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DEVELOPING AN ANTI-AGEIST APPROACH WITHIN LAW

**Advancing Substantive Equality for Older Persons
through Law, Policy and Practice**

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I. Introduction

This paper suggests an approach to evaluating legislation through an anti-ageist “lens,” focusing on two areas that may be subject to legislation and that will tend to disproportionately affect older adults: substitute decision making and elder abuse and exploitation. The evaluative lens used asks the following general questions:

- Does the legislation reflect negative ageist stereotypes and/or paternalistic attitudes (explicitly or implicitly)? Is the policy or legislation based on the unarticulated premise that with age comes increasing incompetence and decreasing intellectual capacity?
- Are there sufficient mechanisms provided for by the legislation to prevent or protect against the legislation being implemented in an ageist manner (including the acting-out of individual ageism, given the prevalence of ageist attitudes)?
- Does the legislation respond appropriately to the real needs of older persons as a group (understanding that older adults are extremely diverse), recognising that older adults generally are situated differently from younger people and have different needs?

The principle of *human dignity* runs through all aspects of the evaluative lens. Recognising and giving effect to dignity requires both:

- respect for personal autonomy; and
- recognition of society’s obligation to provide support and assistance where needed, and effective mechanisms for carrying out that obligation.

These requirements may be coincidental, or may require a balance, depending on the specific situation or context. Both are essential, however, and neither can be entirely subsumed by the other. Legislation in Ontario, in the case of substitute decision making, and non-legislative approaches, in the case of elder abuse and exploitation, is discussed and evaluated with reference to the questions given above. Legislation across Canada dealing with substitute decision making and elder abuse and exploitation is then surveyed, and evaluated with reference to these questions. “Benchmark” legislation is then identified, and the Ontario approach is discussed in terms of its relationship to this benchmark.

The question of implementation, or how the law is actually carried out in practice, is extremely important in this context, and a fully developed anti-ageist evaluation must include an analysis of implementation. Social de-valuation of older adult’s autonomy, internalised by family members and health professionals, increases the importance of having structures in place to actively counter its effect. Older adults are, together with psychiatric patients (a group which may include older adults), disproportionately subject

to the *Substitute Decisions Act* and the *Health Care Consent Act*; older adults are more likely to be subject to care facility admission. A legal *scheme* (including mechanisms directed at implementation) that is sensitive to the real needs and situations of older adults will actively promote decision making rights.

A thorough review of implementation and the empirical research it would require is beyond the scope of this paper, however. Responses received from the Advocacy Centre for the Elderly and Ontario Bar Association during the consultation carried out for the Law Commission of Ontario project include several insightful comments regarding implementation of legislation in Ontario, and those are referred to here.

A. What is ageism?

Many of the most damaging or negative effects of the ageing process are a consequence of society's negative response to the ageing process. As the Supreme Court of Canada explained in *Granovsky v. Canada (Minister of Employment and Immigration)*, considering section 15 in the context of disability, "[e]xclusion and marginalization are generally not created by the individual with disabilities but are created by the economic and social environment and, unfortunately, by the state itself."¹ The court described the "concept" of disability as multilayered, accommodating within it actual physical and mental limitations; "true" functional limitations (where physical and mental limitations, which are not met through assistance or devices such as eyeglasses, give rise to individual functional limitations); and the "social handicap" resulting from the "exaggerated or unjustified consequences to whatever [true] functional limitations in fact exist," "the problematic response of society to that condition."² The *Granovsky* analysis, applied to the "concept" of age and ageing, unpacks the social idea of age (in and of itself) as limitation in the context of modern society, where the great majority of actual limitations associated with mere ageing have been or are capable of being met and do not, or need not, manifest as "true" functional disabilities.

Society's response to ageing includes both negative stereotypes about ageing and older adults (older adults are weak and unintelligent) and attitudes that dis-empower and infantilise older adults as objects to be "done to" rather than actors in control of their own lives. (older adults can't know what's best for them and other more competent persons must be entrusted with those decisions). Negative and paternalistic attitudes towards older persons include the following:³

- Older adults are inflexible, resistant to change and have difficulty learning new things;
- Older persons are chronically ill, dependent and no longer make a contribution to society;
- Older persons are a burden on their families and loved ones, as well as on society at large;
- Older persons are depressed, isolated and waiting to die;

- Older persons have declining capacity, are incapable of making responsible decisions and must be protected from themselves

The Ontario Bar Association described “ageism and negative stereotypes about the characteristics, capacities and contributions of older adults [as] pervasive and harmful... We need to make the same effort to eliminate age discrimination as we have made to promote multiculturalism, and to eliminate homophobia.”⁴

Ageist stereotypes and attitudes may be expressed on the personal level, influencing the way in which individuals relate to one another. Ageism can also find expression in social norms, rules and institutions, including the law. Institutional ageism can be overt and explicitly discriminatory, as with mandatory retirement policies (see discussion below under “Canadian Charter of Rights and Freedoms”). *Implicit* institutional ageism underlies the “tendency to structure society based on an assumption that everyone is young, thereby failing to respond appropriately to the real needs of older persons [by failing to] design systems and structures that are inclusive of older persons.”⁵ One consequence of institutional ageism is the invisibility of older adults in the law generally and in the law reform process.

Identification of the effects of implicit institutional ageism is consistent with the substantive (as opposed to formal) equality rights guaranteed by section 15 of the *Canadian Charter of Rights and Freedoms*;⁶ identical treatment can cause unequal outcomes where significant personal differences exist but are not recognised and provided for. Where a blind person cannot succeed at a written test, for example, or a person in a wheelchair cannot access a library, “the discrimination does not lie in the attribution of untrue characteristics to the disabled individual. The blind person cannot see and the person in a wheelchair needs a ramp.”⁷ Substantive inequality arises from a “construction of a society based solely on “mainstream” attributes.”⁸

It is a well-established principle of human rights law that systemic discrimination exists where a law, policy or program that is neutral on its face with respect to a prohibited ground of discrimination, in this case age, disproportionately impacts a protected group.⁹ Systemic discrimination may therefore be shown if the implementation of the legislation discussed below, or the effect of any specific provisions, has a disproportionately negative impact on older adults.

B. Developing an anti-ageist approach within the law

Developing an anti-ageist approach within the law requires developing and applying an “age-based lens” to evaluate the impact of the law on older adults, whether negative differential impact is intentional or not.¹⁰ An age-based lens includes the following questions:

- Does the legislation include or refer to, explicitly or implicitly, ageist stereotypes and/or paternalistic attitudes?

- Are there sufficient mechanisms provided for by the legislation to prevent or protect against the legislation being implemented in an ageist manner (including the acting-out of individual ageism, given the prevalence of ageist attitudes)?
- Does the legislation respond appropriately to the real needs of older persons as a group (understanding that older adults are extremely diverse), recognising that older adults generally are situated differently from younger people and have different needs?

Particular subject areas will also include additional, subject-specific questions.

While each of these points is essential to developing an anti-ageist approach within law, there may be a tension between recognising and responding to characteristics associated with older adults and avoiding negative stereotypes and attitudes. Not recognising difference is a form of formal equality that apparently negates ageism (“older adults are no different from, and therefore just as strong, capable, and valuable, as younger persons”). If significant differences do exist, however, formal equality is not realistic and creates unequal impact (and the identification of value with being “just like” younger people itself internalizes ageist attitudes).

The key to addressing that tension is the underlying characterisation of factors associated with the ageing process and with older adults as a group. The belief that ageing-related differences are necessarily negative is itself an expression of ageism; that any departure from the youthful paradigm is insulting, necessarily harmful and stigmatizing. Indeed, difference has often been interpreted in negative stereotypical terms. An age-based analysis must be careful to avoid replicating negative ageist attitudes.

This report looks at two areas of law that are of particular relevance to older adults - substitute decision making and elder abuse and exploitation - through an age-based lens. One of these, substitute decision-making, does not apply specifically to older adults as such but will disproportionately involve and impact older adults. Applying an age-based lens in this context means asking whether this age-neutral legislation takes account of the real differences and needs associated with ageing. Age responsive substitute decision-making legislation must include mechanisms to prevent or guard against ageism in implementation, for example, as the individuals giving effect to that legislation may be affected by ageism on the individual or the social level.

Unlike substitute decision making, elder abuse and exploitation is explicitly age-specific as an area of law or legal subject. Identification of elder abuse and exploitation as a distinct social problem is predicated on the understanding that older adults as a group are especially vulnerable to these kinds of harm and/or face special obstacles in seeking redress. Legislation that deals with elder abuse and exploitation in Canada, however, is *not* age specific: the *Criminal Code*, adult protection legislation, and domestic violence legislation may all provide a response to types of elder abuse and exploitation. Very few provisions within this legislation make reference to age. An age-based analysis of elder

abuse legislation will therefore need to consider whether the overall approach within the province (including all applicable legislation) is adequate and appropriate, taking into account and responding to the needs of older adults without replicating ageist stereotypes and attitudes.

II. Framing the Discussion: United Nations Principles and the National Framework on Ageing

Canada has adopted broad statements of principles and values that create a general framework for the treatment of older persons within and by the law. These statements of principle are not legally binding, but should inform and guide the development of law and policy in this area. The statements are also significant as formal recognition of the need to promote the rights and needs of older adults as a matter of social policy.

A. United Nations Principles for Older Persons and the Madrid Action Plan

The first United Nations World Assembly on Ageing was held in 1982. The United Nations Principles for Older Persons, adopted by the UN General Assembly in 1991,¹¹ were intended to provide guidelines regarding the entitlements of older persons. Signatory states were encouraged to incorporate those guidelines into national programmes, including legislation.

While Canada is the signatory to the United Nations Principles, policy and legislation affecting older adults is also developed at the provincial level. The Principles provide a practical and effective frame of reference for provinces seeking to develop an anti-ageist approach within legislation.

The Principles include:

- Independence;
- Participation;
- Care (including access to social and legal services to enhance their autonomy, protection and care and the ability to enjoy human rights and fundamental freedoms when residing in any shelter, care or treatment facility, including full respect for their dignity, beliefs, needs and privacy and for the right to make decisions about their care and the quality of their lives);
- Self-fulfillment; and
- Dignity (including the ability to live in dignity and security and be free of exploitation and physical or mental abuse).

No evaluation appears to have been carried out regarding the extent and degree to which the Principles have been incorporated into Canadian legislation and policy, unlike the UN Convention on the Rights of the Child.¹²

A second World Assembly on Ageing was held in Madrid in 2002. The Madrid International Plan of Action on Aging (MIPAA), endorsed by the General Assembly in 2002,¹³ included the following action matters:

- The full realization of all human rights and fundamental freedoms of all older persons;
- Empowerment of older persons to fully and effectively participate in the economic, political and social lives of their societies;
- Ensuring the full enjoyment of economic, social and cultural rights, and civil and political rights of persons and the elimination of all forms of violence and discrimination against older persons; and
- Provision of health care, support and social protection for older persons, including preventive and rehabilitative health care.

As a signatory to the MIPAA, Canada is committed to upholding the spirit and intent of the Plan of Action by integrating the rights and needs of older persons into national and international economic and social development policies.¹⁴

B. National Framework on Ageing

The United Nations Principles for Older Persons are mirrored in the principles and vision statement included in the National Framework on Ageing, an initiative of the Federal, Provincial and Territorial Ministers Responsible for Seniors (the Ministers).¹⁵

The Framework is voluntary, with a shared Vision Statement and five Principles at its core:

Vision

Canada, a society for all ages, promotes the well-being and contributions of older people in all aspects of life

Five Principles

Dignity, Independence, Participation, Fairness, Security

The purpose of the National Framework is to facilitate a common approach for monitoring and reviewing changes to seniors programs and services across jurisdictions, and to assist in examining the cumulative effects of policy changes on Canadian seniors.

1. National Framework on Ageing Principles: Commentary and Suggestions

In *A Time for Action: Advancing Human Rights for Older Ontarians*, a Report released in 2004, the Ontario Human Rights Commission recommended that “the five principles contained in the National Framework on Ageing be integrated into policies and programs of public and private sector organisations.”¹⁶ The Framework is also mirrored in the principles adopted by the Law Commission of Ontario to guide law reform in this area:

- Independence;
- Participation;
- Security;
- Dignity; and
- Respect for diversity.

In their response to the Law Commission’s Consultation, the Ontario Bar Association urged the Commission to consider adding two additional principles:

- the right to receive “care”- the right to access to health and institutional care, and to legal aid and social services; and
- the principle of respect for human rights and freedoms

The Advocacy Centre for the Elderly (ACE), in its response to the Law Commission Consultation, expressed concern about the use of the word “care” as it is “sometimes negatively equated with best interests.”¹⁷ The ACE response suggested that the desired objective could be achieved if the principles of security (expressed in the National Framework on Aging) was “strengthened... to include access to legal and social services, as well as legal definitions of program eligibility for health and community based long-term care services, such that a person who meets the eligibility criteria is entitled to fully participate in the program regardless of competition for scarce resources.”¹⁸ The principle of security is also consistent with the Canadian Charter of Rights and Freedoms.

III. Canadian Charter of Rights and Freedoms

The fundamental rights and freedoms of older adults in Canada are protected by the *Canadian Charter of Rights and Freedoms*. Unlike the principles and values discussed above, the *Charter* is law in Canada.

A. Section 1: Limiting *Charter* Rights

Charter rights are not absolute: section 1 states that the rights guaranteed by the Charter of Rights and Freedoms are “subject only to such limits as can be demonstrably justified in a free and democratic society.” The question of whether a law constitutes a reasonable limit on a Charter right requires the following considerations, or steps:¹⁹

- Are the objectives of the impugned law sufficiently important to warrant the limitation of the right?

- When the objective of the law is balanced against the nature of the right, is the degree to which the limitation furthers other rights or policies of importance in a free and democratic society proportionate to the extent of the limitation of the right?
- Is there a rational connection between the limitation of the right and the objective of the law?

Applying this analysis, discrimination on the basis of age (mandatory retirement policy) has been found to be justified under section 1 (see discussion below, “Section 15”). The appropriate balance between individual rights and social objectives under section 1 may shift, however, as the social context of attitudes, beliefs and values changes and develops. For this reason and in this way more recent case law has found that mandatory retirement is no longer “saved” by section 1, for example.

B. Section 32: Scope of Application

The Charter is also limited in scope of application, applying to the decisions and actions of government and government entities only.²⁰ The Charter does not apply to the actions of private entities (to which provincial human rights legislation applies).

The distinction between private and public entities is not always self-evident. A hospital, for example, may be a public or government entity with regards to certain kinds of decisions and actions, and a private actor with regards to other kinds of decisions or actions. Public actions and decisions must comply with the rights guaranteed by the Charter. Private actions and decisions are not subject to Charter review.

Two decisions of the Supreme Court of Canada concerning the equality rights guaranteed by section 15 illustrate this distinction. The issue in *Stoffman v. Vancouver General Hospital*²¹ was whether Vancouver General Hospital’s mandatory retirement policy violated the equality rights guaranteed by section 15 (discussed below) by discriminating on the basis of age. The Court concluded that the hospital’s retirement policy could not be subjected to a Charter review as the hospital was not a government entity. In the subsequent case of *Eldridge v. British Columbia*²² (also discussed below) the Supreme Court concluded that a hospital’s provision and delivery of medically necessary services *was* subject to Charter review. The issue in that case was whether the failure to provide interpretation services to deaf patients violated the patients’ equality rights guaranteed by section 15. Publicly provided health services were a “comprehensive social program” provided by the government;²³ the government had chosen to implement that program through the hospitals. When hospitals exercised their authority (conferred by legislation) to make decisions about service provision, they were acting as vehicles for implementation of that government program. The hospital’s retirement policy was, in contrast, an internal and “private” (as opposed to public) management matter.

Legislation must always be consistent with the *Charter*. In *McKinney v University of Guelph*²⁴ (discussed below) for example, the Supreme Court of Canada considered the

question of whether Ontario's *Human Rights Act* discriminated on the basis of age (in violation of section 15) by excluding persons over 65 in its provisions regarding employment discrimination. That case concerned a university's mandatory retirement policy; the Court concluded that the university was a private entity and so the *Charter* did not apply, although it went on to consider the section 15 issue regardless. The human rights legislation under consideration was discriminatory and therefore violated section 15, but was "saved" (see discussion below) by section 1 (that legislation has since been amended, and age is no longer excluded).

Even where a public body is not involved, as in cases concerning private nursing homes or care facilities, practices should be consistent with Charter values, on the basis that the Charter enshrines fundamental social values and generalised ideas of justice and fairness.

C. Section 33: The Notwithstanding Clause

Both Parliament and provincial legislatures have a limited power under section 33 to pass laws that are exempt from certain Charter provisions – those concerning fundamental freedoms and legal and equality rights. This section is sometimes referred to as the "notwithstanding clause".

In order to rely on this section, Parliament or a legislature must state specifically that a particular law is exempt from the Charter. It must also state which sections of the Charter do not apply. An exemption from the Charter lasts a maximum of five years. After that, if Parliament or the legislature concerned wishes it to continue to be exempt from the Charter, it must make a new declaration under this section.

The purpose of this section is to require a government that wishes to limit Charter rights to say clearly what it is doing and accept the political consequences of doing so.

It also ensures that Parliament and the legislatures, not the courts, have the final say on important matters of public policy. If, at a certain point, the rights in the Charter no longer reflect Canadian values, then democratically elected bodies like Parliament and the legislatures can make laws that are not bound by the Charter.

To date, provincial legislatures have used this section rarely. It has never been used by the federal Parliament.

D. *Charter Protected Rights and Freedoms*

The Charter provisions regarding equality (section 15), liberty and security of the person (section 7), and arbitrary detention (sections 10 and 12) are especially relevant to substitute decision making and responses to elder abuse and exploitation, the focus subject areas in this Report.

1. Section 15

The equality rights guaranteed by section 15 will be of obvious relevance to the development of anti-ageist legislation. It is important to note that discrimination is permitted where justified under section 1, and also where it is used as a factor in designing programs, activities or laws that are intended to ameliorate disadvantage (under subsection 2) as where benefits are conferred on individuals over the age of 65, for example.

Section 15 guarantees equal protection and benefit of the law without discrimination:

15. (1) Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability

(2) Subsection (1) does not preclude any law, program or activity that has as its object the amelioration of conditions of disadvantaged individuals or groups including those that are disadvantaged because of race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.

The grounds listed in section 15 are known as the “enumerated grounds.” The section has been interpreted as prohibiting (subject to section 1) discrimination on the basis of characteristics analogous to the enumerated grounds, in addition to the enumerated grounds themselves.

Age is an enumerated ground, but the Supreme Court of Canada has described age as different, in significant ways, from other enumerated grounds:

[U]nlike race, religion, or gender, age is not strongly associated with discrimination and arbitrary denial of privilege. This does not mean that examples of age discrimination do not exist. But age-based distinctions are a common and necessary way of ordering our society. They do not automatically evoke a context of pre-existing disadvantage suggesting discrimination and marginalization under this first contextual factor, in the way that other enumerated or analogous grounds might.... The fact that ‘[e]ach individual of any age has personally experienced all earlier ages and expects to experience the later ages’ (P. W. Hogg, *Constitutional Law of Canada* (loose-leaf ed.), vol. 2, at p. 52-54) operates against the arbitrary marginalization of people in a particular age group. Again, this does not mean that age is a “lesser” ground for s. 15 purposes. However, pre-existing disadvantage and historic patterns of discrimination against a particular group do form part of the contextual evaluation of whether a distinction is discriminatory.²⁵

a) **Discrimination**

Differential treatment on the basis of one of the enumerated or analogous grounds will not, in every instance, be discriminatory. The nature of discrimination was explained by the Supreme Court of Canada in the case of *Law v. Canada (Minister of Employment and Immigration)*:²⁶

[T]he purpose of section 15(1) is to prevent the violation of essential human dignity and freedom through the imposition of disadvantage, stereotyping, or political or social prejudice, and to promote a society in which all persons enjoy equal recognition at law as human beings or as members of Canadian society, equally capable and equally deserving of concern, respect, and consideration.... Human dignity ... is concerned with physical and psychological integrity and empowerment. Human dignity is harmed by unfair treatment based upon personal traits or circumstances which do not relate to individual needs, capacities, or merits. It is enhanced by laws which are sensitive to the needs, capacities, and merits of different individuals, taking into account the context underlying their differences. Human dignity is harmed when individuals and groups are marginalized, ignored or devalued, and is enhanced when laws recognize the full place of all individuals and groups within Canadian society. Human dignity... concerns the manner in which a person legitimately feels when confronted with a particular law. Does the law treat him or her unfairly, taking into account all of the circumstances regarding the individuals affected and excluded by the law?²⁷

Law involved a claim by a 35 year old widow that she had been discriminated against because she did not qualify for Canada Pension Plan survivor benefits available to persons 45 years or older. The Supreme Court held that this age based distinction was not discriminatory, and so did not violate section 15. Discrimination on the basis of age, where it existed, is most likely to affect “people of advanced age who are presumed to lack abilities that they may in fact possess.”²⁸

b) **Substantive equality**

The equality rights guaranteed by section 15 have been interpreted as substantive, rather than formal rights. This means that a law applying in a uniform way which, in implementation, has a disproportionately negative effect on “enumerated” classes of persons will be in violation of section 15. As explained by McIntyre J. in *Andrews v. Law Society of British Columbia*,²⁹ “accommodation of differences . . . is the true essence of equality”.

In *Eldridge v. British Columbia*,³⁰ for example, a group of deaf patients asserted that their equality rights were infringed by the failure of the BC Medicare system to ensure that sign language interpreters would be available during hospital visits and medical appointments. The policy was, on its face, an example of formal equality: everyone was treated in the same way, with the same access to medical services. However, by treating

the hearing impaired as if they were “the same as everyone else” and did not have particular requirements this formal equality had the effect of infringing the *substantive* equality of deaf patients; if a deaf patient is unable to communicate with a medical service provider, he or she does not have equal access to medical care.

c) Discrimination on the basis of age

Discrimination on the basis of age was considered by the Supreme Court of Canada in a number of decisions issued in 1990: *McKinney v. University of Guelph*,³¹ *Stoffman v. Vancouver General Hospital*,³² *Harrison v. University of British Columbia*,³³ *Douglas/Kwantlen Faculty Assn v. Douglas College*.³⁴ All concerned mandatory retirement policies. Although the Court concluded in each case that the entity in question was private, it went on to consider the section 15 issue. The most complete discussion can be found in *McKinney*.

Giving the majority decision in that case, Justice LaForest concluded that, while discrimination on the basis of age was clearly prohibited by section 15, age was qualitatively different from the other enumerated grounds:

...there is nothing inherent in most of the specified grounds of discrimination, e.g. race, colour, religion, national or ethnic origin, or sex that supports any general correlation between those characteristics and ability. But that is not the case with age. There is a general relationship between advancing age and declining ability... Racial and religious discrimination and the like are generally based on feelings of hostility or intolerance. The truth is, that while we must guard against laws having an unnecessary deleterious impact on the aged based on inaccurate assumptions about the effects of age on ability, there are often solid grounds for importing benefits on one age group over another in the development of broad social schemes and in allocating benefits.

Justice Wilson took a different approach to the question of discrimination. The mere fact of an age-based distinction did not establish prejudice but “compelled” the following questions:

Was there prejudice? Did the mandatory retirement policy reflect the stereotype of old age? Was an element of human dignity at issue? Were academics required to retire at age 65 on the unarticulated premise that with age comes increasing incompetence and decreasing intellectual capacity? The answer was clearly yes and section 15 was therefore infringed... Declining intellectual ability is a coat of many colours - what abilities, and for which tasks? The discrepancies between physical and intellectual abilities amongst different age groups may be more than compensated for by increased experience, wisdom, and skills.. Many an athlete is “washed up” by the age of 35... [h]owever many remain competitive well into their forties, while some younger athletes continue to strive for, but never attain, professional status.

The majority found that, although the policy was clearly discriminatory the limitation was “demonstrably justified in a free and democratic society” and therefore “saved” by section 1. Mandatory retirement was justified by its connection to the university system of employment generally and the tenure system in particular. Individuals working within that system had agreed to mandatory retirement as part of the employment bargain, getting return the significant advantages associated with an enriched working environment. Society generally also benefited from the system, which ensured both academic freedom and ensured that research remained fresh and “cutting edge” by regularly replacing older academics with younger ones (the other cases decided on this issue found the discrimination was justified under section 1 for similar reasons).

The majority also found that the exclusion of workers over the age of 65 from the protection of the Human Rights Code was, while discriminatory in effect (if not purpose), “saved” by section 1. Mandatory retirement was permitted, not required, by the legislation and served an important organizational function in the workplace

Mandatory retirement and section 15 were revisited by the Ontario Supreme Court in 2008 in *Association of Justices of the Peace in Ontario v. Ontario (Attorney General)*.³⁵ Crucially, the social context, including consciousness of ageism and its effects, had changed dramatically in the intervening years:

[I]n the sixteen years since the Supreme Court of Canada’s decision in *McKinney*, there has been a sea change in the attitude to mandatory retirement in Ontario, led by the efforts of the [Human Rights] Commission.... Ageism has been recognised by the Commission as an “insidious kind of discrimination having an impact on policies, programs, and legislation affecting large segments of society”.³⁶

Judicial interpretation of section 15 had also evolved during this period, and the threshold question of discrimination now had to be answered with reference to the analysis in *Law v. Canada (Minister of Employment and Immigration)*,³⁷ which explained discrimination as involving the violation of human dignity and freedom. Considering these factors in *Association of Justices of the Peace in Ontario v. Ontario (Attorney General)*, the court concluded that the distinction in this case (age-based retirement):

- Reinforced pre-existing ageist stereotypes;
- Was inconsistent with the actual needs, capacities and circumstances of the Applicants;
- That the ameliorative purpose of the impugned law did not make it any less discriminatory; and
- That the interest affected was profound - the Applicant’s fundamental dignity.

There is clearly a stereotypical application of preconceptions about age - that, without regard to their individual capabilities and needs, justices of the peace over 70 no longer have the mental acuity or the physical stamina to engage in their challenging work... mandatory retirement of justices of the peace, like mandatory retirement of university professors in *McKinney* and physicians in *Stoffman*, is based on the

stereotypical application of presumed group characteristics that serves to perpetuate the view that they are less deserving of respect in Canadian society.”³⁸

The infringement of section 15 could no longer be “saved” by section 1. Society’s “appreciation of the insidious effects of age discrimination ha[d] expanded... improvements in medicine, physical and mental fitness and changed social attitudes have allowed people to make useful contributions to society well beyond the age that was once considered to be the time of retirement. The benefits to society can hardly be doubted.”³⁹

d) Section 15(2)

Section 15(2) provides that a law, program or activity with the objective of ameliorating disadvantages facing members of an enumerated or analogous group will not be discriminatory under section 15. Section 15(2) was explained by the Supreme Court of Canada in *Lovelace v. Ontario* as “confirmatory” of and supplementary to subsection 1, rather than providing a “defence or exemption”; laws or programs intended to ameliorate disadvantage would not negatively affect the “human dignity” of the affected group and so would not violate the rights guaranteed by section 15.⁴⁰ The Court did not rule out the possibility that s. 15(2) could be considered independently in a future case and, indeed, the interpretation of s. 15(2) was revisited by the Court in *R. v. Kapp*.⁴¹ The issue in that case was whether the federal government’s Aboriginal Fisheries Strategy was discriminatory under section 15 and, if so, the impact of section 15(2). Referring to the “exemptive” and “interpretative” approaches to section 15(2) described in *Lovelace*, the Court identified a “third option”:

if the government can demonstrate that an impugned program meets the criteria of s. 15(2), it may be unnecessary to conduct a s. 15(1) analysis at all. As discussed at the outset of this analysis, s. 15(1) and s. 15(2) should be read as working together to promote substantive equality. The focus of s. 15(1) is on *preventing* governments from making distinctions based on enumerated or analogous grounds that have the effect of perpetuating disadvantage or prejudice or imposing disadvantage on the basis of stereotyping. The focus of s. 15(2) is on *enabling* governments to proactively combat discrimination. Read thus, the two sections are confirmatory of each other. Section 15(2) supports a full expression of equality, rather than derogating from it. ‘Under a substantive definition of equality, different treatment in the service of equity for disadvantaged groups is an expression of equality, not an exception to it’: P. W. Hogg, *Constitutional Law of Canada* (5th ed. 2007), vol. 2, at p. 55-53.⁴²

2. Section 7

Section 7 guarantees the right to life, liberty and security of the person:

7. Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.

“The analysis of s. 7 of the Charter involves two steps. To trigger its operation there must first be a finding that there has been a deprivation of the right to "life, liberty and security of the person" and, secondly, that that deprivation is contrary to the principles of fundamental justice.”⁴³

a) **“right to life, liberty and security of the person”**

Autonomy

The right to liberty includes the right to make fundamental personal decisions in addition to freedom from physical constraint and interference with physical freedom. Liberty includes the right to an irreducible sphere of personal autonomy regarding matters that “can properly be characterized as fundamentally or inherently personal such that, by their very nature, they might implicate basic choices going to the core of what it means to enjoy individual dignity and independence.”⁴⁴ Within that sphere, individual choices must be free from state interference. The Supreme Court of Canada has also held that the “security of the person” protected by section 7 includes an individual’s “psychological integrity”⁴⁵ where the interference is sufficiently serious.

The security rights protected by section 7 include the right to make decisions regarding one’s own medical treatment.⁴⁶ Where a person is no longer capable of making his or her own wishes known, previously expressed wishes (while capable) must be taken into account in order to preserve, in so far as possible, this autonomous sphere.⁴⁷ Both the *Substitute Decisions Act* and the *Health Care and Consent Act* in Ontario seek to maximise personal autonomy for persons who are currently incapable by allowing for prior expressed wishes, values and beliefs to guide substitute decision as follows:

- a substitute decision for an incapable person must take into account prior expressed wishes applicable in the circumstances when making a decision on behalf of the incapable person;⁴⁸ and
- where there is no prior expressed wish applicable in the circumstances the substitute decision maker must make a decision in the best interests of the incapable person, which will include considering prior expressed wishes generally (that do not apply directly to the decision in question), the values and beliefs of the incapable person, the general benefit of the treatment to the proposed person and whether any less intrusive alternative is available.⁴⁹

Section 7 will also be relevant in the context of legislation applying to elder abuse and exploitation. Inquiries into a potentially abusive situation may be interpreted as an intrusion into the individual’s sphere of autonomous decision making and independence,

and so an infringement of the personal security protected by section 7. Unless an adult person is mentally incapable they are considered responsible for reporting and accessing help regarding any abuse (outside of a criminal offence) that they may be experiencing⁵⁰ in the absence of mandatory reporting laws. Orders restricting a respondent's rights made pursuant to adult protection or domestic violence legislation (emergency protection orders for example) may also be considered to infringe the respondent's section 7 rights, although the infringement may be considered to be justified under section 1.⁵¹

Dignity

Section 7 has been interpreted as *not* including “a generalized right to dignity”, although “respect for the inherent dignity of persons is... an essential value in our free and democratic society which must guide the courts in interpreting the *Charter*.”⁵² Dignity will be an important consideration in the determination of best interests, where a person is no longer capable and where no prior expressed wishes are directly applicable in the situation. This situation is “more complex” than a situation in which known prior wishes directly apply; it is unknowable whether the person would have consented to the particular treatment “[y]et, respect for the dignity and welfare of an incapable person may require that person to be treated.”⁵³ The Ontario Consent and Capacity Board considered the significance of dignity in *Re E.J.G.*,⁵⁴ finding “guidance” in the following passage from the decision of the House of Lords in *Airedale NHS Trust v. Bland*.⁵⁵

The medical and nursing treatment of individuals in extremis and suffering from these conditions (persistent vegetative state) entails the constant and extensive handling and manipulation of the body. At some point, such a course of treatment upon the insensate patient is bound to touch the sensibilities of even the most detached observer. Eventually, pervasive bodily intrusions, even for the best motives, will arouse feelings akin to humiliation and mortification for the helpless patient. When cherished values of human dignity and personal privacy, which belong to every person living or dying, are sufficiently transgressed by what is being done to the individual, we should be ready to say: enough.⁵⁶

The substitute decision maker does not “stand in the shoes” of the incapable person, and respecting the incapable person's decision making rights under section 7 does not require deference to the substitute decision maker with regards to best wishes; “[t]he S.D.M. is important but only as part of a statutory regime which, by its terms, tries to respect an incapable person's well-being and dignity where that person's consent or refusal to treatment cannot be established.”⁵⁷ Where there is a conflict between the substitute decision maker and the treating physician regarding a person's best interests in the medical context, the Review Board will hear submissions from all parties and make a decision that will be consistent with the person's rights to autonomy and with his or her dignity and well being.⁵⁸

b) “the right not to be deprived thereof except in accordance with the principles of fundamental justice”

Section 7 provides that an individual *can* be deprived of his or her right to “life, liberty and security of the person” but only where this is done in accordance with the “principles of fundamental justice.” This allows the state to incarcerate individuals of criminal offences, for example, but only where that incarceration follows procedures that are consistent with the “principles of fundamental justice.”

The “principles of fundamental justice” have been given some definition and explanations by the courts. They are the “basic tenets of our legal system,” with both procedural and substantive dimensions,⁵⁹ and must meet the following criteria:

1. The principle must be a legal principle.
2. The principle must be vital or fundamental to societal notions of justice.
3. The principle must be capable of being identified with some precision.⁶⁰

The principles of fundamental justice have both a procedural and a substantive aspect. Procedural principles include the right to full and proper disclosure⁶¹ and the right to silence.⁶² Substantive principles include the subjective *mens rea* or “guilty mind” requirement for a conviction of murder.

This aspect of section 7 will be relevant in all situations involving a potential loss of liberty and security rights, including capacity assessments generally (which may result in a loss of personal decision making authority) and capacity assessments preceding care facility admission in particular. In *Saunders v. Bridgeport Hospital*, for example, the court found that a person should be informed that a capacity assessment, for the purposes of determining admission to a care facility, is going to be undertaken (and the significance of that assessment) as a matter of procedural fairness.⁶³

Section 7 rights must be realistically realisable in situations where the individuals who are in fact most likely to be at risk, with regards to their section 7 rights, are less likely (*vis a vis* “mainstream society”) to be able to independently protect and enforce those rights. In the substitute decision making context, discussed below, and, in particular, substitute decision making relating to care facility admittance, a robust system, for independent review of decisions, including both an independent review body and accessible independent advocacy, is essential to this objective.

3. Section 9

Section 9 protects the right of an individual not to be arbitrarily detained or imprisoned. Although section 9 is considered most frequently in the criminal law context, as opposed to the civil, it has been considered in the context of mental health and (unsuccessfully) with regards to child protection proceedings. Section 9 will have obvious relevance to a substitute decision to place an individual in a care facility or nursing home, where the legislative criteria on which that decision is made can be shown to be arbitrary.

a) Detention

Detention under both section 9 and section 10 of the Charter was defined by the Supreme Court of Canada in *R. v. Grant* as a “suspension of the individual’s liberty interest by a significant physical or psychological restraint. Psychological detention is established either where the individual has a legal obligation to comply with the restrictive request or demand, or a reasonable person would conclude by reason of the state conduct that he or she had no choice but to comply.”⁶⁴

The question of whether section 9 could apply to “detention” under child welfare legislation was considered in the recent (2006) case of *C.H.S. v. Alberta (Director of Child Welfare)*.⁶⁵ No authority was provided for the point, and the court determined that being apprehended by child welfare was neither a punishment nor a detention, and the section 9 argument was not permitted on the basis that it could have no prospect of success.

b) Arbitrary

Detention is defined as “not arbitrary where there are “standards that are rationally related to the purpose of the power of detention.”⁶⁶ The rights protected by section 9 are a particular manifestation of the general principle articulated in section 7, that a person’s liberty is not to be curtailed except in accordance with the principles of fundamental justice.⁶⁷ Section 9 serves to protect individual liberty against unlawful state interference. “A lawful detention is not arbitrary within the meaning of s. 9 unless the law authorizing the detention is itself arbitrary. Conversely, a detention not authorized by law is arbitrary and violates s. 9.”⁶⁸

Section 9 may be applicable where a person is “involuntarily committed” to a care facility or nursing home and where the criteria for committal is found to be vague and overly broad. The applicability of section 9 in the context of involuntary committal and mental health legislation was considered in *Thwaites v. Health Sciences Centre Psychiatric Facility*, with the court ruling that the criteria for involuntary committal contained in the legislation was vague and overly broad, and therefore arbitrary.⁶⁹ The criteria at the time required that a medical practitioner, having examined the patient, state his or her opinion that the “person should be confined as a patient of a psychiatric facility.” Manitoba’s *Mental Health Act*⁷⁰ was amended following *Thwaites*, and the criteria for involuntary admission are now stated as follows, to require that a person:

- a) is suffering from a mental disorder;
- b) because of the mental disorder,
 - (i) is likely to cause serious harm to himself or herself or to another person, or to suffer substantial mental or physical deterioration if not detained in a facility, and

- (ii) needs continuing treatment that can reasonably be provided only in a facility; and
- c) cannot be admitted as a voluntary patient because he or she refuses or is not mentally competent to consent to a voluntary admission.

The provision survived a subsequent constitutional challenge, with the court finding that the amended “test” answered the concerns raised in *Thwaites* regarding the “arbitrariness” of the procedure prior to amendment.⁷¹ A similar provision pertaining to involuntary commitment under British Columbia’s *Mental Health Act* also withstood a section 9 challenge in *McCorkell v. Riverview Hospital Review Panel*.⁷² The decision in that case emphasised the importance of a contextual analysis of *Charter* protected rights, taking into account the particular purpose and objectives of mental health legislation which were distinct from those in the criminal law context (the context in which the rights protected by section 9 would most often be interpreted). In this context, standards for committal must “strike a reasonable balance between the rights of the individual to be free from restraint by the state and society’s obligation to help and protect the mentally ill... [u]nlike incarceration in the criminal justice system, involuntary committal is primarily directed to the benefit of the individual”.⁷³

4. Section 10

Section 10 protects the right, on arrest or detention to be:

- Informed promptly of the reasons therefore
- Retain and instruct counsel without delay and to be informed of that right
- To have the validity of the detention determined by way of *habeas corpus* and to be released if the detention is not lawful.

Violation of rights protected under section 10, 12 and 15 of the *Charter* were raised in *Saunders v. Bridgepoint Hospital*,⁷⁴ concerning committal to a care facility following a finding that the plaintiff was not capable of making the decision. The court declined to consider the *Charter* violations in that case, but noted that the plaintiff’s “non-consensual detention” in a care facility “enforced by threat and intimidation” was “relevant” to the Court’s decision that Mr. Saunders was capable of consenting to admission to a care facility.

5. Section 12

Section 12 guarantees the individual’s right not to be subjected to cruel and unusual treatment or punishment. The extent or degree to which “cruel and unusual treatment or punishment” will apply in a non-penal/non-quasi-penal context was considered in *Rodriguez*,⁷⁵ specifically, the definition of “treatment” at the hands of the state for the purposes of section 12. The Court observed that section 12 had been considered in cases involving deportation,⁷⁶ and medical care imposed without consent on mentally ill patients,⁷⁷ both non-criminal contexts, while noting the decision in *Re McTavish and*

Director, Child Welfare Act,⁷⁸ in which it was held that s. 12 “was not intended to extend to medical treatment and may even be restricted to penal or *quasi*-penal matters”. For the purposes of the challenge in *Rodriguez*, the Court concluded that “a mere prohibition by the state on certain action, without more, cannot constitute “treatment” under s. 12,” while “assuming” for the purposes of the analysis, that ““treatment’ within the meaning of s. 12 may include that imposed by the state in contexts *other than* that of a penal or quasi-penal nature.” Beyond this, the scope of treatment in section 12 has not been definitely determined. Once “treatment” or “punishment” has been established, the standard for “cruel and unusual” is that the treatment or punishment be “so excessive as to outrage standards of decency.”⁷⁹

E. Summary

Consistent with the post-*McKinney*, post- *Law* approach to age discrimination and section 15 (as described in *Association of Justices of the Peace in Ontario v. Ontario (Attorney General)*) the evaluation of age-distinction in law or policy for consistency with section 15, involves the following questions:⁸⁰

- Is there prejudice?
- Does the policy or legislation in question reflect the stereotype of old age?
- Is an element of human dignity at issue?
- Is the policy or legislation based on the unarticulated premise that with age comes increasing incompetence and decreasing intellectual capacity?

Where substitute decision making and/or protective legislation specifies (old) age as a factor, these questions will be relevant.

Section 7 requires that legislation relating to substitute decision making and to protection from abuse and exploitation must be structured to ensure that independence and autonomous decision making are respected and enabled while physical integrity and dignity are also adequately protected.

Sections 9, 10 and 12 may apply in the nursing home/care facility context, depending on the applicable legislation and interpretation of both “treatment” and “outraging the standards of decency” in this context. It is important to note that care facilities, and care facility residence, are not considered “health care” for the purposes of either universal medical care insurance coverage or the *Canada Health Act*,⁸¹ and this status will be relevant to any analysis of these sections in the care facility context.

IV. Substitute Decision Making

A. Substitute Decision Making in Ontario

1. Current legislation in Ontario: *Health Care Consent Act 1996*⁸² and *Substitute Decisions Act 1992*⁸³

In 1992, Ontario codified the common law of informed consent in three separate but interrelated statutes, the *Consent to Treatment Act*,⁸⁴ the *Substitute Decisions Act*,⁸⁵ and the *Advocacy Act*.⁸⁶ This legislative package was substantially amended in 1996 when the *Consent to Treatment Act* and the *Advocacy Act* were repealed, the *Substitute Decisions Act* was amended, and the *Health Care and Consent Act, 1996* was enacted. The *Substitute Decisions Act* applies to both court appointed personal and property guardianship and to powers of attorney. The *Health Care Consent Act* applies to health care decisions generally, and applies to both the patient who is not incapable and to the substitute decision maker. The *Health Care Consent Act* also provides for when a person lacks capacity and requires a substitute decision maker for a health care decision, and sets out a hierarchy of substitute decision makers where one has not been appointed under the *Substitute Decisions Act*. The Act applies to care facility admission (not including hospitals or mental health facilities), in addition to administration of medical treatment and the provision of personal assistance services.⁸⁷

Together, the *Substitute Decisions Act* and the *Health Care Consent Act* provide a markedly comprehensive framework for substitute decision making in Ontario. Key components of the system are discussed below.⁸⁸

a) Principles and Procedures: Maximising Autonomy and Participation

Both the *Substitute Decisions Act* and the *Health Care Consent Act* provide for the principles and procedures to be followed in appointing substitute decision makers, and in making substitute decisions and, where necessary, in making decisions on the basis of the best interests of the incapable person. The principles and procedures to be followed in all contexts are intended to maximise personal autonomy and involvement in decision making, even after the loss of capacity, by requiring that applicable previously expressed (while the person was capable) wishes be considered by the substitute decision maker. Decision makers are also required to take into consideration the wishes of the incapable person (while incapable) where relevant. The *Substitute Decisions Act* requires the Public Guardian and Trustee to investigate situations in which an allegedly incapable person may have suffered adverse effects to their person or property.

b) Graduated Approach to Capacity/Decision Making

Consistent with the modern approach to adult guardianship that requires the “least restrictive, intrusive, stigmatizing and depowering mode of intervention necessary to meet an adult’s needs, which reflects an adult’s wishes to the maximum possible degree,”⁸⁹ the *Substitute Decisions Act* and the *Health Care Consent Act* take a *graduated* approach to capacity and decision making (a person may be fully capable of making some kinds of decisions independently, while requiring assistance with other kinds of

decisions or requiring a substitute decision maker for certain kinds of decisions) as opposed to the global approach (a person is either capable or incapable), and recognises that capacity may change over time. The graduated approach is also consistent with capacity as it is defined in the common law. Capacity is defined in the legislation, as is the process through which capacity must be assessed.

c) Capacity Assessment

The question of who evaluates capacity is decision dependent: the answer will turn on the kind of decision in issue, and whether the legislation specifies that a particular type of assessor or evaluator must make the determination. If no particular assessor/evaluator is specified, the common law rules applying to capacity assessment will apply.⁹⁰ In all cases, a person must be informed of the right to have the finding reviewed by the Capacity and Consent Board.

Regarding health treatment, the health practitioner proposing the treatment is responsible for assessing the capacity of the patient to consent to that treatment.⁹¹ The *Health Care Consent Act* also specifies that capacity to consent to enter into a care facility must be determined by an “evaluator,” defined in section 2(1) of the Act.⁹² “Capacity assessors” must be used to assess capacity for the purposes of statutory guardianship of property, and to “trigger” a continuing power of attorney for property or for a power of attorney for personal care unless an alternate “triggering” evaluation has been specified in the document. Capacity assessors *may* be used to determine capacity in other situations, outside of the health context. The *Substitute Decisions Act, Regulation 460/05* sets out the necessary qualifications of “capacity assessors” for the purposes of the Act. Capacity assessors must follow the “Guidelines for Conducting Assessments of Capacity.”⁹³

The *Substitute Decisions Act* specifies that a person must be informed that a capacity assessment is being carried out, and the possible consequences of that assessment must be explained.⁹⁴ No similar provisions exist in the *Health Care Consent Act*, but the courts have found that principles of procedural fairness require that an individual be given this information.⁹⁵

d) Consent and Capacity Board

Individuals can ask that a finding of incapacity or a decision be reviewed by the Consent and Capacity Board. A treating physician, for example, may request a review of a substitute decision maker’s decision, or the substitute decision maker or person assessed may request a review. Where there is a conflict and the person is no longer capable, with no prior applicable expressed wishes, the Board will determine the decision that will be in that person’s best interests. Parties appearing before the Board are entitled to legal representation; where a person whose capability is in issue does not have legal representation, the Board may direct the Public Guardian and Trustee to arrange for it to be provided.⁹⁶

A review of the decisions of the Consent and Capacity Board, and Supreme Court reviews of decisions, reveals that the Board provides a significant safeguard. The decisions of the Board, which may be appealed to the Supreme Court, have also generated an important body of case law interpreting the legislation and bringing greater clarity to its operation.

2. Evaluation

a) Does the legislation reflect negative ageist stereotypes and/or paternalistic attitudes (explicitly or implicitly)? Is the policy or legislation based on the unarticulated premise that with age comes increasing incompetence and decreasing intellectual capacity?

The legislation is “age-neutral” in the sense that age is not explicitly identified as a factor in, or potential cause of, mental incapacity. Three of the key components discussed above - principles and procedures intended to maximise autonomy and contribution; a graduated approach to capacity and decision making; and the review powers of the Capacity and Consent Board - are actively non-paternalistic and consistent with the autonomous decision making rights guaranteed by section 7 of the *Charter* (see discussion under “*Canadian Charter of Rights and Freedoms*”).

b) Are there sufficient mechanisms provided for by the legislation to prevent or protect against the legislation being implemented in an ageist manner (including the acting-out of individual ageism, given the prevalence of ageist attitudes)?

In its response to the Law Commission consultation, the Advocacy Centre for the Elderly (ACE) identified “Good Law, Bad Practice” as a “common theme with respect to the administration of the law as it applies to older adults, particularly in the health sector.”⁹⁷ Changes to the legislation itself were not necessary; what needed to be addressed was the *implementation* of that law. Several reasons were identified as responsible for inadequate compliance with the law governing substitute decision making in the health care sector:

- Individual internalisation of social stereotypes and paternalistic attitudes regarding older adults as persons to be “done to” rather than persons in control of their own decisions;
- Prioritisation of administrative interests and efficiency over individual decision making regarding treatment;
- Mis-information about the law (and its requirements) in the area (use of misleading or unclear forms exacerbate this problem); and
- Professional associations (responsible for dealing with complaints) may not understand the legal requirements regarding consent.

The result was that the rights of older adults and their substitute decision makers to consent or not consent to treatment, provided for in the legislation, were regularly abrogated in practice. To address the problems in implementation, ACE recommended:

- training and education about the law and about avoiding stereotypical attitudes (on an ongoing basis and in faculties of medicine, nursing and social work);
- a review of the *Regulated Health Professions Act* (to determine whether an alternative to traditional disciplinary procedures “after the fact” regarding failure to obtain consent to treatment was feasible); and
- examination of the statutory requirements regarding rights advice; rights can only be enforced where individuals are aware of those rights, and *how* to enforce them.

The Ontario Bar Association (OBA) in its submission to the Commission also identified underlying stereotypical and paternalistic attitudes on the part of individuals implementing substitute decision making legislation as a significant issue. Those attitudes contributed to a misunderstanding of incapacity and older adults. “Strong policy statements... that ageism, sexism, discriminatory practices and stereotyping has no place in our society” were needed.⁹⁸ The OBA response also noted the following specific concerns with the application of the *Substitute Decisions Act* to older adults, including:⁹⁹

- The adversarial nature of the court process, requiring allegations of incapability, “polarizes positions” and “exacerbates conflict and strips the respondent of dignity”;
- Costs of the court process mean that many allegedly incompetent persons are unable to afford representation by counsel, despite the significance of the matter;
- Non-timeliness of the process;
- Inappropriateness of remedies available through the court process;
- The duties of a substitute decision maker to follow the incapable elderly person’s earlier wishes are not well understood and can be difficult to follow in practice;
- Unavailability of alternative dispute resolution processes;
- Applications regarding capacity were frequently motivated by other issues such as family conflict, or financial needs. The “real motivating issues... are frequently obscured by the focus on ‘capacity’ in the law and legal processes. The primary focus of these processes should be needs-based, addressing the social relationships of the person, how the people in those relationships are interacting with each other, and the best plan for that person and his or her finances or living arrangements;

- The potential for misuse of powers of attorney, and practices in care facilities and hospitals that tend to exacerbate misuse (many care facilities encourage personal powers of attorney, and attribute inappropriate decision making power to them);
- Older adults are frequently pressured by family members and by health professionals.

The OBA submission highlights the importance of the family context in which many substitute decision making matters involving older adults take place. “When the *Substitute Decisions Act* and *Health Care Consent Act, 1996* were passed into law they did not anticipate the degree to which these laws would be applied in the context of ‘high conflict’ families. A significant number of court applications now involve substitute decision making for incapable adults and pit family members against each other. The legislation was never intended to address conflicts of this degree and type, and the current processes do not lend themselves to timely or appropriate resolutions.”¹⁰⁰ The OBA recommended that providing for alternative dispute resolutions would address this issue, providing a more suitable mechanism for resolving disputes in this context.

c) Does the legislation respond appropriately to the real needs of older persons as a group (understanding that older adults are extremely diverse), recognising that older adults generally are situated differently from younger people and have different needs?

Substitute decision making legislation must provide, pro-actively, for mechanisms that will facilitate participation in the process, to the greatest extent possible, by the person whose decision making capacity is in issue. Pro-active mechanisms in this context mean the availability of independent advocacy services, as originally contemplated when the legislative package was introduced by the Ontario government in 1992. The current process for accessing the Capacity and Consent Board is not sufficiently pro-active, and nor is it suitable for high-conflict family situations. The particular vulnerability of older adults who become involved with this system makes a more passive approach unrealistic for many of the individuals concerned. Vulnerability is not exclusive to older adults interacting with the legislation, but for older adults that vulnerability will be emphasised or increased as it connects to social stereotypes and attitudes (older adults are “dodderly” and can’t be trusted to make reasonable decisions; family members know what’s best for their older relatives; medical professionals always know the right thing to do; the institutional interests of the care facility are more important than the opinions of residents). In this respect, the law does not adequately take the needs of older adults into account.

The Advocacy Centre for the Elderly also noted a specific gap in Section 20(1) of the *Health Care Consent Act*, which sets out the hierarchy of substitute decision makers for people found incapable of making decisions regarding treatment, care facility admission and personal assistance services. “Section 20(2) states that an SDM must be ‘capable

with respect to the treatment’; this provision often affects older spouses who are found incapable of giving consent for their spouse. There is no mechanism for reviewing this determination.”¹⁰¹

3. Summary

The system or scheme created by Ontario’s substitute decision making legislation is non-ageist, and does a good job of protecting the individual’s rights; balancing the individual’s rights to autonomy in decision making with the individual’s rights to physical dignity and integrity, not to be subjected to prolonged suffering or denied treatment. The implementation of that legislation is, however, problematic; rights that cannot be effectively exercised are rights “in the air” (as opposed to rights on the ground). Older adults who become engaged with substitute decision making, under either the *Substitute Decisions Act* or the *Health Care Consent Act*, will be in a vulnerable situation; entrenched ageist attitudes and stereotypes among professionals implementing the legislation will increase that vulnerability and the likelihood that autonomy will not be respected. The frequently high-conflict family context in which the legislation is implemented also increases the likelihood that substitute decision making will not occur in accordance with the guidelines set out in the legislation, but reflect conflicts and the interests of family members. As the submission of the Advocacy Centre for the Elderly shows, professionals and (possibly particularly) institutional staff may tend to make decisions that primarily meet institutional interests, in the absence of a strong counterweight. These tendencies do not connote “badness” or selfishness, but reflect the coincidence of basic human tendencies to prefer decisions in one’s own interests, where they can be plausibly justified, with the ageist social attitudes that provide that justification.

The Consent and Capacity Board does provide a venue for resolving disputes in this area, but access is forbiddingly difficult for many individuals in this situation. A system of advocates, under the *Advocacy Act*, was originally contemplated as a necessary complement to the substitute decision making legislative package in 1992, recognising that individuals subject to substitute decision making will almost certainly need an independent advocate to assist with navigating the system. The advocacy legislation was repealed in 1996. Furthermore, no meaningful recourse exists (from the allegedly incapable person’s perspective) where treatment has occurred without consent.

B. Substitute decision making: Canadian legislative review

Legislation pertaining to substitute decision making relates to different kinds of decisions that are made in a number of different contexts. There is no inevitable scheme for organising the regulation of these forms of substitute decision making. The legislation in Ontario, for example, is relatively comprehensive, including provisions applying to powers of attorney (including the appointment of personal/health care proxies, or representatives) as a form of substitute decision making, in addition to court-appointed decision makers. Legislation in other provinces separates these categories of decisions

and decision makers (having separate legislation dealing with powers of attorney and court appointed guardians, for example). The *Decision-Making Support and Protection to Adults Act* in the Yukon is “umbrella” legislation that includes, in Schedule A, “Supported Decisions Making Agreements” (Part 1); “Representation Agreements” (Part 2); “Court Appointed Guardians” (Part 3); “Adult Protection” (Part 4). Schedule B includes the Care Consent Act [pertaining to health care decisions], and Schedule C the “Public Guardian and Trustee Act,” which includes provisions for financial protection. The Yukon legislation is the most comprehensive substitute decision making legislation, and the principles underlying the “modern” approach to substitute decision making, discussed below, run throughout all parts of that legislation.¹⁰²

1. Types of Substitute Decision Making Legislation

Legislation applying to these different kinds/contextes of substitute decision making may be classified as follows:

- **Court appointed guardianship legislation:**¹⁰³ Court appointed guardianship legislation sets out the procedure for appointing a guardian where no substitute decision maker has been designated while capable by a person who is now incapable (through a power of attorney or personal directive/representative document). Court appointed guardianship legislation will also set out the requirements for a finding of incapacity, which will necessarily precede such an appointment.
- **Power of attorney legislation:**¹⁰⁴ Powers of attorney are documents in which a person appoints another to make decisions on his or her behalf. Powers of attorney may be drafted so as to “spring” into effect on the happening of a pre-determined event, or may take effect immediately. Legislation enabling powers of attorney will set out the requirement for creating a power of attorney and may be very brief and general, simply providing that a person can appoint another to make decisions on his behalf with a power of attorney, or more complex, providing for the specific duties of people exercising a power of attorney, guidelines for exercising duties and powers, and protective measures directed to the misuse of powers of attorney. The section of Ontario’s *Substitute Decisions Act* that deals with powers of attorney is an example of this more detailed approach.
- **Personal directive/representative legislation:** All provinces allow for a person, while capable, to appoint another person to make health care decision on their behalf in the event of incapacity. This issue may be dealt with in health care consent legislation of general application, or in specific legislation.¹⁰⁵ In Ontario, this role is incorporated within the personal power of attorney provided for by the *Substitute Decisions Act*. Personal or advance directives are the written wishes of a person to be followed in the event that he or she is later found to be incapable. Of course, anyone can write down wishes of this kind; statutory provisions dealing with advance directives clarify their legal effect. Advance directives have

been controversial, on the basis that they encourage rationing of medical care and the withholding of life saving measures for older adults. Provinces providing for advance directives in legislation include the Yukon's *Decision-Making Support and Protection to Adults Act* (applies also in Nunavut),¹⁰⁶ Alberta's *Personal Directives Act*,¹⁰⁷ Saskatchewan's *Health Care Directives and Substitute Health Care Decision Makers Act*,¹⁰⁸ and Newfoundland's *Advance Health Care Directives Act*.¹⁰⁹ Ontario's *Health Care Consent Act* does not provide specifically for advance directives, but where an advance directive accurately describes the wishes of a person now incapable, where they have not been subsequently over-ridden, it will have the force of prior expressed wishes made in any other form.

- **Legislation applying to substitute decision making in the health care context:**¹¹⁰ Many, but not all, provincial jurisdictions have legislation in place that applies particularly to decisions making in the health care context and will include, as one aspect of health care decision making, substitute decision making in the health care context. Health care decision making legislation may be more or less comprehensive, and may include provisions pertaining to proxy decision makers and or advance directives (see discussion above, under "Personal directive/representative legislation").

There is considerable diversity within these general categories between the provinces and territories. Appointment of a personal representative for health care decision making in Saskatchewan is governed by legislation directed to health care consent, for example, which also sets out a hierarchy of substitute decision makers where no representative has been designated.¹¹¹ In Alberta, by contrast, the *Personal Directive Act* provides for individuals to appoint substitute health care decision makers (in the event that the person becomes incapable), and the provision of the *Dependent Adults Act* pertaining to "treatment of incapable adults" (section 29) authorises treatment on the basis of the opinion of two doctors or dentists, as relevant; there is no additional health care consent legislation (and so no legislated "hierarchy" of decision makers in the absence of a designated decision maker). In Ontario, the categories of personal (court appointed) substitute decision makers and personal powers of attorney created by the *Substitute Decision Making Act* essentially fulfill the functions of personal representatives in some other provinces. Where no decision maker has been appointed or designated pursuant to that legislation, the *Health Care Consent Act* provides for a hierarchy of substitutes.

There is also considerable discrepancy in terms of comprehensiveness. While each province and territory has a statute dealing with powers of attorney, Manitoba has legislation governing *court appointment* of substitute decision makers in limited circumstances only: where a person has a mental disability that is manifest before the age of 18 (explicitly *excluding* incapacity developing in later life)¹¹² or where a person has been admitted to a mental health facility.¹¹³ This contrasts significantly with the comprehensive scheme set out in Ontario's substitute decision making legislation. This structural diversity complicates the task of comparing "substitute decision making legislation" across Canada considerably.

2. Evaluation

Beginning in the 1970s¹¹⁴ modern reform of adult guardianship legislation, replacing the older paternalistic “lunacy” model, began in Canada. The principles of modern adult guardianship legislation were described by Robert Gordon and Simon Verdun-Jones:¹¹⁵

The legal and social relationship known as guardianship is an extreme form of interference in the life of an adult and should be used only as a last resort. It should involve the least restrictive, intrusive, stigmatizing and depowering mode of intervention necessary to meet an adult’s needs, which reflects an adult’s wishes to the maximum possible degree. The need for intervention, the level and form of intervention, and an adult’s wishes should be ascertained through a multi-disciplinary capacity and needs assessment. If the need exists, the adult should be assisted by a competent and caring individual or agency, under a clear duty to follow a prescribed philosophy and fulfil prescribed tasks, appointed following a procedure consistent with the *Charter of Rights* in an accessible, friendly, but rigorous form.

These principles, discussed by Profs. Gordon and Verdun-Jones in the context of adult guardianship, apply equally in the context of substitute decision making more broadly, and may be defined as describing the “modern” approach to substitute decision making. Substitute decision making legislation in Ontario, Saskatchewan, the Yukon, and the Northwest Territories may be considered “modern” in this sense.¹¹⁶

Modern substitute decision making legislation, where it exists, provides far greater protection for the rights and freedoms of older adults as for any persons affected by it. The principles at the core of this approach, consistently implemented in practice, directly undercut ageist attitudes and stereotypes that dis-empower older adults. This opposition or tension between modern substitute decision making principles and entrenched social ageism makes the *implementation* of legislation embodying those principles a key issue. Individuals give effect to legislation, and many of those individuals must be assumed to have internalised prevailing attitudes about age and older adults. Legislation must be directive and explicit and provide for effective and accessible recourse and review.

a) Does the legislation reflect negative ageist stereotypes and/or paternalistic attitudes (explicitly or implicitly)? Is the policy or legislation based on the unarticulated premise that with age comes increasing incompetence and decreasing intellectual capacity?

Substitute decision making legislation generally does not explicitly mention or reference age as a “trigger” for incapacity. The question of implicit, underlying, paternalistic attitudes is more directly relevant in this context. Generally speaking, there is an inverse relationship between the modern approach to substitute decision making described above, which emphasis autonomy and circumscribed powers for professions and for substitute decision makers, and paternalism.

Actively non-paternalistic legislation must also anticipate, and provide for, decisions made on the basis of “best interests” in situations where an incapable person’s applicable wishes, expressed prior to incapacity, are not known. Ontario’s legislation, providing clear guidance to substitute decision makers in this situation regarding both health care decisions and substitute decisions outside the health care context, is an effective model of this kind of provision. Legislation in the Northwest Territories (*Guardianship and Trusteeship Act*) and the Yukon (*Decision-Making Support and Protection to Adults Act*) also refers explicitly to best interests, and the factors that substitute decision makers are required to consider in making that determination.

Court appointed guardianship

Substitute decision making legislation is not age specific and, generally, does not reference age. British Columbia’s *Patients Property Act* provides an exception to this rule; “age” is given as a potential reason for the decline of mental capacity.¹¹⁷ Manitoba’s *Vulnerable Persons Living with a Mental Disability Act*, which provides for court appointment of a substitute decision maker for “vulnerable persons,” specifically *excludes* older adults (“vulnerable persons” are defined so as to specifically exclude older adults whose impairment develops in later life).¹¹⁸

Legislation that actively counteracts paternalistic attitudes (that are likely to influence implementation, even where not articulated in the legislation itself) will incorporate the modern approach to substitute decision making described above. Ontario’s legislation is an example of this approach, providing for the maximum possible participation in the decisions making process by the incapable adult and a graduated approach to capacity and assisted decision making, consistent with the right to “life liberty and security of the person” guaranteed by section 7 of the *Charter* (see discussion under “*Canadian Charter of Rights and Freedoms*”). Saskatchewan’s *Adult Guardianship and Co-decision-making Act*, the Yukon’s *Decision-Making Support and Protection to Adults Act* (applies also in Nunavut), and the Northwest Territories’ *Guardianship and Trusteeship Act*, also incorporates this approach. Proposed legislation in Alberta and British Columbia will introduce the modern substitute decision making model in those provinces (although in British Columbia there has been some controversy regarding the appropriateness of co-decision making in the financial/property context). The current legislation in Alberta (the *Dependent Adults Act*) and British Columbia (the *Patients Property Act*), the *Infirm Persons Act* in New Brunswick, the *Disabled Persons’ Estates Act* in Newfoundland and the *Incompetent Persons Act* in Nova Scotia employ a vague and generalised definition of capacity directed to general mental status (“infirmity” for example) rather than a graduated reference to specific decision making capabilities (the ability to understand and appreciate a particular category of decisions), and do not include provisions providing guidance to substitute decision makers in the exercise of their duties.

Power of attorney

Power of attorney legislation is not age specific and does not, unless specifically identified as a triggering event in a “springing” power of attorney, reference incapacity. Powers of attorney are of particular relevance to older adults to the extent that older adults, in anticipation of a possible future loss of capacity, will appoint a power of attorney to avoid the expensive and time consuming court appointed guardianship process, which may result in the appointment of a guardian that the individual would not, in fact, have chosen.

A “springing” power of attorney allows a person to choose in advance who their substitute decision maker will be in the event that he or she becomes incapable. The power of attorney creates a fiduciary relationship between the attorney (the decision maker) and the donor (the person creating the power of attorney), and the duties and powers of the attorney derive from the fiduciary principle, and the parameters of which are established by the fiduciary relationship. People exercising powers of attorney will be held to that fiduciary standard, whether or not those specific duties are set out in the applicable legislation. Providing some guidance about the content of those duties, for individuals who are unlikely to be familiar with fiduciary principles, makes it more likely that they will be exercised appropriately.¹¹⁹

Legislation permitting powers of attorney have traditionally been very simple, with none of the oversights that are provided for with regards to court appointment of guardians. One reason for this is that, historically, powers of attorney have become inoperable if the donor becomes incapable, with the result that donors will be able to supervise the arrangement themselves. As springing powers of attorney have become accepted, the question of what kinds of safeguards are necessary to prevent misuse of the substitute decision making power has come into focus. Where individuals are exercising powers of attorney of behalf of incapable donors, they will also benefit from clear guidance regarding the exercise of their duties, just as substitute decision makers in other contexts do.

Some have argued that more complex power of attorney legislation including specific duties and limited powers, and protections such as registration intended to minimise power of attorney abuse, infringe donor autonomy and privacy, and dissuade people from providing for their own substitute decision making process, making court appointed guardianship, a more invasive and controlling process, more likely.¹²⁰ On the other hand, it has also been suggested that greater oversight, including registration, allows for a more relaxed approach to capacity for creating a power of attorney, and so increases accessibility. Imposing “too high a standard of capacity” for the execution of a power of attorney would frustrate the intentions of many individuals actually seeking a power of attorney, as “in practice it is likely that many powers will be executed when symptoms of mental incapacity have begun to manifest themselves.”¹²¹ Considering the English statutory scheme in *Re K*, Lord Hoffman concluded that because the exercise of a power of attorney was “hedged about” with statutory protection, specifically registration, “too high a standard of capacity” was not required. Considering the question in *Egli v. Egli*,¹²² the B.C. Court of Appeal concluded that, as no equivalent safeguards were present in British Columbia, a valid power of attorney required a higher level of capacity excluding

a greater number of potential donors, for whom court appointment of a substitute decision maker would become the only option.

The *Egli* point is an important one, contrasting sharply with the perception that increased protective measures incorporated into power of attorney legislation makes this private, relatively non-paternalistic option *less* available to would be donors. Evaluation of powers of attorney legislation is complicated by this dual analysis; given that powers of attorney are in themselves a less paternalistic approach to substitute decision making than the court appointment process, the question of their availability to would-be donors is an important point.

Personal directive/representative legislation

Directive and personal representative legislation is non-age specific and self-consciously non-paternalistic, enabling the individual to select his or her own proxy decision maker for health care decisions or “direct” decision through pre-expressed wishes.

Advance directives, while controversial, are considered by some to be an essential element of a non-paternalistic, autonomy enhancing, approach to substitute decision making in the health care context; in effect, by removing the need for “substitute” decision making at all, with the now incapable individual “directing” his or her care through the wishes expressed in the directive. Legislation enabling the appointment of “proxy” decision makers for health may be considered less paternalistic, as with substitute decision making generally, where the duties of the proxies to consider applicable prior expressed wishes are explicitly set out,¹²³ as opposed to a more generalised approach, enabling the appointment of a proxy decision maker with no further guidance.¹²⁴

Legislation applying to substitute decision making in the health care context

Legislation in this area is, like adult guardianship, non-age specific and age is identified as a criteria or “trigger” for substitute decision making in legislation in any province.

Ontario’s *Health Care Consent Act* works together with the *Substitute Decisions Act* where health decisions involve persons who are incapable; the two pieces of legislation are similar in many respects, providing for the same graduated approach to substitute decision making and incorporating principles and procedures that will maximise patient autonomy and participation in decision making, consistent with the *Charter* rights protected by section 7. As the *Substitute Decisions Act* can be considered to be a model of the “modern” approach to adult guardianship, Ontario’s *Health Care Consent Act* can be considered a model in the area of health care substitute decision making, promoting patient autonomy and contribution as opposed to providing for a paternalistic “doctor knows best” approach on the part of health care providers.

Prince Edward Island’s *Consent to Treatment and Health Care Directives Act*, British Columbia’s *Health Care (Consent) and Care Facility (Admission) Act*, the Yukon’s

Decision-Making Support and Protection to Adults Act, which also applies in Nunavut and also proposed amendments to Alberta's *Personal Directives Act* also incorporate and embody the "modern" approach to substitute decision making found in Ontario's model.

b) Are there sufficient mechanisms provided for by the legislation to prevent or protect against the legislation being implemented in an ageist manner (including the acting-out of individual ageism, given the prevalence of ageist attitudes)?

Because of entrenched ageist attitudes on the individual and social level, legislation must be implemented so as to proactively promote the recognition of rights guaranteed by legislation, and ensure that substitute decision makers exercise their authority in accordance with the legislation.

Due to the fact implementation is largely about how legislation is carried out and interpreted, with difficulties arising where practice deviates from that legislation, problems with implementation will not, primarily be a function of the legislation itself, unless the legislation gives insufficient guidance about how it should be carried out, as where vague and generalised definitions of "capacity" are used, rather than decision-specific and graduated categories of capacities, or where the duties of substitute decision makers are not defined with sufficient detail. The analysis under the first evaluative question, "Does the legislation reflect negative ageist stereotypes and/or paternalistic attitudes (explicitly or implicitly)?" deals with these issues.

Adequate mechanisms for the review of decisions, such as Ontario's Consent and Capacity Board, is one aspect of legislation that is essential to the issue of implementation. In the most obvious sense, a (relatively) accessible process provides for greater opportunities for redress where the legislation has *not* been implemented correctly. The decisions of a specialised tribunal such as the Consent and Capacity Board also generate an important body of jurisprudence interpreting and adding meaning to the legislation, providing necessary guidance to the individuals who must implement the system. At present, only Ontario and the Yukon¹²⁵ have a process of this kind in place. In British Columbia Part 4 of the *Health Care (Consent) and Care Facility Admission Act*, which would have created a review board, has been repealed.

c) Does the legislation respond appropriately to the real needs of older persons as a group (understanding that older adults are extremely diverse), recognising that older adults generally are situated differently from younger people and have different needs?

Court appointed guardianship

Older adults are not per se incapable and are not, of course, in need of court appointed guardians by virtue of age alone. Older adults as a group are, however, especially likely to develop a loss of capacity (as opposed to conditions present from birth that affect capacity) as a result of non-psychiatric conditions. Legislation providing for court appointment of substitute decision makers in specific situations that do *not* include developed loss of non-psychiatric loss of capacity ignores, in effect, the types of capacity impairment that older adults are most likely to experience. Manitoba's *Vulnerable Persons Living with a Mental Disability* is legislation of this kind, excluding older adults whose impairment develops in later life.¹²⁶ Mental health legislation in the province (the *Mental Health Act*)¹²⁷ governs court appointment of a substitute decision maker where a person has been admitted to a mental health facility. Outside of these circumstances, two alternatives exist for the person who becomes incapable in later life: appointment of the Public Trustee (a time consuming and intrusive process) or by court order.¹²⁸ Neither include the protections provided by the legislation applying in situations less specific to/typical of older adults.

Power of attorney

Financial abuse through misuse of springing or enduring powers of attorney has been identified as a problem affecting a significant number of older adults, and is one form of “elder abuse.”¹²⁹ Responding to the needs and circumstances of older adults includes addressing and providing for abuse/misuse. At the same time, as discussed above, it has been argued that powers of attorney must remain relatively simple with minimal burdens on persons exercising powers of attorney, who will most often be family members, and should not be too onerous, or individuals will be dissuaded from using powers of attorney to plan for future, potential, incapacity. The point from *Egli* and *Re K*, however, also discussed above, describes how greater oversight and protection from misuse actually increases the accessibility of the power of attorney given the reality that many people will actually want a power of attorney at a point when their capacity is beginning to diminish.

No province requires registration of powers of attorney, identified by Lord Hoffman as an important safeguard. Legislation discussed in the section on “Elder Abuse and Exploitation” identifies legislation that deals with financial abuse, that will address this issue outside of power of attorney legislation itself.

Personal directive/representative legislation: Legislation applying to substitute decision making in the health care context

The most significant question regarding substitute decision making in the health context, whether by personal directive or representative or in more comprehensive health care and consent legislation, is whether or not consent to care facility admittance is specifically provided for. Care facility admittance should *not* be considered to be subsumed within “medical treatment” or “health care” generally; for most purposes (and in the *Canada Health Act*) care facility residence is excluded from the definition of health care. Nevertheless, admittance to a care facility in a situation involving a substitute decision

maker, a situation in which the individual may be unwilling to go, is made on the basis of a health related determination carried out by a medical professional and objectively qualifies as a “health” decision. As in *Ontario’s Health Care Consent Act*, admittance to a care facility should be provided specifically for in legislation applying to substitute decision making in the health care context. Because substitute care facility admittance involves significant *Charter* issues - section 7, and also sections 9 10, and, possibly, 12, an accessible and timely review process is essential. Only Ontario and the Yukon provide for a Review Board at this time.

At the present time, only Ontario and the Yukon¹³⁰ have legislation in place dealing with care facility admission and, specifically, the question of consent to admission. Part 3 of British Columbia’s *Health Care (Consent) and Care Facility (Admission) Act*¹³¹ that would deal with care facility admissions has never been proclaimed. In the absence of legislation, the most likely procedure will be committal under mental health legislation. The criteria for care facility admission should be distinct; a separate provision is needed.

3. Identification of benchmark Canadian legislation.

“Benchmark” legislation will incorporate the “modern” approach to substitute decision making, defining capacity with reference to decision making, as opposed to mental status; recognising graduated capacities; providing that decision making embody the wishes of the incapable person, to the greatest possible extent; clearly articulating the duties and powers of the substitute decision maker; and providing for an accessible, specialist body to review decisions in a timely manner. Provisions dealing with care facility admittance where a person is no longer capable, that incorporate the factors listed above, is essential.

Applying these criteria, legislation in Ontario and in the Yukon may be identified as benchmarks.¹³² Each is relatively comprehensive, and provides a coherent approach to substitute decision making across the different forms or types of substitute decision making relationships. Crucially, legislation in the Yukon and Ontario provides for a Review Board and deals specifically with the key question of substitute consent to care facility admittance, an issue with particular relevance to older adults and which involves *Charter* protected rights. At present, Ontario and the Yukon are the only Canadian jurisdictions to do so.

A key difference between the Ontario and Yukon legislation is Part 1 of the Yukon Act, which deals with Adult Protection. As described in more detail below, these provisions have no analogue in Ontario.

V. Elder abuse and exploitation

“Elder abuse” has been recognised by governments in Canada and in jurisdictions such as Australia, the United Kingdom and the United States as a significant social problem requiring a legal response. The question of what form this response should take is a difficult one, and remains the subject of ongoing discussion and development.

Indeed, the very definition of “elder abuse” has been and remains controversial although some consensus has formed around identifiable categories and types of abuse:

The lack of a generally acceptable definition has spawned a wide variety of definitions of abuse and neglect, which, to this day, still generates controversy and debate. Nevertheless, most would agree on three basic categories of abuse and neglect: (1) domestic elder abuse; (2) institutional abuse; and (3) self-neglect or self-abuse. Most would also agree on the major types of abuse—physical, psychological,¹³³ and financial abuse. Beyond this classification, however, there is little agreement.¹³⁴

Elder abuse includes, but is not confined to, a number of *Criminal Code* offences where the victim is an older adult. Relevant criminal offences include theft; assault; sexual assault; false imprisonment; failure to provide the necessaries of life to a dependent; fraud; misappropriation of funds by a person in a position of trust; and theft by power of attorney (section 331). The sentencing provisions in section 718 of the *Criminal Code*, providing that evidence that the offence was motivated by bias, prejudice or hate, based on age shall be deemed an aggravating factor for sentencing (718.2(a)(i)), are also important in this context. Section 718 also recognizes intimate partner abuse (718.2(a)(ii)) and abuse of a position of trust or authority in relation to the victim (718.2(a)(iii)) as aggravating factors.

The criminal law has unique and significant attributes as a response to elder abuse, but also important limitations. Treating instances of elder abuse as crimes, where the elements of the criminal definition are met, denotes the seriousness of the offence and the social opprobrium that attaches to it. The criminal law can also provide meaningful protection for victims by removing, restraining or incarcerating offenders and/or providing restitution.¹³⁵ Unless a relatively narrow definition of elder abuse requiring legal response is adopted, restricted to the elements of the offences set out in the *Criminal Code*, the criminal law alone may not be able to respond to the complexity of elder abuse, however. The “transactional model of crime that isolates and decontextualises violence... conceals the reality of an ongoing pattern of conduct occurring within a relationship characterised by power and control.”¹³⁶ The criminal paradigm, and the criminal law, cannot provide a complete response to elder abuse.

Unlike some American states, no province currently has an “elder abuse” statute. The types of elder abuse referred to above fall within the scope and application of a range of statutes that may apply to older adults but are not specific to the older demographic. The applicable provincial legislation may be categorised as follows:

- **Domestic violence legislation** (applying in the family context and to physical, sexual and emotional/psychological abuse and, less frequently, material exploitation/financial abuse, depending on the particular statute in question).¹³⁷ The objective of domestic violence legislation generally is to “reduce and prevent family violence and facilitate legal protection for victims by providing speedy

civil remedies.”¹³⁸ Intervention in cases of domestic violence (as provided for in the legislation) will be self-generated by the victim.

- **Adult protection legislation** (applying in the family and non-familial context, to physical, sexual and psychological abuse and to self-neglect, and to material exploitation/financial abuse depending on the particular statute in question).¹³⁹ Applicability is generally limited to adults who are incapable or who cannot otherwise access assistance independently. In New Brunswick, uniquely, protection for elderly and disabled persons is provided for in the *Family Services Act*¹⁴⁰ (which also provides for child protection). The primary objective of adult protection legislation is to connect individuals with social and medical services as necessary. Adult protection legislation, in contrast to domestic violence legislation, provides for intervention initiated by third parties.
- **Human rights legislation** (Article 48 of Quebec’s *Charte des droits et libertés de la personne*¹⁴¹ has been interpreted to provide broad protection to “aged and disabled persons” from exploitation). Unlike adult protection legislation generally, damages (as opposed to connection with services) are the available remedy. It applies in the family and non-familial context, to physical, sexual and psychological abuse and to self-neglect, and to material exploitation/financial abuse.
- **Institutional abuse legislation** (applying in the institutional context and, depending on the particular statute in question, dealing with physical, sexual and psychological abuse and to material exploitation/financial abuse).¹⁴² Abuse is generally defined broadly. Institutional abuse legislation, like adult protection legislation, provides for intervention initiated by third parties.

Developing an anti-ageist approach to legislation has significance for elder abuse and exploitation in two distinct ways. Negative ageist attitudes and assumptions, on both the individual and the social level, contribute to elder abuse and exploitation. Existing legislation of general application such as domestic abuse violence or legislation that does not take the particular situation and needs of older adults into account is also ageist as it has the effect of excluding older adults from the scope of their protection. The legislation discussed below will be analysed with reference to both aspects of ageism.

A. Current legislation in Ontario

Ontario has relatively little legislation in any of the areas discussed above: no domestic abuse/violence legislation; no adult protection legislation; and no explicit/specific institutional abuse legislation. The “Residents’ Rights” (including the “right to be treated with courtesy and respect and in a way that fully recognizes the resident’s dignity and individuality and to be free from mental and physical abuse”) and reporting provisions of

the Ontario legislation applying to nursing homes, charitable homes and rest homes are not “abuse legislation” in the same sense as the other statutes discussed in this section (and indeed do not include a definition of abuse) but are or may be applicable in abuse situations.¹⁴³ Similar to the institutional abuse-specific legislation considered here, the Ontario legislation creates a duty to report suspected abuse.

The *Substitute Decisions Act* creates a duty for the Public Guardian and Trustee to investigate where persons are alleged to be incapable and may suffer adverse effects to their person (s. 62) or property (s. 27). The Public Guardian and Trustee will act only where the person making the complaint is able to provide evidence of the alleged incapacity and the serious adverse effects which have occurred or may occur; in terms of response, the role of the Public Guardian and Trustee is to connect individuals with services.

The main thrust of Ontario’s response to elder abuse has been non-legislative; the development of a comprehensive (not explicitly legal) strategy. In 2002, the government introduced a “Strategy to Combat Elder Abuse.” The Strategy involves three main “planks”:

- Coordination of community services;
- Training for front-line staff; and
- Public education to raise awareness

The “Strategy to Combat Elder Abuse” was developed by the Ontario Seniors Secretariat (OSS) and implemented by the OSS in partnership with the Ontario Victims Services Secretariat, Ministry of the Attorney General and Ontario Network for the Prevention of Elder Abuse. Elder abuse consultants promote and support efforts to address and prevent elder abuse, and act as resources to justice and community service providers.

The Strategy to Combat Elder Abuse also includes a “Prevention of Elder Abuse Policy and Program Lens,” which provides a standardised approach to evaluating policies, practices, and programs to test their support for the rights, dignity and safety of older adults. The Ontario Network for the Prevention of Elder Abuse has also launched a province wide hot line to provide information, referrals, and support for abused and at risk seniors.

1. Evaluation

The key question is whether the non-legislative approach taken in Ontario is adequate to take into account the needs of older adults victimized by abuse or exploitation, or whether legislation is required that would enable intervention in the situation. The question is controversial; it may be argued that intervention, in cases where an adult is not incapable and where no crime has been committed, would violate a person’s right to privacy and autonomous decision making protected by section 7. Others may argue that *not* providing for intervention in cases of abuse and exploitation is a violation of section 7 rights and takes away from the human dignity of the individuals affected and is, in any

event, justified as “demonstrably justified in a free and democratic society” in the same way that domestic violence legislation is justified.

- a) Does the legislation reflect negative ageist stereotypes and/or paternalistic attitudes (explicitly or implicitly)? Is the policy or legislation based on the unarticulated premise that with age comes increasing incompetence and decreasing intellectual capacity?**

The non-legislated approach specifically avoids this problem. A criticism of legislation applying to elder abuse and exploitation where the adult is not incapable is that it effectively infantilizes older adults by equating them to children “in need of protection.” Where a person is incapable, the *Substitute Decisions Act* provides for intervention by the Public Guardian and Trustee, but incapacity must be established.

- b) Are there sufficient mechanisms provided for by the legislation to prevent or protect against the legislation being implemented in an ageist manner (including the acting-out of individual ageism, given the prevalence of ageist attitudes)?**

The key players in the system, in design and implementation, are organisations of long standing with particular knowledge of and expertise in elder abuse and exploitation, and their implementation of the policies can be expected to be actively non-ageist.

- c) Does the legislation respond appropriately to the real needs of older persons as a group (understanding that older adults are extremely diverse), recognising that older adults generally are situated differently from younger people and have different needs?**

It may be argued that, rather than “infantilizing” older adults as discussed above, legislation that applies to elder abuse and exploitation generally (and is not limited to the incapable) recognises that many (but not all) older adults are more vulnerable to abuse and exploitation than younger individuals and in fact are more likely to suffer this kind of harm. Refusing to recognise and provide for this real difference, pretending that older adults are “just like” younger ones and therefore just as “good,” is itself a form of discrimination. The debate can only be resolved through empirical research and greater knowledge about elder abuse and exploitation, and the effectiveness of different legislative and non-legislative approaches to the problem.

B. Elder abuse and exploitation: Canadian legislative review

Comprehensive “elder abuse legislation” of the kind which exists in some American states has been criticised for “attempting to merge concerns about many issues into one broad prohibition against mistreatment of the elderly.”¹⁴⁴ In this respect, “[r]esponses to elder abuse may be attempting to accomplish too much for too many persons.”¹⁴⁵

Canada's provinces have taken a different approach. Different aspects of elder abuse may be dealt with or addressed within non-elder abuse specific legislation: legislation concerning domestic violence or abuse; institutional abuse legislation; and adult protection legislation for a (non-age specific) class of adults defined with reference to incapacity or the inability to independently access assistance. Article 48 of Quebec's *Charte des droits et libertés de la personne* and the provisions of New Brunswick's *Family Relations Act* applying to protection of the elderly from abuse are exceptional elder specific provisions within legislation of much broader application. Evaluation of legislation, and the identification of benchmarks, must therefore be carried out within these different categories: domestic violence legislation, adult protection, human rights legislation and institutional abuse legislation.

1. Evaluation

- a) **Does the legislation reflect negative ageist stereotypes and/or paternalistic attitudes (explicitly or implicitly)? Is the policy or legislation based on the unarticulated premise that with age comes increasing incompetence and decreasing intellectual capacity?**

Domestic violence

Ageist, paternalistic or stereotypical assumptions about older adults is not evident in provincial domestic violence legislation except to the extent that domestic violence is defined with reference to the traditional nuclear family paradigm (parents and children) thereby leaving out other forms of domestic violence affecting older adults such as intergenerational and caregiver violence. This is more in the nature of invisibility (see analysis below) than stereotypical assumptions although stereotyping may be a source of this invisibility (the relevant connection perceived as one between violence and sexual relationships, as opposed to violence and the wider variety of intimate relationships).

Adult protection

Adult protection legislation is in place in the provinces of British Columbia (*Adult Guardianship Act* (Part Three),¹⁴⁶ Manitoba (*Vulnerable Persons Living with a Mental Disability Act*),¹⁴⁷ Nova Scotia (*Adult Protection Act*),¹⁴⁸ Prince Edward Island (*Adult Protection Act*)¹⁴⁹ the Yukon (*Decision-Making Support and Protection to Adults Act*, Schedule A, Part 4 Adult Protection)¹⁵⁰ and Newfoundland and Labrador (*Neglected Adults Welfare Act*).¹⁵¹ Provisions for the Protection of the elderly are set out in New Brunswick's *Family Services Act*¹⁵² (Part III, Protection Services). None of these statutes refer to age or aged persons specifically with the exception of New Brunswick's *Family Services Act*, which applies to both children and adults (elderly or disabled persons) in need of protection. An "Elderly person" is defined in the Act to mean one who has reached the age of sixty-five years, and, in the absence of positive evidence of age, means a person who apparently has reached that age. The other statutes mentioned here apply to persons who are unable to help themselves because of physical or mental infirmity or incapacity with no specific reference to age. Manitoba's *Vulnerable Persons Living with*

a *Mental Disability Act* provides protection for “vulnerable persons” defined so as to *exclude* persons developing infirmities or impairments in later life (“vulnerable person” is defined as “an adult living with a mental disability who is in need of assistance to meet his or her basic needs with regard to personal care or management of his or her property”; “mental disability” means “significantly impaired intellectual functioning existing concurrently with impaired adaptive behaviour and manifested prior to the age of 18 years [**excluding**] a mental disability due exclusively to a mental disorder as defined in section 1 of *The Mental Health Act*.”)

Despite this non-age specificity, adult protection has been criticised as an inherently paternalistic approach. But to the extent that the legislation may incorporate paternalism it does not include an explicitly ageist assumptions, with the possible exception of the reference to “elderly persons” in the New Brunswick legislation.

Human rights legislation

Article 48 of Quebec’s *Charte des droits et libertés de la personne* does specifically mention age as a potential source of vulnerability and, therefore, need for protection: “Every aged person and every handicapped person has a right to protection against any form of exploitation” and that “[s]uch a person also has a right to the protection and security that must be provided to him by his family or the persons acting in their stead.” Article 48 has been applied by the Courts to confer a broad right of protection from exploitation in situations where a mentally capable older adult’s vulnerability has been exploited.

The reference to age seems to imply a stereotypical equation of age with helplessness, but the provision has been interpreted by the courts so as to exclude that implication. The term “aged person” has been interpreted to have “no connotation other than to mean a person of an advanced age. Being an older person does not in itself [connote] a sense of dependency [or] vulnerability. These characteristics must be found rather in the very notion of exploitation. The legislature has signaled its intention to protect in this article two segments of the population.”¹⁵³

Institutional abuse legislation

Some Canadian provinces have enacted legislation that deals specifically with abuse occurring in an institutional setting.¹⁵⁴ Institutional abuse legislation will apply to older adults as residents of care institutions or nursing homes. Assisted living or supportive housing legislation (although neither form of housing properly falls within the scope of institutional care) may also contain provisions that address the issue of abuse. Institutional abuse legislation does not refer specifically to older adults and the legislation cannot be said to incorporate or reflect ageist presumptions or stereotypes; the issue of how that legislation is applied by the individuals charged with applying it is a more significant site of ageism in this context.

b) Are there sufficient mechanisms provided for by the legislation to prevent or protect against the legislation being implemented in an ageist manner (including the acting-out of individual ageism, given the prevalence of ageist attitudes)?

A review of the case law reveals very little evidence of the legislation discussed above being used in an elder abuse context, with the exception of Quebec's *des droits et libertés de la personne*. Adult protection legislation may also apply to self neglect/abuse, and review of the case law indicates that it is much more likely to be used for this purpose.

Very little is known about how this legislation is applied in situations involving older adults experiencing abuse and exploitation by others. The absence of case law may indicate that, in fact it is *not* used in this context; on the other hand, the absence of case law may indicate the success of legislation, where it exists in resolving situations before they reach the courts. The distance between these very different interpretations is significant, and needs to be explored. Similarly, some suggest that adult protection laws providing for intervention in abusive situations actually exacerbate the abuse, while others have suggested that the very act of intervention and the penetration of secrecy is sufficient to defuse many abusive relationships. The discrepancy between these accounts is also extremely significant. Research focusing on other, extra-judicial sources of information is necessary to construct a meaningful picture of how the legislation discussed here is used in practice to deal with different types or aspects of elder abuse.

c) Does the legislation respond appropriately to the real needs of older persons as a group (understanding that older adults are extremely diverse), recognising that older adults generally are situated differently from younger people and have different needs?

Domestic violence legislation

To the extent that domestic violence legislation is limited in scope and application to spousal and parent/minor child relationships, it is inadequate as a response to the range of domestic violence situations that are experienced by older adults.

Nova Scotia's *Domestic Violence Intervention Act* and Newfoundland and Labrador's *Family Violence Protection Act* are perhaps the most restrictive in terms of scope (to whom the legislation applies), limited in application to cohabiting adults in a conjugal relationship and co-parents of children. The definition of "family members" (persons to whom the Act applies) given in Alberta's *Protection Against Family Violence Act* (section 1) is more expansive, including persons who are or have been "adult interdependent partners," persons who are residing or have resided together in an "intimate relationship" and persons who are related to each other by "blood, or adoption or by virtue of an adult interdependent relationship." The categories of adult interdependent partners or persons in "intimate relationships" *may* be interpreted as encompassing intergenerational abuse or abuse in the context of a non-family caregiving relationship (where the incidents of abuse fall within the definition of "family violence" given in the statute), although there is no reported case law to this effect. Manitoba's

Domestic Violence and Stalking Act also applies to broadly stated categories of “family”¹⁵⁵ and “intimate”¹⁵⁶ relationships (section 2(1)).¹⁵⁷ Manitoba and Saskatchewan’s legislation applies to persons in a family or intimate relationship who are cohabitants or who have been in a cohabiting relationship.

The *Protection Against Family Violence Act* in the Northwest Territories refers specifically to a “parent or grandparent” of a respondent as a possible “applicant” under that Act.

Nunavut’s *Family Abuse Intervention Act* defines “family abuse” as “when a person, a child of or in the care of a person, a parent of a person or another family member of a person is subjected to one or more of the acts or omissions listed in section 3 by another person with whom the person has:

- (a) a spousal relationship;
- (b) an intimate relationship;
- (c) a family relationship; or
- (d) a care relationship.¹⁵⁸

The relative broadness/narrowness of the scope of conduct or behaviour to which provincial domestic violence applies will also make that legislation more or less responsive to the situation of older adults.

All domestic violence statutes apply to acts of physical (including sexual) violence and damage to property. Threats “creating a reasonable fear of property damage or injury to a family member” (the language used in the Alberta statute) are defined as a form of domestic violence in most provincial and territorial statutes¹⁵⁹ (excluding Saskatchewan, which defines family violence as “any intended or reckless act or omission that causes bodily harm or damage to property; forced confinement; or sexual abuse.”) Threats may be interpreted as a form of emotional or psychological abuse, although the association of threats with injury and damage (violence) appears to exclude other forms of psychological/emotional abuse that do fall within the social definition of elder abuse.¹⁶⁰

Some statutes include specific reference to psychological and emotional abuse in addition to threats of injury or damage. Manitoba’s legislation specifically includes “conduct that reasonably, in all the circumstances, constitutes psychological or emotional abuse” within its definition of “domestic violence” (given in section 2(1.1)) in addition to “threatened acts” to cause physical or property damage. Prince Edward Island’s *Victims of Family Violence Act* also includes specific reference to emotional/psychological abuse in addition to threats. The Nunavut statute’s definition of “family abuse” includes, specifically, “conduct that reasonably, in all the circumstances, constitutes mental or emotional abuse” (section 3). The Northwest Territories’ *Protection Against Family Violence Act* also includes “psychological abuse, emotional abuse... that causes harm or the fear of harm to the applicant, any child of the applicant or any child who is in the care of the applicant.”

Neglectful conduct (“depriving a person of food, clothing, medical attention, shelter, transportation, or other necessities of life”¹⁶¹) is referred to in the domestic violence statutes of the Yukon, Nunavut, and Newfoundland and Labrador. The Yukon’s *Family Violence Prevention Act* refers to “depriving a person of food, clothing, medical attention, shelter, transportation, or other necessities of life.” Nunavut’s *Family Abuse Intervention Act* contains very similar language (“an intentional or reckless act or omission that unjustifiably or unreasonably deprives a person of food, clothing, shelter, medical attention, transportation or other necessities of life”), as does the *Family Violence Protection Act* in Newfoundland and Labrador (“the deprivation of food, clothing, medical attention, shelter, transportation or other necessities of life.”)

Threats of damage to property may be interpreted to apply to certain acts of financial abuse, although no reported cases apply this interpretation. Legislation in the Northwest Territories and Nunavut makes specific reference to “financial abuse” as within the definition of family violence (Northwest Territories) and family abuse (Nunavut). Section 1(e) of the Northwest Territories’ *Protection Against Family Violence Act* refers to (together with psychological and emotional abuse) “financial abuse that causes harm or the fear of harm to the applicant, any child of the applicant or any child who is in the care of the applicant.” The reference in Nunavut’s *Family Abuse Intervention Act* is to “conduct of any kind the purpose of which is to control, exploit or limit a person’s access to financial resources for the purpose of ensuring the person’s financial dependency” (section 3). The requirement of purpose, or motive, is interesting, and seems more aligned with the spousal abuse paradigm than the more generic reference to “financial abuse” in the *Protection Against Family Violence Act*, which seems more broadly applicable to financial abuse in the elder abuse context.

Adult protection legislation

The question of whether adult protection legislation responds adequately to the needs and situations of older adults will be controversial, and will turn on the question of whether older adults are a category of adult persons that requires special protection (the premise of section 48 of Quebec’s *Charte des droits et libertés de la personne* as described in *Québec (Commission des droits de la personne et des droits de la jeunesse) v. Brzozowski*).¹⁶² Some would answer this question with a definite no; that the non-age specific limitation to persons suffering from incapacities and inabilities that create the inability to independently access assistance is essential (and that extending the ability of the state to intervene in cases of abuse, where adults are involved, would violate section 7 of the *Charter of Rights and Freedoms*). Others would agree with the Quebec approach, that older adults are a group in need of an additional mechanism for protection from exploitation, and that the idea of “vulnerability” inherent in this approach lies in the definition of exploitation (and not the category of age).

Human rights legislation

Quebec’s *Charte des droits et libertés de la personne* does explicitly mention older adults as a group in need of protection from exploitation specifically (as opposed to the more

general abuse). “Exploitation” for the purposes of the *Charte* refers to any situation in which one person abusively takes advantage of the vulnerability and dependence of another to the detriment of the more vulnerable person’s interest.¹⁶³ In this respect the legislation strongly resembles the equitable doctrine of unconscionability, through which a court can set aside an otherwise enforceable transaction where it would be inequitable to give it effect because of one person’s exploitation of the vulnerability of another.¹⁶⁴ The purpose is twofold: to protect the vulnerable and to prevent enrichment through exploitation. An award of damages, including “moral” damages where appropriate, may follow a finding of exploitation under Article 48. This feature distinguishes Quebec’s human rights legislation from adult protection legislation generally, the purpose or objective of which is to connect the individual in need with the appropriate social and/or medical services (as opposed to the provision of damages).

To the extent that one recognises that older adults are more likely to be subject to exploitation than other adults, Article 48 either uniquely recognises the real needs and situations of older adults generally, or internalises ageist assumptions. The extent of exploitation for this group is unknown and (using the *Charte*’s definition of exploitation) ultimately unknowable.

Institutional abuse legislation

Abuse is generally given a more inclusive definition in this context than in adult protection or domestic violence legislation, with explicit reference to emotional/psychological abuse and material exploitation/financial abuse in addition to physical and sexual abuse. “Intention” is given as a requirement for abuse only in Alberta’s *Protection for Persons in Care Act*, which defines “abuse” as follows:

- intentionally causing bodily harm;
- intentionally causing emotional harm, including, but not limited to, threatening; intimidating, humiliating, harassing, coercing or restricting from appropriate social contact;
- intentionally administering or prescribing medication for an inappropriate purpose;
- subjecting to non-consensual sexual contact, activity or behaviour;
- intentionally misappropriating or improperly or illegally converting money or other valuable possessions; or
- intentionally failing to provide adequate nutrition, adequate medical attention or other necessity of life without valid consent.

“Abuse” is defined in Manitoba’s *Protection for Persons in Care Act* as “mistreatment, whether physical, sexual, mental, emotional, financial or a combination of any of them, that is reasonably likely to cause death or that causes or is reasonably likely to cause serious physical or psychological harm to a person, or significant loss to the person’s property.” In Nova Scotia, the definition of “abuse” is set out in the *Protection for Persons in Care Regulations*¹⁶⁵ as follows:

- (a) the use of physical force resulting in pain, discomfort or injury, including slapping, hitting, beating, burning, rough handling, tying up or binding;
 - (b) mistreatment causing emotional harm, including threatening, intimidating, humiliating, harassing, coercing or restricting from appropriate social contact;
 - (c) the administration, withholding or prescribing of medication for inappropriate purposes;
 - (d) sexual contact, activity or behaviour between a service provider and a patient or resident;
 - (e) non-consensual sexual contact, activity or behaviour between patients or residents;
 - (f) misappropriation or improper or illegal conversion of money or other valuable possessions;
 - (g) failure to provide adequate nutrition, care, medical attention or necessities of life without valid consent.
- (2) “Abuse” does not occur in situations in which a service provider carried out their duties in accordance with professional standards and practices and health facility based policies and procedures.

British Columbia’s *Adult Care Regulations* provide that a “licensee must ensure that no person in care is subjected to neglect, emotional abuse, financial abuse, physical abuse or sexual abuse.”¹⁶⁶ All categories of abuse are given further, more concrete definition. “Emotional abuse” is defined as “any act, or lack of action, which may diminish the sense of well-being of a person in care, perpetrated by a person not in care, such as verbal harassment, yelling or confinement.” Financial abuse is defined as “the misuse of the funds and assets of a person in care by a person not in care,” or “the obtaining of the property and funds of a person in care by a person not in care without the knowledge and full consent of the person in care or their substitute decision maker.” Physical abuse in this context means “any physical force that is excessive for, or is inappropriate to, a situation involving a person in care and perpetrated by a person not in care;” sexual abuse is defined to mean “any sexual behaviour directed towards a person in care by an employee of the licensee, volunteer or any other person in a position of trust, power or authority and includes any sexual exploitation whether consensual or not but does not include consenting sexual behaviour between adult persons in care.” Neglect is defined as “the failure of a care provider to meet the needs of a person in care, including food, shelter, care or supervision.”¹⁶⁷

2. Identification of benchmark Canadian legislation.

Because of the division of “elder abuse” as a category between different kinds of provincial legislation, identification of a benchmark will include a consideration of all

types of legislation, and the combination of benchmarks will provide the necessary extent of protection while avoiding the over-inclusiveness (and potential ageism) of specific “elder abuse” legislation.

Domestic violence legislation that is inclusive of older adults and the kinds of relationships in which they may experience domestic *abuse*, defined broadly to include non-violent forms of abuse including exploitation, is (potentially) an extremely effective approach to elder abuse, in combination with the kinds of education strategy that the government of Ontario has undertaken. Nunavut’s *Family Abuse Intervention Act*, described above, is sufficiently broad both in terms of both to whom it applies and to what conduct/behaviours it applies.

Limited adult protection legislation, as provided for by British Columbia’s *Adult Guardianship Act* Part 3, should be accompanied by human rights legislation similar to Quebec’s *Charte* Article 48 to provide protection from exploitation.

British Columbia’s *Adult Guardianship Act* (Part 3) applies “whether an adult is abused or neglected in a public place, in the adult’s home, a relative’s home, a care facility or any other place except a correctional centre (section 45).” “Abuse” is defined (section 1) as “the deliberate mistreatment of an adult that causes the adult:

- (a) physical, mental or emotional harm; or
- (b) damage to or loss of assets,

and includes intimidation, humiliation, physical assault, sexual assault, overmedication, withholding needed medication, censoring mail, invasion or denial of privacy or denial of access to visitors.” “Neglect” is defined as “any failure to provide necessary care, assistance, guidance or attention to an adult that causes, or is reasonably likely to cause within a short period of time, the adult serious physical, mental or emotional harm or substantial damage to or loss of assets, and includes self neglect.”

Where the circumstances (including vulnerability) required for “exploitation” are met, an additional level of protection is provided and is justified in this context. The response provided for (“moral” damages and the restoration of money or property lost through exploitation) involves a minimal level of interference with autonomy, unlike the loss of autonomy at stake in the determination of capacity or interference in living situations.

Institutional abuse legislation should not include a requirement of intention, and should provide detail about the kinds of behaviours that will constitute “abuse”. All categories of abuse (neglect, emotional abuse, financial abuse, physical abuse or sexual abuse) provided for in British Columbia’s *Adult Care Regulations*¹⁶⁸ are given further, more concrete definition that is, at the same time, sufficiently broad to capture the reality of abusive behaviours experienced by older adults in institutional settings. “Emotional abuse” is defined as “any act, or lack of action, which may diminish the sense of well-being of a person in care, perpetrated by a person not in care, such as verbal harassment, yelling or confinement.” Financial abuse is defined as “the misuse of the funds and

assets of a person in care by a person not in care,” or “the obtaining of the property and funds of a person in care by a person not in care without the knowledge and full consent of the person in care or their substitute decision maker.” Physical abuse in this context means “any physical force that is excessive for, or is inappropriate to, a situation involving a person in care and perpetrated by a person not in care;” sexual abuse is defined to mean “any sexual behaviour directed towards a person in care by an employee of the licensee, volunteer or any other person in a position of trust, power or authority and includes any sexual exploitation whether consensual or not but does not include consenting sexual behaviour between adult persons in care.” Neglect is defined as “the failure of a care provider to meet the needs of a person in care, including food, shelter, care or supervision.”¹⁶⁹

Ultimately, the question of whether legislation is a necessary component of an effective response to elder abuse and exploitation, in addition to non-legislative initiatives such as Ontario’s Strategy to Combat Elder Abuse, depends on the question of how, and to what extent, this legislation is actually used in the context of abuse and exploitation (as opposed to self-neglect). Aside from the Quebec human rights legislation there is little evidence on which to draw a conclusion. Certainly, however, the benchmark legislation described above at least potentially provides a powerful tool for response. Perhaps a provincial strategy to combat elder abuse, in connection with potentially effective legislation of this kind, will provide the most productive response, with the strategy raising awareness of the legislative tools and monitoring their effectiveness.

VI. Conclusions

The great majority of the legislation discussed in this paper is facially “age neutral.” Both subject areas will disproportionately impact older adults. Ensuring substantive equality in these areas means, therefore, recognising how “age neutrality” may play out in real life situations involving older adults in vulnerable situations: where capacity is in question and where others must make decisions on the person’s behalf, and where a person is suffering from abuse or exploitation or where abuse and exploitation is suspected. In these situations, pervasive social and individual-level ageist attitudes will interact with personal vulnerability in a way that makes ostensibly available “age-neutral” rights difficult to assert. Legislation that allows “space” for patronising and ageist approaches (as where incapacity is defined broadly and substitute decision making guidelines are not specific) effectively invites those attitudes in these contexts.

Ontario’s non-legislated approach to elder abuse and exploitation proceeds from an understanding that the primary need in this area is for assistance in exercising existing rights; the key question is whether effective assistance in this context requires additional tools, such as the tools provided by domestic violence legislation. The comprehensive scheme created by the *Substitute Decisions Act* and the *Health Care Consent Act* is a Canadian benchmark, in terms of the rights it creates and the guidance it provides. A continuing challenge is ensuring that these provisions are understood and easily exercised by the persons to whom they apply.

Situating the legislation discussed in this paper in the context of national and international statements of principle and the *Canadian Charter of Rights and Freedoms* clarifies the ultimate objectives of developing an anti-ageist approach in legislation. Respecting both autonomy and human dignity means recognising that older adults in the vulnerable situations described in this paper face the further obstacle of pervasive ageism and disrespect; respecting autonomy and human dignity means accepting that difference does not equal weakness, and that ignoring difference can be systemic discrimination. These issues are brought most sharply into focus with regards to care facility admittance, one area which (although ostensibly age neutral) disproportionately affects older adults and which involves fundamental *Charter* rights and principles. Ontario and the Yukon aside, the invisibility of this issue in the legislation is itself a manifestation of a deeply rooted social ageism.

APPENDIX A: SUBSTITUTE DECISION MAKING LEGISLATION

1. Court appointed guardianship

Dependent Adults Act R.S.A. 2000, c. D-11
Infirm Persons Act, R.S.N.B. 1973, c. I-8
Mentally Disabled Persons Estates Act, R.S.N.L. 1990, c. M-10.
Incompetent Persons Act, R.S.N.S. 1989, c. 218
Public Curator Act, S.Q. c. C-81, Civil Code of Quebec
Adult Guardianship and Co-decision-making Act, S.S. 2000, c. A-5.3.
Patients Property Act, R.S.B.C. 1996, c. 349; *Adult Guardianship Act (Part 2)* R.S.B.C. c. 6 (awaiting proclamation)
Mental Health Act C.C.S.M. c. M110; *Vulnerable Persons Living with a Mental Disability Act*, C.C.S.M. c. V90
Decision-Making Support and Protection to Adults Act, S.Y. 2003, c. 21.
 (applies also in Nunavut)
Guardianship and Trusteeship Act, S.N.W.T. 1994, c. 29.
Substitute Decisions Act, S.O. 1992, c. 30.

2. Powers of Attorney

Powers of Attorney Act, R.S.A. 2000, c. P-20
Powers of Attorney Act, C.C.S.M. c. P97
Enduring Powers of Attorney Act, R.S.N.L. 1990, c. E-11
Powers of Attorney Act, R.S.N.S. 1989, c. 352.
Powers of Attorney Act, R.S.P.E.I. 1988, c. P-16.
Power of Attorney Act, R.S.B.C. 1996, c. 370
The Powers of Attorney Act, S.S. 2002, c. P-20.3
Property Act, R.S.N.B. 1973, c. P-19.
Enduring Power of Attorney Act, R.S.Y. 2002, c. 73.
Powers of Attorney Act, S.N.W.T. 2001, c.15
Powers of Attorney Act, S.Nu. 2005, c. 9.
Substitute Decisions Act, S.O. 1992, c. 30.

3. Personal Directive/Representative Legislation

Representation Agreement Act, R.S.B.C. 1996, c. 405.
Personal Directives Act, S.N.W.T. 2005, c. 16
Personal Directives Act, R.S.A. 2000, c. P-6.
Decision-Making Support and Protection to Adults Act, S.Y. 2003, c. 21.
 (applies also in Nunavut)

4. Substitute decision making in the health care context (including care facility admission)

Health Care Directives Act, C.C.S.M. c. H27

Medical Consent Act, R.S.N.S. 1989, c. 279

Consent to Treatment and Health Care Directives Act, R.S.P.E.I. 1988, c. C-17.2

Decision-Making Support and Protection to Adults Act, S.Y. 2003, c. 21.

(applies also in Nunavut)

An Act Respecting Health Services and Social Services, R.S.Q. c. S-4.2.

Health Care Directive and Substitute Health Care Decision Makers Act, S.S. 1997, c. H-0.001

Health Care (Consent) and Care Facility (Admission) Act, R.S.B.C. 1996, c. 181.

Advance Health Care Directives Act, S.N.L. 1995, A-4.1.

Infirm Persons Act, R.S.N.B. 1973, c. I-8

Health Care Consent Act S.O. 1996, c. 2.

ENDNOTES

¹ *Granovsky v. Canada (Minister of Employment and Immigration)*, [2000] 1 S.C.R. 703, 2000 SCC 28, at para. 30.

² *Granovsky v. Canada (Minister of Employment and Immigration)*, [2000] 1 S.C.R. 703, 2000 SCC 28 at paras. 30 and 37. See also, D. Surtees “What Can Elder Law Learn From Disability Law?” in I. Dorn, Ed., *Theories on Law and Ageing: The Jurisprudence of Elder Law* (Berlin: Springer Publications, 2009).

³ (2008) Law Commission of Ontario, *Older Adult PreStudy Consultation Report* (page 18).

⁴ (2008) Ontario Bar Association, *The Law as it Affects Older Adults* Submission to the Law Commission of Ontario (p. 11).

⁵ Ontario Human Rights Commission *Time for Action: Advancing Human Rights for Older Ontarians* (Toronto: Queen’s Printer for Ontario, 2008) (Page 15-16).

⁶ See *Andrews v. Law Society of British Columbia*, [1989] 1 S.C.R. 143.

⁷ *Eaton v. Brant County Board of Education*, [1997] 1 S.C.R. 241 at para. 67.

⁸ *Ibid.*

⁹ *Chapdelaine v. Air Canada* (1987), 9 C.H.R.R. D/4449 (C.H.R.T.); *Bitonti v. British Columbia (Ministry of Health) (No. 3)*, (1999), 36 C.H.R.R. D/263; *British Columbia (Public Service Employee Relations Commission) v. B.C.G.S.E.U.*, [1999] 3 S.C.R. 3. See discussion, *Pivot Legal Society v. Downtown Vancouver Business Improvement Association*, 2009 BCHRT 229.

¹⁰ *Granovsky v. Canada (Minister of Employment and Immigration)*, [2000] 1 S.C.R. 703, 2000 SCC 28.

¹¹ Resolution 46/91.

¹² Canadian Coalition on the Rights of the Child, “The UN Convention on the Rights of the Child: How Does Canada Measure Up?” 1999 and International Institute for Child Rights and Development *Meeting Canada’s Obligations under the UN Convention on the Rights of the Child: From Paper Concepts to Living Benefits for Children*, Brief to Canada’s Senate Committee on Human Rights (2005). It has been suggested that evaluation of this kind would be one function of a federal Ombudsman for Older Adults—see Paris Principles; UN General Assembly, Principles relating to the Status of National Institutions for the Promotion and Protection of Human Rights, Resolution A/RES/134 (20 Dec. 1993)

¹³ http://www.un.org/esa/socdev/ageing/madrid_recommendations.html

¹⁴ See *Addressing the challenges and opportunities of ageing in Canada*, Prepared for the United Nations Commission for Social Development for the 5th Anniversary of the 2002 United Nations Second World Assembly on Ageing (2002: Government of Canada).

¹⁵ The National Framework is available from Health Canada, Health Promotions and Programs Branch, Division of Aging and Seniors and online: Health Canada www.hc-sc.gc.ca/seniors-aines/nfa-cnv/.

¹⁶ Ontario Human Rights Commission *Time for Action: Advancing Human Rights for Older Ontarians* (Toronto: Queen’s Printer for Ontario, 2008) (Page 14).

¹⁷ Advocacy Centre for the Elderly, *Submission to the Law Commission of Ontario Concerning: The Law As It Affects Older Adults*, at 5 <http://www.advocacycentreelderly.org/pubs/Law as it Affects Older Adults July 2008.pdf>.

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- ¹⁸ *Ibid.*
- ¹⁹ *R. v Oakes*, [1986] 1 S.C.R. 103.
- ²⁰ Section 32(1). See, *R.W.D.S.U. Local 580 v Dolphin Delivery Ltd.* [1986] 2 S.C.R. 483.
- ²¹ [1990] 3 S.C.R. 483.
- ²² [1997] 3 S.C.R. 624..
- ²³ *Eldridge*, [1997] 3 S.C.R. 624 at 665.
- ²⁴ [1990] 3 S.C.R. 229.
- ²⁵ *Gosselin v. Quebec (Attorney General)*, [2002] 4 S.C.R. 429, 2002 SCC 84 at para. 31-32.
- ²⁶ [1999] 1 S.C.R. 497.
- ²⁷ *Ibid.*, paras. 51 and 53.
- ²⁸ *Gosselin v. Quebec (Attorney General)*, [2002] 4 S.C.R. 429, 2002 SCC 84 at para. 32
- ²⁹ [1989] 1 S.C.R. 143, at p. 169.
- ³⁰ [1997] 3 S.C.R. 624
- ³¹ [1990] 3 S.C.R. 229.
- ³² [1990] 3 S.C.R. 483.
- ³³ [1990] 3 S.C.R. 451.
- ³⁴ [1990] 3 S.C.R. 570.
- ³⁵ (2008), 292 D.L.R. (4th) 623. See also, *Vilven v. Air Canada*, 2009 FC 367.
- ³⁶ *Ibid.*, para. 38 and 45, per G.R. Strathy J.
- ³⁷ [1999] 1 S.C.R. 497.
- ³⁸ (2008), 292 D.L.R. (4th) 623
- ³⁹ *Ibid.*, at para. 178.
- ⁴⁰ *Lovelace v. Ontario*, [2000] 1 S.C.R. 950 at para. 105.
- ⁴¹ 2008 SCC 41.
- ⁴² *Ibid.*, at para. 37.
- ⁴³ *R. v. Beare*, [1988] 2 S.C.R. 387 at para. 28.
- ⁴⁴ *Godbout v. Longueuil (City)*, [1997] 3 S.C.R. 844; see also *B. (R.) v. Children's Aid Society of Metropolitan Toronto*, [1995] 1 S.C.R. 315.
- ⁴⁵ *New Brunswick (Minister of Health and Community Services) v. G.(J.)*, [1999] 3 SCR 46.
- ⁴⁶ *Fleming v. Reid* (1991), 82 DLR (4th) 298 (Ont. C.A.); *Conway v. Jacques*, [2002] O.J. No. 2333 (Ont.C.A.), (2001), 32 Admin.L.R.(3d) 248 (S.C.J.), leave to appeal to S.C.C. refused [2002] S.C.C.A. No. 341
- ⁴⁷ *Ibid.*
- ⁴⁸ *Health Care Consent Act*, S.O. 1996, c.2, Section 21(1) 1.
- ⁴⁹ *Ibid.*, Section 21(1)2 and 21(2).
- ⁵⁰ See, *Report on Inquest into the Death of Cory Clifford Moar*, May 14, 2003, Provincial Court of Manitoba.
- ⁵¹ See Manitoba Law Reform Commission Report, Adult Protection and Elder Abuse (Report #103) (Winnipeg, 1999) at 62 <http://www.manitoba.ca/justice/mlrc/report/103.pdf>;

C.(A.L.G.) v Prince Edward Island (1998), 157 D.L.R. (4th) 523 (P.E.I.S.C.T.D.); *Baril v. Obelnicki*, 2004 MBQB 92

⁵² *Blencoe v. British Columbia (Human Rights Commission)*, [2000] 2 S.C.R. 307, 2000 SCC 44.

⁵³ *M.A. v. Benes* (1999), 46 O.R. (3d) 271 (C.A.) at para. 38.

⁵⁴ 2007 CanLII 44704 (ON C.C.B.).

⁵⁵ [1993] AC 789.

⁵⁶ Per Lord Butler-Sloss, quoting from *Re Conroy*, (1985) NJ 321, 398-399. Both *Bland* and *Conroy* involved patients in a persistent vegetative state with no prospect of recovery.

⁵⁷ *M.A. v. Benes* (1999), 46 O.R. (3d) 271 (C.A.) at para. 42.

⁵⁸ *M.A. v. Benes* (1999), 46 O.R. (3d) 271 (C.A.) (Health Care and Consent); *Scardoni v. Hawryluck*, Superior Court of Justice file 03-94/03; 2004 CanLII 34326 (ON S.C.) (*Substitute Decisions Act*).

⁵⁹ *Rodriguez v. British Columbia (Attorney General)*, [1993] 3 S.C.R. 519.

⁶⁰ *R. v. Broyles*, [1991] 3 S.C.R. 595.

⁶¹ *R. v. Morgentaler*, [1988] 1 S.C.R. 30.

⁶² *R. v. Heywood*, [1994] 3 S.C.R. 761.

⁶³ 2005 CanLII 47735 (Ont. S.C.). See also *Re Koch*, 1997 CanLII 12138 (On. S.C.).

⁶⁴ *R. v. Grant*, 2009 SCC 32 at para. 44. See also, *R v Thomsen*, [1988] 1 S.C.R. 640.

⁶⁵ 2006 ABQB 528.

⁶⁶ P. W. Hogg, *Constitutional Law of Canada* (loose-leaf ed.), vol. 2, at p. 46; *Charkaoui v. Canada (Citizenship and Immigration)*, [2007] 1 S.C.R. 350, 2007 SCC 9.

⁶⁷ *Charkaoui v. Canada (Citizenship and Immigration)*, 2007 SCC 9, [2007] 1 S.C.R. 350, at para. 88.

⁶⁸ *R. v. Grant*, 2009 SCC 32 at para. 54.

⁶⁹ *Thwaites v. Health Sciences Centre Psychiatric Facility* (1988), 48 D.L.R. (4th) 338 (Man. C.A.). See also, *Lussa c. Health Sciences Centre* (1983), 9 C.R.R. 350 (Man. Q.B.), 5 C.H.R.R. D/2203.

⁷⁰ C.C.S.M. c. M110.

⁷¹ *Bobbie v. Health Science Centre*, [1989] 2 W.W.R. 153 (Man QB).

⁷² *McCorkell v. Riverview Hospital Review Panel* (1993), 104 D.L.R. (4th) 391 (B.C.S.C.)

⁷³ *Ibid.*

⁷⁴ 2005 CanLII 47735 (Ont. S.C.).

⁷⁵ *Rodriguez v. British Columbia (Attorney General)* [1993] 3 S.C.R. 519.

⁷⁶ *Chiarelli v. Canada (Minister of Employment and Immigration)*, [1992] 1 S.C.R. 711.

⁷⁷ *Howlett v. Karunaratne* (1988), 64 O.R. (2d) 418.

⁷⁸ *Re McTavish and Director, Child Welfare Act* (1986), 32 D.L.R. (4th) 394 (Alta. Q.B.),

⁷⁹ *R. v. Smith*, [1987] 1 S.C.R. 1045, at p. 1072; *Harvey v. New Brunswick (Attorney General)*, [1996] 2 S.C.R. 876 *Rodriguez v. British Columbia (Attorney General)* [1993] 3 S.C.R. 519; *Canadian Foundation for Children, Youth and the Law v. Canada (Attorney General)*, [2004] 1 S.C.R. 76, 2004 SCC 4.

⁸⁰ Adapted from Madam Justice Wilson's dissent in *McKinney*.

⁸¹ *Canada Health Act* (R.S., 1985, c. C-6).

⁸² S.O. 1996, c. 2.

⁸³ S.O. 1992, c. 30.

⁸⁴ S.O. 1992, c. 31.

⁸⁵ S.O. 1992, c. 30.

⁸⁶ S.O. 1992, c. 26.

⁸⁷ “Personal Assistance Services” are defined in section 2 to mean “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, but does not include anything prescribed by the regulations as not constituting a personal assistance service.”

⁸⁸ See also, *A Comparative Analysis of Adult Guardianship Laws in BC, New Zealand and Ontario*, CCELS Report No. 4 http://www.llbc.leg.bc.ca/public/PubDocs/bcdocs/408281/Comparative_Analysis_Guardianship_Laws.pdf

⁸⁹ R. Gordon & S. Verdun-Jones, *Adult Guardianship Law in Canada* (Toronto: Carswell, 1992) at 6-38.

⁹⁰ Wahl, J. *Capacity and Capacity Assessment in Ontario*, paper prepared for the CBA Elderlaw Programme March 24-25 2006. http://www.practicepro.ca/practice/PDF/Backip_Capacity.pdf

⁹¹ *Health Care Consent Act*, S.O. 1996, c. 2, Section 10(1).

⁹² See also Evaluators, O.Reg 104/96.

⁹³ <http://www.attorneygeneral.jus.gov.on.ca/english/family/pgt/capacity/2005-05/guide>

⁹³ *Re Koch* (1997), 33 O.R. 485 (Gen. Div).

⁹⁴ Sections 78(2)(b) and (c).

⁹⁵ *Re Koch* (1997), 33 O.R. 485 (Gen. Div); *Saunders v. Bridgeport Hospital*, 2005 CanLII 47735 (Ont. S.C.).

⁹⁶ *HCCA* section 80.

⁹⁷ Advocacy Centre for the Elderly (2008) *The Law as it Affects Older Adults* Submission to the Law Commission of Ontario http://www.advocacycentreelderly.org/pubs/Law_as_it_Affects_Older_Adults_July_2008.pdf at page 6.

⁹⁸ at 12.

⁹⁹ *Ibid.*

¹⁰⁰ (2008) Ontario Bar Association, *The Law as it Affects Older Adults* Submission to the Law Commission of Ontario http://www.oba.org/en/pdf/older_adults_lco.pdf at 4.

¹⁰¹ Advocacy Centre for the Elderly (2008) *The Law as it Affects Older Adults* Submission to the Law Commission of Ontario http://www.advocacycentreelderly.org/pubs/Law_as_it_Affects_Older_Adults_July_2008.pdf at page 18-19.

¹⁰² Mental health legislation is relevant to many of these issues, but is beyond the scope of this study.

¹⁰³ *Dependent Adults Act* R.S.A. 2000, c. D-11; *Adult Guardianship and Trusteeship Act*, c. A- 4.2 (awaiting proclamation); *Infirm Persons Act*, R.S.N.B. 1973, c. I-8; *Mentally Disabled Persons Estates Act*, R.S.N.L. 1990, c. M-10; *Incompetent Persons Act*, R.S.N.S. 1989, c. 218; *Public Curator Act*, S.Q. c. C-81; *Civil Code of Quebec*, S.Q. 1991, c. 64 (art. 11-25, Integrity of the Person- Care; art. 256-297 Protective Supervision

of Persons of Full Age); *Adult Guardianship and Co-decision-making Act*, S.S. 2000, c. A-5.3; *Patients Property Act*, R.S.B.C. 1996, c. 349; *Adult Guardianship Act (Part 2)* R.S.B.C. c. 6 (awaiting proclamation); *Mental Health Act* C.C.S.M. c. M110; *Vulnerable Persons Living with a Mental Disability Act*, C.C.S.M. c. V90; *Decision-Making Support and Protection to Adults Act*, S.Y. 2003, c. 21; (applies also in Nunavut); *Guardianship and Trusteeship Act*, S.N.W.T. 1994, c. 29; *Substitute Decisions Act*, S.O. 1992, c. 30.

¹⁰⁴ *Powers of Attorney Act*, R.S.A. 2000, c. P-20; *Powers of Attorney Act*, C.C.S.M. c. P-97; *Enduring Powers of Attorney Act*, R.S.N.L. 1990, c. E-11; *Powers of Attorney Act*, R.S.N.S. 1989, c. 352; *Powers of Attorney Act*, R.S.P.E.I. 1988, c. P-16; *Power of Attorney Act*, R.S.B.C. 1996, c. 370; *Powers of Attorney Act*, S.S. 2002, c. P-20.3; *Property Act*, R.S.N.B. 1973, c. P-19; *Enduring Power of Attorney Act*, R.S.Y. 2002, c. 73; *Powers of Attorney Act*, S.N.W.T. 2001, c.15; *Powers of Attorney Act* S.Nu. 2005, c. 9; *Substitute Decisions Act*, S.O. 1992, c. 30; *Civil Code of Quebec*, S.Q. 1991, c. 64 art. 2130-2185 (mandate).

¹⁰⁵ *Representation Agreement Act*, [R.S.B.C. 1996] c. 405; *Personal Directives Act* S.N.W.T. 2005, c. 16; *Personal Directives Act*, R.S.A 2000, c. P-6; *Advance Health Care Directives Act* S.N.L. 1995, c. A-4.1.

¹⁰⁶ SY 2003, c. 21.

¹⁰⁷ R.S.A. 2000, c. P-6.

¹⁰⁸ S.S. 1997, c. H0.001.

¹⁰⁹ S.N.L. 1995, c. A-4.1.

¹¹⁰ *Health Care Directives Act*, C.C.S.M. c. H27; *Medical Consent Act*, R.S.N.S. 1989, c. 279; *Consent to Treatment and Health Care Directives Act*, R.S.P.E.I. 1988, c. C-17.2; *Decision-Making Support and Protection to Adults Act*, S.Y. 2003, c. 21 (applies also in Nunavut);

An Act Respecting Health Services and Social Services, RSQ c. S-4.2; *Health Care Directive and Substitute Health Care Decision Makers Act*, S.S. 1997, c. H-0.001; *Health Care (Consent) and Care Facility (Admission) Act*, R.S.B.C. 1996, c. 181; *Advance Health Care Directives Act*, S.N.L. 1995 A-4.1; *Infirm Persons Act*, R.S.N.B. 1973, c. I-8; *Health Care Consent Act* S.O. 1996, c. 2.

¹¹¹ As in Saskatchewan's *Health Care Directive and Substitute Health Care Decision Makers Act*, SS 1997, c. H0.001.

¹¹² *Vulnerable Persons Living with a Mental Disability Act*, C.C.S.M. c. V90.

¹¹³ *Mental Health Act* C.C.S.M. c. M110

¹¹⁴ The Alberta Act proclaimed in 1978 was the first Canadian "reform" adult guardianship legislation; Law Reform Commission of Nova Scotia *Reform of the Laws Dealing with Adult Guardianship and Personal Health Care Decisions: Final Report* (Halifax, NS: The Commission, 1995).

¹¹⁵ R. Gordon & S. Verdun-Jones, *Adult Guardianship Law in Canada* (Toronto: Carswell, 1992) at 6-38.

¹¹⁶ See also, proposed legislation in Alberta (*Adult Guardianship and Trusteeship Act*, c. A- 4.2) and British Columbia (*Adult Guardianship Act (Part 2)* R.S.B.C. c. 6).

¹¹⁷ A "patient" is defined in section 1(a) as a person "who is, because of mental infirmity arising from disease, age, or otherwise, incapable of managing his or her affairs."

¹¹⁸ *Vulnerable Persons Living with a Mental Disability Act*, C.C.S.M. c. V90.

¹¹⁹ See, *Powers of Attorney Act*, S.S. 2002, c. P-20.3; *Substitute Decisions Act*, S.O. 1992, c. 30; *Enduring Powers of Attorney Act*, R.S.Y. 2002, c. 73.

¹²⁰ See Alberta Law Reform Institute *Enduring Powers of Attorney: Safeguards Against Abuse*, Final Report No. 88 (2003: Edmonton, Alberta) <http://www.law.ualberta.ca/alri/>. See also, Western Canada Law Reform Agencies, *Enduring Powers of Attorney: Areas for Reform*, Final Report, 2008. <http://prejury.law.ualberta.ca/alri/docs/WCLRA-EPA%report.pdf>.

¹²¹ *Re K*, [1988] 1 All ER. (H.L.) at 363.

¹²² *Egli v Egli* 2005 BCCA 267.

¹²³ *Substitute Decisions Act* S.O. 1992, c.30. (personal power of attorney) and *Health Care Directive and Substitute Health Care Decision Makers Act*, S.S. 1997, c. H0.001, e.g.

¹²⁴ *Advance Health Care Directives Act* S.N.L. 1995, c. A-4.1; *Medical Consent Act*, R.S.N.S. 1989, c. 279.

¹²⁵ The Capability and Consent Board established under the *Care Consent Act* (Schedule B to the *Decision-Making Support and Protection to Adults Act*).

¹²⁶ *Vulnerable Persons Living with a Mental Disability Act*, C.C.S.M. c. V90.

¹²⁷ *Mental Health Act* C.C.S.M. c. M110

¹²⁸ The *Health Care Directives Act*, S.M. 1992, c. 33 applies to decision-making with regards to health care.

¹²⁹ L. Watts & K. Zakreski “Powers of Attorney: Moving Towards Best practices in Canada” paper given at the CBA Canadian Legal Conference, St. John’s, August 13-15 2006; R.M. Gordon “Material Abuse and Powers of Attorney in Canada: A Preliminary Examination” (1992) *J. Elder Abuse & Neglect* 173.

¹³⁰ *Decision-Making Support and Protection to Adults Act*, S.Y. 2003, c. 21, applicable also in Nunavut.

¹³¹ R.S.B.C. 1996, c. 181.

¹³² Bearing in mind legislative changes pending in British Columbia and Alberta.

¹³³ Health Canada has defined psychological abuse as “psychosocial abuse.”

¹³⁴ *Abuse and Neglect of Older Adults: A Discussion Paper* (Ottawa: Public Health Agency of Canada, 2005).

¹³⁵ See the Report of the Manitoba Law Reform Commission, *Adult Protection and Elder Abuse*, Report #103 (Winnipeg, MB: Government of Manitoba, 1999) at 15.

¹³⁶ Tuerkheimer, D., (2004) 94 “Recognising and remedying the harm of battering: a call to criminalise domestic violence” *Journal of Criminal Law and Criminology* 959.

¹³⁷ *Protection Against Family Violence Act*, R.S.A. 2000, c. P-27; *Domestic Violence and Stalking Act*, C.C.S.M. c. D93; *Victims of Domestic Violence Act*, S.S. 1994, c. V-6.02; *Victims of Family Violence Act*, R.S.P.E.I. 1988, c.V-3.2; *Family Violence Prevention Act*, R.S.Y. 2002, c. 84; *Protection Against Family Violence Act*, S.N.W.T. 2003, c. 24; *Family Abuse Intervention Act*, S.Nu. 2006, c. 18; *Domestic Violence Intervention Act*, S.N.S. 2001, c. 29; *Family Violence Protection Act*, S.N.L. 2005, c. F-3.1.

¹³⁸ As stated in the *Victims of Family Violence Act*, R.S.P.E.I. 1988, c.V-3.2.

¹³⁹ *Adult Guardianship Act (Part Three)*, R.S.B.C. 1996, c. 6.; *Vulnerable Persons Living with a Mental Disability Act*, C.C.S.M. c. V90; *Adult Protection Act*, R.S.N.S. 1989, c. 2; *Adult Protection Act*, R.S.P.E.I. 1988, c.A-5.; *Decision-Making Support and Protection*

to Adults Act, (Schedule A, Part 4 Adult Protection) S.Y. 2003, c. 21; *Neglected Adults Welfare Act*, R.S.N.L. 1990, c. N-3.

¹⁴⁰ S.N.B. 1980, c. F-2.2.

¹⁴¹ L.R.Q. c. C-12.

¹⁴² *Adult Guardianship Act (Part Three)*, R.S.B.C. 1996, c. 6; *Protection for Persons in Care Act*, R.S.A. 2000, c. P-29; *Protection for Persons in Care Act*, C.C.S.M. c. P144; *Protection for Persons in Care Act*, S.N.S. 2004, c. 33; *Protection for Persons in Care Regulations*, N.S. Reg. 364/2007, s. 3; *Adult Care Regulations*, B.C. Reg. 536/80.

¹⁴³ *Nursing Homes Act*, R.S.O. 1990, c. N.7; *Homes for the Aged and Rest Homes Act*, R.S.O. 1990, s. H.13; *Charitable Institutions Act*, R.S.O. 1990, c. C9.

¹⁴⁴ Macolini, R. M. (1995). Elder abuse policy: Considerations in research and legislation. *Behavioral Sciences & the Law*, 13, 349-

¹⁴⁵ *Ibid.*

¹⁴⁶ R.S.B.C. 1996, c. 6.

¹⁴⁷ C.C.S.M c. V90.

¹⁴⁸ R.S.N.S. 1989, c. 2

¹⁴⁹ R.S.P.E.I. 1988, c.A-5.

¹⁵⁰ S.Y. 2003, c. 21

¹⁵¹ R.S.N.L. 1990, c. N-3.

¹⁵² S.N.B. 1980, c. F-2.2.

¹⁵³ *Québec (Commission des droits de la personne et des droits de la jeunesse) v. Brzowski*, [1994] RJQ 1947.

¹⁵⁴ *Protection for Persons in Care Act*, C.C.S.M. c. P144; *Protection for Persons in Care Act*, R.S.A. 2000, c. P-29; *Protection for Persons in Care Act*, S.N.S. 2004, c. 33; *Adult Care Regulations*, B.C. Reg. 536/80.

See also, in Saskatchewan, Bill 205 (2002), *An Act respecting the Protection of Persons in Care*.

¹⁵⁵ See also, *Victims of Family Violence Act*, R.S.P.E.I. 1988, c. V-3.2 (Prince Edward Island)

¹⁵⁶ See also, the *Family Violence Prevention Act*, R.S.Y. 2002, c. 84 (Yukon).

¹⁵⁷ See also, *Victims of Domestic Violence Act*, S.S. 1994, c. V-6.02 (Saskatchewan).

¹⁵⁸ A “care relationship” is defined in section 6 as “exist[ing] between two persons, whether or not they have ever lived together, if one person is or was dependent on the other person for assistance in his or her daily life activities because of disability, illness or impairment.” “Daily life activities” are defined in section 7 as including “personal grooming, preparing meals, shopping for groceries, taking care of financial affairs, making appointments and arranging transportation to appointments.”

¹⁵⁹ Alberta, Manitoba, Prince Edward Island, Yukon, Northwest Territories, Nunavut, Nova Scotia, Newfoundland and Labrador.

¹⁶⁰ See, also, the *Family Violence Prevention Act*, R.S.Y. 2002, c. 84 (Yukon).

¹⁶¹ The Yukon’s *Family Violence Prevention Act*, R.S.Y. 2002, c. 84.

¹⁶² [1994] RJQ 1947.

¹⁶³ *Québec (Commission des droits de la personne et des droits de la jeunesse) v. Vallée*. (2003) 18 CCLT (3d) 27 (Trib. des droits de la personne); *Longtin v. Plouffe*, [2001] RJQ

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¹⁶⁴ See M.I. Hall “Equity and the Older Adult: The Doctrines of Unconscionability and Undue Influence” in A. Soden, ed. *Advising the Older Client* (Toronto: LexisNexis Butterworths, 2005).

¹⁶⁵ N.S. Reg. 364/2007, s. 3.

¹⁶⁶ The Regulations apply to facilities for children in addition to those for adults.

¹⁶⁷ Note that the *Adult Guardianship Act (Part 3)*, discussed above under *Adult Protection*, also applies in the institutional setting.

¹⁶⁸ The Regulations apply to facilities for children in addition to those for adults.

¹⁶⁹ Note that the *Adult Guardianship Act (Part 3)*, discussed above under *Adult Protection*, also applies in the institutional setting.

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	Domestic Violence/Abuse	Adult Protection	Institutional Abuse
Alberta	<i>Protection Against Family Violence Act</i> RSA 2000, c. P-27 • physical (includes stalking, forced confinement and sexual abuse) •emotional/psychological (limited- threat of physical injury or damage to property) •material exploitation/financial abuse (limited- "property damage")		<i>Protection for Persons in Care Act</i> RSA 2000, c. P-29 • physical • emotional/psychological • material exploitation/financial abuse
British Columbia		<i>Adult Guardianship Act (Part Three)</i> RSBC 1996, c. 6 • physical • emotional/psychological • material exploitation/financial abuse	
Manitoba	<i>Domestic Violence and Stalking Prevention, Protection and Compensation Act</i> SM 1998, c. 41. • physical (includes stalking, forced confinement and sexual abuse) • emotional/psychological (explicit) •material exploitation/financial abuse (limited- "property damage")	<i>Vulnerable Persons Living With a Mental Disability Act</i> CCSM, c. V90 • physical • emotional/psychological • material exploitation/financial abuse	<i>Protection for Persons in Care Act</i> SM 2000, c. 12 • physical • emotional/psychological • material exploitation/financial abuse
New Brunswick		<i>Family Services Act (Part 3)</i> SNB 1980, c. F-22 • physical • emotional/psychological	
Newfoundland and Labrador	<i>Family Violence Protection Act</i> SNL 2005, c. F-3.1 • physical (includes stalking, forced confinement, sexual abuse and deprivation of the necessities of life) •emotional/psychological (limited- threat of physical injury or damage to property) •material exploitation/financial abuse (limited- "property damage")	<i>Neglected Adults Welfare Act</i> RSNL 1990, c. N-3 • physical (limited- "persons not receiving proper care and attention")	
Northwest Territories	<i>Protection Against Family Violence Act</i> SNWT 2003, c. 24 • physical (includes forced confinement, sexual abuse) • emotional/psychological (explicit) • material exploitation/financial abuse (explicit)		
Nova Scotia	<i>Domestic Violence Intervention Act</i> SNS 2002, c. 30 • physical (includes stalking, forced confinement and sexual abuse) •emotional/psychological (limited- threat of physical injury or damage to property) •material exploitation/financial abuse (limited- "property damage")	<i>Adult Protection Act</i> RSNS 1989, c. 2 • physical • emotional/psychological	<i>Protection for Persons in Care Act</i> SNS 2004, c. 33 • physical • emotional/psychological • material exploitation/financial abuse
Nunavut	<i>Family Abuse Intervention Act</i> S.Nu. 2006, c. 18 • physical (includes forced confinement, sexual abuse and deprivation of necessities of life) • emotional/psychological (explicit) • material exploitation/financial abuse (explicit)		
Ontario			<i>Nursing Homes Act</i> RSO 1990, c. N.7 • physical • emotional/psychological ("mental")
Prince Edward Island	<i>Victims of Family Violence Act</i> RSPEI 1988, c.V-3.2 • physical (includes forced confinement, sexual abuse and deprivation of the necessities of life) •emotional/psychological (limited- threat of physical injury or damage to property) •material exploitation/financial abuse (limited- "property damage")	<i>Adult Protection Act</i> RSPEI 1988, c. A-5 • physical • emotional/psychological • material exploitation/financial abuse	

	Domestic Violence/Abuse	Adult Protection	Institutional Abuse
Quebec		Article 48, <i>Charte des Droits et Libertés de la Personne</i> LRQ c. C-12 • exploitation (broad)	
Saskatchewan	<i>Victims of Domestic Violence Act</i> SS 1994, c. V-6.02 • physical (includes forced confinement, sexual abuse and deprivation of necessities of life)• emotional/psychological (explicit) •material exploitation/financial abuse (limited- "property damage")		
Yukon	<i>Family Violence Prevention Act</i> RSY 2002, c. 84 • physical (includes forced confinement, sexual abuse and deprivation of necessities of life) •emotional/psychological (limited- threat of physical injury or damage to property) •material exploitation/financial abuse (limited- "property damage")	<i>Decision Making Support and Protection to Adults Act (Part 4)</i> SY 2003, c. 21 • physical • emotional/psychological • material exploitation/financial abuse	

These charts were initially prepared for work done for the Department of Justice Canada and are included here with permission.

	Physical	Emotional/Psychological	Mat. Exploitation/Fin. Abuse	Exploitation
Alberta	Protection Against Family Violence Act RSA 2000, c. P-27 domestic ; Protection for Persons in Care Act RSA 2000, c. P-29 institutional	Protection for Persons in Care Act RSA 2000, c. P-29 institutional	Protection for Persons in Care Act RSA 2000, c. P-29 institutional	
British Columbia	Adult Guardianship Act (Part Three) RSBC 1996, c. 6 domestic and institutional	Adult Guardianship Act (Part Three) RSBC 1996, c. 6 domestic and institutional	Adult Guardianship Act (Part Three) RSBC 1996, c. 6 domestic and institutional	
Manitoba	Domestic Violence and Stalking Prevention, Protection and Compensation Act CCSM c. D93 domestic ; Vulnerable Persons Living With a Mental Disability Act CCSM, c. V90 domestic ; Protection for Persons in Care Act CCSM c. P144 institutional	Domestic Violence and Stalking Prevention, Protection and Compensation Act CCSM c. D93 domestic ; Vulnerable Persons Living With a Mental Disability Act CCSM, c. V90 domestic ; Protection for Persons in Care Act CCSM c. P144 institutional	Vulnerable Persons Living With a Mental Disability Act CCSM, c. V90 domestic ; Protection for Persons in Care Act CCSM c. P144 institutional	
New Brunswick	Family Services Act (Part 3) SNB 1980, c. F-2.2 domestic	Family Services Act (Part 3) SNB 1980, c. F-2.2 domestic		
Newfoundland & Labrador	Neglected Adults Welfare Act RSNL 1990, c. N-3 domestic ; Family Violence Protection Act SNL 2005, c. F-3.1 domestic			
Northwest Territories	Protection Against Family Violence Act SNWT 2003, c. 24 domestic	Protection Against Family Violence Act SNWT 2003, c. 24 domestic	Protection Against Family Violence Act SNWT 2003, c. 24 domestic	
Nova Scotia	Adult Protection Act RSNS 1989, c. 2 domestic ; Domestic Violence Intervention Act SNS 2001, c. 29 domestic ; Protection for Persons in Care Act SNS 2004, c. 33 institutional	Adult Protection Act RSNS 1989, c. 2 domestic ; Protection for Persons in Care Act SNS 2004, c. 33 institutional	Protection for Persons in Care Act SNS 2004, c. 33 institutional	
Nunavut	Family Abuse Intervention Act S.Nu. 2006, c. 18 domestic	Family Abuse Intervention Act S.Nu. 2006, c. 18 domestic	Family Abuse Intervention Act S.Nu. 2006, c. 18 domestic	
Ontario	Nursing Homes Act RSO 1990, c. N.7 institutional	Nursing Homes Act RSO 1990, c. N.7 institutional		
Prince Edward Island	Victims of Family Violence Act RSPEI 1988, c. V-3.2 domestic ; Adult Protection Act RSPEI 1988, c. A-5 domestic	Adult Protection Act RSPEI 1988, c. A-5 domestic	Adult Protection Act RSPEI 1988, c. A-5 domestic	
Quebec				Charte des Droits et Libertés de la Personne LRQ c. C-12 domestic and institutional
Saskatchewan	Victims of Domestic Violence Act SS 1994, c. V-6.02 domestic	Victims of Domestic Violence Act SS 1994, c. V-6.02 domestic		
Yukon	Family Violence Prevention Act RSY 2002, c. 84 domestic ; Decision - Making Support and Protection to Adults Act (Part 4) SY 2003, c. 21 domestic and institutional	Decision - Making Support and Protection to Adults Act (Part 4) SY 2003, c. 21 domestic and institutional	Decision - Making Support and Protection to Adults Act (Part 4) SY 2003, c. 21 domestic and institutional	

	Domestic	Institutional
Alberta	physical	physical; emotional/psychological; material exploitation/financial abuse
British Columbia	physical; emotional/psychological; material exploitation/financial abuse	physical; emotional/psychological; material exploitation/financial abuse
Manitoba	physical; emotional/psychological; material exploitation/financial abuse	physical; emotional/psychological; material exploitation/financial abuse
New Brunswick	physical; emotional/psychological	
Newfoundland & Labrador	physical	
Northwest Territories	physical; emotional/psychological; material exploitation/financial abuse	
Nova Scotia	physical; emotional/psychological	physical; emotional/psychological; material exploitation/financial abuse
Nunavut	physical; emotional/psychological; material exploitation/financial abuse	
Ontario		physical; emotional/psychological
Prince Edward Island	physical; emotional/psychological; material exploitation/financial abuse	
Quebec	exploitation	exploitation
Saskatchewan	physical; emotional/psychological	
Yukon	physical; emotional/psychological; material exploitation/financial abuse	physical; emotional/psychological; material exploitation/financial abuse