



2 Carlton Street, Suite 701
Toronto, Ontario M5B 1J3
Tel: (416) 598-2656
Fax: (416) 598-7924
www.ancelaw.ca

Chair, Board of Directors
Lyndsay O'Callaghan

Lawyers
Judith A. Wahl, B.A., LL.B.
Rita A. Chrolavicius, LL.B.
Graham Webb, LL.B., LL.M.
Jane E. Meadus, B.A., LL.B.
Brendan Gray, B.A., LL.B.

Via Email: LawCommission@lco-cdo.org

October 17, 2014

Ms. Lauren Bates, Senior Lawyer
Law Commission of Ontario
2032 Ignat Kaneff Building,
Osgoode Hall Law School, York University
4700 Keele Street, Toronto, ON M3J 1P3

Dear Ms. Bates,

Re: Commentary on Discussion Paper: Legal Capacity, Decision-Making and Guardianship

We write to provide commentary on the Law Commission of Ontario's discussion paper on Legal Capacity, Decision-Making and Guardianship (the "Paper").

We would like to thank the Law Commission of Ontario for preparing such a detailed paper outlining the difficulties and options for reform in this broad area of the law. While we critique some of the potential reforms discussed in the Paper, we recognize that the Law Commission is not endorsing any particular reform recommendations at this time and is instead seeking a fulsome discussion of this complex issue.

Overview of ACE's Position

The Advocacy Centre for the Elderly (ACE) believes that the laws in Ontario on legal capacity, decision-making and guardianship are fundamentally sound. However, the application of these laws in practice is fraught with misunderstanding and error. ACE believes that substantial changes to our laws on legal capacity, decision-making and guardianship are unnecessary and will have little, if any, effect on the ground. What is needed are resources for enforcement and education. Without significant inputs of resources, the problems identified by the learned persons and organizations that have provided comments to the Law Commission will likely remain unremedied.

The law reforms embodied in the current *Substitute Decisions Act* and *Health Care Consent Act* are over twenty years old. Yet, to look at the incorrect practices of many health care institutions and substitute decision-makers, one would think we are just beginning the process of reforming out-dated views on capacity, guardianship, and health

care consent. As we noted in our commissioned paper for the Law Commission on Health Care Consent and Advance Care Planning in Ontario, our “new” laws on capacity and consent are often fundamentally misunderstood and misapplied. There is no reason to believe that substantial law reforms will be better understood by those operationalizing Ontario's laws (and indeed many reasons to suspect those on the ground will find many of the proposed reforms more vague and complex). ACE recommends discrete law reforms targeting education and enforcement, combined with a significant input of resources.

ACE is very concerned about law reform proposals recommending so-called “modern” approaches to capacity and decision-making – such as supported decision-making and co-decision-making. Those advocating for these approaches argue that they are grounded in real-world decision-making practices – recognizing that many of us make important decisions supported by others. While this is certainly true, as a legal structure for decision-making these proposals significantly miss the mark. In ACE's view, these approaches, first, misunderstand Ontario's current laws, and, second, misunderstand how these laws interact with real-world decision-making. Specifically, Ontario's laws already permit informal and supported decision-making arrangements. If a person is mentally capable with supports then they are mentally capable, full stop.

ACE does not recommend adopting a non-cognitive capacity threshold. ACE believes that cognitive capacity is a reasonable and legitimate basis for distinguishing between legally effective and ineffective decisions – provided that the assessment of capacity is conducted in accordance with Ontario law and with appropriate supports.

About the Advocacy Centre for the Elderly (ACE)

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

ACE staff have had extensive experience in issues related to health care consent, advance care planning, guardianship, substitute decision-making and elder abuse and have been involved in many of the law, policy, and education initiatives related to these issues that have taken place in Ontario over the last 30 years. These have included:

- participation on the Ontario Medical Association, President's Advisory Panel on End-of-Life Care 2013-2014;
- consultation with the Erie-St.Clair Local Health Integration Network, on Health Care Consent and Advance Care Planning, 2013 to date;
- member, Alzheimer Knowledge Exchange's Community of Practice Group on Health Care Consent and Advance Care Planning, 2010 to date;

- member, Alzheimer Roundtable, Ministry of Citizenship and Ministry of Health and Long-Term Care, 2004 to 2007 and Alzheimer Initiative Advance Care Planning Consultation Committee, 2001-2002;
- writer and presenter, Advance Care Planning Programme 2003 Ontario Alzheimer's Initiative #2 Family Physicians' Training, Health Professionals Training, and Community Training on Advance Directives for Care Choices
- chair, Interim Advisory Committee for the Implementation of the Substitute Decisions Act at the Office of the Public Trustee, 1992 – 1995 (by appointment of the Ontario Attorney-General);
- participation as a member of the Fram Committee, the work of which resulted in the passage of the *Substitute Decisions Act, 1992* and the *Consent to Treatment Act* (the predecessor to the *HCCA*);
- member, Review of Advocacy for Vulnerable Adults (O'Sullivan Committee), 1987
- participation as a member of the Elder Health Coalition Elder Abuse Working Group that created a Policy lens tool to evaluate Elder abuse response programmes;
- participation as a member of the Fact Finding Working Group on Prevention and Awareness of the Abuse of Older Adults with Disabilities, 2009-2010 and the Expert Roundtable on Elder Abuse, 2008, both initiatives organized by Human Resources and Social Development Canada;
- participation as an organizer, presenter and facilitator of the Federal-Provincial-Territorial Working Group Consultation on Financial Abuse, Ottawa, June 2008;
- participation as an organizer and presenter at training programmes on Elder Abuse Response for the Ontario Police College;
- organizing and co-chairing of the First National Conference on Elder Abuse and Crime, 1990; and,
- currently participating on the Advisory Committee for the Law Commission of Ontario's Project on Legal Capacity, Decision-making and Guardianship.

Commentary on the Paper

In order to assist the Law Commission of Ontario with organizing responses to the Paper, we have divided our comments according to the questions for discussion (found at Appendix B to the Paper). ACE has targeted our comments to particular questions for discussion raised in the Paper.

As an overarching comment on the status of Ontario's laws on Legal Capacity, Decision-Making and Guardianship, ACE believes that Ontario's laws are sound. What is needed in Ontario are targeted law reforms to encourage knowledge and require

enforcement and, of course, a significant input of resources to those organizations tasked with investigating and stopping abuse.

1. *Health Care Consent and Advance Care Planning in Ontario (Questions for Discussion 59 and 60)*

With funding from the Law Commission, ACE and the law firm of Dykeman Dewhirst O'Brien LLP prepared a paper on Health Care Consent and Advance Care Planning in Ontario.¹ As we found in our paper, there remain significant and persistent misconception surrounding Ontario law, and serious errors in health care institutions' forms, policies and practices. We have enclosed an excerpt from our paper on the Issues Identified in Ontario and our Recommendations as Appendix "A".

ACE Supports Ontario's Legislative Scheme Emphasizing Health Care Consent

As we identified in our paper, with the narrow exception of treatment in emergencies, Ontario law requires that informed consent be obtained from a patient (or if incapable, his/her substitute decision-maker [SDM]) before treatment is administered. Where the patient is capable, the law of Ontario limits the ability of a patient to consent to every possible prospective treatment. The patient can only lawfully give informed consent to treatments connected to the patient's current health condition. Where a patient is incapable, an SDM is required to determine whether the patient has expressed applicable prior capable wishes (which must be followed by the SDM); or otherwise has expressed other wishes, values, and beliefs (which must be considered). The patient may express wishes, values and beliefs in any form, and recent expressions of prior capable wishes will prevail over older statements.

Importantly, with the narrow exception for emergencies, regardless of whether a patient is capable or not, or has expressed prior capable wishes or not, when a treatment is proposed informed consent must be obtained from a person. Even where an SDM has been found by the CCB to have not complied with his/her obligations, the CCB does not bypass the role of the SDM and order the health practitioner to either administer or withhold treatment. Instead, the HCCA provides that the Consent and Capacity Board will give "directions" to be followed by SDM in giving or refusing consent.

In our paper for the Law Commission, we compared Ontario's laws with the laws of several other jurisdictions. As we found, the Ontario statutory scheme balances informed consent to treatment with the applicability of prior statements made by the patient. To this extent, Ontario law places more of an emphasis on contextualized patient decision-making through informed consent than the other jurisdictions we reviewed in preparing our paper. The emphasis placed on contextualized patient decision-making in Ontario is also reflected by the fact that Ontario law limits the ability of patients to consent to future treatments, unless such treatments relate to the patient's current health condition. Many other jurisdictions have emphasized formally expressed wishes (for example in an 'advance directive'), and have diluted the requirement that informed consent be obtained from a capable individual aware of the risks and benefits of treatment where an 'advance directive' is in place.

ACE believes that Ontario has adopted a more flexible and contextual approach to health care decision-making than other jurisdictions. Our model restricts the ability of individuals to give uninformed and out-of-context consent to future health care decision-

making (while balancing this against the right of individuals to express future health care wishes and have them applied where applicable) and also limits the role of health practitioners in directly interpreting and acting upon previously expressed patient wishes (or indeed making other treatment decisions for patients) – subject to an application to the Consent and Capacity Board by the health practitioner challenging a decision made by the SDM.

ACE believes that Ontario's model is preferable to the other legislative models reviewed. Ontario legislation ensures that prior capable wishes are situated in the present health context of the patient as part of the process of giving informed consent to treatment and are interpreted by an SDM of the patient's choosing or a close relative (in many cases) according to the hierarchy under s. 20 of the *Health Care Consent Act, 1996*. This model best ensures that authentic decisions are made by SDMs for incapable patients, by requiring that patient wishes are checked against the risks and benefits of treatments proposed.

Other legislative models that give more authority to health practitioners and that allow patients to pre-select treatments, risk losing a fundamental feature of health-care decision-making – informed consent. Rather than either removing the requirement to obtain informed consent when giving effect to 'advance directives', or requiring that SDMs make purely independent decisions, Ontario's legislation provides a balance. Prior wishes are contextualized in the patient's current health condition and the treatment information provided by the health practitioner. Where the wishes are still applicable, they are binding on the SDM. Where they are not applicable, the SDM is not bound by an uninformed choice.

Importantly, the Ontario legislative model also protects health practitioners. As the Fram Report noted, "providers of services should not be asked to determine the value of their services to the life of an individual."ⁱⁱ The role of the health practitioner is to obtain an informed consent. Where the patient is incapable, the health practitioner is provided with the clarity and simplicity of a default list of SDMs who may give consent on the patient's behalf. The HCCA protects health practitioners from liability where they act reasonably and in good faith.

Operational Problems in Ontario

In our paper, we concluded that policies, forms, and health practitioners do not place enough emphasis on informed consent to treatment, and instead focus on the solicitation and recording of patient wishes, values and beliefs. In a similar vein, we noted a common misconception in Ontario that formalized 'advance directives' can be acted upon directly by health practitioners where the patient is incapable. As noted above, the law in Ontario is that all patient wishes regarding future care must be interpreted by an SDM as part of the process of giving informed consent on behalf of an incapable patient (except in emergencies). Similarly, we note that some health care organizations believe that health practitioners should be pre-screening the treatments proposed to SDMs on the basis of the incapable patient's prior expressed wishes, values and beliefs. In ACE's view, this has the potential to usurp the statutory role of the SDM as the interpreter, at first instance, of the patient's wishes in giving or refusing consent.

We also identified a concern that many health care organizations' advance care planning forms incorrectly provide that they can be completed by SDMs – when under

Ontario law SDMs cannot advance care plan on behalf of incapable patients. Lastly, we noted our concern that health practitioners in Ontario are uncritically relying on advance care planning documents and research from other jurisdiction, which may not be applicable in Ontario.

Recommendations for Reform

As more fully set out in Appendix “A”, we have suggested a comprehensive education program for all health practitioners, with specific emphasis on those practicing in hospitals, long-term care homes, and retirement homes (as well as community agencies), providing training on the Ontario law of informed consent to treatment and its relationship to advance care planning. This educational program should be tied to funding of health care organizations. We have provided examples of how this educational program could be mandated legislatively.

We have also recommended that, in addition to health practitioners’ current statutory obligation to obtain informed consent, health practitioners be clearly statutorily obliged to inform SDMs of their role and responsibilities (in addition to this requirement as developed in caselaw). Where health practitioners fail to comply with this requirement, a consent obtained from an SDM will not be lawfully obtained, with all of the same legal consequences as currently exist. With knowledge of their role to interpret and apply prior capable wishes, and to make decisions in the patient’s best interests, ACE believes that active SDMs could help health practitioners ensure that advance care planning tools and forms are used appropriately, and that informed consent is obtained. From a practical perspective, the best way to ensure that SDMs obtain the information they need to make decisions on behalf of incapable patients is for health practitioners to provide this information to them. Of course, health practitioners also have a role in regulating SDMs, by considering whether to bring an application to the Consent and Capacity Board.

2. *Should Ontario Adopt Supported Decision-Making, Co-Decision-Making, and/or a Non-Cognitive Capacity threshold (Questions for Discussion 4, 10, 20-24)*

In our commentary to the Law Commission on its project on RDSP reform, ACE has provided a critique of supported decision-making, co-decision-making and a non-cognitive capacity threshold.ⁱⁱⁱ We repeat and add to many of these comments, below.

On adopting a Non-Cognitive Capacity Threshold

ACE believes that a cognitive capacity threshold is “a necessary evil”^{iv} to prevent abuse and harm to the incapable individual. ACE believes that cognitive capacity is a reasonable and legitimate basis for distinguishing between the legal effect of decisions, while recognizing that the specific cognitive threshold for each decision type should be carefully tailored to be as minimally restrictive as possible.

In our practice, and in preparing our Paper for the Law Commission on Health Care Consent and Advance Care Planning, ACE has seen numerous cases where professionals and whole institutions have misunderstood Ontario law, and employed an unduly restrictive cognitive capacity threshold. ACE continues to educate members of the public and professionals to correct these misconceptions – and believes that these errors should be the target for law reforms recommended by the Law Commission.

ACE does not recommend a non-cognitive test for capacity. The Paper references the following potential non-cognitive threshold: “the capacity to express one’s will and/or intentions and the ability of one’s life story of values, aims, needs and challenges to be understood by others, who can then give effect to one’s will and/or intentions.”^v As ACE commented to the Law Commission as part of its RDSP project, we see at least three difficulties with this approach:

(a) the ability to express an intention or wish does not, by itself, provide a principled basis for making that wish legally binding on either the expresser or third parties. Fundamentally, we understand that the non-cognitive capacity threshold accepts that an adult decision-maker need not have the ability to understand the nature or consequences of a decision in order for binding legal effect to be given. While we disagree with this approach in principle, we also believe it creates an increased risk of abuse;

(b) the ability for one’s life story of values, aims, needs and challenges to be understood is both so broad as to be potentially meaningless and so complex as to be impractical. Adopting this, or similar, criteria could make decisions impenetrable to outside review; and,

(c) the non-cognitive model is often associated with legal recognition of the ability of a close caregiver to understand the will and intentions of an adult, even if others less familiar with the adult are unable to intuit these signals. While it is certainly true that caregivers develop these interpretive abilities, ACE is concerned that this proposal will, again, create opportunities for abuse that are impenetrable to review.

ACE also disagrees that the Convention on the Rights of Persons with Disabilities (CRPD) requires that persons with disabilities be considered legally capable at all times. This is not what a plain reading of the CRPD requires of its signatories. Instead, the CRPD requires governments to avoid discriminating against persons with disabilities by correlating legal incapacity and disability. Canada’s Declaration and Reservation on the CRPD also eliminates any purely legal basis for stating Ontario is required to abolish substitute decision-making.

While ACE agrees that, in practice, capacity assessments often incorrectly correlate incapacity with disability and age, this does not mean that Ontario should abandon cognitive thresholds altogether. Cognitive capacity (and more specifically the “understand and appreciate” test) is a rational and legitimate tool – and one about which there exists a significant body of caselaw which can be used effectively to advocate on behalf persons improperly deemed incapable. ACE is concerned that fundamental changes to the law will sever the application of legal precedents to this new legislative structure, without any tangible benefits for those on the ground.

On Adopting Supported Decision-Making and Co-Decision-Making

ACE believes that supported decision-making models create a greater risk of financial abuse than exists under Ontario’s current legislated scheme for Legal Capacity, Decision-Making and Guardianship. Supported decision-making permits the adult to retain legal capacity to make decisions, while allowing the adult to receive support and

assistance. The difficulty with this arrangement is that it creates a risk of undue influence by a legally designated support person. While this risk also exists in Ontario's current legislated scheme involving attorneys and guardians for property, we are concerned that actual abuse by a support person will be more difficult to detect as the true identity of the decision-maker, and the factors influencing each decision, may become opaque. While we recognize that the use of "monitors" may result in concerns being brought to the attention of investigators more readily, the vagaries inherent in the supporter's role may make these concerns more subjective and difficult to substantiate for investigators.

We understand that the primary benefit of supported decision-making models is that adults who might be considered incapable without a support person can be found capable because of the assistance they receive. ACE believes that this same benefit already exists under Ontario law, if properly understood and applied. Fundamentally, if a person is capable through receipt of appropriate supports and interpretive services, then the person is capable, full stop. As a capable adult, this person may decide whom he/she wishes to include in the decision-making process.

ACE understands that the other main benefit of the supported decision-making model is that adults avoid the stigma of being labelled "incapable." While ACE recognizes this as a legitimate concern, we believe it does not justify adopting a legislative model that may make it more difficult to detect abuse. If there were alternatives to respond to the concern of stigmatization without potentially increasing the risk of abuse, we would welcome these suggestions.

Furthermore, ACE understands that in jurisdictions that have adopted supported decision-making models (specifically British Columbia), supported decision-making has not been widely adopted, particularly among seniors and persons with psycho-social or brain injuries.^{vi} Rather, supported decision-making is being utilized by a small and highly engaged community.^{vii} ACE is concerned that a supported decision-making legislative model cannot be transplanted to the broader public without creating an increased risk of abuse. Specifically, supported decision-making may not work well for individuals with more tenuous social, family and economic relationships.

With regard to co-decision making, ACE understands that this legislative model is generally operationalized as a co-signing requirement – both the adult and supporter must sign contracts at the same time. While co-decision making creates clearly defined roles and responsibilities, and may not create an increased risk of abuse (provided it is implemented through a cognitive capacity threshold and with appropriate safeguards), we believe it is impractical, inefficient and no more conducive to individual dignity and self-determination than Ontario's current model.

3. Discrete Reforms to Ontario Law

Require Investigation of All Abuse under the *Substitute Decisions Act*

ACE is very concerned that reports of financial or personal care abuse are seldom investigated by government agencies in Ontario. Reporting of such abuse to the police rarely results in an active investigation. In ACE's experience, those reporting financial abuse are often told 'this is a civil matter' – even where there is clear evidence of

misapplication of funds. In those cases where an investigation is commenced and charges laid, Crown attorney's often do not proceed.

While changes to the criminal law and prosecutorial policies are beyond the scope of the Law Commission's current project, changes to the Public Guardian and Trustee's (PGT's) duty to investigate under the *Substitute Decisions Act* are not. Under that *Act*, the PGT is required to investigate any allegation that a person is incapable of managing property and/or personal care and that a serious adverse effect is occurring or may occur as a result^{viii}. In ACE's experience, person's calling the office of the PGT to report such concerns are often told that they need better proof of incapacity before the PGT will commence an investigation. ACE has also seen numerous examples of the Office of the PGT narrowly interpreting "serious adverse effect" - limiting their investigation to only the most extreme cases of abuse and neglect.

ACE recognizes that the PGT is doing the most that it can with limited resources. However, as the government agency primarily responsible for investigating concerns of neglect and abuse of mentally incapable adults, the PGT is not meeting the need in Ontario. ACE recommends reforming the *Substitute Decisions Act* to require the PGT to commence an investigating into all allegations of abuse and neglect of the mentally incapable. Of course, ACE anticipates that the scope of the investigation will vary depending on the allegations raised and the information obtained. ACE also recommends the creation of an independent board to review investigative actions by the PGT. Specifically, ACE envisages a board that could review whether investigations conducted by the PGT are adequate in the context of the allegations raised and the initial information and documents obtained.

Allow Capable Persons to Exclude HCCA SDMs

ACE has seen numerous cases where seniors are being abused by their lone family member. In these cases, even where the senior revokes a power of attorney for personal care, the abusive family member remains the lone willing and available person to act as SDM for the senior for decisions governed by the *HCCA*. The senior often does not know anyone who is trustworthy, willing, and legally able to act as their new attorney for personal care. It is ACE's experience that, where the PGT is asked to consent to being named as the senior's attorney for personal care under the *Substitute Decisions Act*, this consent is refused. As such, under the *HCCA* hierarchy, the abusive family member remains the highest ranking SDM – and the senior is required to rely on informal arrangements in which health practitioners are asked to skip over the abusive family member and proceed directly to ask the PGT for a treatment decision in the event the senior becomes incapable in the future.

To correct this problem, ACE recommends allowing persons to exclude particular family member SDMs from the hierarchy under the *HCCA*. ACE envisages that this would be achieved through a document similar to a revocation of a power of attorney for personal care, and would require the same capacity threshold and witnesses.

Require Rights Advice and Documentation of Incapacity under HCCA

It is ACE's experience that persons found incapable under the *HCCA* (with the exception of *Mental Health Act* patients) are rarely advised of this finding and are even more seldom advised of their rights. ACE's experience is that incapacity is also seldom

appropriately documented in the patients' medical chart. ACE recommends expanding *Mental Health Act* style rights and procedures in relation to findings of incapacity under the *HCCA* to all persons found incapable under the *HCCA*.

Allow Incapable Patients to Bring a Form "G"

Under the *HCCA*, only a health practitioner (for treatment), the CCAC (for admission to long-term care), or a member of a service provider's staff (for personal assistance services), may bring an application to the Consent and Capacity Board to determine whether an SDM for an incapable person is complying with his/her obligations.^{ix} The incapable person him/herself cannot bring an application to the consent and capacity Board to challenge whether a decision by his/her SDM was made appropriately.

ACE believes that this is a hole in the *HCCA* statutory scheme that should be fixed by amending the legislation to permit incapable persons to bring applications to the Consent and Capacity Board to determine whether they have complied with their obligations.

More broadly, ACE supports the submissions by the Mental Health Legal Committee on amending the *HCCA* to include more robust provisions on notification, documentation and codification of patients' rights when found incapable under that Act.

Conclusion

Thank you for providing this opportunity to comment on the Paper. We would be pleased to expand upon, or clarify, any of the opinions expressed herein.

Yours very truly,
ADVOCACY CENTRE for the ELDERLY

Judith A. Wahl
Executive Director
Barrister and Solicitor

Brendan Gray
Staff Lawyer
Barrister and Solicitor

Encl.

ⁱ Judith Wahl, Mary Jane Dykeman & Brendan Gray, *Health Care Consent and Advance Care Planning in Ontario* (Toronto: Law Commission of Ontario, January 2014), online: <http://lco-cdo.org/en/capacity-guardianship-commissioned-paper-ace-ddo>

ⁱⁱ Stephen V. Fram, *Final Report of the Advisory Committee on Substitute Decisions Making for Mentally Incapable Persons* (Toronto: Guardianship & Advocacy Review Committee, 1987) at 251

ⁱⁱⁱ Correspondence from Judith Wahl and Brendan Gray (Advocacy Centre for the Elderly), to Sarah Mason-Case (Law Commission of Ontario), February 28, 2014, Re Comments on Discussion Paper: Capacity of Adults with Mental Disabilities and the Federal RDSP

^{iv} *Supra*, Note ii, at 42

^v Law Commission of Ontario, *Legal Capacity, Decision-Making and Guardianship: Discussion Paper* (Toronto: Law Commission of Ontario, May 2014) at 77, citing Michael Bach & Lana Kerzner, *A New Paradigm for Protecting Autonomy and the Right to Legal Capacity* (Toronto: Law Commission of Ontario, October 2010) at 65-66

^{vi} Krista James & Laura Watts (Canadian Centre for Elder Law), *Understanding the Lived Experiences of Supported Decision-Making in Canada* (Toronto: Law Commission of Ontario, March 2014) at 50-51

^{vii} *Ibid.*

^{viii} *Substitute Decisions Act, 1992*, S.O. 1992, c. 30, ss. 27 and 62.

^{ix} *Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sched. A, ss. 37(1), 54(1) or 69(1).