health/publications/pdfiles/longtermcarestandard.pdf>> [LTC OS].

339. CHAR, *supra* note 279 at 28.

340. Charmaine Spencer, "Canadian Care and Protection Laws and Regulations: Newfoundland and Labrador" a part of *A Way Forward: Promoting Promising Approaches to Abuse Prevention in Institutional Settings* online: <<http://elderabuse.aging.utoronto.ca/>> at 5 [Spencer NL].

341. PCHR NL, *supra* note 336, s. 13.

Higher-level care is provided in nursing homes, special care homes, and community health centres, which “provide accommodation, supervisory care, personal care, and nursing and medical services on a 24-hour basis”.³⁴² They also may provide pharmaceutical, rehabilitative, and pastoral care services.³⁴³ The Operational Standards require that an integrated health plan be created for every resident:

1.2 The integrated care plan must include, but is not limited to, the following information:

- 1) the kinds of assistance required with bathing, dressing, mouth and denture care, skin care, hair care, nail care, foot care, eating, physical activity, mobility, transferring, types of transfers required, positioning, bladder and bowel function, including incontinence care products required;
- 2) available family and community supports;
- 3) hearing and visual abilities and required aids;
- 4) rest periods and bedtime habits, including sleep patterns;
- 5) language and speech, including any loss of speech capability and any alternate communication method used;
- 6) food preferences and diet orders;
- 7) medications and treatments ordered by a physician;
- 8) mental and emotional status, including personality and behavioural characteristics³⁴⁴

4. RESIDENTIAL TENANCY LEGISLATION APPLICABILITY

The *Residential Tenancies Act*³⁴⁵ excludes “living accommodation provided in a hospital, nursing home or a home established to provide personal care for the aged.”³⁴⁶ This excludes supportive living and nursing home care in Newfoundland.

342. Best in Care, *Long Term Care in Newfoundland and Labrador*, online: Manulife Financial <[https://hermes.manulife.com/canada/repsrcfm-dir.nsf/Public/ThecostoflongtermcareinNewfoundland/\\$File/NEWFOUNDLAND_LTC_CostReport.pdf](https://hermes.manulife.com/canada/repsrcfm-dir.nsf/Public/ThecostoflongtermcareinNewfoundland/$File/NEWFOUNDLAND_LTC_CostReport.pdf)> [Best in Care, Newfoundland].

343. LTC OC, *supra* note 338 at 4.

344. *Ibid.* at 23.

345. S.N.L. 2000, c. R-14.1.

346. *Ibid.*, s. 3 (2) (e).

5. CONSUMER PROTECTION

There is no applicable consumer protection legislation in the province.

6. FUNDING

Personal care homes are privately owned and operated, and residents must pay the costs themselves.³⁴⁷ Subsidies for the costs are available for some residents up to a maximum of \$1500 / month.³⁴⁸

Nursing homes residents must also pay the full cost of their care, although the maximum rate facilities are allowed to charge is \$2800 / month.³⁴⁹ Due to the potentially high expense of this care, the government will ensure that residents have at least \$115-125 per month in spending money by subsidizing the difference between the income of the client and the cost of the nursing home.³⁵⁰ This money operates similarly to New Brunswick's comfort allowance, and can be used to pay for non-included services.

7. COMPLAINT / DISPUTE RESOLUTION

Inspectors may inspect personal care homes to ensure compliance with the PCHR and its regulations.³⁵¹ The inspector has a wide purview, and may enter a personal care home at any time and inspect books, documents, perform tests, take pictures, take videos, and generally inquire into all matters relating to personal care of residents in a personal care home.³⁵²

The complaints system is focussed on in-facility resolution of concerns. The Operational Standards require that long-term facilities have a complaints procedure marked by simplicity, clarity, and accessibility to residents.³⁵³ Complainants must also receive an initial response to complaints within two business days, followed by a post-investigation reply within one month.³⁵⁴

347. Spencer NL, *supra* note 340 at 5.

348. CHAR, *supra* note 279 at 28.

349. *Ibid.*

350. Best in Care, Newfoundland *supra* note 342.

351. PCHR NL, *supra* note 336, s. 11.

352. *Ibid.*

353. LTC OS, *supra* note 338 at 59.

354. *Ibid.*

The complaint system is quite complex. People with concerns relating to personal care homes have to report them to a confusing myriad of authorities. In St. John's, a Personal Care home program can be contacted, while in others they would contact either a Health and Community Services office, or the Director of Long Term Care and Residential Services.³⁵⁵

8. STAFFING INDICATORS

While the *Personal Care Home Regulations*³⁵⁶ state that employee qualifications for personal care homes are to be set out in standards, as of yet none have been created.³⁵⁷

Long-term care facilities are required to have “staffing numbers and skill mix... appropriate to residents’ assessed needs”.³⁵⁸ Staff must not only meet hours of care per resident guidelines, but they must also attempt to maintain some form of stability and continuity that the residents require for their social and mental well-being.³⁵⁹

9. ENTRY / EXIT CRITERIA

To enter a personal care home, potential residents must apply through a single entry system under their regional boards.³⁶⁰ Residents are able to stay in the personal care home as long as their needs do not exceed the available care. A person who “requires constant, daily, on-site professional care of a registered nurse or physician” must find more suitable accommodations.³⁶¹

For entry into long-term care, the appropriate home will be determined by a health needs assessment performed by a Regional Health Authority.³⁶² Newfoundland has a “first available bed” policy, which means that a resident must move to the first available bed in their region, and may be returned to their community once a space

355. Spencer NL, *supra* note 340 at 7.

356. PCHR NL, *supra* note 336.

357. Hall, *supra* note 13 at 35.

358. LTC OS, *supra* note 338 at 10.

359. *Ibid.*

360. Spencer NL, *supra* note 340 at 6.

361. PCHR NL, *supra* note 336, s. 13.

362. Best in Care, Newfoundland, *supra* note 342.

becomes available.³⁶³ The Operational Standards require that residents be placed in appropriate care environments, according to their needs and if possible, preferences.³⁶⁴

K. The Territories

Due to the differences in population distribution and the number of inhabitants, comparing the seniors' housing frameworks in the territories with those in the provinces can be problematic.³⁶⁵ The number of facilities in the region is much smaller than in the provincial jurisdictions, and this means that governments are more likely to create individual standards for homes rather than legislate broadly. This section is therefore less detailed than the foregoing provincial summaries.

1. MAIN LEGISLATION

There is no specific legislation that regulates seniors' housing in the Yukon Territory, although it generally falls under the scope of the *Health Act*.³⁶⁶ The only act that touches upon seniors' services is a limited regulation that deals only with fees for an adult day care service.³⁶⁷

In both the Northwest Territories and Nunavut, supportive housing is managed by local regional health authorities, and there is no specific legislation governing these residences.³⁶⁸ The Northwest Territories' Department of Health and Social Services has published *Service Standards and Guidelines for People in Supported Living Homes* that outline how supportive housing should be administered in the province.³⁶⁹

363. Spencer NL, *supra* note 340 at 9.

364. LTC OS, *supra* note 338 at 14.

365. Charmaine Spencer, "Canadian Care and Protection Laws and Regulations: Yukon" a part of *A Way Forward: Promoting Promising Approaches to Abuse Prevention in Institutional Settings* online: <<http://elderabuse.aging.utoronto.ca/>> at 6 [Spencer YT].

366. R.S.Y. 2002, c. 106. Section 1 (1) (d) includes continuing care services in the definition of a "health and social service".

367. *Thomson Centre Continuing-Care-Day-Program Fees Regulation*, Y.O.I.C. 1998/219.

368. For a list and summary of services of the Northwest Territories' regional health authorities see *HSS Authorities*, online: Department of Health and Social Services <http://www.hlthss.gov.nt.ca/english/our_system/authorities/>.

369. See *Service Guidelines for persons in supported living homes* online: Northwest Territories Health and Social Services <http://www.hlthss.gov.nt.ca/content/publications/manuals/supported_living_homes/pdf/service_guidlines.pdf> [NWT Guidelines]; and *Service Standards for persons in supported living homes* online: Northwest Territories Health and Social Services <http://www.hlthss.gov.nt.ca/content/publications/manuals/supported_living_homes/pdf/ser

Nursing home care in the NWT and Nunavut is regulated by the *Hospital Insurance and Health and Social Services Administration Act*³⁷⁰ and *Hospital and Health Care Facility Standards and Regulations*.³⁷¹ This legislation is primarily geared at regulating hospital care, and there is little detail specific to long-term care facilities.

2. ANCILLARY LEGISLATION

N/A

3. LEXICON/PARAMETERS OF CARE

In the Yukon, lower level care is provided in what is called Adult Group Homes and Approved homes for persons with disabilities. These homes are approved by the government, and their standards are set contractually as a part of the approval process.³⁷²

In the Northwest Territories lower level care is administered in a variety of ways, including “arrangements in family homes, apartments, and group-living homes, where clients can live as independently as possible”.³⁷³ These are organized through regional health authorities. These vary from family style accommodations for small groups of residents to apartments that support independent seniors.³⁷⁴

The Yukon has three community care facilities, which generally provide higher levels of care. These facilities are not uniformly high needs service providers, and as such seniors in McDonald Lodge, a home with lower care services, will generally have much lower care needs than those living in Copper Ridge Place, a home for those requiring more complex care such as residents with dementia.³⁷⁵

Both Nunavut and the Northwest Territories also have traditional nursing home care with 24-hour care for higher needs clients.³⁷⁶

vice_standards.pdf> [NWT Standards].

370. R.S.N.W.T. 1988, c. T-3.

371. N.W.T. Reg. 036-2005 [HHCFSR].

372. Spencer YT, *supra* note 365.

373. CHAR, *supra* note 279 at 209.

374. NWT Guidelines, *supra* note 369 at 9.

375. Yukon Health & Social Services “Residential Care Programs” online: <<http://www.hss.gov.yk.ca/programs/continuing/residential>>.

376. CHAR, *supra* note 279 at 209 & 222.

4. RESIDENTIAL TENANCY LEGISLATION APPLICABILITY

Yukon's *Landlord and Tenant Act*³⁷⁷ is silent on the issue. The definition of residential premises as "premises used for residential purposes..." might include supportive housing.³⁷⁸

The Northwest Territories and Nunavut are both subject to the *Residential Tenancies Act*,³⁷⁹ which defines rental premises as "a living accommodation or land for a mobile home used or intended for use as rental premises and includes a room in a boarding house or lodging house." This definition might include supportive housing.

5. CONSUMER PROTECTION FUNDING

There is no consumer protection funding in any of the territories.

6. FUNDING

Fees for supportive housing vary across the territories, but the cost of nursing home care is quite inexpensive by national standards. Care and accommodation costs are "unbundled" and residents of the NWT living in assisted living must generally pay for their accommodations, in combination with a granting agency.³⁸⁰ The amount of funding supportive housing receives is determined by the Department of Health and Social Services authorities.³⁸¹

In the Yukon nursing home residents must pay between \$18 - \$21 per day regardless of their income.³⁸² Nursing Homes in NWT cost \$712 per month, but

377. R.S.Y. 2002, c. 131.

378. *Ibid.*, s. 59.

379. R.S.N.W.T. 1988, c. R-5, s. 1.

380. NWT Guidelines, *supra* note 369 at 9.

381. *Ibid.* at 14.

382. Best in Care, *Long Term Care in Yukon*, online: Manulife Financial <[https://hermes.manulife.com/canada/repsrcfm-dir.nsf/Public/ThecostoflongtermcareintheYukon/\\$File/YUKON_LTC_CostReport.pdf](https://hermes.manulife.com/canada/repsrcfm-dir.nsf/Public/ThecostoflongtermcareintheYukon/$File/YUKON_LTC_CostReport.pdf)>.

every client receives a pension that covers this cost.³⁸³ Residents of Nunavut have their nursing homes costs entirely subsidized by the territorial government.³⁸⁴

7. COMPLAINTS / DISPUTE RESOLUTION

Nunavut and the NWT's long-term care facilities are inspected for health and safety issues, but the inspector only has the power to make recommendations to the minister.³⁸⁵

Beyond that, there are no complaint / dispute resolution mechanisms in the territories.

8. STAFFING INDICATORS

None of the territories have legislated staffing requirements, although the Northwest Territories has imposed mandatory standards in the area. In the Northwest Territories, supportive housing facilities must have a service plan that outlines the minimum number of staff members required. A failure to follow the service plan is a breach of the mandatory service standards.³⁸⁶

9. ENTRY / EXIT CRITERIA

In all three jurisdictions, clients are assessed by regional health authorities and then referred to an appropriate care facility.³⁸⁷ In the NWT, authorities require operators of supportive housing services must take "a careful review" the assessment into account when residents enter the home.³⁸⁸

383. Best in Care, *Long Term Care in Northwest Territories*, online: Manulife Financial <[https://hermes.manulife.com/canada/repsrcfm-dir.nsf/Public/ThecostoflongtermcareintheNorthWestTerritories/\\$File/NWT_LTC_CostReport.pdf](https://hermes.manulife.com/canada/repsrcfm-dir.nsf/Public/ThecostoflongtermcareintheNorthWestTerritories/$File/NWT_LTC_CostReport.pdf)>.

384. Best in Care, *Long Term Care in Nunavut*, online: Manulife Financial <[https://hermes.manulife.com/canada/repsrcfm-dir.nsf/Public/ThecostoflongtermcareinNunavut/\\$File/NUNAVUT_LTC_CostReport.pdf](https://hermes.manulife.com/canada/repsrcfm-dir.nsf/Public/ThecostoflongtermcareinNunavut/$File/NUNAVUT_LTC_CostReport.pdf)>.

385. HHCFSR, *supra* note 371, s. 8.

386. NWT Standards, *supra* note 369 at 10.

387. See Best in Care summaries for Yukon, Northwest Territories, and Nunavut *supra* notes 382, 383, and 384.

388. NWT Standards, *supra* note 369 at 14.

V. LEGISLATIVE FRAMEWORK ANALYSIS

A thematic review of provincial frameworks provides some insights into the state of the “middle option” of health / housing in Canada. Three key questions arise, which underpin the various existing models:

- A. Whose Responsibility is it and Who is Providing Services?
- B. Can Old and New Models Exist Harmoniously in the Same Jurisdiction?
- C. How Does Regulation and Philosophy Co-Exist?

This section will consider the information gathered in the national thematic review within the context of these questions.

A. Whose Responsibility Is It and Who is Providing Services?

Fundamentally this question harkens back to the past trends and historical overview of social housing and disability issues. Canada’s history in this area of governance is actually quite limited, and less than a century old. Since governments turned their respective minds to the issue, Canada and its provinces / territories have wrestled back and forth on the issues of both health and housing, with the trend in the past 25 years, (and markedly in the past 15 years) being an increased devolution of responsibility to the provincial and municipal levels. This responsibility, in many jurisdictions, has completely devolved out of government control altogether, and into the private profit or non-profit sectors.

In some other jurisdictions, notably Ontario, the concentrated population base, combined with a wide-open legislative framework, paved the path for private enterprise to grow. Ontario’s entrepreneurial spirit took hold, creating a broadly available “private pay option”.

Most other jurisdictions, however, have significantly less of a concentration of population than Ontario. There seems a rough corresponding relationship in less populous jurisdictions to have a broad number of options (e.g. Manitoba, NS), rather than one main option (Ontario). There is a sense of scarcity of resources and “making do” in many jurisdictions (Saskatchewan, NB, PEI), which can lead to some creative programming.

BC and Alberta appear to have taken on the mantle of responsibility for the “middle option” of health / housing fairly comfortably, and made space for both public and private schemes. Funding for these programs is reflective, generally, of the politics of each province – with BC’s having more publicly funded programming and Alberta having more emphasis on private-pay options.

In the past five to eight years, however, there has been an increased focus from many jurisdictions on the role and function of SH / AL. Throughout Canada this has taken shape via policy papers, SH / AL frameworks, governmental committees, and multi-disciplinary working groups.

It seems that SH / AL has reached a “tipping point” in the governmental and public consciousness, at least to the point where issues are now being raised and discussed.

There is broad and general agreement that a “middle option” is necessary. Analysis of the literature indicates that Canadians want forms of SH / AL that are predictable, flexible, user-friendly, senior-centred, affordable, and adaptable, existing as a congregate care, non-nursing home venue.

Talking about these issues cross-jurisdictionally, as this Discussion Paper demonstrates, is extremely challenging. Use of terms such as SH or AL do not merely give shades of grey within a broader area of agreement; rather, they mean utterly different things in different parts of Canada. The only framework of agreement is that they fall either within “heavy” home support (non-congregate housing) to “near” nursing home care. They are funded differently. They are governed differently. They are regulated differently. They have different philosophical underpinnings.

This discordance makes legislative, policy and systems development difficult. For most Canadians, understanding the systems within their home jurisdiction is hard enough; understanding the systems outside their jurisdiction is nearly impossible.

B. Can Old and New Models Exist Harmoniously in the Same Jurisdiction?

Part of the confusion is that historically, several SH / AL older models developed and existed largely in a vacuum of government regulation or responsibility. Prior the devolution of responsibility to the provinces and to the peak of “age wave” awareness, SH / AL existed in a largely benign, “pay attention to it only if you need it” sort of way. Smaller local efforts tended to be connected with charitable, religious or ethnocentric organizations that “provided for their own”. In jurisdictions where adequate population concentrations existed and a regulatory climate was amenable, private enterprise sprung into the opportunity gap.

Narratives of “charity for our poor seniors” vs. “luxury for those who can afford it” have been created, understandably, in response to a large void in service for the average Canadian.

What Canada is seeing now, however, indicates a more purposeful rethinking about what will be a significant need for a much larger incoming demographic cohort.

It seems likely that this patchwork of service models will have to re-align to a more understandable continuum of options. It seems unlikely, however, that private-pay options will disappear and that public options will move to take their place. Rather, a national awareness of standards in terms of tenancy rights – and in places where tenancy rights have been excluded, a movement towards ensuring that some form of tenancy protection (either pursuant to a residential tenancy act inclusion or by some other legislative framework entirely) is very likely.

It also seems likely that seniors' advocates will address the issue of consumer protection rights in SH / AL. Currently, there is little that seniors can do about non-tenancy and non-health and safety issues which arise in SH / AL. Seniors generally move into SH / AL because of the need for services, and they select, wherever possible, based on how those services will be delivered. The "hospitality" model is increasingly being adopted by SH / AL providers. However, many of these services are very personal in their orientation, such as bathing or dressing. If the SH / AL operator advertises that such personal tasks will be done in a certain manner, and they are not, the qualitative experience is significantly harmed. Similarly, food quality is an issue of central importance. It does not fall under any tenancy purview, nor is undesirable food quality usually a health and safety risk. It may be nutritionally sound. However, tenants of SH / AL often choose, where possible, services with advertised high quality of food, or certain menu options. If those are not provided, one of the key bases for staying in the SH / AL is significantly diminished.

Without a well-functioning, affordable, accessible way of resolving disputes that does not place the resident at risk for "reporting," consumer protection issues remain an area of significant concern. Such a dispute-resolution system must also include investigation and the ability to sanction in a meaningful way, without causing secondary resultant harms to residents.

C. How Does Regulation and Philosophy Co-Exist?

Underlying philosophies about *how* SH / AL should operate vary significantly.

There are those whose philosophy can be tracked to the disabilities movement of Community living – that residents should be free from invasion and regulation commonly found in congregate housing models. This "Autonomous" model espouses supports integrated into seniors' lives in a fundamentally private, non-governmental way. Ironically, many proponents of this model wish to rely on

government for subsidies and support. The Autonomous model is generally regulatory and inspection averse on philosophical grounds of independence and personal choice.

A second model is based on the notion of service delivery and “Hospitality.” This Hospitality model is more philosophically aligned with hotels, restaurants, cruise lines and valet services. It is a higher-end concept generally and one with more of a “private-pay” client base. However, in the same way that hotel chains offer higher, middle and lower end options, so too could this model provide services across the spectrum. A Hospitality model regulatory structure would provide analogies to other regulation of like industries, such as hotels, resorts, and private health clinics (some of which do exist in Canada for limited services).

A third model responds to the reality that many in SH / AL really do need a higher level of care than many programs provide and they predict that this trend will only continue with the “age wave”. Advocates of this model note that most seniors will not choose a SH / AL option until well after they probably need the services.³⁸⁹ This “Pragmatist” philosophy rejects stand-alone notions of independent living and focuses on ensuring that residents are protected and served well, for who and how they are. Its proponents would generally espouse a higher level of regulation, regular inspection and provision of services to older adults who fall into the “grey zone” of mental capability, but whose other care needs do not require nursing-home style residential care.

Canadians would benefit from national discussion on the role of SH /AL and which philosophy best suits the needs. In essence, nationally and provincially, providers and government need to agree to some purposeful strategic planning. SH / AL could significantly benefit from clarity on issues such as “missions, visions and values.” Some provinces, arguably, have done this already, but most have not been explicit about the basis which service provision should be sought and will be provided.

Once jurisdictions have undergone this work, a national discussion can then ensue that compares provincial missions, visions, and values and delves into the future role of the federal government in this increasingly important area of health / housing.

While the present trends are significant, it is also important to consider what issues and trends can be anticipated in the future for SH / AL.

389. As previously discussed, BC’s model of Assisted Living was designed for a much younger and more “able” group of residents than those who actually live within that system.

VI. FUTURE TRENDS

This section of the Discussion Paper focuses on a few specific examples of identifiable trends to in SH / AL in Canada. Its scope is in no way exhaustive; rather, it provides some insight into discrete issues.³⁹⁰

This “future trends” section will consider the following five examples of issues of growing importance in SH / AL in Canada:

- A. Smoking
- B. Gay, Lesbian and Bisexual Issues
- C. Transgendered Issues
- D. Persons with Physical or Mental Challenges
- E. Alcohol and Drugs

A. Smoking and SH / AL

In 2005, there were fewer than five million Canadian smokers over the age of 15.³⁹¹ According to the Public Health Agency of Canada, this marked the lowest overall smoking rate since the government began monitoring smoking in 1965.³⁹² Since that time, government research has revealed that daily smokers consume an average of 15.7 cigarettes a day,³⁹³ that men continue to smoke more than women,³⁹⁴ and that the proportion of daily smokers progressively increases with age.³⁹⁵ Nonetheless, despite more than 40 years of research in this area, there is remarkably little data on smoking practices among the elderly.

Indeed, “recent evidence suggests that substance abuse by the elderly has been under-recognized and underreported” due to a “general lack of interest in this age

390. This section of the Discussion Paper borrows heavily from unpublished project work carried out by the CCEL entitled “Aging with Challenges.”

391. Health Canada, *Smoking Rates: Canadian Tobacco Use Monitoring Survey: Highlights—2005 Results* (12 July 2006), online: Health Canada <http://www.hc-sc.gc.ca/hl-vs/tobac-tabac/res/news-nouvelles/fs-if/ctums-esutc_e.html> at ¶1 [Smoking rates].

392. The Division of Aging and Seniors, *Tobacco Use and Smoking Cessation Among Seniors: Magnitude of the Problem* (Workshop on Healthy Aging, November 2001) [unpublished] online: Public Health Agency of Canada <http://www.phac-aspc.gc.ca/seniors-aines/pubs/workshop_healthy_aging/tobacco/tobacco2_e.htm> at ¶1 [Tobacco use and smoking cessation].

393. *Smoking Rates*, *supra* note 391 at ¶1.

394. *Ibid.*

395. *Tobacco use and smoking cessation*, *supra* note 392 at ¶2.

group.”³⁹⁶ Evidence also suggests that medical practitioners often refrain from speaking with older patients about quitting smoking,³⁹⁷ and symptoms of addiction are frequently misattributed to features of advanced age.³⁹⁸ There is also a growing realization that seniors with lengthy smoking histories are less likely to be affected by anti-tobacco messages³⁹⁹ and are more likely to require assistance with cessation.⁴⁰⁰ For older adults across Canada it appears that acquiring cessation assistance has been difficult and aging with a smoking addiction has particular challenges. One of the most important difficulties faced by older adults aging with a smoking addiction occurs in locating, securing and maintaining appropriate SH / AL. Predominantly, the problems stem from the tension between a resident’s private right to smoke and the public’s interest in having smoke-free environments. This intersection between smoking addiction and appropriate SH / AL has been identified as an area of particular concern. Indeed, many older adults who smoke have found that recent laws or policies governing smoking have become a significant barrier to securing or maintaining these types of appropriate SH / AL.

A national discussion of smoking and SH / AL is beyond the scope of this Discussion Paper. However, an analysis of the issues in one jurisdiction in Canada may usefully add to understandings about the tangled intersection of addiction, individual rights, worker safety, and tenancy laws. For the purposes of this Discussion Paper, the province of BC was chosen, due to its fairly advanced, purposeful regulation of one “end” of the SH / AL spectrum, what BC refers to as “Assisted Living,” reviewed earlier in this Discussion Paper.

1. OVERVIEW

Generally, people may smoke in their own home. Smoking is a legal activity for adults. While it is an activity that is regulated in workplaces and public areas,⁴⁰¹ it is

396. Health Canada, *The Use of Alcohol and Other Drugs by Older Canadians and its Consequences: Introduction* (1 October 2004), online: Health Canada <http://www.hc-sc.gc.ca/ahec-asc/pubs/drugs-drogues/alcohol-alcool/highlights-saillants_e.html> at ¶2 [Use of Alcohol].

397. Charmaine Spencer, “Smoking and Alcohol: What About Suggesting Stopping Smoking to People in Outpatient Programs or Other Health Settings?” (28 January 2004), online: Alcohol and Seniors <<http://www.agingincanada.ca/smoking1.htm>> at ¶6 [Spencer, Smoking and Alcohol]. See also David W. Appel, MD and Thomas K. Aldrich, MD, “Smoking cessation in the elderly” (2003) 19:4 *Clinics in Geriatric Medicine* 77 at 84.

398. Use of Alcohol, *supra* note 396 at ¶2.

399. Tobacco use and smoking cessation, *supra* note 392 at ¶6.

400. *Ibid.* at ¶2.

401. On March 29th 2007, the British Columbia Legislature passed Bill 10, the *Tobacco Sales (Banning*

not regulated in private homes, or generally in private suites in congregate settings. Smoking bans are, however, appearing in Canada's AL facilities. This section will consider three possible legislative sources which may apply to smoking bans in AL facilities.

2. CHALLENGES PURSUANT TO THE BC *RESIDENTIAL TENANCY ACT*

With the new amendments to the BC RTA brought forward in Bill 27 to include SH / AL, guidance with regards to smoking and tenancy issues is most naturally sought pursuant to that Act. However, the BC RTA remains completely silent on residential smoking rights. It does nothing either to prevent or to protect in-suite smoking.⁴⁰²

Similarly, the "prohibition on smoking, or for that matter, any reference to smoking, is not mentioned in the CCAL, Regulations, policies or guidelines".⁴⁰³ As a result, there is significant uncertainty about an individual tenant's right to smoke in AL residences in BC. There is also a lack of clarity over the competing rights of workers and other residents, the impact of nicotine addiction, and how the addiction specifically affects older adults. This uncertainty is common throughout most jurisdictions in Canada.

In the absence of any specific legislative guidance, many BC AL operators have inserted anti-smoking clauses into their tenancy agreements.⁴⁰⁴ Although every tenancy agreement is unique to its operation, many BC AL agreements have elected to ban smoking in both suites and corridors, and have enforced such bans as grounds for termination of the rental agreement contract.⁴⁰⁵ This scenario has raised important issues for both BC AL operators and their residents alike.

Tobacco and Smoking in Public Places and Schools) Amendment Act, 2007, which banned smoking in all indoor public places and school grounds. Section 2.3 of the Act prohibits smoking in public places, workplaces, prescribed places, or within a prescribed distance from a doorway, window, or air intake area. Section 4.23 of the *Tobacco Control Regulation*, B.C. Reg. 232/2007, however, exempts "residents" within the meaning of the *Community Care and Assisted Living Act* from the smoking ban in designated rooms in community care facilities, assisted living residences, or hospitals.

402. Keith McBain, *Smoking Rights in Assisted Living in British Columbia* (Masters in Health Administration Thesis, University of British Columbia, Faculties of Medicine and Commerce 2006) [unpublished] at 24.

403. *Ibid.* at 23.

404. *Ibid.*

405. *Ibid.* at 22-23.

3. A LEGAL REVIEW OF SMOKING IN SH / AL

Canada Mortgage and Housing Corporation ("CMHC") notes that if a rental agreement is silent on smoking, then smoking is necessarily permitted in that rental unit.⁴⁰⁶ This same position is reflected in Canadian case law. In *Feaver v. Davidson*,⁴⁰⁷ the Ontario Rental Housing Tribunal determined that, in the absence of legislative restrictions or rental agreement clauses, tenants possess the "*prima facie* right" to smoke in their own units.⁴⁰⁸

While there is nothing in BC's residential tenancy laws that prohibit smoking in residential suites, a landlord and tenant may introduce no-smoking clauses into their rental agreement. Indeed, no-smoking clauses frequently accompany no-pet clauses in standard rental agreements, and the RTA specifically permits no-pet clauses, limited pet clauses, and pet damage deposits.⁴⁰⁹

This position is supported by the CMHC, which has stated that a landlord may "refuse to rent to a tenant who has pets or smokes".⁴¹⁰ CMHC's position further suggests that if a tenant breaches a no-smoking clause, the landlord may issue a breach letter advising the tenant that they must comply with the rental agreement or else face eviction. If the matter proceeds to arbitration, the eviction may or may not be upheld depending on whether the no-smoking clause is characterized as a material term of the tenancy agreement.⁴¹¹

It seems likely, however, that where an existing rental agreement is silent on smoking, a "smoke-free policy" prohibiting smoking in individual units and/or on outdoor balconies cannot be instituted retroactively, but rather must be phased in over time.⁴¹²

406. Canada Mortgage and Housing Corporation, *Renting in British Columbia* (5 July 2006) online: Canada Mortgage and Housing Corporation <http://www.cmhc-schl.gc.ca/en/co/reho/yogureho/fash/fash_002.cfm> at ¶25 [Renting in BC].

407. [2003] O.R.H.T.D. No. 103 (QL) [*Feaver*].

408. *Ibid.* at ¶42.

409. RTA, *supra* note 43, s. 18.

410. *Renting in BC*, *supra* note 406 at ¶25.

411. Clean Air Coalition of B.C., Information for Tenants on Drifting Second-hand Smoke in Multi-Unit Dwellings, online: Clean Air Coalition of B.C. <<http://www.cleanaircoalitionbc.com/PDF/Fact%20Sheet%20-%20For%20Tenants.pdf>> at 1-2 [Drifting Second-hand Smoke].

412. *Ibid.* at 1.

4. CHALLENGES PURSUANT TO THE CANADIAN CHARTER OF RIGHTS AND FREEDOMS

Could the right to smoke in AL be protected under the *Charter*?⁴¹³ Over the past decade, challenges to anti-smoking prohibitions or smoking bans have been the subject of more than one unsuccessful *Charter* challenge. Regardless, there may still be some room for a *Charter* argument on this issue. This argument, however, requires one to overcome several significant hurdles.

First, a challenge to smoking prohibitions based on the *Charter* must overcome the initial hurdle of application. It is far from clear whether the *Charter* actually applies to BC AL (or other provinces SH / AL) facilities. The *Charter* only governs public actors (such as the government and other public operations). While publicly funded SH / AL facilities may be considered “public actors” for the purposes of the *Charter*, privately funded SH / AL facilities may not. In situations where a SH / AL facility features both publicly and privately funded units, the facility units may be considered “public” in nature with respect to some residents, but not with respect to others. Similarly, a SH / AL facility may be “public” in respect of some of its functions, but not others; this can be especially difficult to determine with respect to the provision of social objectives such as medical care and education.

The issue of *Charter* protection (and the difficulty in determining its application) was highlighted in two significant Supreme Court of Canada decisions, *Stoffman v. Vancouver General Hospital*,⁴¹⁴ and *Eldridge v. British Columbia (Attorney General)*.⁴¹⁵ In *Stoffman*, the Court held that “the provision of a public service, even if it is one as important as health care, is not the kind of function which qualifies as a governmental function under s. 32”.⁴¹⁶ The Supreme Court classified a hospital’s impugned mandatory retirement policy as a non-governmental matter internal to hospital management, and thus outside the scope of *Charter* protection.

A very different decision was arrived at in *Eldridge*, where the petitioner initiated a *Charter* challenge regarding a hospital’s failure to provide sign-language translation to patients with hearing impairments. In discussing the *Charter*’s applicability, the Court stated that “the *Charter* applies to private entities in so far as they act in furtherance of a specific governmental program or policy.”⁴¹⁷ Although the Court

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

414. [1990] S.C.R. 483.

415. [1997] S.C.R. 624.

416. *Supra* note 414 at ¶42.

417. *Supra* note 415 at ¶43.

declined to identify a list of factors for making this determination, it did clarify two bases upon which the *Charter* could be said to apply to a private entity:

First, it may be determined that the entity is itself “government” for the purposes of s. 32...either by its very nature or in virtue of the degree of governmental control exercised over it...Second, an entity may be found to attract *Charter* scrutiny with respect to a particular activity that can be ascribed to government...If the act is truly “governmental” in nature – for example, the implementation of a specific statutory scheme or a government program – the entity performing it will be subject to review under the *Charter* only in respect of that act, and not its other, private activities.⁴¹⁸

The Court ultimately characterized the impugned policy as being intimately connected to the medical service delivery system instituted by the legislation, and held as follows:

[T]he provision of these services is not simply a matter of internal hospital management; it is an expression of government policy. Thus, while hospitals may be autonomous in their day-to-day operations, they act as agents for the government in providing the specific medical services set out in the Act. The Legislature, upon defining its objective as guaranteeing access to a range of medical services, cannot evade its obligations under s. 15(1) of the *Charter* to provide those services without discrimination by appointing hospitals to carry out that objective. In so far as they do so, hospitals must conform with the *Charter*.⁴¹⁹

How might these distinctions apply in the SH / AL context? In BC, both the regulation of AL facilities and the creation of new AL units are the product of specific government policy initiatives (however this is not necessarily the case for SH or “supportive living”).

These initiatives are designed to address the housing needs of a rapidly growing seniors’ population, and are constructed in a manner advertised as equally cost-effective and respectful to the independence and personal autonomy of older adults.

Given the multifaceted nature of AL, which combines housing and hospitality services with the provision of personal services, it could be argued that policies respecting the provision of recreational activities and smoking rights are “governmental” for the purposes of *Charter* scrutiny. In other words, at least in BC, AL residences may be characterized as intimately connected with the implementation of a specific statutory scheme or government program. This is much less likely to be the case in a province with little public involvement in SH / AL.

418. *Ibid.* at ¶44.

419. *Ibid.* at ¶51.

As one commentator observed, the Supreme Court's reasoning in *Eldridge*:

suggests that other quasi- or non-governmental bodies, and the administrators and staff they employ, will also be required to act in conformity with the *Charter* when engaged in the planning and delivery of government funded health care services. Such bodies might include, for example, regional and local health authorities, community health clinics, nursing homes, long-term and chronic care facilities and other diagnostic and treatment facilities in receipt of public funding.⁴²⁰

However, as outlined above, this argument will still need to overcome the potential characterization of BC AL no-smoking policies as matters of internal management, ultimately unrelated to the delivery of medically necessary services.

Assuming that the BC AL facility could be considered "public" and the *Charter* deemed applicable, the second hurdle lies in identifying a valid ground of *Charter* protection for residents of BC AL facilities.

One purported ground which has been tried and has failed is the argument that a nicotine addiction is a "disability," and thus protected from discriminatory conduct by s. 15. In 1998, the Ontario case of *McNeill v. Ontario (Ministry of the Solicitor General & Correctional Services)*⁴²¹ involved a very public challenge to a blanket no-smoking policy at a correctional facility. The petitioner claimed that the facility's smoking ban breached s. 15 of the *Charter*, and argued that a nicotine addiction was a "disability." The court disagreed, holding that an "addiction to nicotine, insofar as it can be considered a disability at all, falls far short of the types of disabilities intended to be included in [s. 15 of the *Charter*]." ⁴²² The court characterized nicotine addiction as a "temporary condition" that "does not interfere with a person's effective physical, social and psychological functioning", and stated that "the 'mental or physical disability' enumerated as a ground for protection in the *Charter* should not be trivialized or minimized".⁴²³

The *McNeill* decision was subsequently followed in *R. v. Ample Annie's Itty Bitty Roadhouse*,⁴²⁴ another s. 15 challenge against a no-smoking bylaw which had been

420. Martha Jackman, "The Application of the Canadian Charter in the Health Care Context," (2000) 9:2 Health Law Review 22 at 22.

421. (1998) 126 C.C.C. (3d) 466 (Ont. Gen. Div.).

422. *Ibid.* at ¶28.

423. *Ibid.* at ¶28 - 29.

424. [2001] O.J. No. 5968 (Ont. C.J.) (QL).

imposed by the City of Guelph. As in *McNeill*, the Ontario Court of Justice weighed the s. 15 claim using the test set out in *Law Society of British Columbia v. Andrews*⁴²⁵ (“*Andrews*”) for establishing analogous grounds.⁴²⁶ That case holds that “smokers are not a ‘discrete and insular minority’ and have not ‘suffered historical disadvantage independent of the challenged distinction’”.⁴²⁷

An alternative, and as of yet unexplored argument, is that no-smoking bans effectively discriminate on the basis physical disability or age. In *Andrews*, the Supreme Court of Canada defined discrimination as:

a distinction, whether intentional or not but based on grounds relating to personal characteristics of the individual or group, which has the effect of imposing burdens, obligations, or disadvantages on such individual or group not imposed upon others, or which withholds or limits access to opportunities, benefits, and advantages available to other members of society.⁴²⁸

In the SH / AL context, then, a policy restricting smoking in individual units might be challenged on the basis that it discriminatorily disadvantages adults in need of physical support and assistance in their activities of daily living and housing. As such, no-smoking policies might limit a resident’s access to the benefits and advantages available to other older adults.

If accepted on this basis, accommodation must be provided for SH / AL residents who smoke. While smoking may not be a healthy lifestyle choice, it is still a legal choice for adults. In BC, the AL mandate is founded on the premise that adults have the right to live at risk, and the right to live in a home that respects their privacy, dignity, and personal autonomy. A smoking ban might have the result of depriving older adults of their rights to live independently and to make their own lifestyle decisions. Nonetheless, this argument is untried and has yet to be judicially considered. However, previous *Charter* challenges to no-smoking policies have so far generally met with poor success.

The final hurdle to overcome, as with any *Charter* challenge, lies in the s. 1 analysis. Even assuming that a claimant can successfully apply the *Charter* to SH / AL residences and can also successfully establish a valid ground for protection, a court may nonetheless uphold the impugned policy as a “reasonable limit” under s. 1 of

425. [1989] 1 S.C.R. 143.

426. Referred to as the “*Andrews* test.”

427. *Supra* note 424 at ¶67.

428. *Supra* note 425 at ¶37.

the *Charter*. That section provides that any right or freedom may be subject to reasonable limits that can be demonstrably justified in a free and democratic society.

To determine whether an impugned policy qualifies as a reasonable limit under a s. 1 *Charter* analysis, Canadian courts will apply the test as set out by the Supreme Court of Canada in *R. v. Oakes*.⁴²⁹ There are two major components of the *Oakes* test. First, the respondent must demonstrate that the objective of an impugned policy constitutes a pressing and substantial concern such as to warrant a *Charter* infringement. Second, the respondent must show that the means chosen to attain that objective are proportional to the end sought.

Applying that test, total smoking bans might not be considered a reasonable intervention. Even though protecting AL employees and other residents from the effects of environmental tobacco smoke might well be a pressing and substantial concern, the enactment of total smoking bans may not be proportional to that objective. In making this determination:

the Court must examine the nature of the right, the extent of its infringement, and the degree to which the limitation furthers the attainment of the desirable goal embodied in the legislation. Also involved in the inquiry will be the importance of the right to the individual or group concerned, and the broader social impact of both the impugned law and its alternatives.⁴³⁰

The right in question is the right to *equality*, not the right to smoke. This distinction is especially important when balancing the infringed right against the stated objective. When balancing these factors, the court applies the following test: first, the court will determine whether the stated end is rationally connected to the applied means; second, the court will determine whether the infringement minimally impairs the right in question; and third, the court will determine whether the benefits of the infringement outweigh the costs of that infringement.⁴³¹

Although the regulation of smoking in SH / AL facilities is rationally connected to the right of employees and fellow residents to be free from second-hand smoke, it is

429. [1986] 1 S.C.R. 103.

430. *Supra* note 425 at ¶51.

431. *Supra* note 429 at ¶69-71. See *Dagenais v. Canadian Broadcasting Corp.*, [1994] 3 S.C.R. 835 at ¶95 for the modern phrasing of the third part of the *Oakes* test: "I would, therefore, rephrase the third part of the *Oakes* test as follows: there must be a proportionality between the deleterious effects of the measures which are responsible for limiting the rights or freedoms in question and the objective, and there must be a proportionality between the deleterious and the salutary effects of the measures."

arguable that a total smoking ban might surpass what is necessary to achieve that objective, and accordingly might fail the minimal impairment test.

With respect to the final cost / benefit analysis, the benefit in question is arguably found more in protecting *others* from second-hand smoke, rather than in protecting the smoker from him or herself. Admittedly, government has the right (and perhaps the obligation) to educate adults about the dangers of smoking, to encourage adults to quit smoking, and to regulate smoking in public places. The central question is whether the government has the right to enact a total no-smoking policy that strips adults of necessary supports, and removes a benefit or advantage that is available to others (namely, the freedom to smoke in the privacy of one's own home). As summarized by the Ontario Court of Justice in *R. v. O'Reilly*,⁴³² the provision of designated smoking areas, rather than total smoking bans, might arguably provide an adequate clean-air living space, while ensuring that individual rights remain protected. In discussing a nursing home's designated smoking area, the court observed that:

this room is set aside for the specific use of the very few residents at Summit Place who are smokers. The court has heard that these are very elderly people. And while it is an accepted fact that tobacco smoking is harmful to individual's health, Summit Place is in compliance with the requirements of the Nursing Homes Act by respecting and ensuring that the dignity of these individuals' rights are [sic] protected.⁴³³

In light of this analysis, it is therefore reasonable to presume that partial smoking prohibitions (such as those that provide for designated smoking areas) would be more likely to withstand *Charter* scrutiny than total smoking bans. Regardless, jurisdictions have increasingly moved to total smoking bans.

While relying on the *Charter* to oppose SH / AL smoking bans is a difficult challenge, it is still a narrow possibility.

5. CHALLENGES PURSUANT TO THE BRITISH COLUMBIA *HUMAN RIGHTS CODE*

Another method of challenging a smoking ban in AL may be through the use of the British Columbia's *Human Rights Code*⁴³⁴ (BCHRC). Human Rights Codes broadly exist across Canada.

432. (2004) 50 M.P.L.R. (3d) 284, 62 W.C.B. (2d) 175.

433. *Ibid.* at ¶33.

434. R.S.B.C. 1996, c. 210 [BCHRC].

The BCHRC has previously treated smoking rights more generously than courts have treated smoking ban challenges pursuant to the *Charter*.

In contrast to *Charter* decisions which have declined to recognize nicotine addiction as a disability, BCHRC judgments have granted nicotine addiction the status of a disability. In *Cominco Ltd. v. United Steelworkers of America, Local 9705*,⁴³⁵ the arbitrator could “not accept that nicotine addiction, as a pure matter of principle, is not a disability in the same manner as an addiction to alcohol or heroin and cocaine.”⁴³⁶ The arbitrator further recognized addicted smokers as a “defined minority group,” and accordingly characterized the impugned no-smoking policy as discriminatory. In evaluating Cominco’s blanket smoking ban on company property, the arbitrator held that the policy affected a defined minority group—in this case, addicted smokers. He noted that the smoking ban could not “meet the criterion of neutrality, which is an essential element of a defence to direct discrimination.”⁴³⁷ According to the arbitrator, the impugned provision was “tantamount to telling [the smoking minority] that they will not continue to be employed at Cominco because the inevitable result is that they will be terminated.”⁴³⁸

Having determined that the company’s total no-smoking policy was discriminatory, the arbitrator’s discussion then turned to the question of whether the no-smoking policy was reasonably necessary to justify its continued application. Specifically, the arbitrator assessed whether the defined minority group had been accommodated to the point of undue hardship. In making his assessment, the arbitrator applied the three-part test as set out in the case of *British Columbia (Public Service Employee Relations Commission) v. B.C.G.S.E.U. (“Meiorin”)*.⁴³⁹ According to the *Meiorin* test, the policy in question must be: a) rationally connected to the function being performed; b) adopted in good faith; and c) reasonably necessary to accomplish its purpose or goal, because the defendant cannot accommodate persons with the characteristics of the claimant without incurring undue hardship, “whether that hardship takes the form of impossibility, serious risk or excessive cost.”⁴⁴⁰ In the result, Cominco’s no-smoking policy failed the *Meiorin* test, and the arbitrator referred the matter back to the parties to resolve how to accommodate the employer’s nicotine-addicted (and thus disabled) employees.

435. [2000] B.C.C.A.A.A. No. 62 (QL) [*Cominco*].

436. *Ibid.* at ¶186.

437. *Ibid.* at ¶204.

438. *Ibid.*

439. [1999] 3 S.C.R. 3.

440. *Ibid.* at ¶32.

Although these cases appear within the employment law context, the duty to accommodate persons with disabilities to the point of undue hardship arises in several other circumstances, including cases involving the residential tenancy relationship and cases regarding the provision of services.⁴⁴¹

In the relatively recent case of *Kernaghan v. Andras Place Co-operative*,⁴⁴² the BC Human Rights Tribunal considered whether an affordable housing co-operative's "over-housing policy" discriminated against a resident's physical disability. According to the policy, "there shall be not less than one person per bedroom in a unit of housing."⁴⁴³ In the event of a surplus, the policy stated that the housing member would be twice requested to "move to a smaller unit."⁴⁴⁴ If the member refused, the member would be subsequently required to "pay regular market housing charges without any subsidy."⁴⁴⁵ The housing co-operative submitted that its policy was both "fair and reasonable,"⁴⁴⁶ but its policy had the effect of preventing a visually impaired resident from remaining in her two-bedroom suite. According to the resident, she relied on her second bedroom for storing "bulky electronic equipment that she required as a result of her disability," including a brail-adapted computer, reel-to-tape machines, and a voice-activated scanner for the blind.⁴⁴⁷ In the end, the Tribunal rejected the co-op's application to dismiss, and found that the allegations were sufficient to suggest a possible contravention of the BCHRC. Indeed, the Tribunal held that the mere potential for a policy or rule to adversely affect persons with disabilities must be investigated and accordingly minimized to the point of undue hardship.⁴⁴⁸

The case of *Howard v. University of British Columbia*⁴⁴⁹ arrived at a comparable conclusion regarding the provision of services. In this case, a complainant alleged that the University discriminated against him by failing to provide a sign language

441. *Council of Canadians with Disabilities v. Via Rail Canada Inc.*, [2007] S.C.J. No. 15 (QL) at ¶118-120; *Iverson v. Bodner*, [1994] B.C.C.H.R.D. No.7 (QL) at ¶34.

442. 2006 BCHRT 354.

443. *Ibid.* at ¶9.

444. *Ibid.*

445. *Ibid.*

446. *Ibid.* at ¶14.

447. *Ibid.* at ¶21.

448. *Ibid.* at ¶33.

449. [1993] B.C.C.H.R.D. No. 8 (QL).

interpreter, and accordingly denying him access to education.⁴⁵⁰ Although the complainant could moderately lip read, his principal means of communication was American Sign Language.⁴⁵¹ And while the (then) British Columbia Council of Human Rights found that the University had not intentionally discriminated against the hearing impaired (on the contrary, “there was evidence that the University was very supportive of the Complainant’s desire to enrol”,⁴⁵² and took steps to accommodate the Complainant by issuing an emergency grant and making provisions for the newly developed Disability Resource Centre),⁴⁵³ its actions were deemed insufficient to enable the Complainant to benefit from his classes.⁴⁵⁴ The University was required to accommodate the Complainant’s disability to the point of undue hardship, and this entailed providing a sign-language interpreter at a “significant”⁴⁵⁵ financial cost to the Administration.

These decisions under the BCHRC suggest that a total smoking ban at a SH / AL residence, instituted for the purpose of protecting employees from exposure to environmental tobacco smoke, might be vulnerable as failing to accommodate the minority of residents who may be nicotine-addicted. Provided that the nicotine-addicted BC AL residents can bring themselves within the purview of the BCHRC, their defined disability would have to be accommodated by the AL residence to the point of undue hardship for the employer. Examples of such accommodation might involve providing a communal designated smoking area, making arrangements for residents to smoke in their rooms at certain times, and / or orchestrating the provision of in-suite services to prevent or minimize exposure of others to second-hand smoke. The provision or accommodation of the right to smoke in one’s own AL residence is supported by the value of independent living. However, given the nature of AL as a type of congregate housing, such considerations must also acknowledge the competing interests of neighbouring residents or employees.

Ultimately, in light of the above case law it would appear that both the *Charter* and the BCHRC may provide some recourse to exercise an AL resident’s right to smoke in their home. While the *Charter* arguably supports a viable (albeit difficult) challenge on the basis of age discrimination, the BCHRC supports a reasonable claim on the basis of disability. Although it remains to be seen whether any of these applications

450. *Ibid.* at ¶1, 23, 32-33.

451. *Ibid.* at ¶15.

452. *Ibid.* at ¶43.

453. *Ibid.* at ¶53.

454. *Ibid.* at ¶54.

455. *Ibid.* at ¶60.

would succeed, recent amendments to the BC RTA specifically addressing AL tenancy rights, while not yet in force, may nevertheless encourage the pursuit of such challenges in the near future.

6. COMPETING RIGHTS

SH / AL residences generally have a complex legal character. They are both the home of the older resident and, at least in a limited sense, a workplace for those employed to provide support and assistance. This section will consider two categories of persons who may have rights or restrictions associated with smoking in SH / AL: a) other residents, and b) AL employees.

(a) Competing rights of other Assisted Living residents to be free from second-hand smoke

There is no direct case law on this issue, nor much direct legislative guidance. This uncertainty has led to significant confusion regarding the rights of other residents of BC AL to live in a smoke-free environment. Further, while it is almost certain that the relationship at common law between residents and a landlord would be found to be a tenancy relationship,⁴⁵⁶ the changes to the RTA regarding AL are not currently in force. Until these changes are brought into force, the Residential Tenancy Office does not yet have specific purview over AL facilities in BC.

However, it appears that the weight of consideration given to other tenants depends on the chosen forum for the competing rights challenge. Whereas *Charter* challenge cases have been quite sympathetic to the competing rights of other residents, the BC RTA decisions have been much less focussed on other tenants' rights to be free of second-hand smoke. Rather, the decisions have been rooted in the individual right of the tenant, as opposed to that of a group of tenants who might be complaining of another tenant's behaviour.

Although the BC RTA provides that "all tenants have the right to 'quiet enjoyment' of their premises, including the right to be free from the unreasonable disturbances of other tenants,"⁴⁵⁷ that right does not appear to include the right to a smoke-free environment. Even the anti-smoking advocacy group the "BC Clean Air Coalition" admits that, "there are no laws that protect people from unwanted second-hand smoke drifting into their homes" in BC.⁴⁵⁸

456. Particularly with the changes specifically stating this relationship already in law, if not in force, and also based on the strength of the *Grenadier* decision in Ontario.

457. RTA, *supra* note 43, s. 28.

458. Drifting Second-hand Smoke, *supra* note 411 at 1.

Currently, if a tenancy agreement does not include a “no smoking” clause, then it appears that the right to “quiet enjoyment” does not specifically include the right to be free from drifting smoke.⁴⁵⁹

However, some narrow Ontario common law exists that did take into account other tenants’ rights in an independent, but congregate, housing setting. In *Feaver*, the Ontario Rental Housing Tribunal found that a tenant’s smoking did in fact interfere with the neighbouring landlord’s “reasonable enjoyment of the residential complex”.⁴⁶⁰ This tribunal consequently ordered the tenant to cease smoking in his suite, stating that:

[The Landlord] has a right to be free of the risks of smoking in her unit. With the severity of the threat, it is not reasonable for the Tenant to expect to continue smoking in this unit where he shares the air with the other occupants of the complex, when another occupant of the complex perceives a threat to their health. Although the Tenant may choose to accept the risks associated with smoking, he has no right to require the Landlord to share them.⁴⁶¹

The tribunal refused to grant his eviction order, however, on the basis that “the tenant [had] always smoked in his unit”.⁴⁶² According to the tribunal, the landlord’s no-smoking policy was novel, and it was therefore “not unreasonable for [the tenant] to assume that he had a right to continue [to smoke in his suite]”.⁴⁶³ It was held that when an existing rental agreement is silent on smoking, a “smoke-free policy” prohibiting smoking in individual units and/or on outdoor balconies must be phased in over time.⁴⁶⁴ In this instance, the rights of the nicotine-addicted tenant succeeded, and trumped the rights of other residents on that specific issue.

In sum, absent specific tenancy-agreement provisions, legislative changes or common law developments, there are no clearly defined laws in BC which can protect an AL resident’s right to be free of second-hand smoke.⁴⁶⁵ That said, the

459. *Ibid.*

460. *Feaver*, *supra* note 407 at ¶12.

461. *Ibid.* at ¶28-30.

462. *Ibid.* at ¶33.

463. *Ibid.* at ¶33-34.

464. *Ibid.*

465. British Columbia Ministry of Health, “Drifting Second-hand Smoke in Multi-unit Dwellings” (August 2005), online: BC Health Guide <<http://www.bchealthguide.org/healthfiles/hfile30b.stm>> at ¶5.

British Columbia Ministry of Health has identified some steps that may be taken to resolve the problem of second-hand smoke exposure in multi-dwelling units, including: discussing matters with neighbouring residents and devising individual solutions; alerting landlords/strata groups about the problem of unwanted smoke; and pursuing structural repairs or building improvements to minimize drifting smoke (e.g. sealing cracks, installing weather stripping doors, and upgrading ventilation systems).⁴⁶⁶ This is likely to be an area of future court or tribunal challenge, as the number of buildings that allow smoking continues to decrease.

(b) Competing rights of employees to be free from second-hand smoke

When considering issues of individual AL resident smoking rights one must also consider the rights of staff to work in a safe and smoke-free environment. This consideration not only involves a review of requisite workers compensation legislation, but also requires an examination of the applicable case law.

In BC, the *Workers Compensation Act*⁴⁶⁷ Occupational Health and Safety Regulation 4.81⁴⁶⁸ directs employers to control employee exposure to environmental tobacco smoke in the workplace. According to this regulation, employers must control exposure to environmental tobacco smoke by *either* prohibiting smoking in the workplace *or* restricting smoking to designated smoking areas, or by other equally effective means. The arbitrator in *Cominco* considered the definition of “workplace” for the purposes of this provision, and concluded as follows:

[T]he word “workplace” is defined broadly to mean a ‘place of employment’ or a “place of work,” which obviously could include outdoors areas...but the fact is that it must be read in the context of the particular hazard that it is purporting to control, which is to say, environmental tobacco smoke. In that context, what it must be taken to say is not that employers are entitled to prohibit smoking as a general right but that they must control exposure to environmental tobacco smoke, wherever that might occur in the workplace. *It does not permit employers to prohibit smoking, save to prevent the exposure of non-smokers to environmental tobacco smoke.*⁴⁶⁹

As discussed earlier, *Cominco* involved an employer-instituted policy prohibiting smoking anywhere on company property, including outdoor areas. The arbitrator found that while Regulation 4.81 does give employers the statutory authority to control employees’ exposure to environmental tobacco smoke, this regulation does

466. *Ibid.* at ¶5-6.

467. R.S.B.C. 1996, c. 492.

468. B.C. Reg. 296/97.

469. *Cominco*, *supra* note 435 at ¶168 (emphasis added).

not grant employers the power to prohibit smoking in outdoor areas where there is no substantial risk of exposure.⁴⁷⁰ Further, the arbitrator held that an employer cannot make rules that extend beyond its employees' work environment into their personal lives,⁴⁷¹ and cannot justify its rules on the ground of being directed at improving employees' general health and welfare.⁴⁷²

The case of *Lee Manor Home for the Aged and Christian Labour Association*⁴⁷³ ("*Lee Manor*") reflects a similar conclusion. There, the arbitrator held that a no-smoking policy is "beyond the power of the employer" where it is either:

- a) unconnected to the protection of non-smokers;
- b) unduly broad in its objectives; or
- c) unnecessarily intrusive or discriminatory; and
- d) cannot be justified on the grounds of efficiency.⁴⁷⁴

The arbitrator observed that "the right of the employee, however ill-conceived from a health perspective, to smoke on her own time when off duty, where such action does not endanger the health of others is, in our society, still a matter of the employee's freedom of choice".⁴⁷⁵

In the context of a BC AL residence, the method by which an employer controls its employees' exposure to environmental tobacco smoke is complicated by AL residents' right to smoke in the privacy of their "own home." Accordingly, any policy that purports to impose a total ban on smoking in individual AL units may exceed what is necessary for the employer to discharge their statutory duty under Regulation 4.81.

In *O'Reilly*,⁴⁷⁶ the Ontario Court of Justice expressly recognized a nursing home's "dual function of being both a workplace and a private residence".⁴⁷⁷ It held that nursing home residents should not be treated "the same as residents who live in other workplaces, such as: a jail; a youth detention centre; a hospital or other

470. *Ibid.* at ¶169.

471. *Ibid.* at ¶162.

472. *Ibid.* at ¶165.

473. (1998), 74 L.A.C. (4th) 201, [1998] O.L.A.A. No. 606 (QL).

474. *Ibid.* at ¶140.

475. *Ibid.* at ¶220, quoted in *supra* note 434 at ¶140.

476. *Supra* note 432.

477. *Ibid.* at ¶37.

healthcare facility,” for such places are no more than “secondary residences”.⁴⁷⁸ The Court went on to find that to associate nursing homes with secondary residences is an “unfair comparison,” as residents “in a nursing home have no other place to call home”.⁴⁷⁹ Indeed, the Court not only recognized that individual suites were private spaces, but held that common areas were private residences as well. In other words, the *entire* nursing home facility was, first and foremost, the residents’ home.⁴⁸⁰

With the new RTA amendments confirming that AL residents and operators are in a tenancy relationship, it is clear that AL units are the residents’ own home, despite the additional contracts for services. One can therefore expect that, similar to nursing homes, AL facilities would be found to serve a dual function of being both a workplace and a primary residence.⁴⁸¹ It remains to be determined if a court would characterize an AL residence as primarily a “home” or a “workplace”; however, there exists a very strong argument that AL units are first and foremost a resident’s home. As such, the exact extent of AL tenants’ rights is still unclear when balanced with AL workers’ rights. However, no decision has yet been made specifically on this point, and this is an area which will require close observation as it develops both in BC and across Canada.

7. SH / AL SMOKING CONCLUSION

Smoking is a contentious issue in SH / AL. This limited overview of the intersections of competing rights and interests brings to light some of the significant challenges inherent in SH / AL. SH / AL is many things: private home, workplace, service delivery, public or private enterprise, and in many ways a business. Adding layers of protected rights and accommodation for persons with addictions and/or lifestyle choices makes it even more complex.

Currently, there is no “cut and dried” answer in Canada regarding smoking and SH / AL. It will continue to be an area to watch.

478. *Ibid.*

479. *Ibid.*

480. Regardless, Ontario has continued to ban smoking in congregate care homes.

481. However, the 1941 case of *Protestant Old Ladies Home v. Prov. Treas.*, noted that a “home is something very different from a hotel or lodgings, where it is simply a question of payment. A home is a place where you find merely the reasonable comforts of life, but also those comforts which are peculiarly associated with what the English people term ‘home’.” [1941] 2 D.L.R. 534, quoting, in part, from *Re Estlin, Prichard v. Thomas* (1903), 89 L.T. 88.

B. Gay, Lesbian and Bisexual Seniors and SH / AL

Gay, lesbian, and bisexual older adults are a population nearly invisible to demographers, social scientists and the general public alike. The reasons for this invisibility include the general ability of older gay, lesbian and bisexual adults to “pass” for heterosexuals in combination with societal misconceptions about older adult sexuality in general.⁴⁸²

First, ageist assumptions “help” gay, lesbian and bisexual older adults “pass” for heterosexual members of the community. “Passing” refers to the phenomenon of homosexual and bisexual people appearing as, or being mistaken for, heterosexual people. This phenomenon is fairly complex. Aside “from the deep fear that the idea of concealed homosexuals can engender in paranoid heterosexuals”,⁴⁸³ passing can be either *transgressive* or *repressive*, depending on the situation.

Second, one of the general societal misconceptions about older adults is that they are asexual.⁴⁸⁴ This misconception may ironically work to the advantage of older gay, lesbian, and bisexual adults in stable long-term relationships, as it “allows older same-sex couples to live together without causing any undue distress or homophobic anxiety among heterosexual members of the community”.⁴⁸⁵

These two concepts are directly interrelated. The peculiar social protection of passing is derived from a mainstream social conception that fails to acknowledge older adults as sexual beings.

As one lesbian older adult ruefully stated, “no one looks at me twice with my short hair and lack of makeup. No one expects some old woman to dress to the nines anymore. So I can really blend in if I want to”.⁴⁸⁶ Her ability to blend in is an example of transgressive passing.

Although homosexuality has been decriminalized and is now a prohibited ground of discrimination under s. 15 (1) of the *Charter*⁴⁸⁷ and the BCHRC,⁴⁸⁸ many members of

482. Jennifer L. Hillman, *Clinical Perspectives on Elderly Sexuality* (New York: Plenum Pub., 2000) at 13 [Hillman].

483. Carol Johnson, “Heteronormative Citizenship and the Politics of Passing” (2002) 5:3 *Sexualities* 317 at 318.

484. Hillman, *supra* note 482 at 163.

485. *Ibid.*

486. *Ibid.*

487. *Charter*, *supra* note 413.

Canadian society adopt a “gay is okay as long as it is not on display” attitude.⁴⁸⁹ This can put significant pressure on gay, lesbian, and bisexual older adults to repress or self-police their behaviour. This *repressive* form of passing can have a detrimental impact on gay, lesbian, and bisexual older adults, as the “concealment of homosexual identity leads to poor self-concepts, depression and other emotional problems”.⁴⁹⁰

Surveys in Canada very rarely inquire into older adults’ sexual identity. Even if questions of this nature were built into studies, the phenomenon of passing would again complicate and obscure the gathering of the data. If surveys did ask about the sexual identity of older adults, they could only count those who openly self-identify with these sexual orientations. Accurate data on this issue is difficult to capture.

1. DEMOGRAPHIC ESTIMATES FOR AN INVISIBLE POPULATION

“Although they are one of the most neglected subgroups of elders, older gays and lesbians do comprise a significant proportion of the general aging population”.⁴⁹¹ Gay, lesbian, and bisexual older adults have been ignored in much of the statistical and academic literature on aging. Notably, the most recent Statistic Canada report, *A Portrait of Seniors 2006*, does not ask a single question on issues addressing sexuality or sexual orientation.⁴⁹²

One of the challenges in estimating the population of gay, lesbian, and bisexual older adults in Canada turns on how that cohort is defined. Estimates at the lower end of the scale (i.e. suggesting that between 1% and 2% of the total adult population are gay, lesbian or bisexual) tend to be derived from reports from people who self-identified as homosexual, gay, lesbian, or bisexual. By contrast, estimates at the upper end (which suggest that an estimated 5% of adult women and 9% of adult men are gay, lesbian and bisexual) are usually derived from people who report any same-sex sexual behaviour from puberty onwards.⁴⁹³

488. BCHRC, *supra* note 434.

489. Sexual Orientation is protected as an enumerated ground following *Egan v. Canada* [1995] 2 S.C.R. 513.

490. Raymond M. Berger, “The Unseen Minority: Older Gays and Lesbians” (1982) 27 Social Work 236 [Berger].

491. Hillman, *supra* note 482 at 160.

492. Statistics Canada, “A Portrait of Seniors in Canada” by Grant Schellenberg & Martin Turcotte, Statistics Canada. (Ottawa: Statistics Canada Catalogue no. 89-519-XIE, 2006), online: <<http://www.statcan.ca/english/freepub/89-519-XIE/89-519-XIE2006001.pdf>>.

493. Laura Dean *et al.*, “Lesbian, Gay, Bisexual, and Transgender Health: Findings and Concerns”(2000) 4:3 Journal of the Gay and Lesbian Medical Association 102 at 102.

While gay, lesbian, and bisexual older adults may be very similar to their heterosexual peers in some aspects, there are a few significant differences that emerge due to their historical lifecourse. Indeed, many of the negative attitudes towards homosexuality of gay, lesbian, and bisexual older adults had been shaped in a different era. Twenty-five years ago Raymond Berger noted:

It is only necessary to look at the historical period during which an elderly homosexual was raised to understand the importance of passing. Today's 60-year-old homosexual was a teenager during the Great Depression, a time when people discussed sex only in private. The term "homosexual" was not in current use—words such as "pervert" and "sexual deviate" were common even among helping professionals. Today's 60-year-olds lived out his twenties and thirties, the peak of sexually active years, during periods of even greater suppression of homosexuality—World War II and the McCarthy era—that convinced [people] ... that subversion and sexual deviance went hand in hand.⁴⁹⁴

That 60-year-old that Berger described would be 85 today. Gay, lesbian, and bisexual older adults over the age of 85 are likely to have very different attitudes towards sexuality than would gay, lesbian, and bisexual older adults who are currently in their 60s. This younger cohort lived out the peak of their sexually active years in the post-Stonewall era, whereas the older cohort—those over 85—spent the better part of their adult lives learning to repress their homosexual identities in very homophobic times where sexuality of any kind was not widely discussed.⁴⁹⁵

Older adults "may engage in any variety of activities such as dating, cohabitation, affairs, same-sex relationships, abstinence, and masturbation, and they may have romantic relationships in community living, assisted living, or full nursing care facilities".⁴⁹⁶ Homophobia is an irrational fear of homosexuals that often manifests itself as a form of discrimination. It can also be interpreted as a form of a wider aversion to the recognition of sexuality that tends toward stereotyping older adults in SH / AL and Long-term care environments as de-sexualized beings.⁴⁹⁷ Homophobia, however, can make gay, lesbian, and bisexual older adults more vulnerable to abuse and neglect by care providers—especially when care is withheld because staff do not want to look after homosexual residents.

494. Berger, *supra* note 490 at 236.

495. *Ibid.*

496. Hillman, *supra* note 482 at 1.

497. Sean Cahill, Ken South & Jane Spade. *Outing Age: Public Policy Issues Affecting Gay, Lesbian, Bisexual and Transgender Elders* (New York: The Policy Institute of the National Gay and Lesbian Task Force Foundation, 2000) at 53 [Cahill, South & Spade].

Gay, lesbian, and bisexual older adults who disclose their sexual orientation may make themselves “vulnerable to discrimination or abuse”.⁴⁹⁸ There are anecdotal reports of care being withheld by SH / AL and LTC staff. For example, staff in one facility refused to wash one female resident because they were afraid of touching “the lesbian”.⁴⁹⁹ “Lesbians and gays may suffer homophobia within a home from staff or other guests, and the only alternative may be to conceal their homosexuality or their long-term relationships”.⁵⁰⁰ Concealing homosexuality or bisexuality—even if the gay, lesbian, or bisexual older adults had lived openly in the past—effectively puts these individuals “back in the closet.”

Homophobia is potentially a serious problem in SH / AL and LTC facilities. A study by Susan Fairchild, Gerard Carrino, and Mildred Ramirez found that more than half of a random sampling of social workers and nursing home staff in New York state had homophobic attitudes, and a further 38% refused to answer questions on their attitudes towards same-sex sexuality in AL and LTC facilities.⁵⁰¹ While it may be that Canadians have a more accepting culture of homosexuality and bisexuality, the American studies combined with Canadian anecdotal evidence suggests that further research should be done on this issue in this country.

The prevalence of homophobic attitudes among caregivers could force many gay, lesbian, and bisexual older adults “back into the closet.” When gay, lesbian and bisexual older adults are forced back in the closet, they could be forced to repress their true identities—and doing so may come at an unacceptable personal cost.⁵⁰²

As the future demographic Boomer cohort ages, SH / AL facility operators will need to be aware of, and sensitive to, the fact that many “open” and “in the closet” gay, lesbian, and bisexual older members of society will both in the present and future require SH / AL.

498. *Ibid.*

499. General Accounting Office, Abstracts of GAO Reports and Testimony, FY97, OGC-97-16 (31 January 1997), online: U.S. Government Accountability Office <<http://www.gao.gov/AindexFY97/abstracts/og97016>>.

500. Angelo Pantazis, “Lesbian and Gay Elders and the Law” (2002) 119 S. African L. J. 534 at 547.

501. Susan K. Fairchild, Gerard E. Carrino & Mildred Ramirez, “Social Workers’ Perceptions of Staff Attitudes Toward Resident Sexuality in a Random Sample of New York State Nursing Homes: A Pilot Study” (1996) 26:1/2 Journal of Gerontological Social Work 154 at 167.

502. For a more detailed analysis and review of some of the social science literature on the detrimental affect of being forced “back in the closet,” see “Aging With Challenges Chapter 5b: Aging with a Transgendered Identity.”

SH / AL facility operators should have policies specifically addressing inclusiveness and consider staff training on gender and/or sexuality issues. When hiring, SH / AL operators should pose questions to prospective staff about their views on gender / sexuality issues. Some progressive SH / AL may seek to advertise that they are “GLB friendly” and consider providing GLB culturally specific activities.

C. Transgendered Issues

The transition from living alone to living in a SH / AL environment can be a difficult time for many older adults. However, Don is having an especially hard time. Don is transgendered, and she is afraid that she will not fit in with her new residence. Upon admission, Don was required to fill out a form indicating her gender—was Don male or female? Although Don outwardly lives as a woman, she does not confine herself within such rigid categories. Feeling the pressure to conform, Don wonders whether it would be easier to subscribe to these normative standards. Don requires SH / AL, but will this housing truly support her?

Over the past 50 years, advances in medical technology have made sexual reassignment surgery considerably more accessible. As a result, there is an aging population which simply never existed before. In particular, young adults who underwent sexual reassignment surgery in the late 1960s and mid 1970s are on the cusp of becoming seniors. As this is a new aging population, very little is known about how transgendered adults will age.

Aging transgendered adults are likely to face a number of unique challenges. Some of these challenges will be medical, such as health complications arising from sexual reassignment surgery,⁵⁰³ interactions between prescriptions and hormone therapy,⁵⁰⁴ and difficulties obtaining medical treatment for their non-traditional bodies.⁵⁰⁵ Some of these challenges are likely to be *social* such as heterosexism, transphobia, and pervasive heteronormativity.⁵⁰⁶

Such social barriers are also likely to affect transgendered older adults with non-traditional bodies such as adult cross-dressers, adults who self-identify as members of the opposite gender, adults who do not identify themselves within the traditional

503. Tarynn M. Witten & Stephen Whittle, “Transpanthers: The Greying of Transgender and the Law” (2004) 9:2 Deakin L.R. 503 at 512-13 [Whitten, “Transgender Aging”].

504. William E. Dressler & James R. Bindon, “Social Status, Social Context, and Arterial Blood Pressure” (1997) 102:1 American Journal of Physical Anthropology 55.

505. Whitten, “Transgender Aging” *supra* note 503 at 19.

506. Cahill, South & Spade, *supra* note 497 at 4.

male and female genders, and adults who have undergone some form of sexual reassignment surgery or hormone therapy.⁵⁰⁷ A transgendered identity is distinctly different from sexual orientation. For example, male-to-female (“MTF”) transsexuals who were attracted to men and engaged in homosexual behaviour prior to their sexual reassignment surgeries remain attracted to men after their operations, whereas MTF transsexuals who were attracted to women before their operations remain attracted to women and identify as lesbians after their operations.⁵⁰⁸

Many of these medical and social barriers are also layered with other levels of social vulnerability or isolation. Indeed, many transgendered older adults “do not have the same family support systems as heterosexual people,”⁵⁰⁹ which can make them more vulnerable to abuse if adequate and appropriate community support systems are not available.

Although transgendered persons have always existed, the Post-Stonewall generation will be the first generation to reach older age in sufficient numbers, and the very first generation which had the option of sexual reassignment surgery.⁵¹⁰ They are, in short, the “Transgendered Boomers.”

While the Boomer⁵¹¹ generation is often typified by past activism, this sub-cohort of Transgendered Boomers has been particularly activist. Some Transgendered Boomers have already protested the discriminatory way in which they have been treated by health and housing providers in supportive care environments such as SH / AL and LTC and when they came into contact with facilities while caring for their aging parents.⁵¹² This same cohort is now looking ahead to their own aging needs and seriously questioning the availability of appropriate, truly SH / AL for themselves as transgendered older adults.

507. Witten, *supra* note 503 at 16.

508. Anne Lawrence, “Sexuality Before and After Male-to-Female Sex Reassignment Surgery” (2005) 34:2 Archives of Sexual Behavior 47.

509. Cahill, South & Spade, *supra* note 497 at 2.

510. Michael D. Shankle, Charles A. Maxwell, Esther S. Katzman, & Stewart Landers, “An Invisible Population: Older Lesbian, Gay, Bisexual, and Transgender Individuals” (2003) 20:2 Clinical Research and Regulatory Affairs 159 at 164.

511. The term “Boomers” refers to those in the Baby Boom generation who were born between 1946 and 1964. The Baby Boom is marked by demographic spike in birth rates in many Western, post-industrial countries following World War II.

512. Linell Smith, “Gay Boomers, Who Fought Discrimination and Confronted AIDS, Face a New Fight” *Baltimore Sun* (Apr 01, 2007), online: <<http://www.mglpc.org/story.php?id=393>>.

In the publication “Transpanthers: The Greying of Transgender and the Law” Tarynn Witten and Stephen Whittle have expressed these issues in the following way:

The emergence of a vocal population of trans individuals of all ages mandates that we address the problems of aging in this population. The combined stigma of being elderly and trans can serve as a strong traumatising force in the lives of such individuals, as they face disclosing their “different” bodies and their care needs in an environment which has never been known to be conducive to respecting difference.⁵¹³

Indeed, transgendered older adults experience a lack of recognition of their differences the moment they come into contact with the housing system. When being admitted into SH / AL or LTC facilities, they first have to deal with the intake forms, which typically only specify two genders, male and female.⁵¹⁴ This binary choice at best makes the person’s identity invisible, and at worst indicates active discrimination. Feelings of shame may be exacerbated by uninclusive supported housing services commonly found in SH / AL and LTC.

The Policy Institute of the National Gay and Lesbian Task Force Foundation publication, *Outing Age: Public Policy Issues Affecting Gay, Lesbian, Bisexual and Transgender Elders*, describes the growing social risk of disassociation from health services in the following way: “as GLBT people grow older and rely more and more on public programs and social services for care and assistance, they may have less independence from heterosexist institutions”.⁵¹⁵

The intersection of SH / AL and gender identity can be the trigger for discrimination and barriers. One study describes how a 71-year-old female-to-male transgendered man with early onset Alzheimer’s was placed in an all woman facility because he had only had chest reconstruction and had not undergone genital reconstruction. In that case “the staff at the care home was very uncomfortable with meeting his bodily needs and were very unhappy with his constant removal of his incontinence pads”,⁵¹⁶ which he refused to wear because he “regarded them as women’s aids”.⁵¹⁷ The discriminatory gendering of this older adult led to both patient and caregiver distress, personal humiliation on the part of the person requiring care, and an increased personal care workload for the caregivers. Had the staff not assumed that

513. Witten, *supra* note 503 at 512.

514. Interview of Chris Morrissey (Generations Project: Vancouver, Jan 16, 2007) [*Morrissey interview*].

515. Cahill, South & Spade, *supra* note 497 at 17.

516. Witten, *supra* note 503 at 513.

517. *Ibid.*

this resident was a woman, then they would have experienced as many problems caring for him. Indeed, after the intervention of an advocate, this particular resident was no longer a behaviour problem after he was moved to facility that housed only men.⁵¹⁸

While transgendered older adults are estimated to be a small population, it is a minority that exists and will increasingly impact policies and procedures in SH / AL. Again, the need for staff orientation to transgendered issues will be an important future trend. Operators should already consider changing binary “male / female” forms and strategize about how best to support and include this population which has historically be isolated and subject to abuse.

D. Physical and Mental Challenges

Dawn is a 52-year-old woman aging with Down’s Syndrome. Like others with her disability, Dawn’s chronological age no longer reflects her physiological characteristics. She requires assistance with daily living activities, and cannot live on her own. Although Dawn currently resides with her elderly parents, her mother and father are concerned about her future living arrangements. And while Dawn is in need of housing supports, there is no existing or available SH / AL attuned to her characteristics. She seems unlikely to be able to direct her own care; however, she does not require the round-the-clock services of LTC either. Like many persons aging with disabilities, Dawn has limited economic means, and even specialized housing arrangements are beyond her abilities. Dawn has a core housing need, and a serious housing problem and a desire for privacy and independent living, suitable to an “older adult” of her demographic Down’s Syndrome cohort.

On April 12th, 2005, the medical community celebrated the 50th anniversary of the Salk vaccine—a vaccine whose very introduction “signalled the end” of the world’s poliomyelitis epidemic.⁵¹⁹ In the decades after the vaccine’s introduction, polio was virtually eliminated worldwide,⁵²⁰ and polio survivors all but “disappeared from society’s view”.⁵²¹ Disappeared, that is, until new issues emerged which brought persons who had polio back into the limelight. By 1970 it became increasingly apparent that early polio survivors were aging differently than their non-afflicted

518. *Ibid.*

519. Mike Mitka, “Aging Brings New Challenges for Polio Survivors” (11 October 2006) 296:14 JAMA 1718 at 1718 [Mitka].

520. *Ibid.*

521. *Ibid.*

peers.⁵²² Among the most common symptoms were the premature onset of fatigue, joint pain, and new muscle weakness.⁵²³ The condition was later diagnosed as “post-polio syndrome,” and while early polio survivors constituted the first group of persons to exhibit these difficulties, they were not alone in their experiences.⁵²⁴ In the coming years, countless other persons with different congenital and early-onset disabilities were also encountering their own challenges with aging, including individuals with cerebral palsy, spina bifida, spinal cord injury, muscular dystrophy, and Down’s syndrome.⁵²⁵ It was the beginning of a new medical phenomenon; and not simply because persons with disabilities were experiencing difficulties with aging. The simple fact was that many persons with mental or physical disabilities had never before lived to encounter these age-related challenges.⁵²⁶

Because of recent advances in medical technologies and rehabilitative therapies, persons who “often did not survive into middle age because of complications related to their disability”⁵²⁷ are now experiencing a significant increase in life expectancy.⁵²⁸ For the first time in history, children with severe congenital and early-onset disabilities are living well into middle and late life.⁵²⁹ Today, persons with spinal cord injury have a life expectancy of approximately 85% of the average population.⁵³⁰ Over half of the estimated 600,000 early polio survivors are now 55 years of age or over,⁵³¹ and approximately 600,000 persons with cerebral palsy are

522. Bryan J. Kemp, Ph.d., and Laura Mosqueda, MD, “Introduction” in Bryan J. Kemp, Ph.D., and Laura Mosqueda, MD (eds.) *Aging with a disability: what the clinician needs to know* (Baltimore and London: The John Hopkins University Press, 2004) 1 at 2 [Kemp].

523. *Ibid.*

524. *Ibid.*; Mitka, *supra* note 519 at 1718.

525. Kemp, *supra* note 522 at 1; Margaret L. Campbell, “A Lifecourse Perspective: Aging with Long-Term Disability” (Spring 1996) 1: 3 *Maximizing Human Potential*, online: Rehabilitation Research and Training Center on Aging With a Disability <<http://www.usc.edu/dept/gero/RRTConAging/ALTD.html>> at ¶1 [Campbell].

526. Kemp, *supra* note 522 at 1.

527. J. Sheets, “Aging with Disabilities: Ageism and More” (2005) XXIX:3 *Generations* 37, online: <http://www.asaging.org/publications/dbase/GEN/Gen29_3.Sheets.pdf> at 37 [Sheets].

528. *Ibid.* at 37; Campbell, *supra*, note 525 at ¶1; Nancy L. Young, et al. “Use of health care among adults with chronic and complex disabilities of childhood” (December 2005) 27:23 *Disability and Rehabilitation* 1455 at 1455 [Young].

529. Kemp, *supra* note 522 at 1; Young, *ibid.* at 1455.

530. Kemp, *ibid.*

531. Sheets, *supra*, note 527 at 37.

surviving beyond middle age.⁵³² As of 2001, there were more than 120,000 Canadians aged 15 and over with developmental disabilities, and more than 55,000 of them were aged 45 and over.⁵³³ In addition, it is estimated that between 330,000 and 660,000 Canadians have intellectual challenges.

These groups constitute a new category of older adults aging *with* physical or mental disability.⁵³⁴ It is a cohort defined by individuals who develop physical or mental disabilities at birth, in youth, or early adult years as opposed to persons who first acquire disabilities in their later years.⁵³⁵ Although not large yet,⁵³⁶ this population's increased longevity has already created new and unexpected challenges for many Canadians.⁵³⁷

According to recent statistics, approximately 15% of the adult population with disabilities require some form of specialized housing feature; over half of these individuals are older adults.⁵³⁸ Not surprisingly, persons with mobility and agility disabilities rely on specialized housing features the most.⁵³⁹ Among the most popular features include grab or lift bars, ramps, and street level entrances.⁵⁴⁰ Other specialized features include automatic doors, widened doorways and hallways, elevators or lift mechanisms, visual and audio alarms, and lowered tables and countertops.⁵⁴¹

While each of these features is designed to accommodate a wide range of needs, much of these needs remain unmet. For example, the 2001 Canadian Participation

532. *Ibid.*

533. Social Development Canada, "Disability in Canada" (29 March 2004), online: Social Development Canada <<http://www.sdc.gc.ca/asp/gateway.asp?hr=/en/hip/odi/documents/PAL>>.

534. Michelle Putnam, Ph.D., "Linking Aging Theory and Disability Models: Increasing the Potential to Explore Aging With Physical Impairment" (2002) 42:6 *The Gerontologist* 799 at 799.

535. *Ibid.*

536. *Ibid.*

537. *Ibid.*; Sheets, *supra* note 527 at 37.

538. Gail Fawcett et al., "Supports And Services For Adults With Disabilities In Canada: An Analysis Of Needs And Gaps: Housing Features" (3 December 2004) Canadian Council on Social Development, online: Social Union <<http://www.socialunion.ca/pwd/section4.html>> at ¶2.

539. *Ibid.* at ¶5.

540. *Ibid.* at ¶7.

541. *Ibid.* at ¶1.

and Activity Limitation Survey⁵⁴² revealed that only 63% of persons with disabilities had fully-met housing needs.⁵⁴³ A full 26% of individuals reported that their housing needs remained entirely unmet (among the least met needs included lowered kitchen counters and other structural accommodations).⁵⁴⁴ Although sex did not appear to be a factor in the degrees of unmet need, age and disability type were noticeable contributors. For example, working-age individuals were more likely to have an unmet need than non-working older adults (36% of working adults experienced unmet needs versus 18% of non-working seniors).⁵⁴⁵ These figures are perhaps resultant of the specialized housing offered to older adults in Canada (e.g. forms of SH / AL such as Long-term Care facilities and Assisted Living residences) that are not traditionally associated with, or intended for, younger age groups. Although SH / AL has been historically directed towards older adults, this kind of restriction invariably overlooks the process of accelerated aging, and its effect on those individuals who experience physical aging far beyond their chronological age. Traditional conceptions of Canada's SH / AL facilities thus act as an effective barrier to those in need of aged care, but who fall short of these age requirements. These barriers are particularly formidable for adults aging with developmental disabilities.

For adults aging with developmental and intellectual disabilities, the availability of SH / AL options is an important concern. Approximately 50% adults aging with developmental disabilities live with a primary care-giving parent. If they outlive their parent, they may require home supports, or have to move into some form of SH / AL, or LTC. Without advance planning, this transition is likely to be more difficult, and the person may end up in housing that is either inadequate or inappropriate for their needs. Even with advance planning, there is a lack of appropriate SH / AL for "younger" adults (according to more generalized notions of "aging") with developmental disabilities. In addition, there is a lack of information on the effects of integrating adults with developmental and intellectual disabilities into programs and services for older adults with age-related mental disabilities.

Adults with Down's syndrome have a significantly higher risk of developing Alzheimer's disease (AD), and "increasingly, older adults with Down's syndrome are being integrated into generic service programs for the elderly".⁵⁴⁶ However, persons

542. The Participation and Activity Limitation Survey (PALS) is a national post-censal survey of persons with disabilities conducted by Statistics Canada.

543. *Ibid.* at ¶1.

544. *Ibid.* at ¶8.

545. *Ibid.* at ¶9.

546. Valerie Temple and M. Mary Konstantareas, "A Comparison of the Behavioural and Emotional

with Down's show signs of AD/dementia much earlier (typically by age 40), and they are more physically active, less aggressive, and show fewer signs of psychosis than older adults with AD alone. Few studies have been done on the behavioural and emotional characteristics of persons with both Down's and AD, and it is not clear whether it is appropriate or beneficial to integrate them into programs for older adults, nor whether it is appropriate to integrate persons with developmental disabilities into housing designed for adults with age-related cognitive or mental disorders.

This problem is illustrated by the effective gap that exists in the SH / AL continuum. The term continuum describes the range of SH / AL options from in-home support services to assisted-living residences to Long-term Care. Thus, many older adults, particularly those with developmental or intellectual disabilities, are likely to experience a significant period during which they are ineligible for SH /AL due to care needs or concerns about not being able to direct their own care, but do not require LTC either.

As persons with pre-existing physical or mental disabilities are living longer, more productive and more independent lives, SH / AL facilities will have to consider how they will respond to this demographic trend. These aging adults will have specialized "middle option" needs and currently the SH / AL marketplace seems unprepared for this coming aging group.

E. Alcohol and Drugs

*Ever since his wife passed away six months ago, John has started to drink more and more each day. Recently, John has neglected to shower and change his clothes. He appears angry most of the time and he cries a lot. John is 83 years old.*⁵⁴⁷

*Before her retirement, Gloria devoted her entire career to working with the developmentally disabled. A single mother, she raised a son entirely on her own. No one suspected that Gloria used crack cocaine on the weekends.*⁵⁴⁸

Characteristics of Alzheimer's Dementia in Individuals with and without Down Syndrome" (Spring 2005) 24 (2) Canadian Journal on Aging 179-189, at 180.

547. Virginia Arnold, "When Seniors Drink: Alcoholism and the Elderly" (2006), online: The Missouri Bar <<http://www.mobar.org/803194a8-8a33-463a-a738-b760f16c3318.aspx>> at ¶1.

548. Reed Karaim, "Calling It Quits: There's a 'hidden epidemic' of older drug addicts. The good news is they're kicking the habit and giving back" (March 2005), online: AARP Bulletin <http://www.aarp.org/bulletin/yourhealth/calling_quits.html?print=yes> at ¶11 [Karaim].

*After a failed investment opportunity, Rita experienced bouts of anxiety and insomnia. Like many older women, she was prescribed sleeping pills to help her cope with her stress. This prescription would lead to a decade-long addiction to prescription sedatives.*⁵⁴⁹

Although alcohol and drug addiction crosses social, cultural, and economic lines, substance abuse is rarely associated with members of the older adult population.⁵⁵⁰ Cases like those of John, Gloria, and Rita remain remarkably absent from mainstream consideration.⁵⁵¹ Prevention efforts and treatment options continue to be targeted towards the country's younger demographics,⁵⁵² and physicians easily mistake the symptoms of substance addiction for the signs of advanced age.⁵⁵³ As summarized by one journalist: "No one worries about grandpas on drugs".⁵⁵⁴ Yet, what has long-been described as a "hidden epidemic" is quickly becoming a visible health issue with current and increased future impact on SH / AL facilities, their operators and residents.⁵⁵⁵

While earlier studies have suggested that alcohol and drug abuse declines with age, recent research indicates that "even the best estimates for prevalence rates significantly underestimate the problem."⁵⁵⁶ Moreover, the prevalence of alcohol and drug addiction in Canada's older adult population is expected to increase as the country's "baby boomers" (those born between 1947 and 1965) enter their sixties.⁵⁵⁷ Unlike today's "65-plus generation," Canada's baby boomers are characterized by prominent alcohol consumption and drug use.⁵⁵⁸ Not surprisingly,

549. Janet C. Currie, "Manufacturing addiction: The Over-Prescription of Benzodiazepines and Sleeping Pills to Women in Canada" (July 2003), online: The British Columbia Centre of Excellence for Women's Health <http://www.bccewh.bc.ca/policy_briefs/Benzo_Brief/benzobriefv3.pdf> at 1-3.

550. Karaim, *supra* note 548 at ¶11.

551. B.G. Knight and D.D. Satre, "Alcohol expectancies and their relationship to alcohol use: age and sex differences" (2001) 5 *Aging & Mental Health* 73 at 73.

552. Karaim, *supra* note 548 at ¶6.

553. Lianne George, "A New Kind of Senior Moment" (29 January 2007) *MacLean's* 43 at 43 [George].

554. Karaim, *supra* note 548 at ¶5.

555. *Ibid.*

556. Christopher Barrick and Gerard J. Connors, "Relapse Prevention and Maintaining Abstinence in Older Adults with Alcohol-Use Disorders" (2002) 19: 8 *Drugs & Aging* 583 at 585.

557. Constance Drohanes, "Portrait in a glass" (April 1999) *CARPNews*, online: 50plus.com <<http://www.50plus.com/50plus-article-print.cfm?documentID=5790>> at ¶10.

558. *Ibid.*

epidemiologists predict that an increasing number of alcohol and drug dependencies will carry over from youth into old age.⁵⁵⁹ Canada's older adult population will continue to expand, the need for SH / AL will grow and correspondingly, so will the issues of aging with alcohol and drug addiction in the "middle option" of the health / housing continuum.⁵⁶⁰

1. ALCOHOL

According to recent statistics, there are proportionally fewer current drinkers among the older adult population than there are among younger age groups.⁵⁶¹ Indeed, Statistics Canada reports that there are proportionally fewer *heavy* drinkers among individuals aged 65 and older than there are within younger cohorts.⁵⁶² In short, the older the individual is, the less likely that individual will be a problem drinker,⁵⁶³ will drink much,⁵⁶⁴ or will drink at all.⁵⁶⁵

Such statistical findings support the myth that alcohol abuse is not a problem for the older adult population.⁵⁶⁶ It has been notably difficult for researchers to acquire accurate estimates of alcohol abuse in this segment of the population.⁵⁶⁷ Several different factors have contributed to this investigative difficulty.

559. *Ibid.*

560. Centre for Substance Abuse Research, "Aging Baby-Boom Generation May Result in Increased Number of Older Adults Using Drugs" (29 May 2006) *CESAR Fax*, online: Centre for Substance Abuse Research <<http://www.cesar.umd.edu/cesar/cesarfax/vol15/15-21.pdf>> at 1.

561. David Hewitt et al., eds., "Older Canadians' Alcohol and Other Drug Use: Increasing our Understanding" (1995) *Horizons One*, online: Health Canada <http://www.hc-sc.gc.ca/ahec-asc/alt_formats/hecs-sesc/pdf/pubs/drugs-drogués/horizons1/hor1_e.pdf> at 10, 12 [Hewitt].

562. Statistics Canada, "A Portrait of Seniors in Canada: 2006" (February 2007), online: Statistics Canada <<http://www.statcan.ca/english/freepub/89-519-XIE/89-519-XIE2006001.pdf>> at 56 [Hewitt].

563. Neal Krause, "Race, Religion, and Abstinence from Alcohol in Late Life" (2003) 15 *J Aging Health* 508 at 508.

564. *Ibid.*

565. *Ibid.*

566. National Advisory Council on Aging, "Seniors and Addictions: A bad gamble" (Fall 2006) 19:4 *Expressions* 1 at 3 [Seniors and Addictions].

567. Lynn McDonald & Tracy Peressini, "An Evaluation of a Training Program on Alcoholism and Older Adults for Health Care and Social Service Practitioners" (1998) 18(4) *Gerontology & Geriatrics Education* 23 at 24 [McDonald].

First, there is no clear guidance about safe levels of alcohol use for older people.⁵⁶⁸ A review of the biomedical and social science literature reveals a strong consensus that alcohol abuse in older populations is a complex issue, “clouded by imprecise definitions” and inconsistent recommendations.⁵⁶⁹ Second, the definitional imprecision of key terms⁵⁷⁰ such as “alcohol abuse,” “problem drinking,” and “senior” make it difficult to collect and analyse data with accuracy.⁵⁷¹ There is, however, an acknowledgement in the literature that alcohol use is likely “more widespread and harmful than is commonly realized outside some specialisms [sic] in the health and social care professions”.⁵⁷²

In the clinical setting, health and social care professionals can be disinclined to recognize and report cases of alcohol addiction, in part from uncertainty about how to make assessments of addictions in older populations.⁵⁷³ Traditional evaluation techniques for recognizing alcoholism are not directly relevant to older patients.⁵⁷⁴ For instance, one common conventional indicator of alcohol abuse is problems or absences from work. This indicator may simply not be relevant in a population which is predominately retired.⁵⁷⁵ In fact, the broad majority of screening instruments used to investigate possible alcohol addiction has been based on younger populations.⁵⁷⁶ There are few studies or tools available to assess alcohol

568. Roger Clough et al., “Older people and alcohol: A summary and recommendations arising from research in Ayrshire & Arran” (February 2004), online: Third Sector First <<http://www.3sf.co.uk/images/SummaryFeb04.pdf>> at 1.

569. *Ibid.*

570. In 2006, the Centre for Addictions Research BC issued new “low-risk drinking recommendations” that follow similar guidelines adopted by Australia in 2001. However, many professionals observe that these new recommendations contain significant departures from Health Canada guidelines presently endorsed in Canada — particularly in regards to the recommended weekly maximum of alcohol consumption (the new guidelines allow for much higher alcohol consumption thresholds). Such inconsistencies can create considerable confusion for health care providers and professionals in recognizing cases of problematic alcohol use. (The Canadian Centre for Elder Law wishes to thank Susan Match of Richmond Addictions Services for her assistance on this portion of the paper.)

571. McDonald, *supra* note 567 at 24.

572. *Ibid.*

573. *Ibid.*

574. *Ibid.* See also M. Saleem Ismail, “Alcohol Abuse: a hidden epidemic among elders” (Fall 2002) 2 *Elder’s Advisor* 61 at 62.

575. McDonald, *supra* note 567 at 24.

576. L.W. Depree and L. Schonfeld, “Older problem drinkers—long-term and late-life onset abusers: What triggers their drinking?” (1990) 361 *Aging* at ¶6.

addiction adequately.⁵⁷⁷ Additionally, self-reporting in the older adult population is also much lower than in alcohol-addicted younger adults. Alcohol abuse among seniors can tend to be covert, and characterized by denial of the problem.⁵⁷⁸

Despite the difficulty in gathering comprehensive, accurate data regarding alcoholism in the older adult population, there is still convincing data available.

Older adults are particularly at risk of developing an alcohol addiction, especially as they enter their senior years (a condition commonly referred to as “late onset” alcoholism).⁵⁷⁹ This transition can trigger problematic drinking, driving the perceived solace in alcohol.⁵⁸⁰ Among the most common trigger transitions related to age involve events such as: retirement and the loss of one’s employment identity; increased social isolation; the death of partners, relatives, and close friends; decreased mobility and a corresponding disconnectedness to the community; as well as ailing physical and mental health.⁵⁸¹ Indeed, the older substance abuser is commonly described as being “ill, isolated, and depressed”.⁵⁸²

Given the significance of these findings as well as the severity of alcohol-related diseases, it is clear that alcohol addiction constitutes a significant issue facing the

577. *Supra* note 548 at ¶73.

578. McDonald, *supra* note 567 at 24.

579. There are two main categories of older adults who experience problematic alcohol use: those identified as “late onset alcoholics,” and those described as “early onset alcoholics.” Late onset alcoholics represent one-third of older adults who experience problem drinking. Individuals within this category are most commonly characterized by a compromised social network, minimal (if any) employment consequences, and a significant life event triggering excessive alcohol consumption (such as retirement, increased physical frailty, or the death of a spouse). As can be inferred by its name, late onset alcoholics initiate their problem drinking during their senior years. By contrast, “early onset alcoholics” commence problem drinking earlier in life, and continue to drink excessively into their senior years. Early onset alcoholics are most commonly characterized by prior alcohol abuse treatment, a family history of alcoholism, and chronic alcohol-related medical conditions. This category represents two-thirds of older adults who experience problem drinking. *Supra* note 547 at ¶10-11 and *supra* note 574 at 63.

580. Sarah Woodend, “Booze beaten, lives reclaimed” (May 10, 1999) *North Shore News*, online: North Shore News <<http://www.nsnews.com/issues99/w051099/booze.html>> at ¶1.

581. Donald MacPherson et al., “Preventing Harm From Psychoactive Substance Use” (November 2005), online: City of Vancouver <<http://www.city.vancouver.bc.ca/fourpillars/pdf/PrevHarmPsychoSubUse.pdf>> at 31.

582. Paulette M. West and Kathryn Graham, “Clients Speak: Participatory Evaluation of a Nonconfrontational Addictions Treatment Program for Older Adults” (1999) 11 *J. Aging and Health* 540 at 560.

province's older adult population that is certain to have increased impact on SH / AL needs and provision. It is also apparent that this problem extends well beyond alcohol abuse, and into other kinds of drug use — both legal and illegal.

2. ALCOHOL POLICIES AND SH / AL

One of the most common restrictions in SH /AL facilities concerns the possession, distribution, and consumption of alcohol.

In 1996, a survey of approximately 170 health / housing (including LTC) care facilities across the country revealed that British Columbia and the Maritimes retained the most restrictive kinds of alcohol regulations.⁵⁸³ This finding is in stark contrast to prevailing “community attitudes about the individual[s] choice to consume alcohol,” as well as the “personal responsibility about when or whether to drink” in the first place.⁵⁸⁴ According to this particular survey, 64% of Canadian care facilities required a doctor's order before a resident is even permitted to consume alcohol.⁵⁸⁵ British Columbia was cited as having the most restrictive alcohol consumption policies, with 85% of the province's care facilities retaining this requirement. Conversely, only 9% of care facilities in Quebec endorsed these restrictions.⁵⁸⁶

This doctor's order requirement prevalent in the housing residences surveyed stands in stark contrast to alcohol service and consumption in the broader community. Indeed, doctors have “little or no control over the matter of whether an adult drinks” in the community at large.⁵⁸⁷

This same survey noted that alcohol tended to be served by care facility staff, as opposed to “self-service” by the older adult (if served at all), and only 32% of facilities permitted residents to store alcohol in their rooms.⁵⁸⁸ Surprisingly, the survey did not find a relationship between how restrictive an alcohol policy was and

583. Charmaine Spencer, “Alcohol and Seniors: Alcohol Policies in Care Facilities” (June 23, 2004), online: Aging in Canada <<http://www.agingincanada.ca/Seniors%20Alcohol/1g3-2.htm>> at ¶16; The most common reason for instituting restrictive alcohol policies was the high percentage of residents on psychoactive medications.

584. *Ibid.* at ¶15.

585. *Ibid.*

586. *Ibid.* at ¶3.

587. *Ibid.*

588. *Ibid.* at ¶6, ¶8.

the degree of care administered by the facility. Indeed, the regulatory trends are relatively consistent across the spectrum of AL and LTC facilities.⁵⁸⁹

Even among the most permissive supportive homes, alcohol policies still require the SH / AL provider's permission for mentally capable residents to keep alcohol in their rooms for personal use.⁵⁹⁰ Although the above-mentioned survey was conducted several years ago, its results still appear to be reflective of today's trends.

Ultimately, while SH / AL facilities may advertise a "homelike atmosphere" and standards of "independent living," restrictive alcohol policies may appear to undermine this environment and infringe both on freedom of choice and cultural norms. Such policies also create an added obstacle for older adults struggling with an alcohol or drug addiction — particularly those who are unable to safely or successfully withdraw from substance use.

3. ILLEGAL DRUGS

According to current research, the rate of illegal drug use among the older adult population is extremely low.⁵⁹¹ In fact, incidents of illegal drug use among seniors across Canada are exceedingly rare.⁵⁹² In light of these figures illegal drug addiction is largely considered to be a "phenomenon of youth".⁵⁹³

Health care professionals will often confuse the symptoms of illegal drug use with the signs of advanced age.⁵⁹⁴ For many health care providers, it may seem far easier and more familiar to treat an older patients' gastrointestinal disorder or cardio-respiratory difficulty than it is to diagnose illegal drug use by seniors.⁵⁹⁵ There are good reasons for this difficulty. First, the symptoms of drug addiction often manifest in ways that mimic the signs of age-related conditions or disease (e.g. liver damage,

589. *Ibid.* at ¶9.

590. *Ibid.* at ¶10.

591. Dan Reist et al., "Every Door is the Right Door: A British Columbia Planning Framework to Address Problematic Substance Abuse and Addiction" (May 2004), online: Ministry of Health Services <http://www.moh.hnet.bc.ca/mhd/pdf/framework_for_substance_use_and_addiction.pdf> at 17 [Reist].

592. Hewitt, *supra* note 561 at 10, 36.

593. Dr. Axel Klein, "Emerging Populations: The need for research into drug use among the elderly" (July 2006) 6:2 *Drugs and Alcohol Today* 12 at 12.

594. George, *supra* note 553 at 43.

595. *Ibid.*

anxiety, and insomnia).⁵⁹⁶ Second, many older patients are reluctant to report their problems with illegal drug use. For older adults in particular, there continues to be a considerable stigma and embarrassment associated with drug dependencies.⁵⁹⁷ Accordingly, many older patients will refrain from informing their doctor about their drug addiction, for fear of further shame or judgment.⁵⁹⁸ Moreover, by the time older adults encounter serious drug-related medical conditions, they have already learned to manage and mask their addiction for quite some time, and may have hidden their problem from family, friends, and the larger community.⁵⁹⁹ As may be expected, treatment is hard to come by when the tendency is to say “He’s such a nice old man, he couldn’t be...a drug addict”.⁶⁰⁰

While it is difficult to identify instances of illegal drug addiction in seniors, ignoring its prevalence would be an oversight. Although current rates of illegal drug addiction are very low, researchers predict that these figures will greatly expand in the coming years.

Current lower rates of illegal drug addiction among Canada’s older adults are due to the so-called “maturing-out” of the drug-using population.⁶⁰¹ That is, illegal drug use traditionally peaks during an individual’s early twenties, and ultimately declines to a considerably smaller percentage by middle age.

Because today’s 65-plus generation were rarely exposed to illegal drugs in their youth, such percentages would be especially minute. In fact, illegal drug use “only became prevalent in the 1960s”.⁶⁰² Conversely, the province’s baby boomers were afforded “widely different opportunities to use illegal drugs” that translate into more drug-related dependencies in later life.⁶⁰³

596. Seniors and Addiction, *supra* note 566 at 1.

597. *Ibid.*

598. *Ibid.*

599. George, *supra* note 553 at 43.

600. Karaim, *supra* note 2 at ¶10.

601. Hewitt, *supra* note 561 at 35; See also: Joseph Gfroerer et al., “Substance abuse treatment need among older adults in 2020: the impact of the aging baby-boom cohort” (2003) 69 *Drug and Alcohol Dependence* 127 at 127 [Gfroerer].

602. Hewitt, *ibid.* at 35.

603. *Ibid.*

Many researchers are predicting that Canada (as well as the United States and European nations)⁶⁰⁴ are at the “leading edge of a wave” of elderly drug addiction, primarily for two reasons: first, because of the “sheer numbers” of the baby boom generation; and second, because of the higher incidence of illegal drug use among that sizeable demographic.⁶⁰⁵ Studies emerging from the United States have already confirmed the start of this phenomenon. According to some recent American studies, “the fastest-growing demographic of drug users in the U.S. is white, middle-aged, and well-to-do”.⁶⁰⁶ Further, the 2005 National Survey on Drug Use and Health found that middle-age drug use has increased by 63% since 2002, while incidents of middle-aged drug overdoses have increased by 800% since 1980.⁶⁰⁷ Ironically, while illegal drug use is often associated with younger age groups, this 2005 report revealed that illegal drug use among teens declined by 15% between 2002 and 2005. As summarized by the spokesperson for the United States Office of National Drug Control Policy, it is “almost like a tale of two generations and their perceptions on drug use.”⁶⁰⁸

With the baby boomers rapidly aging, the generation who came of age during the most drug-friendly era in modern Western history are becoming the “new seniors”.⁶⁰⁹ SH / AL operators can expect to see increasing numbers of cases of drug addiction in this demographic wave. However, the rising prevalence of drug addiction is not strictly limited to substances obtained on the street, but also extends to drugs obtained over-the-counter.

4. PRESCRIPTION DRUGS

While the present rate of illegal drug addiction in seniors is currently still relatively low, the extent of prescription drug abuse is nothing short of staggering.⁶¹⁰ Apart from alcohol, prescription drugs represent the most common form of substance addiction facing the province’s older adults today.⁶¹¹ Since older adults constitute

604. Gfroerer, *supra* note 601 at 134.

605. Karaim, *supra* note 548 at ¶8.

606. George, *supra* note 553 at 43.

607. *Ibid.*

608. *Ibid.*

609. *Ibid.*

610. Reist, *supra* note 591 at 17; Seniors and Addiction *supra* note 566 at 4.

611. Jim Kouri, “Senior Citizen Drug Abuse Rising” (19 September 2005) *The Conservative Voice*, online: Partners: Seeking Solutions With Seniors <http://www.solutionsforseniors.cimnet.ca/cim/29C427_696T30836T697T30867.dhtm> at ¶2.

the largest class of medication consumers, the prevalence of prescription medication addictions is hardly surprising.⁶¹²

Prescription medication presents a daunting paradox for older adults.⁶¹³ While these drugs can provide a welcome source of relief when taken appropriately, prescription medication abuse (both intentional and unintentional) is an all-too-common side-effect for seniors. Prescription medications in seniors can lead to cases of over-prescription, adverse medication mixtures, and ultimately drug-dependence.⁶¹⁴ Once drug-dependence develops, the temptation to acquire the substance may become so powerful that older adults will consult with multiple doctors to increase their drug supply.⁶¹⁵

One of the most commonly prescribed medications that result in addiction is a class of drugs known as benzodiazepines (sometimes referred to as sleeping pills). Benzodiazepines (including Xanax, Valium, and Ativan) are anti-anxiety medications that are used to treat cases of acute stress and insomnia.⁶¹⁶ They target the body's central nervous system and encourage skeletal, heart, and muscle relaxation.⁶¹⁷ In general, benzodiazepines are prescribed to older adults after life upsetting life events, such as the death of a spouse or relative.⁶¹⁸ This class of drug is also more likely to be prescribed to older women.⁶¹⁹

Although most benzodiazepine prescriptions are only meant to be taken for short periods of time (e.g. 30 days to a few months), an increasing number of

612. For example, recent studies show that seniors “fill an average of 15 prescriptions per year, may take up to 10 different medications at one time, buy various over-the-counter drugs, and account for more than one-third of all adverse drug reaction reports made to Health Canada.” Seniors and Addiction, *supra* note 566 at 4.

613. *Ibid.*

614. *Ibid.*

615. *Ibid.*

616. Charmaine Spencer, “Alcohol and Seniors: Benzodiazepine Use Among Seniors” (31 October 2004), online: Aging in Canada <http://www.agingincanada.ca/benzodiazepine_use_among_seniors.htm> at ¶1.

617. *Ibid.* at ¶3.

618. *Ibid.* at ¶24.

619. *Ibid.* at ¶14; Health Canada, “Straight Facts About Drugs & Drug Abuse” (2000), online: Health Canada <http://www.hc-sc.gc.ca/ahc-asc/alt_formats/hecs-sesc/pdf/pubs/drugs-drogués/straight_facts-faits_mefaits/facts-faits_e.pdf> at 18; Charmaine Spencer, “Best Practices: alcohol and other substance use withdrawal” (2004) Seeking Solutions Project, online: Aging in Canada <http://www.agingincanada.ca/BEST_7.PDF> at 3 [Spencer, Best Practices].

prescriptions are being used beyond therapeutically recommended levels.⁶²⁰ Indeed, it is not uncommon for an older adult to use and ultimately abuse their prescription medication for years and even decades at a time.⁶²¹ Despite the general pharmacological recommendation of prescribing older adults with approximately half the dose recommended for younger adults, recent studies show that these drugs are being prescribed more frequently and at much higher levels. For example, a study conducted in British Columbia's North Shore region during the mid 1990s discovered that 25% of seniors over the age of 75 were regular prescription users of benzodiazepines.⁶²² Identical figures emerged out of Nova Scotia that same year.⁶²³ A recent international review likewise revealed that 23% of seniors were taking these medications on a long-term basis (although the maximum recommended dosage did not exceed 30 days), while fully 11% of older adults reported dependence on the anti-anxiety drugs.⁶²⁴

In addition to the apparent over-prescription of benzodiazepines for persons living independently, studies have also demonstrated an equally high prescription rate in SH / AL and LTC.⁶²⁵ Indeed, it has been suggested that these middle and high end care providers enable prolonged benzodiazepine use to keep cognitively impaired residents quiet or passive, "particularly where the staff levels are not adequate or staff have not had proper training in positive ways of addressing difficult behaviours".⁶²⁶ However, prolonged benzodiazepine dependence can be very damaging to older adults.

Indeed, after long-term dependence, older adults often experience severe withdrawal symptoms. As with many other substance addictions, a benzodiazepine addiction can result in serious post-withdrawal anxiety (otherwise known as "rebound anxiety") if users attempt to discontinue use too quickly.⁶²⁷

620. *Supra* note 616 at ¶1.

621. *Ibid.* at ¶20; *Supra* note 37 at 2, 3.

622. Spencer, Best Practices, *supra* note 619 at ¶11.

623. *Ibid.*

624. Seniors and Addiction, *supra* note 566 at 4.

625. Long-Term Care is a form of supportive housing that is intended for individuals whom are no longer able to live independently. In addition to providing round the clock medical services, Long-Term Care facilities also offer a range of personalized services and assistance with daily living.

626. *Supra* note 616 at ¶26.

627. *Ibid.* at ¶22.

5. ALCOHOL AND DRUG ADDICTION: TREATMENT OPTIONS

Over the last two decades, researchers and health care professionals have increasingly recognized that “older people who experience alcohol or drug problems often have different treatment needs than their younger counterparts”.⁶²⁸ Indeed, age-related physiological changes and generational differences play an important role in shaping age-appropriate treatment services.⁶²⁹ For example, successful seniors’ addiction programs tend to be slower-paced with more opportunities afforded towards quiet time.⁶³⁰ Because many of today’s older adults grew up during an era that expected stoicism and privacy when confronting personal problems, this demographic tends to benefit from these gentle forms of treatment and less aggressively paced programs.⁶³¹

Perhaps flowing from the demographic discomfort of discussing problems in a public fashion, combined with the need for a slower pace of treatment, many older substance abusers often report greater benefits from private rather than group sessions.⁶³²

A harm-reduction approach has also been recommended for older adults. Across Canada, one of the most successful treatment programs directed towards older adults specifically employs the harm-reduction model, which is based on a non-confrontational and non-judgmental method of addiction treatment.⁶³³ Rather than attempting to eliminate substance use entirely, the program aims to reduce problematic substance use to more manageable levels — effectively catering to an individual adult’s needs, while building the necessary levels of trust in the drug treatment relationship.⁶³⁴

628. Paulette M. West and Kathryn Graham, “Clients Speak: Participatory Evaluation of a Nonconfrontational Addictions Treatment Program for Older Adults” (1999) 11 J. Aging and Health 540.

629. Vancouver Island Health Authority, “Mental Health and Addictions Services: Fact Sheet and Service Inventory, Southern Vancouver Island” (October 2006), online: Vancouver Island Health Authority <http://www.viha.ca/NR/rdonlyres/EEA0B836-310A-4D00-A0763ADB9874E91E/0/fs_mhas_inventory_august_2006_final_4oct06.pdf> at 6; *Supra* note 581 at 27.

630. *Supra* note 547 at ¶15.

631. *Ibid.* at ¶13-14.

632. Spencer, Best Practices, *supra* note 619 at 4.

633. *Ibid.* at 1.

634. *Ibid.* See also: Charmaine Spencer, “When Alcohol Problems And Abuse In Later Life Intersect,” online: Ontario Network for the Prevention of Elder Abuse <<http://www.onpea.org/en/SideNavigation/Publications/ConferenceProceedings/conference04/01/Doerksen.pdf>> at 29.

This harm-reduction strategy has proved particularly well-suited to the older alcohol or drug user. Indeed, not every older adult will want to stop substance use upon entering a treatment program⁶³⁵ and harm-reduction can provide older adults needed assistance in situations where they believe “it’s impossible to stop right now”.⁶³⁶ It also gives older adults reasonable and realistic goals in reducing the immediate harms resulting from substance abuse.⁶³⁷

Similarly effective harm-reduction strategies have focused on remedying the causes of substance addiction, rather than simply reducing the amount of substance use. One of the common precipitants of substance addiction is an older adult’s compromised social network and feelings of social isolation, particularly after retirement or a spousal death.⁶³⁸ Harm-reduction attempts to reduce an older adult’s feelings of social isolation by instituting integrative strategies, including: offering community outreach programs and at-home addiction treatment; directing seniors to peer support groups and self-help organizations; and reconnecting older adults with willing family members and friends.⁶³⁹

Regrettably, while the harm-reduction approach and above-mentioned treatment strategies have demonstrably assisted seniors with their substance addiction, many older adults remain unable to access these kinds of services. In particular, senior-centered resources tend to be located exclusively within urban centres.⁶⁴⁰ Given that older adults commonly face transportation and mobility challenges, travelling to these regions can pose a significant barrier to treatment.⁶⁴¹ Distant treatment services also deter older adults from seeking assistance because of their regional unfamiliarity and a fear of new or strange surroundings.⁶⁴²

In conjunction with these accessibility challenges, there is also an overwhelming lack of senior-specific treatment programs to access. According to recent estimates,

635. Spencer, Best Practices, *supra* note 619 at 1.

636. *Ibid.*

637. *Ibid.*

638. *Supra* note 547 at ¶10-11; *Supra* note 574 at 63.

639. Spencer, Best Practices, *supra* note 619 at 2.

640. Charmaine Spencer, *A Cross Canada Look at Helping Seniors Who Are Experiencing Alcohol Problems* (2001) (Vancouver: Gerontology Research Centre, Simon Fraser University) at 62.

641. Spencer, Best Practices, note 619 at 4.

642. *Ibid.*

senior-centred addiction programs across Canada only serve 1200-1500 older adults each year (less than 1% of those affected by drug and alcohol addiction).⁶⁴³ Further, of the senior-specific programs in existence today, many are “stretched very thin, and often do not know whether they will still be around next year.”⁶⁴⁴ As one scholar describes, there is “a major gap between need and resources.”⁶⁴⁵

Future trends in SH / AL are likely to include a broadening of current notions of SH / AL resident diversity, to reflect more the cultural rights and social challenges existing in non- facility population. These future trends also force a more individual and “realistic” view of aging, challenging certain homogeneous presumptions that people all become blank slates as they age. In particular, the Boomer generation is unlikely to hand over the hard-earned mantle of “protestors” and “social justice” advocates.

VII. CONCLUSION

This Discussion Paper provides a starting point to engage in a national conversation about a critical “middle option” of health / housing in Canada. It does not purport to cover every issue. Rather, its goal was to bring key past, current and some future trends in SH / AL together to prompt discussion and to assist in creating a common understanding of challenges.

SH / AL is already of significant concern to Canadians, and with the impending “age wave” will only be more so in the immediate future. However, it is clear that Canadians will need to find legislative and regulatory systems that make sense and govern the entire “field” of issues, while staying true to the chosen philosophical underpinnings of SH / AL.

In order to achieve this, a more focussed discussion on the needs of residents and operators must begin. This Discussion Paper concludes by asking a series of questions, and inviting input and consultation on these questions and other issues not specifically raised, in order to better inform the process.

Some key discussion questions open for consultation include:

643. *Ibid.* at 67.

644. By way of illustration, a 1999 report found that Canada spent approximately \$110 million on addiction programs, but devoted only half of one percent towards seniors’ addiction treatment. See: Charmaine Spencer, “Alcohol and Seniors: Policy Issues” (October 31, 2004), online: Aging in Canada <http://www.agingincanada.ca/policy_issues.htm> at ¶2.

645. *Supra* note 640 at 54.

1. Should SH / AL have national definitions which are standardized?
2. Should the “field” of SH / AL be regulated by a single statute in each jurisdiction or should SH / AL be regulated by a variety of legislation (e.g. Residential Tenancy, health and food safety standards etc)?
3. How can consumer protection issues be best addressed by legislation or regulation (e.g. food quality, services not up to standards, but not a risk to health and safety)?
4. What complaint systems are preferable? (e.g. reports based by resident, inspection-based required by legislation, hotline?)?
5. How can that information on complaints or standards best be made public or used by the public (e.g. online reports, independent body’s publications etc?)?
6. What should be the best entry and exit criteria for SH / AL in Canada?
7. What do you think some of the “hidden issues” not raised in this Discussion Paper are?
8. What are the biggest challenges for SH / AL residents now? In future?
9. What are the biggest challenges for SH / AL operators now? In future?
10. What would your ideal SH / AL look like or provide to you?

Responses to this Discussion Paper can be sent to the Canadian Centre for Elder Law in the following ways:

By email at: ccels@bcli.org

By web at: <http://www.bcli.org/ccel> (click on the “consultations” page)

By fax at: 1-604-822-0144

By mail at:

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1822 East Mall

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Vancouver, BC V6T 1Z1

Responses to this Discussion Paper will be consolidated and analysed. Results will form part of the Final Report, which will be released in 2009.

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