

Assessing Capacity for Admission to Long-Term Care Homes

A Training Manual for Evaluators

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FOREWORD



Capacity evaluation for admission to a long-term care home (Nursing Home) involves an important and complex assessment with significant consequences for those being assessed. If a person is deemed capable, he/she retains the right to decide where they will live, including whether or not they will move to a long-term care home. If declared incapable, he/she loses that autonomy, and someone else will make the decision.

For evaluators, completing capacity evaluations can often be a difficult and daunting responsibility. Evaluators must have an accurate understanding of decision-making capacity and how it is assessed. They must also recognize two obligations simultaneously: first, the obligation to respect the right of capable people to make their own decisions, including what we may regard as “foolish” decisions; and second, the obligation to assist incapable people who require help.

A collaborative research project completed in 2002 between Sunnybrook Health Sciences Centre and the then North York Community Care Access Centre revealed some important findings. The research focused on admission to long-term care homes from the patients’ and families’ perspective, as well as from the social workers’ perspective in their role of facilitating the move to a long-term care home. The findings revealed that:

- 77.5% of patients assessed for admission to a long-term care home were found mentally incapable.
- Social work was recognized as the discipline primarily responsible for completing the capacity evaluation.
- Social workers identified the completion of the capacity evaluation as the most challenging part of their role in discharge planning to a long-term care home.

Specifically, social workers did not feel they had adequate training and supervision in this very important and complex aspect of their role. Recommendations from this study included the need for an essential competence level for staff completing capacity evaluations and the development of a capacity evaluation training program. These recommendations formed the basis for this training manual, in response to the need for training for health professionals (social work, occupational therapists, MDs, etc) involved in completing capacity evaluations.

The purpose of this manual is to provide practical assistance to health practitioners completing capacity evaluations for admission to long-term care homes. It covers the legislative framework for capacity evaluation, guidelines for completing the evaluation, and highlights ethical issues arising from the evaluation process. It also includes results from court decisions and Consent and Capacity Board Hearings. The manual is intended to enhance competency in the evaluation of capacity when health practitioners are unable to presume a person is capable.

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Assessing Capacity
for Admission to
Long-Term Care Homes

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*A Training Manual
for Evaluators*

Background

Background

What Is Capacity?

Evaluation Principles

Capacity Evaluation Framework

Tool on Capacity and Consent



WHAT IS CAPACITY?

Defining Capacity

Both the *Health Care Consent Act* (Section 4) and the *Substitute Decisions Act* (Section 6) define capacity as the ability to understand information relevant to a decision and the ability to appreciate the reasonably foreseeable consequences of a decision or lack of a decision. This is a legal definition; medical or cognitive tests (e.g. Mini-Mental State Examination [MMSE] or similar tests) can provide background and supporting information, but these are not the determinants of capacity or incapacity.

Ability to understand refers to the cognitive ability to factually grasp and retain information. Does the person know his/her medical problems as well as physical and functional limitations? Does he/she have the ability to understand the risks and benefits of admission to a long-term care home vs. refusing admission?

Ability to appreciate refers to the ability to attach personal meaning to the facts in a given situation. Appreciation focuses on the reasoning process. Does the person demonstrate insight and can that person justify his/her choice with respect to admission to a long-term care home? Does the person have the ability to appreciate how the consequences of the decision will affect him/her directly? A general understanding of the risks of the decision, without an insight into how the risks affect him/her, may be insufficient to support a finding of capacity.

The Consent and Capacity Board (CCB) has said:

“When it comes to making a specific decision, capacity is not an abstract concept. The person whose decision it is must be able to understand the information relevant to that decision and must be able to appreciate the reasonably foreseeable consequences of that decision.”

L.M. (Re), 2005 Can LII 48162

Defining Capacity Evaluation

Capacity evaluation is the process of determining a person’s ability to make his/her own decision about admission to a long-term care home. It includes asking the person questions related to admission. It may be supplemented by tests or procedures to measure cognitive ability, but these are not the determinants of capacity. It involves the evaluator’s analysis and reasoning before finding incapacity, communicating the finding and the provision of rights advice.

The evaluator determines capacity, but does not determine what the decision will be. The evaluation process is an objective one; if the individual is unable to either “understand” or “appreciate”, then he/she is incapable. There must be cogent and compelling evidence of incapacity. Refusing admission to a care facility does not equal incapacity, nor does the age of the individual have anything to do with determining capacity. It is also important to acknowledge that a person’s capacity may fluctuate.

There is always a presumption of capacity, and compelling evidence is required to override this presumption. As well, there is a desire to enlist the least intrusive (to the client) means to resolve situations, therefore alternatives to a long-term care home should be explored with the client, and the need for a capacity evaluation may be avoided. Reasonable grounds to proceed with a capacity evaluation

process might be bizarre, erratic or dangerous behaviour, repetitive speech, extreme disorientation and risk to self or others. The person should have an opportunity to respond to the “trigger” behaviours; for example, they may be the result of medications, dehydration, pain or lack of sleep.

EVALUATION PRINCIPLES

Domain Specific: A finding of incapacity related to the decision about admission into a long-term care home is limited to that decision and does not apply globally to the person’s mental capacity.

Process versus Outcome: The intention of a capacity evaluation is for an evaluator to assess an individual’s decision making process; are they able to understand and appreciate his/her situation? This evaluation should not be unduly influenced by what might happen in the future, or what has occurred in the past. Capacity evaluation is not risk management.

Communication: Meaningful communication is often based on trust, and this is enhanced through a positive rapport with the individual. Three considerations to be aware of in regard to meaningful rapport are: recognition of any physical barriers to communication (e.g. stroke, neurological disorder); language preference of the individual (get an objective interpreter, if necessary); and the comprehension and vocabulary level of the individual, taking into account his/her education and background, etc. (refrain from professional jargon and abbreviations, etc.).

Education and Disclosure: Ensure that the client has received adequate and appropriate information in order to exhibit an “understanding” and “appreciation” of his/her condition and situation.

Reversible Conditions: Rule out any treatable condition prior to a capacity evaluation that might affect mental capacity (e.g. depression, delusions, effects of medications, dehydration)

Special Populations: Be sensitive to possible characteristics of specific groups such as the following: the elderly with any bio/psycho/social age related issues; neurological disorders with and sensory-motor symptoms; psychiatric diagnoses with feelings of stigmatization or anger and distrust of health professionals; and intellectual disabilities which may impair communication or be influenced by a life of being institutionalized.

Capacity Evaluation Framework

Legislative framework

The *Health Care Consent Act*, the *Substitute Decisions Act*, the *Mental Health Act* and the *Personal Health Information Protection Act* are four interrelated statutes that affect the liberty and autonomy of the individual. These *Acts* attempt to structure an appropriate balance between the rights of the individual and the authority of the state to protect all citizens, including incapable persons from self-harm, exploitation or needless suffering. The decision with respect to admission to a long-term care home is governed by the *Health Care Consent Act*. A person is entitled to make this decision for his/herself as long as he/she is mentally capable. The *Health Care Consent Act* ensures that people who are not capable of making an admission decision will have a Substitute Decision Maker, whether or not they have prepared a Power of Attorney by including a legislatively defined hierarchy. Links to these acts are provided here:

- *Health Care Consent Act:*
http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_96h02_e.htm
- *Mental Health Act:*
http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_90m07_e.htm
- *Personal Health Information Protection Act:*
http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_04p03_e.htm
- *Substitute Decisions Act:*
http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_92s30_e.htm

Long Term Care legislation:

- *Nursing Homes Act*
http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_90n07_e.htm
- *Homes for the Aged and Rest Homes Act*
http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_90h13_e.htm
- *Charitable Institutions Act*
http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_90c09_e.htm

Note: The Long Term Care Act, 2007, is not yet in force.

Consent to admission

In order to be admitted to a long-term care home, the person must consent to the admission. If the person is incapable of consenting, then a Substitute Decision Maker, as determined by Section 20 of the *Health Care Consent Act*, must consent on his/her behalf.

VALID CONSENT

In order for consent to be valid, the person giving it must be capable of making the decision. If the person obtaining consent believes the person giving consent may be incapable, he/she should not accept the consent but administer a capacity evaluation first.

INFORMED CONSENT

The elements of informed consent can be found in Part II (Sec. 11; 1-3) of the *Health Care Consent Act*. Prior to requesting consent, the health practitioner must do the following:

- Provide the person with all of the information about admission that a reasonable person in the same circumstances would need in order to make the decision. The following information must be explained:
 - That the person is being asked to consent to admission to a long-term care home.
 - What a long-term care home is.
 - What the expected benefits of admission are.

- What the possible risks of admission are.
- What the alternatives to admission are.
- What the likely consequences of not being admitted are.
- Answer any questions the person may have about the issue.

Crisis Admissions

If a person is found by an evaluator to be incapable with respect to his/her admission to a long-term care home, the person's admission may be authorized and the person may be admitted, without consent, if in the opinion of the person responsible for authorizing admissions to the care facility (i.e. CCAC staff):

- The incapable person requires immediate admission to a long-term care home as a result of a crisis and
- It is not reasonably possible to obtain an immediate consent or refusal on the incapable person's behalf

In the event of a crisis admission, the person responsible for authorizing admission to the long-term care home should ensure that reasonable efforts are made to find the SDM and obtain consent or refusal of consent to the admission. If a person is capable, he/she cannot be admitted without his/her consent.

Professional framework

The *Health Care Consent Act* requires that capacity to make a decision with respect to admission to a long-term care home must be assessed by an evaluator. An evaluator is defined in the statute as a member of one of the following health colleges:

- College of Audiologists and Speech-Language Pathologists of Ontario: www.caslpo.com
- College of Dietitians of Ontario: www.cdo.on.ca
- College of Nurses on Ontario: www.cno.org
- College of Occupational Therapists of Ontario: www.coto.org
- College of Physicians and Surgeons of Ontario: www.cpsso.on.ca
- College of Physiotherapists of Ontario: www.collegept.org
- College of Psychologists of Ontario: www.cpo.on.ca
- Ontario College of Social Workers and Social Service Workers: www.ocswwsw.org
who holds a certificate of registration for social work.

Each of these health colleges has developed guidelines for completing capacity evaluations, which can be found at the websites noted above.

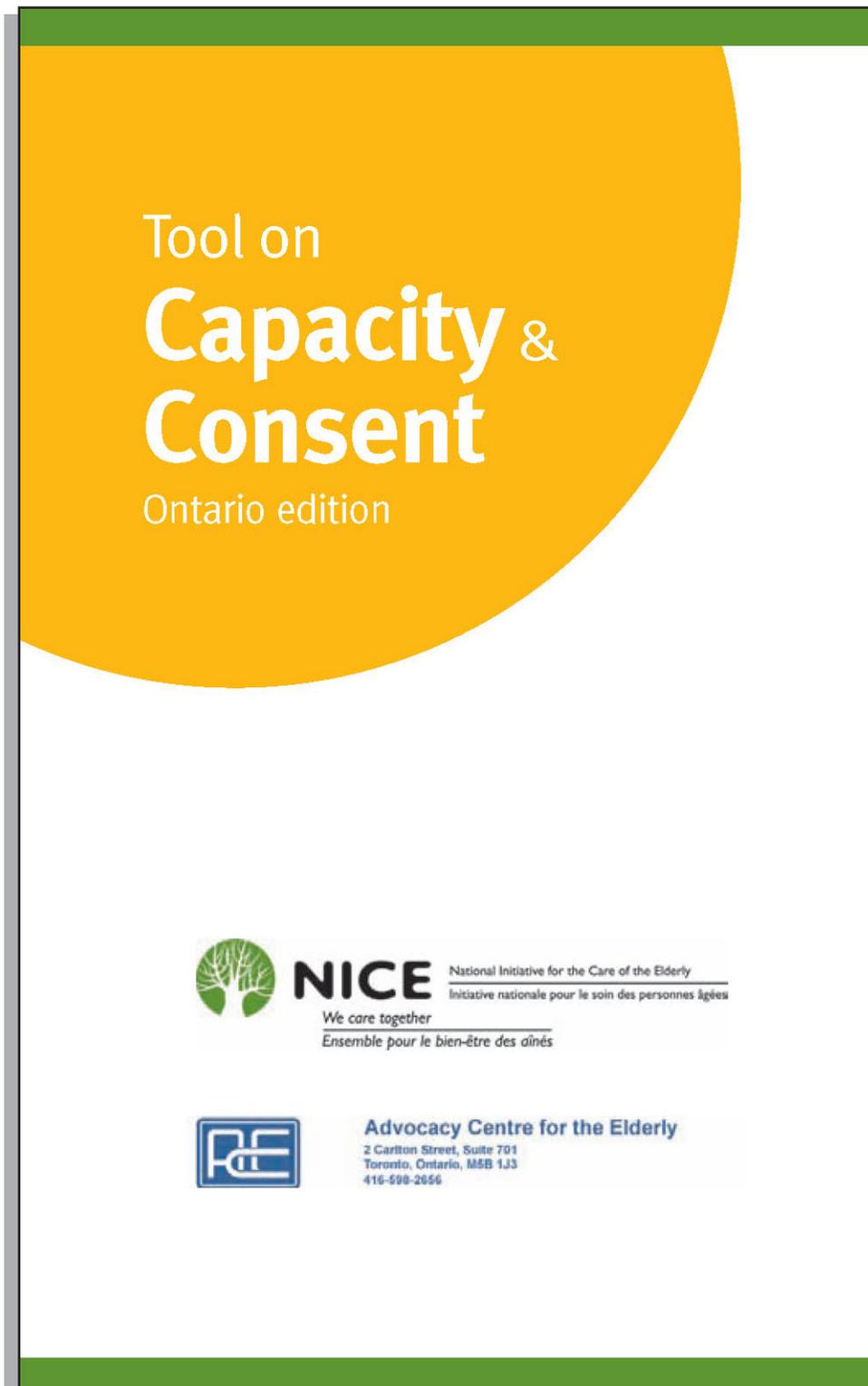
Capacity evaluation vs. capacity assessment

Assessment of capacity is done by different types of people depending on the circumstances. For purposes of admission to a long-term care home, it is an *evaluator* who assesses capacity. A *capacity assessor*, on the other hand, is defined in the *Substitute Decisions Act*, and the chart below summarizes the differences between capacity evaluation and capacity assessment, and in which circumstances each is used.

	Capacity evaluation	Capacity assessment
Legislation	<i>Health Care Consent Act</i>	<i>Substitute Decision Act</i>
When used	<ul style="list-style-type: none"> • Admission to a long-term care home • Personal Assistance Services 	<ul style="list-style-type: none"> • Capacity to manage property to trigger statutory guardianship under s. 16 of the <i>Substitute Decision Act</i> • Activating power of attorney for property when the document includes the statement that the power of attorney does not come into effect until the person has been assessed as incapable of managing property and the method of assessment is not specified • Terminate Statutory Guardianship under s. 20 of the <i>Substitute Decisions Act</i> • To determine capacity when entering into or revoking a Power of Attorney which includes a use of force provision under s. 50 of the <i>Substitute Decisions Act</i> (Ulysses Contract) • Provide an opinion regarding capacity to manage property as part of a Guardianship application under s. 72 of the <i>Substitute Decisions Act</i> or to terminate a Guardianship of property under s. 73 of the <i>Substitute Decisions Act</i> • Provide an opinion regarding capacity to make personal care decisions as part of a Guardianship application under s. 74 of the <i>Substitute Decisions Act</i> or to terminate a Guardianship of the person under s. 75 of the <i>Substitute Decisions Act</i>.
Who assesses	<p>Member of:</p> <ul style="list-style-type: none"> • College of Audiologists and Speech-Language Pathologists of Ontario • College of Dietitians of Ontario • College of Nurses of Ontario • College of Occupational Therapists of Ontario • College of Physiotherapists of Ontario • College of Psychologists of Ontario • Ontario College of Social Workers and Social Service Workers 	<p>Member of:</p> <ul style="list-style-type: none"> • College of Nurses of Ontario • College of Occupational Therapists of Ontario • College of Physiotherapists of Ontario • College of Psychologists of Ontario • Ontario College of Social Workers and Social Service Workers <p>And:</p> <ul style="list-style-type: none"> • Has successfully completed qualifying course for assessors • Complies with required continuing education courses • Complies with required minimum annual number of assessments • Is covered by professional liability of not less than \$1,000,000

Please note: Consent to treatment evaluations are not included in this chart.

This tool is a handy and concise summary of the main concepts of the Health Care Consent Act related to Capacity and Consent. These are available at no cost from the National Initiative for the Care of the Elderly (NICE) at www.nicenet.ca under the heading of Tools and the sub-heading of End-of-Life Issues.





Ethical Issues in Capacity Evaluation

Seeking Out Creative Options for Your Client

Due Respect for the Client in the Face of Declining Competence and Personhood

Best Interests are not Determinants of Capacity

The More You “Care,” the More You Feel You Can Intervene

Evaluation of Capacity is not a Risk Management Tool

Being Sensitive to the Client

Evaluation Is of Capacity, not Values and Morals

Client vs. the System

Client vs. Family/Substitute Decision Maker

Client-Worker — the Ongoing Therapeutic Relationship

“Whose life is it anyway?” *Globe and Mail* article



ETHICAL ISSUES IN CAPACITY EVALUATION

Seeking out Creative Options for Your Client

Every client has a right to individual and undivided attention; no two cases are exactly alike

An attitude of client focus is manifest in respecting the needs of each client and his/her unique situation. Although there are rules and guidelines and legislation regarding capacity evaluation, no client is ever a neat and exact match to them. Individual assessment, together with a customized analysis of options, is the right of each client and the challenge for the evaluator. Familiarity with relevant legislation and guidelines are a prerequisite for this.

An example of creative problem solving might be where siblings, (there is no POA for Personal Care), all equal according to the legislated hierarchical list, cannot agree on the admission decision for a parent. Rather than turn to the Public Guardian and Trustee Office, and allow the decision to be made by a non-family member, which might seem like an easy solution, one or more of the siblings, can apply to the Consent and Capacity Board, under the Health Care Consent Act to be appointed a representative(s) of the incapable individual, for making the admission decision; this way the decision will be made within the family.

Another creative use of the Health Care Consent legislation might occur where the CCAC is questioning the mental capacity of a Substitute Decision Maker as indicated on the hierarchical list and who is not named as Attorney for Personal Care. That potential Substitute Decision Maker can apply to the Consent and Capacity Board to become a representative of the incapable person to make the admission decision. This would avoid a potentially bitter confrontation between him/her and the CCAC, and resolve the issue of who the Substitute Decision Maker should be.

Knowing your client, his/her situation, and the relevant legislation can lead to client-centered and resourceful solutions.

Due Respect for the Client in the Face of Declining Competence and Personhood

Having one's mental capacity challenged can be a harrowing experience; be empathic and sensitive to this

“Going through the motions” of evaluating capacity is inappropriate and not in compliance with legislation, in fact or in spirit. The questioning of a person’s mental capacity can be very demeaning and embarrassing; sensitivity and an empathic approach are mandatory.

While there is no obligation under the Health Care Consent Act to obtain a person’s consent to conduct an evaluation, there certainly is an obligation to fairness, and acting in accordance with the principles of natural justice. A basic tenet of our society is unrestricted freedom unless otherwise prescribed by law.

“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 lack of capacity, there is a process that must be followed.”

(P. (Re), 2005 Can LII 24581)

It is therefore the responsibility of an evaluator to follow a process that is fully compliant with the appropriate legislation, and attempt to maintain the dignity of the individual being evaluated, through

what can be a demeaning process.

Best Interests Are Not Determinants of Capacity

Understanding and appreciation are the two key determinants of capacity, not what we or anyone else thinks is best for the client

Unpopular, unwise or eccentric choices may not be evidence of incapacity, and capable individuals have the right to self-determination and autonomy. Whether the evaluator agrees with a client's intended life choices based on his/her personal perspective is irrelevant when it comes to determining capacity.

“It is mental capacity and not wisdom that is the subject of the SDA and the HCCA. The right knowingly to be foolish is not unimportant; the right to voluntarily assume is to be respected. The state has no business meddling with either. The dignity of the individual is at stake”

(Koch (Re), 1997 Can LII 12138 [ON S.C.]

The More You “Care,” the More You Feel You Can Intervene

Objectivity is essential in the process of evaluating capacity; follow the rules, not your heart

There is a tendency for health professionals to want to help and do the best for their clients, but this approach can be at odds with legislation and clients' rights. Beneficence with the best of intentions can quickly slip into paternalism and an erosion of clients' rights. Objectivity is a necessity, along with application of the legislation.

This situation is illustrated in the case of Mrs. H, a diabetic who did not always regulate her diet properly, and was admitted to hospital following a codeine overdose. Subsequently she was discharged to a Nursing Home where her physical and mental health improved considerably; notwithstanding the fact that she did not always accept advice from staff concerning safety issues. Mrs. H decided she wanted to move back to her apartment and live on her own. Staff in the Nursing Home had concerns about this decision and the CCAC was called in to do an evaluation of capacity for making the decision about admission to a care facility and to determine if her capacity had changed. The evaluator found Mrs. H to be incapable, and she made application to the Consent and Capacity Board to review the finding.

The lawyer presiding over the Consent and Capacity Board hearing concluded:

“... any inclination I had to confirm the finding of incapacity evaporated in the face of the evidence of Mrs. H's substantial improvement both mentally and physically during her stay in Brantwood. The combination of care, diet and protection from the effects of drug overdose restored Mrs. H's capacity. What her future held, should she decide to return home, was beyond the scope of my authority to examine.”

(CCB hearing — Mrs. H Brantwood Lifecare, 2003)

The prospect of Mrs. H moving out of the nursing home to live alone and possibly repeat the cycle of improper medication and poor nutrition and need for hospitalization was real, and the temptation existed for a health professional to try and intervene in the best interest of Mrs. H, but speculation is not grounds for intervention, and as a capable client she had the right to make an unwise choice.

“Finally, the test for incapacity is an objective one. Subjective findings, even when based on the best of intentions for the patient's well being, are improper. The best interests of the patient are irrelevant to the issue before the Board.”

(Saunders vs. Bridgepoint, Ontario court file 03-39/05)

Evaluation of Capacity Is not a Risk Management Tool

Risk is not the determinant of whether or not a client is mentally capable

A client may choose to live in a situation that places him/her at risk. This should not influence the determination of capacity; there is such a thing as accepting a risk (i.e. where the individual understands and appreciates the risk), which will override the desire for societal protection.

“She described returning home as ‘Not the choicest way to live, but it is what I choose.’ ... She is also aware that at home she is unsupervised and is at risk of falling or going into a diabetic coma. She prefers this risk to living in a nursing home, where she feels she would lose her dignity and independence.”

(CCB hearing — R.H.M., Trillium Health Centre, 2002)

“Mr. C had the right to voluntarily assume the risk of going home. If he had the ability to appreciate the risk, his best interests were irrelevant to the issue of his capacity.”

(Saunders vs. Bridgepoint, Ontario court file 03-39/05)

Being Sensitive to the Client

Evaluators may be employed by a government-funded entity (i.e., “the system”), but they should remember that they are working for the client

The evaluator has an onerous responsibility when determining an individual’s capacity. He/she comes armed with weight of the law, the government, knowledge of the rules and backed by the “system” pitted against a client, who is, in most cases, at an extremely vulnerable point in his/her life, often confused by his/her condition and by the “system.” Given this mismatch, it behooves the evaluator to take the side of the “underdog” and make every effort to guarantee the rights of the client, both in fact and in spirit. The evaluator, when in doubt, should always choose capacity.

“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 ... Obviously, there has to be an evaluation ... 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 ... Further, Ms. E. (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.”

(CCB hearing — Mr. A.B., Queen Street Retirement Home, 2004)

Evaluation is of Capacity, Not of Values and Morals

The thoughts, feelings and values of the evaluator have no place in the evaluation, but those of the client do

As the evaluator, whether you think a client's behaviour is bizarre or immoral is not relevant in determining capacity. You may strongly disagree with the client's choice, but as a professional, your education, socio-economic status, background, experience and beliefs are not factors in your evaluation. The measurement of capacity is a legal and objective "yardstick."

Client vs. the System

Adherence to the evaluation process is essential, but the client is more essential than the process

As an evaluator, evaluation is your job, but for the client it is his/her life. For the client our process can be demeaning, insensitive, bureaucratic, and even seem oppressive. Your responsibility as an evaluator is to support the client in as sensitive and caring way as possible. Evaluation should not be an adversarial process, but a collaborative interaction. You are not trying to prove a point or support a position; you are attempting to reveal a truth about your client. Institutional issues such as an employer's interest in discharging a client from hospital should have no place in the evaluation process.

Client vs. Family/Substitute Decision Maker

Ensuring a client's rights via due process may not lead to the same conclusion as a family/Substitute Decision Maker would make, but the client's rights are always paramount

Family/Substitute Decision Makers can have the best interests of the client at heart, but this should not influence the evaluation. Despite what can be "pressure tactics" by family/Substitute Decision Makers, the evaluator must not be diverted from an objective evaluation of capacity. Expediency in complying with a family/ Substitute Decision Maker's wishes has no bearing in the evaluation process.

The following is an example of how not to use the evaluation process:

"JD's sister did not want JD returning to live with her in the home she jointly owned with him and where he resided for many years with her. It then became a matter that JD required a place to live. A nursing home placement would solve the problem. However, the answers attributed to JD on the evaluator's questionnaire were more consistent with someone refusing to consider admission to a care facility than they were with incapacity."

(CCB hearing — JD, St. Joseph's Health Centre, 2004)

Client-Worker — the Ongoing Therapeutic Relationship

The formal evaluation of capacity should not be influenced by the history of the client-evaluator relationship even though the process may affect that history

There is a difference between evaluating a client you are meeting for the first time and evaluating a client you have seen multiple times. This has been noted in a Board hearing:

"When the decision regarding capacity is not the result of a discrete process but rather, is done after a period of therapeutic interaction, the situation is obviously somewhat different."

(CCB hearing – Ms. P, Norfolk Hospital, 2005)

A new client can usually be dealt with in a more discrete way, making the evaluation process clear to the client from the start, but:

“Where the capacity assessment occurs as part of ongoing treatment ... the information noted above (i.e., that a capacity assessment for the purpose of admission to a long-term care home is going to be undertaken ... and the significance and effect of a finding of capacity or incapacity) should be provided as soon as a decision to perform a capacity assessment is made and thereafter on an ongoing basis to ensure that the patient is very clear on the process.”

(Saunders vs. Bridgepoint, Ontario court file 03-39/05)

The evaluation cannot be hidden within the client-worker relationship, despite the fact that the relationship may have developed over a period of time. There must be clear distinction between the current relationship and the capacity evaluation, which is a totally separate event. It is also important to note that the result of the evaluation may have an irreversible effect on the worker-client relationship. For this reason, and to ensure a proper evaluation, it may be better, in certain circumstances, to have a colleague perform the evaluation in cases where a client-worker relationship already exists.

The evaluation process is formidable, and the consequences can be life-altering; the context is anxiety-provoking and support minimal, at best. Health care professionals have to rise to these challenges guaranteeing transparency of process, and strict adherence to protecting the rights of your client. Making the right ethical decisions will always be in your client’s best interests.

GLOBE AND MAIL - April 4, 2000

Whose life is it anyway?

'She wants to live and die with dignity, in her family home. It was that simple'

DAVID THOW

My patient, I'll call her Anne, has had practically every bad break in the book. Anne, you see, has Huntington's disease. She is only 47. Huntington's is a genetic syndrome characterized by what is referred to as chorea -- which means a ceaseless occurrence of rapid, jerky, involuntary movements -- and a progressive mind-numbing dementia. It combines the worst characteristics of some of the most miserable illnesses known. Like cancer, it is terminal. But cancer is quick in most cases; people with Huntington's can suffer for 15 to 20 years before dying. It starts off slowly, proceeds from bad to worse, then gets downright awful.

People with severe Huntington's look as if they are being zapped with electric shocks every two seconds. Their arms and legs flail, their necks hyperextend and their torsos contort. The disease even finds its way to the tiny muscles of their tongues, making speech a big garble. Sometimes, this fools one into thinking that the person is, well, a little crazy, because what they're saying sounds like it doesn't make any sense. But these people's brains are fine. They suffer the most because they realize what's happening to them. Eventually, though, the dementia catches up with all of them.

Those with Huntington's don't get out much. Anne needed a doctor who would go to her. So for the past year, I have visited Anne in her parents' home, the place where she grew up.

The dilemma I faced was simple: Was Anne out of touch? If the answer was no, she could decide how and where she wanted to live. But if the answer was yes, she could be placed, against her will, in an institution. I was asked by Anne's social worker to perform what's called a capacity assessment, which consists of five questions. The answers are used to determine a person's mental capacity to understand a given set of circumstances. The situation Anne faced was the imminent departure of her 24-hour attendant. She had also run out of money to pay for a caregiver in the home; in other words, she would have been abandoned.

Her disease was so severe that she required help with activities as simple as boiling an egg.

There were other problems. Anne's father, who had been willing to care for her, died of a heart attack last year. Anne was married, but her husband left her and moved to the United States a couple of years ago. Anne kept a suitcase packed and, night after night, she tried to sneak out of the house and take a bus to Florida -- except her attendant would grab her and drag her back into the house.

In any event, Anne's answers on that day did not indicate that she recognized any danger to being left on her own. Of course, she was hard to understand. Nevertheless, when I asked her how she would manage on her own, she said, "Fine." I asked her what she would do if I found her incapable; she said, "Call my lawyer," which she asked the social worker to do afterward.

What Anne wanted, what we all wanted, was for her to live in the community with appropriate assistance. I deal with a lot of patients who suffer from severe illnesses and, if there's one thing that binds them, it's their desire to live at home, in their communities. Anne was prepared to take her chances alone. But I asked myself, what would be my responsibility if harm did come to her?

So I declared her incapable, the caregiver left, and I had to commit Anne to hospital. It was the last thing I wanted to do, but she kept insisting on remaining at home alone. The two psychiatrists who assessed Anne in hospital agreed with my conclusions regarding her capability.

The next thing I knew, I was in a conference room, seated in front of a panel of three men, stating my case. Anne had her lawyer and I had mine. A few observers sat in the back.

Although they nodded sympathetically, the panel members didn't seem to be buying a word of it. Every time I mentioned "long-term-care facility" or "placement," Anne howled and shouted, "No. Never." A couple of times, she nearly fell out of her chair. Once, she almost tipped over.



LEON ZERNITSKY

During questioning, it came out that it was the second anniversary of the departure of Anne's husband. It also came out that Anne had witnessed her mother, who also suffered from Huntington's, being committed to an institution.

At the end, the panel's chairman repeatedly asked me whether I had informed Anne that she had a right to have a lawyer present during my interview with her. I had read the evaluator information sheet closely and not once did it mention anything about this issue. Furthermore, the panel didn't seem to think that I had clearly explained the ramifications of this questionnaire. By then, I knew the writing was on the wall: Anne was going to be declared competent. She would be free to leave the hospital, to go wherever she wanted to.

After it was over and a nurse had helped Anne back to the ward, I overheard someone say, "Did you hear the way she carried on in there? I can't believe that they would let her go." It was then that it began to dawn on me that maybe I was wrong -- not out of malice, mind you, but out of ignorance.

I was wrong not because of some silly technicality but because Anne is rational. She is not crazy. Scared maybe, but definitely not crazy. She wants her husband back. She wants to live, and die, with dignity in her family home. It was that simple.

I shared my revelation with the social worker as we left the hospital. She nodded and said, "Anne would walk home barefoot in the snow if she had to, or at least she'd die trying."

And it was probably true, but the decision was now Anne's, which is the way it should be.

David Thow is a family physician at a community health centre in Toronto.



Capacity Evaluation

Decision Tree

Pre-evaluation Requirements

The Evaluation

Beyond the Tools

Post-Evaluation Considerations

Documentation

Appendices

A — *The Evaluation Questionnaire*

B — *Evaluator Questionnaire Assist*

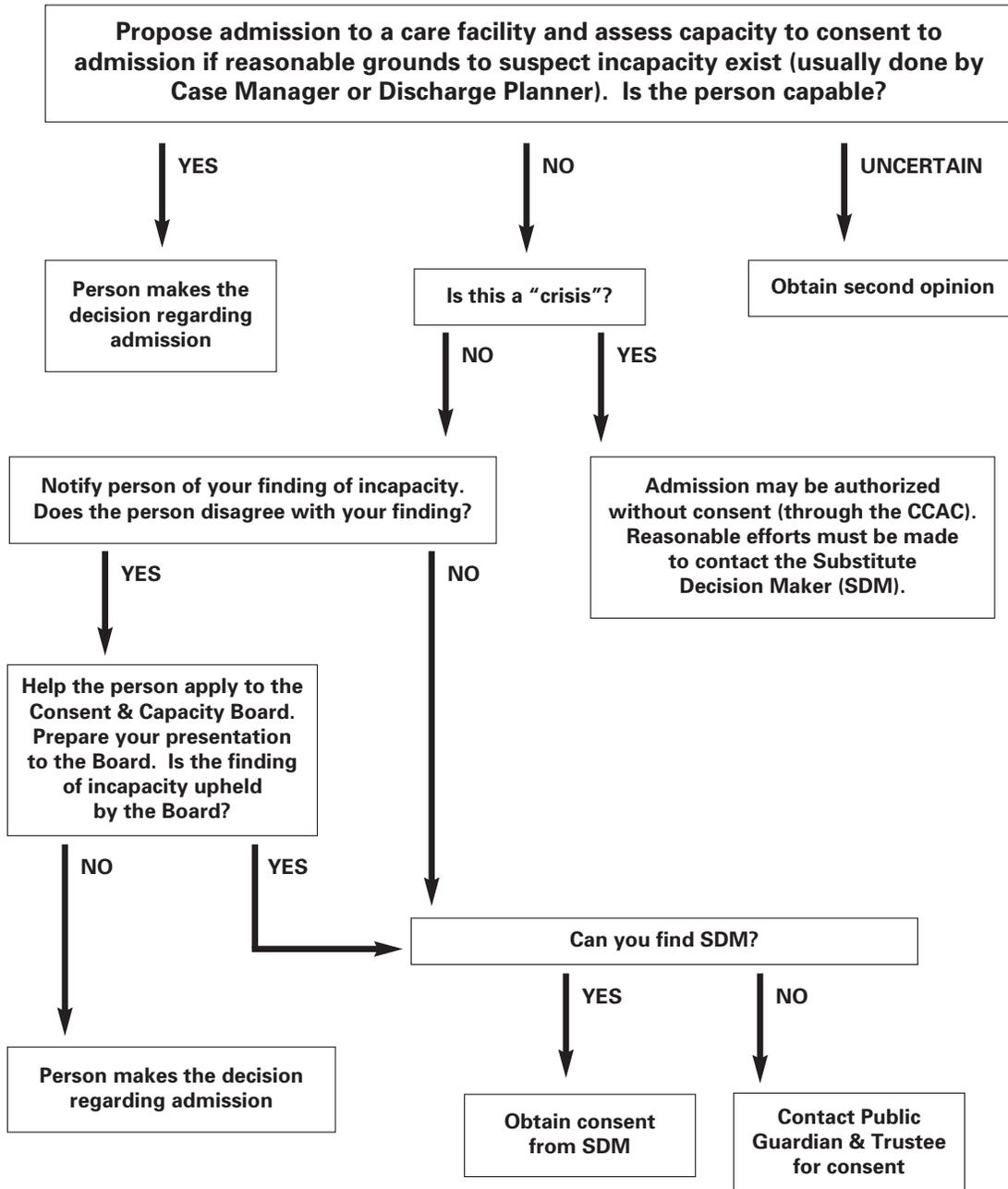
C — *PACE—Placement Aid to Capacity Evaluation*

D — *Capacity Evaluation (sample document)*



This is a simple decision tree to assist in understanding the process for obtaining consent from a person suspected of being incapable. It is assumed that by following this process, any other possible options have been explored (i.e. retirement home; supportive housing; home care)

Capacity to Consent to Admission to a Care Facility



CAPACITY EVALUATION

The *Canadian Charter of Rights and Freedoms* is an assurance that individuals are treated in a fair and equitable manner that supports individual freedom. When this fundamental right may be abrogated due to cognitive incapacity, due process according to the letter and spirit of the legislation is essential. For this reason, the following capacity evaluation guidelines and procedural framework has been developed.

Pre-evaluation Requirements

It is important to adequately set the stage for the capacity evaluation process in order to ensure that the rights of the client are respected, and that the process and finding would stand up to the scrutiny of the Consent and Capacity Board or the Ontario courts.

First thing to consider is whether you are the most appropriate person to evaluate capacity; if possible, have someone who knows the client best conduct the evaluation, or participate in the evaluation process.

Outline who, what, and why?

“It is entirely unclear how the evaluation came about ... So what we have is an evaluator about to embark on a procedure that may have the effect of stripping him/her of some fundamental legal rights and the evaluator does not know who requested that it be done.”

(Koch (Re), 1997 Can LII 12138 [ON S.C.])

Before starting, clarify in your own mind the purpose of the evaluation. Be clear on the decision that is at hand, so that you can clearly articulate it to the client. Remember, this is not a ‘best interest’ test.

Capacity evaluation is an assessment that occurs independently of an ongoing client-worker relationship. An individual has the right to refuse to be evaluated, and although there is no obligation to obtain formal consent for doing an evaluation, legislation, regulations and practice mandate certain responsibilities for the evaluator. Be sure to introduce who you are, who you work for, your role and how you came to make contact (i.e., referral source and reason for the referral). For example, you could say: “Your doctor is concerned about you and asked me to speak to you about where you are going to live after you leave the hospital.” Tell the client that you propose to conduct an evaluation of his/her cognitive capacity, and why you want to do it; the purpose of the evaluation must be made very clear and in the language of the client. Explain that you would like to ask some questions to assist in your evaluation.

Communicate possible consequences

“The notes of the evaluator are silent as to whether the client was made aware of the significance and effect of a finding of incapacity — that is the immediate loss of liberty and freedom to live where and how he/she chooses — there should be clear and convincing evidence that this warning was given.”

(Koch (Re), 1997 Can LII 12138 [ON S.C.])

It is important that you clearly inform the client that the interview may result in you finding the client incapable of making the decision about where he/she will live, and that someone else (name the

person if known) will make the decision on his/her behalf. It is important to provide the client detailed information about long-term care homes prior to the evaluation.

Respect individual rights

“Of greater concern is the failure of Talosi to inform the individual that she had the right to refuse to be interviewed and evaluated.”

(Koch (Re), 1997 Can LII 12138 [ON S.C.])

Procedural fairness in regard to the interview process must be assured; this includes the right of the client to have a lawyer, friend or family present at the evaluation if he/she so wishes. Refusal by the client to be part of the evaluation process is his/her right. Possible strategies to employ when the person refuses to be evaluated include walking away and trying again at another time, or getting someone else to do the evaluation.

Communicate clearly your lack of ‘a vested interest’ in the outcome of the evaluation, and that you have nothing to gain from a finding of incapacity. It is acceptable to tell your client that you want to find him/her capable and want him/her to make the decision, but that you have a legal obligation to ensure that they are able to do so. It is important to spend time with the client discussing the decision at issue, including the risks and benefits, before beginning the evaluation.

Prepare adequately

It is critical to try to create the best possible environment within which to conduct the interview. Consideration should be given to client privacy and confidentiality, unless the individual requests otherwise. Doing an interview in a hospital room with other patients present would not be appropriate.

Try to allot as much time as needed to properly execute the evaluation; for example, one judge expressed shock that an evaluator had spent only 90 minutes doing an evaluation. A recent decision by the Consent and Capacity Board praised the evaluator for the fact that about one hour was spent speaking to the client prior to starting the actual evaluation. If the evaluation was to extend much beyond one hour, it is suggested that it might be done in two parts.

As well, the client should be prepared for the evaluation, and allowed to “be at his/her best.” One means of ensuring this is through disclosure. The client should receive accurate and adequate information in order to be able to understand his/her situation and appreciate the likely outcome of making a decision. Providing information to the client may occur over time, and from a variety of sources. At times the information may be complex, confusing and conflicting, and should be clarified prior to conducting an evaluation.

Other considerations include checking for adverse effects caused by medication(s), pain, sleep deprivation, hunger, sundowning, lack of recovery time, language or any other possible communication issue. Is there a diagnosis that may change over time, either increasing or decreasing capacity? Consider whether there is a diagnosis which may explain, in some way, the client’s responses. If the individual is severely demented and engaging with him/her is not possible, it is not necessary to continue through the entire evaluation (use common sense), although the evaluator must still carry out the obligatory “pre” and “post” evaluator functions. It is also important to document why the whole interview was not done.

The Evaluation

When conducting the capacity evaluation, the evaluator should use an Evaluator Questionnaire (*see Appendix A*), which must accompany all Long-Term Care Home placement applications. This form consists of a series of questions that help determine if the person has the ability to *understand* the information relevant to a proposed transfer to a long-term care home and the ability to *appreciate* the consequences of a decision or lack of decision related to admission to a long-term care home.

Ask questions in an understandable (to the client) way, and aimed at eliciting information about his/her insight into his/her current situation. Does the client understand how the pending decision applies to him/her?

The Consent and Capacity Board has stated:

“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.”

(A.B. (Re), 2004 Can LII 29602)

Test the client’s orientation

Begin a dialogue with the client. It may be useful to start by testing the client’s orientation to time, person and place. It is important to remember that the result of the person’s orientation test does not determine his/her capacity, but this information can be used to obtain an impression of the person’s cognitive status. Orientation questions may include the following:

- What is today’s date?
- What time is it?
- What season is it?
- What is your address?
- What kind of building are we in?
- What city are we in?
- What country are we in?
- What is your date of birth?

Ask questions that address the client’s ability to ‘understand’ and ‘appreciate’

The following questions are provided to assist the evaluator in obtaining relevant information and can be asked in whatever way seems appropriate. The list is not exhaustive, and questions should relate to the individual’s unique situation:

- Why are you in hospital?
- Tell me about your living arrangements.
- Do you have any difficulties completing your personal care (e.g., dressing, bathing, walking, stairs)?
- Do you have any difficulties with your household activities (e.g., housekeeping, meal preparation, laundry, shopping)? If yes, how are you managing your problems?

- Do you have any help at home? (e.g., family, Community Care Access Centre, Meals on Wheels, Lifeline)
- What medical needs do you have?
- How do you take care of these needs?
- How do you get out to see the doctor?
- What would you do if you had a fall at home, or if there was a fire?
- What do you believe is the best living arrangement for you now? Why?
- Are you familiar with long-term care homes? (If the response to this question is “no,” education must be provided.)
- What do you think of these places?
- Have you considered going to a long-term care home?
- How do you think living in a long-term care home could help you with your situation?
- What could happen to you if you choose not to live in a long-term care home?
- When do you see yourself needing to live in a long-term care home?
- What do you think is good and not good about:
 - Staying in your current living situation?
 - Moving to a long-term care home?

Other tools have been developed to assist evaluators in completing capacity evaluations. One of them, the “*PACE: Placement Aid to Evaluation*” is included in the appendices (*Appendix C*).

It is important to remember, however, that while other tools can assist with the capacity evaluation, they do not replace the Evaluator Questionnaire; it must still be completed.

Beyond the Tools

It is imperative to test the responses given, against knowledge of the true situation. Review the information collected prior to the evaluation, from all sources before conducting the interview. If the answers given and clinical/incidental information do not line up, go back to the client and specifically address the discrepancies. You can use a multi-disciplinary approach, but one person is the evaluator and who will be responsible for the final decision.

“...Mr. was living in an apartment that was filthy and an ongoing health hazard. Public Health refused to enter the home and a special clean up team would have been necessary to clean the home and rid it of mice, cockroaches and flying insects. Mr., while saying he knew these were a health hazard, offered no explanation as to why he took no steps to clean his apartment or why he let it get so filthy. Mr. stated it could be cleaned in 30 minutes and the toilet fixed in 5 minutes. If this were true then the behaviour of Mr. in allowing himself to live in squalor is even more baffling and his evidence that he would clean his apartment rings hollow.”

H.S. (Re), 2007 Can LII 20041

Two key strategies should be utilized when carrying out the evaluation: first is verifying the details; and second is probing for the underlying meaning and significance of what is being said. This means going beyond the mere accumulation of facts; it is essential to uncover the veracity of the information, and then the implications, related to the decision at issue.

With regard to probing and verifying data, the following is from the Judge in a court case reviewing an evaluator’s practice:

“One forgotten appointment and one instance of confusion over a bus hardly support a finding of mental incapacity. If the evaluator seriously wished to rely upon these events in support of her evaluation she was required to do more. With respect to the missed appointment, she should have probed the appellant and given her an opportunity to explain. The explanation might have been logical. As for the confusion over the bus, the evaluator could have, for example, discreetly spoken to the janitor (who was in the hallway) or perhaps others in the building to learn if the appellant was in the habit of waiting for buses that had already gone. In other words, before automatically drawing an adverse inference from a fact, the evaluator should have sought independent verification. Probe and verify – two elementary requirements of reliable fact-gathering.”

“...the appellant’s apartment was found to be “very cluttered, disorganized, food in all rooms...” These facts appear to have figured prominently in the evaluator’s evaluation....although I have great difficulty in elevating an untidy apartment to the point where it is indicia of mental incapacity, in fairness, before so concluding, the evaluator should have given the appellant an opportunity to explain the state of the premises.”

“The evaluator recounted accusations made by the appellantstolen things....her husband having stolen her automobile and wanting to kill her....the evaluator seems to have considered these stories (and other accusations) as far-fetched. She did so without, again, probing the appellant as to particulars. It is obvious that the evaluator assumed the appellant was delusional. There is no factual basis for that assumption.”

Koch (33 O.R. (3d) 485, 1997)

A final example of this is expressed through the Supreme Court of Canada in considering the *Starson v. Swayze*:

“It is imperative that the Board inquire into the reasons for the patient’s failure to appreciate consequences. A finding of incapacity is justified only if those reasons demonstrate that the patient’s mental disorder prevents him from having the ability to appreciate the foreseeable consequences of the decision.”

2003 SCC 32 (Can LII)

Another important consideration is the distinction that can be drawn between the individual failing to exhibit an understanding and/or appreciation of risks and consequences, and being unable to understand and/or appreciation risks and consequences. It is only the latter that can lead to a finding of incapacity.

Koch (33 O.R. (3d) 485, 1997)

Through probing and verifying the evaluation information, the evaluator can more readily focus on the person’s abilities and deficits, for example, poor memory or lack of insight. This will assist in avoiding conclusions about the person’s mental capacity based on assumption and conjecture.

Post-evaluation Considerations

Finding of Capacity

A finding of capacity may not be challenged, even if there are pressures to do so.

Finding of Incapacity

Compelling evidence is required to override the presumption of capacity found in s. 4 (1) of the Health Care Consent Act. The nature and degree of the alleged incapacity must be demonstrated to be sufficient to warrant depriving the person of their right to live as they choose. Notwithstanding the presence of some degree of impairment, the question to be asked is whether the person has retained sufficient capacity to satisfy the statute.

Koch (33 O.R. (3d) 485, 1997)

If the client is determined incapable, the following must be communicated in the most empathic, sensitive, and open way:

- You have been found incapable of making the decision about admission to a long-term care home.
- Another person will be making the decision about admission to a long-term care home for you (name the substitute decision maker if known).

Individual's rights

There is no formal provision in the *Health Care Consent Act* for providing rights advice to the client, but the act does speak to enhancing the autonomy of individuals and allowing those who have been found incapable to apply for a review of the finding.

Each of the relevant professional colleges has developed a protocol for protecting individual rights, and these should be followed. As well, it is accepted practice for the client to be given written information that would assist him/her in making an application for a review of the finding of incapacity to the Consent and Capacity Review Board; this written information should be reviewed with the individual. (see Evaluator Questionnaire—Rights Information Sheet in the Appendix A) Even further, you should be watching for indications that the client disagrees with your finding (e.g., “I don’t want to go to a nursing home”) and assisting him/her in applying to the Board for a hearing; this includes even submitting an application for a hearing to the Consent and Capacity Board on behalf of the individual, and assisting him/her in obtaining a lawyer if he/she wishes (for a list of lawyers who provide representation before the Consent and Capacity Board, contact Legal Aid Ontario). No admission can proceed until this situation has been settled. The evaluator can also discuss with the individual that he/she can apply for the appointment of a representative to make the decision on his/her behalf.

Non-communication or passivity

In situations in which the person being evaluated is non-communicative or passive, it is important to consider the circumstances. Does the client have a medical condition (e.g., coma, extreme dementia) precluding meaningful communication? Is the client aphasic and there are means of communication outside of the verbal norm? Does the client refuse to be engaged in the evaluation process? In each circumstance, the appropriate action must be taken. In the first case, a finding of incapacity would likely be proper, while in the second, other means of communication should be sought (e.g., language board). In the third case, the client’s agreement to the process would have to be obtained before proceeding with an evaluation.

Fluctuating capacity

In cases of fluctuating capacity, it is important to determine how often, and for how long the client is capable vs. incapable. As well, what are the client's manifest behaviours when in an incapable state? Does he/she have an understanding of his/her condition, and is he/she appreciative of the likely foreseeable consequences of the decision he/she is making? If not, then a finding of incapacity may be appropriate, due to the lack of understanding of his/her condition, and the failure to appreciate the probable foreseeable consequences of his/her decision. A Ulysses contract (relinquishing the right to make decisions at all times) may be a possibility.

Uncertain result

If there is a doubt as to whether the client is capable or not after having completed the capacity evaluation, you can redo the evaluation with a focus on the areas of doubt. As well, you can seek out additional information about the client; this information may legal, medical, psychiatric, or from family and/or friends, prior to redoing the evaluation. Other options are to again investigate for the presence of a reversible condition, or have someone else carry out an evaluation.

Documentation

It is important to document your work thoroughly (*see Appendix D*). Remember that a person is presumed to be capable until proven otherwise. The onus of proof is on the evaluator alleging incapacity — not on the person to prove capacity.

Your documentation must support your findings. It should include confirmation that you have clearly explained what the evaluation was, why it was happening and what the potential consequences were. It should also include confirmation that you educated the person at the outset of the evaluation by providing information about admission that a reasonable person in the same circumstances would need in order to make the decision. Questions asked and the person's verbatim responses should be included.

Documentation must also include the result of the evaluation (i.e., capable or incapable). If the person is found incapable, be sure to document that a Rights Information Sheet was provided and explained to the person and outline whether the person wishes to appeal the decision.

Documentation is very important if a review of the finding of incapacity is requested by the person and you attend a Consent and Capacity Board Hearing.

One Consent and Capacity Board Chair stated:

“I was also very troubled by the absence of verbatim recording of Mr.'s responses to the several questions in the evaluator's questionnaire....the failure to record responses is poor practice and leaves the person assessed and the Board as reviewer in the dark as to what led the evaluator to the conclusion they reached, as what remains a subjective opinion without a foundation.”

H.S. (Re) 2007 Can LII 20041

The Consent and Capacity Board comments further on documenting verbatim responses:

“In many cases failure to record the verbatim responses of the person being assessed is fatal to the whole assessment process.”

H.S. (Re) 2007 Can LII 20041

Health Care Consent Act
Evaluation of Capacity for Admission to a Long-Term Care Home

Instructions for Evaluators

1. Persons who are qualified to be evaluators are members of one of the following: (a) the College of Audiologist and Speech-Language Pathologists of Ontario, (b) the College of Nurses of Ontario, (c) the College of Occupational Therapists of Ontario, (d) the College of Physicians and Surgeons of Ontario, (e) the College of Physiotherapists of Ontario, (f) the College of Psychologists of Ontario, and (g) Social Workers registered with the Ontario College of Social Workers and Social Service Workers.
2. Capacity is the ability to understand information relevant to a placement decision and the ability to appreciate the reasonably foreseeable consequences of a decision, or the lack of decision.
3. The purpose of the questions on the reverse of this page is to assist evaluators in determining an individual's capacity to decide about an admission to a long-term care facility.
4. Before determining capacity, the evaluator must:
 - (i) Explain the purpose of the evaluation, and whenever possible, provide information that a reasonable person would require in the same circumstance, in order to make an admission decision.
 - (ii) Respond to any questions that person may have.
5. Discussion of the information in #3 above may continue throughout the capacity evaluation.
6. Meaningful communication requires a level of expression compatible with that of the person being evaluated.
7. Before determining capacity, identify and address any barriers to communication (e.g. hearing or visual impairment, language barrier, dysphasia, etc.) Others may be used to help the person communicate (e.g. translator), but should not answer questions for the person.
8. Do no attempt to determine whether you agree with the person's decisions. Assess the person's ability to understand and appreciate his/her circumstances.
9. **THE QUESTIONNAIRE MUST BE COMPLETED FOR ALL APPLICANTS. ONLY SECTION I & IV APPLY TO CAPABLE APPLICANTS. PLEASE ATTACH THIS FORM TO ALL APPLICATIONS.**
10. The questions to be asked of potentially incapable applicants are written on the reverse. It is not necessary to read them word for word; communicate them in an informal and natural manner which will not compromise their purpose and meaning. Make note of the answers and your assessment of the person's comprehension. Sign and print your name. If the person does not wish to contest the finding of incapacity, forward this form together with the application to the CCAC. If the person does want to challenge the finding of incapacity and make application to the Consent and Capacity Board, he/she can apply directly or with the CCAC assistance.
11. *Caution:* This is not a global assessment of capacity, but specific to the admission decision.
12. **Rights Information Sheet must be given to all applicants who have been found incapable.**

EVALUATOR QUESTIONNAIRE re: CAPACITY TO MAKE ADMISSION DECISIONS

SECTION 1: APPLICANT IDENTIFICATION

_____ APPLICANT NAME _____ DOB (yyyy/mm/dd) _____ HEALTH CARD # _____

CAPABLE (*Proceed to Section 4*)

If in doubt, please proceed to Sections 2 and 3

SECTION 2: DETERMINATION OF CAPABILITY

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

CAPABLE – DETERMINATION MADE AFTER ASSESSMENT

INCAPABLE (*must complete Section 3 below*)

NO COMMUNICATION WAS POSSIBLE. COMMENTS: _____

SECTION 3: RIGHTS INFORMATION (for incapable applicants only)

APPLICANT INFORMED OF FINDING OF INCAPACITY

APPLICANT GIVEN RIGHTS INFORMATION SHEET (*refer to attachment*)

APPLICANT INTENDS TO APPEAL FINDING OF INCAPACITY

COMMENTS: _____

SECTION 4: EVALUATOR INFORMATION

_____ EVALUATOR NAME (Print) _____ PROFESSIONAL STATUS _____ SIGNATURE _____ DATE _____

ADDRESS _____ PHONE _____ FAX _____

PLEASE RETURN THIS FORM TO THE CCAC WHERE APPLICANT RESIDES

RIGHTS INFORMATION SHEET

Admission to a Long-Term Care Home

An evaluator has decided that you are not capable of making a decision about admission to a nursing home or home for the aged. This means that another person must make a decision about admission for you.

If you do not agree with the evaluator's finding, you have the right to ask for a review of this decision from the Consent and Capacity Board.

To apply for a review call:



**in TORONTO
(416) 924 – 4961**

You may ask this same Board (Consent and Capacity Board) to appoint someone to make admission decisions for you. As well, a person who would like to be appointed as your representative may apply to the Consent and Capacity Board to be granted this authority.

If you have a guardian or Power of Attorney for Personal Care, this is the person who would make the admission decisions for you.

If you would like further information about your rights, please call your Community Care Access Centre, or your coordinator.



This Evaluator Questionnaire Assist is a summarized information sheet that is a 'companion' and can be used in conjunction with the Evaluator Questionnaire.

Evaluator Questionnaire Assist

The Basics

The questions on the Evaluator Questionnaire are addressing two specific legal requirements: the ability to understand and the ability to appreciate the reasonably foreseeable consequences of a decision or lack of a decision. Because every situation is unique, the questions asked by the evaluator should be tailored to the circumstance, and applied in an appropriate and sensitive way. Don't follow the script; it hasn't been written yet.

When posing the questions, the evaluator should account for the following: rapport with the client, level of education and comprehension, client's vocabulary and method of expression; language issues, cultural issues, and the client's physical and emotional status or any transient condition in the client.

The evaluation is more than just a face-to-face dialogue; the answers provided have to be probed, and the information communicated should be verified. The client's perception of his/her abilities and limitations should be cross-referenced with objective information. For example, the client's self-appraisal could be compared with his/her behaviour as witnessed or assessed by others, and if the data sources do not agree, the evaluator should consider potential bias in reporting. It may be denial or an underestimation of the problem by the client, or the informant is deliberately misrepresenting or not aware of the client's true level of functioning. For resolution, the evaluator might defer to more objective behavioural evidence (e.g. OT report).

Initial Interview Responsibilities for the Evaluator

The following information should be conveyed to the client in a very clear and straightforward manner:

- who you are and what your role is
- the purpose of the assessment
- the significance and effect of a finding of incapacity
- the client has a right to refuse to be assessed
- explain to the client all about long-term care home and what living in one would be like (i.e. what assistance would be provided)

Determining Capacity to Understand

Does the client understand his/her current condition, abilities, limitations and an appropriate option(s) for the situation? Questions #1 and #3 on the *Evaluator Questionnaire* address this.

Additional questions that might be asked to assist in determining if the client is able to understand:

- What problems are you having at home?
- People are worried about you and you don't seem to be; why is that?
- If you were sent home from the hospital today, what concerns would you have?
- What help do you receive at home?
- Who helps you at home, and how often?
- What help do you need when you get dressed?
- What help do you need to prepare your meals?
- If you don't move into a Nursing Home, where will you live?
- Who will help take care of _____
(*identify the specific care need*) on a daily basis?
- What would you do if a fire started in your house?
- How will you know when you need more help at home?
- When will you know when it is time to move from your home?

Determining Capacity to Appreciated Consequences

Does the client appreciate what will likely happen if he/she chooses to, or chooses not to, live in a long-term care facility? Questions #2, #4 and #5 on the *Evaluator Questionnaire* address this.

Additional questions that might be asked to assist in determining if the client is able to appreciate:

- What kind of help would you get in a Long-Term Care Home?
- What will happen if you move into a Long-Term Care Home?
- What would staff at the Nursing Home help you with?
- What will happen if you refuse to move to a Long-Term Care Home?
- What would happen if you don't take your medications?
- If you had a fall and couldn't get up, what would you do?
- How are you doing to do the shopping?
- What would happen if you were too ill to live at home?

Post-Interview Responsibilities for the Evaluator

When there is a finding of incapacity, the following information should be given to the client:

- that the client has been determined incapable of deciding whether or not to go into a long-term facility
- that the client has a right to challenge the finding of incapacity (client should be give a copy of the rights information sheet and it should be reviewed with them)
- that another person, (*provide name of SDM if known*), will be making the decision about possible admission to a long-term facility
- assist with application to the Consent and Capacity Board if client wishes to challenge a finding of incapacity, and assist with finding a lawyer if client wishes.

APPENDIX C

This is another tool that can be used to assist in evaluating capacity for admission to a Long-Term Care Home.

PACE: PLACEMENT AID TO CAPACITY EVALUATION

Instructions for administration

Capacity is defined as the ability to understand information relevant to a decision *and* the ability to appreciate the reasonably foreseeable consequences of a decision (or lack of a decision).* The purpose of the PACE tool is to help clinicians systematically evaluate capacity and to document findings when a person is facing a decision regarding admission to a long term care facility. It is intended to be most useful when a clinician is not able to presume a person is capable and capacity is uncertain. The following are some guidelines to consider before and during any capacity evaluation:

1. A qualified evaluator is a member of one of the following: (a) the College of Audiologists and Speech-Language Pathologists of Ontario, (b) the College of Nurses of Ontario, (c) the College of Occupational Therapists of Ontario, (d) the College of Physicians and Surgeons of Ontario, (e) the College of Physiotherapists of Ontario, (f) the College of Psychologists of Ontario, and (g) the College of Social Workers and Social Service Workers.
2. Before evaluating capacity, identify and address any barriers to communication (i.e., hearing impairment, visual impairment, language barrier). People other than family/friends/POA may help the person communicate (i.e., by translating). These other people should not attempt to answer questions for the person being evaluated and, if available, should be trained professionals. If a communication barrier is due to dysphasia or dysarthria, it is recommended that a speech-language pathologist be consulted.
3. Before and while evaluating capacity, the evaluator must:
 - a) Explain the purpose and consequences of the evaluation, obtain informed consent from the person being evaluated, and whenever possible, provide information that a reasonable person would require in the same circumstance in order to make an admission decision.
 - b) Respond to any questions or requests for other information the person being evaluated may have.
4. Before evaluating capacity, obtain and document any information (i.e., assessments/reports from health care professionals, EMS staff, police, formal/informal community supports, family/significant others, etc.) related to the ability of the person to safely cope at home and/or the capacity of the person to make decisions regarding admission to a long term care facility.

5. Before evaluating capacity, consultation with a physician is recommended to ensure that the person is medically stable and that any acute and reversible medical conditions that may cause confusion (i.e., delirium secondary to pneumonia, infection, drug toxicity) have been ruled out or appropriately treated.
6. While evaluating capacity, be aware of the cognitive signs of depression (i.e., hopelessness, worthlessness, guilt, and punishment) as this may affect decision-making (i.e., “Just let me die...there’s no point in sending me to a nursing home”). Also, if the person is suffering from a mental health illness, decision-making may be affected by delusion/psychosis (i.e., “I don’t want to go to a nursing home because the vampires there will kill me”). Further, the person may suffer from a chronic/progressive cognitive impairment (i.e., dementia). In such cases, it is recommended that a referral be made to a physician, psychiatrist or psychogeriatrician for an independent assessment and appropriate treatment. It may be necessary to evaluate the person’s capacity over time or to wait until the person is declared stable.
7. The process of disclosure may continue throughout the capacity evaluation. For example, if the person does not appreciate that they may be unsafe to live at home and may require more supervision and assistance with ADLs than can be provided at home, then redisclose this information and reevaluate appreciation/understanding.
8. Use the person's own words whenever possible (i.e., “old folks’ home,” “nursing home,” “old age home”).
9. Do not evaluate whether you agree or disagree with the person's decision. Evaluate the person's ability to understand and appreciate their decision.

*This is the definition of capacity from the *Health Care and Consent Act*, 1996, legislation in Ontario, Canada. Although similar definitions exist across North America, we suggest that users check existing legislation, case law and professional policy statements in their own province or state.

SECTION I: IDENTIFICATION

Last Name: _____ First Name: _____

Date of Birth: Day _____ Month _____ Year _____ Health Card #: _____

PRESUMED CAPABLE (evaluation not indicated, proceed to Section IV)

If in doubt and not able to presume person is capable, proceed with Sections II, III and IV. Indicate your score for each domain with a checkmark. Record observations that support your score in each domain, including exact responses of the person being evaluated. Refer to attached sample questions as a guide.

SECTION II: EVALUATION OF CAPACITY

Person expressed consent to capacity evaluation or did not express refusal after being informed regarding implications of evaluation results and right to refuse capacity evaluation.

1. Able to understand care needs

Observations:

YES
NO
UNSURE

2. Able to understand proposed long-term care placement

Observations:

YES
NO
UNSURE

3. Able to understand option of refusing proposed long-term care placement

Observations:

YES
NO
UNSURE

4. Able to appreciate reasonably foreseeable consequences of accepting proposed long-term care placement

Observations:

YES
NO
UNSURE

5. Able to appreciate reasonably foreseeable consequences of refusing proposed long term care placement

Observations:

YES
NO
UNSURE

6. Able to understand alternative to proposed long term care placement (if any)

Observations:

YES
NO
UNSURE

Overall impression

CAPABLE	
INCAPABLE	
UNSURE	

Comments/recommendations:

If the overall impression is *unsure*, then take further steps to clarify. It may be necessary to re-evaluate over time. Further disclosure and discussion with the person which specifically focuses on domains evaluated as *unsure* is recommended. Similarly, it may be necessary to have further discussion with family/significant others. It may also be appropriate to consult with cultural/religious figure(s) and/or other health care team members (i.e., physician, psychiatrist, psychogeriatrician, social worker, occupational therapist, physiotherapist, speech-language pathologist, etc.).

SECTION III: RIGHTS INFORMATION (FOR PERSON EVALUATED AS INCAPABLE ONLY)

If the person is evaluated as incapable, the person must be informed of the findings and informed of his/her rights (i.e., given the CCAC “Rights Information Sheet — Admission to a Long-Term Care Facility”). If the person wants to appeal the finding of incapacity and make application to the Consent and Capacity Board for review, he/she can apply directly or with the assistance of the evaluator.

Informed of finding of incapacity

Given rights information

Intention to appeal finding of incapacity *not* indicated

Intention to appeal finding of incapacity indicated

SECTION IV: EVALUATOR IDENTIFICATION

Evaluator's Name (include credentials/title):

Evaluator's Signature: _____

Evaluator's Telephone #: _____

Date: Day: _____ **Month:** _____ **Year:** _____ **Hour:** _____

Time taken to administer PACE: _____ **minutes**

Sample questions

The list of sample questions below is not exhaustive. The questions are meant as a guide only and it is not necessary to ask all questions for each evaluation. The questions do not need to be asked word for word, but should be communicated in an informal and natural manner that is culturally sensitive. It is important that communication be at a level of expression compatible with that of the person being evaluated. It may be necessary to repeat questions and to rephrase questions in a way that is relevant to the individual person being evaluated. It is important to document the specific responses either verbatim or paraphrased. The responses/comments should be recorded in the corresponding sections of the PACE. A copy of the PACE can be used for documentation purposes (i.e., for Consent and Capacity Board review hearings, for hospital chart) and should be forwarded with the application to long-term care.

Sample preamble

Hello, my name is _____, I am a [state profession]. I have been talking with the doctors/health care team/your family and there are concerns about your ability to live at home. It has been suggested that you need to move to a long-term care facility/nursing home. I need to ask you some questions to decide if you are able to make a decision about where you should live. If you are able to decide for yourself, I need you to tell me where you want to live and what help you will need. If I think you are unable to make a decision for yourself, I will talk with [legally authorized substitute decision maker] to help decide where you should live. You have the right to refuse a capacity evaluation. Also, if you are found to be incapable, you have the right to appeal this decision by applying to the Consent and Capacity Board for a review (provide rights info sheet). If you do not understand or do not want to answer any questions and refuse to be evaluated, please let me know. (Proceed if person expresses consent or does not object/indicate refusal).

Orientation/memory

Before using the PACE tool, it is recommended to assess and document a general impression of the person's orientation/memory. Sample questions would include the following:

Question	Response/Comments
What is your name?	
How old are you?	
What is your date of birth/birthday?	
Where do you live/what is your home address?	
What is your home telephone number?	
Who is your family doctor?	
Who is your family/emergency contact?	
Where are you right now?	
What is the date/month/year/season?	

If the person presents as confused, disoriented and/or forgetful, consultation with a physician or psychiatrist is recommended and more formal cognitive assessment/testing (i.e., MMSE) may be indicated.

Depression/delusion/psychosis (optional)

After using the PACE tool, below are suggested questions if there are concerns that the person's ability to make a decision is affected by depression or delusion/psychosis. Always refer to a physician, psychiatrist, and/or psychogeriatrician for further assessment and treatment as appropriate.

Question	Response/Comments
Can you help me understand why you've decided to accept/refuse placement?	
Do you feel that you are being punished?	
Do you think you are a bad person?	
Do you have any hope for the future?	
Do you deserve to be taken care of?	
Do you think anyone is trying to hurt/harm you?	
Do you trust your doctor/nurse?	

1. Able to understand care needs

Question	Response/Comments
What happened that brought you here (i.e., for person in hospital)?	
What health problems are you having right now?	
What has the doctor told you?	
What problems are you having at home?	
What do you need help with on a daily basis?	
What help do you receive at home on a daily basis?	
Who provides you with help at home and how often?	
What do you need more help with on a daily basis?	
What problems are you having when you walk?	
What do you use to help you walk (i.e., cane/walker/person)?	
Have you had any falls? How often do you fall? What happened the last time you fell?	
What help do you need when getting in and out of bed?	
What help do you need when going to the bathroom?	
What help do you need when having a bath/shower?	
What help do you need when getting dressed?	
What help do you need when you eat?	
What help do you need when preparing meals?	
What help do you need with cleaning/doing laundry?	
What help do you need with shopping/buying groceries?	
What help do you need with transportation (i.e., to doctor's appointment, to go home today)?	
What help do you need with getting/taking medications?	
What problems do you have with your memory?	
When/how often do you feel confused?	
When/how often do you feel forgetful?	

What concerns do you have if you are alone at home?	
What concerns do you have about your safety at home?	
What concerns do you have about your ability to manage at home (i.e., if discharged from hospital today)?	

2. Able to understand proposed long-term care placement

Question	Response/Comments
What do you know about any long-term care facility/nursing home/home for the aged?	
What kind of help/care is available at a long-term care facility?	
Who needs to live at a long-term care facility and why?	

3. Able to understand option of refusing proposed long-term care placement

Question	Response/Comments
I/the healthcare team/your family think you need to move to a nursing home. Please tell me if you agree or disagree.	

4. Able to appreciate reasonably foreseeable consequences of accepting proposed long-term care placement

Question	Response/Comments
What will happen if you move to a nursing home?	
What kind of help could you receive if you live in a nursing home?	

5. Able to appreciate reasonably foreseeable consequences of refusing proposed long-term care placement

Question	Response/Comments
What will happen if you refuse to move to a LTC facility?	
If you felt sick or unsafe, what would you do?	
If you had a fall, what would you do?	
What could happen if you smoke in bed or leave the stove on?	
If there was a fire, what would you do?	
What could happen if you do not take your medication?	
What could happen if you do not have 24 hour care and supervision?	

6. Able to understand alternative to proposed long-term care placement

Question	Response/Feedback
If you do not move to a nursing home, where will you live (i.e., when you leave the hospital)?	
Who will help take care of you on a daily basis (i.e., be specific re: care needs/concerns identified by health care team assessment or by family or by other informants such as CCAC staff, EMS staff, police, etc.)?	
Where/how can you get the help you need? (Note: identify and confront conflicts if expectations do not meet reality of what formal/informal supports are able/willing to provide)	
Where/how can you get the help you need that your family/friends/CCAC can not provide (i.e., insurance benefits, privately hired help to supplement family/CCAC)?	

PACE: Placement Aid to Capacity Evaluation

Instructions for Scoring

1. Domains **1-3** evaluate whether the person understands and appreciates his/her current care needs, the proposed option of long term care placement, and the consequences of a decision to accept the proposed placement. Domains **4-6** evaluate whether the person understands and appreciates the option to refuse the proposed placement, the consequences of a refusal, and other realistic options if any exist (i.e., hiring private help, living with family) (*see sample questions above*).
2. If the person responds appropriately to open-ended questions, score **YES**. If they need repeated prompting by closed-ended questions, score **UNSURE**. If they cannot respond appropriately despite repeated prompting, score **NO**.
3. Record observations that support your score in each domain, including exact responses of the patient.
4. Remember that people are presumed to be capable. If you are uncertain regarding your overall impression, then do not err on the side of calling a person incapable. Reevaluate at another time and consult with other professionals (i.e., OT, PT, Psychiatrist) to request additional evaluation and assessment.

The developers of the PACE (i) assume no liability for any reliance by any person on the information contained herein; (ii) make no representations regarding the quality, accuracy or lawfulness related to the use of the PACE, and (iii) recommend that PACE users attend a PACE training session.

The PACE may be copied by any person for non-commercial use.

If you have any questions regarding PACE please contact:

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For an additional resource on capacity, please see Dr. Etchells' paper, "[Bioethics for Clinicians: 3. Capacity](#)" (*Canadian Medical Association Journal* 1996; 155. 657-61)

Updated 10 April 1997

APPENDIX D

SAMPLE DOCUMENTATION (CAPACITY EVALUATION)

KELLY, Joan HFN: 000000
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Date: March 12, 2008

- Capacity evaluation completed on today's date.
- In preparation for the assessment I met with Mrs. Kelly on three previous occasions, received input from her long time friend,, and consulted with following hospital staff/services: attending physician, Dr....., hospital Geriatric Consult Team, Occupational Therapist (OT) and Physiotherapist (PT).
- I also consulted with community OT, community social worker, and Community Care Access Centre case manager.
- Pocket talker was used during assessment as Mrs. Kelly is hearing impaired.
- I informed Mrs. Kelly at the outset of the purpose of the evaluation ("I need to determine if you are able to make a decision about going to a nursing home"), and the consequences of the outcome. At that time Mrs. Kelly was educated as to what a nursing home is and the care and services provided in a nursing home. She did not object to proceeding with the evaluation.
- The legal test for capacity to decide one's own admission to a nursing home is in S4(1) of the *Health Care Consent Act*. A person is capable with respect to admission to a care facility (nursing home) if the person is able to understand the information that is relevant to making the decision about admission and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision.
- Re: orientation...Mrs. Kelly was oriented to year only...knew she was in hospital but not the name of hospital.
- When asked if she had any medical problems, she responded..."not sure I have any". When asked why she was in hospital, she was slow to respond and when probed, responded..."I felt dizzy." When asked what happened when she felt dizzy, she responded..."I sat down". When reminded she was brought to hospital because she had fallen and had been found on the floor of her apartment she responded ..."oh yes." When asked if she had used her Lifeline when she fell, she responded that she had but could not account for why there had been no response to her call. When asked if she has had previous falls she denied she had. CCAC case manager was aware of at least two previous falls in the past six months. When this information was shared with Mrs. Kelly, she denied these falls. When asked what

she would do if she had a further fall she responded..."Oh no, that won't happen again."

- When asked if she has problems with her blood pressure she responded..."I don't think so."
- When asked if she has problems with her cholesterol she responded..."No, I don't think so." (In fact she has had high blood pressure and high cholesterol for several years for which she takes medication).
- When asked if she takes medication she responded..."I have pills that I take for some reason but I have no idea what for."
(In fact she has had high blood pressure and high cholesterol for several years for which she has been prescribed medications). CCAC case manager informs that Mrs. Kelly frequently forgets to take her morning medications and has to be reminded to do so.
- When asked how her vision and hearing are, Mrs. Kelly responded..."fine." It is noted she has impaired vision which CCAC case manager states likely contributes to falls.
- When asked if she had any problems with looking after her self care Mrs. Kelly reported she had no problems. She reported she takes a tub bath twice a week. CCAC case manager reports Mrs. Kelly has poor personal hygiene and frequently smells of urine. She further reported Mrs. Kelly refuses help with bathing and stated she did not believe Mrs. Kelly gets into the tub but rather washes at the sink. When Mrs. Kelly probed about this discrepancy she became irritated and stated..."she should mind her own business." She denied having any problems with incontinence.
- When asked about home support services, Mrs. Kelly reported there is a woman who comes in a few days a week to see her but denied she helps her with personal care, shopping or meal preparation. When informed that CCAC reports they provide assistance in these areas, she denied same. She further denied she sometimes refuses to allow them into her apartment as reported by CCAC.
- When asked about alcohol consumption Mrs. Kelly responded..."I have a beer once in a blue moon." When probed re: reports (from long time friend) that she drinks at least a bottle of sherry a week, Mrs. Kelly denied doing so.
- When asked what she would do if there was a fire in her apartment, she responded ... "I would run screaming."
- When asked why she thought a nursing home was being proposed she replied, "No, I am sure they are nice places but not for me."
- Mrs. Kelly was again informed about what a nursing home is and the care and services provided and again asked why a nursing home was being proposed at this time to which she replied "I am quite comfortable where I am now. I don't need a nursing home."

- When asked if she knew why people are worried about her living alone whereas she is not, she responded...“No, I am fine.”
- When asked when she would know it was time to move to a nursing home she replied, “I won’t need a nursing home.”
- I find Mrs. Kelly incapable of making a decision re: nursing home placement. She did not meet the legal test for capacity ie. ability to understand information relevant to the decision and ability to appreciate the consequences of her decision. The ability to understand includes the ability to grasp and retain information which Mrs. Kelly was unable to do. She did not recall previous discussions about how she manages at home. She did not understand her medical problems and reasons for medications. She did not recall the fall that precipitated her admission to hospital or that she had had previous falls. Appreciate refers to the ability to weigh information in the context of one’s own circumstances which Mrs. Kelly was unable to do...she demonstrated a lack of insight about her limitations and possible consequences of these limitations. I find Mrs. Kelly incapable by virtue of poor memory, lack of insight and cognitive impairment.
- I informed Mrs. Kelly of the finding of incapacity and her right to appeal this decision. Rights Information Sheet was provided. She again stated she wants to remain in her apartment as she was managing fine and does not want to go to a nursing home.
- Although Mrs. Kelly did not articulate her wish to apply to the CCB for a review of this finding of incapacity, she did repeat her wish not to go to a nursing home. As such I have assisted her in applying to CCB for review of this finding.

(Time spent in completing evaluation...70 minutes to complete evaluator questionnaire. Several additional hours spent in interviews with patient, consulting with friend, health team, Geriatric Consult Team, and community care providers; there would also be detailed documentation of these consultations in the client’s chart)

Assessing Capacity
for Admission to
Long-Term Care Homes

•••

*A Training Manual
for Evaluators*

Substitute
Decision Makers

Substitute Decision Makers

Introduction

Choosing a Substitute Decision Maker

The Role of an Attorney for Personal Care

— *Jane Goddard and Associates • Lawyers, 2001*

4

SUBSTITUTE DECISION MAKERS

Introduction

Admission to a care facility cannot occur without consent of the individual being admitted, if they are capable of giving consent, or a Substitute Decision Maker (SDM), if the individual has been deemed incapable through the capacity evaluation process as described in the previous chapter. If an evaluator has deemed a person incapable of making the decision, and administered rights information to him/her and there is no application being made to the Consent and Capacity Board (CCB), then the CCAC would turn to the SDM of highest ranking (see below for the ranking) for consent or refusal of consent.

If the incapable person intends to apply or has already applied to the CCB for a review of the finding of incapacity, or they intend to apply or has applied to the CCB for the appointment of a representative, or another person intends to apply or has applied to be appointed as a representative, then the admission to a care facility process is put on hold. If 48 hours have elapsed since first being informed of the intended application and no application has been started, or the CCB application is withdrawn, then the CCAC can proceed with the SDM.

Choosing a Substitute Decision Maker (SDM)

The Health Care Consent Act provides the following hierarchical list of potential SDMs in priority order:

- Guardian of Person with authority for admission decision
- Attorney for Personal Care with authority for admission decision
- Representative appointed by the Consent and Capacity Board
- Spouse or partner
- Child or parent or Children's Aid Authority or other person lawfully entitled to give or refuse consent for admission in place of the parent – not including parent with right of access only – if Children's Aid Society or other person is lawfully entitled to give or refuse consent for admission in place of the parent.
- Parent with right of access only
- Brother or sister
- Any other relative
- If there is no person according to this list, or he/she does not meet requirements to be an SDM, then go to the Office of the Public Guardian and Trustee

Persons ranked lower on the list may give consent only if no person higher up meets requirements (*see following*). An exception to this rule is where a family member is present, or contacted and believes that is no person higher or on the same level, or if a person higher exists, and is not guardian, Power of Attorney for personal care, CCB appointed representative, and would not object to him/her making the decision, then he/she may give or refuse consent. Where there is a conflict between persons in the same category, and cannot agree, then the Public Guardian and Trustee should be contacted to make the decision.

Where there is no Guardian or Person with authority for admission decision or no Attorney for Personal Care with authority for admission decision, the following are circumstances for applying to the Consent and Capacity Board to be a representative:

- Where individuals on the same level do not agree, one or more may apply
- Where a lower ranked individual wants to be SDM, he/she may apply
- Where a person (i.e. friend) is not listed in the hierarchy, he/she may apply
- Where a potential SDM (even if they are Guardian or Attorney for Personal Care) on the hierarchy is believed to be incapable, he/she may apply

Requirements for SDM

SDM in the list may give or refuse consent only if he/she is:

- Capable with respect to the admission decision, according to the person obtaining consent
- 16 years or older
- Not prohibited by court order or separation agreement from having access to incapable person or giving or refusing consent on his/her behalf
- Is available (can be by various means (i.e. phone, fax), BUT not by proxy); and
- Is willing to assume the responsibility of giving or refusing consent

Principles for Giving or Refusing Consent

The SDM who gives or refuses consent on an incapable person's behalf must do so in accordance with the following principles: firstly, if the incapable person after attaining 16 years of age has expressed a prior capable wish relevant to the decision, this must be followed (clarification of the wish, or departure from it can only be done through application to the CCB); and secondly, if there are no known wishes or if it is impossible to comply with the wish then the SDM must act in the incapable person's best interests (see below for an explanation of best interests). The SDM is entitled to receive all the information required in order to make the decision.

If the CCAC believes that the SDM is not complying with a known wish, or in the person's best interest, it can bring an application (Form G) to the Consent and Capacity Board under s. 54 of the Health Care Consent Act.

What are Best Interests?

In deciding what the incapable person's best interests are, the following are some things to be taken into consideration by the SDM:

- The values and beliefs that the incapable person held when capable, and that the SDM believes he/she would still act on
- Whether admission to a care facility is likely to,
 - improve the quality of the incapable person's life
 - prevent the quality of the incapable person's life from deteriorating, or
 - reduce the extent to which, or rate at which, the quality of the incapable person's life is likely to deteriorate

- Whether the quality of the incapable person's life is likely to improve, remain the same or deteriorate without admission to the care facility
- Whether the benefit the incapable person is expected to obtain from admission to the care facility outweighs the risk of negative consequences to him/her
- Whether a course of action that is less restrictive than admission to the care facility is available and is appropriate in the circumstances

Other Considerations

An individual who has been deemed incapable by an evaluator may still be capable of executing a Power of Attorney for Personal Care. He/she may also apply to the CCB to have a representative of his/her choice appointed as SDM.

An SDM must be mentally capable of making the decision at issue, but the process for determining this, is not the same process as laid out in the Health Care Consent Act. If there are reasonable grounds to believe that the potential SDM is mentally incapable of making the decision, then there is an obligation to obtain consent or refusal of consent from the next person ranked on hierarchical list. Due to the failure of the potential SDM to meet the criteria for being an SDM, he/she should be informed that they will not be asked for consent due to his/her mental capacity, and has no right of review at the Consent and Capacity Board for having been bypassed due to incapacity. If there is a doubt as to the potential SDM's capacity, consult with a subject matter expert before proceeding.

An SDM, cannot assign the responsibility of making decisions to another individual. If the person named as the Attorney for Personal Care does not meet the requirements (e.g. is unwilling to accept the role), then it is as if that Power of Attorney does not exist and the evaluator would turn to the next person from the hierarchical list to act as SDM. An Attorney for Personal Care can resign if they so wish (see s.52 of the Substitute Decision Act).

If the person responsible for authorizing admission to the care facility (i.e. CCAC staff) is of the opinion that the SDM is not acting according to the incapable person's capable wishes, if known, or in his/her best interests, then the person for authorizing the admission to a care facility may apply to the CCB for determination as to whether the SDM has complied with the Health Care Consent Act (application to the CCB is made on a Form G).

An Attorney for Personal Care has specific responsibilities about how they must make decisions as laid out in the capacity legislation. This is a summary of those obligations and responsibilities.

Jan Goddard and Associates • Lawyers

Nimali D. Gamage • Jan Goddard • Alessandra P. Goulet

THE ROLE OF AN ATTORNEY FOR PERSONAL CARE

Introduction

The purpose of this fact sheet is to explain the important role of an attorney for personal care. It explains what is involved in being an attorney for personal care, what the attorney is allowed to do and how the attorney is supposed to meet his or her obligations to an incapable person.

The powers and duties of an attorney for personal care are fully set out in the *Substitute Decisions Act, 1992* and the *Health Care Consent Act, 1996*. **This fact sheet is a summary only.** It is not legal advice, and if you have questions about how to interpret this information, you should consult with a lawyer.

The purpose of a power of attorney for personal care

Most people make their own personal care decisions. Personal care decisions can include decisions about where to live, what to eat, safety, clothing, personal hygiene and health care, including treatment.

Making a power of attorney for personal care is an important step in planning for mental incapacity. By making a power of attorney for personal care, a person selects **who** he or she wants to make personal care decisions if he or she becomes incapable.

A power of attorney for personal care may also include wishes or instructions regarding how the person wants decisions to be made about him or her if he or she becomes incapable. These wishes or instructions can apply to decisions about the person's health care, including treatment, where the person lives, what the person eats as well as matters such as safety, clothing and hygiene.

The essential role of any attorney for personal care is to be a **substitute decision maker**. The attorney “steps into the shoes” of the person, if he or she becomes incapable, and makes personal care decisions when necessary. These need to be made carefully and sensitively.

When a power of attorney for personal care is used

An attorney for personal care only makes personal care decisions that the person is incapable of making for himself or herself. For example, a person may be incapable of making decisions about a complicated medical treatment, such as surgery under a general anesthetic. If such surgery is recommended, the surgeon may ask the attorney to consent. However, the person may be capable of consenting to a routine

physical examination. The fact that the attorney has been asked to consent to the surgery does not mean that the attorney will be asked to consent to all treatment given to the person. In most cases, it is up to the individual health practitioner to decide whether the person is incapable and the attorney is needed to make a decision.

Most frequently, an attorney for personal care is asked to make a decision for an incapable person regarding treatment or placement in a long-term care facility. However, a power of attorney for personal care that covers all types of personal care decisions extends beyond these situations. An attorney for personal care may need to assist an incapable person by making decisions regarding the person's safety, where the person lives, what he or she eats and matters of personal grooming.

An attorney for personal care is a decision maker, and is not expected to provide personal care services directly to the incapable person. However, the attorney may sometimes have to be involved in making arrangements for an incapable person. For example, an attorney for personal care may be the one who arranges for home care services, although these are actually provided by someone else.

A typical power of attorney for personal care does not give an attorney the power to force the incapable person to go along with his or her decisions. For example, an attorney cannot make the person eat food delivered by Meals-on-Wheels. Some powers of attorney for personal care require that it be confirmed that the person is incapable of making personal care decisions before the attorney can make decisions.

Some powers of attorney for personal care contain special provisions that allow an attorney to use force, if necessary, to require the person to undergo a capacity assessment or be admitted to hospital. Attorneys who have been appointed under such powers of attorney should consult with a lawyer before starting to make decisions.

Legal responsibilities of an attorney for personal care

An attorney for personal care must exercise his or her duties and powers diligently, and in good faith. When an attorney steps in and makes a personal care decision for an incapable person, that decision must be made solely for the benefit of the incapable person.

The following are some of the legal responsibilities of an attorney for personal care:

- The attorney must explain his or her powers and duties to the incapable person.
- The attorney must encourage the incapable person to participate in decisions the attorney makes, to the best of the incapable person's ability to do so.
- The attorney must seek to foster the incapable person's independence.
- The attorney must choose the least restrictive and intrusive course of action that is available and is appropriate.
- The attorney must seek to foster regular personal contact between the incapable person and supportive family members and friends.
- The attorney must consult from time to time with supportive family members and friends who are in regular personal contact with the incapable person and with the persons from whom the incapable person receives personal care.

- The attorney must keep records of decisions he or she makes on the incapable person's behalf.
- The attorney must make reasonable efforts to find out if the incapable person expressed any wishes and instructions, while capable, that apply to the decision the attorney is making.
- The attorney must not use confinement, monitoring devices or physical or chemical restraints on the incapable person or consent to their use unless doing so is essential to prevent serious bodily harm to the incapable person or others, or allows the incapable person greater freedom or enjoyment.

An attorney who is asked to consent to electric shock as aversive conditioning, sterilization or the removal of tissue for transplantation, or the incapable person's participation in a procedure whose primary purpose is research should consult with a lawyer before making a decision.

Guiding principles for decision making

In making a decision for an incapable person, an attorney for personal care must follow these principles:

1. If the attorney knows of a **wish** the person expressed when capable, and the wish applies to the circumstances, the attorney must make the decision in accordance with the wish. For example, if the attorney knows that the incapable person did not wish to receive antibiotics for the treatment of pneumonia, the attorney must refuse to consent to treatment with antibiotics.

The wish can be in writing, such as in a "living will", but it does not have to be.

2. If the attorney does not know of any wish, or if it is impossible to comply with the wish, the attorney must act in the incapable person's **best interests**. In doing so, the attorney must consider:
 - The values and beliefs the attorney knows the person held when capable and believes the person would still act on if capable
 - The person's current wishes (if they can be ascertained)
 - Whether the decision is likely to improve the person's situation, prevent the person's situation from deteriorating or reduce the extent to which, or the rate at which, the person's situation is deteriorating. The person's situation could include his or her condition and well being (where a treatment decision is being made) or his or her quality of life (where a placement decision or other personal care decision is being made).
 - Whether the incapable person's situation is likely to improve, remain the same or deteriorate if the attorney does not choose the course of action under consideration.
 - Whether the benefit to the incapable person from the proposed course of action outweighs the risk of harm to him or her.
 - Whether there is a more desirable alternative to the course of action under consideration (for example, a less restrictive or intrusive course of treatment, or a less restrictive option than admission to a long-term care facility)

An attorney for personal care is entitled to receive the information relating to the incapable person that is necessary for the attorney to make a decision regarding treatment or admission to a long-term care facility. This may include 5 medical reports, hospital records and reports and records from a community care access center.

Assistance from the Consent and Capacity Board

Sometimes an attorney may find it difficult to interpret a wish, or may believe that if the incapable person were capable at the present time, and asked to make the decision, he or she would now make a decision contrary to the wish.

If the decision is about treatment or admission to a long term care facility, the attorney may ask the Consent and Capacity Board to assist him or her in interpreting the wish or deciding whether the attorney may depart from the wish.

An attorney who wants to ask the Consent and Capacity Board for assistance may wish to consult with a lawyer before doing so.

Records to be kept by an attorney for personal care

An attorney should always keep a copy of the power of attorney for personal care in a safe place.

The records that an attorney must keep include:

- A list of all decisions regarding health care, safety and shelter made on behalf of the incapable person, including the nature of each decision, the reason for it and the date
- A copy of medical reports or other documents, if any, relating to each decision
- The names of any persons consulted, including the incapable person, in respect of each decision and the date
- A description of the incapable person's wishes, if any, relevant to each decision, that he or she expressed when capable and the manner in which they were expressed
- A description of the incapable person's current wishes, if these can be ascertained, and if they are relevant to the decision
- For each decision taken, the attorney's opinion on each of the guiding principles listed above

Maintaining confidentiality

An attorney is not allowed to disclose any information contained in his or her records unless required to do so in order to make decisions on the incapable person's behalf or otherwise fulfill the attorney's duties, or if ordered to do so by a court.

An attorney must produce copies of his or her records to:

- The incapable person
- The incapable person's attorney under a continuing power of attorney for property or guardian of property
- The Public Guardian and Trustee

Conclusion

The role of an attorney for personal care is to take on the important responsibility of making decisions for an incapable person about shelter, diet, clothing, safety, hygiene and health care, including treatment. These decisions must be made sensitively, with respect for the incapable person and in consultation with

supportive family members and friends. The attorney also has a duty to follow the guiding principles for decision making set out in the law.

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The purpose of this Fact Sheet is to provide information to clients of **Jan Goddard and Associates** and others. This Fact Sheet is not legal advice, and should not be relied upon as legal advice. If you are choosing an attorney for personal care, you should consult with a lawyer. Please do not copy or distribute this Fact Sheet without the author's express permission.

The Consent and Capacity Board

Consent and Capacity Board—Preface

Introduction to the Board

Types of Application to the Consent and Capacity Board

Consent and Capacity Board—Rules of Practice

Preparing for a Board Hearing

Mock Hearing of the Consent and Capacity Board

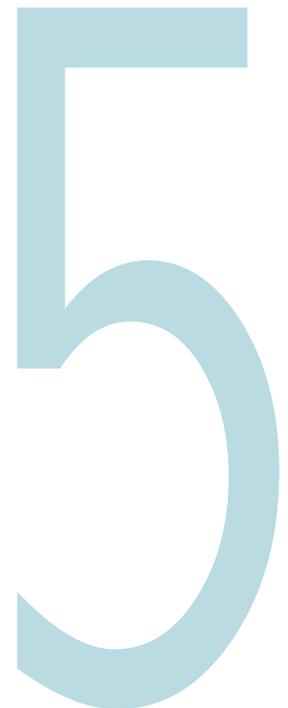
Web Resource Links

Appendices

A—*Consent and Capacity Board Applications*
Weblinks to: Form A, Form B, Form C,
Form D, Form E, Form G
Summary Template (for Form G)

B—*Clinical Summary - Sample #1*

C—*Clinical Summary - Sample #2*



Preface

A determination of incapacity is a legal finding and as such, every person has a right to challenge that finding. Since there is an element of subjectivity in any finding of incapacity, questions can be raised as to the decision's validity. The *Consent and Capacity Board* is there to ensure that the correct legal process was followed, and that there is evidence to support the finding. The Board may come to a different conclusion than the evaluator does; most important is that the evaluator is prepared prior to attending the Hearing.

Introduction to the Board

The Consent and Capacity Board is an independent body created by the provincial government of Ontario under the Health Care Consent Act. It conducts hearings under the Mental Health Act, the Health Care Consent Act, the Personal Health Information Protection Act and the Substitute Decisions Act. Board members are psychiatrists, lawyers and members of the general public appointed by the Lieutenant Governor in Council. The Board sits with one, three, or five members. Hearings are usually recorded in case a transcript is required.

The Board has the authority to hold hearings to deal with the following matters:

Health Care Consent Act

- Review of capacity to consent to treatment, admission to a care facility or personal assistance service.
- Consideration of the appointment of a representative to make decisions for an incapable person with respect to treatment, admission to a care facility or a personal assistance service.
- Consideration of a request to amend or terminate the appointment of a representative.
- Review of a decision to admit an incapable person to a hospital, psychiatric facility, nursing home or home for the aged for the purpose of treatment.
- Consideration of a request from a substitute decision maker for directions regarding wishes.
- Consideration of a request from a substitute decision maker for authority to depart from prior capable wishes.
- Review of a substitute decision maker's compliance with the rules for substitute decision making.

Mental Health Act

- Review of involuntary status (civil committal).
- Review of a Community Treatment Order.
- Review as to whether a young person (aged 12 to 15) requires observation, care and treatment in a psychiatric facility.
- Review of a finding of incapacity to manage property.

Personal Health Information Protection Act

- Review of a finding of incapacity to consent to the collection, use or disclosure of personal health information.
- Consideration of the appointment of a representative for a person incapable of consenting to the collection, use or disclosure of personal health information.
- Review of a substitute decision maker's compliance with the rules for substitute decision making.

Substitute Decisions Act

- Review of statutory guardianship for property.

How are applications made to the Board?

Application forms may be available from health or residential facilities. Completed applications should be faxed to the Board. Health practitioners and officials of health and residential facilities are expected to fax forms to the Board within one hour of completion. If necessary, call the Board to have the application forms and specific information sheets faxed.

When and where will the hearing be?

The parties will receive a notice from the Board with the time and place of the hearing. If you are not a party, you may ask the Board for the time and place. The hearing will usually take place within a week after the Board receives the application and will be held in the facility where the subject of the hearing resides or receives treatment or at some other place convenient to the parties.

How much does it cost?

There is no charge to the participants for the services of the Board. The Board is publicly funded and requests that all participants assist in keeping costs down.

What will happen at the hearing?

Each party may attend the hearing and invite anyone they want to come. Family members and friends are also encouraged to attend. The presiding member will introduce everyone and explain how the hearing will work, who the official parties are and the order in which people will speak.

Each party may have a lawyer, call witnesses and bring documents. Each party and the Board members may ask questions of each witness. At the end of the hearing, each party will be invited to summarize and the presiding member will then end the hearing.

What happens after the hearing?

The Board will meet in private to make its decision. The Board will issue its decision within one day. The Board may also issue written reasons explaining its decision. Written reasons will be issued if any of the parties request them. This request may be made within thirty days of the hearing.

Can the Board's decision be appealed?

Any of the parties may appeal the Board's decision to the Superior Court of Justice.

How can I get more information?

Information sheets, application forms and any further information can be obtained by contacting the Board or on our web site at www.ccboard.on.ca.

Types of Application That Can be Made to the Consent and Capacity Board

Review of capacity to make the decision with respect to admission to a care facility

(see Appendix for sample: **FORM A**)

If an evaluator makes a finding of incapacity to make the decision about admission to a care facility, the individual who has been deemed incapable is entitled to apply to the CCB for a review of this finding.

Applying to the CCB to have a representative appointed to make the decision with respect to admission to a care facility

(see Appendix for sample: **FORM B**)

An individual who has been found incapable of the admission decision to a care facility, may apply to the CCB for a hearing to have a representative of his/her choice appointed to give or refuse consent on his/her behalf.

Applying to the CCB to be appointed a representative to make the decision with respect to admission to a care facility

(see Appendix for sample: **FORM C**)

An individual may apply to the CCB, where there has been a finding of incapacity, to be appointed as representative of the incapable person in order to give or refuse consent on behalf of the incapable person.

Applying to the CCB for directions, when an individual has been found incapable, and where there are previously expressed wishes with respect to admission to a care facility, but there is uncertainty about the nature of the wishes or their validity

(see Appendix for sample: **FORM D**)

A Substitute Decision Maker may apply to the CCB if he/she is aware of a past wish expressed by the incapable person with respect to admission to a care facility, and: a) the wish is not clear; b) it is not clear if the wish applies to present circumstances; c) it is not clear if the person was capable when the wish was expressed, or d) it is not clear if the wish was expressed when the person was at least 16 years old.

Applying to the CCB to depart from the previously expressed wishes of an individual that has been found incapable in regard to admission to a care facility

(see Appendix for sample: **FORM E**)

One rule governing decision making requires that an SDM gives or refuses consent in accordance with the wishes of the incapable person if those wishes were expressed when the person was capable and at least 16 years old. An SDM may apply to the CCB to depart from these prior capable wishes, and the CCB may grant permission if it is satisfied that the likely outcome of the proposed action is significantly better than would have been anticipated in comparable circumstances at the time the wish was expressed.

Applying to the CCB to determine whether or not the SDM has complied with the rules for substitute decision making in regard to admission to a care facility

(see Appendix for sample of **FORM G** which includes a summary template used for a Form G related to Treatment decisions, but can be used a guide)

Where the person responsible for authorizing admission to the care facility (i.e. CCAC staff, not a family member or hospital staff) believes that the SDM is not following the principles for decision making as prescribed in the HCCA, that person may apply to the CCB for a determination as to whether the principles have been followed and for an order to the SDM to comply with the Act.



CONSENT AND CAPACITY BOARD

RULES OF PRACTICE

NOTE

The Board will issue a **Users' Guide to the Rules of Practice** following the proclamation of the Rules for the purpose of assisting those using the Rules.

If you have any questions concerning the Rules, please contact the Board at (416) 327-4142 or fax at (416) 327-4207. Access to all relevant legislation is available through the Board's website at www.ccboard.on.ca

French version available upon request. Please contact the Board.

PREAMBLE

These Rules have been adopted by the Consent and Capacity Board (the "Board") pursuant to section 25.1 of the *Statutory Powers Procedure Act*. Except where their application is statutorily excluded, these Rules apply to hearings held under the *Health Care Consent Act, 1996*, *Long-Term Care Act, 1994*, *Mental Health Act* and *Substitute Decisions Act, 1992*.

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PURPOSE OF THE RULES

1.1 The purpose of these Rules is to provide a just, fair, accessible and understandable process for parties to proceedings before the Board. The Rules attempt to facilitate access to the Board; to promote respectful hearings; to promote consistency of process; to make proceedings less adversarial, where appropriate; to make proceedings as cost effective as possible for all those involved in Board proceedings and for the Board by ensuring the efficiency and timeliness of proceedings; to avoid unnecessary length and delay of proceedings; and to assist the Board in fulfilling its statutory mandate of delivering a just and fair determination of the matters which come before it.

APPLICATION OF RULES

2.1 These Rules apply to all proceedings of the Board.

2.2 Where any of these Rules conflicts with any statute or regulation or where the application of these Rules is statutorily excluded, the provisions of the statute or regulation shall prevail.

2.3 Where something is not provided for in these Rules, the practice may be decided by referring to a similar provision in these Rules.

BOARD POWERS

3.1 The Board may exercise any of its powers under these Rules on its own initiative or at the request of any party. Unless otherwise provided, members of the Board, sitting alone or in a panel of three or five members to deal with particular applications, may exercise the powers provided to the Board in these Rules.

3.2 During any proceeding, the Board may do whatever is necessary and permitted by law to enable it to effectively and completely adjudicate on the matter before it. The Board may decide the procedure to be followed for any proceeding and may make procedural directions or orders at any time. The Board may impose such conditions as are appropriate and fair.

3.3 The Board may waive or vary any of these Rules at any time in order to ensure the fair and just determination of the proceedings before it.

COMPUTING TIMES

4.1 In computing time periods under these Rules or in an order or decision, except as provided by statute or where a contrary intention appears:

(a) where there is a reference to a number of days between two events, they shall be counted by excluding the day on which the first event happens and including the day on which the second event happens;

(b) where the time for doing an act under these Rules expires on a non-business day, the act may be done on the next day that is a business day;

(c) where, under these Rules, a document would be deemed to be received or service would be deemed to be effective on a day that is a non-business day, it shall be deemed to be received or effective on the next day which is a business day; and

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(d) if a document is received after 4 p.m. on a business day, it shall be deemed to have been received on the next business day.

4.2 “Business day” means any day other than a Saturday, Sunday or a holiday. A “holiday” includes New Year’s Day, Good Friday, Easter Monday, Christmas Day, Boxing Day, Civic and Provincial Holidays (including the first Monday in August), the birthday or the day fixed by proclamation of the Governor General for the celebration of the birthday of the reigning Sovereign, Victoria Day, Canada Day, Labour Day, Remembrance Day and any day appointed by proclamation of the Governor General or Lieutenant Governor as a public holiday or for a general fast or thanksgiving, and when any holiday, except Remembrance Day, falls on a Sunday, the day next following is in lieu thereof a holiday.

PARTIES

5.1 The following persons are parties to an application for the purpose of these Rules:

- (a) persons specified as parties by the statute under which the application arises; and
- (b) any other person the Board specifies.

5.2 In deciding whether to specify a person as a party to an application, the Board may consider:

- (a) the nature of the case;
- (b) the issues;
- (c) whether the person has a genuine interest in the issues;
- (d) whether the person’s interests may be directly and substantially affected by the hearing or its result;
- (e) whether the person is likely to make a useful and distinct contribution to the Board’s understanding of the issues in the hearing; and
- (f) any other relevant factor.

5.3 The Board may require persons who have similar interests to designate one person to act as their spokesperson, or to co-ordinate their submissions.

5.4 If it appears to the Board, prior to the commencement of or at any time during the hearing, that the subject of the application will not have legal representation at the hearing, the Board may exercise its powers under section 81 of the *Health Care Consent Act, 1996* to arrange legal representation for that person.

5.5 In order to exercise its powers under section 81 of the *Health Care Consent Act, 1996*, the Board or its administrative staff may make inquiries for the sole purpose of determining whether the subject of the application is or may be incapable with respect to treatment, admission to a care facility or a personal assistance service and/or whether he or she wishes to be represented by counsel at the hearing.

FILING APPLICATIONS AND OTHER DOCUMENTS WITH THE BOARD

6.1 In these Rules, “filing” of any document means the delivery in person or by fax of that document to the Board’s Deputy Registrar and its receipt by the Board.

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6.2 An application, notice or any other document shall be filed with the Board, unless otherwise directed by the Board.

6.3 Subject to Rule 4, documents are deemed to be filed as of the date and time they are received by the Board.

SERVICE OF DOCUMENTS

7.1 Service may be effected by:

- (a) personal delivery of a document to a person or to the person's lawyer or agent in the proceeding;
- (b) faxing the document to the last known fax number of the person or to the person's lawyer or agent in the proceeding;
- (c) delivery of the document by courier or Priority Post, to the last known address of the person or to the person's lawyer or agent in the proceeding; or
- (d) any other means authorized or permitted by the Board for delivery of the document or for communicating the information contained in the document.

7.2 If the Board is aware that the subject of an application is a young person under the age of 16, a document shall be served on the young person or the young person's lawyer in the proceeding, if any. If the young person does not have a lawyer, a document may be served on both the young person and the Children's Lawyer.

7.3 Unless advised to the contrary by a person's lawyer or agent, the Board shall assume that the lawyer or agent in the proceeding knows the whereabouts of the person and is able to contact that person.

7.4 Service is deemed to be effective, when delivered by:

- (a) personal delivery, before 4 p.m. on the day of delivery, and after that time, on the next day;
- (b) fax, before 4 p.m. on the date it was sent, and after that time, on the next day;
- (c) courier, on the day after the courier picks it up for delivery; or
- (d) any means authorized or permitted by the Board, on the date specified by the Board in its direction.

7.5 After an application is filed with the Board, a party may waive service by the Board or by any other party, of a notice of hearing or any other document.

7.6 Parties serving documents shall clearly show their name, address, and telephone and fax numbers on a covering document.

INCOMPLETE OR TECHNICALLY DEFECTIVE APPLICATIONS

8.1 In this section, "Board" includes the Board's administrative staff.

8.2 Upon receiving an application that appears incomplete, the Board will contact the person submitting the application to obtain the missing information. If information required to establish the nature of the application, the parties thereto or other facts material to the ability to hold a hearing

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cannot be obtained following reasonable inquiry, the Board may decide not to process the application.

8.3 Upon receiving an application that appears to be materially defective, the Board will notify the person submitting the application of the defect. If the defect is not remedied, the Board may decide not to process the application.

8.4 The Board shall give the applicant and such other persons as the Board deems appropriate notice of its decision not to process the application and set out the reasons for the decision and the requirements for commencement processing of the application.

8.5 The application will be deemed to have been received by the Board if and when these requirements have been met to the satisfaction of the Board.

DISMISSAL OF APPLICATION WITHOUT HEARING

9.1 The Board may dismiss an application without a hearing if:

- (a) the application is frivolous, vexatious or is commenced in bad faith;
- (b) the application relates to matters that are outside of the jurisdiction of the Board; or
- (c) the statutory requirements for bringing the application have not been met.

9.2 Before dismissing an application under this section, the Board shall give notice of its intention to dismiss the application to:

- (a) all parties to the application, if the application is being dismissed for reasons referred to in Rule 9.1(b);
or
- (b) the party who commenced the application, if the application is being dismissed for any other reason.

9.3 The notice of intention to dismiss an application shall set out the reasons for the intended dismissal and inform the parties of their right to make written submissions to the Board with respect to the dismissal within five days of service of the notice.

NOTICE OF WITHDRAWAL OF APPLICATION

10.1 An applicant who does not want to continue with all or part of an application may withdraw all or part of the application by faxing a notice of withdrawal to the Board.

10.2 A party in the proceedings before the Board who, before the time of the hearing, takes an action that makes a hearing unnecessary shall notify the Board about such action immediately by fax.

10.3 An application cannot be withdrawn until the Board receives a written notice of withdrawal or until the Board is reasonably satisfied that appropriate documentation has been completed. If, for any reason, the Board is not satisfied that an application has been properly withdrawn or that a hearing has become unnecessary, the Board may proceed with the hearing.

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NOTICE OF HEARING

11.1 Notice of a hearing shall be served by the Board on the parties and other persons as permitted by statute.

11.2 In addition to providing the information required by statute, the Board may include in a notice of hearing any other information or directions it considers necessary for the proper conduct of the hearing.

11.3 The Board may serve notice of a hearing by way of telephone call, only if the Board considers this form of notice appropriate and necessary in the circumstances.

11.4 If, at the commencement of a hearing, the Board is not satisfied that all parties have received notice of the hearing, the Board may adjourn the hearing until all parties have received proper notice.

PLACE OF HEARING

12.1 Unless the Board decides otherwise, the hearing will be held as close as possible to the place where the person who is the subject of the application is physically located at the time of the hearing.

MOTIONS

13.1 “Motion” means a request for the Board’s ruling or decision on a particular issue at any stage within a proceeding or intended proceeding.

13.2 A motion may be made by a party to the proceeding or by a person with an interest in the proceeding.

13.3 A person who has an interest in the proceeding and makes a motion will be dealt with by the Board as if he or she were a party for the purposes of the motion only.

13.4 At the earliest possible date before the hearing, and in any event no later than 4 p.m. on the day before the hearing, the party or person who wishes to bring a motion shall give notice of the motion to all other parties and to the Board. If necessary, leave to bring a motion may be sought at the commencement of the hearing.

13.5 Except as otherwise permitted by the Board, all motions shall be heard at the commencement of the hearing.

13.6 Notice of a motion does not need to be in any particular form. In appropriate circumstances, notice may be given by telephone call. Notice of a motion must adequately set out the grounds for the motion and the relief requested.

13.7 The Board may direct the procedure to be followed for dealing with a motion and set applicable time limits. The Board may direct that the motion will be dealt with in writing or by any other means.

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PRE-HEARING CONFERENCES

14.1 The Board may, at the request of a party or on its own initiative, direct the representatives for the parties, either with or without the parties, and any party not represented by counsel to appear before a member of the Board for a pre-hearing conference for the purpose of considering any or all of the following:

- (a) the identification, simplification and/or resolution of some or all of the issues;
- (b) identifying facts or evidence that may be agreed upon by the parties;
- (c) identifying all parties to the hearing;
- (d) the estimated duration of the hearing;
- (e) identifying the witnesses;
- (f) any other matter that may assist the just and most expeditious disposition of the proceeding.

14.2 The Board may direct the parties to serve documents or submissions prior to the pre-hearing conference.

14.3 A pre-hearing conference will not be held unless the party who is the subject of the application has legal representation.

14.4 A pre-hearing conference shall be conducted by a Board member.

14.5 A pre-hearing conference may be held in person, in writing or electronically. A pre-hearing conference shall not be open to the public.

14.6 All documents intended to be used at the hearing that may be of assistance in achieving the purposes of a pre-hearing conference shall be made available to the member presiding at the pre-hearing conference.

14.7 (1) At the conclusion of the pre-hearing conference,

(a) counsel or any party not represented may sign a memorandum setting out the results of the conference; and/or

(b) the member of the Board who presides at a pre-hearing conference may make such orders as he or she considers necessary or advisable with respect to the conduct of the proceeding, including an order adding parties, and the memorandum or order binds the parties unless the member presiding at the hearing orders otherwise to prevent injustice.

(2) A copy of a memorandum or an order made under subrule (1) shall be placed in the hearing file and made accessible to the hearing panel.

14.8 No communication shall be made to the panel presiding at the hearing of the proceeding with respect to any statement made at pre-hearing conference, except as disclosed in the memorandum or order under Rule 14.7.

14.9 Upon conclusion of the pre-hearing conference, all original documents shall be returned to the party who provided them.

14.10 The member of the Board who presides over a pre-hearing conference shall not participate in the hearing unless all parties consent.

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MEDIATION

15.1 Mediation, which is part of the proceeding but not a part of the hearing, may be held for the purpose of attempting to reach a settlement of any or all of the issues, or at least their simplification

15.2 The Board may arrange for mediation only if all the parties consent to participate in the process. Any party can, at any time during the mediation, request an end to the mediation process. If such a request is made, mediation ends and a hearing will take place, if appropriate.

15.3 Mediation will not be held unless the party who is the subject of the application has legal representation.

15.4 Mediation shall be conducted by a person designated by the chair to sit as a mediator.

15.5 If a member of the Board presides over a mediation, that member shall not participate in the hearing unless all parties consent.

15.6 Mediation shall not be open to the public.

15.7 After mediation, all documents shall be returned to the party who provided them. Documents created or statements made for the sole purpose of mediation are not part of the record and are not admissible in a hearing unless all parties consent. Discussions held at mediation are privileged and may not be disclosed in further proceedings

15.8 If all parties to mediation wish to resolve all or some of the issues in dispute by way of an order of the Board, a request in writing shall be made by the parties to the mediator. The request shall record the agreements and undertakings made during mediation. The request shall be submitted forthwith to the Board by the mediator.

WRITTEN AND ELECTRONIC HEARINGS

16.1 In appropriate cases and where permitted by law, the Board may decide in its discretion to conduct all or any part of the proceedings in person or by way of written or electronic hearing.

16.2 In deciding whether to hold a written or electronic proceeding, the Board may consider any relevant factors, including but not limited to:

- (a) the suitability of a written or electronic hearing format considering the subject matter of the hearing;
- (b) whether the nature of the evidence is appropriate for a written or electronic hearing, including whether credibility is in issue and the extent to which facts are in dispute;
- (c) the extent to which the matters in dispute are questions of law;
- (d) avoidance of unnecessary length or delay of the hearing;
- (e) the convenience of the parties;
- (f) the ability of the parties to participate in a written or electronic hearing;
- (g) the cost, efficiency and timeliness of proceedings; and
- (h) whether the hearing deals with procedural or substantive matters.

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16.3 If possible, a party who objects to a written or electronic proceeding shall file a written objection with the Board before the hearing. An objection to an electronic hearing shall set out how an electronic hearing would cause that party significant prejudice. An objection to a written hearing shall set out the reasons why a written hearing is not appropriate.

HEARINGS IN ENGLISH AND FRENCH

17.1 Subject to the provisions of the *French Language Services Act*, the Board may conduct its proceedings in English or French, or partly in English and partly in French.

17.2 Parties are required to notify the Board if they or their witnesses wish to receive any or all services in the French language. This notification shall occur at the time the application is made or at the earliest possible opportunity thereafter.

INTERPRETERS

18.1 If a party or a party's witness requires an interpreter in a language other than the language of the hearing, the party shall notify the Board. This notification shall occur at the time the application is made or at the earliest possible opportunity thereafter.

18.2 If a health practitioner, legal counsel, helping professional or rights adviser is of the opinion that a party or a party's witness requires an interpreter at the hearing, that person shall notify the Board office at the earliest possible opportunity.

18.3 The Board, at its expense, will arrange for an interpreter as it deems necessary for the proper conduct of the hearing.

18.4 Where a written submission or written evidence is provided in a language other than the language of the hearing, the Board may order any person presenting the submission or evidence to provide it in the language of the hearing if the Board considers it necessary for the fair disposition of the matter.

SPECIAL NEEDS

19.1 Parties, lawyers and agents, and witnesses should notify the Board of their request for accommodation of any special needs during the hearing process. This notification shall occur at the time the application is made or at the earliest opportunity thereafter. The Board will determine, in its discretion, whether those special needs can be met.

19.2 If a health practitioner, a helping professional or a rights adviser is of the opinion that a party has special needs that should be met during the hearing process, that person shall notify the Board office at the earliest possible opportunity.

PROCEDURE AT A HEARING

20.1 The Board controls its own process and will determine its own practices and procedures during the hearing according to the legislation and principles of common law.

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20.2 Unless directed otherwise by the chair of the Board, only members of the Board who are also members of the Law Society of Upper Canada shall preside over hearings.

PUBLIC ACCESS TO HEARINGS

21.1 All Board hearings shall be open to the public except where, in accordance with the criteria provided in section 9(1) of the *Statutory Powers Procedure Act*, the Board is of the opinion that a matter should be heard in the absence of the public. At any time after the commencement of the hearing, the Board may close the hearing on its own initiative or at the request of a party.

ADJOURNMENTS

22.1 Once commenced, a hearing may be adjourned at the discretion of the Board. The Board may adjourn the hearing on its own initiative or at the request of a party. In granting an adjournment, the Board may impose such conditions as it considers appropriate.

22.2 At the request of the parties or on its own initiative, the Board may recess or adjourn the hearing to allow parties to attempt to resolve the issues in dispute.

EVIDENCE

23.1 At a hearing, the Board may admit any evidence relevant to the subject matter of the proceeding. The Board may receive any facts agreed upon by the parties without proof or evidence. The Board may direct the form in which evidence shall be received.

ORDER OF PRESENTATION OF EVIDENCE

24.1 Evidence at a hearing shall be presented by the parties in the order directed by the Board. Questioning of witnesses will follow in the same order as the parties adduced evidence.

FILING DOCUMENTS AT A HEARING

25.1 Any person tendering a document as evidence in a hearing shall provide one copy for each member of the Board at the hearing and one copy for each party. Except as otherwise permitted by the Board, documents shall be tendered and exchanged among the parties prior to the commencement of the hearing and any objections to those documents raised at the commencement of the hearing.

OATH OR AFFIRMATION

26.1 The Board may require that evidence be given under oath or affirmation.

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WITNESSES

27.1 The Board may issue a summons to a party or any other person or witness, on its own initiative or upon the request of a party, to give evidence and produce documents relevant to the proceedings. A party shall inform the Board as soon as possible concerning the need to summon a witness. The party is responsible for providing the Board with all the information necessary to prepare the summons.

RECORDING OF PROCEEDINGS

28.1 The Board will arrange for the recording of the proceeding by:

- (a) verbatim reporter; or
- (b) a visual or audio recorder, or both.

28.2 Subject to Rule 28.1, recording devices of any sort are not permitted at a hearing. Provided the Board is notified of the request in advance of the hearing, the Board, in its discretion, may allow:

- (a) a credentialed, professional journalist acting in the course of his or her duties to unobtrusively make an audio recording at a hearing for the sole purpose of supplementing or replacing that person's notes; and/or
- (b) a person requiring an assistive device, who may use that device to enable them to participate in a hearing.

No other use shall be made of these recordings.

28.3 Any journalist permitted by Rule 28.2 to make an audio recording at a hearing shall give an undertaking in a form satisfactory to the Board that the recording will not be used for broadcast or any other purpose other than that permitted by Rule 28.2.

28.4 Except as provided in Rules 28.1 and 28.2, the panel of the Board conducting a hearing has no discretion to permit any other audio or visual recording of a hearing.

ARGUMENT AND SUBMISSIONS

29.1 After all of the parties have had an opportunity to present evidence, the Board shall give all parties an opportunity to make a final argument in support of the decision or order they want the Board to make. No new evidence may be presented during final argument.

29.2 The Board may order the parties to submit written arguments on any issue and shall direct the order and timing of submission of written arguments.

DECISIONS, ORDERS AND REASONS FOR DECISIONS

30.1 In addition to regular letter mail or fax, the Board may serve or deliver a decision and reasons for decision by any method it deems appropriate in the circumstances and which allows for proof of receipt, including but not limited to personal delivery.

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AMENDING A DECISION

31.1 The Board may at any time correct a typographical error, error of calculation, clerical error, or other similar error made in its decision or reasons.

31.2 The Board may at any time, if considers it advisable, review all or part of its own decision or order, and may confirm, vary, suspend or cancel the decision or order.

REQUESTING LEAVE TO MAKE A NEW APPLICATION

32.1 A party to an application under section 32, section 34, section 50 or section 65 of the *Health Care Consent Act, 1996* which has been finally disposed of by the Board may request leave to make a new application within six months after the final disposition of the earlier application.

32.2 A request for leave to bring a new application shall be made in writing and signed by the person making the request.

32.3 The request must include:

- (a) details of the material change in circumstances which justifies reconsideration of, depending on the application, the decision to admit to a place of treatment or the person's capacity; and
- (b) any evidence which supports the request.

32.4 The Board shall issue a notice of the request to the parties to the application. The notice will include the information provided by the requester under Rule 32.3 (a) and will inform the parties of their right to deliver a written respond and supporting evidence to the Board within seven days.

32.5 In exceptional circumstances, the Chair of the Board or a member designated by the Chair may order a hearing, which may be held in person or electronically, to hear the request for leave. The chair of the Board or a member designated by the chair may make any other procedural order to deal with the request for leave to bring a new application as he or she considers appropriate.

32.6 The Board shall issue a written decision to grant or refuse leave after the seven-day period referred to under Rule 32.4 has expired.

32.7 Until leave to bring a new application is granted, any application made under section 32, section 34, section 50 or section 65 of the *Health Care Consent Act, 1996* brought within six months after the final disposition of an earlier application shall be deemed not received by the Board.

PREPARING FOR CONSENT AND CAPACITY BOARD HEARINGS

When an application to the CCB is filed:

The Hearing must take place within 7 days of the application unless the CCB grants an adjournment. If the client is in hospital the Hearing will likely take place there, and if the client is in his/her own home, and has difficulty getting around, the Hearing will probably take place in the person's home.

In certain circumstances you can request that the CCB conduct a pre-Hearing. A single Board Member will attend and talk to the parties and other interested individuals, such as family members. The Board Member will explain about the Hearing, its purpose, what the parties can expect to happen and as well, the possible outcomes. It is possible that a Hearing can be avoided through the pre-Hearing process, or issues may become clarified so that the Hearing will be briefer and potentially less damaging to therapeutic and family relationships.

Avoiding inconvenience and delays:

Scheduling the time for a Hearing is always difficult, logistically, therefore try to apprise the CCB staff of available times after checking with your witnesses, and at the time of application, if possible. The Hearing may be adjourned so the client can get a lawyer, so best to alert the CCB when the application is filed that the person should probably have a lawyer. The evaluator is also entitled to have a lawyer, paralegal or a representative. Delays can occur when the client's lawyer has not been allowed access to the client's clinical record. Counsel has full right to access and copies, at reasonable expense (s. 76, HCCA). If you plan to introduce reports that are not in the clinical record, or if such reports exist, counsel is entitled to them also.

Before the Hearing:

- Be clear in your own mind what you have to prove at the Hearing.
- Frame your evidence based on what you have to prove. When the issue is incapacity do not concentrate on best interests; keep the evidence focused on why you feel the client is not capable.
- Decide who will give verbal evidence and who will give evidence by written report.
- Prepare a written clinical summary (*see Appendix B and C*), but do not send it to the CCB in advance
- Make sure the client's lawyer (and all the other parties or their lawyers) have copies of your summary and any other exhibits you plan to file, such as reports by other health care professionals.
- Notify the CCB of any preliminary or procedural matters (i.e. adding parties to the proceeding) by 4:00 p.m. of the day prior to the hearing (CCB Rules of Practice 13.1). Do not contact the CCB prior to the hearing about the subject matter of the case.

For the Hearing:

- Assume there will be three Board Members, although there may only be one at the Hearing.
- Make enough copies of every exhibit for the Board (3) and for each party. The parties are the evaluator, CCAC staff (who may be the evaluator) and the incapable person; the Board may add parties such as family members.
- Distribute the exhibits only with the consent of all parties. Board Members will arrive about 15 minutes before the Hearing begins, and usually accept any proposed exhibits to read before the Hearing begins if the person offering them says that the other parties or their lawyers or other representatives have been given copies.
- Make sure your witnesses are available. They do not have to be at the Hearing, just available on short (i.e. 5 minute) notice. Witnesses may be excluded at the request of any party until it is his/her turn to testify.

At the Hearing:

- The Evaluator's job is to prove, at the time of the Hearing, that the person is incapable of consenting to, or refusing to consent to admission to a long-term care home. After providing a little background information about who you are and your role and relationship in regard to the client, explain your finding including the process you followed before conducting the evaluation. Then describe in detail your evaluation, including: the steps taken to protect the rights of the client; an outline of the substance of the evaluation; a review of how you addressed both parts of the test, understanding and appreciation. If possible provide evidence of the verbatim answers received from the client during the evaluation.
- The Evaluator produces evidence first, usually starting with his/her own written and verbal evidence, however, they can call witnesses in any order they wish, even prior to their own testimony. Confirm that you still believe the client is incapable and are not aware of information to cause you to change your view since conducting your evaluation. The other parties or their lawyers then question the Evaluator, and the Board Member(s) may also ask questions. Respond truthfully, to the point and be brief.
- The Evaluator offers, as part of his/her verbal evidence, any other reports from people who will not be giving verbal evidence. Other parties may object to the production of this evidence and the evaluator should be prepared to explain why it is relevant. Less weight may be given by the CCB when considering evidence that cannot be cross-examined.
- The Evaluator calls and questions his/her next witness, who is subsequently questioned by the other parties or lawyers, and then the Board. The same applies to all succeeding witnesses called by the Evaluator. In calling another witness you should ask him/her to explain his/her role in dealing with the client, why he/she has an opinion on the client's capacity, what his/her opinion is of the client's capacity and why (remember not to 'lead' the witness i.e. suggesting the answer to the question posed).
- The other parties each call witnesses if they wish, with the person found incapable going last.

- The person found incapable is not required to testify.
- The Evaluator may be given an opportunity to present “reply” evidence.
- After all the evidence has been presented, each party may make a “submission”, which is a chance to characterize the evidence and the law in an attempt to convince the Board of the position taken by the party.
- By the next day each party will receive a copy of the Board’s decision.
- At the Hearing or within 30 days of it, any party may request written reasons for the decision, which will be distributed to each party, usually within 2 business days of when the request was made.

Helpful Hints:

- Present evidence focusing on what you have to prove (N.B. know the relevant legislation).
- The Board will not act according to the person’s best interests, but is obliged to determine if the person has the capacity to make the decision. Capable people are allowed to make poor, unwise and even dangerous decisions.
- The person’s lawyer is not entitled to advocate for the person’s best interests, but is obliged to advocate according to the person’s instructions. A common instruction is: “I never want to go into a nursing home”. At the Hearing that usually translates into trying to overturn the finding of incapacity to consent or refuse consent to admission to a care facility.
- Filing as exhibits one or two legible extracts from a clinical record can be far more persuasive than one hour of verbal evidence.
- A good clinical summary (*see Appendix B and C*):
 - Should stick to objective facts
 - Can be brief
 - Can be an outline of the evidence to be presented
 - Saves time at the Hearing as it can contain information that need not be repeated verbally (e.g. medications, health history, hospitalizations)
 - Does less damage to therapeutic relationships than the same evidence presented verbally
 - Reduces the time spent on cross-examination by the person’s lawyer

This mock hearing is an example of how the Consent and Capacity Board might proceed with a hearing concerning a finding of incapacity to make long-term care decisions.



MOCK HEARING OF THE CONSENT AND CAPACITY BOARD OF ONTARIO

FINDING OF INCAPACITY TO MAKE LONG TERM CARE DECISIONS

**Filmed and Funded Jointly
By the
Consent and Capacity Board of Ontario
And
The Ottawa Hospital,
Social Work Department**

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Introduction

In the early summer of 2007 a video of a mock hearing of the Consent and Capacity Board was filmed jointly by social workers of The Ottawa Hospital and the Consent and Capacity Board (CCB) of Ontario. This video is intended to help educate health professionals, physicians and Consent and Capacity Board members who are preparing to participate in a hearing held by the CCB. The video shows the process and procedures followed at all Board hearings. The documents that accompany the video will provide additional information on these procedures and on the process of preparing for a hearing.

This video depicts a hearing of a finding of incapacity to make Long Term Care decisions. The evaluator is a hospital based social worker but could be from any discipline with the authority to perform this type of capacity evaluation.

To further prepare anyone presenting before the board and to make the video a more useful tool, a toolkit has been provided in addition to the video. This toolkit contains documents that we hope will further explain board procedures and practice. It also contains the mock documents submitted by the evaluator during the mock hearing. These mock documents are intended to give the viewer of the video examples of the type of documentation that can be given into evidence.

This first document in the toolkit is the Order of the Hearing. All CCB hearings follow the same process. This document summarizes the steps that will be followed in the hearing. The second document is a list of teaching points. This includes those discussed by the narrator in the video and other points that will help the viewer prepare for and participate in the hearing.

ORDER OF THE HEARING

PRELIMINARY MATTERS

Presiding Members Opening Remarks:

1. Explains the purpose and nature of the hearing.
2. Introduces the parties to the hearing and board members.
3. Lists documents that were provided to the board as evidence.
4. Explains the process of the hearing.
5. Determine if the social worker (health practitioner) is the person who made the incapacity finding.
6. Asks if there are any preliminary or procedural matters and deals with them. (i.e. The documents have not been completed properly and therefore the finding of incapacity is invalid. A request can be made to have all witnesses excluded from the hearing unless they are testifying.)

THE HEARING

1. Evaluators present evidence first (i.e. introduce the patient, brief review of clinical summary, capacity evaluation)
2. Patient's lawyer may question the evaluator
3. Other parties to the hearing and board members may question evaluator
4. Evaluator calls and questions witnesses
5. Patient's lawyer questions evaluator's witnesses
6. Other parties to the hearing and board members may question evaluator's witnesses
7. Patient's lawyer calls and questions witnesses
8. Evaluator may question lawyer's witnesses
9. Other parties to the hearing and board members may question lawyer's witnesses

CLOSING SUBMISSIONS

- Closing submissions are presented starting with the evaluator

CLOSING THE HEARING

- Chairperson thanks everyone for attending and reminds them that the decision of the board will be faxed to them within 24 hours.

TEACHING POINTS

The Test for Capacity

This test, as stated in the Health Care Consent Act, describes the nature of capacity. The evaluator must demonstrate that on the day of the hearing the client lacks these abilities and thus is incapable of making long term care decisions.

All CCB hearings are held to determine if the evaluators' finding of incapacity to make long term care decisions meets the test stated in the legislation. The test for a finding of incapacity to make long term care decisions is (Health Care Consent Act):

4. (1) A person is capable with respect to a treatment, admission to a care facility or a personal assistance service if the person is able to understand the information that is relevant to making a decision about the treatment, admission or personal assistance service, as the case may be, and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision. 1996, c. 2, Sched. A, s. 4 (1)



This symbol indicates teaching points discussed by the narrator during the video.

Pre-hearing Teaching Points:

- The Ontario Consent and Capacity Board will convene a Hearing within 7 days of receiving the application. The hearing takes place somewhere convenient to the parties, usually in a hospital, community centre, care facility or CCAC office, but sometimes at the home of the person found incapable.
 - Rules govern who may attend a hearing and the individuals' role during the hearing. The board members, the court reporter and witnesses attend the hearing. The presiding member of the board (the lawyer member) may ask the witnesses to wait outside of the hearing room until they are called to give testimony. Those people who are entitled to attend the hearing are called "parties". They are (Health Care Consent Act):
50. (3) The parties to the application are:
1. The person applying for the review (and their lawyer).
 2. The evaluator.
 3. The person responsible for authorizing admissions to the care facility (CCAC).
 4. Any other person whom the Board specifies. 1996, c. 2, Sched. A, s. 50 (3).

- The board for this type of hearing often consists of one member. This person will be a lawyer. When a three person panel is present it consists of the member.
- It is the role of the presiding member who is always a lawyer to “Preside,” which means controlling the Hearing. That includes describing the Hearing process at its beginning, ensuring the parties call and question witnesses in the right order, maintaining order, safety and security and ruling on evidentiary and procedural issues--after consulting with his or her fellow adjudicators where necessary. The presiding member will also sign and fax the Decision and write Reasons when requested.
- Each presiding member will conduct the opening process of a CCB hearing in a somewhat different fashion. This video intends to illustrate the best practice.
- Evaluators, all documents entered as exhibits at the hearing must be made available to the client or their lawyer before the hearing begins. It is best practice for the evaluator to provide copies of these documents to all Board Members and parties to the hearing at least 15 minutes before the hearing is scheduled to begin. The client’s lawyer has the right to review all medical and other records without the client’s consent.
- It is the job of the client’s lawyer to have the finding of incapacity reversed. The lawyer is following the client’s instructions



The Evaluator:

- A client must be informed that an evaluation of capacity to make long term care decisions is being made and the possible outcome of this evaluation. The evaluator must demonstrate during the hearing that the client was fully informed.
- When deciding how to conduct yourself at the hearing, what witnesses to call, what documents to submit, what questions to ask **remember the test** and use common sense. If you are wrong, the board will tell you. In this way you will learn more about how a hearing is conducted.
- (Best Practice) Evaluators, all documents entered as exhibits at the hearing must be made available to the client or their lawyer before the hearing begins. It is best practice for the evaluator to provide copies of these documents to all Board Members and parties to the hearing at least 15 minutes before the hearing is scheduled to begin. The client’s lawyer has the right to review all medical and other records without the client’s consent.
- Be sure that the client’s lawyer has a copy of the documents before the hearing begins or there will be delays.

- Documents submitted to the board can be anything that demonstrates that the test has been met. Examples of these documents include: assessment or capacity evaluation reports, notes from the client's chart, a family physician report or letter, reports and assessment from any health discipline, RAI, police report(s), letters from family, friends and neighbours.
- If a lawyer asks the evaluator for information about the client's case, in advance of the hearing, confirm that he/she is representing the client.



- The evaluator gives a brief introduction of the client. This will help orient the client to the hearing and assist the board in getting to know this client and their current situation. The evaluator refers to the clinical summary at this point in the hearing. Preparing a detailed clinical summary saves time and ensures that the evaluator will not miss any important evidence. It also decreases the possibility of affronting the client's dignity with oral evidence that may be offensive.



- The evaluator's evidence is the first opportunity to demonstrate that the test for a finding of incapacity to make long term care decisions has been met. In the video the evaluator demonstrates that the test has been met by quoting from the reports of the Neuropsychologist and Occupational Therapist.

Know the legal definition of "capacity!!"



- After the evaluator gives evidence, the client's lawyer and the board may question the evaluator.
- All board members may question anyone who testifies at the hearing.

Witnesses:

- The evaluator may call witnesses to support the finding of incapacity to make long term care decisions but is not obliged to do this. The person/client seeking review or their lawyer can also choose to call witnesses. Many types of witnesses can be called: nurses, family members, friends, any type of health care provider, family physician, neighbours, etc.
- The evaluator may educate the witness about the CCB hearing process, the nature of the test and the need to provide facts over emotion. The evaluator may not tell the witness what answers to give, but can tell the witness what questions to expect.



- The witness can and should be asked to provide information about the nature of their relationship with the client. The witness may be asked the following questions. How long has the witness known the client? How do you know the client? What problems has the witness observed? When did the problem start and how often did it occur? The details of the problems are more relevant than the

emotional impact of the problems. Witnesses who have an on-going relationship with the client may be very helpful in assisting the board to discern any relevant indicators of change during the interval between the assessment and the review of the finding of incapacity.

- Witnesses often find testifying at the hearing emotionally difficult. They worry about damaging their relationship with the client as they are asked to present information that the client can perceive as humiliating. Helping the witness to deal with their emotions prior to the hearing can be beneficial for the hearing and the witness.
- Hearsay evidence, information that is told to you by others, can be admitted but is of less weight than that offered by the person who has first hand knowledge of events.
- A witness must be sure to give all pertinent information when testifying, as this is the only opportunity to provide information. Encourage a witness to organize the information they wish to present prior to the hearing.
- The evaluator, the client (or their lawyer) or board members may cross examine any witness.

Board Issues:

- The hearing reporter must have access to a power outlet and for safety reasons should be seated away from the client.
- The hearing room should be selected and set up with everyone's safety in mind.
- For safety reasons the client should be seated so that they have easy access to the room exit.

Clinical Summary

Reason for Referral: Mrs. Edna Watson has been referred to social work on April 2, 2007 to assess her psychosocial situation and assist with discharge planning. Treatment team and patient's daughter have considerable concern about this patient's ability to return home and live independently.

Source of Information: Met with patient and her daughter, chart was reviewed and spoke with staff.

Reason for Admission: On April 1, 2007 she was brought to hospital after being found on the floor of her home by her daughter. Mrs. Watson had a cut on her temple where she hit her head but had no broken bones.

Additional Presenting Problems: During recent months, the patient's daughter (Mrs. Lucy Jones) has become more concerned about her mother's ability to live alone. Lucy has found a scorched pot in her mother's kitchen; medications spilled all over the kitchen floor; milk in the cupboard and sugar in the fridge. Lucy reports having received phone calls from her mother's neighbour reporting that she had found Mrs. Watson wandering outside. It happened twice in March and at least one other time in the month of February. Lucy believes that her mother could have frozen to death as she was only in her slippers and house coat. She further expresses her concern that there may have been other times that her mother wandered outside but that she is not sure if this neighbor has always reported these to her. Lucy reports that her mother's appetite has decreased and she seems weaker and less stable on her feet as there have been other falls. She'll often forget to use her walker although Lucy believes it is becoming quite clear that she needs it more and more. Lucy organized meals on wheels and sent a CCAC worker to help in the house but the pt. refused to let them in. Lucy also reports that she is becoming exhausted from providing care to her mother while looking after her own children. She does not believe that she will be able to care for her mother in the future and that her mother cannot live alone any longer. However, when Lucy has discussed this with her mother Mrs. Watson has denied that she needs any help.

Demographics/Cultural Information: Pt. is a widowed 79 yr. old Caucasian woman who has lived in the same small bungalow for more than 20 years.

Health Hx/Diagnosis: Pt. has been diagnosed with early Alzheimer's, Arthritis, high blood pressure and Angina by her family physician. She also had a left hip replacement a year ago. The GP has prescribed medication to assist with some of these conditions.

Family/Social Hx and Support: Pt. has one daughter Mrs. Lucy Jones who is 52 years old and works full time for the federal government. She is a single mother with four children under the age of 16. Lucy visits before and after work to check on medication use, to prepare her evening meal, to paying her mother's bills and do her shopping.

Education/Employment Hx: Lucy reports that her mother completed high school and worked for many years as an executive secretary in the Federal Government prior to her retirement. I was told she was a very accomplished and effective worker. Following retirement, she remained quite active by participating in various volunteer and seniors organizations. She had many leisure activities and frequent outings on a regular basis until about 2 years ago when she started to reduce her involvement at various levels.

Finances/Housing: Prior to admission to hospital the pt. lived alone in a small bungalow that she has owned for the last 20 years. She shared this home with her husband until he died approximately 10 years ago following a heart attack. According to the daughter the house is not well maintained as her mother refused to allow workmen to enter the home during the last year.

The patient has an income of about \$3500 a month from a combination of pensions. However, the patient's daughter pays all of the bills and does all the shopping for or with her mother during the last 18 months. Lucy reports that bills were going unpaid until she began to supervise the finances.

Impression/Psychosocial Issues:

1. Mrs. Lucy Jones (pt.'s daughter) appears to be experiencing caregiver burn out and is unable to provide the level of support required for Mrs. Watson to live at home.
2. Mrs. Watson appears to be unsafe to live in her own home as:
 - she has been found wandering outside her home in the winter inappropriately dressed and unable to find her way home
 - there are concerns about her safety in the kitchen
 - she appears unable to manage her medication appropriately
 - her memory appears to be declining as demonstrated by the inability to remember previous falls and to pay bills
3. Mrs. Watson lacks insight into the risks of returning home as she denies the existence of any of the above problems.
4. Recommend an OT and Neuropsychology assessment.

Discharge Plan:

1. Provide Mrs. Watson with information about LTC.
2. Complete a capacity evaluation.
3. If found incapable, work with daughter to find suitable housing.

Evaluator's Signature

Date

OTTAWA COMMUNITY CARE ACCESS CENTRE

Capacity Evaluation Form

Name: *Edna Watson*

D.O.B: *21 - 01 - 1927*

- 1. What problems are you having right now (Does client understand his/her condition) e.g. Tell me how well you are managing at present? Do you have any medical conditions that are making it hard to care for yourself at home?**

Mrs. Watson, do you know why you came into the hospital and what your medical problems are?

"I had an accident and fell down at home, so they say. My daughter brought me to the hospital. I know I had a cut on the side of my head. I must have tripped."

Do you remember having tripped and falling?

"Not really, but I believe my daughter and I know I had a cut".

Do you remember having fallen in your home at any other times?

"Not that I can remember. I don't think so."

Your daughter tells me that neighbors have found you outside your home and unable to find your way back home. Did this occur?

"This has never happened; that's a lie. I know how to get home."

Your daughter has also reported to me that on one occasion she has found a scorched pot in your kitchen and sometimes milk in the cupboard and sugar in your fridge. Has this happened?

"I'm a good cook and have prepared meals all my life."

Are you aware of having any medical problems?

"Not that I can think of. My health is fine. I just tripped and fell."

- 2. Can you think of any other way of looking after your condition/problem (Does client understand his/her condition/problem)?**

Can you think of any other way of looking after yourself where you would be safer?

"I don't need other ways of looking after myself. I look after myself at home. I had an accident and I fell; it happens."

Do you make use of your walker at home?

"I use it sometimes but I don't need it that much."

3. How do you think admission to a nursing home or home for the aged could help with your condition (Does client appreciate the foreseeable consequences of his/her admission or not)? E.g. What kind of things will they do for you in a nursing home? Will you get your meals provided? Will your family and friends be able to visit whenever they want?

Do you think going into a nursing home would help keep you safer?

“Why would I need a nursing home? I look after myself in my own home.”

Do you find you have difficulty looking after yourself at home?

I do just fine, thank you.”

4. What could happen if you choose not to live in a nursing home or home for the aged (Does client appreciate the foreseeable consequences of his/her admission or not)? E.g. What kind of problem might you encounter if you choose not to go into a nursing home? Is that likely to happen? What if your caregiver is no longer able to prepare your meals or oversee your health care/medications?

What kind of problems do you think you will have if you choose to continue to live at home?

“I don’t expect to have any problems living at home. I can look after myself; I always have.”

5. What could happen to you if you choose to live in a nursing home or home for the aged (Does client appreciate the foreseeable consequences of his/her admission or not)? E.g. If you did decide to go into a nursing home, how would you go about finding the one suited to your need? At what point would you consider it time to go into a nursing home?

What do you think it would be like for you to live in a nursing home?

“I don’t want to live in a nursing home. I just want to go home.”

Finding

Capable		Incapable	X	Informed client of finding	X
Incapable, no communication				Rights information sheet given	X

Comments: *Based on my assessment, the daughter’s report & assessments by Neuropsychology and O.T., I conclude that Mrs. Watson lacks the ability to appreciate the risks to her health and the consequences of refusing consent to admission to a care facility.*

Client's Response to Finding of Incapacity:

Mrs. Watson. Based on your answers to my questions I conclude that you are not capable of appreciating the safety risks when living at home alone and therefore also do not appreciate the consequences of refusing to consent to admission into a nursing home. I will need to ask your daughter to make the decision for your admission into a nursing home. Of course, you have the right to not agree with my evaluation.

"I don't agree with you. I don't need a nursing home and my daughter is not going to put me in one."

Since you don't agree with my evaluation you have the right to apply to the Consent and Capacity Board, which is a review board that will re-examine your situation to either confirm or overturn my finding. Would you like me to help you complete and file an application to the Consent and Capacity Board?

"I'm not going to a nursing home."

I'll help you make an application.

Evaluator Name: *Mark Preston*

Professional status: *Social Worker*

Signature of evaluator: *Mark Preston*

Date: *April 10th, 2007*

CCB Hearing: Neuropsychology Report

Neuropsychologist: Dr. Francine F-A. Sarazin, C.Psych.

I saw Mrs. Watson for a neuropsychological assessment which is an examination of various cognitive functions. These typically include attention and concentration, expressive and receptive language, memory and learning, visuospatial skills, reasoning, judgment, problem solving and executive functions (e.g. planning, organization, anticipation). When interpreting the results of these assessments, the examinee's scores are always compared to peers of similar age and education.

I understand from Mrs. Watson and her daughter that Mrs. Watson completed high school and her longest occupation was that of an executive secretary in the Federal Government until she retired. I was told she was a very accomplished and effective worker. Following retirement, she remained quite active by participating in various volunteer and seniors organizations. She had many leisure activities and frequent outings on a regular basis until a few years ago when she started to reduce her involvement at various levels. A further decline in activities became apparent after she sustained a fall and had to undergo hip replacement.

During the assessment, Mrs. Watson proved to be an alert and engaging individual who appeared to be eager to do well on testing. In her opinion, she had no decline in higher mental functions other than those expected on the basis of normal aging. Her basic attention skills were intact as she had no difficulty following a conversation or simple test directives. However, deficits became apparent with more complex tasks requiring mental manipulations or divided attention (e.g. she would lose mental set). Her expressive speech was featured some word finding difficulty in casual conversation but a more severe difficulty was noted on formal measures of naming or word fluency. Short-term memory was diminished as evidenced by difficulty recalling simple information within a few minutes, her repetitiveness during the assessment, the need for repeated instructions, and the fact that she was disoriented to time. Even with repetition, she had difficulty learning new information. She could not recall having seen me a few hours earlier that day. When I asked her about her current usual activities, she described her lifestyle dating back to the time before her hip replacement. Other areas of cognitive decline included reduced abstract thinking, difficulty with solving simple financial transactions, reduced visuospatial abilities with inattention to details, and diminished judgment when having to state what she would do in various emergency type situations.

In summary, the present neuropsychological profile depicted a diffuse deterioration in higher mental functions which cannot be explained on the basis of normal aging and warrants a diagnosis of dementia. Given the pattern of results and Mrs. Watson's medical history, she likely

has a mixture of early Alzheimer Disease together with cognitive changes secondary to vascular risk factors and diseases (e.g. hypertension, diabetes, coronary artery disease). Finally, Mrs. Watson has no insight into her cognitive deficits. Even after being informed of these results, she minimized the significance of these and their implication with respect to her safety in living alone. In my clinical opinion, on the basis of Mrs. Watson cognitive decline, she has lost the ability to understand the current circumstances of her cognitive status and functional needs, and his not able to appreciate the potential consequences of her desire to return to independent living.

Date: April 12, 2007

Dr. Francine F-A. Sarazin, C.Psych.

Mock Hearing Occupational Therapy Report

As an Occupational Therapist, I was asked to see Mrs. Watson to assess her safety and ability to live alone in her own home.

As part of my assessment I met with her to discuss her home situation. At the time, Mrs. Watson could tell me that she lived in a bungalow but could not state her home address. She did not remember the events leading to her hospital admission, could not give any information regarding her medication and denied any trouble with her memory. Overall she claimed that she would be able to manage her own self care as well as other tasks such as meal preparation and grocery shopping without any difficulty once she returned home. When asked, she did not anticipate any difficulties walking to the grocery store and carrying items home with her walker.

The following day I assessed Mrs. Watson in the OT kitchen, where after a thorough orientation of the kitchen she was asked to prepare three items (egg, toast and coffee). She did not recognize me nor remember our conversation of the previous day, but did agree to the assessment. Throughout the assessment, she required reminders on where to find items and what was asked of her to prepare. On one occasion Mrs. Watson was looking for the milk in the cupboard and needed direction to locate the fridge. She had difficulty managing the controls of the stove and at one point had two empty burners on and in the end forgot to turn one of the burners off. She needed repeated reminders to use her walker and was unstable on her feet without it.

At the end of the assessment she was asked how she felt she managed the task and how she thought she would be able to manage at home. Mrs. Watson replied that she was a good cook and did not anticipate any concerns or difficulty in her ability to manage in or outside of her home. When asked about the need for her to use a walker on a regular basis she stated that she really didn't need one.

Overall I find Mrs. Watson does not understand her current limitations and need for assistance nor does she appreciate the risk associated with returning to live home alone.

Date: April 13, 2007

Gina Doré

Health Report / Rapport médical

Last name / Nom de famille WATSON	Address / Adresse 16 Magician Ave.
Given name / Prénom Edna	City / Town / Ville Ottawa
Health Card No. / Carte santé no. 555 324 2895	Province & Postal Code Ontario, M7S 3B2

Medical Diagnosis/Diagnostic medical

Diagnosis and date of onset:/Trouble diagnostiquées et date d'apparition:

- Fall at home (April 1st / 07): small cut near right temple.

Diagnosis discussed with applicant/ Yes
Diagnostic discuté avec le/la patient(e)

Diagnosis discussed with family with applicant's consent/ Yes
Diagnostic discuté avec la famille

History/Antécédens

- Dementia
- Angina
- HTN
- Left hip replacement about 1 year ago
- Arthritis

List any drug sensitivities, allergies, addictions/Énumérez toute sensibilité à certains médicaments

NKDA

Present condition/État actuel

Stable

Last chest X-ray/Dernière radiographie pulmonaire:

N/A

Last MRSA Screening/Dernier test de dépistage du SARM

Date : *2007/04/02* Result/Résultat : *Neg.*

Last VRE Screening/Dernier test de dépistage des ERV

Date : *2007/04/02* Result/Résultat : *Neg.*

Prognosis	Pronostic Prognosis discussed with applicant Pronostic discuté avec le/la patient(e)	Prognosis discussed with family: Pronostic discuté avec la famille :
<i>Stable</i>	<i>Yes</i>	<i>Yes</i>

Current medications/Médicaments actuels

- Aricept
- Nitropatch
- Advil
- Tylenol Pl.

Other special needs/Autres besoins particuliers

Walker

Has applicant been seen by other health care providers/Est-ce que la patiente ou le patient a consulté d'autres fournisseurs de soins de santé

Social Worker for D/C planning

Current treatments required/Traitements en cours

Small dressing on cut near right temple

Person completing form / Nom de la personne Dr. J. Fielding	Telephone no. / No. de téléphone (613) 555-5555
Address / Adresse 501 Smyth Street	City / Ville Ottawa, Ontario, K1H 8L6
Signature / Signature <i>Dr. J. Fielding</i>	Date 2007 / 04 / 02

WEB RESOURCE LINKS

Consent and Capacity Board

<http://www.ccboard.on.ca/scripts/english/index.asp>

Board of Decisions and Resources

CanLii

Web resource providing access to legal documents from Canada's federal, provincial and territorial governments for both legal practitioners and the general public

<http://www.canlii.org/en>

e-Laws

Database of Ontario's statutes and regulations

<http://www.e-laws.gov.on.ca/index.html>

Consent and Capacity Board

<http://www.ccboard.on.ca/scripts/english/index.asp>

APPENDIX A**Types of Application to the Consent and Capacity Board**

direct weblinks to secure forms

Form A - Application to the Board to Review a Finding of Incapacity

under Subsection 32(1), 50(1) or 65(1) of the Act

[http://www.forms.ssb.gov.on.ca/mbs/ssb/forms/ssbforms.nsf/GetAttachDocs/014-2973-04~3/\\$File/2973-04_.pdf](http://www.forms.ssb.gov.on.ca/mbs/ssb/forms/ssbforms.nsf/GetAttachDocs/014-2973-04~3/$File/2973-04_.pdf)

Form B - Application to the Board to Appoint a Representative

under Subsection 33(1), 51(1) or 66(1) of the Act

[http://www.forms.ssb.gov.on.ca/mbs/ssb/forms/ssbforms.nsf/GetAttachDocs/014-2975-04~3/\\$File/2975-04_.pdf](http://www.forms.ssb.gov.on.ca/mbs/ssb/forms/ssbforms.nsf/GetAttachDocs/014-2975-04~3/$File/2975-04_.pdf)

Form C - Application to the Board to Appoint a Representative

under Subsection 33(2), 51(2) or 66(2)

[http://www.forms.ssb.gov.on.ca/mbs/ssb/forms/ssbforms.nsf/GetAttachDocs/014-2976-04~3/\\$File/2976-04_.pdf](http://www.forms.ssb.gov.on.ca/mbs/ssb/forms/ssbforms.nsf/GetAttachDocs/014-2976-04~3/$File/2976-04_.pdf)

Form D - Application to the Board for Directions

under Subsection 35(1), 52(1) or 67(1)

[http://www.forms.ssb.gov.on.ca/mbs/ssb/forms/ssbforms.nsf/GetAttachDocs/014-2977-04~3/\\$File/2977-04_.pdf](http://www.forms.ssb.gov.on.ca/mbs/ssb/forms/ssbforms.nsf/GetAttachDocs/014-2977-04~3/$File/2977-04_.pdf)

Form E - Application to the Board for Permission to Depart from Wishes

under Subsection 36(1), 53(1) or 68(1) of the Act

[http://www.forms.ssb.gov.on.ca/mbs/ssb/forms/ssbforms.nsf/GetAttachDocs/014-2978-04~4/\\$File/2978-04_.pdf](http://www.forms.ssb.gov.on.ca/mbs/ssb/forms/ssbforms.nsf/GetAttachDocs/014-2978-04~4/$File/2978-04_.pdf)

Form G - Application to the Board to Determine Compliance

under Subsection 37(1), 54(1) or 69(1) of the Act

[http://www.forms.ssb.gov.on.ca/mbs/ssb/forms/ssbforms.nsf/GetAttachDocs/014-2981-04~3/\\$File/2981-04_.pdf](http://www.forms.ssb.gov.on.ca/mbs/ssb/forms/ssbforms.nsf/GetAttachDocs/014-2981-04~3/$File/2981-04_.pdf)

SUMMARY FOR CONSENT AND CAPACITY BOARD (CCB)

APPLICATION TO DETERMINE SDM COMPLIANCE (FORM G)

The following summary has been prepared for use by physicians presenting before the Consent and Capacity Board. The summary is recommended as a useful tool for hearings. It is not intended to replace the physician's oral presentation to the Board. Physicians are reminded to distribute the completed summary and any relevant documents and materials to all other parties to the hearing or their counsel before the start of the hearing. (Use additional sheets of paper if necessary).

Incapable Person's Name:

Date of Birth:

Personal background (i.e., health status, co-morbid conditions, social conditions, etc.):

Incapable Person's substitute decision-maker(s) (SDM(s) and the relationship to the incapable person:

Is there a power of attorney for personal care? Yes No

Does the power of attorney for personal care contain wishes applicable to the circumstances? Yes No

Most recent health information, including prognosis:

Treatment plan proposed by the clinical team:

SDM's position re: the proposed treatment plan:

Does the treatment plan proposed by the clinical team reflect the patient's previously expressed wishes which are now applicable to his/her circumstances?

- Yes
- No
- There are no previously expressed wishes
- The previously expressed capable wishes are not applicable to the circumstances.
- The previously expressed wishes are "impossible to comply with", *HCCA* s. 21(1).2.

Please Explain:

Supporting evidence:

If there are no previously expressed capable and applicable wishes, how is the clinical team’s proposed treatment plan in the incapable person’s best interests as defined in s. 21(2), HCCA?

- 21. (2) *In deciding what the incapable person’s best interests are, the person who gives or refuses consent on his or her behalf shall take into consideration,*
 - (a) *the value and beliefs that the person knows the incapable person held when capable and believes he or she would still act on if capable;*
 - (b) *any wishes expressed by the incapable person with respect to the treatment that are not required to be followed under paragraph 1 of subsection (1); and*
 - (c) *the following factors:*
 - 1. *Whether the treatment is likely to,*
 - i. *improve the incapable person’s condition or well-being,*
 - ii. *prevent the incapable person’s condition or well-being from deteriorating, or*
 - iii. *reduce the extent to which, or the rate at which, the incapable person’s condition or well-being is likely to deteriorate.*
 - 2. *Whether the incapable person’s condition or well-being is likely to improve, remain the same or deteriorate without the treatment.*
 - 3. *Whether the benefit the incapable person is expected to obtain from the treatment outweighs the risk of harm to him or her.*
 - 4. *Whether a less restrictive or less intrusive treatment would be as beneficial as the treatment that is proposed.*

Supporting evidence:

The Applicant believes that the SDM is not complying with the principles for giving or refusing substitute consent.

Supporting evidence:

Incapable Person's Capacity to Make Treatment Decisions (Section 4 HCCA)

Date of the finding of incapacity:

Section 4(1):

A person is capable with respect to a treatment, admission to a care facility or a personal assistance service if the person is **able to understand the information that is relevant to making a decision about the treatment**, admission or personal assistance service, as the case may be,

Supporting evidence:

and **able to appreciate the reasonably foreseeable consequences of a decision or lack of decision.**
1996, c. 2, Sched. A, s. 4 (1).

Supporting evidence:

Completed By: _____

APPENDIX B

Capacity evaluator clinical summaries for presentation at Consent and Capacity Board hearings have proven an effective means of organizing evidence, and expediting the CCB hearing process. Appendices B and C are two examples.

CLINICAL SUMMARY**Reason for Request for Capacity Evaluation**

As part of the CCAC record (April 25 2007 and December 31 2007) there was identification that Mr. B. is borderline capable/incapable. In the community, Mr. B. was living in a high risk and unsafe situation. Assessment of his understanding the risks to living in the community, appreciating the consequences to live with those risks, his ability to understand information related to placement and appreciate the consequences of making a decision or lack of decision was the best course of action prior to discharge given his high vulnerability in the community. I was requested to complete the assessment given my knowledge of his home environment and the risks he faced in the community and having a good prior relationship with Mr. B. would promote open dialogue.

Central Community Care Access Centre - History of Services Provided over the Past Year

- Occupational Therapy
- Personal Care (3 different agencies)
 - First agency was in for a period of several years
 - Second agency was ordered from August 4, 2007 to September 14, 2007
 - Third agency provided service from September 16, 2007 until the client entered the hospital on September 26, 2007. (Note September 27, 2007 - confirms hospital date)
- Nursing
- Case Management
- Physiotherapy was ordered in September 2007 however not seen in the home prior to his admission.

Sources of Information

As a Case Manager for the Community Care Access Centre I have been working with Mr. B. in the community since June 2007. (Note June 6 2007) When Mr. B. was admitted to the hospital, I attended a discharge meeting with the social worker and Mr. B. on October 9, 2007. (Note October 9 2007). I reviewed the CCAC record and spoke with KC (Hospital Case Manager). On March 3, 2008, I met with Mr. B. for a capacity assessment for Long Term Care Placement. On March 11, 2008 I became aware of another assessment coming to a contrary conclusion. I met with Mr. P., Social Worker and Evaluator on March 13, 2008 and reviewed his assessment. I also met with Mr. B. again on March 13, 2008. In considering the issues carefully I still believe Mr. B. is incapable of making the decision in question.

Demographics

Client is a 46 year old male, lives alone in an apartment in Toronto. His uncle and aunt are the only family supports and live in Orillia. Based on interactions and involvement with the client, the uncle and aunt provide telephone support, rather than in the daily hands-on care and visit occasionally.

Health History

Review of CCAC records identifies the following diagnoses:

- Stroke in 2003, with left sided weakness, contractures of the left arm and leg and seizures
- Medical report completed September 22, 2008, as part of the application for Long Term Care placement lists hip(R) infection, seizures, personality disorder and major/multiple drug abuse
- Functional assessment for placement also notes old non-union fracture R. hip and left hemiparesis.
- Mr. B. was admitted to Hospital on September 26, 2008 via Emergency Medical Services (EMS). According to CCAC records, a nurse in the Hospital stated that the doctor initiated the call to EMS and EMS reported failure to thrive, not eating properly. Mr. B. was admitted with diagnosis of Sepsis R. hip due to arthritis. (Note September 29, 2008)

Presenting Problems

1) Failure to thrive, poor nutrition

Mr. B. is dependent on personal support worker for food shopping and preparation and picking up food from the food bank. On two separate occasions CCAC records identified limited or no food in the home (October 4 to October 11, 2006 and April 25, 2007).

Mr. B. is totally dependent for his personal care. This includes meal preparation. The personal support worker (PSW) assisted in preparing food for Mr. B. on a regular basis. This was stored in tupperware containers at his bedside. The most recent Personal Support Worker Agency noted the risk of salmonella food poisoning as Mr. B. was having food left at his bedside for the whole day without proper refrigeration. (September 23, 2007). To address this risk, CCAC increased PSW to 2 times per day to allow for twice daily food preparation. According to CCAC records it is our understanding that when questioned by the hospital OT, Mr. B. stated that he was not receiving any help from the CCAC other than a daily visit to empty bed pan and urinal. He stated that he ate only one sandwich per day. (January 7, 2008) Malnourishment is a serious concern in living in the community given his limited food sources, being bedridden and thus total dependence for care relating to nutrition.

2) Verbal abuse and racial slurs towards care providers

Three PSW agencies have provided service over the past year. The first two refused to return due to inappropriate language and behaviour. Examples of this include, referring to the PSW as a “nigger” and a “black bitch” and throwing feces on the floor and demanding that the PSW clean it up. Frequent home visits were made to the client by the Case Manager to address this issue. In addition to telephone calls and home visits, letters

were also sent to Mr. B. in April 2007 and again in August 2007 to address the issue of inappropriate language and behaviour and to discuss the consequences of this behaviour. It was explained to Mr. B. that he would be at risk without the care of the service providers. If he did not change his behaviour, Central CCAC will have difficulty finding and putting in service providers to meet his needs. The client acknowledges his bad behaviour and that he has anger management problems, but it did not result in a change in his behaviour. It is noted by an agency in one occasion that he apologized for his behaviour, however erupts again in anger by the end of the service date. (January 18, 2008) Occupational therapy was offered to the client to work on his anger management issues, but he was reluctant to work on this goal. (Note April 28, 2008 and OT report June 13, 2008 and September 29, 2008). Mr. B. is able to acknowledge the inappropriateness of his language and behaviour however, does not understand the consequences of potential limitations of service provision and the serious impact this has on his day to day care and well being.

3) Inability to manage activities of daily living

Mr. B. has been offered PSW for assistance with bathing but will not accept this assistance. It appears that the client has not had a bath in years. The OT report of June 13, 2007, stated his toenails had not been cut in 3 years. On various occasions, in August and September 2007, Mr. B. misplaced his drug card, health card, mail key and then his automatic door opener. Loss of these necessary items resulted in significant difficulties and risks to him. Without his drug card, he was at risk of not getting the medications he required had CCAC not provided a new one for him (Note September 9, 2007). Without his mail key, he could not get the food vouchers that his uncle had mailed to him (Note August 25, 2007). Without his door opener, he was unable to open the door for the PSW and he went without care for the day. (Note September 22, 2007). The health card was important given he depends on a home physician service that requires a health card (September 4, 2007).

4) Ability to manage finances

It is unclear how Mr. B. is managing his finances. He has reported using "volunteers" in his building in the past to do errands, but also reported having lost amounts of cash. His sole source of food seems to be the food bank. As another example of concern and dependency on others, there was a reliance on the Case Manager supports in getting his bed fixed as he was unable to progress this himself even with coaching. Mr. B. was unable to follow through in obtaining eye glasses, although Case Manager coached him on contacting ODSP for this. He was also unable to recall who his worker at ODSP was. (December 2006) He is dependent on his uncle to continue to pay his cell phone bill. The Hospital Case Manager for CCAC, in contact with his aunt on March 4, 2008 mentioned that Mr. B. is having difficulty managing his finances.

5) Agrees to actions, but then changes his mind

Mr. B. agreed to treat PSWs with respect, after one of the discussed incidents in January 2007, but continued to be verbally abusive. The current PSW agency identified in September 2007 that his apartment was extremely dirty and they would only agree to continue to service him upon discharge from hospital if he agreed to have his apartment cleaned. Initially he agreed to this condition, however, when it came time to sign the consent for the cleaning company, our understanding is he refused to do so. As per our records, it is our understanding he was in agreement to see a dentist but then would not

go due to fear of falling. (February 19, 2008) These are just some of the examples. This agreeing to actions but then not following through or changing his mind makes having a viable, successful treatment plan challenging and is another risk for an individual with such high needs and limited supports. Understanding the consequences of his decisions or lack of decisions becomes questionable.

6) Lack of a physician

Mr. B. does not have a family doctor. He is unable to get out to a doctor, therefore is reliant on a physician home visit service to address any medical needs as they arise, or to renew his prescriptions. He has no family physician for regular follow-up and as per the significant diagnoses listed above including seizures proper medical management is necessary for ongoing optimum health. Mr. B. is very specific about which doctor he will see through the home visit service and will only accept one particular doctor to visit. Given the limitations of the physician home visit service medical management is limited in the community.

Client Ability to Understand Risks of Living In the Community

On March 3, 2008, risks in the community were discussed with Mr. B. at length prior to asking him some specific questions on capacity. This included client care in the community, risks, consequences, level of care provided in the community through CCAC versus in a long term care home. There was discussion with Mr. B. about the inability to provide the amount of service that meets his needs given his functional limitations and total dependence for personal care. The concerns in regards to his access to food and limitations in inadequate nutrition were also discussed. Mr. B. did acknowledge that he was malnourished while living at home and he has been eating properly at the hospital. In addition he stated, "the hospital will most likely be the place where I eat my last meal"

(Note March 3, 2008). Risks in relation to medical management were also discussed including his need for medical monitoring and only allowing one physician in and the limitations of the service. Discussion occurred about the risk of medication management that he has reported in the past not necessarily taking medication as it is prescribed, but what he thinks is best at a specific time period. Questions and risks were discussed in regards to money management. Mr. B. was asked if he does not have the help of his uncle, how will he manage and he was unable to provide an answer. In addition, there was the discussion of his past inappropriate behaviours with the service providers and that these impact the potential for CCAC's ability to have service providers available to provide the care he requires. Mr. B. was able to engage in the conversation but repeatedly stated that if he goes home CCAC will take care of him. He did not appear to understand that Central CCAC cannot provide the level of care that he requires to manage safely in the community. The client was not able to understand the risks and vulnerability of returning to the community.

Client Ability to Understand Information Relevant to Placement

Mr. B. was pleasant and cooperative for most of the assessment on March 3, 2008. Mr. B. had fears that if he goes to Long Term Care Placement, then he will be kicked out and alternatively if he goes back home he has a roof over his head. This case manager assured him that he would not be kicked out of a facility. Based on review of CCAC records (January 19, 2008) this concern was raised previously, however, Mr. B. continues to believe this concept.

It was explained to Mr. B. of what services a Long Term Care Placement will provide. The specifics are elaborated below. He did not understand the information of what care could be provided and continued to fixate on being kicked out of a facility. This impact on his ability to appreciate the consequences of the decision or lack of decision as outlined below.

Clients Ability to Appreciate the Consequences of the Decision or Lack of Decision

When asked, Mr. B. did not understand what the risks of returning to the community were even though these were discussed at length. He was unable to articulate any risks. Mr. B. did not understand the risks therefore making a decision in regards to the consequences of making the decision or lack of decision did not occur. He stated he did not know what would happen if he chooses not to live in a nursing home. He also was unable to think of any other ways to look after his condition or problem.

When asked the question “How do you think admission to a nursing home or home for the aged could help you with your condition/problem?” Mr. B. responded, “Don’t think there is help for me”. Mr. B. did not understand how nursing home placement could help him. The services that a nursing home would provide were previously discussed not long before asking this question. Information was verbally provided to Mr. B. that a nursing home could provide the following; provision of food, medical services, medication provision, bathing, laundry and other personal care needs. However, even with the prompting of the above he was unable to list even one basic necessity of life such as a nursing home would provide him with meals. As noted above Mr. B. did identify he was malnourished in the community. When asked “What would happen to you if you chose to live in a nursing home or home for the aged?” He was able to identify he would be properly cared for, but unable to elaborate as to how.

TL
Community Case Manager

APPENDIX C**CLINICAL SUMMARY**

KELLY, Grace HFN: 123 456 789
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CONSENT & CAPACITY BOARD HEARING**Clinical Summary Re: Mrs. Grace Kelly****July 18, 2008**

-
- 87 year old widowed woman brought to ER June 13, 2008 via EMS following a fall...accompanied by son.
 - X-rays showed L humeral neck fracture...sling applied but patient non compliant.
 - While in ER patient's behaviour escalated throughout the day, especially after being given pain medication. Called Police from ER stating son attempting to harm her.
 - Initial plan had been for patient to return home with referral to CCAC
 - Patient's behaviour escalated further when discharge was attempted...refused to go home with son...hit observer with cane...combative with security guard...attempted to bite/kick nurse...patient sedated and placed on Form 1:
 - Threatening to cause bodily harm to self
 - Behaving violently towards another person
 - Shown lack of competence to care for herself
 - Background information obtained from son...patient and son live in a bungalow...patient on main floor and son occupies self contained apartment in basement. Home is jointly owned by patient and son. Patient lived in her own two storey until 8 years ago...moved to bungalow with son so he could be of more assistance to her.
 - Patient has been widowed x many years. She raised her son, George, and daughter, Margaret, on her own. Daughter lives in UK...has had no contact with patient for twenty years.
 - Son has POA for Property, signed by patient in April 2000.
 - Patient has not seen GP x many years...prior to admission patient was taking no medications
 - Son reported short term memory impairment, paranoid ideation & delusions x 1+ yrs. Patient forgets where she puts things and accuses him of stealing from her. Also believes son and his friends enter her home in the middle of the night to steal from her. Patient believes son and friends belong to a cult...son wants "to get rid of me" so the cult can take over her home. Son reports patient has several locks on the door to the main floor of the house, preventing son from entering. The front door to patient's home is reported to be barricaded.
 - Patient has burned pots on stove...melted stove burner...son replaced with toaster oven which has not been used... will not consider using microwave.
 - Son reports he contacted CCAC for help and states he was given "forms to fill out" but no further assistance or guidance.
 - Son works full time and is away from home during the day.

Course in hospital:

- Admission diagnosis: delirium on dementia, paranoid ideation, fall, left humeral neck fracture.
- Seen by Psychiatry June 14/08...note “primary diagnosis of dementia with possible superimposed delirium”...however, “not suicidal/homicidal...therefore no further need to detain under Mental Health Act”. Psychiatry opinion that patient “incapable of consent to treatment”.
- Seen by Geriatrics June 18/08...note “delirium/dementia with paranoid delusions/visual hallucinations, lack of insight...resolving delirium with borderline capacity”.... “incapable of personal care decisions.”
- Seen by Occupational Therapy June 18/08...note “patient seems to have limited insight re: own condition and has questionable judgment....also has difficulty with abstraction.” OT opinion as documented in Family Meeting Record of June 21/08... 24 hour supervision recommended.
- Seen by Physiotherapy June 21/08...note...”history of falls...continues to be at high risk for falls due to ↓ cognition and weakness.”
- Referred to social work June 15/08 for discharge planning. Met with Mrs. Kelly on three occasions to discuss current living situation and discharge plans. Mrs. Kelly wishes to return home upon discharge. Not accepting of home help. Interview held with son to obtain collateral information. Family meeting held June 21/08 with recommendation of 24 hour supervision due to ↓ cognition/memory. Option of hiring home help also explored with son who reported mother would not allow people coming into the home.
- Capacity evaluation completed June 25/08 with a finding of “incapable” (see attached).
- Application to CCAC for long-term care initiated June 28/08.
- July 6/08...staff and son note patient brighter, more co-operative and no longer expressing visual hallucinations. Mrs. Kelly refers to early days of admission...“I was in a fog for a few days and then one morning I woke up and I’m back to myself.”
- Re-assessed by Psychiatry July 9/08 at request of social work ...note “she’s better ...however, does not have the ability to understand & appreciate...her ↓memory diminishes her understanding and makes her not appreciate foreseeable consequences of going home vs. LTC.” Mini Mental Status Examination score was 26/30...lost points for memory.
- Re-assessed by Occupational Therapy July 9/08 at request of social work... “still recommend supervision for safety due to patient’s ↓ cognition, ↓ anticipatory awareness, memory, reasoning, etc...unable to provide specifics and details of plan to ensure her own safety in daily activities ...not capable to make decision re: admission to LTC.”
- Re-assessed by Physiotherapy July 10/08 at request of social work...“continues to require supervision with mobility greater than 5 metres due to poor judgment, memory and high risk for falls.”
- Capacity re-evaluated July 11/08 by this social worker, Dr. Hill, and Jill Green (OT) with a further finding of “incapable” (see attached).
- Conclusion: Incapable as patient unable to understand information relevant to making decision about going to nursing home, unable to retain information from session to session, unable to problem solve re: other options, unable to appreciate care and services provided in nursing home and how admission may help her situation.

Assessing Capacity
for Admission to
Long-Term Care Homes

•••

*A Training Manual
for Evaluators*

Putting It All Together

*Rulings from the Consent and Capacity Board
and Ontario Court*

Putting It All Together

*Rulings from the Consent and Capacity Board
and Ontario Court*

Introduction

Appendices

A—CCB Hearing in the Matter of Ms. P

B—CCB Hearing in the Matter of G

C—CCB Hearing in the Matter of K

D—The Case of Linda Koch
and her Appeal to the Ontario Court



Putting it All Together –

Rulings From the Consent and Capacity Board and Ontario Court

Introduction

Legislation is the framework within which the capacity evaluation process operates, but making the connection between the two is not always direct or obvious. For this reason decisions from both the Consent and Capacity Board and Ontario Courts are considered critical in developing ‘best practice’ for capacity evaluations.

The following are a selection of Consent and Capacity Board and Ontario Court decisions that are presented as appendices for their educational value. *Appendix A, B and C* are prefaced separately with a list of some concepts that are addressed in the body of the ruling; they are highlighted in blue and footnoted with a numeric reference in the text. *Appendix D* is the presentation of the decision made by the Ontario Court in the case of Linda Koch, who successfully contested her being declared incapable of making both property and admission decisions, findings that had been upheld by the Consent and Capacity Board. This case is looked to frequently for establishing ‘best practice’. We suggest it be read in its entirety, with special attention to the Sections noted below.

Appendix A – CCB Hearing in the Matter of Ms. P

Some Concepts Highlighted:

Fair Process According to Legislation	1
Documentation	2
Communication Issues	3
Flawed Process	4
The Evaluator Questionnaire	5
Client Rights Provisions	6
Best Interest is Not the Test for Capacity	7

Appendix B – CCB Hearing in the Matter of G

Some Concepts Highlighted:

Ability to Understand	1
Ability to Appreciate	2

Appendix C – CCB Hearing in the Matter of K

Some Concepts Highlighted:

Mental Capacity Can Change	1
Fair Process According to Legislation	2
Ability to Understand and Appreciate	3
Documentation	4
Separation Between On-going Treatment and Capacity Evaluation	5
Client Rights Provision	6

Appendix D – The Case of Linda Koch and her Appeal to the Ontario Court

Special Note to Sections: 34 – 51 and 88 - 90

APPENDIX A

IN THE MATTER OF
The Health Care Consent Act, 1996
S.O. 1996, CHAPTER 2, Schedule A, as amended

AND IN THE MATTER OF
Ms. P
a patient at
General Hospital

REASONS FOR RULINGS**PURPOSE OF THE HEARING**

Ms. P was a patient at General Hospital in Ontario. A panel of the Board convened at the request of AS and AA. They brought Form C Applications to the Board under Subsections 33(2) and 51(2) of the *Health Care Consent Act*, to be appointed as representatives on behalf of Ms. P (i) to give or refuse consent to a treatment; and (ii) to give or refuse consent to admission to a care facility.

Applications to the Board under subsection 33(2) and 51(2) of the *Health Care Consent Act* are deemed, pursuant to subsections 54.1 of the *Health Care Consent Act* to include applications to the Board by Ms. P with respect to her capacity to consent to her own treatment and admission to a care facility, unless the person's capacity to consent to such treatment or admission (as the case may be) has been determined by the Board within the previous six months.

DATES OF THE HEARING

Tuesday April 19, 2005 by teleconference
Friday April 29, 2005 at General Hospital
Monday May 2, 2005, Hearing closed to submissions

LEGISLATION CONSIDERED

Health Care Consent Act, 1996, including Sections 2, 4, 20, 32, 33 40, 41, 50, 51 and 54.1

PANEL MEMBER

Mr. Michael Newman, Presiding Lawyer Member

PARTIES

Ms. P's Deemed Form C – Treatment Application

Ms. P, patient
Dr. MG, health practitioner

Ms. P's Deemed Form C – Admission Application

Ms. P, patient
JA, evaluator
AC, the person responsible for authorizing admissions to the care facility.

AS and AA's Form C – Treatment Application concerning Ms. P

Ms. P, patient
AS, proposed representative
AA, proposed representative
Dr. MG, health practitioner

AS and AA's Form C – Admission Application concerning Ms. P

Ms. P, patient
AS, proposed representative
AA, proposed representative
AC, the person responsible for authorizing admissions to the care facility.

Ms. P attended the Hearing on April 29, 2005 and gave evidence.
AS and AA attended the Hearing by teleconference on April 19, 2005 and at General Hospital on April 29, 2005 and gave evidence
Dr. M. G attended portions of the Hearing by teleconference on April 19, 2005 and on April 29, 2005 and gave evidence
AC and JA attended the Hearing by teleconference on April 19, 2005 and at General Hospital on April 29, 2005, and gave evidence.

APPEARANCES

For Ms. P: Mr. JO, counsel
For AA: unrepresented
For AS: unrepresented
For Ms. AC: unrepresented
For Ms. JA: unrepresented
For Dr. MG: unrepresented

RECORD AND EXHIBITS

The record consisted of:

1. Form C under the *Health Care Consent Act*, AS's and AA's Applications to the Board to be appointed as representatives re admission to a care facility and a treatment concerning Ms. P received February 1, 2005
2. Amended Notice of Adjournment dated April 13, 2005.

The exhibits consisted of:

1. Dr. M. G's Consultation Note dated February 18, 2005
2. Janet A's Evaluator Questionnaire dated January 26, 2005
3. Dr. W's medical report dated June 4, 2004

PRELIMINARY MATTERS

I found there had not been within the previous six months a determination by the Board of either Ms. P's capacity to consent to admission of a care facility or her capacity to consent to treatment.

I also found that Ms. P had neither a Guardian of the Person nor a Power of Attorney for Personal Care containing a provision waiving her rights to apply for the review of either a health practitioner's finding that she is incapable with respect to the treatment or an evaluator's finding, in accordance with Section 32 and Section 50 respectively of the *Health Care Consent Act*. Finally, I found Ms. P had no other family. I ruled the Board had jurisdiction to conduct this Hearing.

CHRONOLOGY

On December 31st, 2004 Ms. P was admitted to General Hospital. On January 26, 2005 JA conducted an evaluation of Ms. P's capacity with respect to admission to a care facility. On January 27, 2005 AA and AS completed Form C Applications for appointment as representatives for Ms. P. The Applications were received by the Board on February 1, 2005.

On February 3, 2005 the Chair of the Board ordered and directed the Public Guardian and Trustee to arrange for legal representation for Ms. P. On February 4, 2005 the Office of the Public Guardian and Trustee sent a letter confirming Mr. O's agreement to represent Ms. P.

On February 7, 2005 on consent of the parties and on request of Mr. O the Hearing was adjourned to a date after February 15, 2005 to be set by the Board. A Lithuanian interpreter was also required to be in attendance at the Hearing. On February 18, 2005 Dr. G conducted her assessment of Ms. P.

THE EVIDENCE

On December 31st, 2004 Ms. P a ninety two year old woman was brought to General Hospital by police and admitted after a fall in her home. Police had been called to assist Ms. P when she was unable to get up on her own from her fall. She resides alone in the community and had lived very independently for many years.

JA, a social worker at General Hospital, was asked to see Ms. P after her admission to hospital to evaluate her capacity with respect to admission to a care facility. She met with Ms. P once or twice briefly before January 26, 2005.

On January 26, 2005 Ms. A conducted a fifteen minute evaluation of Ms. P's capacity with respect to admission to a care facility. This evaluation took place in the presence of AA, a close friend of Ms. P and one of the proposed representatives, who acted as an interpreter.

Ms. A acknowledged Ms. P spoke very broken English and had poor eyesight. Ms. A did not give any thought to having an independent interpreter. She said she introduced her questions by saying she

wanted to talk with Ms. P about her health wishes and getting her health needs met. She asked the questions on the Evaluator Questionnaire and had AA interpret the questions and Ms. P's answers. Ms. A said she wrote out the answers in her own handwriting on the questionnaire as close as possible to Ms. P's actual answers and that some of the answers may have been in English. Ms. A said she only asked Ms. P the questions on the questionnaire.

After her evaluation Ms. A determined that Ms. P was incapable with respect to her admission to a care facility. She testified that she did not indicate on the questionnaire that she informed Ms. P of the finding of incapacity nor did she provide Ms. P with a rights information sheet. Ms. A believed she would have let Ms. P know her decision but did not record that anywhere. She did not provide Ms. P with the rights information sheet because she did not know how Ms. P would use the information.

Ms. A explained the process at General Hospital when completing an Application for Long Term Care Placement. She said that all the various sections of the Application including the Medical, Social Work and Occupational Therapy sections are put together and faxed to the Community Care Access Centre (CCAC) once they are completed. In this case, only the medical and evaluation sections had been completed and nothing had been sent to CCAC yet.

Dr. G, a geriatrician at General Hospital referred to her extensive consultation note filed. That note was written after Dr. G met with Ms. P on February 18, 2005 for about two hours and following Dr. G's review of the hospital chart and various notes. Dr. G said that from her review of notes, on admission to hospital Ms. P was noted to be quite confused, in poor shape and malnourished nutritionally according to biochemical markers. Assessments all pointed to Ms. P having a significant cognitive disorder.

Dr. G said she met with Ms. P for the purpose of "assessment regarding cognition". In conducting her assessment Dr. G said she utilized the services of a Lithuanian-speaking interpreter from the community because Ms. P spoke broken English. Dr. G's assessment was conducted in Lithuanian. Dr. G said Ms. P handled her own finances but she did not know how well. Dr. G said Ms. P spoke Lithuanian, German and some English. She noted that Ms. P denied any particular concerns, any previous falls, any specific memory changes, functional decline or need for personal care assistance. Dr. G also noted that neighbours told hospital staff Ms. P had been seen falling many times.

Dr. G said that in hospital Ms. P has had a hard time learning the proper use of a walker. She was continent and neither delirious nor delusional when assessed and looked quite well. In her report, Dr. G noted:

"she is pleasant, engaging yet vague. At times, would ramble on about nothing sensible according to the interpreter. Tended to be repetitive. Her MMSC score on repeat was very poor at 8/22, she didn't know the year (on another occasion had guessed at 1600), she thinks it is summer (it is snowing outside) and she had 0/3 recall of 3 words in 5 minutes. She was paying adequate attention. She gave good effort but had very poor memory. Her visual spatial skills were very abnormal as evidenced by poor pentagons, clock drawing, etc. I asked her many questions regarding life in general, general memory issues as well as assessed her for capacity to make long-term care decisions as well as personal care decisions."

Dr. G said that Ms. P presented with advanced dementia, and was incapable of making long-term care and personal care decisions. She said Ms. P lacked awareness to make adequate judgments and rational

decisions regarding her personal care. Dr. G said attending staff and other care workers did not believe Ms. P was capable of returning to her home to live safely.

Dr. G noted that Ms. P would be at significant risk if allowed to go home to live on her own, that she would not be able to accept or determine the appropriate resources to attend to her needs, that she had no insight to her condition.

Dr. G said that Ms. P would not be able to agree to any treatment when proposed by a health practitioner. She believed that Ms. P had no understanding of the benefits of taking or not taking medication, although Ms. P had not been receiving oral medication prior to admission and received medication as prescribed for her in hospital.

AC, who has worked at the Community Care Access Centre for just over four years, said no placement application had been received concerning Ms. P.

AS was Ms. P's personal lawyer although she did not know Ms. P. She said Ms. P was a long time client of her law firm. However, the lawyers with personal knowledge of Ms. P were retired. AS said Ms. P has a Will and Continuing Power of Attorney for Property appointing AA as her attorney for property. AS said that Ms. P did not have a Power of Attorney for Personal Care. She agreed to put her name forward as a proposed representative for Ms. P at the request of AA and in order to help AA. AS said she met Ms. P twice, once at an earlier meeting in the hospital and again on April 29, 2005, the second day of the Hearing. She said she was "part of the neighbourhood" and that this was not the first time she agreed to become someone's representative. She said she and AA completed the Applications before the Board on January 27, 2005.

AA a long-time friend of Ms. P's and one of the proposed representatives had been Ms. P's friend since 1980. They were members of the same Church and spoke to each other in their native language, Lithuanian. AA said that prior to the recent hospital admission Ms. P used to walk to the corner store to buy groceries even though she could only see shadows. AA said Ms P paid her bills by direct withdrawal. AA mentioned an incident which occurred prior to Ms. P's admission to hospital on December 31, 2004 when Ms. P said a vehicle hit and knocked her down while she was walking. Ms. P said she had just left the store and was walking home when she was struck.

AA referred to other incidents when Ms. P fell down both outside and inside her home, resulting in her not being able to get up on her own. AA said Ms. P could not return home from hospital because of her poor eyesight and her refusal to receive assistance from Meals on Wheels, a nurse or even a cleaner. She said it broke her heart to see her friend in her current state.

Ms. P could not recall how long she had resided in her home. She asked to speak in Lithuanian. She said she understood English "a little bit". She said she has a bundle buggy, which she used to bring home her groceries. Other times she said took a taxi to the store to attend to her shopping. She acknowledged falling at times and not being able to grab hold of anything to pull herself up. She mentioned one recent incident when she fell and could not get up on her own.

She said a friend came by and helped her and she might have died if the friend had not been there for her.

SUBMISSIONS

Ms. A submitted that she knew her evaluation was flawed, that she had not adequately informed Ms. P about the incapacity finding or about rights advice. However, she submitted that Dr. G's evaluation replaced her evaluation and was more than adequate.

AC submitted that CCAC would work with the hospital to process the Application for Long Term Care.

AS submitted that she is part of Ms. P's neighbourhood, knew of her history and her needs. AA submitted that it was hard to sign the Long Term Care Application because her friend was so against it, but it is so necessary.

Dr. G submitted that Ms. P was incapable of making both treatment decisions and long term care decisions.

Mr. O submitted that the flaws in the evaluation process could not be corrected, that his client's rights had not been protected. He submitted both Applications should be dismissed.

THE LAW

General

The onus is always on the health practitioner or evaluator (as the case may be) at a Board Hearing to prove his or her case. The burden in capacity matters is a civil balance of probabilities. However, there must be clear, cogent and compelling evidence before me to satisfy the burden.

While hearsay evidence is admissible, uncorroborated hearsay, which is contradicted by direct testimony, should not be relied upon on key points in issue. Hearsay should be assigned only the weight appropriate to it in all the circumstances, particularly in light of the serious consequences for the individual subject of the applications. Therefore in order for the Board to find in favour of the health practitioner or evaluator, it must hear clear, cogent and compelling evidence in support of their cases.

The person appearing before the Board does not have to prove anything; the onus being entirely on the health practitioner or evaluator.

ANALYSIS

I carefully considered the Applications, reviewed the evidence, submissions and the law.

There were two Form C applications before me, brought by proposed representatives to make decisions concerning treatment and admission to a care facility on behalf of Ms. P, a ninety two year old woman. She had resided alone in her own home for many years until December 31, 2004 when she was brought to hospital after a fall in her home. Ms. P's vision was agreed to be very poor and her English limited. Her first language is Lithuanian.

Applications of these types are deemed by legislation to include applications to this Board by Ms. P with respect to her own capacity to make the proposed treatment and long term care decisions. The Board may confirm the finding or determine that the person is capable. The Board has no authority to conduct a new evaluation. It follows that there has to be something to review.

{There is no doubt that a finding of incapacity has important ramifications for a patient and will result in the loss of fundamental rights. That is why when a person is approached for the specific purpose of conducting a capacity evaluation, a meticulous process and careful note taking must take place.} **1, 2**

{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.} **1**

When the decision regarding capacity is not the result of a discrete process but rather, is done after a period of therapeutic interaction the situation is obviously somewhat different. While careful note taking is important and compliance with the test for capacity imperative, it is not reasonable to assume that the same sort of charting will take place. {In the present case there was not an ongoing therapeutic relationship between Ms. A, a social worker and Ms. P. Careful note taking was required.} **2**

{The evaluator should address barriers in communication with the person. If there are hearing or visual disabilities or other disabilities, the evaluator must take steps to address them. The evaluation should be conducted in the person’s language. It is strongly advised that where there is a language barrier, an impartial translator be used. Use of a proposed representative or substitute decision maker as translator raises conflict issues where the person and proposed representative or substitute decision maker may not be in agreement in relation to the issue of admission to a nursing home. Typically these issues as well as a requirement to inform the patient of the incapacity finding and about rights advice are addressed in the instructions to the evaluator.} **3**

{On January 26, 2005 Ms. A conducted a fifteen-minute evaluation of Ms. P’s capacity to make long term care decisions. Ms. A’s evaluation process was legally flawed and inadequate. In addition to failing to address the communication barriers before conducting the evaluation Ms. A did not provide a sufficient explanation of the nature and purpose of the evaluation and also clearly did not explain the potential consequences to Ms. P. Consequently Ms. P’s consent was not properly obtained. Alternatively, Ms. A failed to justify to the panel why such an explanation was not provided. I also found that Ms. A failed to maintain adequate notes or records and failed to ensure a fair process.} **4**

Ms. A’s only notes were the answers to questions on the evaluator’s questionnaire. The questions and Ms. P’s answers are repeated below:

1. “What problems are you having right now? (Does the person understand her/his condition or problem?” “Pt states that everything is good. She states she cannot walk. It would be good but she can’t walk”.
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?)” “Pt does not want to go to nursing home. She thinks she could hire someone to help”. “I not go.”

3. “Can you think of any other ways of looking after your condition/problem? (Does the person understand the condition/problem?)” “Pt thinks she could hire someone to live with her. Pt identifies those who could help-but these people are not able to help”.
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?)” Pt thinks she could do everything on her own if she went home-hospital has mixed everything up”.
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?)” “Pt not willing to consider nursing home. She does not want to pay for nursing home-wants to go home-everything mixed up in hospital”. Why nursing home when I have my own home”.

{The “Evaluator Questionnaire Re: Capacity to Make Admission Decisions” utilized by Ms. A is filed as an Exhibit. That Evaluator Questionnaire is a guide and 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 and expanded upon, at the very least, to make them applicable to the person whose capacity is being evaluated.

Merely asking the five questions on the questionnaire and getting (or not getting) answers is not a fair test of a person’s capacity. Answers to the questions that do not seem appropriate responses should be probed with more questions. The evaluator should record those questions and the answers given at the time. The same should happen if a person does not answer a question.} **5**

The Evaluator Questionnaire comprises the five questions set out earlier. At the end of the questions are three boxes, one of which is to be checked. The boxes offer the following choices: Capable-Determination made after assessment; Incapable; and Incapable-No communication was possible. After the last box there is space for comments. Ms. A checked the box indicating Ms. P was incapable.

{There is another section of boxes to check, with which the evaluator is to confirm the person being evaluated was informed of the finding of incapacity, given a rights information sheet and indicates intent to appeal the finding of incapacity, to the extent those three choices are applicable. Ms. A said she did not complete these sections nor provide or have explained to Ms. P the rights information sheet. Ms. A testified she did not know what Ms. P would do with this information.} **6**

{In my view the evidence focused upon what some might consider was in Ms. P’s best interests and not upon her capacity. The evaluator’s evidence clearly indicated that she gave little weight to Ms. P’s rights to a fair process.} **1**

To her credit Ms. A acknowledged the inadequacies of her evaluation process. She submitted that her evaluation was superseded by the evaluation of Dr. G. I note that Dr. G did use an independent interpreter. However, I am not satisfied that when Dr. G performed her assessment she was conducting an evaluation nor was I satisfied that the process followed up Dr. G was significantly better than that of Ms. A. I am also not satisfied that Dr. G's assessment replaced Ms. A's evaluation insofar as evaluating capacity with respect to admission to a care facility. I am certainly not satisfied that Ms. P was advised by Dr. G what the consequences of her assessment were to her, based on the evidence.

{In short, while there were declarations of incapacity, they were not the result of considered evaluations resulting in a finding of incapacity that could be reviewed. What transpired fell so drastically short of what the legislation contemplates 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*.}4

As a result, Ms. P is presumed capable of making her own decisions regarding admission to a care facility until such time as a further evaluation in accordance with the appropriate requirements is performed resulting in a finding of incapacity.

Hospital staff must have realized the inadequacy of the initial evaluation by Ms. A. One needs only look at the chronology of events in this case. On January 27, 2005 the day following Ms. A's evaluation and finding of incapacity with respect to long term care admission, AA and AS applied to this Board for appointment as Ms. P's representatives. On February 3, 2005 this Board issued an Order directing the Office of the Public Guardian and Trustee to arrange for legal representation for Ms. P. Mr. O subsequently agreed to represent Ms. P. On February 18, 2005 after these matters were already before the Board Dr. G conducted her assessment of Ms. P with the assistance of an independent interpreter and determined Ms. P was incapable with respect to treatment and long-term care decisions.

In turning to the issue of treatment capacity I find that Dr. G did not specify any particular treatment that Ms. P was incapable of consenting to. She wanted the Board without any specific proposed treatment in mind to give permission for treatment whenever a health practitioner determines Ms. P was incapable with respect to that treatment.

Section 15 of the *Health Care Consent Act* provides that a person may be incapable with respect to some treatments and capable with respect to others. That section also provides that a person may be incapable with respect to a treatment at one time and capable at another.

Nowhere in Dr. G's written or oral evidence did she refer to any specific treatment. She said Ms. P took medication as prescribed in hospital and that Ms. P had not been receiving any medication prior to admission. There is no evidence of Dr. G suggesting a treatment or attempting to suggest a treatment and Ms. P refusing to engage the doctor in the discussion.

Section 17 of the *Health Care Consent Act* provides:

A health practitioner shall, in the circumstances and manner specified in guidelines established by the governing body of the health practitioner's profession, provide to a person found by

the health practitioner to be incapable with respect to treatment such information about the consequences of the findings as is specified in the guidelines.

There was no evidence of this taking place. Whenever the alteration of fundamental rights are at stake, such as in this case the procedure giving rise to the alteration must be cloaked with appropriate safeguards and capable of withstanding rigorous review.

As I have already said findings of incapacity of whatever type have important ramifications for a person and will result in the loss of fundamental rights. Only when a health practitioner for Ms. P proposes a treatment is the issue of her capacity important. Consequently, I find that there is no valid finding of incapacity with respect to a treatment.

Having found there are no valid findings of incapacity with respect to treatment and admission to a care facility, the Form C Applications by the proposed representatives are dismissed. In disposing of the applications as I did, the Board did not have to satisfy itself as to whether the criteria for appointment of representatives were met.

{It was clear to me that Ms. P should be in a care facility. That was in her best interests, if one defines that phrase as being able to ensure safety, proper diet, supervision, compliance with medication and assistance with activities of daily living. However, the test for capacity is not whether a person acts in his or her own best interests.} 7

I had the benefit of observing Ms. P during the Hearing and of listening to her answers to questions. She was responsive to all the questions and her answers were not inappropriate. She knew what was going on around her.

RESULT

As there was no proposed treatment, there was no finding of incapacity by a health practitioner with respect to the treatment to review. In addition, the evaluator's finding of incapacity with respect to admission to a care facility was invalid.

The applications to consider the appointment of a representative (i) to give or refuse consent to a treatment; and (ii) to give or refuse consent to admission to a care facility, on behalf of Ms. P are dismissed.

Dated at Toronto, this 12th day of May, 2005

Michael Newman, Presiding Lawyer Member

APPENDIX B

**Consent and
Capacity Board**

**Commission du consentement
et de la capacité**



File Number: TO-09-2284

**IN THE MATTER OF
THE *Health Care Consent Act*
as amended**

**AND IN THE MATTER OF
G
A RESIDENT OF
TORONTO, ONTARIO**

REASONS FOR DECISION

PURPOSE OF THE HEARING:

The Board met at the request of Mrs. G to review a finding of incapacity with respect to admission.

DATE OF THE HEARING:

September 28, 2009

LEGISLATION CONSIDERED:

The *Health Care Consent Act*, ss. 4, 50(1), 50(2)

PANEL MEMBERS:

Ms. Karen Lindsay-Skyner

Lawyer - Presiding Member

PARTIES:

G., Patient
GM, Evaluator
SR, Evaluator
AA, Representative of CCAC

APPEARANCES:

G. was represented by counsel, Mr. M
Ms. GM and Ms. SR represented themselves

PRELIMINARY MATTERS:

At the commencement of the hearing, Mr. M asserted that the finding of incapacity was not valid as Ms. G's power of attorney stated that her capacity for personal care had to be determined by two physicians. The Evaluators took the position that this applied to treatment rather than admission. The Board found that the issue of capacity with respect to admission was different than a finding of incapacity with respect to personal care which would include treatment. As such, the power of attorney did not apply to this set of circumstances. The finding was validly made.

EXHIBITS:

The following documents were marked as Exhibits to the Hearing:

1. Summary for Consent and Capacity Board dated September 24, 2009
2. Evaluator Questionnaire dated August 20, 2009
3. Capacity Evaluation regarding Long Term Care Decision
4. Remainder of package provided by Evaluators

THE EVIDENCE

Both Evaluators, the Representative for the CCAC and Mrs. G provided evidence at the hearing. Mrs. G was assisted by an interpreter.

INTRODUCTION

Mrs. G was an 83 year old widow, who had been diagnosed with dementia three years ago. Prior to hospitalization, she had been residing in the community with one of her three daughters. The daughter that she was residing with had some mental health limitations and was unable to care for her mother. Mrs. G had been previously cared for by her husband. Her husband died in September of 2008. After his death, the family had hired a live in caregiver to assist Mrs. G. With the help of the family, Mrs. G was able to be cared for at home for a period of time. Previous to admission to hospital, the caregiver had given the family notice that she intended to leave her position as she was having difficulty managing Mrs. G's care. At home, the family noted that Mrs. G was seldom getting out of bed and required assistance for all activities, including toileting.

She was admitted to Providence Healthcare on June 16, 2009, from Scarborough Grace, after a fall at home. Admission to a long term care facility was proposed and Mrs. G was found incapable of a decision regarding admission on August 20, 2009.

THE LAW:

The issue for the Board was whether, at the time of the Hearing, Mrs. G., was capable with respect to a decision regarding admission. A person is presumed to be capable, and the onus is always upon the evaluator to establish otherwise. The burden of proof rests with the evaluator to prove his or her case on the balance of probabilities. The patient appearing before the Board does not have to prove anything. The onus is entirely on the evaluator.

The Board must be satisfied on the basis of clear, cogent and compelling evidence that the onus has been discharged in order to confirm the patient's incapacity.

The Board may consider both direct and hearsay evidence, although hearsay must be assigned only the weight that is appropriate to it in the circumstances.

The Health Care Consent Act:

The statutory test for determining incapacity to manage property is found in Section 4 of the *Health Care Consent Act*. Section 4 states:

- s. 4 (1) A person is capable with respect to ...admission to a care facility ...if the person is able to understand the information that is relevant to making a decision about theadmission...and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision.

ANALYSIS.

The Board carefully considered and reviewed the evidence, submissions and the law, including the criteria set out in the applicable legislation. The Board listened to and observed the witnesses carefully. In the opinion of the Board, Mrs. G was not capable with respect to either branch of the test for capacity.

{Ability to Understand:

Based upon the evidence of the evaluators, and corroborated by Mrs. G's evidence, Mrs. G was not able to understand the health problems that were currently affecting her. For example, during the evaluation itself, she specified that her knee was her only health problem. During the hearing, Mrs. G again stated that she had arthritis. She said that as she used a cane it was not possible that she would fall. According to her, she had fallen only once a long time ago.

In the opinion of the Board, Mrs. G had no insight at all into the information about the limitations to her health caused by her dementia. Due to the illness, she had lost the ability to understand the information. She was not aware that she suffered at all from dementia. She denied having problems with her memory. She was also not able to recall that a fall had brought her to hospital and that she had continued to fall even in the hospital during the current admission. The illness had taken away her ability to process the information about the physical problems that she was currently suffering from.} **1**

{Ability to Appreciate:

Based upon the evidence of all the witnesses, and again corroborated by Mrs. G's testimony, Ms. G did not have the ability to appreciate the consequences of a decision or lack of decision regarding admission. As she was not able to understand her physical limitations, she was correspondingly unable to appreciate the consequences of choosing to go home. She repeatedly stated that she liked home best during her evidence. However, she was unable appreciate that she would likely continue to fall at home, just as she had been falling in hospital. Her inability to appreciate was due to the fact that she was unable to remember any of the falls she had experienced recently.

She further was not able to appreciate that her dementia and lack of mobility made her unable to care for herself at home. She stated that she would like the help of the caregiver and her daughters, but said if they could not help, she could do it herself. In the opinion of the Board, Mrs. G was not capably assuming the risks that went along with returning home. Due to her illness, she was unable to appreciate that any risk existed.}2

RESULT:

For the reasons set out above, the Board found Mrs. G. incapable with respect to a decision regarding admission.

Dated at Toronto this 22nd day of October , 2009.

Karen Lindsay-Skynner, Lawyer Member

APPENDIX C**Consent and
Capacity Board****Commission du consentement
et de la capacité**

TO-09-1935

TO-09-1936

IN THE MATTER OF
the *Health Care Consent Act*
S.O. 1996, chapter 2, schedule A,
as amended

AND IN THE MATTER OF
K
a resident of
TRILOGY LONG TERM CARE
TORONTO, ONTARIO

REASONS FOR DECISION**PURPOSE OF THE HEARING**

K a resident of Trilogy Long Term Care, Toronto, Ontario (“Trilogy”) had been found incapable with respect to admission to a care facility. The Board convened at K’s request to review his capacity with respect to admission to a care facility. K also brought an application to the Board to review his capacity with respect to certain treatment.

DATES OF THE HEARING, DECISION AND REASONS

The hearing took place on August 26, 2009, September 8 and 10, 2009. On September 18, 2009 the panel released its Decision. Reasons were released on September 25, 2009.

LEGISLATION CONSIDERED

The *Health Care Consent Act*, including Sections 2, 4 and 50.
Board Rules of Practice.

PARTIES

K, resident

Ms. R and Ms. Y, as evaluators

Ms. P and Ms. M, as the person responsible for authorizing admissions to the care facility, from Toronto Central CCAC

M attended the entire hearing. Ms. P attended the hearing on August 26, 2009 and was replaced by Ms. M on September 8 and 10, 2009. Ms. R attended the hearing on August 26, 2009 and September 8, 2009. Ms. Y attended the hearing on September 8, 2009. K, Ms. R, Ms. Y and Ms. M gave evidence.

PANEL MEMBER

Michael Newman, vice-chair, senior lawyer and presiding member

APPEARANCES

K was represented at the hearing by counsel, Mr. M

Ms. M and Ms. P represented themselves at the hearing.

Ms. R represented herself on August 26, 2009. Ms. R and Ms. Y were represented by counsel, Ms. J for the balance of the hearing.

PRELIMINARY MATTERS

Incapacity with respect to admission to a care facility

The panel was advised that K's incapacity related to a finding made by Ms. R and Ms. Y that K was incapable with respect to admission to a care facility.

After considering subsections 50(2) and 50(4) of the *Health Care Consent Act*, I ruled that the Board maintained jurisdiction to conduct the hearing of K's application. K did not have a Guardian of the Person or a Power of Attorney for Personal Care in which he gave up his right to apply for Board review as in this case. I was satisfied that K did not waive any rights to apply for the review contemplated by subsection 50(1) of the *Health Care Consent Act*. Finally, I found that no prior review of the evaluators' August 29, 2008 finding of incapacity had taken place.

Treatment Application- withdrawn

On September 8, 2009 Mr. M advised the panel that he was unable to locate a finding of incapacity concerning his client's treatment. He asked that the Board mark his client's Application withdrawn, which was done.

THE EVIDENCE

The evidence at the hearing consisted of the oral testimony of seven (7) witnesses, Ms. R, Ms. Y, Ms. M, O, K's sister, RB, KR and K and six Exhibits:

- 1) K's Power of Attorney for Personal Care dated June 15, 2008
- 2) Dr. S's letter dated December 18, 2008
- 3) Dr. M's letter dated March 2, 2009
- 4) Document Brief filed by evaluators
- 5) Standard of Practice for social workers
- 6) Ms. Y's handwritten notes

PRELIMINARY MOTION

Mr. M, counsel for K's sister, O sought party status for her. He submitted O was K's substitute decision-maker. He referred the Board to Rule 5.2 of the Board's Rules of Practice. He submitted that his client had no personal financial interest or position on capacity but submitted that without O being a party she would not receive further notice of the hearing. Both Ms. R and Ms. P supported the request for party status.

Mr. M opposed the request for party status. Mr. M submitted that O had no particular expertise concerning his client's capacity and any comments O had would likely be concerned with what she viewed as K's best interests.

RULING

The issue before the Board concerned whether K is capable with respect to admission to a care facility. The decision under review was based on the evaluation by two evaluators. The onus or burden of satisfying the Board that K is incapable lay with the evaluators on a balance of probabilities, not what were his best interests.

O sought party status to her brother's application. I considered all aspects of the Board rules and in particular Rule 5.2. The law (Section 50(3) of the HCCA) did not grant O statutory party status. The HCCA granted statutory party status to her brother K, the evaluator(s) and the person responsible for authorizing admissions to the care facility. However, by Section 50(3) the Board could specify any other person as a party to the type of application before it. Through her counsel O stated she would not receive further notice of the Hearing. In the Board's view that concern can be remedied by ensuring she received notice. In addition, any relevant information O believed she had concerning the issue before Board could be presented by O being called as a witness. I found O had no genuine interest in the capacity issue before me. She would be notified of any further hearing dates and if not called by a party as a witness, would be so called by the Board.

INTRODUCTION

K was a fifty two year old single man with a long history of alcoholism. On April 27, 2008 K was found in an unresponsive state while participating in an alcohol rehabilitation program at the Centre for Addiction and Mental Health (CAMH). K suffered a brain haemorrhage requiring surgery and rehabilitation. On August 29, 2008 K's capacity with respect to admission to a care facility was assessed and he was found incapable. K was subsequently placed into nursing home care from where many months later he was able to retain counsel and challenge the finding of incapacity.

THE LAW

On any review of an individual's capacity with respect to admission to care facility, the onus of proof at a Board hearing is always on the evaluator to prove the case. The standard of proof is proof on a balance of probabilities. The Board must be satisfied on the basis of cogent and compelling evidence that the evaluator's onus has been discharged. There is no onus whatsoever on the individual. The Board must consider all evidence properly before it. Hearsay evidence may be accepted and considered, but it must be carefully weighed.

CAPACITY WITH RESPECT TO ADMISSION TO A CARE FACILITY

The issue was whether K is capable with respect to admission to a care facility. A person is presumed to be capable, and the onus is upon the evaluator to establish otherwise.

The test for capacity to decide one's own admission to a care facility is set out in Section 4(1) of the *Health Care Consent Act* ("HCCA"):

“A person is capable with respect to a treatment, admission to a care facility or a personal assistance service if the person is able to understand the information that is relevant to making a decision about the treatment, admission or personal assistance service, as the case may be, and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision.”.

The degree of onus required was set out in *Starson v Swayze* 2003 1 SCR 722. In that case the issue was capacity to consent to treatment rather than capacity to consent to admission to a care facility. But, the definitions are identical, in the same section of the same legislation. I saw no reason to apply a different degree of onus from one issue to the next.

ANALYSIS

I carefully considered the Application before me and reviewed the evidence, submissions and the law. The issue was whether K is capable with respect to admission to a care facility. Capacity is defined in Section 4 of the HCCA as set out earlier.

The legislative authority for K's application to review the finding of incapacity is in s. 50(1) of the HCCA.

A person may apply to the Board for a review of an evaluator's finding that he or she is incapable with respect to his or her admission to a care facility.

{The wording in the HCCA is in the present tense and therefore the evaluator must prove on a balance of probabilities that the person remains incapable as at the Hearing. The reason for that is the recognition in Section 15 of the legislation that a person may be incapable at one time and capable at another.} ¹ While that section addresses capacity with respect to treatment decisions and not admission decisions, one cannot imagine that anyone would argue there is a difference between the two in this context.

{In our rights based society an individual's liberty can be constrained, as in the case where a person is found incapable with respect to their admission to a care facility. That person has both procedural and substantive rights including insofar as the process of evaluation of capacity.}2

An examination of the issue of capacity here required a determination of:

- 1) whether the process followed by the evaluators was procedurally fair
- 2) whether substantively K was incapable as of the finding of incapacity and
- 3) whether K remained incapable as of the Hearing

Did the evidence establish that K is unable to understand the information that is relevant to making a decision about admission to a care facility?

Did the evidence establish that K is unable to appreciate the reasonably foreseeable consequences of a decision or lack of decision?

Prior to entering into the alcohol rehabilitation program in April 2008 K was a completely independent individual, residing in a home he owned in the community. He had a college education in the field of music. He had worked for a number of years including as a stock trader and more recently had been self employed.

After his collapse at CAMH in April 2008 K was taken to Toronto Western Hospital where a CT scan of his head revealed he suffered a large subdural haematoma, with frontal lobe damage. Surgery was then performed at Toronto Western Hospital. Following surgery K began to gradually improve in hospital, receiving treatment by way of physiotherapy, occupational therapy and speech language pathology.

On August 7, 2008 K was transferred to the Acquired Brain Injury unit at Toronto Rehabilitation Institute (TRI). On admission to TRI, K complained of double vision and began using a device to cover one eye at a time. He also complained of cognitive changes including decreased memory, changes in his balance and dizziness. According to the medical report of Drs. A and V dated August 7, 2008 filed, K “expressed concern for his situation following his head trauma”.

In their report Drs. A and V wrote:

“On examination today, K was a pleasant individual. His affect was normal, though he did seem extremely concerned about his current situation. He was fully oriented to his past personal information and was quite well oriented to place and time; he knew the year and the month and almost knew the day of the month, he did not know the day of the week, he knew that he was in a hospital, though he did not know in which hospital.

His attention was fair. He could say the days of the week backwards, though had difficulty saying the months of the year backwards. He could repeat 7 digits forward and 4 backward.

With regard to his short term memory, after 10 minutes from memorizing 3 words, he did not remember any of the words. He also could not find the words in a list presented to him. His speech was fluent, though the sentences were built in a simple grammatical fashion. He

could repeat a long sentence and could understand and perform 3-step tasks. Pronounced difficulty was found with naming; he could not name a pen cap, a glove, or fingernails. Additionally, he could not read simple words and when asked to name the letters, it was evident that he could not do so. He was able to put numbers in a circle representing a clock, though he had difficulty organizing the numbers within the circle, and could not place the hands to show a requested time. He did well on a go-no-go finger test. He had difficulty finding similarities or differences between two given objects.”

At TRI, K met Ms. R, a registered social worker, working on her Master’s Degree employed at TRI under the supervision of RB on the acquired brain injury unit. Ms. R met with K weekly both formally and informally, until the end of August 2008. Ms. R also met and spoke by phone with O, K’s sister.

Ms. R recalled attending a family conference with K in attendance on August 19, 2008. The conference was charted and notes filed. Ms. R noted a discussion of the Recommendations set out in the note, including “3-24 hour supervision d/t visual and cognitive changes – likely LTC”. Ms. R further recalled that K was upset at hearing about the recommendations for long-term care.

On August 21, 2008 Ms. R noted however, that K responded well to education and redirection. On August 29, 2009 Ms. R administered several “inventory scales” to assess K for mood and behaviour. In her notes filed, Ms. R wrote that K scored in the severe anxiety range and indicated moderately depressive symptoms. She noted K presented calmly and more mentally alert than she had observed, that he “was able to sustain his attention throughout the time it took to conduct the 3 scales (approximately 20 minutes in total) and he also corrected my addition in the scoring looking at the page upside down”.

In addition, on August 29, 2008 Ms. R and her colleague Ms. Y, an occupational therapist conducted a formal assessment of K’s capacity with respect to long term care. K’s consent to the assessment was requested and obtained. He was also explained the potential consequences of the assessment. Ms. R said she had conducted two prior evaluations under supervision and estimated she had conducted 8-12 prior evaluations.

Ms. Y was K’s occupational therapist at TRI. She was involved with his care from the time of admission until his discharge. She recalled her initial meeting with him on admission and he was able to report his brain injury and some changes he was experiencing. Ms. Y said she was the main person looking at K’s cognitive functioning. Ms. Y said she “participated a little” in the capacity assessment considering long term care. Ms. R noted the assessment in K’s personal health information records where she wrote that K:

“was fully advised and educated as to the purpose of the questionnaire and the implication of the results. He agreed to complete the questionnaire. K made a great effort in answering the questions to the best of his ability and was able to make some beginning statements about his care needs currently. Throughout the questionnaire, MSW student (Ms. R) provided education and rephrased questions as needed. K was advised of the finding of incapacity and strongly expressed his disagreement. K was advised of his right to appeal, the Rights Information was read to him and a copy left with him”.

He voiced that he intends to appeal but demonstrated no follow through actions at the time. He was advised that SW RB would follow up with him on Tuesday, to see if he needed any further assistance in this matter.

Ms. R and Ms. Y also testified that K was advised prior to the evaluation that he could choose not to answer the questions, although that was not charted.

Both Ms. R and Ms. Y said the evaluation was based on the questions they asked K on August 29, 2009. They estimated that the evaluation took possibly about an hour although Ms. R said it was hard to recall. Ms. R completed the five questions on the “Evaluation Questionnaire Regarding Capacity to Make Admission Decisions.” The questions on the questionnaire and K answers set out in quotes were:

1. What problems are you having right now? (Does the person understand her/his condition or problem?) “my eyesight is the biggest problem I have currently ... this was not a problem before meeting with persons from this “firm”.
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 understand the condition/problem?) “it wouldn’t help me. Evaluator provided education as to care services he currently receives and patient was unable to explain his current care needs.
3. Can you think of any other ways of looking after your condition/problem? (Does the person understand the condition/problem?) “I would go to another place.... find an alternative place.....a place where I could go to someone for an appointment for an hour a day, I could go to the library and study about the brain”
4. What could happen to you if you choose not to live in a nursing home or home of the aged? (Does the person appreciate the foreseeable consequences of admission or not?) “I would do very well....much better than in a care home. I always have been able to look after myself. It’s going to take an adjustment...I could ask certain people to do things for me. I can take the TTC by myself.”
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?) “I would become a vegetable”.

Ms. R said that the “....” in places of K’s answers on the evaluation form referred to “irrelevant information” in accordance with her practice.

Both evaluators testified that they made notes of K’s responses to the questions asked. Ms. R said she destroyed her additional notes after the evaluation. Ms. Y said she kept her notes and provided them to her lawyer. They were produced at the hearing for the first time. She said if probing questions were asked of K, they were not written down. She said that she and Ms. R discussed what to put on the evaluation form. She did not recall K wanting to appeal the incapacity finding.

Ms. R said for each of the five questions on the evaluator questionnaire K was asked 3-4 additional questions. Neither evaluator could recall nor did they record the additional questions or K’s answers.

Ms. Y said the questionnaire reflected the questions asked and K's answers. While Ms. Y made a chart note on August 29, 2009 she did not chart the capacity evaluation. She said K required assistance in many areas.

Ms. Y's written notes related to the questions on the Evaluator Questionnaire and provided K's answers as well. Ms. Y could not recall why the questions and answers in her notes did not make it into the Evaluator Questionnaire. Her handwritten notes including K's answers were as follows:

1. Problems?
 - Causing me great stress and distress
 - No problems i(i meaning with) eye sight before getting involved i type of firms
What do pple help you with in here?
 - Streessul situations to help i taking pills, alcohol problems
What pills?
 - First time ever, I've taken lorazepam, first time i this group
 - Usually its valium very little, only mood altering drug I take

2. it wouldn't help me
 - Go to places where they'll help me. I need time to search for places that can help i my affliction
 - A place where I can go for an hour once a day. They do affect arms & I give them the appropriate answers
Another way?
 - Investigate a lot when I have a condition, go to the library to study brain care
What other places 24/7...
 - I would do well. I would do much better. I don't like these health care places
 - I would need to make an adjustment. I would need ppl to pick things up for me (e.g. my family)
 - - ppl to take me to aforementioned groups, just go on my own
What could happen if you chose to go to LTC?
 - Be a vegetable
Need for medical care?
 - No doctors have come to see me
 - How would take care (re ↓ memory)
 - For years I used logs, I have my little logs

Both Ms. R and Ms. Y testified that K failed the test for capacity because he was unable to understand information about his condition and was unable to appreciate consequences related to his poor memory. When asked what information was relevant concerning the first part of the test for capacity, Ms. R referred to K's safety, care needs and supervision. She believed that her probing questions would have asked about those concerns. She acknowledged she could have written those additional questions down.

In responding to questions about why she did not assist K in appealing the finding of incapacity Ms. R testified that she complied with her college standards of practice in conducting the evaluation and had "advocated" on behalf of K. Ms. Y last saw K on December 5, 2008.

Ms. B was Ms. R's supervisor and K's social worker on the acquired brain injury unit at TRI. Ms. B said she came to know K very well and supported the finding that he was incapable with respect to admission to a care facility. She said Ms. R did most of the assessment. Ms. B said she was aware that K wanted to appeal the finding. However, K never asked her for assistance. She noted that K was quite co-operative about visiting a long-term care facility (Leisureworld), that he understood he was going to stay there, with his goal being returning home. She recalled that after K was discharged to Leisureworld, he called her a number of times and left voice mail messages asking for her help in leaving the nursing home.

Ms. R was a registered nurse at Trilogy and provided current care to K. She said K was a patient in a unit consisting of Alzheimer's patients ranging in age from 72-95 years. Ms. R said K was the youngest resident on the locked unit. She said he did not socialize with co-residents but participated in one on one activity with staff, usually 10-15 minute conversations.

K said he had a brain "malfunction", as a function of his addiction to alcohol. He knew he ended up in hospital but could not remember the events of over one year ago. He said he had been able to speak with different law firms and interviewed lawyers before deciding on hiring his current lawyer to challenge the finding of incapacity. His goal with the application before the Board was to either go to his own home or into a care facility of his choice. He believed he had made great strides. He did not believe he should be residing in the locked secure unit in a nursing home. He acknowledged that he had a lot of recovery ahead of him. He said Trilogy was a place to stay and eat in and where there were people to help him. He said he had been residing at Trilogy for a number of months and had not tried to escape. He believed his thinking was a lot clearer than before. He knew he still had problems with his memory. He felt he was capable of deciding for himself where he should live. He said he faced challenges if he left his current residence. He said his first choice was to stay in Toronto, but he could go stay with his brother in PEI, although knew his brother was an alcoholic. He said his girlfriend in Kingston had not answered him yet on whether he could stay with her.

K said he would not feel comfortable just walking out the door of Trilogy. He believed he would stay at Trilogy for a while, likely a month and had to find out where he stood financially. He would likely go through the newspaper in order to try and find a place to live and would need to obtain government assistance for support. He might have to find employment, perhaps at MacDonald's.

K referred to "falling off the wagon" a number of times in talking about his alcoholism. He said he had problems with the eyesight in his left eye. He said his long term memory seemed okay but his interim memory i.e. from last week was not so good. To help him K said he wrote notes. He said he never had a problem asking for help. He also said he could always ask for help. K said he knew he was an alcoholic, that he had the problem going back many years. He could not promise he would not drink again. He felt the longer he went without alcohol the easier it would be for him. He said he would go back to AA for support and help or he could call Trilogy or a brain injury program and ask for help. He knew that drinking alcohol caused him a lot of damage.

K was able to identify RB and his sister's address. He acknowledged that his sister and he have never fully seen eye to eye. He said that when he escaped from a Leisureworld nursing home prior to transfer to Trilogy he took the subway wherever he wanted to go, went to a bar and drank.

K said that when he recently went to see Dr. S he had not slept well the night before. He did his best and tried to be as truthful as possible. If he told Dr. S he had not had a drink in 18 months, he was erroneous. He was able to tell the Board of a number of medications he received and for what reason he took them.

A great deal of background evidence concerning K was provided by his sister O, who was K's attorney for personal care. O informed the Board that:

- she was the only person who cared for her brother and he was a long-term alcoholic
- that when he drank he did not stop drinking on his own
- that she used to drag him to medical appointments
- that she had brought him to CAMH in April 2008 for alcohol rehabilitation
- that previously her brother had alcohol delivered to his home by a delivery company
- that her brother lost all his jobs through his alcoholism
- that K left his house in a very poor state
- that for years she cleaned his home and then stopped
- that Doctors told his brother his life would be different after the brain injury, that he almost died and if he drank again, he would probably die
- that she wanted her brother to be safe and has only tried to help him
- that when she took K to her home for Thanksgiving in October 2008 he drank all the alcohol he could find in her home
- that she has continued to pick her brother up from the nursing home regularly and bring him to visit their mother in another nursing home in Toronto
- that prior to her brother's transfer to a locked unit at Trilogy in January 2009 he was resident in a unlocked unit in a Leisureworld nursing home from where he had escaped several times and been found twice in a bar drinking and unable to pay his bill
- that if K could make his own decisions concerning long term care, he would not keep himself safe
- that her brother has surprised people and has improved somewhat in some areas

Starson v Swayze (2003) SCC 32 is the leading case in relation to the law on consent to treatment in Ontario. As set out earlier, Section 4(1) of the HCCA provides a two part test to determine whether a person is capable with respect to a treatment, admission to a care facility and personal assistance service.

Justice Major wrote the majority opinion for the Supreme Court in the *Starson* decision. He commented upon the onus of proof required to displace the statutory presumption of capacity at paragraph 77: "I agree with the Court of Appeal that proof is the civil standard of a balance of probabilities."

Chief Justice McLachlin, who wrote the dissent, agreed on this point. At paragraph 13, she wrote, "the person is presumed to be competent and the standard of proof for a finding of incapacity is a balance of probabilities." I found the same standard applies in the current case before the Board.

Justice Major analyzed capacity at paragraph 78 of the *Starson* decision as follows:

"Capacity involves two criteria. First, a person must be able to understand the information that is relevant to making a treatment decision. This requires the cognitive ability to process, retain and understand the relevant information. Second, a person must be able to appreciate the reasonably foreseeable consequences of the decision or lack of one. This requires the patient to

be able to apply the relevant information to his or her circumstances, and to be able to weigh the foreseeable risks and benefits of a decision or lack thereof.

Before turning to an analysis of the reviewing judge's decision, two important points regarding this statutory test require comment. First, a patient need not agree with the diagnosis of the attending physician in order to be able to apply the relevant information to her own circumstances. Psychiatry is not an exact science, and "capable but dissident interpretations of information" are to be expected. While a patient need not agree with a particular diagnosis, if it is demonstrated that he has a mental "condition", the patient must be able to recognize the possibility that he is affected by that condition. Professor Weisstub comments on this requirement as follows (at p. 250, note 443):

Condition refers to the broader manifestations of the illness rather than the existence of a discrete diagnosable pathology. The word condition allows the requirement for understanding to focus on the objectively discernible manifestations of the illness rather than the interpretation that is made of these manifestations.

As a result, a patient is not required to describe his mental condition as an "illness", or to otherwise characterize the condition in negative terms. Nor is a patient required to agree with the attending physician's opinion regarding the cause of that condition. Nonetheless, if the patient's condition results in him being unable to recognize that he is affected by its manifestations, he will be unable to apply the relevant information to his circumstances, and unable to appreciate the consequences of his decision.

Secondly, the Act requires a patient to have the **ability** to appreciate the consequences of a decision. It does not require **actual** appreciation of those consequences. The distinction is subtle but important... In practice, the determination of capacity should begin with an inquiry into the patient's actual appreciation of the parameters of the decision being made: the nature and purpose of the proposed treatment; the foreseeable benefits and risks of treatment; the alternative courses of action available; and the expected consequences of not having the treatment. If the patient shows an appreciation of these parameters-regardless of whether he weighs or values the information differently than the attending physician and disagrees with the treatment recommendation – he has the ability to appreciate the decision he makes.

However, a patient's failure to demonstrate actual appreciation does not inexorably lead to a conclusion of incapacity. The patient's lack of appreciation may derive from causes that do not undermine his **ability** to appreciate consequences. For instance, a lack of appreciation may reflect the attending physician's failure to adequately inform the patient of the decision's consequences. Accordingly, it is imperative that the Board inquire into the reasons for the patient's failure to appreciate consequences. A finding of incapacity is justified only if those reasons demonstrate that the patient's mental disorder prevents him from having the **ability** to appreciate the foreseeable consequences of the decision."

The analysis utilized in Starson was just as applicable to an analysis of the two part test concerning capacity with respect to admission.

There was no evidence that K presented with any barriers to communication. The actual Evaluator Questionnaire was filed. A finding of incapacity has important ramifications for a person and will result in the loss of fundamental rights. Accordingly, the evaluators were questioned extensively concerning how they came to determine K was incapable. When a person is approached for the specific purpose of conducting a capacity evaluation there is no doubt that a meticulous process and careful note taking must take place. When the decision regarding capacity is not the result of a discrete process but rather, is done after a period of therapeutic interaction the situation is obviously somewhat different. While careful note taking is important and compliance with the test for capacity imperative, it is not reasonable to assume that the same sort of charting will take place. However as Justice Quinn noted at paragraph 89 in *Re Koch* (1997), RR O.R. (3d) 485 “any procedure by which a person’s legal status can be altered (which is the *inevitable* result on a finding of mental incapacity) must be cloaked with appropriate safeguards and capable of withstanding rigorous review”.

{The evaluators had a responsibility to take meticulous notes. It was wholly inadequate to just record information and then form an opinion. Clearly in this case probing of K was required to determine the thought process by which he arrived at answers to questions. Until his thought process was known it was neither fair nor reasonable to impugn K’s mental capacity.} **2, 4**

In *Saunders v. Bridgepoint Hospital*, 2005 CanLII 47735 (ON S.C.), 2005 CanLII 47735 (ON S.C.) an appeal to the Superior Court from this Board, Madam Justice Spies held at paragraphs 118, 120 and 124 that:

{“[118] as a matter of procedural fairness, a patient must be informed of the fact that a capacity assessment, for the purpose of admission to a care facility, is going to be undertaken, the purpose of the assessment and the significance and effect of a finding of capacity or incapacity. Given what is at stake for the patient, this seems to be a minimal requirement for procedural fairness. Furthermore, this will ensure that the information collected from the patient, which forms the basis of the assessment, is reliable....} **2**

{[120] Where the capacity assessment occurs as part of ongoing treatment as it did in this case the information noted above should be provided as soon as a decision to perform a capacity assessment is made and thereafter on an ongoing basis to ensure that the patient is very clear on the process. This would not hamper the assessment process and addresses the concerns of counsel for the respondent, in that the assessors would not have to do their official assessment at a specific point of time. This would however ensure procedural fairness to the patient and assist the Board in assessing the evidence of the patient’s responses to questions asked, that are relied upon to support a finding of incapacity.} **5**

{[124] The Board addressed the importance of maintaining adequate notes and records in assessing capacity and concluded in the *Matter of HT*, that the finding of incapacity could not be upheld on the ground that:

the evidence was inadequate and flawed as a result of the failure of the evaluator to maintain adequate notes or records and the failure of the evaluator to explain the nature and purpose of the evaluation to HT or alternatively, to justify why such an explanation was not provided[14]} **4**

{The Board ought to be able to ascertain from the questions asked of K, his answers given and other notes of the evaluation process how the evaluators arrived at their conclusion that K was incapable. Fairness and rules of natural justice demand it. Capacity is issue and time specific. How could I review the finding of incapacity if I did not know exactly the questions asked and answers given?} **2, 4**

At paragraph 106 in *Bridgepoint*, Justice Spies wrote:

{“It is submitted by the appellant that in the absence of expressed procedural provisions, procedural fairness must be found to be impliedly required by the HCCA in order to comply with the rules of natural justice and the *Charter*, which by definition is an objective concept where it can be applied consistently in all cases. I accept that as a matter of law, an objective test must be applied to the HCCA for determining the existence of specific rules of natural justice and in considering whether or not there was a breach of the rules of natural justice in the capacity assessment process”.

Justice Spies clearly required that an assessment of a person’s capacity to make an admission decision must be conducted in a fashion that is procedurally fair and complies with the rules of natural justice and the Charter.} **2**

{The evaluators testified that they asked the questions set out on the Evaluation Questionnaire. We know what the precise questions on the questionnaire were. However, K’s answers were only partly recorded. The evaluators said they recalled asking additional questions but these were not recorded. We do not know what they were. Ms. R testified she likely asked 2-3 additional questions to each of the five questions on the evaluator questionnaire. None of those questions or K’s answers was written or recorded anywhere. Without being able to examine the questions asked of K and his answers how I could assess capacity properly. The evaluators had a duty to maintain adequate notes and records of all their questions and K’s answers. They did not. The evaluation procedure utilized in finding K incapable was fatally flawed.} **4**

I reviewed the questions on the Evaluator Questionnaire and K’s answers. I found from the answers given by K that I could not ascertain how the evaluators found K incapable. I noted that Ms. Y wrote additional comments on her personal notes that were not carried over the evaluator’s questionnaire. Ms. R destroyed her personal notes. I examined Ms. Y’s notes and found K’s answers on Ms. Yuen’s notes appropriate. He knew about his medications and what they treated. He used logs to help with his memory deficits.

The evidence clearly revealed that K suffered from alcoholism. However, K answers to the questions which formed the evaluation did not reveal on a balance of probabilities that K failed either part of the two part test for capacity set out in Section 4(1) of the HCCA. While answers were vague at times, they appeared appropriate. That was why probing to ascertain K’s thought process would have been so important.

{In using the Supreme Court analysis in *Starson* I was not able to determine that K failed either part of the two branch test for capacity set out earlier. The evaluators did not establish K was unable to understand the information that is relevant to making a decision about admission to a care facility. As

well, they did not establish K was unable to appreciate the reasonably foreseeable consequences of a decision or lack of decision. K certainly knew what a long term care facility was and he was able to process and retain enough information that he knew of and was able to appreciate the benefits to him of a long term care residence. He wanted to make his own choices, would likely stay a month at Trilogy before deciding what he would do next. He was also clear that he would accept help.} **3**

{The evidence was clear that K was informed of the finding of incapacity, was given the rights information sheet and verbalized an intention to appeal the finding. The evidence was also clear that neither evaluator nor anyone in a position of supervision did anything to assist K in applying to the Board, in spite of what appear to be clear standards of practice for members of the College of Social Workers and Social Service Workers, filed.} **6**

Part of the process of evaluation also involved determination of what was required of an evaluator should an individual's right(s) to make their own decision be removed by the evaluator's finding of incapacity. For example the standards of practice for members of the College of Social Workers and Social Service Workers required that social workers in a circumstance after finding an individual incapable with respect to their admission to a care facility and the individual disagreeing with the need for a substitute decision maker, that the social worker will "assist the client if he or she expresses the wish to exercise the options". The standards of practice set out that these options include applying to the Consent and Capacity Board for review of the finding of incapacity...." Plainly put, there was an obligation on the social worker evaluator Ms. R to provide assistance with the application process. She did not. Surely nothing less should have been expected of Ms. Y an occupational therapist and the second evaluator.

In addition, even if I found the evaluation procedure fair, which I did not, I would reverse the finding of incapacity on the basis that the substantive evidence of the evaluation failed to support a finding of incapacity at the time of evaluation. In addition the evidence of current incapacity was lacking.

The evaluators conducted the evaluation of August 29, 2008, over one year ago. As set out earlier, the evaluators must satisfy the Board that K is incapable as of the Hearing. The Hearing took place from late August 2009 to mid September 2009. On September 2, 2009 K's sister O brought him to see Dr. S. In his report Dr. did not mention assessing K's capacity with respect to long term care. Dr. S's impression as noted from his report was that:

"Unfortunately, though K has improved in his level of attention reading capacity and mood, he continues to have important executive function problems such as abstract thought, judgement issues, visuospatial problems and especially problems with immediate recall and short and long-term memory that, in my opinion, put him at risk if he lived without supervision. I am also quite concerned given his past history that should he live independently, he would immediately relapse into his alcoholism, further injuring himself and potentially others. As a further example of how he could put himself at risk if he lives independently, could not recall the names, doses and times of his medication, he would likely miss doses, double dose or altogether not comply with treatment.

Unfortunately, K has dealt with alcohol dependence for many years, and has had many problems secondary to it. His acquired brain injury puts him at further risk should he lived independently.

Hence, I would have to agree with my previous statement of December 18, 2008 in the sense that I do not think he can live independently without supervision and that he is at high risk of relapse into his alcohol dependence. As such, my recommendation would be for K to continue living in assisted care. Given the length of time since his injury and the presence of the above mentioned deficits, his prognosis remains grim.”

{That was not a formal assessment of K’s current capacity with respect to long term care with the appropriate legal safeguards. I found much of the evidence led was based on what others saw was in K’s best interest, which was not the standard to determine capacity.} **2**

{K has clearly improved in his presentation over time. The evidence was clear in that regard. K faces very serious challenges. Consequently, as of the hearing on a balance of probabilities the evidence was not clear, cogent or compelling that K is incapable with respect to admission.} **1**

RESULT

For all of the above reasons, I found K remained presumed capable in law with respect to admission to a care facility.

Dated: September 24th, 2009

Michael Newman
Presiding Lawyer Member

1 Mental Capacity Can Change

2 Fair Process According to Legislation

APPENDIX D

Canadian Legal Information Institute

Koch (Re), 1997 CanLII 12138 (ON S.C.)

Ontario Supreme Court**Koch (Re),****Date: 1997-03-26**

Re Koch

*Ontario Court (General Division), Quinn J. March 26, 1997**D.G.E. Toppari, for respondents, David M. Higgins and Rita Talosi.*

I. INTRODUCTION

[1] Linda Koch has suffered from multiple sclerosis for 15 years. She is confined to a wheelchair, although able to walk short distances with a walker. Ms. Koch and her husband separated in January 1996. Each retained lawyers and negotiations commenced with a view to resolving the usual property and support issues. On April 23, 1996, her lawyer forwarded a draft separation agreement to the husband's lawyer. Apparently, the terms of the separation agreement were not acceptable to the husband. In or about May 1996, the husband complained to the necessary authorities that his wife was demonstrating an inability to manage her finances. This complaint triggered the formidable mechanisms of both the *Substitute Decisions Act, 1992*, [S.O. 1992, c. 30](#) ("SDA"), which was proclaimed in force on April 3, 1995, and the *Health Care Consent Act, 1996*, S.O. 1996, c. 2 ("HCCA"), which, on March 29, 1996, replaced the previous *Consent to Treatment Act, 1992*, [S.O. 1992, c. 31](#). A hearing was held before the Consent and Capacity Board ("Board") on July 22, 1996. On that date Ms. Koch, who is 37 years of age, was adjudged by the Board to be:

1. incapable of managing her financial affairs and property; and
2. incapable of consenting to placement in a care facility

[2] Ms. Koch now appeals to this court pursuant to s. 20.2(6) of the *SDA* and s. 80(1) of the *HCCA*. She seeks a reversal of the Board's decision. In the vernacular, her cry is, "My husband had me committed."

[3] This appeal raises grave concerns as to what is required before the state can deprive a citizen of her liberty on the grounds of mental incapacity

II. THE ISSUES

[4] The issues would appear to be these:

1. Did the Board err in its decision?
2. Should the parties be permitted to adduce *viva voce* evidence on the appeal?

III. THE EVIDENCE

[5] Following the complaint of the husband, Ms. Koch (“appellant”) was interviewed by Rita Talosi, an “evaluator” within the meaning of s. 2(1) of the *HCCA*, and by David Higgins, an “assessor” within the meaning of s. 1(1) of the *SDA*. Their involvement in this matter can be summarized conveniently by means of the following brief chronology:

May 30, 1996	—	Rita Talosi (“Talosi”) telephoned the appellant and arranged an appointment to interview her on June 4, 1996.
June 4, 1996	—	Talosi spoke with the appellant in the hallway of the latter’s apartment building. This conversation lasted 30 minutes.
June 7, 1996	—	Talosi evaluated the appellant for the purpose of determining whether she was capable of consenting to placement in, or admission to, a care facility. The evaluation consisted of a 90-minute interview of the appellant in the latter’s apartment following which Talosi prepared a written functional assessment pursuant to the <i>HCCA</i> . She found that the appellant lacked the mental capacity needed to satisfy the requirements of s. 4(1) of that Act.
June 7, 1996	—	The appellant was admitted to Welland County General Hospital as a result of urinary incontinence caused by her multiple sclerosis. There is no connection between this admission and the interview earlier that day by Talosi. Talosi was not aware that there was to be an admission.

June 19, 1996	—	David Higgins (“Higgins”) spoke with the husband in the course of which the latter expressed concern in respect of the appellant’s “irresponsible spending habits.”
June 22, 1996	—	An assessment was conducted by Higgins pursuant to the <i>SDA</i> for the purpose of determining whether the appellant was capable of managing her property. The assessment was conducted at Welland County General Hospital and at the request of the husband.
July 2, 1996	—	Higgins prepared a written report (Form C, Assessment Form, under the <i>SDA</i>). He found that the appellant lacked the mental capacity needed to satisfy the requirements of s. 6 of that Act.
July 8, 1996	—	The appellant made application to the Board for a review of Talosi’s finding of incapacity.
July 17, 1996	—	The appellant made application to the Board for a review of Higgins’ finding of incapacity.
July 22, 1996	—	The Board conducted a hearing of both applications at Welland County General Hospital following which the appellant was adjudged to be incapable of managing her financial affairs and property and incapable of consenting to placement in a care facility. The Board consisted of one person, J. David Helson (“Chair”).

[6] I propose now to review the evidence of those who testified before the Board: Talosi, Higgins, Judy Collins (“Collins”) and Shelly McShane (“McShane”).

1. *Talosi*

[7] Talosi is a registered nurse. Her evidence consists of a three-page functional assessment report (which is, in large measure, a check-list), six pages of handwritten notes and her testimony before the Board.

[8] From the handwritten notes, her counsel relies upon certain passages which are found at pages three and four of his factum and excerpted below:

(a) ...on May 30, 1996, Ms. Talosi spoke with the appellant by telephone, and made an appointment for her to visit the appellant Tuesday a.m. at 09:00 hours. On the Tuesday, June 4, 1996, the appellant was not in her apartment. The janitor of the building where the appellant lived, directed Ms. Talosi to the appellant who was in the hallway. The appellant indicated to Ms. Talosi that she was waiting for a bus which was to pick her up at 8:45. The actual time was 9:20. When this was pointed out to the appellant she said “That’s O.K. I still have time, it’s not 8:45.” Ms. Talosi asked about making another appointment and the appellant said that this could be done in the front entrance of the apartment

building. Ms. Talosi suggested that her apartment would be a quieter place, however the appellant indicated that she'd have to clean it before Ms. Talosi could go there. The appellant then offered to go to the conference room, at which point Ms. Talosi reminded her about the ride she was waiting for, in response to which the appellant answered "Oh yeah." Friday was discussed as a possible day to conduct the appointment.

(b) On the Friday, June 7, 1996, Ms. Talosi first phoned the appellant to determine if it would be O.K. to visit. The appellant said it would be. At the appointment, at the appellant's apartment, the apartment was very cluttered, disorganized, food in all rooms, some opened and some crushed packages. There were no clear pathways for the appellant's wheelchair. Ms. Talosi noted that the appellant uses the wheelchair at all times and has not used the walker for a long time. The appellant was non-responsive to Ms. Talosi's questions. The appellant talked about shopping, her daughter, dissatisfaction with her husband. Her attention span wandered. She changed thoughts quickly, especially when asked difficult or unpleasing questions by Ms. Talosi. The appellant correctly stated the date, year and time, but not the month. The appellant accused a man named Ron of stealing her things. She accused her husband of stealing her car. The appellant kept repeating that her husband has wanted to kill her by strangling her in a love scene. She kept repeating that she was not happy with her apartment. She indicated she wanted to move out of St. Catharines but anywhere else might not be better. She is unsure where she would like to go... She felt she was capable of making her own decisions. The appellant admitted to needing more help, and is unsure what is out there. The appellant's voice was low and she speaks very quickly. Her eyes wandered when uncomfortable with a question. The appellant did agree that she needed more assistance with her personal care and home maintenance to promote safety and well-being...

[9] Counsel for Talosi relies upon the following portions of her testimony at the consent and capacity hearing:

(c) [The appellant's] thought processes they changed quickly when we were speaking. When asking a question she would come up with an idea that was totally unrelated. [Transcript, p. 22, line 20]

(d) It was obvious when she was talking about the high frustration level that she was experiencing, in fact she did say that the high frustration levels were clouding her thoughts and that it was difficult for her to make a decision because her thoughts were clouded. [Transcript, p. 24, line 2]

(e) [The appellant] said she likes to cook... Dressing. She said she needed help with complicated clothing... there was a couple of people that came in to do eye drops... Bathing, she does require assistance... [Transcript, p. 24, line 17]

(f) Her apartment is very, very, cluttered, various things all over the place, anything from clothes to food... basically I didn't have anywhere to sit... so what I ended up doing was cleaning a spot in front of her wheelchair... and sitting on the floor... It was obvious that the stuff had been accumulating for a period of time. [Transcript, p. 24, line 27]

(g) [During the interview the appellant] put her hand in and pulled out something from a bag and began to eat the cookie or whatever it was. [Transcript, p. 25, line 11]

(h) ...there didn't seem to be an understanding how the environment, the safety, the assistance of personal care, and thought process were all relevant information that

you have to consider when you're making a decision into—for assistance, and as well appreciating what the consequences would be if she did stay where she was or if she did go to a place where she would get more help. [Transcript, p. 25, line 20]

(i) [The appellant] does look a lot better today. [Transcript, p. 26, line 6]

(j) [Whether or not she was happy with where she was staying] wasn't a consistent feeling or thought or whatever that she had throughout that hour and a half when I was there. [Transcript, p. 31, line 17]

(k) [The appellant] didn't want to go anywhere, but yet she realized that she needed help and that right now her thoughts were too clouded to make that decision and she could use some help... [Transcript, p. 33, line 7]

(l) [During the interview] all of a sudden I looked up and she pulled a bra from out of a bag and she couldn't put that on, so I had to help her put that on. But she just pulled that out of a bag that was on the floor. [Transcript, p. 34, line 25]

[10] Counsel for the appellant submits that, since Talosi, at the outset of the interview on June 7, 1996, made it known to the appellant that she might be sent to a nursing home, this could easily have caused the appellant to feel sufficient stress so as to affect her words, thinking and conduct that day. Counsel relies upon the following transcript references from the evidence given by Talosi at the hearing of July 22, 1996, in response to questions put to her by the Chair:

[11] At p. 33, line 24:

Q. ...

A. We talked about it in length about different places, and the thing was trying to find something that would be appropriate for her.

Q. Can you remember what the options were that you requested?

A. Well, the word "nursing home" did come up, and that's not a very pleasant term you've got to admit...

...

Q. ...Like you say with most people when you mention the word "nursing home" you don't get a positive reaction?

A. No.

Q. Can you remember what her reaction was?

A. ...She wasn't happy at all with that. She said, "No, not the nursing home."

[12] This line of questioning was pursued further by counsel for the appellant at p. 36, line 14:

Q. Nursing home has negative connotations?

A. Yes, it does.

Q. Aren't there a lot of seniors that see it as another step towards the grave?

A. Not necessarily.

Q. Okay. Some seniors see it that way?

A. Some do.

Q. Some fight very strongly to stay out?

A. Some do...

[13] And farther at p. 38, line 23:

Q. ...Was the word, "nursing home" raised in the discussion?

A. Maybe once and maybe twice at the beginning but then we avoided that...

[14] 2. *Higgins*

[15] In the case of Higgins, we have his written assessment form, five pages of handwritten notes apparently taken in the course of his interview of the appellant and his testimony before the Board. The nature of his qualifications is unclear. The Chair asked, "Your background is in psychology?" to which Higgins replied, "In social work and psychotherapy, yes."

[16] Higgins' assessment form states that the husband claimed the appellant "spends the bulk of her income frivolously and has accumulated debts at... department stores purchasing items she has no use for or need of [and she] is in arrears with hydro [and] telephone bills." The husband further advised Higgins that the appellant "has little understanding of the possible consequences of her spending". Later in the interview the husband apparently altered his opinion and claimed that the appellant "has no appreciation of the consequences of her irresponsible spending". The husband provided Higgins with two medical reports, from the period 1993 to 1995, relating to the appellant. I will deal with those medical reports later in these reasons.

[17] Higgins states that the appellant, when interviewed, "admitted she enjoyed spending and did not view her actions as causing anybody any harm". It was Higgins' observation that because the husband "is paying [the appellant's] rent, she interprets this as giving her licence to spend the income she receives in any way she chooses, no matter how inappropriate this may be". Higgins further observed that "in the course of the interview with [the appellant] she was disinclined to discuss options open to her as she does not see anything wrong with the way she currently handles her affairs.

[18] He also states, "From the response given to me by [the appellant] I would conclude she lacks insight into her situation and does not possess the level of understanding required to make decisions appropriate to her circumstances". He further concludes that "during our interview... on June 22, 1996, it was evident [the appellant] did not see any negative consequences arising as a result of her impulsive spending, expressing the view things would be alright if people would leave her alone". His final observation is that "in the course of my interview on June 22, 1996 [the appellant] admitted spending her money freely and at times unwisely. She was unable to offer any explanation for her behaviour other than to say it made her feel better. Her bank book showed withdrawals for which she was unable to offer any explanation nor say how she had spent the money.

[19] The following are excerpts from Higgins' handwritten notes upon which his counsel particularly relies:

(a) My impression of Ms. Koch, who was in a wheelchair, was of an undernourished, physically unwell individual. She also seemed agitated and nervous.

(b) I learned from Ms. Koch that her income was a disability pension of around \$700.00 per month.

(c) When I asked her what she did with her money, she replied she spent it mostly on food and jewellery.

(d) In response to my question—"Do you purchase jewellery every month?" Ms. Koch replied "Of course."

(e) Ms. Koch then suddenly announced she had been "ditched" by her family doctor.

(f) Ms. Koch then launched an attack on her estranged husband calling him a "bastard" a "thief" and a "liar". She also claimed her husband had been violent towards her.

(g) For the next several minutes Ms. Koch jumped rapidly from one topic to another. Firstly, the fact she had M.S., secondly, how she seldom sees her daughter, thirdly, why she was in hospital, no one comes for her. Throughout this episode Ms. Koch displayed a range of emotions from near hysteria, laughter, bitterness, anger and dejection. The most striking feature was the incongruity between what was being said and the mood being displayed.

(h) She freely admitted to spending a significant amount of money, she was vague as to the exact amount but said it was usually several hundred dollars, purchasing non-essential, frivolous items, mainly in the dollar store.

(i) In response to questions about the wisdom of such actions and the possible consequences to her financial well being, Ms. Koch merely shrugged, stating "I do it because I feel better then."

(j) Further questions around her finances with particular regard to payment of rent, hydro, telephone, etc. elicited only vague responses. I formed the impression that Ms. Koch lacked the insight to appreciate the consequences of her behaviour and could not understand why it

was a matter of such concern. Her responses also suggested she did not consider her actions irresponsible nor did she see any difficulties arising for her, indicating to me that there would always be someone to take care of her.

(k) Ms. Koch also informed me that a short time before being admitted to hospital she had spent several hundred dollars at Sears, having a portrait of herself taken, adding quickly that it was to prove to herself she was "not getting old." Ms. Koch went on to tell me it was her intention to buy a car as soon as she returned home and felt better. In response to questions concerning her ability to drive because of her physical health, Ms. Koch replied that such concerns were unfounded.

(l) At this juncture Ms. Koch once again became upset and emotional making further comments about her health, her family, being in hospital, becoming quite euphoric in the process.

(m) In the course of this outburst Ms. Koch denies ever having any financial problems, claimed she managed her affairs well and would be alright if she were left alone.

(n) As with the previous episode, Ms. Koch after several minutes became more settled. We were then able to discuss how well she cooked at home. Ms. Koch indicated she managed very well and did not have any problems. However, in response to further questions Ms. Koch admitted she “always” felt depressed and as a result frequently lacked the motivation to do anything.

(o) I cannot help but feel sorry for this unfortunate young woman. It is not possible for me to imagine what life must be like for a thirty-five year old who finds herself afflicted by a progressively degenerative disease with no prospect of recovery.

(p) Ms. Koch appears to have little or no insight into her present condition and is therefore unable to appreciate or understand the possible consequences of her actions. Ms. Koch seems to believe that no matter what she does nothing ill will come of it.

[20] As for the testimony of Higgins before the Board, his counsel relies upon the following passages:

(a) ...my concern was that Linda did not appear to have insight into her own behaviours and was unable to understand or foresee the consequences if she continued to act in such a manner. [Transcript, p. 5, line 7]

(b) I certainly have a great deal of sympathy with that position from Linda but bearing in mind that the capacity assessment is a legal construct and therefore the definition of capacity and appreciation and understanding falls within the legal construct, and it is not an issue that should be decided on emotional states. I certainly felt strongly that Linda was in need of some form of supervision to better manage her finances, and while I had sympathy, a great deal of sympathy with her and still have for the situation in which she finds herself, I concluded having spoken with her... that it would be in Linda's best interests if a finding of incapacity was reached, and accordingly I made that finding. [Transcript, p. 5, line 15]

(c) I was aware... in the course of the conversation I had with Linda of the stress, the considerable stress she was suffering from as a consequence of her, the state of her marriage and also had a great concern over the fact that she had very little contact with her daughter, and a fairly recent development, I think, at the beginning of June was the fact that she had been removed from her family doctor's list. The family doctor felt that he no longer wanted to provide that service for Linda. So, I think there were a number of factors which were causing Linda considerable stress. [Transcript, p. 6, line 7]

(d) I agree with that. Yes, that is still another factor—that is a social economic judgment as opposed to a legal construct, which is how the [SDA], capacity assessments are made on the legal construct of understanding and appreciation, and this was what I based my finding on. [Transcript, p. 15, line 16]

3. Collins

[21] The involvement of Collins in this matter consists of what appears to be one or two minutes of *viva voce* evidence before the Board. Her position was described as “with Placement Coordination Service [Niagara].” She never saw the appellant but apparently it was her task to analyze certain information provided to her and make a determination whether the appellant was eligible for a long-term care facility. She read from a check list and her evidence included this passage (Transcript, p. 40, line 17):

So, then in the next area you talk about where the applicant must meet one of the criteria... The applicant requires nursing care, applicant requires assistance each day with activities of daily living, which is the one I was able to check off. Applicant requires on site supervision or monitoring at frequent intervals throughout the day to ensure his or her safety or well being. Applicant is at risk of being harmed if the applicant lives in his or her residence, and the applicant is at risk of suffering harm due to environmental conditions that cannot be resolved, and the applicant may harm another someone if the applicant lives in his or her residence. *Of all of these eligibility criteria the only one that I thought, that I ticked off for Linda was that she did require assistance with daily living.*

(Emphasis added)

4. McShane

[22] McShane is a friend of the appellant and she gave evidence at the consent and capacity hearing on July 22, 1996. I will set out below some portions of her testimony. Since the transcript does not follow the format of a typical “court” transcript (it does not identify questions and answers with the customary “Q” and “A” and, instead, identifies the name of the questioners—Mr. Banfield and the Chair—and the name of the witness) I will substitute, for convenience, as I have done previously in these reasons, the designations “Q” and “A”.

[23] At p. 61:

Q. How long have you known Linda Koch?

A. I moved into the building in April, 1st of April so I’ve known her since the 1st of April of this year.

Q. And how far is your apartment from hers?

A. On the right hand side of her apartment, I live directly next door

Q. Now, I understand that you have a son who has a disability?

A. Yes, I do.

Q. And you yourself have no medical or mental disabilities?

A. No.

Q. When Linda was living beside you how frequently would you have contact with Linda?

A, We see Linda once or twice a day at least.

Q. Would you have occasion to go into her apartment?

A. I have.

Q. Did you talk to Linda on a daily basis?

A. Yes.

[24] At p. 62:

Q. Were you able to carry on a conversation with Linda?

A. Many times.

Q. Can you give us your opinion in regard to Linda's mental capacity?

A. Linda is a very smart woman, Linda knows what's going on. You know, we have some good times together evenings watching movies and popcorn and so forth.

Q. For the period you've known Linda did you see any evidence of gross financial mismanagement?

A. No, I haven't.

Q. Now, if Linda does return to her apartment are you prepared to assist her in any way?

A. Sure, not a problem.

Q. What sort of assistance could you render?

A. I can make sure that everything is fine in the apartment with Linda, make sure she's eating properly...

Q. ...what type of health care givers are in the building?

A. It's supposed to be nursing aids as well as one R.N. on per shift.

[25] At p. 63 McShane was questioned by the Chair:

A. ...for people to come and see a person like Linda and sit and talk to her for an hour and say that she's not capable of managing her money, and her ex-husband, you know, sending this gentleman to do a job, I just have this thing... this thing to me is just ridiculous. Come and stay with this girl for a day and see what she does. I have two [children], a son and an eight year old. My seven year old has cerebral palsy, and I would not hesitate to have this woman look after my children, and my children aren't just left with anybody...

Q. ...

A. ...I'm sitting in the back of a room hearing people condemn somebody for, you know, because she gets flustered when she's nervous.

5. *Medical Reports*

[26] It will be recalled that the husband provided Higgins with copies of medical reports relating to the appellant.

[27] There is a report from Dr. M.A. Lovegrove, the appellant's former family physician, dated November 21, 1995, addressed to Dr. R. Paulseth (an expert, I was informed by counsel, in treating multiple sclerosis). It includes these passages:

I would like to refer Linda for reassessment of her Multiple Sclerosis (Chronic Progressive). Her mental functions have deteriorated. She lacks insight which has made it difficult to help Linda...

In 1993, Linda's competence was assessed during an admission to McMaster (Dr. A. Hildebrand) she was discharged as borderline competent...

[28] There is also a report by Dr. W.A. Fulton, Chief, Department of Psychology, Hamilton Civic Hospitals. It is dated February 9, 1993. The appellant had been referred to Dr. Fulton by Dr. Paulseth. I will set out some excerpts from Dr. Fulton's report:

Mrs. Koch was brought to the current examination by her husband Tony. Mr. Koch was interviewed individually, and was able to provide some important information regarding the couple's current predicament. It was Mr. Koch's perception that his wife had been deteriorating significantly with regard to her mental functions over the last number of months. He indicated that she had now become severely suspicious, mistrustful, and aggressive towards him... clearly there is a great deal of conflict and animosity within the home environment at the present time.

...Her thought processes were quite tangential and disconnected, and Mrs. Koch had a difficult time in reporting her current symptoms...

She described her mood as being very shaky and unstable, and appeared very anxious throughout the testing session. Mrs. Koch was fearful that she would have to "stay" in the hospital as a result of her performance on the test... At the time of the present testing session, it was clear that Mrs. Koch was having some difficulties in thinking and communicating clearly. Her reality contact seemed to be quite tenuous, and there was clearly a delusional quality to some of her thought processes...

Overall results of the current assessment show gross impairment in cognitive abilities, neuropsychological functions, and memory abilities with Mrs. Koch. She is also experiencing extreme psychological distress. It is suspected that she has deteriorated significantly over the last number of months...

Taken overall, it is evident that Mrs. Koch is experiencing severe deterioration and decline with regard to her mental abilities. Her overall intellectual skills (I.Q.) are profoundly impaired as are her neuropsychological and memory functions. Given this level of functional ability, it is clear that Mrs. Koch will need some assistance in managing her affairs within the home environment...

...There are markers of extreme conflict and distress within the marital relationship, and it is evident that Mrs. Koch is having extreme difficulties in coping with and adapting to her current situation...

...It is my view that there is an organic basis to Mrs. Koch's psychiatric symptoms. It is thought that these are associated with her diagnosis of MS...

...From a practical viewpoint, Mrs Koch is likely to need some significant input and assistance in order to be able to manage her personal affairs...

[29] Dr. Fulton concluded his report with three recommendations which are excerpted below:

1. It is therefore recommended that some steps be taken to provide Mrs. Koch with the assistance that she needs in managing both her activities of daily living and her personal affairs. She currently receives some in-house physiotherapy, and it is my understanding that there is a home-maker that comes in to clean the house. These activities should be continued, and whatever further support can be provided with regard to these basic activities is recommended for Mrs. Koch on a frequent basis.

2. ...Behavioral interventions directed towards increasing Mrs. Koch's functional levels within the home environment is suggested in light of her current functional levels.

3. *It is my view that there is an organic basis for Mrs, Koch's current psychiatric symptoms... It might be helpful to review her medications.*

(Emphasis added)

[30] A further medical report is found in the records of Welland County General Hospital (those records, at the request of the Chair, were marked as an exhibit at the consent and capacity hearing on July 22, 1996). The medical report is that of Dr. Venkatesh. It is dated December 9, 1995 and reads, in part, as follows:

Linda has had multiple sclerosis namely demyelinating lesion involving several parts of the neurological system *with remissions and relapses over the years...*

(Emphasis added)

IV. THE REASONS FOR THE BOARD'S DECISION

[31] It will be recalled that the Board consisted of one person. He issued reasons for decision, on behalf of the Board, consisting of slightly more than three pages. The material parts of his reasons would appear to be these:

Mr. Higgins indicated that the assessment took place in the Welland County General Hospital and that the Patient was pleasant and co-operative although she made it quite clear that she did not want anyone else managing her finances. The reason she gave Mr. Higgins was that she felt that she had nothing else left to her other than her financial independence as a result of... the multiple sclerosis. Mr. Higgins was of the view... that she had in fact been managing her available financial resources in an irresponsible manner in that she had incurred debts with Sears, Zehrs Stores and the Bay as well as one other account totalling some \$1,200. The patient had evidently done this even though she only receives a sum of about \$700 per month by way of provincial disability

benefits. It appears that she had also gone on a shopping expedition at the dollar stores and spent approximately \$200 on a number of items for which she had no apparent need but for which she subsequently explained as being articles that she thought she would have in order to regain custody of her child or make available to her child on visits.

Mrs. Talosi had seen the patient in her apartment which she found to be quite cluttered to the point that it might have been considered an unsafe environment for someone with the patient's disability. The patient appeared to Mrs. Talosi to have some difficulty with respect to recalling the date, time and month and exhibited definite symptoms of impaired cognitive functioning.

Mrs. Talosi indicates that the patient had difficulty remaining on topic in their discussions and would occasionally make an inappropriate comment or drift off topic into irrelevant matters. Mrs. Talosi also came to the conclusion that the patient was not capable of understanding and appreciating the risks and benefits which would be associated with her being placed in a long-term care facility.

At the hearing, the patient did indicate that she wished to continue to manage her own affairs and felt that she could continue to live on her own with some assistance from home care. The patient admitted that she was taking lithium and seemed to be aware that she was taking that medication as a result of having been diagnosed some time ago as suffering from a bi-polar affective disorder or manic depression. The patient could not explain the nature of that illness and in fact did need some prompting in recalling that lithium was the medication required to control it. The patient similarly seemed to have a somewhat unrealistic attitude to her multiple sclerosis in that she still seemed to be strongly of the opinion that she might experience a significant improvement in that illness. The patient also expressed the belief that she would like to have another daughter, would like to buy a car and also acknowledged that she gets very down at times and always feels some degree of depression.

The patient could not clearly recollect whether the money she was receiving by way of disability originated from the federal government or the provincial government and could not recollect how she had come to get that pension other than that her husband Tony had arranged it.

The patient had no clear idea what her monthly expenses for food, clothing and other items might be other than that she did know that her rent was approximately \$325.00 per month.

It was obvious from the evidence and the patient's own evidence that the patient did not fully comprehend the financial resources available to her and had only a very imperfect knowledge of what expenses she could afford based on that income. It was quite obvious that the patient had little or any capacity to budget.

When asked about the possibility of any proceedings through Family Court with respect to her marriage, the patient was not able to give any answer which would demonstrate a clear understanding of the various remedies available to her or what her domestic situation is.

On all of the evidence, I am satisfied that the patient would not be able to adequately appreciate the consequences of making expenditures on her limited income and is therefore incapable of managing her finances.

It is also clear that the patient's insight into both of her disorders... is impaired. The patient... could not describe in a meaningful way the nature of [her multiple sclerosis] without prompting and clearly had no appreciation for the fact that it is unfortunately a progressive illness. The patient appears to be quite unrealistic in assessing her current needs, let alone her ongoing needs and the fact that she requires daily assistance with a great many of her activities of daily living. The patient similarly does not seem to be able to appreciate the safety risks which would be a consequence of her continuing to live largely on her own...

V. LEGISLATION

[32] This appeal involves the application of a number of provisions from two recently enacted pieces of legislation. For convenience, I will set out here the various sections which I reviewed.

1. *Substitute Decisions Act, 1992*

1(1) In this Act,

...

“assessor” means a member of a class of persons who are designated by the regulations as being qualified to do assessments of capacity;

“capable” means mentally capable, and “capacity” has a corresponding meaning;

...

“incapable” means mentally incapable, and “incapacity” has a corresponding meaning;

...

2(1) A person who is eighteen years of age or more is presumed to be capable of entering into a contract.

(2) A person who is sixteen years of age or more is presumed to be capable of giving or refusing consent in connection with his or her own personal care.

(3) A person is entitled to rely upon the presumption of capacity with respect to another person unless he or she has reasonable grounds to believe that the other person is incapable of entering into the contract or of giving or refusing consent, as the case may be.

...

6. A person is incapable of managing property if the person is not able to understand information that is relevant to making a decision in the management of his or her property, or is not able to appreciate the reasonably foreseeable consequences of a decision or lack of decision.

...

6(1) A person may request an assessor to perform an assessment of another person's capacity or of the person's own capacity for the purpose of determining whether the Public Guardian and Trustee should become the statutory guardian of property under this section.

(2) No assessment shall be performed unless the request is in the prescribed form and, if the request is made in respect of another person, the request states that,

(a) the person requesting the assessment has reason to believe that the other person may be incapable of managing property;

(b) the person requesting the assessment has made reasonable inquiries and has no knowledge of the existence of any attorney under a continuing power of attorney that gives the attorney authority over all of the other person's property; and

(c) the person requesting the assessment has made reasonable inquiries and has no knowledge of any spouse, partner or relative of the other person who intends to make an application under section 22 for the appointment of a guardian of property for the other person.

(3) The assessor may issue a certificate of incapacity in the prescribed form if he or she finds that the person is incapable of managing property.

(4) The assessor shall ensure that copies of the certificate of incapacity are promptly given to the incapable person and to the Public Guardian and Trustee.

(5) As soon as he or she receives the copy of the certificate, the Public Guardian and Trustee is the person's statutory guardian of property.

(6) After becoming a person's statutory guardian of property under subsection (5), the Public Guardian and Trustee shall ensure that the person is informed, in a manner that the Public Guardian and Trustee considers appropriate, that,

(a) the Public Guardian and Trustee has become the person's statutory guardian of property; and

(b) the person is entitled to apply to the Consent and Capacity Board for a review of the assessor's finding that the person is incapable of managing property.

20. A statutory guardianship of property for a person is terminated if any of the following events occur:

...

4. In the case of a statutory guardianship created under section 16,

...

(iii) an appeal from a decision of the Consent and Capacity Board on an application under section 20.2 is finally disposed of, if an appeal is taken and it is finally determined that the person is capable of managing property.

...

20.2(1) A person who has a statutory guardian of property may apply to the Consent and Capacity Board for a review of a finding that the person is incapable of managing property...

(2) A person may not make an application under this section if he or she made an application under this section in the previous six months.

(3) An application under this section must be made within six months after the finding of incapacity was made.

(4) The parties to the application are:

1. The applicant.
2. The assessor or physician who made the finding of incapacity.
3. Any other person whom the Board specifies.

(5) The Board may confirm the finding of incapacity or may determine that the person is capable of managing property, and in doing so may substitute its opinion for that of the assessor or physician.

(6) Sections 73 to 80 of the *Health Care Consent Act, 1996* apply with necessary modifications to an application under this section.

...

78(1) An assessor shall not perform an assessment of a person's capacity if the person refuses to be assessed.

(2) Before performing an assessment of capacity, the assessor shall explain to the person to be assessed,

- (a) the purpose of the assessment;
- (b) the significance and effect of a finding of capacity or incapacity; and
- (c) the person's right to refuse to be assessed.

[33] 2. Health Care Consent Act, 1996

2(1) In this Act,

...

"Board" means the Consent and Capacity Board;

"capable" means mentally capable, and "capacity" has a corresponding meaning;

...

"evaluator" means, in the circumstances prescribed by the regulations, a person described in clause (a), (l), (m), (o), (p) or (q) of the definition of "health practitioner" in this subsection or a member of a category of persons prescribed by the regulations as evaluators;

...

"incapable" means mentally incapable, and "incapacity" has a corresponding meaning;

...

"personal assistance service" means assistance with or supervision of hygiene, washing, dressing, grooming, eating, drinking, elimination, ambulation, positioning or any other routine activity of living, and includes a group of personal assistance services or a plan setting out personal assistance services to be provided to a person...

...

4(1) A person is capable with respect to a treatment, admission to a care facility or a personal assistance service if the person is able to understand the information that is relevant to making a decision about the treatment, admission or personal assistance service, as the case may be, and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision.

(2) A person is presumed to be capable with respect to treatment, admission to a care facility and personal assistance services.

(3) A person is entitled to rely on the presumption of capacity with respect to another person unless he or she has reasonable grounds to believe that the other person is incapable with respect to the treatment, the admission or the personal assistance service, as the case may be.

...

42(1) A person who gives or refuses consent on an incapable person's behalf to his or her admission to a care facility shall do so in accordance with the following principles:

1. If the person knows of a wish applicable to the circumstances that the incapable person expressed while capable and after attaining 16 years of age, the person shall give or refuse consent in accordance with the wish.

2. If the person does not know of a wish applicable to the circumstances that the incapable person expressed while capable and after attaining 16 years of age, or if it is impossible to comply with the wish, the person shall act in the incapable person's best interests.

(2) In deciding what the incapable person's best interests are, the person who gives or refuses consent on his or her behalf shall take into consideration,

(a) the values and beliefs that the person knows the incapable person held when capable and believes he or she would still act on if capable;

(b) any wishes expressed by the incapable person with respect to admission to a care facility that are not required to be followed under paragraph 1 of subsection (1); and

(c) the following factors:

1. Whether admission to the care facility is likely to,

i. improve the quality of the incapable person's life,

ii. prevent the quality of the incapable person's life from deteriorating, or

iii. reduce the extent to which, or the rate at which, the quality of the incapable person's life is likely to deteriorate.

2. Whether the quality of the incapable person's life is likely to improve, remain the same or deteriorate without admission to the care facility.

3. Whether the benefit the incapable person is expected to obtain from admission to the care facility outweighs the risk of negative consequences to him or her.

4. Whether a course of action that is less restrictive than admission to the care facility is available and is appropriate in the circumstances.

...

50(1) A person may apply to the Board for a review of an evaluator's finding that he or she is incapable with respect to his or her admission to a care facility.

...

(3) The parties to the application are;

1. The person applying for the review.
2. The evaluator.
3. The person responsible for authorizing admissions to the care facility.
4. Any other person whom the Board specifies.

...

59(1) A person who makes a decision on an incapable recipient's behalf concerning a personal assistance service shall do so in accordance with the following principles:

1. If the person knows of a wish applicable to the circumstances that the recipient expressed while capable and after attaining 16 years of age, the person shall make the decision in accordance with the wish.
2. If the person does not know of a wish applicable to the circumstances that the recipient expressed while capable and after attaining 16 years of age, or if it is impossible to comply with the wish, the person shall act in the recipient's best interests.

(2) In deciding what the recipient's best interests are, the person shall take into consideration,

(a) the values and beliefs that the person knows the recipient held when capable and believes he or she would still act on if capable;

(b) any wishes expressed by the recipient with respect to the personal assistance service that are not required to be followed under paragraph 1 of subsection (1); and

(c) the following factors:

1. Whether the personal assistance service is likely to,
 - i. improve the quality of the recipient's life,
 - ii. prevent the quality of the recipient's life from deteriorating, or
 - iii. reduce the extent to which, or the rate at which, the quality of the recipient's life is likely to deteriorate.
2. Whether the quality of the recipient's life is likely to improve, remain the same or deteriorate without the personal assistance service.
3. Whether the benefit the recipient is expected to obtain from the personal assistance service outweighs the risk of harm to him or her.
4. Whether a less restrictive or less intrusive personal assistance service would be as beneficial as the personal assistance service that is the subject of the decision.

5. Whether the personal assistance service fosters the recipient's independence.

...

80(1) A party to a proceeding before the Board may appeal the Board's decision to the Ontario Court (General Division) on a question of law or fact or both.

...

(9) The court shall hear the appeal on the record, including the transcript, but may receive new or additional evidence as it considers just.

(10) On the appeal, the court may,

(a) exercise all the powers of the Board;

(b) substitute its opinion for that of a health practitioner, an evaluator, a substitute decision-maker or the Board;

(c) refer the matter back to the Board, with directions, for rehearing in whole or in part.

VI. ANALYSIS OF THE EVIDENCE

1. Talosi

[34] As an "evaluator" under the *HCCA*, Talosi was required to determine whether the appellant had the capacity defined in s. 4(1). That capacity is a cognitive capacity. It involves the functions of understanding and appreciation as they relate to admission to a care facility. In ascertaining if the appellant has the capacity to consent to placement in, or admission to, a care facility, Talosi must evaluate whether the appellant is able to *understand* the information that is relevant to make such a decision and is able to *appreciate* the reasonably foreseeable consequences of such a decision (or lack of decision).

[35] The problems with the evidence of Talosi appear from the outset. It is entirely unclear how it came about that she telephoned the appellant on May 30, 1996 for the purpose of arranging a s. 4(1) evaluation. In her evidence at the consent and capacity hearing, she stated, "I'm not sure who requested that it be done." So, what we have is Talosi about to embark on a procedure that may have the effect of stripping the appellant of some fundamental legal rights and Talosi does not know "who requested that it be done". It was incumbent on Talosi to keep meticulous notes of her *entire* involvement in this matter. The reason for this is so obvious that further comment is not needed.

[36] There is no evidence that, when she telephoned the appellant on May 30, 1996, she explained the purpose of the interview she sought to arrange. Did she inform the appellant that the interview might result in the appellant being taken from her apartment and housed in a nursing home? There should have been notes of precisely what was said on May 30, 1996.

[37] I gather that there are two aspects to the events of June 4, 1996 upon which Talosi relies in support of her evaluation: since the appellant was found waiting for a bus, the appointment must have been forgotten; and, the appellant appears to have been still waiting for the bus beyond its scheduled time of arrival. All of this is proffered as evidence of impaired cognitive

functioning. Although I accept the evidence of Talosi as to what occurred on June 4, 1996, I reject its suggested implications. One forgotten appointment and one instance of confusion over a bus hardly support a finding of mental incapacity. If Talosi seriously wished to rely upon these events in support of her evaluation then she was required to do more. With respect to the missed appointment, she should have probed the appellant and given her an opportunity to explain. The explanation might have been logical. As for the confusion over the bus, Talosi could have, for example, discreetly spoken to the janitor (who was in the hallway) or perhaps others in the building to learn if the appellant was in the habit of waiting for buses that had already come and gone. In other words, before automatically drawing an adverse inference from a fact, Talosi should have sought independent verification. Probe and verify—two elementary requirements of reliable fact-gathering.

[38] The evidence is unsatisfactory as to whether Talosi made clear to the appellant the full implications of the June 7, 1996 interview. Certainly her notes do not contain any reference regarding what was said to the appellant. She gave the following evidence in response to questioning by the Chair (Transcript, p. 33, line 18):

Q. ...did she understand what the placement coordination service was?

A. I explained it to her. Explained and talked to her about what it meant.

Q. Did you feel she understood what the significance of it was?

A. We talked about it in length about different places, and the thing was trying to find something that would be appropriate to her.

[39] I cannot help but notice that Talosi did not answer the Chair's question. She was asked whether the appellant *understood* "what the placement coordination service was". The fact that Talosi and the appellant "talked about it in length" is not responsive to the question. I do not wish to be seen as flippant, but the appellant would be justified in suggesting that perhaps Talosi was trying to avoid answering a "difficult or displeasing question," an allegation, it will soon be seen, which was made by Talosi about the appellant. In any event, Talosi should have been in a position to indicate precisely the nature of the explanation she gave to the appellant regarding the purpose of the interview as well as the appellant's response. In the result, Talosi has wholly disabled this court from making a finding that the appellant fully understood the purpose and implications of the June 7, 1996 interview.

[40] Of greater concern is the failure of Talosi to inform the appellant that she had the right to *refuse* to be interviewed and evaluated.

[41] Furthermore, the appellant, in my view, had the right to have her lawyer present during the interview and the interview should not have proceeded in the absence of a clear and unequivocal waiver of that right.

[42] On June 7, 1996, the appellant's apartment was found to be "Very cluttered, disorganized, food in all rooms". These facts appear to have figured prominently in Talosi's evaluation. They were contained in her notes and they were included in her testimony before the Board. Although I have great difficulty in elevating an untidy apartment to the point where it is an indicium of mental incapacity, in fairness, before so concluding, Talosi should have given the

appellant an opportunity to explain the state of the premises. A perfectly logical explanation might have been forthcoming. At the hearing on July 22, 1996, the appellant, in my view, gave such an explanation in the course of a response to questions from her counsel (Transcript, p. 46, line 24):

Q. Now, we've heard some discussion about your apartment being cluttered.

A. It's worse than that.

Q. So, it was worse than that...

A. Well, you can't do much from a wheelchair, your legs don't walk. I wash my own dishes, do my laundry. I'm very embarrassed, okay?

[43] Talosi stated that the appellant "changed thoughts quickly" especially when asked "difficult or unpleasing questions". All members of the Bench have witnessed this phenomenon in counsel and it would be only the most uncharitable of judges who would attribute such evasiveness to mental incapacity.

[44] There was evidence that, at one point in the interview of June 7, 1996, the appellant "pulled a bra from out of a bag and she couldn't put that on, so I had to help her". Talosi appears to regard this as a significant event on the road to a finding of incapacity. However, we will never know whether it is significant. Why? Because Talosi never probed. She never afforded the appellant the opportunity to explain the bra incident. The explanation might have been entirely logical. Perhaps the appellant, if she is physically unable to put on her bra, as appears to be the case, decided that morning to have her bra handy since she was expecting a female visitor whose assistance she could enlist. This is but one of many examples of Talosi injecting her own value judgments into the process; Talosi does not carry her bra in a bag and so anyone who does must be mentally incapacitated.

[45] Talosi recounted accusations made by the appellant regarding a man named Ron having stolen things and her husband having stolen her automobile and wanting to kill her, to name three. Talosi seems to have considered these stories (and the other accusations) as far-fetched. She did so without, again, probing the appellant as to particulars. It is obvious that Talosi assumed the appellant was delusional. There is no factual basis for that assumption.

[46] It was also stated by Talosi that the appellant sometimes would, when asked a question, "come up with an idea that was totally unrelated". The evidence is insufficient as to how often this occurred and in what context, and so I find that it is not terribly supportive of the existence of the incapacity defined in s. 4(1) of the *HCCA*. It would have been helpful to this court had Talosi probed the appellant as to her explanation for the "unrelated ideas". Perhaps, if the truth were known, some of them were not as unrelated as assumed.

[47] I cannot leave this area of my reasons without expressing my incredulity on the observation by Talosi that, in the course of the interview on June 7, 1996, the appellant appeared to take something, perhaps a cookie she speculated, from a bag and eat it. I am unaware of any authority, medical or legal, by which eating a cookie in one's premises places one at risk for a finding of mental incapacity.

[48] I consider it unnecessary to continue on in my analysis of Talosi's evidence. The pattern of my comments should be obvious. Virtually all of Talosi's observations are tainted by the same shortcomings: the failure to probe, and, in some cases, verify.

[49] Counsel for Talosi makes a submission that would normally be persuasive—that, although no single observation by Talosi may be sufficient in itself to warrant a finding of incapacity, taken together they do. I have no hesitation in concluding that, in the circumstances of this case, the individual observations of Talosi do not gain strength by accumulation.

[50] Finally, I mention one feature of this case which, to my mind, is remarkable, if not frightening. I put to counsel for Talosi the question of whether it was fair to judge the mental capacity of the appellant by resorting to such a brief snapshot in time (the interview on June 7, 1996 lasted 90 minutes) and whether there should have been interviews with friends and neighbours and follow-up interviews with the appellant, before a finding of incapacity was made. I was told that these evaluations usually consist of only one interview with the subject and it customarily lasts a mere 30 minutes. As well, evaluators (and, I gather, assessors) are not paid by the hour but by the interview.

[51] Accordingly, I hold that the evaluator's conclusion of incapacity is not supported by the facts. A finding of mental incapacity must withstand the test of objective scrutiny. That test was failed in the case at bar.

2. *Higgins*

[52] Higgins is Talosi's counterpart under the *SDA*. He is an "assessor". His involvement in this matter consisted of one interview with the appellant and one with her husband. We do not know the length of either. He has five pages of notes of his interview with the appellant and no notes of his interview with the husband. I take it as safe to assume that the time he devoted to his task was no greater than that spent by Talosi.

[53] I find disquieting the manner in which Higgins entered the picture. His investigation was precipitated by a complaint from the husband as to the appellant's spending habits. An assessor should be alive to the presence of improper motives of those who seek to have another found to be without mental capacity. Here we have an estranged husband making the complaint. This fact should have prompted a series of obvious questions: How long had they been separated? Had legal proceedings been commenced and, if so, what was the status of those proceedings? Did the parties have lawyers? If so, who? Was the husband's lawyer aware that this complaint was being made? The following testimony by Higgins, when questioned by the appellant's lawyer, is telling (Transcript, p. 9, line 8):

Q. Did you talk to her lawyer before you made the appointment to see her?

A. No, I didn't know at that point. I didn't know that Linda had a lawyer at that point.

Q. Do you not think the lawyer would have some input to give you in regard to her capacity, in regard, in regard to property and legal matters? It's just common sense, isn't it?

A. Yes, had I known.

[54] With the knowledge that the parties had lawyers, Higgins should have notified the lawyers about the complaint. He was about to embark on a course of action that might have a significant impact on the parties' matrimonial litigation, if such had been instituted, or on the matrimonial negotiations which were underway, if litigation had not yet been commenced. The appellant had the right to have her lawyer present during the interview and the interview should not have proceeded in the absence of a clear and unequivocal waiver of that right.

[55] There is unsatisfactory evidence that Higgins advised the appellant the interview might result in the loss of her right to manage her property. In his hand-written notes this passage appears on p. 1:

I explained the purpose of my visit to Mrs. Koch, namely that I had been asked to see her for the purpose of determining if she was capable of managing her financial affairs.

[56] Under the circumstances, I find that the above statement by Higgins does not go far enough.

[57] The evidence reveals that, broadly speaking, there are two bases for the conclusion reached by Higgins: the appellant's spending habits; and the medical reports of Dr. Lovegrove and Dr. Fulton. I will deal briefly with each.

[58] I confess that I do not find anything terribly atypical in the appellant's spending habits. For example, anyone with experience in reading or preparing the financial statements which are a part of matrimonial litigation would not, in my view, be alarmed by the particulars of the appellant's finances. To his credit, Higgins did probe the appellant's admitted spending habits. In seeking an explanation for this spending, the appellant informed him that "it made her feel better". If running up \$1,200 in credit card debts will make a 37-year-old woman with multiple sclerosis, who is living in a small apartment rather than the \$180,000 matrimonial home and is separated from her husband and young daughter, feel better, then an argument can be made that the money is well spent. And is it really frivolous to spend \$200 on a portrait? In any event, it must be remembered that the appellant has the right to spend her money foolishly if she desires. The right to be foolish is an incident of living in a free and democratic society. The problem here is that Higgins is being influenced by his personal beliefs and value judgments in arriving at his conclusions in respect of the appellant's handling of her finances. This court cares not a whit about the personal beliefs and values of assessors or evaluators. Such subjective matters are anathema to the assessment and evaluation process.

[59] In considering the spending habits of the appellant, it is worthwhile noting that her husband earns \$70,000 to \$80,000 annually and so the appellant may have reason, ultimately, to anticipate an award of spousal support. On top of that, it would be reasonable for her to expect a net equalization payment even if the only property involved is the matrimonial home. In the light of such anticipated benefits, are the appellant's spending habits truly irresponsible? If Higgins had spoken with the appellant's lawyer, as, in my view, he should have, he would have learned of the range of relief that the appellant could reasonably expect in a matrimonial proceeding or settlement.

[60] As for the two medical reports, I have dealt with them below at Part VI(5). of these reasons and I will not repeat myself here.

[61] In my opinion, there was no objective basis for the conclusion by Higgins that the appellant was mentally incapacitated.

3. *Collins*

[62] It was the task of Collins to review certain reports and documents and identify the existence of eligibility criteria to support placement of the appellant in a nursing home. She was able to identify only one criterion: the appellant requires assistance with the activities of daily living. Thus, the evidence of Collins does not support a finding of mental incapacity.

4. *McShane*

[63] In some respects, the most helpful witness for the court is McShane. She had far more contact with the appellant than did Talosi or Higgins; her contact was more recent than that of Dr. Lovegrove and Dr. Fulton; and, her contact was in a more natural setting than the stress of a short interview intended to deprive the appellant of her liberty.

[64] McShane's evidence is not to be discounted merely because she is a lay person. Lay witnesses are competent to testify as to testamentary capacity and, when the opportunity to observe exists, they are able to give opinion evidence on the issue of insanity. Consequently, I find that lay evidence is admissible on the issue of incapacity under the *HCCA* and the *SDA*.

[65] I would have preferred more evidence from McShane. However, what I have is relevant, helpful and contrary to a finding of incapacity.

5. *Medical Reports*

[66] Initially, the reports of Dr. Lovegrove and Dr. Fulton caused me considerable concern. I saw them as an obstacle, the only obstacle, to the success of this appeal. Upon further study, I have come to a contrary view.

[67] To begin with, the report of Dr. Fulton is dated February 9, 1993. In other words, it predates the consent and capacity hearing by over three years. When one considers that, in his report of December 9, 1995, Dr. Venkatesh, describes the appellant's multiple sclerosis as being marked by "remissions and relapses over the years", I do not consider it safe to assume that Dr. Fulton's findings are appropriate to the appellant's condition as it existed on July 22, 1996. It is the appellant's mental capacity on that date that is the issue and not her capacity three years before or eight months later (the latter being the date of this appeal).

[68] Furthermore, as I read Dr. Fulton's report, it speaks of the appellant's mental problems having an organic basis for which medication might provide relief. We know that the appellant is now taking lithium and it may be that this fact would alter the 1993 findings of Dr. Fulton.

[69] There being a presumption of capacity, mandated by both the *HCCA* and the *SDA*, I do not think that I should allow that presumption to be rebutted by a stale-dated medical report.

[70] As for the report of Dr. Lovegrove, it refers to a 1993 admission to McMaster which would make the diagnosis on discharge subject to the same flaw as the report of Dr. Fulton. In the opening lines of his report, Dr. Lovegrove states that the appellant “lacks insight which has made it difficult to help Linda”. Without more particulars, I am unable to accept that opinion as supportive of a finding of mental incapacity.

VII. ANALYSIS OF THE REASONS FOR THE BOARD’S DECISION

[71] In the light of my comments and findings in respect of the evidence adduced at the consent and capacity hearing on July 22, 1996, it is obvious that the decision of the Board cannot stand. Nonetheless, I would like to address several aspects of the Board’s reasons for decision:

[72] 1. The Board found that, due to the clutter in the appellant’s apartment Talosi was of the view “that it might have been considered an unsafe environment for someone with the patient’s disability”. That may not be an accurate recounting of the evidence. In her testimony, Talosi stated, “the pathway for the wheelchair was very limited” (Transcript, p. 24, line 27). Since Talosi never elaborated on this statement, I do not think that one can necessarily leap from “very limited” to “unsafe”.

[73] 2. The Board held that Talosi “came to the conclusion that the patient was not capable of understanding and appreciating the... benefits which would be associated with her being placed in a long-term care facility [and] the safety risks which would be a consequence of her continuing to live largely on her own”. However, on my understanding of the evidence, Talosi did not put any questions to the appellant which would permit such a conclusion: she never ascertained why the appellant was opposed to a nursing home; and, she never asked the appellant whether she (the appellant) considered that there were any benefits to being moved to a long-term care facility or whether she could identify any risks involved in remaining in her apartment. Therefore, Talosi has failed to prove this important aspect of mental incapacity.

[74] 3. It was the conclusion of the Board that the appellant “could not explain the nature of [her bi-polar affective disorder] and did need some prompting in recalling that lithium was the medication required to control it”. At p. 50, line 26 of the transcript, the Chair asked the appellant:

Q. ...I guess it was December of '95 that one of the diagnoses one of the doctors made was bi-polar affective disorder.

A. What’s that?

[75] It was then explained to the appellant that another name for bipolar affective disorder is manic depression. There is no evidence that the appellant was ever told, in any meaningful way, that she suffered from bi-polar affective disorder. It is more likely that, perhaps having been told initially, the illness was thereafter referred to by its colloquial title—manic depression. Regarding the medication, at p. 50, line 19 of the transcript, the Chair asked:

Q. ...I noticed [in your hospital chart] that one of the medications that you’re taking is a medication called lithium carbonate.

A. I’m not the doctor.

[76] I am not convinced that this response betrays the existence of any incapacity. However, if knowledge of her medication is of significance, the following exchange from p. 49, line 27 of the transcript should be noted, where the Chair asked:

Q. ...can you tell me how it is you came into hospital [June 7th, 1996]?

A. My bladder wasn't working properly. No control of my bladder.

Q. Okay So...

A. So, I had a catheter put in, oral premarone. I'm taking the oral premarone...

Q. I take it that's an ongoing problem?

A. Yes it is unfortunately.

[77] This answer was never shown to be inaccurate.

[78] 4. The Board found that the appellant "expressed the belief that she would like to have another daughter". My reading of the transcript does not support such a statement. At p. 47, line 20, there is the following exchange with her counsel:

Q. ...

A. ...Do you know what my little girl said to me, "Mommy, could you make me another baby, can you have a little girl so I get a baby sister" and I said, "Your daddy and mommy don't live together anymore, it's kind of hard."

[79] 5. The Board also found that the appellant "would like to buy a car". Presumably this stems from the appellant's exchange with Higgins at p. 48, line 13, of the transcript:

Q. That was one of your plans when we spoke about your plans that you'd like to buy a car?

A. Yeah.

[80] However, in fairness to the appellant, perhaps the above passage should be read in the context of an answer that she gave to her counsel less than one page earlier in the transcript, at p. 47, line 15:

Q. ...So, you have some plans for the future and what you would like to do?

A. They're dreams.

[81] The appellant should be entitled to her dreams without incurring the risk of being labelled delusional.

[82] 6. The Board found that the appellant "had no clear idea what her monthly expenses for food, clothing and other items might be". On my perusal of the transcript, at pp. 56-57, I do not find that such a conclusion is warranted.

[83] 7. With respect to the appellant's separation, the Board stated that the appellant "was not able to give any answer which would demonstrate a clear understanding of the various remedies available to her". I respectfully disagree. The appellant was questioned by the Chair at p. 59, line 15 of the transcript:

Q. At the beginning [your counsel] mentioned in some of his questions that you were pursuing some legal remedies against your husband?

A. Say that again, please.

Q. You were following up some legal remedies against your husband?

A. Remedies?

Q. Yes, you were going to court with your husband?

A. Not me. Tony wants a divorce. I filed for separation, is that what you mean?

Q. What is it that you think the court might be able to do for you?

A. Nothing. All on paper and Tony won't sign the papers.

[84] It is not surprising that the appellant would fail to understand the term "remedies". It is a touch stilted for day-to-day discourse with matrimonial clients. Otherwise, she is accurate in her answers: she is not going to court; she is not asking anything of a court; and, a separation agreement was sent to her husband and he refuses to sign.

[85] 8. The Board held that the appellant "seemed to have a somewhat unrealistic attitude to her multiple sclerosis in that she still seemed to be strongly of the opinion that she might experience a significant improvement in that illness". That is not how I read the evidence. At p. 45, line 17, of the transcript, in answer to a question by her lawyer she stated:

A. Well, the M.S. is very bad...

[86] And at p. 48, line 4, in answer to another question from her lawyer:

A. Yes, I do know that M.S. there's no cure, and I'm holding on pretty good though.

[87] 9. The Board observed that "the patient appeared to Mrs. Talosi to have some difficulty with respect to recalling the date, time and month". I disagree. Talosi's notes read, "she correctly stated the date, year and time. She did not state the month correctly."

VIII. SUMMARY OF FINDINGS

[88] From what I am able to determine, this appeal does not involve any dispute over material facts. I accept, as truthful, the evidence of the witnesses as to their factual description of events and conversations. The problem lies in the conclusions drawn by Talosi, Higgins and the Board from those events and conversations. I find that each erred in law in their conclusions as they relate to the mental incapacity of the appellant.

[89] For convenience, I will now summarize the comments and findings made, explicitly or implicitly, above:

1. The mechanisms of the *SDA* and the *HCCA* are, as I stated at the outset, formidable. They can result in the loss of liberty, including the loss of one's freedom to live where and how one chooses.

2. Their formidable nature becomes apparent if we compare the two statutes, on the one hand, and the criminal law, on the other hand. Under the criminal law, a not atypical chain of events would be this:

- (a) The police receive word of the commission of a crime. The word may come, for example, from an informant.
- (b) The police conduct an investigation which leads to the identification of the suspected perpetrator.
- (c) The police interview the suspected perpetrator.
- (d) The police charge the suspected perpetrator.
- (e) The suspected perpetrator (having had ample opportunity to retain and instruct counsel) stands trial on the charge and his guilt or innocence is determined by a judge or jury. If there is a finding of guilt, the suspected perpetrator becomes a convicted perpetrator and, depending on the sentence, *may* be deprived of his or her liberty or other rights.

Under the *SDA* and the *HCCA* a matter unfolds in this fashion:

- (f) The “authorities” (it never was made clear to me precisely how one triggers the operation of these statutes) receive word from someone (“informant” seems as good a word as any to describe this individual) regarding the possible incapacity of, for example, a family member.
- (g) An assessor/evaluator is appointed and interviews the family member and, concurrently, may make a finding of incapacity which *will* (not *may*) deprive the family member of his or her liberty and other rights.

The differences between the two procedures virtually leap from the page:

- (h) There is no investigation, as that term is commonly understood, carried out by the assessor/evaluator.
- (i) The assessor/evaluator takes on the role of police, judge and jury.
- (j) At no point does the family member have access to a lawyer.

Succinctly put, the consequences of the *SDA* and the *HCCA* are best understood if one envisions the interview by the assessor/evaluator as a trial—a trial for which the family member has no preparation and at which he or she sits alone at the counsel table.

3. Any procedure by which a person’s legal status can be altered (which is the *inevitable* result on a finding of mental incapacity) must be cloaked with appropriate safeguards and capable of withstanding rigorous review.

4. From the outset, the assessor/evaluator must maintain meticulous files.

5. The assessor/evaluator must be alive to an informant harbouring improper motives. Higgins should have done more than merely accept the complaint of the husband,

coupled with the medical reports (the shortcomings of which are chronicled above), before charging ahead with his interview of the appellant. Since the parties were separated and represented by lawyers, Higgins must have realized that matrimonial issues were in the process of being litigated or negotiated and that a finding of incapacity could have a significant impact on those procedures. He should have ensured that the husband's lawyer was aware of the complaint of incapacity. More importantly, Higgins should not have proceeded to interview the appellant without securing her waiver of notice to her lawyer.

6. The notes of Talosi and Higgins are silent as to whether the appellant was made aware of the *significance* and *effect* of a finding of incapacity (that is, the immediate loss of liberty and the freedom to live where and how she chose, in the case of Talosi's interview and the immediate loss of the freedom to manage her property and finances, in the case of Higgins' interview). This "warning" is a requirement of s. 78(2)(b) of the *SDA*. There should be clear and convincing evidence that this warning was given to the appellant. Had it not been possible for me to decide this appeal on other issues, I would have held that the failure to give a s. 78(2)(b) warning rendered the finding of incapacity by Higgins and Talosi a nullity. They have the burden of establishing that such a warning was given. They failed to do so at the consent and capacity hearing and on this appeal. Their failure is egregious. (Perhaps I should add that there does not appear to be a section in the *HCCA* comparable to s. 78(2)(b). Whether this is by design or not I do not know. Nonetheless, I hold that a similar warning must be given by Talosi as an evaluator under the *HCCA*.)

7. Talosi's notes do not show that she informed the appellant of the right to refuse to be interviewed (Higgins' notes indicate that he did). This "warning" is mandated by s. 78(2)(c) of the *SDA*. Had it not been possible for me to decide this appeal on other issues, I would have held that the failure to give a s. 78(2)(c) warning rendered the finding of incapacity by Talosi a nullity. Talosi has the burden of establishing that such a warning was given. She failed to do so at the consent and capacity hearing and on this appeal. Her failure is egregious. (Again, the *HCCA* does not have the equivalent of s. 78(2)(c). However, I hold that a similar warning must be given by an evaluator under the *HCCA*.)

8. The requirements of s. 78 of the *SDA* (which I find also apply to evaluations under the *HCCA*) represent, in my view, minimal requirements. For example, the appellant should have been advised that she had the right to have her lawyer (or a friend or relative) present during the interview.

9. In my view, it was not sufficient for Talosi and Higgins merely to record information provided by the appellant and then form an opinion. In some instances the appellant should have been probed to determine the thought process by which she arrived at an answer or statement. Until her thought process is known, it is neither fair nor reasonable to impugn the appellant's mental capacity. By not exploring the process by which the appellant arrived at her decisions, answers and statements, Talosi and Higgins have assumed, quite unfairly, the absence of logic. In doing so, they greatly impaired their ability to assess and evaluate the appellant's cognitive abilities. In addition, of course, they adulterated their credibility.

10. In some instances, verification should have been sought. For example, regarding the allegations made by the appellant against her husband (which Talosi seems to have dismissed as delusional) Talosi should have made some effort to verify their accuracy. At the very least, she might have spoken with the appellant's lawyer to ascertain whether he had any corroborative particulars.

11. Higgins did not establish whether the appellant was able to understand information that is relevant to making a decision in the management of her property. He (and the Board) assumed that she was not, but there is insufficient evidence to support such an assumption. Similarly, he did not establish whether the appellant was able to appreciate the reasonably foreseeable consequences of a decision or lack of decision. He (and the Board) assumed that she was not able, but the supporting evidence is lacking. The appellant may have fully appreciated the consequences and chose to shoulder the attendant risks. As a result, the requirements of s. 6 of the *SDA* have not been met,

12. Talosi did not establish whether the appellant was able to understand the information that is relevant to making a decision about admission to a care facility. She (and the Board) assumed an inability, but there is insufficient evidence to support such an assumption. As well, she did not establish whether the appellant was able to appreciate the reasonably foreseeable consequences of a decision or lack of decision. She (and the Board) assumed an inability, but the supporting evidence is lacking. The appellant may have fully appreciated the consequences and chose to accept the attendant risks. Accordingly, the requirements of s. 4(1) of the *HCCA* have not been met.

13. There is a distinction to be drawn between the appellant *failing* to understand and appreciate risks and consequences and being *unable* to understand and appreciate risks and consequences. It is only the latter that can lead to a finding of incapacity. Here, the evidence is lacking in this regard.

14. It is immaterial whether the appellant's words, deeds and choices appear reasonable to the assessor/evaluator. Reasonableness in the eyes of the assessor/evaluator (or the Board) is not the test. The assessor/evaluator (and the Board) are not to inject their personal values, judgments and priorities into the process.

15. Talosi and Higgins have confused their view of the *best interests* of the appellant with the state of the appellant's *cognitive capacity*. The former, no matter how well-intentioned, is irrelevant. I do not doubt the good intentions of Talosi and Higgins. However, history has shown that the road to injustice is frequently lit with the light of good intentions.

16. The test, under both statutes, for incapacity is an objective one.

17. It is mental capacity and not wisdom that is the subject of the *SDA* and the *HCCA*. The right knowingly to be foolish is not unimportant; the right to voluntarily assume risks is to be respected. The State has no business meddling with either. The dignity of the individual is at stake.

18. The relatively brief contact of Talosi and Higgins with the appellant does not afford either a unique or special position from which to assess mental capacity. Indeed, the observations of McShane are more relevant and reliable in the circumstances of this case.

19. Compelling evidence is required to override the presumption of capacity found in s. 2(2) of the *SDA* and s. 4(1) of the *HCCA*. The nature and degree of the alleged incapacity must be demonstrated to be sufficient to warrant depriving the appellant of her right to live as she chooses. Notwithstanding the presence of some degree of impairment, the question to be asked is whether the appellant has retained sufficient capacity to satisfy the statutes.

20. It is to be remembered that mental capacity *exists* if the appellant is able to carry out her decisions with the help of others. The appellant's apartment was located in a building that was operated under the auspices of the March Of

Dimes and, as such, she had access to a number of services and social supports that allowed her to function in that environment.

21. Before argument of the appeal commenced, counsel for the appellant indicated a wish to call the appellant to give *viva voce* evidence and counsel for Talosi and Higgins expressed a similar wish in relation to his clients. Reliance was placed on s. 80(9) of the *HCCA* which empowers this court to "receive new or additional evidence as it considers just" (and s. 20.2(6) of the *SDA* makes s. 80(9) applicable to the *SDA*). I do not consider it advisable to treat this appeal as, effectively, a continuation of the consent and capacity hearing. To adduce evidence from three witnesses who testified before the Board, for the apparent purpose of affording them the opportunity to improve on their evidence of July 22, 1996, would be an abuse of the appellate process. Allowing such testimony would create a real risk of turning the appeal into a trial *de novo*. The appellant's mental capacity today is not relevant. The function of this court is to ascertain whether that capacity existed on July 22, 1996.

IX. CONCLUSION

[90] For the above reasons, it is the finding of this court that the Board erred in its decision. The decision is set aside. The appeal is allowed. The appellant is capable of managing her property, in particular, her finances and she is capable of consenting to placement in, or admission to, a care facility. If costs are an issue, I may be spoken to.

Appeal allowed.