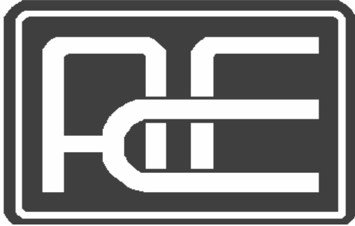

ACE NEWSLETTER

SPRING/SUMMER 2006, Vol. 4, No. 1 ACE is a Legal Clinic Serving Low Income Seniors

ADMISSION TO LONG-TERM CARE HOMES:

ARE EVALUATIONS OF CAPACITY BEING CONDUCTED IN ACCORDANCE WITH THE LAW?

By Jane E. Meadus, Barrister & Solicitor, Institutional Advocate

You live alone and have a fall. You are admitted to hospital. While there, a social worker comes to talk to you about moving to a nursing home. You tell her no you are not interested. She feels that you can no longer cope at home and insists that you need to move to a nursing home. You listen, answer her questions, and politely decline.

The next thing you know, you're told that you have been found "incapable" of making a decision about going to a nursing home, someone else has made that decision for you, and you will be moving to the nursing home as soon as a bed can be found. A bed becomes available and you are taken against your will to a nursing home where you are told that you cannot leave.

Could this happen to you? Unfortunately, yes. In a review of recent reasons for decision by the Consent and Capacity Board ("CCB"), violation of the rights of people found incapable with respect to admission decisions would appear to be widespread. Given that few people actually apply to the CCB for a review, it is argued that is likely that many persons are being admitted into long-term care homes in contravention of the law.

The Law

In order to be admitted in a long term care home (also known as a nursing home or home for the aged), someone

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MAKING TREATMENT DECISIONS

By Graham Webb, Barrister & Solicitor

The Advocacy Centre for the Elderly holds special expertise in the law of consent, capacity and substitute decision-making. ACE provides advice and representation is in the area of treatment decisions. It also has taken a leading role in educating lawyers, health practitioners, service providers, and most importantly, older adults who are interested in these issues about the law of consent, capacity and substitute decision-making. Its intake staff would be pleased to speak with older adults about these issues at any time. There are many areas of substitute decision-making, and many subtle and complex legal issues within the realm of

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ACE LECTURE SERIES

"The Practice of Elder Law — Raising the Bar"

November 6, 2006

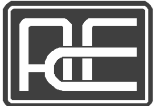
featuring

The Honourable Flora MacDonald

&

Ontario Superior Court of Justice The Honourable Mr. Justice Paul Perell

REPORT OF THE CHAIR



By Gerda Kaegi, Chair, Board of Directors

On behalf of the Board we, once again, want to thank all the staff of ACE for the great work they are doing for seniors in Ontario and across Canada. ACE could not have achieved its remarkable reputation without having built a strong team to do all the work that is being done.

Gerda Kaegi
Chair
ACE Board of Directors

An important part of this recognition is the special award that Judith Wahl, the Executive Director of ACE has been awarded by Osgoode Hall Law School - the "2006 Osgoode Hall Law School Alumni Gold Key Award" for achievement for her extraordinary contributions in the Public Sector. Judith received her award on May 23, 2006.

The Gold Key Award is given to outstanding Osgoode Hall Law School Alumni who have made contributions to the Law School and the community. The Public Sector Award recognizes the achievements of public sector or government lawyers based on:

- sustained outstanding service or a specific extraordinary accomplishment;
- significant contributions to social justice or public service; and
- a recognizable contribution to the Law School and/or the community at large

There are a number of activities the Board is undertaking this year that will be reported on more fully in the next newsletter. We are deeply concerned about decisions that are being made by LAO that may be adversely affecting the salaries and benefits of Legal Aid Clinic staff across the province. We believe that this is reflective of the under-valuing of our clinic system by the government and the community at large. We will need your help to make everyone aware of the importance of poverty law in our society and the absolute need to strengthen, not weaken, the clinic system

ACE – HONOURS

Judith Wahl and Jane Meadus have both been named as "Distinguished Fellows" of the Canadian Centre for Elder Law Studies.

The Canadian Centre for Elder Law Studies ("CCELS") is a non-profit organization committed to enriching and informing the lives of older adults in their relationship with the law; to meet the increasing need for education and research in relation to legal issues of particular significance for older adults and to serve as a national focal point for this emerging field. The CCELS organizes an annual conference aimed at educating various both professionals and lay persons on important legal issues relating to older adults. Its goal is to promote contribution and access to a knowledge base pertaining to legal issues affecting older adults, with a view to reducing vulnerability, social isolation and abuse.

NEW TENANCY LEGISLATION

The *Residential Tenancies Act, 2006*
Changes to Rules about Retirement Home Tenancies

By Judith Wahl, Barrister & Solicitor

INTRODUCTION

The Ontario Government has introduced new tenancy legislation. The *Residential Tenancy Act, 2006* will replace the *Tenant Protection Act*, the existing legislation that sets out the rules about the relationship between landlords and tenants in Ontario, including the rules that apply to tenancies in retirement home accommodation. The new legislation has been passed but is not yet in effect. It will come into effect on a future date to be determined.

This article highlights only those sections that specifically affect tenancies in retirement homes. Retirement homes are referred to as "care homes" in both the old and new legislation. The term "care home" is defined as "a residential complex that is occupied or intended to be occupied by persons for the purpose of receiving care services, whether or not receiving care services is the primary purpose of the occupancy". Based on this definition, retirement homes are residential accommodation, and persons living in retirement homes are tenants. This definition of care home is the same in both the old and new legislation.

Only minor changes were made in respect to the parts of the legislation that apply to care home tenancies, and it would appear that most of these changes benefit care home tenants.

TENANCY AGREEMENTS

In the new legislation, just as in the old, care home landlords are required to provide written tenancy agreements to care home tenants. These agreements must set out the charges for rent as well as the charges for care services and meals that the care home tenant has agreed to purchase from the landlord.

What is new is that if a landlord fails to provide a written tenancy agreement that sets out the charges for rent, care services and meals, the care home tenant can apply to the Landlord and Tenant Board (formerly called the Ontario Rental Housing Tribunal), to ask for an order of abatement of rent until the landlord complies with this requirement. This is a positive change, as the requirement for a written tenancy agreement is intended to ensure that care home tenants are provided with the details of all their expenses related to living in the care home. This change gives tenants a remedy when the landlord has not provided them with this written agreement. It also acts as an impetus for care home landlords to provide a written tenancy agreement from the start of the tenancy as required, so that the terms of the agreement between the landlord and the tenant are clear to both parties.

CARE HOME INFORMATION PACKAGE

The new legislation has continued the requirement that care home landlords must supply tenants with a "Care Home Information Package" or "CHIP" before entering into the tenancy agreement. This information package must include the following:

(a) A list of the different types of accommodation provided and the alternative packages of care services and meals available as part of the total charges;
(b) Charges for the different types of accommodation and for the alternative packages of care services and meal;
(c) Minimum staffing levels and qualifications of staff;
(d) Details of the emergency response system, if any, or a statement that there is no emergency response system;

(Continued on page 4)

(Continued from page 3)

(e) A list and fee schedule of the additional services and meals available from the landlord on a user pay basis; and
(f) Internal procedures, if any, for dealing with complaints.

Just as in the old legislation, the new legislation states that the landlord cannot give a notice of a rent increase or a notice of increase for care services or meals until the tenant receives this information package.

TERMINATION OF TENANCY BY THE TENANT

As in the old legislation, the new legislation provides that a care home tenant is required to give only 30 days notice to the landlord if he or she wants to terminate the tenancy.

However, a new section has been added that states that a tenant who gives such a notice may also require the landlord to stop the provision of care services and meals before the tenancy terminates, if the tenant also gives the landlord a notice of this request. This notice must be given at least ten (10) days in advance of the date that the tenant wants the care services and meals to stop being provided.

This is a good addition to the legislation as it means that the tenant who moves out of a care home before the termination date will not have to pay for meals and care services he or she is not using up to the termination date. This is fair as the tenant is not receiving the services or having the meals as he or she has already moved out.

The new legislation also provides that the estate of a deceased care home tenant is obligated to pay for only ten (10) days of care services and meals after the death of the care home resident.

EXTERNAL CARE PROVIDERS

Another new provision in the legislation prevents landlords of care homes from stopping a care home tenant from obtaining additional care services from a person of the tenant's choice outside of those agreed to in the tenancy agreement. As well, the landlord may not interfere with care providers which are hired by the tenant that are in addition to the services provided by the landlord under the tenancy agreement. This is a positive change as tenants can then decide not to purchase extra care services from the landlord, but instead can privately purchase or otherwise arrange for these services from service providers in their community if the tenant prefers other providers or can get the services at a better cost that that charged by the landlord.

APPLICATION TO TRANSFER A TENANT

Just as in the old legislation, the new legislation continues to provide that a landlord may apply to a tribunal, the Landlord and Tenant Board, for an order to "transfer" a tenant out of the care home and to evict the tenant if the tenant either no longer requires the level of care provided by the landlord or the tenant requires a level of care that the landlord is unable to provide.

These orders may be granted by the Board only if the Board is satisfied that appropriate alternative accommodation is available for the tenant, and the level of care that the landlord is able to provide combined with community based services available

(Continued on page 5)

(Continued from page 4)

through the Community Care Access Centre and other resources provided to the tenant cannot meet the tenant's needs. If a dispute arises, the matter must be sent to mediation before the Board makes an order.

An important change has been enacted that care home residents should be aware of with respect to these transfers. Under the old legislation, the landlord was not able to get a default order under this section. Unfortunately, this section is not contained in the new legislation. This means that tenants served with a notice of transfer or eviction under this section must file a dispute if they disagree with the landlord and want to fight the eviction or transfer.

This is not a positive change. Tenants in these circumstances may, for a variety of reasons, be unable to file a dispute within the time period, for example they may be in hospital or have other issues which prevent them from so doing. As well, it is our experience that this section has been poorly understood, and landlords often try to "transfer" or "evict" persons without appropriate cause or without following the rules.

We believe that care home tenants should have the same rights as those who live in their own homes in the community. People who live in their own homes in the community do not lose their accommodation merely because they have become ill and need a higher level of care for a period of time.

It is therefore our position that care home tenants should have the same opportunity to maintain their housing, even if they have temporary health problems. By allowing default orders, the tenant in hospital could find that he or she is evicted because they were unable to file a dispute.

The old legislation ensured that all tenants in these situations would have the opportunity for a hearing even if delayed in filing a dispute.

Tenants of care homes should become familiar with all the sections of the new *Residential Tenancies Act*, *2006,* not just the specific sections that apply to retirement homes, as it is the whole legislation that defines the relationship between tenants and landlords, no matter what type of tenancy it is.

The care home sections are provisions that address some of the specific needs of care home tenants and landlords, but these apply in addition to the main part of the legislation. The full text of the legislation may be found on the Ontario Government website at www.gov.on.ca . Look for the link for "legislation" and then follow the link to "annual consolidated statutes and regulations". Then click on the letter "R" in the alphabetical list and look for the title "*Residential Tenancies Act, 2006*".

Many public libraries (99 in Toronto alone!) provide public access to the internet so anyone wanting to look at the full text of the legislation should be able to access it through a library.

As reading and understanding legislation can be challenging, it is often easier to get information about the law through public legal education materials. ACE plans to produce new plain language pamphlets and information sheets on the *Residential Tenancies Act, 2006* and how it applies to retirement homes by early fall 2006.

As well, it is expected that Community Legal Education Ontario (www.cleo.on.ca) will also be updating all their public legal education material on tenancy law in the very near future. Contact ACE in the fall (September 2006) for further information on the availability of pamphlets and information on tenancy rights under the *Residential Tenancies Act, 2006.* ■

ADMISSION TO LONG-TERM CARE HOMES: The Tests

(Continued from page 1)
must consent to the admission. If you are mentally competent, you consent to that admission.

Where there are reasons to question your capacity, an evaluator will perform an "evaluation" to determine whether or not you are able to make your own decisions, pursuant to the *Health Care Consent Act* ("*HCCA*"). An evaluator is someone defined in the *HCCA* as being a member of a specified health or social work college.[1] They require **no training** in conducting evaluations.

The *HCCA* states that you are presumed capable until you have been legally determined to be incapable. To be capable with respect to admission to a long-term care home means that you are able to understand the information that is relevant to making a decision about the admission and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision.[2] If you are determined to be incapable, your substitute decision-maker ("SDM") will make that decision on your behalf, unless you challenge the finding.[3]

There is not such thing as "global incapacity" – incapacity is determined on an issue by issue basis. For example, you may be capable to consent to treatment, but not capable to consent to admission to long-term care, and vice-versa. (For more information on treatment decision-making, please see the article "Making Treatment Decisions" by Graham Webb starting on page 1 of this newsletter.)

If an evaluator finds you incapable, he/she is required to tell you that you have a right to challenge the finding by requesting a hearing before the CCB. At the hearing, you have a right to be represented by a lawyer. If you want to have a hearing, the evaluator must assist you in completing the application for the hearing and finding a lawyer. If you are low income, you may also qualify for a legal aid certificate to pay for the lawyer. In most cases, the lawyer will assist you in completing the legal aid application.

If the CCB finds you are incapable, your SDM will make the decision on your behalf regarding admission, unless you appeal to Court, in which case the admission will not occur until there is a final determination of your capacity has been made by the Courts. (Even if you are found to be incapable, in law there is actually no way to force you to go to a long-term care home. For further discussion, please see *Long-Term Care Facilities in Ontario: The Advocate's Manual, 3rd ed.* published by the Advocacy Centre for the Elderly.)

If the CCB finds that you are capable, you get to make your own decisions about admission to a long-term care home. The determination by the CCB is about whether you get to make your own decisions, **not** about whether you need to be in a long-term care home.

The Evaluation

There is no specific "test" or list of questions to determine capacity in respect of admission to a long-term care home. There are no magic questions, and no magic answers. "Capacity" is a legal issue, not a medical one. Unfortunately, evaluations are poorly understood, even by those who are conducting them. This leads to improper evaluations, which can lead to people being admitted in long-term care homes against their will.

The "Tests"

There is no specific "test" which one can use to determine capacity in respect of admission to a long-term care home. In order to determine capacity, the evaluator must determine whether the person understands and appreciates the issue before them. However, because some evaluators do not understand capacity, they purport to use a variety of tests to make this determination. These tests either test the wrong issue, for example memory or cognition or are not sufficient to make the determination. While

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The Practice of Elder Law - Raising the Bar
November 6th, 2006

The Honourable Flora MacDonald

ACE Special Lecture Series

The Board of Directors

Advocacy Centre for the Elderly

Second Biennial ACE Special Lectures

presents

The Honourable Flora MacDonald

&

The Honourable Mr. Justice Paul Perell

of the Ontario Superior Court of Justice

Evening of

November 6th, 2006

This event will include a reception and will be preceded by the ACE Annual General Meeting. Times to be confirmed.

Additional notices of the event with complete details will be available in early September.

The Honourable Mr. Justice Paul Perell Ontario Superior Court Of Justice

Location

Professional Development Program Centre for

Osgoode Hall Law School of York University,

1 Dundas Street West, Suite 2602, in Toronto.

Please contact Tammy Gillard at ACE (416) 598-2656) to register, for further details or to be put on the mailing or e-mail list for the future notices.

ADMISSION TO LONG-TERM CARE HOMES: The Problem

(Continued from page 6)

these tests may be a resource in assisting an evaluator in coming to a conclusion, by themselves they cannot be used to determine capacity. Below are a few examples of these tests:

Mini-Mental Status Exams: The "Mini Mental Status Exam", also known as the "MMSE" or "Folstein Test", is a test of cognition. It consists of 30 questions. It does not test legal capacity.

Clock Test: This test is often used in conjunction with the MMSE and again, does not determine capacity.

Evaluator's Questionnaire: This is the most common way of "testing" capacity to make admission decisions, as the questionnaire is included in the application package for admission to a long-term care home. It consists of the following five questions:

1. What problems are you having right now? (Does the person understand his/her condition or problem?)

2. How do you think admission to a nursing home or home for the aged could help you with your condition/problem? (Does the person appreciate the foreseeable consequences of admission or not?)

3. Can you think of any other ways of looking after your condition/problem? (Does the person understand the condition/problem?)

4. What could happen to you if you choose not to live in a nursing home or home for the aged? (Does the person appreciate the foreseeable consequences of admission or not?)

5. What could happen to you if you choose to live in a nursing home or home for the aged? (Does the person appreciate the foreseeable consequences of admission or not?)

The evaluator will ask the person the five questions, writes down their answers, and base their determination based upon this. The CCB has consistently held that this simply asking these five questions is not sufficient for a finding of incapacity.

"Best Interest" Test: This is not a specific test, *per se*. However, this is most often how the evaluator comes to their decision, no matter what "formal" test they use. Based upon this model, if the person disagrees with what the evaluator believes is in their best interest, they are found to be incapable.

Functional Test: The functional test determines the person's physical ability to perform a task, and is not a test of the person's mental capacity to understand and appreciate admission to a long-term care home.

The Problem

In a review of the case law, it becomes obvious that many evaluators do not understand the law under which they are supposed to be operating. Both the CCB and the Court have found again and again that many evaluators are ill-informed as to the test of capacity.

As the issue here is the person's liberty (i.e. choosing where he or she will live), complying with the law is of utmost importance. Where the evaluation is improperly performed, the person's fundamental rights are violated and any admission will be illegal. One of the most fundamental tenets of our society is that one's freedom cannot be restricted except in accordance with the law.

Unfortunately, in the case of admission, when the cases come before the CCB, we find repeated instances of person's rights being violated. An example of the types of violations which occur can be found in the case of *Re AB*,[4] in which the Board held that what occurred was so inadequate that it could not be considered an evaluation. It held as follows:

(Continued on Page 9)

- While the legislation did not contain a statutory requirement that the person to be evaluated be advised of the reason for the evaluation, misleading the person either intentionally or unintentionally about the purpose of the evaluation is not something to condone.

- When society authorizes taking away a person's right to make his or her own decisions regarding such fundamental issues as where the person will live, even when this is done to protect a person from his or her own lack of capacity, there is a process that must be followed. The process is an evaluation of the person's capacity to make the decision, replete with safeguards such as the right to apply to this Board for a review of the finding of incapacity. The decision of the Board is automatically appealable to the Superior Court of Justice. The evaluator must be a member of one of the health care colleges prescribed in the legislation or regulations.

- There had to be an evaluation. The Board found that there was no evaluation and what transpired fell so short of what the legislation contemplates before stripping a person of the right to make his or her own decision that it could not be considered an evaluation within the meaning of the law.

- The Evaluator Questionnaire is a guide, a resource tool, on how to conduct an evaluation. It is not, by itself, an exam the answers to which are marked by the evaluator and scored "capable" or "incapable." The evaluator has to be a member of one of the prescribed health professions and a member of that profession's College. He or she is expected to bring his or her professional training to bear on the question of capacity. The legislation contains a highly subjective test for capacity that cannot be scored on the basis of answers to five simplistic questions. In many cases, the questions must be modified, at the very least, to make them applicable to the person whose capacity is being evaluated.

- Even though there was a clinical record available, which one would have thought would have been rich with notations that could have illuminated his capacity or lack thereof, it was neither reviewed nor was any evidence from it at the Hearing.

- The evaluator did not record the person's answers on the questionnaire or make notes of them. The Board stated that it wondered how it could review a conclusion without knowing what had actually been said in response to the questions?

- The evaluator did not know the legislative test for capacity. This is equivalent to a police officer charging a person for speeding without knowing what the speed limit is.

- The Board found that there was only a skeletal declaration of incapacity, not a considered evaluation, resulting in a finding of incapacity that could be reviewed. What transpired fell so drastically short of what the legislation contemplated before depriving a person of the right to make his or her own admission decision, that it could not be considered an evaluation of capacity within the meaning of the *Health Care Consent Act*.

Because the vast majority of the persons being admitted are seniors with health problems, there is little complaint about this. The common perception is that the admission is being done in the person's "best interest", and therefore everything done, whether in strict compliance of the law, is reasonable.

For example, in the case *In Re L.M.*,[5] Ms. Scott, (the person responsible for authorizing admission to the care facility and therefore for ensuring that legal consent for admission was obtained) actually voiced this opinion. In this matter, there were a number of issues being dealt with, including whether or not the SDMs were capable themselves of making the decision. Ms. Scott's evidence was analyzed by the CCB as follows:

(Continued on page 10)

(Continued from page 9)

> Ms Scott concluded by saying that in her view the legal definition of capacity was irrelevant to the consent process. She guided her approach based upon whether or not consent was given or refused in accordance with what she thought was in the patient's best interests: "We try to obtain the best result for the patient".
>
> . . . .
>
> Consequently, when substitute decision-makers disagreed with her view of the incapable person's "best result," she simply bypassed them and went to Public Guardian and Trustee for consent to admission to a care facility. Substitute decision-makers who disagreed with her were *ipso facto* incapable, though based upon her definition of capacity as, "did the substitute decision-maker agree with my decision?"
>
> . . . .
>
> The whole process is mandatory because informed consent is the linchpin of the admission, the difference between lawful admission and false imprisonment.
>
> . . . .
>
> Put differently, Ms Scott disregarded Mrs. L.M.'s legal rights as well as those of her husband and son. Respect for a person's legal rights and adherence to one's own legal obligations in professional relationships is a minimum ethical standard for any health care professional. How can Ms Scott say she respected Mrs. L.M.'s dignity and autonomy when she ignored her legal rights?
>
> . . . .
>
> Ms. Scott bypassed legal process and ethical obligations and there are practical consequences. First, Ms. Scott's approach erodes the trust health professionals must have in each other and the trust clients must have in the health care system it if is to function in an era of escalating costs, complex decisions, and limited funding. Second, knowing that Ms Scott sees fit to bypass the process and ignore her client's rights, how can the staff at the office of the Public Guardian and Trustee ever again rely on her capacity assessments? Third, in this case, Ms Scott fuelled Mr. P.M.'s otherwise unjustified distrust for the system and process. Fourth, her approach in this case rendered her evidence too suspect to be credible.

In 1997, in a case called *"Re Koch"*,[6] the judge, Mr. Justice Quinn, was extremely critical of the process used to assess capacity and in fact, compared it to the criminal justice process, stating that that the evaluator was acting as "police, judge and jury". He found that, given the impact of the finding, the evaluator's review had fallen far below that which had been expected. Mr. Justice Quinn went on to describe what would be necessary to support a finding of incapacity

Despite this case having taken place almost ten years ago, evaluators continue to be woefully uninformed when it comes to the evaluation process. Time and again, we see evaluators making findings where it is clear from their evidence that they not only do not know how to execute an evaluation, they do not even know the legal test for capacity. The result is that persons are found to be incapable at law of making decisions, are taken out of their home and put into a long-term care home that they do not wish to go to,, despite the fact that the evaluator does not understand the fundamental law under which they are operating. For example In Re G.B.,[7] the CCB stated the following regarding the evaluation of Mr. G.B.:

> The question I asked Ms. C.P. [the evaluator] focused upon her definition of "capacity" and test for capacity against which she measured Mr. G.B., Ms. C.P. said she measured Mr. G.B. against his ability to look after himself, the risks he faced and the safety concerns his treatment teams identified. The first time I asked her what definition of capacity she used, she said she based her conclusion on the facts.

(Continued on page 11)

(Continued from page 10)

The second time I asked her the same question, she referred to a *Mental Health Act* definition of inability to weigh and retain information.

. . . .

Ms. C.P. assessed Mr. G.B.'s capacity while being part of a treatment team that already decided Mr. G.B. could not safely go home and in furtherance of the goal of getting him into a care facility. This made the result of the capacity assessment appear preordained, that a decision was made to get Mr. G.B. into a care facility because that was in his best interests. It is the obligation of health care professionals to be concerned about their patient's and clients' best interests. But, it is the role of a person assessing capacity to divorce those concerns from the assessment. When the assessor is part of the treatment team, the onus rests with him or her to satisfy the Board that the finding of incapacity was based upon the test for capacity, not a determination of the person's best interests.

. . . .

I don't expect an evaluator to have the definition of capacity memorized. However, I don't think I set the standard too high by expecting an evaluator either to know that the definition is in the *Health Care Consent Act* and be able to point to it there, or that being capable requires both the ability to understand information relevant to the decision and the ability to appreciate the reasonably foreseeable consequences of making or not making the decision.

. . . .

Even so, the finding of incapacity takes away the incapable person's right to make his or her own decision about where to live. Evaluators are authorized by the state to take that right away if the person fails a certain test – the test for capacity to make that specific decision at that particular time. They ought to know the test, else how can it be said the process is fair?

There are many other examples of cases where the evaluator does not know the legal test for capacity, does not understand how to evaluate a person's capacity, and violates the person's fundamental rights of liberty. [8]

What is not known, however, is the number of admissions that are made following improper evaluations where the person does not apply to the CCB. Given the high percentage of cases reviewed where the evaluations were conducted improperly and the person's fundamental rights were otherwise violated, it is argued that the number is high This suggests that there are many persons who are living in long-term care homes who have been admitted illegally.

It is therefore imperative that those who are in the admission process know their rights, and contact a lawyer when they disagree with the finding, to prevent being admitted in a long-term care home against their will. Names of lawyers who specialize in this area of law can be obtained by contacting the local area office of Legal Aid Ontario. ■

End Notes:

1. *HCCA* s. 2(1).

2. *HCCA* s. 4(1).3. For a full discussion of substitute decision-making, see the article entitled "Making Treatment Decisions" in this issue.

4. 2004] O.C.C.B.C. No. 233, TO 04-1257, 1260, May 5, 2004.

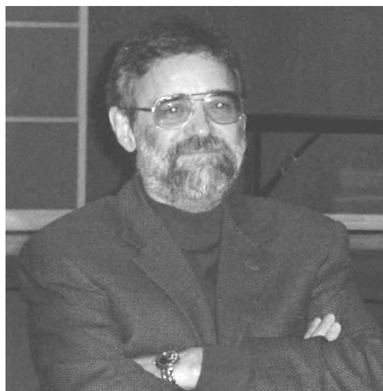
5. O.C.C.B.C., TO-05-7935, 7936, November 25, 2005.

6. (1997), 33 O.R. (3d) 485 (Gen. Div.).

7. O.C.C.B.C., KI-06-1556, May 29, 2006.

8. See for example, *Saunders v. Bridgepoint Hospital* [2005] O.J. No. 5531, (OCJ), December 14, 2005; *In Re A.B.*, [2006] O.C.C.B.D. No. 144, OT-06-1192, April 27, 2006; *In Re S.S.* [2005] O.C.C.B.D. No. 19, TO-05-4570, February 2, 2005; *In Re D*, O.C.C.B.D., TO-06-1481, May 25, 2006; *In Re J.*, [2005] O.C.C.B.C. No. 198, TO-05-6548, July 8, 2005; *In Re P.G.* [2005] O.C.C.B.D. No. 362, TO-05-7785, 7786, 7787, October 17, 2006; and *In Re J.D.*, [2004] O.C.C.B.D. No. 528, TO-04-3232.

COMINGS AND GOINGS



GEORGE T. MONTICONE

B.A. Ph.D. LL.B

George Monticone retired from ACE In August 2005. George had worked at ACE since 1988 as the first lawyer in the Research Lawyer position. George has been a tremendous asset to ACE and the work of our clinic on behalf of older adults. He brought to our clinic many different skills and experiences.

George received his B.A. Philosophy from Washington State University in 1967 and his Ph.D. Philosophy from the University of Calgary, 1972. He taught Philosophy at a number of universities before attending law school at the University of Alberta, graduating in 1984. He was called to the Ontario Bar in 1986. While working as a Legal Research and Writing instructor at Osgoode Hall Law School, he came into contact with staff from ACE – and started working here in 1988.

At ACE, George performed many different types of work, as is required of a practitioner in a busy legal clinic. He was co-counsel on the Grenadier case, in which ACE represented 125 seniors in a Toronto retirement home, seeking an interpretation at to whether a retirement home was subject to the existing rent control legislation. The Grenadier case continued for approximately eight years in a variety of tribunals and courts until the case was resolved, agreeing with ACE that rent control did indeed include retirement homes. George's contributions included the development of the major arguments in that case: much of the credit for the results should go to him.

Subsequently, George became the ACE "expert" on retirement and care homes, providing both client representation and acting as the lead on policy and law reform work undertaken by ACE on retirement home issues. He was one of the primary writers of both the care home pamphlets produced by CLEO and the materials produced by ACE on these topics.

George also became our expert on home care issues at ACE, undertaking client representation in litigation and preparing educational and research materials on home care issues. He worked with ARCH and CLEO to create the home care pamphlets also produced by CLEO.

George was the Editor of the ACE newsletter and became the Editor-in-Chief of the ACE Manual on long-term care law entitled *Long-Term Care Facilities in Ontario: The Advocate's Manual*. Under his direction the manual went through three editions and is now used as a reference text by seniors and their advocates, at universities, at long term care homes, at law firms, and by government Ministries. George was also the scriptwriter and producer of the ACE Video on Powers of Attorney and acted as a consultant with seniors organizations, the City of Toronto, and the provincial government on a variety of issues.

We will miss George. Among his contributions to ACE is a tremendous body of work, particularly in the areas of retirement homes and home care. We will miss our interactions with him both on a personal and professional level. We will miss his many areas of interest, including the sport of kings (horseracing); wine and good food and gardening. George was the "best dressed' member of the office and described by many of the ACE staff as a "real gentleman". We wish him the best in his very busy retirement, traveling, gardening and working as a consultant We hope we will be able to have George work with us on some projects in the future as he continues to be a great advocate, lawyer, and friend.

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BEVERLEY NOTLEY

Beverley Notley, our longtime Office Manager, retired from ACE in March 2006. Beverley was one of four original staff in 1984, working as Office Manager until her retirement in May 2006. A fixture in the legal clinic system, Bev worked at Flemington Community Legal Services before coming to ACE.

What was Bev's job at ACE? It seemed that anything that whatever had to be done around the office – it was Bev's job. From taking intakes, talking to clients, finding new office space, preparing financial accounts, paying bills, writing cheques, ordering office equipment and supplies – it was Bev's job. Getting office equipment to work was Bev's job, and whether she fixed it herself or called the repair man – she got it done. Her job including making the office run smoothly, and keeping the Board, staff and clients all happy! Even in her retirement she continues to help, by assisting ACE through a spot audit by the LSUC, and continuing to draft a new office manual.

Bev was the primary contact with the Board members of ACE. She knew everything about ACE, the legal clinic system, and legal aid that the Board members needed to know and ensured that they had the information to fulfill their obligations, by preparing documents as well as by providing a Board manual. Each year, Bev made sure that a helpful orientation was given to the Board members.

Bev was active in the Support Staff Association. As one of the more experienced OMs, she was a mentor to many new OMs over the years. She was very generous in her time, always willing to help in whatever way she could.

On a personal level, Bev is a complex person - forthright and direct, kind and considerate. At the office, she ensured that special occasions and life events were celebrated in some way, helping to make our small office a family. Her own family - being a mother, grandmother, daughter and sister – were central to her life. She is an independent and adventurous woman, traveling alone and enjoying the sites.

We will miss her at ACE. Her legacy will continue through the policies and procedures that she helped develop. She is primarily responsible for the way ACE works from day to day, and for that we are all thankful!

NEW STAFF

Maleksultan Kaba is the new Office manager at ACE. Maleksultan came to ACE in March 2006 with experience working in the university and non-profit sector. This is her first experience in the legal field. She arrived at ACE at a challenging time. Within a short time of commencing, she was faced with an LSUC spot audit, as well as the trials and tribulations associated with the rollout of the new computer system. She was described by one of her references as an “organizational diva” so we have high expectations of her, particularly when ACE moves its offices, which is expected to happen in the next year.

Pauline Rosenbaum is our new research lawyer at ACE. She will start in September 2006. Pauline is a graduate of the University of Toronto law school and clerked at the Superior Court of Ontario. After her call to the Bar, she continued to work at the Superior Court as Counsel/Manager of Legal Research in the Office of the Chief Justice and comes to ACE from that position. Her position includes client work; as well as acting as lead at ACE on research projects, including briefs to government on law reform issues. She will also be taking over as Editor of the ACE Newsletter.

WORLD ELDER ABUSE AWARENESS DAY

In Madrid in April 2002, countries throughout the world adopted the United Nations' International Plan of Action on Ageing. The Plan of Action recognized the importance of addressing and preventing abuse and neglect of older adults. It identified that mistreatment of older adults was a violation of internationally recognized human rights.

The International Network for the Prevention of Elder Abuse (INPEA) introduced the first World Elder Abuse Awareness Day to support the Madrid Plan of Action on Ageing. World Elder Abuse Day was celebrated on June 15th, 2006 for the first time.

The intent of this day was to share information, learn more, discuss the issue of abuse of older adults, and develop plans to take action to address abuse. Canada's Federal/Provincial/Territorial (F/P/T) Working Group on Safety & Security for Seniors has produced public information materials (e.g. poster, fact sheets, and promotional items) in support of World Elder Abuse Awareness Day. These materials can be downloaded from the Ontario Seniors Secretariat website at www.citizenship.gov.on.ca/seniors/english/weaad/.

ACE was honoured to be invited by the Saskatoon Council on Aging to assist them in a day-long workshop to develop an action plan to raise awareness and develop responses to abuse of older adults in Saskatchewan. The event was attended by about 150 people. Attendees included many seniors as well as persons from a wide variety of agencies and services providing assistance and support for older adults in Saskatoon.

After a number of speakers, (including a representative of ACE), who presented information about elder abuse and the variety of resources and responses available in Saskatchewan to assist or work with seniors, the attendees spent the rest of the day developing an action plan, identifying key issues on which to work, and setting out an agenda to get the work done.

It was confirmed that much work had to be done to raise awareness, not only as to what constitutes abuse, but also on the basic rights of seniors, with respect to home care services, in private care homes and special care homes. Private care homes are similar to retirement homes and special care homes are the same as long-term care homes in Ontario.

There were recommendations for the Council to advocate for the development of regulations for private care homes (retirement homes), to develop enforceable standards for the care and accommodation in these homes, as well as to regulate in some way the costs of both accommodation and care in these homes. This is especially important since an increasing proportion of older people in Saskatchewan cannot neither afford to pay these care and accommodation costs, yet cannot get sufficient community care from either public or private resources to assist them to stay in their own homes in the community.

This is also a key issue in Ontario, where the accommodation in retirement homes is regulated by tenancy legislation, (now called the *Residential Tenancies Act, 2006*), but the care services have only limited regulation. Many seniors and seniors groups have been advocating for comprehensive retirement home legislation that would, among other things:

- regulate both the care and accommodation portions, which
- provide retirement home tenants with more effective ways of enforcing their rights as both a tenant and care recipient; and
- which would be under the control of the Ontario provincial government, similar to the legislation and regulation that now exists for long term care homes.

There were also recommendations to the Council to stimulate and assist in the development of a Seniors' Advocate or Seniors' Legal Service, similar to the service offered by ACE. Local lawyers in Saskatoon have expressed an interest in helping to organize such a legal service, although the

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model for the service would need to be different since Saskatchewan does not have a legal clinic system or poverty law legal aid services such as those that operate in Ontario. ACE has committed to assist the Council and the local bar in this work by providing information on the operation and history of ACE.

ACE appreciates the opportunity to work with the Saskatoon Council on Aging on raising awareness as well as advocating for action on Elder Abuse. ■

SPONSORING PARENTS AND SPONSORSHIP DEBT

By Rita Chrolavicius, Barrister & Solicitor

Children have traditionally been able to apply to sponsor their parents so that the parents could become residents in Canada.

In order to sponsor an individual, the sponsors must sign an undertaking agreeing to provide for the basic requirements of the sponsored person. They must promise to provide food, clothing, shelter, fuel, utilities, household supplies, personal requirements and other goods and services including health needs not provided by public health care. The undertaking also contains a promise that the sponsored person will not need to apply for social assistance. In Ontario, this is Ontario Works (welfare) and the Ontario Disability Support Plan.

In the past, there was no clear mechanism for enforcing these agreements. Last year, the provincial government and the federal government enacted a number of changes which would permit a provincial ministry to take steps to collect any social assistance payments paid out to sponsored immigrants from the defaulting sponsor.

The Ministry of Community and Social Services is initially sending out collection letters to sponsors of immigrants who are presently receiving social assistance. The Ministry is also garnisheeing any income tax refunds payable to the defaulting sponsors. The Ministry can take other steps to try to collect sponsorship debts owing, such as starting court actions against the defaulting sponsor.

The Ministry will suspend collection procedures in certain cases. The Ministry has stated that it will not pursue collection where the sponsors themselves are in receipt of social assistance or where the sponsors have income below the current years' low income threshold set by the federal government ($19,709.00 in 2005). The Ministry has stated that it will not pursue collection procedures "in cases where this would cause undue hardship, e.g. illness, limited resources". The Overpayment Recovery Unit, (Tel: 1-888-346-5184) determines whether collection would cause undue hardship in a particular case.

Sponsored Immigrants and Admission to Long-Term Care Facilities

Sponsored immigrants who require care are eligible for admission to long-term care facilities, even if their sponsors are not providing them with any financial support. Lack of income or funds is not a ground for denying admission into a long-term care facility.

Sponsored immigrants who are applying for admission into long care can apply to receive disability benefits from the Ontario Disability Support Program. The rates charged for the accommodation costs of a resident receiving disability benefits is approximately $100 per month less than the rates charged for a resident who receives old age security benefits and the guaranteed income supplement. Residents who receive disability benefits would have approximately $116 per month remaining after paying for the accommodation charges from the disability benefits received. This "comfort allowance" could be use to pay the drug co-payment charges as well as for other expenses.

The Advocacy Centre for the Elderly can provide legal advice to sponsored seniors whose sponsors are not living up to their obligations. Sponsors who owe a sponsorship debt should get independent legal advice about their options. ■

TREATMENT DECISIONS: Rules For Consent

(*Continued from page 1*)

substitute treatment decisions. The following is designed to assist the general public in understanding the framework and general rules which go into decision making and substitute decision making in Ontario.

TREATMENT

Under Ontario law, a "treatment" is anything that is done by a "regulated health practitioner" ("HP") for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose. It does not include an assessment of capacity, a general assessment or examination, the taking of a person's health history, the communication of a diagnosis, an admission to hospital or another facility, or a "treatment" that poses little or no risk of harm to the person. Even with these exceptions, "treatment" has a very broad definition that includes most medical procedures advised and recommended by HPs of all types.

RULES FOR CONSENT TO TREATMENT

It is important that older adults understand the fundamental aspects of the law that relates to consent to treatment in Ontario. Most of this law is set out in the *Health Care Consent Act* ("*HCCA*"), which has been in place since 1996, and by the common law principles which were developed prior to the enactment of statute law. The *HCCA* contains the following elements with respect to consent to treatment:

- It gives a legally-binding definition for "capacity" to make treatment decisions.
- It requires that informed consent be obtained before treatment can be administered, except in defined emergencies.
- It describes the elements and meaning of informed consent.
- It accommodates the giving of informed consent for a course or plan of treatment.
- It allows for substitute consent to be given on behalf of an incapable person, and it provides authority to administer emergency treatment without consent in limited circumstances where the need arises.

Older adults, who are highly interested in the delivery of health care in Ontario, should also understand in general terms how the principles of consent to treatment operate under Ontario law.

MENTAL CAPACITY FOR TREATMENT DECISIONS

Capacity is a legal, not medical, issue. The *HCCA* defines mental "capacity" for treatment decisions as the ability to understand information that is relevant to a treatment decision, and the ability to appreciate the reasonably foreseeable consequences of making or not making a decision. When evaluating capacity, one looks at mental function only. It is not determined by one's age and it is not affected by any physical or mental disabilities that do not affect one's judgment or reason. If a person has the mental capacity to understand information and appreciate consequences about a particular treatment decision, then the person is at law mentally "capable" of making that decision.

The *HCCA* also provides that a person may be capable with respect to some treatments, and incapable with respect to others, at a single point in time. Also, with respect to a single treatment, a person may be incapable at one time and regain capacity at a later time. One's mental "capacity" for treatment decisions is determined on a decision-by-decision basis, and can change from decision to decision and from time to time.

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TREATMENT DECISIONS: Informed Consent

NO TREATMENT WITHOUT CONSENT

A fundamental rule of the *HCCA* is that the HP proposing a treatment shall not administer the treatment, and shall take reasonable steps to ensure that it is not administered by someone else, unless the HP believes:

- the person is capable and has given informed consent; or,
- the person is not capable, and informed substitute consent has been given on the person's behalf.

ASSESSMENT OF CAPACITY

It is up to the HP to determine whether or not the person is mentally capable of making the decision. There is no formal process set out in law for the assessment by the HP of the mental capacity of a person to give or refuse informed consent for a proposed treatment. The HP must apply the correct legal test, which requires the person to be able to understand the information and appreciate the consequences. If, after speaking with the person, the HP believes the person is mentally capable, they must obtain consent from that capable person for that treatment. If the practitioner does not believe the person is mentally capable of making that treatment decision, then they must seek the consent of the incapable person's substitute decision-maker ("SDM").

THE MEANING OF INFORMED CONSENT

A legally-valid "consent" to treatment must:

(1) relate to the treatment that has been proposed;

(2) be informed;

(3) be given voluntarily; and not be obtained through misrepresentation or fraud.

(4) not be obtained through misrepresentation or fraud.

Of these four elements, the meaning of informed consent has further elaboration under Ontario law.

"Informed" consent means that the person is given the information that a "reasonable person" needs to make a decision about the proposed treatment, including information about:

- the nature of the treatment;
- the expected benefits of the treatment;
- the material risks of the treatment;
- the material side effects of the treatment;
- alternative courses of action; and, the likely consequences of not having the treatment.

"Informed" consent also means that the person has received informative, responsive answers to questions or requests for further information. Informed consent does not need to be in writing, although it can be; however, the key is that it must be the end-product of a meaningful exchange of pertinent information between the HP and the person making the treatment decision(s).

COURSES OF TREATMENT AND PLANS OF TREATMENT

Ontario law demands that, outside of an emergency situation, informed consent must be obtained before any treatment is administered by a HP. However, it does not necessarily require that informed consent be given individually for each individual treatment.

The *HCCA* describes a "course of treatment" as a series or sequence of similar treatments administered to a person over a course of time for a particular health problem. Rather than proposing a single treatment, a HP might propose a "course of

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treatment" and obtain informed consent at once for a series of similar treatments all of which are proposed for a health problem the person is actually experiencing.

Similarly, the *HCCA* allows a single informed consent to be given to a "plan of treatment", which is developed by one or more HPs to deal with one or more health problems that a person has, or is likely to have given the person's current health condition. It may include the administration of various treatments or courses of treatments, or the withdrawal of treatment in light of the person's current health condition. However, despite the breadth of this description, informed consent can never be given to a "plan of treatment" in the abstract. Specifically, it cannot be given where it does not relate to the person's current health condition, or in respect of a "treatment" has not yet been proposed.

Informed consent to a "course of treatment" or a "plan of treatment" does not replace the legal requirement of informed consent to all non-emergency medical treatment in Ontario. Instead, it supplements that legal requirement by providing an expedient and convenient way to give informed consent, in cases where there is a defined set of treatment decisions required at one time; where all of the information needed to make a decision can be provided at once; and where all of the other legal requirements of for informed consent are met.

SUBSTITUTE CONSENT

A HP who determines that a person is not capable to make a treatment decision must tell the person of their finding and of the consequences, in the manner required by the HP's governing body (e.g.: for a physician, the College of Physicians and Surgeons of Ontario). One consequence of this decision is that the allegedly "incapable" person may ask the Consent and Capacity Board, an administrative tribunal, to review the HP's finding of incapacity. Another is that the HP may seek substitute consent from a SDM.

In order to give valid consent, a SDM must be "capable" with respect to the specific treatment; be at least 16-years old; be "available" by some means of communication within a reasonable length of time; and be willing to make the treatment decision.

The *HCCA* sets out a list or "hierarchy" of potential SDMs, as follows:

- A court-appointed guardian of the person with authority to act;
- An attorney for personal care, with authority to act;
- A representative appointed by the Consent and Capacity Board.
- A "spouse" (which includes common-law or same-sex spouses, but does not include spouses who are living separate and apart as a result of a breakdown in their relationship); or a "partner" (which is either of two persons who have lived together for at least one year and have a close personal relationship that is of primary importance in both persons' live.
- A parent or child;
- An access-only parent of a minor;
- A brother or sister; or Any other "relative" by blood, marriage or adoption.

Within these categories of decision-makers, anyone named in a higher category will have authority to make a substitute decision in preference to another person named in a lower category. In the unfortunate case that an incapable person should have no one "available" (by phone or any other means of communication, within Ontario or anywhere else in the world) the Public Guardian and Trustee's Treatment Decisions Unit would make a decision on the incapable person's behalf.

TREATMENT DECISIONS: Emergency Treatment

All SDMs within the same category have equal decision-making authority. All SDMs within a category do not need to positively make a decision. If one SDM within a category makes a decision, either by giving or refusing consent, the other possible SDMs within the same category may acquiesce to that decision. However, if more than one SDM within the same category asserts decision-making authority and disagree, then neither decision prevails over the other. This is true of any dissent, even if it is only one out of a number of equal-ranking SDMs who has a differing decision. In that case, no decision is made. The Public Guardian and Trustee's Treatment Decisions Unit may then mediate between the SDMs to reach a consensus. If a consensus is not reached, the PGT has legal authority to make the treatment decision in place of the disagreeing SDMs, and must give or refuse consent applying the principles of substitute decision-making.

PRINCIPLES OF GIVING OR REFUSING SUBSTITUTE CONSENT

In making a substitute decision for treatment, all SDMs must apply the following two principles:

(1) comply with the incapable person's last capable wish that would apply in the circumstances, unless it is impossible to do so; or,

(2) if there is no last capable wish, to act in the incapable person's "best interests".

In deciding what is in the incapable person's "best Interests", an SDM is required by the *HCCA* to take into consideration:

- The incapable person's values and beliefs;
- The incapable person's incapable wishes;
- The likely outcome of the treatment, including the effects of:
- The treatment being given or withheld;
- The expected benefits and risks of harm; and,
- Less restrictive or less intrusive alternatives.

INFORMATION

Before giving or refusing consent, an SDM is also entitled to have all the information the incapable person would need to give or refuse "informed consent" on one's own behalf. This information would be essential in determining the incapable person's "best interests", in the event a last capable wish were not known, not applicable to the circumstances or were impossible to follow.

EMERGENCY TREATMENT

The *HCCA* allows treatment to be administered without consent in very limited circumstances where an emergency exists, and other legal criteria are also present. In this context, an "emergency" means the person in respect of whom a treatment is proposed is apparently under "severe suffering", or is at risk of "serious bodily harm" without the prompt administration of the treatment.

One of the limited circumstances where emergency treatment may be given without informed consent is where the person is mentally incapable of giving or refusing consent to treatment, and the delay required to obtain substitute consent would prolong the person's suffering or put the person at risk of serious bodily harm. Here, it is important to know that "available" does not mean physically present. If an SDM can be contacted with in a time frame that is reasonable in the circumstances, that person is "available" to make a decision.

However, even where an SDM might be technically be "available" (whether physically present or not), but the delay necessary to obtain informed would be harmful, the law authorizes that the emergency treatment can be administered without informed consent.

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TREATMENT DECISIONS: Conclusion

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As well, emergency treatment can be administered to an apparently capable person without informed consent if there is an "emergency", and there is also a language or communication barrier that cannot reasonably be overcome. The following criteria must be met:

- the delay that would be needed to find a practical means of enabling communication would prolong the person's suffering; or
- the delay would put the person at risk serious bodily harm, as long as there is no reason to believe the person does not want treatment.

CONCLUSION

Before making any treatment decisions, whether they be regarding medications, surgery, dental work, or any other health-related issue, for yourself or an incapable person, ensure that you understand your rights so that you are fully informed of whatever treatment is being proposed. ■

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ABOUT THE CLINIC

ACE is a community based legal clinic for low income senior citizens in Ontario. It is the first clinic in Canada to specialize in the legal problems of seniors.

ACE is funded by Legal Aid Ontario to provide a range of legal services including: direct client assistance; public legal education; law reform; community development; and, referral.

ACE is incorporated as a non-profit corporation under the name "Holly Street Advocacy Centre for the Elderly Inc."
Charitable Registration No. 0800649-59

HOURS OF SERVICE

Office Hours:
Monday—Wednesday and Friday: 9 a.m.—5 p.m.
Thursdays: 1 p.m.—5 p.m.

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