

CAPACITY AND CAPACITY ASSESSMENT IN ONTARIO

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Introduction - Older Clients and Capacity

A common theme in the client work at the Advocacy Centre for the Elderly¹, an Ontario community legal clinic, is that of decisional capacity. Capacity may not always be the primary legal issue in the client case, such as in a guardianship application or a hearing to review a finding of incapacity before the Consent and Capacity Board, but often the capacity of an older client to make decisions is questioned by someone as part of the problem or conflict on which the client is seeking help. Some clients of ACE have asked if they can make a particular decision or whether they need to “consult” or get authority from a son or daughter to do something, particularly if they have given that son or daughter a Power of Attorney. Although the older client is mentally capable, he or she reports that others question his or her authority to act independently. In some instances, the client has been told that his or her son or daughter is the decision maker, not him or herself. The family member directs the service provider when in fact the capable client should have been the one the service provider turned to for authorization or consent.

Just because a person has passed some magic age that now places them in the category of “senior” or “older adult”, it doesn’t mean that that person has lost decisional capacity or that his or her capacity should necessarily be put in question. This approach is ageist and based on a wrong assumption. The vast majority of older adults retain decisional capacity and the right to make decision about their own lives, even when their physical abilities

¹ The Advocacy Centre for the Elderly is one of 79 community legal clinics in the Province of Ontario. funded by Legal Aid Ontario, ACE has the mandate to provide legal services to low income seniors. The legal services include client services, - both advice and representation before courts and tribunals at any level; public legal education - by means of the production of written materials and the presentation of education sessions and workshops; law reform activities - such as submissions to government at the local, provincial and federal levels on proposed legislation, existing policies and practices as well as participation in government advisory committees and consultations; and community development – engaging in activities to assist communities to better respond to legal issues that impact on seniors, such as elder abuse. ACE has been in operation since 1984 and was the first of such legal services in Canada to focus on law and aging. See www.ancelaw.ca for more details.

may have declined or they become frail and in need of assistance with activities of daily living.²

In our legal practice at ACE, we have observed lawyers, acting on these wrong assumptions about capacity, asking older clients to obtain capacity assessments of some type, before those lawyers will act for the client in the preparation of a will or power of attorney, or act for them in litigation or in other legal matters. Unfortunately, some of these “assessments” are ultimately meaningless as there is no specific context for the assessment. Mental capacity is always measured in a context, in relation to a particular decision. An assessment that states that the person is “globally capable” or simply “incapable” doesn’t mean much and doesn’t help the lawyer determine if the client is capable to instruct for a particular task on which the lawyer is being retained.

We have also been told by lawyers that they may do a version of the Mini Mental Status Exam (MMSE) on their older clients before being retained. This does not make sense for a number of reasons. The MMSE is not a test of decisional capacity in the legal context. The MMSE is a short screening test that is designed to evaluate basic mental function in a number of areas such as orientation, ability to recall facts, ability to write and to calculate numbers.³ However this clinical test does not shed much light on capacity to instruct in a motor vehicle case or to prepare a power of attorney for property. The results of that test may not identify if a client has the “ability to understand” and the “ability to appreciate” information relevant to making a decision. This ability to understand and ability to appreciate is the legal test of capacity in Ontario. Some persons with high scores may lack capacity to instruct on particular issues. It should not be presumed that a high score equates with capacity or lack of impaired cognitive function. The reverse may also be true, that a person a low score, may have capacity to instruct on the particular legal issue.

Even from the clinical perspective, this test has some identified “flaws”. Persons that have higher education usually score higher on the test even if they have some cognitive impairment. That test also does not reliably measure executive function or insight, an element of the “ability to appreciate” side of the legal test of capacity. Literature describing this common test and critiquing it may be found in various journals and publications.

Lawyers are not ordinarily trained in this test or in interpreting its results appropriately. Had the drafters of the Ontario capacity legislation – the *Substitute Decisions Act* and the *Health Care Consent Act* – and the legislators decided that the MMSE would be the standardized test used to determine decisional capacity, the legislation would have reflected that. In fact, extensive discussions were held at the meetings of the Fram Committee about whether there was a specific gold standard “test” of capacity. The Fram Committee, more properly known as the Attorney-General’s Advisory Committee on

² Specialists in Gerontology that have provided information to the writer on this issue include Gail Elliott of McMaster University and Michael Stones of Lakehead University. Both, as well as others, have said in presentations and discussions that only 6-8% of older adults (over 65) lack decisional capacity.

³ The test provides a quick way to determine if more in-depth testing is needed.

Substitute Decision Making for Mentally Incapable Persons⁴ prepared the report that resulted in the present Ontario legislation. With input from many sectors, including health professionals, the legal community, and the advocacy community, it was determined that there was no such gold standard test or clinical test that appropriately and reliably measured mental capacity, therefore no such test was included as the standard in the legislation. Although this legislation was drafted and proclaimed over fourteen years ago, it is still believed that no such gold standard test yet exists.

In some cases, third party assessments of capacity are appropriate as evidence in a proceeding, or as evidence to be kept on the lawyer's file as a "defense" assessment in the event someone challenges the validity of a will or Power of Attorney. However in other instances the request for the assessment is not appropriate because capacity is not at issue in the case and the client is capable to instruct on the matter on which they seek assistance.

It is the lawyer's obligation to determine any client's capacity to instruct before being retained.⁵ There are some exceptions to this rule, such as when retained by a client who

⁴ The Attorney-General's Advisory Committee for Substitute Decision Making for Mentally Incapable Persons, commonly known as the Fram Committee in honour of its Chair, Stephen Fram, Senior Policy Lawyer at the Ontario Ministry of the Attorney General, was set up in 1984 with the mandate to review the law related to mental capacity and substitute decision making for mentally incapable adults and to make recommendations for reform of this law. The Committee was composed of representatives from a variety of organizations and professions and Ministries, including health professionals, advocacy organizations, and other professional organizations ie Canadian Bar Association Ontario (as it then was). Jim McDonald, for the period in 1984, and then Judith Wahl from 1985 to the dissolution of the Committee, represented the seniors' advocacy community, along with Ivy St. Lawrence, a seniors' activist. The Committee released its report and recommendations in 1988. Legislation was drafted and introduced in 1992 (*Substitute Decisions Act, Consent to Treatment Act, and Advocacy Act*) and proclaimed in 1995. The *Consent to Treatment Act* and the *Advocacy Act* were repealed in 1996 and the *Health Care Consent Act* was introduced and passed that same year. The *Health Care Consent Act* was substantially the same as the *Consent to Treatment Act* with two notable exceptions. All reference to the role of advocates was removed from the legislation and fundamental changes were made to the rights advice processes. The *Substitute Decisions Act* amendments were also primarily related to removing the role of advocates that had been created under the *Advocacy Act* that was repealed

⁵ Law Society of Upper Canada- Rules of Professional Conduct

Client Under a Disability

2.02 (6) When a client's ability to make decisions is impaired because of minority, mental disability, or for some other reason, the lawyer shall, as far as reasonably possible, maintain a normal lawyer and client relationship.

Commentary

challenges a finding of incapacity in a Consent and Capacity Hearing. In any proceedings under the *Substitute Decisions Act* and *Health Care Consent Act* where capacity is at issue, the lawyer may presume capacity of the client to instruct. This is practical as capacity is the issue.⁶

Acting for a client in these circumstances in a proceeding under the *Substitute Decisions Act* or *Health Care Consent Act* does pose challenges for the lawyer. The lawyer is obligated to maintain a professional relationship with that client and advocate for the client. This means not falling into a “best interests” type of representation. The lawyer has to be careful not to make a judgment of the client’s best interests and to fail to take directions from the client if the lawyer believes that the client is incapable or is acting against his or her best interests, despite this direction to presume capacity in the statute.

In Banton v. Banton et al.⁷ the court stated:

The position of lawyers retained to represent a client whose capacity is an issue in proceedings under the *Substitute Decisions Act, 1992* is potentially one of considerable difficulty. Even in cases where the client is deemed to have capacity to retain and instruct counsel pursuant to section 3 (1) of the *Act*, I do not believe that counsel is in the position of a litigation guardian with authority to make decisions in the client’s interests. Counsel must take instructions from the client and must not, in my view, act as if satisfied that capacity to give instructions is lacking. A very high degree of professionalism may be required in borderline cases where it is possible that the client’s wishes may be in conflict with his or her best interests and counsel’s duties to the Court.

This obligation to determine capacity to instruct is not limited to only older clients but applies to all clients. Older clients should not be the only ones targeted for additional scrutiny of capacity. For the purpose of good practice, it is important that lawyers first

Commentary - A lawyer and client relationship presupposes that the client has the requisite mental ability to make decisions about his or her legal affairs and to give the lawyer instructions. A client's ability to make decisions, however, depends on such factors as his or her age, intelligence, experience, and mental and physical health, and on the advice, guidance, and support of others. Further, a client's ability to make decisions may change, for better or worse, over time. When a client is or comes to be under a disability that impairs his or her ability to make decisions, the impairment may be minor or it might prevent the client from having the legal capacity to give instructions or to enter into binding legal relationships. Recognizing these factors, the purpose of this rule is to direct a lawyer with a client under a disability to maintain, as far as reasonably possible, a normal lawyer and client relationship

A lawyer with a client under a disability should appreciate that if the disability of the client is such that the client no longer has the legal capacity to manage his or her legal affairs, then the lawyer may need to take steps to have a lawfully authorized representative appointed, for example, a litigation guardian, or to obtain the assistance of the Office of the Public Guardian and Trustee or the Office of the Children's Lawyer to protect the interests of the client. In any event, the lawyer has an ethical obligation to ensure that the client's interests are not abandoned.

⁶ *Substitute Decisions Act*, s. 3; *Health Care Consent Act*, s. 81

⁷ *Banton v. Banton* (1998), 164 D.L.R. (4th) 176

meet with clients and make their own determination of capacity of the client to instruct before seeking some form of assessment. Lawyers should specifically look at the capacity of the client to “make decisions about his or her legal affairs” as described in the Rules of Professional Conduct. This capacity may be different for giving instructions about a complex business transaction as opposed to asking the lawyer to advocate about his or her rights to have visitors or to take a temporary leave from a long term care home in which he or she resides.

By seeking out an assessment first before making his or her own determination of capacity to instruct, the lawyer assumes that a health professional or some other person from whom he seeks the assessment is more knowledgeable than him or her about capacity to instruct on the particular matter on which the client wants help. This is ironic considering that the capacity that we are talking about is not a clinical assessment but is a legal determination based on legal definitions of capacity. “Clinical assessments underlie diagnosis, treatment recommendations and identify or mobilize social supports. Legal assessments remove from that person the right to make autonomous decisions in specified areas.”⁸

It is also unlikely that the health professional knows the specific legal criteria for capacity for that particular purpose unless the lawyer details the definition of the decisional capacity before seeking the assessment. A report that a client “lacks testamentary capacity” or “has testamentary capacity” is not going to be helpful to the lawyer if the physician that did this assessment did not know the statutory definition of capacity or criteria from the case law about the specific type of capacity.

This is exactly where the opposing party in the action challenging the will document should attack the assessment—cross-examining the physician on what is his or her understanding of testamentary capacity. If the physician does not know the tests of capacity in the legal context, the report should not be given much weight. Likewise a report that states that the client “is capable for all purposes” is of little assistance when the lawyer needs to take instructions for litigation. There is questionable value added from these types of assessments to the lawyer’s own determination of capacity to instruct based on his or her own exchange with the client about the case to be pursued.

If a third party assessment is needed as evidence in a proceeding, or if it is appropriate to obtain a “defense” assessment for the benefit of the client in the event that capacity to instruct or to prepare a particular instrument such as a power of attorney or a will, may be challenged, then what should lawyers be doing to ensure a proper and fair assessment, appropriate to the need, is done? If capacity is at issue in a proceeding, how can a lawyer “assess the assessment” - either the one he or she obtained for the client or assessments submitted as evidence by the opposite side in the action?

The only way a lawyer is going to be able to do this, is if the lawyer understands the applicable law on capacity. This may seem obvious yet, our experience in Ontario is that

⁸ Dr. Janet Munson and Dr Carole Cohen in materials used for training of “Capacity Assessors “as defined in the *Substitute Decisions Act, 1992*, S.O., 1992, c.30

there remains a learning curve for many lawyers, as well as health professionals and service providers dealing with seniors in respect to capacity issues.

Although the *Substitute Decisions Act* and the *Health Care Consent Act*, have been in effect in Ontario since 1995, there is still a great deal of confusion about the definitions of capacity, who assesses capacity under what circumstances, and how capacity is assessed. This paper will outline the legislative framework in Ontario, examine the definitions of capacity, discuss who assesses capacity for what purposes, and review how capacity is assessed. It will also discuss the consequences of assessment and the need to “assess the assessors” if we intend to protect the rights of persons that get caught in the processes and procedures under the legislation.

Capacity – What is Capacity?

What is mental capacity? How is it defined in law? Capacity legislation is provincial therefore the definitions differ from province to province. In Ontario, decision making capacity is a legal definition, determined through a “legal” assessment. The definitions of capacity that appear in the *Substitute Decisions Act* and the *Health Care Consent Act* are as follows:

Capacity to manage property- *Substitute Decisions Act*

6. A person is incapable of managing property if the person is not able to understand information that is relevant to making a decision in the management of his or her property, or is not able to appreciate the reasonably foreseeable consequences of a decision or lack of decision.

Capacity for personal care - *Substitute Decisions Act*

45. A person is incapable of personal care if the person is not able to understand information that is relevant to making a decision concerning his or her own health care, nutrition, shelter, clothing, hygiene or safety, or is not able to appreciate the reasonably foreseeable consequences of a decision or lack of decision.

Capacity in respect to treatment, admission to a care facility, or a personal assistance service – *Health Care Consent Act*

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

The *Substitute Decisions Act* and *Health Care Consent Act* refer to capacity as relating to two streams of decision making – decisions in respect to property and decisions related to personal care. In general all the decisions that a person makes in his or her life should fall into one of these two broad categories.

Property decisions include, for example, all decision related to banking, day to day finances, investments, and real and personal property. Personal Care decisions include all decisions related to shelter, hygiene, nutrition, clothing, safety and health. Health care is the personal care area in which most often it was believed that authority for a particular decision was necessary because of the requirement for consent. That is one of the reasons why a separate *Health Care Consent Act* was created, to clarify consent and to ensure that all persons had a substitute decision maker for health care, even if that person had not executed a power of attorney for personal care or was not the subject of an order for guardianship. Health care decisions are defined as decisions related to treatment, admission to long term care homes, and personal assistance services in long term care homes.⁹

The Fram Report recommendations on this legislation proposed one bill. However two separate but related acts were created to assign administrative authority to the two appropriate Ministries, the Ministry of the Attorney General and the Ministry of Health and Long Term Care.

It is helpful to read the two acts together, as if they were one, as this does help in understanding the legislative scheme.

The two acts confirm that capacity is “issue specific” and relates to a particular decision. A person may be capable for personal care but incapable in respect to property in the broadest sense. A person may be capable in respect to some property decisions, such as simple day to day financial decisions (shopping for food, paying rent), but incapable for management of extensive assets or a business. A person may be capable to make a Continuing Power of Attorney for Property but not capable to manage property¹⁰.

On the personal care side, it is similar. A person may have the ability to consent to some simple and obvious treatments, such as treatments to care for a cut or visible wound, but lack the capacity to consent to more complex treatments such as an operation or treatment for a psychiatric disorder. Likewise, a person may be incapable of making decisions in respect to where he or she should live (shelter) but capable for making decisions about hygiene, nutrition, and clothing, which are other domains of personal decisions making.

The legislation confirms that there is a presumption of capacity.¹¹ Capacity should not come into question unless there is evidence to question that capacity for any purpose and a decision needs to be made. This presumption has broad implications. It means that it is important to look at the individual and his or her own individual “ability to understand and appreciate” information relevant to making a decision and not at any labels or diagnoses of disorders or disabilities. A person in the early stages of Alzheimer’s may still retain capacity for most purposes. A person in later stages of Alzheimer’s may still retain particular capacities and be able to make some choices. Persons with psychiatric disorders may be capable even for treatment decisions.

⁹ *Health Care Consent Act*, s.4

¹⁰ *Substitute Decisions Act*, s 6, s.8

¹¹ *Substitute Decisions Act*, s.2; *Health Care Consent Act*, s.4

The Ontario legislation defines capacity in relation to cognitive function. Assessment of capacity is an assessment of that person's decisional abilities. Capacity in this respect does not relate to functional abilities or the results of a functional assessment. A person may have multiple physical disabilities and yet be mentally capable. Just because a person is considered by service providers as being "at risk" because of his or her abilities to care for him or herself, that is not the criteria for determining that person to be incapable. The issue is whether the person has the ability to understand and appreciate the risks and not that that person chooses to place him or herself at risk.

All the definitions in the legislation focus on the "ability to understand" and the "ability to appreciate". What does this mean?

Some guidance to how to interpret these phrases comes from within the *Substitute Decisions Act*. The drafters of the act included specific definitions of capacity to give a Continuing Power of attorney for Property and a Power of attorney for personal care.

These are as follows:

SDA 8. (1) A person is capable of giving a continuing power of attorney if he or she,

- (a) knows what kind of property he or she has and its approximate value;
- (b) is aware of obligations owed to his or her dependants;
- (c) knows that the attorney will be able to do on the person's behalf anything in respect of property that the person could do if capable, except make a will, subject to the conditions and restrictions set out in the power of attorney;
- (d) knows that the attorney must account for his or her dealings with the person's property;
- (e) knows that he or she may, if capable, revoke the continuing power of attorney;
- (f) appreciates that unless the attorney manages the property prudently its value may decline; and
- (g) appreciates the possibility that the attorney could misuse the authority given to him or her. 1992, c. 30, s. 8 (1)

SDA 47. (1) A person is capable of giving a power of attorney for personal care if the person,

- (a) has the ability to understand whether the proposed attorney has a genuine concern for the person's welfare; and
- (b) appreciates that the person may need to have the proposed attorney make decisions for the person. 1992, c. 30, s. 47 (1).

In looking at the definition of capacity to give a continuing power of property, "ability to understand" is reflected in the requirements that the person know or understand particular relevant factual information – what their property is and the approximate value of it. The

criteria also includes a requirement to “know” of obligations owed to dependents, that the attorney will have the same authority to deal with the grantor’s property that the grantor would have except make a will, that the attorney must account for how he or she deals with the grantor’s property because the attorney is a fiduciary and the money being managed is not the attorney’s and that the grantor may revoke the power of attorney.

Some of the criteria go beyond having factual knowledge and require that the person also must have problem solving ability which is part of “ability to understand”. Knowing of obligations owed to dependents infers that the person must “understand” the competing interests in his or her property and legal obligations of support. Knowing about the duty to account and the ability to revoke infers that the grantor “knows” that he or she can make choices, choosing to revoke the POA or have it continue. He or she also knows that the attorney must use the grantor’s property for the grantor’s benefit and is accountable for the management of the property and can be put to the test of reporting on how that management was done. This demonstrates ability to problem solve.

“Ability to appreciate” is reflected in the requirement that the person appreciates that the property value of his or her assets may decline and that the attorney could abuse this authority that is granted in the POA This demonstrates that the person has insight and can reason, and can appraise potential outcomes of the decision to grant a POA.

The definition of capacity to give a power of attorney for personal care is similar, focusing on whether the person has the factual knowledge about the attorney concern for the grantor’s welfare as well as the appreciation or insight into the attorney’s role as attorney and that the attorney would make decisions for the grantor that impact on the grantor’s life.

What does “ability to understand “and “ability to appreciate” mean?¹² The ability to understand focuses on factual knowledge and problem solving ability, which includes understanding of options.¹³ Does the person have the ability to retain information and have the factual knowledge that he or she needs to consider when making a decision? In the treatment scenario, does the person know that he or she has a health problem and what that health problem is? Does that person have the ability to understand the risks and benefits of the treatment even if he or she does not accept the treatment offered or does not comply with the recommended health care plan? A person is not incapable just because the person refuses treatments that could be beneficial or disagrees with the health providers.

¹² Reference should be made to the cases of *Starson v. Swaze*, [2003] 1S.C.R. 722 and *Re: Koch*, 33 O.R. (35)485, [1997] O.J.No. 1487 for the discussion of these definitions and the assessment process.

¹³ The description of the terms “ability to understand” and “ability to appreciate” in this article is adapted from teaching materials and education sessions delivered by Dr. Janet Munson and Dr. Carole Cohen and from the Guidelines for Conducting Assessments of Capacity, Capacity Assessment Office, Ontario Ministry of the Attorney General , May 2005. The foreword to those Guidelines provides credit to all persons involved. That foreword gives primary credit for the guidelines to Dr. Janet Munson and Dr. Jean Kozak.

Obviously, a person is not incapable just because they have a lack of knowledge. They must be given the opportunity to learn the facts and then be assessed as to whether they understand and can retain that knowledge. In the property context, does the person know what assets and income he or she has and the approximate value of these assets? Again this is contextual. If a person does not do their own financial management, he or she may not know the details of the assets or be able to explain how much is paid for a particular expense. However he or she may be able to explain his or her overall income and that expenses do not exceed income.

In this day and age of electronic banking, many people do not pay bills by signing and mailing cheques. They have set up automatic deductions from bank accounts. This can explain why a person does not have the particular knowledge of the amount of a bill. Not knowing the specific bill amounts would then not reflect incapacity but only lack of specific knowledge.

As well, a person may not have the factual knowledge or appreciate the true value of some of his or her assets because that person has no reason to update his or her knowledge about the value of the assets. House values in Toronto have greatly increased in the past years. It would be unfair to determine that a senior is incapable of managing property just because he or she greatly underestimates the true value of the property. To put this in perspective that senior may have purchased the property in 1964 for \$12,000. He or she may know that property values have increased but when asked about the value of the asset may respond that the property has a value of \$175,000 when in fact the present value may be in excess of \$700,000. If that person is not seeking to sell the property, these answers may make sense. If that person is in the midst of a sale, or is thinking of selling and does not understand how to get the value determined or cannot retain the information about the true value, this may raise some concerns about that person's ability to understand and appreciate.

Can the person understand information about options and risks to make an informed choice? The person may make a decision to live at risk but if he or she has the ability to understand and appreciate that risk that is evidence of capacity. Can the person problem solve around personal issues, such as how he or she will accomplish necessary tasks like getting groceries or paying bills or toileting and maintaining a level of hygiene? Can the person retain information long enough to make a decision?

The ability to appreciate is related to whether that person has a realistic appraisal of outcomes and can justify choices. Appreciation focuses on the reasoning process.” The “appreciate” standard attempts to capture the evaluative nature of capable decision-making, and reflects the attachment of personal meaning to the facts in a given situation.”¹⁴ Does the person demonstrate adequate insight? Does the person acknowledge and recognize his or her own limitations that prevent him or her from meeting his or her own needs or meeting situational demands? Can that person justify his or her choices? Does the person show that he or she can make a reasoned choice? The

¹⁴ Guidelines for Conducting Assessments of Capacity, Capacity Assessment Office, Ontario Ministry of the Attorney General, May 2005, p.II.4

choice does not necessarily need to be a “reasonable” one or best one from the point of view of the observer but can the person explain his or her choices and justify them and are the choices based in reality? A person can be eccentric but still capable. Can the person manipulate the information relevant to making a decision? A person may have delusions but if the delusions do not relate to the decision that needs to be made, that person may be mentally capable.¹⁵

Note that the definitions of capacity in the statute refer to the ABILITY to understand and ABILITY to appreciate, not just understanding and appreciation. As stated by Mr Justice Major, for the majority, commenting on the test of capacity in respect to treatment in the case of *Starson v. Swayze*, [2004] 1 S.C.R. 722,

“... the Act (*Health Care Consent Act*) requires a patient to have the ability to appreciate the consequences of a decision. It does not require actual appreciation of those consequences. The distinction is subtle but important: see L. H. Roth, A. Meisel and C. W. Lidz, "Tests of Competency to Consent to Treatment" (1977), 134 *Am. J. Psychiatry* 279, at pp. 281-82, and Weisstub Report, *supra*, at p. 249 . In practice, the determination of capacity should begin with an inquiry into the patient's actual appreciation of the parameters of the decision being made: the nature and purpose of the proposed treatment; the foreseeable benefits and risks of treatment; the alternative courses of action available; and the expected consequences of not having the treatment. If the patient shows an appreciation of these parameters -- regardless of whether he weighs or values the information differently than the attending physician and disagrees with the treatment recommendation -- he has the ability to appreciate the decision he makes: see Roth, Meisel and Lidz, *supra*, at p. 281.

However, a patient's failure to demonstrate actual appreciation does not inexorably lead to a conclusion of incapacity. The patient's lack of appreciation may derive from causes that do not undermine his ability to appreciate consequences. For instance, a lack of appreciation may reflect the attending physician's failure to adequately inform the patient of the decision's consequences: see the Weisstub Report, *supra*, at p. 249. Accordingly, it is imperative that the Board inquire into the reasons for the patient's failure to appreciate consequences. A finding of incapacity is justified only if those reasons demonstrate that the patient's mental disorder prevents him [page763] from having the ability to appreciate the foreseeable consequences of the decision.”

¹⁵ See also Quick reference Chart on Capacity Assessment at the end of this paper. This chart has been reformatted into a foldout Pocket Tool that is available from The National Initiative for Care of the Elderly – see <http://nicenet.aging.utoronto.ca> or contact the NICE Network Manager Institute for Life Course and Aging, University of Toronto, 222 College St., Suite 106, Toronto, Ontario, Canada M5T 3J1
Phone: 416-978-0377 **Fax:** 416-978-4771

Who Assesses Capacity?

Who assesses capacity? This is a somewhat difficult question to answer as it depends on a number of factors.¹⁶ A chart is attached to this paper that sets out who must be used to assess capacity in particular defined circumstances in the legislation. It is necessary to look at what type of capacity is being assessed or what decision needs to be made. It is also necessary to look at whether the statutes, the *Substitute Decisions Act* or the *Health Care Consent Act*, or any other statute, require a particular class of persons to assess the particular capacity.¹⁷ These two acts provide for two particular special groups of people that must do particular types of capacity assessments. These are “capacity assessors”¹⁸ as defined in the *Substitute Decisions Act* and “evaluators”¹⁹ as defined in the *Health Care Consent Act*. It is important to understand that capacity assessors and evaluators are not required to be used for all assessments of capacity despite the fact they are specifically mandated to do certain assessments. Their role will be described in greater detail later in this paper.

If a statute does not require a particular class of persons to do the determination of capacity, then the answer as to who assesses is in the common law.²⁰

For **capacity to instruct**, as described above, it is the **lawyer** interacting with the potential client that should determine this capacity,

For **health treatment**, the **health practitioner who proposes the treatment** is responsible for the assessment of capacity of the patient.²¹ The term health practitioner²² is defined in the *Health Care Consent Act* as including all persons who are members of any of the regulated health professions, such as physicians, nurses, psychologists, dentists, audiologists, physiotherapists as well as naturopaths registered as a drugless therapists under the *Drugless Practitioners Act*. The full list of health practitioners is in the definitions section 1 of that legislation.

If there is a plan of treatment for a person involving more than one health practitioners, one health practitioner on behalf of the team of health practitioners may determine the person’s capacity in respect to the treatments in the plan.²³

If the health practitioner determines that the person is incapable for the treatment proposed, he or she is required to inform that person of the consequences of that finding

¹⁶ See Chart on Who Assesses Capacity Under What Circumstances at end of paper.

¹⁷ An example of another statute that specifies who assesses capacity in respect to property is the Mental Health Act, R.S.O. 1990, c. M.7. S.54 of that Act requires on admission of a patient to a psychiatric facility, that a physician determine whether that patient is capable of managing property.

¹⁸ *Substitute Decisions Act*, S. 1(1) and Ontario Regulation 460/05, s.2

¹⁹ *Health Care Consent Act*, 1996, S.O. 1996, c.2, Schedule A, s. 2(1) and Ontario Regulation 104/96 as amended by O.Reg 264/00

²⁰ See Chart - Who Assesses Capacity Under What Circumstances at end of paper

²¹ *Health Care Consent Act*, 1996, S.O. 1996, c.2, Schedule A, s.10(1)

²² *Health Care Consent Act*, 1996, S.O. 1996, c.2, Schedule A, s.1

²³ *Health Care Consent Act*, 1996, S.O. 1996, c.2, Schedule A, s.13

of incapacity²⁴, following the guidelines for their particular Health College. In general, the guidelines specify that the finding of incapacity must be communicated and the fact that the health practitioner will turn to the incapable persons substitute decision maker for the consent or refusal of consent to the treatment proposed. As well the person must be informed of the opportunity to challenge the finding of incapacity by way of a hearing before the Consent and Capacity Board. If the person does not challenge this finding then the health practitioner may proceed to get the consent or refusal of consent from the substitute.²⁵ In getting the consent or refusal of consent from the substitute, the health practitioner is also obligated to inform the substitute of his or her obligation to follow the wishes of the person who is now incapable, expressed by that person when capable, that are relevant to the decision to be made. If no such wishes are known, then the substitute must make a decision for the incapable person that is in their best interests²⁶.

It is also a statutory requirement that **capacity to make a decision in respect to admission to a long term care facility** must be assessed by an “evaluator”²⁷. An evaluator is defined in the statute as a member of one of the following Health Colleges:

- (a) College of Audiologists and Speech-Language Pathologists of Ontario
- (b) College of Nurses of Ontario
- (c) College of Occupational Therapists of Ontario
- (d) College of Physicians and Surgeons of Ontario
- (e) College of Physiotherapists of Ontario
- (f) College of Psychologists of Ontario²⁸

In addition to the various health practitioners listed in the statute, social workers are added by Regulation 104/96 as amended by O.Reg. 264/00 under the *Health Care Consent Act* as evaluators. The term "social worker" is defined as a member of the Ontario College of Social Workers and Social Service Workers who holds a certificate of registration for social work.

These health professionals were chosen to undertake this determination of capacity because these are the professionals most likely to be providing direct services to seniors, the primary users of long term care, both in the community and in health care facilities.

The Ontario legislation also provides for persons called “**capacity assessors**”. The term "capacity assessor" is defined in the *Substitute Decisions Act*, Regulation 460/05. This regulation states:

“2. (1) A person is qualified to do assessments of capacity if he or she,

²⁴ *Health Care Consent Act*, 1996, S.O. 1996, c.2, Schedule A, s.17

²⁵ See also *Health Care Consent Act*, 1996, S.O. 1996, c.2, Schedule A., s.18

²⁶ *M. (A.) v. Benes*, 46 O.R. (3d) 271, [1999] O.J. No. 4236 (C.A.) See p.23 in the decision of Justices Abella, Laskin and Moldaver, “When the words "in accordance with this Act" are constructed in a manner consistent with the Charter and afforded the fair, large and liberal interpretation they deserve to best attain the objects of the Act, we are satisfied that s. 10(1)(b) does impose an obligation on health practitioners to ensure that S.D.M.s understand the requirements of s. 21 of the Act when deciding whether consent to a proposed treatment should be given or refused”

²⁷ *Health Care Consent Act*, 1996, S.O. 1996, c.2, Schedule A. 40(1)

²⁸ *Health Care Consent Act*, 1996, S.O. 1996, c.2, Schedule A,s.2(1)

(a) satisfies one of the conditions set out in subsection (2);
(b) has successfully completed the qualifying course for assessors described in section 4;
(c) complies with section 5 (continuing education courses);
(d) complies with section 6 (minimum annual number of assessments); and
(e) is covered by professional liability insurance of not less than \$1,000,000, in respect of assessments of capacity, or belongs to an association that provides protection against professional liability, in respect of assessments of capacity, in an amount not less than \$1,000,000.

(2) The following are the conditions mentioned in clause (1) (a):

1. Being a member of the College of Physicians and Surgeons of Ontario.
2. Being a member of the College of Psychologists of Ontario.
3. Being a member of the Ontario College of Social Workers and Social Service Workers and holding a certificate of registration for social work.
4. Being a member of the College of Occupational Therapists of Ontario.
5. Being a member of the College of Nurses of Ontario and holding a general certificate of registration as a registered nurse or an extended certificate of registration as a registered nurse.

(3) The requirement that the person hold a general certificate of registration as a registered nurse or an extended certificate of registration as a registered nurse, as set out in paragraph 5 of subsection (2), does not apply to a member of the College of Nurses of Ontario who, on November 30, 2005, is qualified to do assessments of capacity under Ontario Regulation 293/96 (Capacity Assessment) made under the Act.

(4) Clause (1) (b) does not apply to a person who, on November 30, 2005, is qualified to do assessments of capacity under Ontario Regulation 293/96 (Capacity Assessment) made under the Act. ... “

Despite this misleading title, capacity assessors are not required to be used for capacity assessments unless the statute so requires. Capacity assessors should not be used to determine capacity for treatment because that responsibility is that of the health professional proposing the treatment.

Although capacity assessors are not required in all instances to determine capacity to manage property, **capacity assessors** are required to assess **capacity in respect to property to trigger a statutory guardianship** under s. 16 of the *Substitute Decision Act*. A statutory guardianship is a type of guardianship of property. A request may be made to a capacity assessor to do this type of assessment if the person to be assessed is believed to lack capacity to manage property, and has not executed a continuing power of attorney for property over all their property.²⁹

If a person has created a **continuing power of attorney for property** and drafted into it a **requirement that the power of attorney should not come into effect until he or she has been assessed as incapable to manage property**, and the **method of assessment is**

²⁹ *Substitute Decisions Act, 1992*, S.O. 1992, c.30, s.16

not specified in that power of attorney document, then the *Substitute Decisions Act*, s.9 (3) specifies that a **capacity assessor** must be used to assess capacity. If the person had specified a different method of assessment, such as by a nurse, physician, or even a person that is not a health professional, such as a family member or friend, that other method of assessment would need to be followed. The assessment by a capacity assessor is the **default**, as set out in the statute.

A similar provision may be included in a **power of attorney for personal care about the confirmation of incapacity before the POAPC comes into effect.**³⁰ As with Continuing POA for Property, the requirement for confirmation of incapacity may state that a particular person or class of persons does this confirmation of incapacity, even if the person or type of person named is not a health professional or capacity assessor. If the **requirement for assessment is included in the POAPC but no person or class of persons is specified to do the assessment, the default is that a “Capacity assessor”** as defined by the legislation do the confirmation of incapacity.³¹

Capacity Assessors are required to conduct assessments in the manner and form as described in the “Guidelines for Conducting Assessments of Capacity” dated May, 2005, available on the internet website of the Ontario Ministry of the Attorney General. Failure to comply with the prescribed guidelines may result in a complaint to the college of the regulated health profession of which the assessor is a member.

No “formal” assessment by a health professional or capacity assessor or evaluator is necessary in all circumstances to determine that a person is incapable and lacks decisional capacity. The formal assessments are required only if the statute so specifies for a particular purpose or a person has drafted this requirement into a power of attorney document. In other circumstances, for example, to trigger a power of attorney for property that does not specify a requirement for a formal assessment, then the named attorney makes the determination of incapacity which would require him or her to take over management of the grantor’s property.³²

Capacity assessors may charge fees for the assessments that they undertake. These fees may range anywhere from \$300 to fairly substantial sums, depending on the time necessary to the assessment and the complexity of the assessment. These fees are not covered by provincial health insurance. The person requesting the assessment is usually responsible for the payment for the assessment although requestors may ask for reimbursement from the person’s estate if the person is found incapable and a statutory guardian is created, and there are sufficient funds in the incapable person’s estate to pay for the assessment.

There is also a Financial Assistance Programme to cover the costs of an assessment where an individual makes this request and cannot afford to pay the fees.

³⁰ *Substitute Decisions Act*, s.49

³¹ *Substitute Decisions Act*, s. 49(2)

³² See Chart at end of paper

As stated in the information sheet from the Capacity Assessment Office³³ this assistance is available if:

- a. the particular assessment required cannot, by law, be completed by anyone other than a designated capacity assessor;
- b. the Capacity Assessment Office agrees that a capacity assessment is appropriate in the circumstances; and
- c. the individual requesting the assessment meets the financial criteria to be eligible for financial assistance. To determine this, the requester will need to provide financial information about his/her **own** finances.”

Applications for Financial Assistance are available from the Capacity Assessment Office which is located at the Office of the Ontario Public Guardian and Trustee.

How is Capacity Assessed?

As described earlier in this paper, whoever is doing assessment of decisional capacity for any purpose in Ontario needs to assess whether a person has the ability to understand and the ability to appreciate the information relevant to making the particular decision. Pages 6 to 11 describe the elements of that assessment. That description is adapted from the Guidelines for Capacity assessors and the case law.

The rules concerning assessments are more proscribed for the designated capacity assessors.

The designated Capacity assessors are required to conduct assessments in the manner and form as described in the “Guidelines for Conducting Assessments of Capacity” dated May, 2005., The Guidelines are not attached to this paper because these are available on the internet website of the Ontario Ministry of the Attorney General, under the page for the Public Guardian and Trustee, at www.attorneygeneral.jus.gov.on.ca/english/family/pgt/capacity.asp

These Guidelines were originally developed in 1995 and used in the training of the designated capacity assessors from the outset. However, the requirement to follow the Guidelines, to have the quality of the assessments reviewed, to have mandatory continuing education, and to do a minimum number of assessments to retain designation only came into effect in December 2005.

Originally, the capacity assessment office and system that oversaw these assessors was more extensive. It had been intended to create a more comprehensive system that would include standards for assessors, peer review, various quality assurance practices, discipline procedures, continuing education and a code of ethics. Prior to proclamation of the legislation, there was not enough time to set up this complete system although the

³³ Capacity Assessment Office: Questions and Answers , Ministry of the Attorney General, www.attorneygeneral.jus.gov.on.ca/English/family/pgt/capacityoffice.asp#12

Capacity Assessment Office was established and originally staffed by 7 or 8 people that were working on this system development, The discussions about the appropriate oversight for assessors included discussions about the establishment of a “College” of assessors or a similar body. The hope was that by committing resources to this work that capacity assessment would be improved and that research on assessment in the legal context would be an outcome.

Unfortunately, as the party in power in the provincial government changed shortly after the proclamation of this legislation, within a year, the legislation was amended, parts of the legislative package were repealed, and the Capacity Assessment Office was reduced to a two person office that could not undertake the system development that had been contemplated. Nor was that the mandate of that office at that time. Passage of this recent regulation has been lauded by many, particularly advocates for the persons most likely to be assessed as it is hoped that the quality of the assessments will improve as a result.

The original education programme to be designated as an assessor took a full week and included testing on the legislation as well as the assessment process. The assessors’ course is now only one day and lacks many of the previous testing requirements.

Assessors originally did not need to be regulated health professionals. Assessor applicants could come from any field and background, including law. This was changed in the 1996 amendments to the *Substitute Decisions Act* primarily to address discipline and complaints. With the dissolution of the broader based Capacity Assessment Office that did develop a Code of Ethics for assessors and had the potential authority to discipline and remove the designation of the assessors, it was decided that capacity assessors had to be regulated health professionals as those systems already had provision for complaints and discipline. Complaints about assessors can now be made to the appropriate Health Colleges.

Capacity assessors cannot do an assessment if the person refuses to be assessed.³⁴ The person does not need to consent; he or she just has to not refuse. This lesser threshold was put in legislation to get around the claim that the person may not be capable of consenting. The capacity assessor must explain to the person to be assessed,

- “(a) the purpose of the assessment;
- (b) the significance and effect of a finding of capacity or incapacity; and
- (c) the person’s right to refuse to be assessed. “

This requirement does not need to be followed if the assessment was ordered by the court under section 79 of the *Substitute Decisions Act*.

This requirement was included in the legislation for fairness. This requirement provides for a level of rights advice prior to the assessment taking place because the consequences of the assessment, if the person is found incapable, will be that person loses authority over the management of their property and a statutory guardianship will be created. If the person refuses the assessment, the person who requested the assessment, usually a family

³⁴ SDA s.78

member, will need to apply to court for a Guardianship order. In that process he or she can ask for an order for an assessment.

When doing the assessment, the expectation is that the capacity assessors will follow a fair process. This would include ensuring that the person is comfortable and can hear the assessor and can understand what the assessor is saying to him or her. The assessor should not use terminology or technical language and should gear his or her questions to the education level and abilities of that individual.

If the person being assessed wants other persons present during the assessment that should be accommodated.

In doing the assessment, the assessors are expected to “probe” and verify – to ask questions to determine the thought process of the person being assessed and to check if what the person is saying is correct or logical and not a delusion. Mr. Justice Quinn in the case of *Re:Koch*, 33 O.R. (3d) 485, [1997] O.J. No. 1487 commented on the assessments of capacity done by a capacity assessor, Talosi, and an evaluator, Higgins. He states:

“In my view, it was not sufficient for Talosi and Higgins merely to record information provided by the appellant and then form an opinion. In some instances the appellant should have been probed to determine the thought process by which she arrived at an answer or statement. Until her thought process is known, it is neither fair nor reasonable to impugn the appellant's mental capacity. By not exploring the process by which the appellant arrived at her decisions, answers and statements, Talosi and Higgins have assumed, quite unfairly, the absence of logic. In doing so, they greatly impaired their ability to assess and evaluate the appellant's cognitive abilities. In addition, of course, they adulterated their credibility.

In some instances, verification should have been sought. For example, regarding the allegations made by the appellant against her husband (which Talosi seems to have dismissed as delusional) Talosi should have made some effort to verify their accuracy. At the very least, she might have spoken with the appellant's lawyer to ascertain whether he had any corroborative particulars.”

Designated capacity assessors are required to be used for particular assessments as required in the *Substitute Decisions Act*. If a capacity assessor is used to do other types of assessments, such as testamentary capacity, caution should be taken to determine if the assessor has the knowledge to do that type of assessment and to make such an opinion. In becoming a designated capacity assessor, he or she does not have any particular training on that type of assessment and may not be aware of the legal test for testamentary capacity. When seeking to challenge or discredit an opinion about incapacity by a capacity assessor that is not an assessment required to be done by a capacity assessor, the person challenging the assessment should examine the capacity assessor's knowledge and expertise, if any, to give such an opinion.

When doing assessments of capacity that are not specified as requiring capacity assessors to do the assessment, the assessors are not doing an “assessment” that triggers a particular event or change of status of the person assessed, such as what happens if an assessor finds a person incapable in respect to property that triggers a statutory guardianship under s. 16 of the *Substitute Decisions Act*. The capacity assessor is only rendering an “opinion” as to capacity.

In contrast to the capacity assessors, the evaluators receive no specific training on capacity assessment. Many evaluators are also case managers at Community Care Access Centres and their CCAC may provide some training on the evaluation process, but such training is not specifically required. Staff from ACE have presented at continuing education programmes for CCAC and long term care home staff on capacity evaluation but those programmes have been in a group setting and do not provide the one on one or small group training that evaluators in training would get more specific benefit from. The evaluators get the authority to assess capacity in respect to consent to admission into long term care homes simply from being a member of one of the Health Colleges that are listed in the definition of evaluator.³⁵

As stated previously, evaluators must be used to assess capacity to consent to admission to a long term care homes. Before a person is admitted into a long term care home that person must be assessed as having health and functional needs of the level required for admission. That person must also consent to admission. If the person is not mentally capable to consent, then that person’s substitute decision maker as defined by the legislation may provide that consent.

There is no equivalent to s. 78 of the SDA in the HCCA that would apply to evaluators, however, in obiter, in *Re: Koch* case, Mr. Justice Quinn stated that the evaluators should also inform the person being evaluated of the purpose and consequences of the evaluation and should not evaluate if the person refuses.

The evaluators use a questionnaire when evaluating the capacity of a person to consent to admission. This questionnaire is not part of the legislation but was created by the Ministry of Health and Long Term Care to assist the evaluators. The questionnaire contains 5 questions which are as follows:

1. What problems are you having right now?
2. How do you think admission to a nursing home or home for the aged could help you with your condition /problem?

³⁵ The writer is a sessional lecturer at the University of Toronto in the Faculty of Social Work and teaches a course on Law and Aging for MSW students. It is interesting to note that a number of students, after graduation, have ended up in employment where they are called upon to evaluate capacity in respect to admission of their clients. Several of these students have informed the writer that they received no additional training in evaluation of capacity in their employment and only had the understanding of their role as evaluators because they had taken the course on Law and Aging. Considering the impact of the determination of incapacity by these evaluators, it is submitted that there should be a requirement for and standards for training in capacity evaluation added to the legislation.

3. Can you think of other ways of looking after your condition/problem?
4. What could happen to you if you choose not to live in a nursing home or home for the aged?
5. What could happen to you if you choose to live in a nursing home or home for the aged?

This questionnaire has come under a great deal of criticism as it is very simplistic. Some evaluators use it in a narrow way, asking only these questions before they form an opinion of capacity of the person being assessed. This approach is inadequate and will likely result in an assessment that is easily challenged if the person applies to the Consent and Capacity Board for a review.

Evaluators should “probe and verify” and approach the assessment in a manner similar to that of the designated capacity assessors. The 5 question questionnaire was intended as a tool, to roughly outline to the evaluator the types of questions that they should ask and the areas to explore to assess the ability to understand and the ability to appreciate in respect to decisions about admission to long term care. The evaluators should ensure that before starting the evaluation that the person is aware of his or her own state of health and what a long term care facility is and how this type of accommodation would assist the person. Many people do not have the factual knowledge about what long term care is and how these homes operate. Without this basic information it would be unfair to assess someone’s capacity to make decisions about admission.

Assessing the Assessments

What should a lawyer do to ensure that a good assessment is done?

First determine why an assessment is needed? Will it be used as evidence in a hearing and what type of hearing? For applications for guardianship, to proceed by summary application, assessments by capacity assessors are required. If not applying for a summary order, then other evidence of incapacity, such as reports by other health providers, affidavits from family and other evidence may be presented instead of a report from a capacity assessor. To trigger a statutory guardianship for property, an assessment by a capacity assessor must be obtained. Make certain that the right type of assessment is obtained from the right party that will be useful for the purpose intended.

Is the assessment going to be used as additional evidence of capacity for a particular purpose, to paper the file in the event that capacity to execute a particular document may be challenged? For this purpose, is an assessment the best evidence or should other evidence also be obtained, such as affidavit evidence from other persons that know the client and have observed the client’s actions and behaviours and could attest to the client’s capacity?

If the lawyer's opinion is that an opinion about the client's capacity for a particular purpose should be obtained, then from whom should that opinion be obtained? Should it be from a "capacity assessor" as defined by the *Substitute Decisions Act* or someone else? For example, if the client has had a stroke, and now wants to change his or her will, but he or she has suffered some effects from that stroke, such as limitations on the ability to communicate, an opinion about testamentary capacity from that client's long time physician, that knew the client both before and after the stroke, and that can give an opinion both on the decisional capacity of the client (based on the definition of testamentary capacity) as well as a clinical assessment of the impact of the stroke on the cognitive functioning of the client may be more effective in a defence situation than an opinion from a designated capacity assessor who would not have met the client before the stroke but is meeting the client only the first time when asked to give an opinion about capacity. As well, any such assessment of a person that has communication difficulties may be facilitated with the help of a speech-language pathologist as that may make it less subject to challenge.

Defence assessments should not be used to "prove" to the lawyer that the client is capable for the purpose he or she is retaining the lawyer. The lawyer should first be satisfied that the client has capacity to instruct and then obtain additional assessments as supplemental to his or her own opinion of capacity.

It is the responsibility of the lawyer to make a good request for an assessment. That would include detailing to the assessor the type of assessment required, the legal tests of capacity, and information from case law as to the criteria in respect to capacity and the process of assessment. Include information on the requirement to "probe and verify", or the requirement that the assessment must follow the Guidelines for Capacity Assessment if the assessment is being done by a capacity assessor and the assessment is one in which the statute requires capacity assessors to be used.

Be specific as to the capacity to be assessed, be it property, or capacity to do a POA, or testamentary capacity etc.

Explain the purpose of the assessment—as to whether it is for defence purposes or to trigger a statutory guardianship. Lawyers have advised us that they were surprised when their client's property suddenly was being managed by the Public Guardian and Trustee when the lawyer was only looking for an opinion on the client's capacity to manage property to assist the lawyer in discussions with the client on possible options for property management.

If the lawyer is given an assessment about his or her client alleging incapacity, how does the lawyer assess the assessment?

Has the assessment been done by the right type of assessor for the purpose the assessment is to be used? Did that assessor follow the proper process of assessment? Is it clear what "test" of capacity was used – did the assessor assess the person in relation to the legal test

of capacity or is it a functional assessment or an assessment based on the MMSE or other type of test?

Did the assessor follow any statutory requirements of process, such as the s.78 requirement to inform the person that he or she could refuse the assessment? Did the client receive the proper rights advice information if required by statute?

Did the assessor accommodate for the client's needs in respect to hearing, language, education level? Did the assessor inform the person that he or she could have others present during the assessment, such as family, friends, his or her lawyer?

Did the assessor "probe and verify"? In one case, an evaluator concluded that a woman was incapable in respect to admission. She based this opinion on a number of factors including her observations on the state of disorder of the woman's home and on the woman's behaviours during the assessment. The woman had been ironing her husband's shirts when the evaluator met with her. The evaluator knew that the woman's husband had died nearly ten years before. The evaluator did not ask the woman why she was ironing these shirts but concluded that the woman was delusional and thought her husband was alive. In fact, if asked, the woman would have explained that she was ironing the shirts because she was planning to give the shirts to the Salvation Army for use by other people. The evaluator had failed to "probe and verify".

Is the written report complete? Does the report properly detail the person's own words used when questioned and the questions asked by the assessor to determine the person's ability to understand and the ability to appreciate the information relevant to the particular decision to be made?

Impact of Assessments

An assessment on incapacity can have a profound effect on a person's life. The assessment can be used in proceedings that could result in the person losing authority to make decisions in major portions of his or her life. In guardianship applications, the judge ultimately makes the decision whether the person is incapable or not for particular purposes and the assessments are only part of the evidence. Other assessments, such as the assessment to trigger a statutory guardianship of property or the determination by a health practitioner that a person is incapable in respect to treatment, can have an almost immediate impact even though the person has the right to have a review of these assessments by the Consent and Capacity Board. That right of review is almost wholly dependent on that person receiving the proper required rights advice and information on how to apply to the Board. This rights advice, although required, may not be given or the person may not fully understand that process or be able to get through that process without assistance.

The assessment process is a major intrusion in a person's life, and should not be undertaken without appreciation of the possible consequences as well as the impact on the individual. It cannot be easy to know that others are questioning your capacity to make decisions for yourself!

Lawyers play a major role in ensuring that capacity assessments are used properly, obtained only when necessary for a particular purpose, and are done in a fair manner.

Who Assesses Capacity Under What Circumstances

PROPERTY	Who Assesses Capacity
A. Contracts	
To make a contract	Parties to the contract (Common Law)
B. Continuing Power of Attorney for Property	
To make a CPOAP	Person assisting person to make the document
To activate a CPOAP	No assessment required - CPOAP is activated on signature unless it states otherwise
To activate the CPOAP if it contains a clause that it is not to come into effect until incapacity	Person/Professional named in the CPOAP to determine incapacity - If no one or no class of persons is named in the CPOAP to determine capacity, then it would be done by a CAPACITY ASSESSOR as defined by the <i>Substitute Decisions Act</i> , s. 9(3)
C. Statutory Guardianship	
Psychiatric Inpatient - For property management on admission as an inpatient for Care, Observation or Treatment for a mental health problem	Physician (<i>Mental Health Act</i> and s.15 <i>Substitute Decisions Act</i>)
Psychiatric Inpatient - For property management on discharge from the psychiatric facility	Physician (<i>Mental Health Act</i>)
Person who is any place other than a psychiatric facility (own home, hospital, long-term care home) NOTE - for the <i>Mental Health Act</i> process to be used the patient must be an inpatient in a psychiatric facility and must be in the facility for care, observation, or treatment of the psychiatric disorder . This process does NOT apply to elderly patients in hospitals even if the hospital is defined as a "psychiatric facility" under the <i>Mental Health Act</i> unless that elderly patient is in that hospital for CARE. OBSERVATION or TREATMENT of a psychiatric disorder.	Capacity Assessor (s.16 <i>Substitute Decisions Act</i>)

D. Court Ordered Guardianship of Property	
Summary Application (application to court that does not require an appearance before a Judge)	Capacity Assessor and a Person Who knows the Alleged Incapable Person (<i>Substitute Decisions Act</i> , s.72(1))
Full hearing before a Judge	Capacity Assessors, Other Health Professionals, Others that know the Alleged Incapable Person (<i>Substitute Decisions Act</i>)

PERSONAL CARE	Who Assesses Capacity
A. Power of attorney for Personal Care	
To make a POAPC	Person assisting person to make Document (Common Law)
To activate POAPC for SDM to make treatment decisions	Health Professional Proposing Treatment (<i>Health Care Consent Act</i> , s. 10(1)(b) and <i>Substitute Decisions Act</i> , s.49(1)(a))
To activate POAPC for SDM to make decisions for admission to a LTC Home	Evaluator (see definition below) <i>Health Care Consent Act</i> , s.40(1) and <i>Substitute Decisions Act</i> , s.49(1)(a)
To activate POAPC for SDM to make decisions for personal assistance services in a LTC Home	Evaluator <i>Health Care Consent Act</i> , s. 57(1) and <i>Substitute Decisions Act</i> , s.49(1)(a)
To activate POAPC for non health care personal decisions where POAPC does not require an assessment before activation	Attorney named in the POAPC <i>Substitute Decisions Act</i> , s.49(1)(b)
To activate POAPC for non health care personal care decisions where POAPC specifies a method of assessment	Person/class of persons specified in the document to do the assessment <i>Substitute Decisions Act</i> , s.49(1)(b) and s.49(2)
To activate POAPC where POAPC silent as to method preferred but does require an assessment before activation	Capacity Assessor (see definition below) <i>Substitute Decisions Act</i> , s. 49(2)
B. Court Ordered Guardianship of the Person	
Summary Application (application to court that does not require an appearance before a Judge)	Statements of two Capacity assessors, <i>Substitute Decisions Act</i> , s. 74(1)
Full hearing before a Judge	Capacity Assessors, Other Health Professionals, Others that know the Alleged Incapable Person (<i>Substitute Decisions Act</i> , S. 71(1))

C. Health Care Consent	
Treatment	Health Practitioner offering the treatment, <i>Health Care Consent Act</i> , s.10(1)(b)
Admission to LTCF	Evaluator <i>Health Care Consent Act</i> , s. 40(1)
Personal assistance services in a LTCF	Evaluator <i>Health Care Consent Act</i> , s. 57(1)

An "**evaluator**" means, "in the circumstances prescribed by the regulations, a person described in clause (a), (l), (m), (o), (p) or (q) of the definition of "health practitioner"... or a member of a category of persons prescribed by the regulations as evaluators." (*Health Care Consent Act*, section 2(1)) .

These health practitioners are:

- (g) a member of the College of Audiologists and Speech-Language Pathologists of Ontario
- (h) a member of the College of Nurses of Ontario
- (i) a member of the College of Occupational Therapists of Ontario
- (j) a member of the College of Physicians and Surgeons of Ontario
- (k) a member of the College of Physiotherapists of Ontario
- (l) a member of the College of Psychologists of Ontario

In addition to the various health practitioners listed in this definition, social workers are added by Regulation 104/96 as amended by O.Reg. 264/00 under the *Health Care Consent Act* as evaluators. The term "social worker" is defined as a member of the Ontario College of Social Workers and Social Service Workers who holds a certificate of registration for social work. .

"**capacity assessor**" is defined in the *Substitute Decisions Act*, Regulation 460/05. This regulation states:

- 2.** (1) A person is qualified to do assessments of capacity if he or she,
- (a) satisfies one of the conditions set out in subsection (2);
 - (b) has successfully completed the qualifying course for assessors described in section 4;
 - (c) complies with section 5 (continuing education courses);
 - (d) complies with section 6 (minimum annual number of assessments); and
 - (e) is covered by professional liability insurance of not less than \$1,000,000, in respect of assessments of capacity, or belongs to an association that provides protection against professional liability, in respect of assessments of capacity, in an amount not less than \$1,000,000.

(2) The following are the conditions mentioned in clause (1) (a):

- 1. Being a member of the College of Physicians and Surgeons of Ontario.
- 2. Being a member of the College of Psychologists of Ontario.
- 3. Being a member of the Ontario College of Social Workers and Social Service Workers and holding a certificate of registration for social work.
- 4. Being a member of the College of Occupational Therapists of Ontario.

5. Being a member of the College of Nurses of Ontario and holding a general certificate of registration as a registered nurse or an extended certificate of registration as a registered nurse.

(3) The requirement that the person hold a general certificate of registration as a registered nurse or an extended certificate of registration as a registered nurse, as set out in paragraph 5 of subsection (2), does not apply to a member of the College of Nurses of Ontario who, on November 30, 2005, is qualified to do assessments of capacity under Ontario Regulation 293/96 (Capacity Assessment) made under the Act.

(4) Clause (1) (b) does not apply to a person who, on November 30, 2005, is qualified to do assessments of capacity under Ontario Regulation 293/96 (Capacity Assessment) made under the Act.

Guidelines

Capacity Assessors are required to conduct assessments in the manner and form as described in the “Guidelines for Conducting Assessments of Capacity” established by the Attorney General, dated May, 2005, available on the internet website of the Ministry of the Attorney General at

<http://www.attorneygeneral.jus.gov.on.ca/english/family/pgt/capacity.asp> are prescribed.

Failure to comply with the prescribed guidelines may result in a complaint to the college of the regulated health profession of which the assessor is a member.

(Regulation 460/05 came into effect December 1, 2005)

WHAT IS DECISIONAL MENTAL CAPACITY?

- Legal Definition NOT Clinical Definition
- Different legal definition in different jurisdictions (ie. different provinces, different countries)
- Assessment of capacity for treatment refers to a LEGAL assessment NOT a clinical assessment
- Not tested by the Mini-Mental Status Test (MMSE)
- Clinical assessments underlie diagnosis, treatment recommendations and identify or mobilize social supports
- Legal assessments remove from the person the RIGHT to make autonomous decisions in specified areas
- Legal Assessments look at Decisional Ability to make a Particular decision (ie Capacity in respect to particular treatment, Capacity to handle property, Capacity in Respect to admission to long-term care, Capacity to make personal care decisions about shelter)
(credit to workshop slide by Dr. Janet Munson)

LEGAL DEFINITION OF CAPACITY IN RESPECT TO TREATMENT, ADMISSION TO CARE FACILITIES, AND PERSONAL ASSISTANCE SERVICES

Health Care Consent Act s.4

Two step definition

- 1) Able to understand the information that is relevant to making a decision about the treatment, admission, or personal assistance service as the case may be, and
- 2) Able to appreciate the reasonably foreseeable consequences of a decision or lack of decision

PRESUMPTION OF DECISIONAL CAPACITY

HCCA s.4

Person presumed to be capable for treatment, admission to care facilities and personal assistance services.

EXCEPTION

Person entitled to rely on presumption **UNLESS** he or she has reasonable grounds to believe the other person is incapable in respect to treatment, admission to care facilities, personal assistance services as case may be.

HCCA s.15

May be capable in respect to some treatments and incapable in respect to others.

May be incapable with respect to treatment at one time and capable at another

ASSESSMENT OF DECISIONAL CAPACITY *

Need to assess:

1. Ability to Understand (factual knowledge + problem solving ability)
2. Ability to Appreciate (realistic appraisal of outcome + justification of choice)

UNDERSTAND - 1ST BASE

Factual knowledge: preservation of old skills & knowledge

Has the person had learning opportunities to acquire the relevant facts:

Updated information re: medical status, new risks or limits in ADL functions?

Does the person understand what treatment is being offered - what it is, benefits of it, risks,

UNDERSTANDING OPTIONS - 2ND BASE

Able to comprehend information about options, risks to make an informed choice

Able to attend to relevant stimuli, understand at conceptual level and retain essential information long enough to reach a decision

Able to remember prior choices and express them in a predictable and consistent manner over time

Able to problem solve around personal issues-probe specific examples

APPRECIATE - 3RD BASE

Able to appraise potential outcomes of a decision

Focus on reasoning process, explore the personal weights, values attached to each outcome

Acknowledges personal limitations/show insight

Decision-making is reality-based, not being affected by delusions (fixed false beliefs) or skewed by emotional states (depression, hopelessness causing an undervaluing of survival issues).

APPRECIATE - 4TH BASE

Justification of choice:

Shows evidence of rational (based in reality) manipulation of information - a "reasoned choice", not necessarily a reasonable choice

Grounded in personal beliefs and values consistent with previous actions, expressed wishes, cultural or religious beliefs

(credit to workshop slides by Dr. Janet Munson)

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September 2003

CONSENT TO TREATMENT - SUMMARY - Health Care Consent Act - Ontario

CONSENT TO TREATMENT REQUIRED

HCCA s.10

No treatment unless:

- a) Health Practitioner (HP) of opinion person CAPABLE in respect to treatment and person has consented, or
- b) HP of opinion that person INCAPABLE in respect to treatment and SDM gives consent.
- c) if Consent and Capacity Board or court finds person capable although HP was of opinion person not capable, HP shall not treat and shall ensure treatment not administered unless person gives consent.

WHAT IS VALID CONSENT?

HCCA s.11

1. must RELATE to TREATMENT
2. must be INFORMED (See box on INFORMED CONSENT)
3. must be given VOLUNTARILY
4. must not have been obtained through misrepresentation or fraud

WHAT IS CAPACITY FOR TREATMENT AND HOW DO YOU ASSESS THIS CAPACITY ? See reverse

WHO ASSESSES CAPACITY IN RESPECT TO TREATMENT?

- the Health Practitioner offering the treatment (HCCA S.10)
- Capacity Assessors (as defined by the Substitute Decisions Act) **DO NOT** do this type of assessment

PROCESS FOR OBTAINING CONSENT TO TREATMENT CAPABLE PERSON

If HP of opinion that a person is capable in respect to the treatment offered,
HP obtains informed consent - treats
Patient refuses consent - HP not treat

HIERARCHY OF SDMs WHO MAY GIVE OR REFUSE CONSENT - HCCA s.20

1. Guardian of person with authority for treatment.
2. Attorney in attorney for personal care with authority for treatment.
3. Representative appointed by CCB.
4. Spouse or partner.
5. Child or parent or Children's Aid Authority or other person lawfully entitled to give or refuse consent to treatment in place of parent - not include parent with right of access only - if CAS or person in place of parent, not include parent.
6. Parent with right of access only.
7. Brother or sister.
8. Any other relative.

.If NO PERSON meets requirement then OPGT.

If **CONFLICT** between persons in same category and cannot agree and claim to be SDM above others OPGT shall act as SDM

RANKING - List of SDMs is a hierarchy

Person ranked lower on list may give consent only if no person higher meets requirements.

Exception - Family member present or contacted may consent if he or she believes :

- a) no person higher or in same paragraph exists OR
- b) if person higher exists, person is not guardian of person, POAPC, Board appointed representative with authority to consent and would not object to him or her making the decision.

WHAT IS INFORMED CONSENT?

HCCA s.11

Patient or SDM (if Patient incapable) received information about:

1. nature of treatment,
2. expected benefits of the treatment,
3. material risks of the treatment,
4. material side effects of the treatment,
5. alternative courses of action, and
6. likely consequences of not receiving treatment

PROVIDE the information about the proposed treatment in these categories that the reasonable person would require to make decisions. The Patient or SDM is also entitled to receive responses to any **further questions** that he or she may have about these matters.

PROCESS FOR OBTAINING CONSENT TO TREATMENT - INCAPABLE PERSON HCCA s.18

- 1.- HP of Opinion
- * that person incapable re treatment proposed
- * HP follows own College guidelines re:Rights information
- * no application to CCB is made
- * HP turns to SDM highest ranking in list for consent or refusal of consent

If HP informed

1. that person intends to apply or has applied to CCB for review of finding of incapacity , or
2. person intends to apply or has applied to CCB for appointment of representative or
3. another person intends to apply or has applied to the CCB to be appointed as representative

HP shall NOT treat and shall ensure treatment not begun:

- a) until 48 hours has elapsed since first informed on intended application to CCB and application not started until application to CCB withdrawn
- c) until CCB renders decision if none of the parties before CCB is informed of intention to appeal
- d) if HP advised of intention to appeal, until a period for commencing appeal has elapsed without an appeal being commenced (8 full days after Board hearing) or until appeal finally disposed of.

REQUIREMENTS FOR SDM - HCCA s.20

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

- i) capable with respect to treatment,
- ii) 16 unless parent of incapable person,
- iii) no court order or separation agreement prohibiting access to incapable person or giving or refusing consent on his or her behalf,
- iv) is available, and
- v) willing to assume responsibility of giving or refusing consent