

PARENS PATRIAE 2.0:
INVOKING THE SUPERIOR COURTS'
PROTECTIVE JURISDICTION TO
HELP LONELY OLDER MEN
AGE-IN-PLACE

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ABSTRACT

Loneliness is associated with paradoxically self-defeating behaviour, in which social contact is simultaneously desired and rejected. This behaviour can manifest in various ways. Lonely people may, for example, unwittingly decline objectively needed services such as home care. For several reasons, lonely older men may be particularly prone to rejecting offers of support. While refusals are often seen as a win for the right to live at risk, the victory can be hollow when it does not translate into a better quality of life. Often an older man can be persuaded to accept services, but sometimes these efforts fail. In such situations, our traditional understanding of the law leaves concerned third parties with two undesirable options: take no further action or categorise the person as incapable to override his decision-making rights. This dilemma is a sad consequence of overcorrecting the medically-dominated approach to elder care with a highly libertarian perspective that lets individuals needlessly suffer. In our pursuit of unfettered individualism, the law has given insufficient weight to internal constraints such as loneliness which affect one's exercise of free choice, yet keep them below the incapacity threshold. Therefore, in this thesis, I propose an intervention approach to loneliness that is not paralysed by the legal fiction of capacity: invoking a superior court's protective jurisdiction. Through a therapeutic jurisprudence lens, I draw on the evolution of the *parens patriae* jurisdiction in Canada and a recent line of English case law to argue that a superior court's protective jurisdiction may be used to help lonely older men age-in-place. I then propose a framework for invoking the jurisdiction. Specifically, I outline the general circumstances in which a court may be justified in exercising the jurisdiction, and I suggest that dignity ought to serve as the guiding principle. Then using B.C.'s laws as a point of reference, I identify the legislative gap which exists in adult guardianship/protection and mental health laws. Next I propose that the jurisdiction ought to be exercised in the most effective, less intrusive manner. I conclude with a discussion of some practical challenges of using the jurisdiction.

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INTRODUCTION

Loneliness is associated with paradoxically self-defeating behaviour, in which social contact is simultaneously desired and rejected.¹ This behaviour can manifest in various ways. Lonely people may, for example, unwittingly decline objectively needed services such as home care. Lonely men may be particularly prone to rejecting offers of support, because of men's general tendency to exhibit less help-seeking behaviour.² Their resistance to care may also be fueled by the status quo bias, which reflects the human preference for maintaining the current state of affairs when faced with new options.³ Among lonely older men, the maladaptive behaviours associated with loneliness may be further compounded by their shrinking realm of independence, in which their physical or cognitive functions may be declining. Faced with diminishing life space, the value of remaining choices takes on increased significance and intensity; “[s]mall choices become ‘write large.’”⁴ Lonely older men may attempt to exert control in any way they can.⁵ We may dismiss them as being self-centred, mean-spirited or cantankerous.⁶ Others may be labelled as feisty. But some lonely older men may be outwardly declining services to protect their remaining shreds of independence, despite internally craving support.

¹ John T. Cacioppo, Stephanie Cacioppo & Dorret I. Boomsma, “Evolutionary mechanisms for loneliness” (2014) 28:1 *Cognition & Emotion* 3 at 9; Louise C. Hawkey & John T. Cacioppo, “Loneliness Matters: A Theoretical and Empirical Review of Consequences and Mechanism” (2010) 40 *Ann Behav Med* 218 [Hawkey & Cacioppo, “Loneliness Matters”]; Christopher M. Masi et al, “A Meta-Analysis of Interventions to Reduce Loneliness” (August 2011) 15:3 *Pers Soc Psychol Rev* 219.

² Jordan I. Kosberg, “Meeting the Needs of Older Men: Challenges for those in Helping Professions” (2005) 32 *J Soc & Soc Welfare* 9 at 18; Michael E. Addis & James R. Mahalik, “Men, Masculinity, and the Contexts of Help Seeking” (2003) 58:1 *Am Psychologist* 5; Tammi Vacha-Haase, Stephen R. Wester & Heidi Fowell Christianson, *Psychotherapy with Older Men* (New York: Routledge, 2011) at 35-36. But see A. Ekmann, M. Vass & K. Avlund, “Preventive home visits to older home-dwelling people in Denmark: are invitational procedures of importance?” (2010) 18:6 *Health & Soc Care Comm* 563 at 569 (higher acceptance rate among men feeling lonely).

³ See William Samuelson & Richard Zeckhauser, “Status Quo Bias in Decision Making” (1988) 1:1 *J Risk & Uncertainty* 7 at 8.

⁴ Robert L. Rubinstein, Janet C. Kilbride & Sharon Nagy, “Elders Living Alone: Frailty and the Perception of Choice” (New York: Walter de Gruyter, Inc., 1992) at 9. See also Patricia A. O’Neill, *Caring for the Older Adult: A Health Promotion Perspective* (Philadelphia: W.B. Saunders Company, 2002) at 227.

⁵ See also Steve Duck, Kris Pond & Geoff Leatham, “Loneliness and the Evaluation of Relational Events” (May 1994) 11:2 *J Soc & Personal Relationships* 253 (“lonely men are considerably more aggressive than other men” at 254); Stephanie Rogers, “Some say Geriatrics is not glamorous, but I say it is” *GeriPal Blog* (12 November 2014), online: <www.geripal.org> (90-year-old hospital patient refusing to let nurses change her soiled underwear because the doctor would not let her go home).

⁶ See e.g. Matthew D. Lieberman, *Social: Why Our Brains are Wired to Connect* (New York: Crown Publishers, 2013) (describing his widowed mother as “self-centered, inattentive, and even mean-spirited at times” at c 1).

While refusals are often seen as a win for the right to live at risk, the victory can be hollow when it does not translate into a better quality of life. It is fashionable to say that capable older adults are asserting their right to make unwise and risky decisions; that they have freely chosen to sacrifice their psychological well-being for independence. But in some cases, the mantra becomes hard to defend when we consider the psychological research showing that chronically lonely people can become stuck in a vicious cycle of loneliness.⁷

Often an older man can be persuaded to accept services, but sometimes these efforts fail. In such situations, our traditional understanding of the law leaves concerned third parties with two undesirable options: take no further action or categorise the person as incapable to override his decision-making rights.⁸ The libertarian approach of taking no further action is unsuitable because it leaves lonely older men to their own maladaptive cognitive devices. It is problematic to abandon symptomatic refusers and let them “rot with their rights on.”⁹ Yet the paternalistic approach of labelling lonely older men as incapable is inappropriate because it is well-established in law that making decisions which others deem unwise or risky does not render someone incapable.¹⁰ Further, the incapacity label is stigmatising, and it may be psychologically harmful.¹¹ Extinguishing a lonely older man’s decision-making rights may also trigger early or unnecessary institutionalisation. Case law reveals such an unsettling pattern. Take the situation in which an older adult refuses home care and is subsequently found incapable of making a long-term care admission decision. Rather than compelling the person to receive home-based services, many cases open the door for third parties to force the “incapable” adult into a care home.¹² This outcome

⁷ John T. Cacioppo & Louise C. Hawkey, “Perceived Social Isolation and Cognition” (2009) 13:10 Trends Cognitive Sci 13 447 at Figure 3 [J Cacioppo & Hawkey, “Perceived”].

⁸ The lesser known option of supported decision-making may also be available in some jurisdictions (e.g., B.C. Alberta, Saskatchewan, Yukon), but for the purposes of this thesis, it is difficult to conceptualise how such a mechanism would work without implicit coercion when a lonely older man is refusing to participate in the scheme.

⁹ See e.g. P.S. Appelbaum & T.G. Gutheil, “‘Rotting with their rights on’: constitutional theory and clinical reality in drug refusal by psychiatric patients” (1979) 7:3 Bull Am Academy Psychiatry & L 306.

¹⁰ See *Koch (Re)* (1997), 33 OR (3d) 485, 1997 CarswellOnt 824 (SC) (WL Canada) at para 54 [*Koch*].

¹¹ See e.g. Bruce J. Winick, “The Side Effects of Incompetency Labeling and the Implications for Mental Health Law” in David B. Wexler & Bruce J. Winick, eds, *Law in a Therapeutic Key: Developments in Therapeutic Jurisprudence* (Durham, NC: Carolina Academic Press, 1996) [Wexler & Winick, *Therapeutic Key*], 17 at 20 & 37 [Winick, “Side Effects”]; Margaret Hall, “Equity Theory: Responding to the Material Exploitation of the Vulnerable but Capable” in Israel Doron, ed, *Theories on Law and Ageing: The Jurisprudence of Elder Law* (Berlin: Springer-Verlag, 2009) [Doron, *Theories*], 107 at 109 [Hall, “Equity”]; Leslie Salzman, “Rethinking Guardianship (Again): Substituted Decision Making as a Violation of the Integration Mandate of Title II of the Americans with Disabilities Act” (2010) 81 U Colo L Rev 157 at 169; Annette Johannesen, Janne Petersen & Kirsten Avlund, “Satisfaction in Everyday Life for Frail 85-year-old Adults: a Danish Population Study” (2004) 11:3 Scan J Occup Ther 3 at 3.

¹² See *below*, Chapter V.1.e (Most effective, less intrusive).

misses a less intrusive step; it leapfrogs over the option of exhausting the menu of home-based services. It manages risk by simply warehousing the person in an institution.

Lonely older men face a dire crossroads. Writing on an analogous issue, Atul Gawande captures the sentiment in his seminal book, *Being Mortal*.¹³ Seeking to improve end-of-life care, Dr. Gawande asks, “How did we wind up in a world where the only choices for the very old seem to be either going down with the volcano or yielding all control over our lives?”¹⁴ This dilemma is a sad consequence of overcorrecting the medically-dominated approach to elder care with a highly libertarian perspective that lets individuals needlessly suffer. To be clear, I do not take issue with the importance of legal safeguards that are in place to protect the rights of capable individuals who resist intervention. Rather, I argue that the pendulum has swung too far.¹⁵ In our pursuit of unfettered individualism, the law has given insufficient weight to internal constraints that affect one’s exercise of free choice, yet keep them below the incapacity threshold. I propose that loneliness is one such constraint, and that excluding lonely individuals with capacity from the ambit of the law’s protective wing is arbitrary. By falling on the “right” side of the fictitious capacity/incapacity dichotomy, people stuck in the downward spiral of loneliness become a paradoxical casualty of state non-intervention.

Therefore, in this thesis, I propose an intervention approach to loneliness that is not paralysed by the legal fiction of capacity: invoking a superior court’s protective jurisdiction. Drawing on the evolution of the *parens patriae* jurisdiction in Canada and a recent line of English case law, I argue that a superior court’s protective jurisdiction may be used to help lonely older men age-in-place by ordering the provision of objectively needed home-based services. The suggestion may be startling; the notion that capable older adults have the right to live at risk has

¹³ (Toronto: Doubleday Canada, 2014).

¹⁴ *Ibid* at 68.

¹⁵ For a discussion of the rights-based movement in the 1960s and 1970s that sought greater patient autonomy, see David J. Rothman, “The Origins and Consequences of Patient Autonomy: A 25-Year Retrospective” (2001) 9 *Health Care Analysis* 255 (“All movements subscribed to a fierce anti-paternalism, a dogged rejection of the principles of beneficence” at 256); David B. Wexler, “Therapeutic Jurisprudence and the Culture of Critique” (1999) 10 *J Contemp Legal Issues* 263 at 267-68; Nathalie Des Rosiers, “Rights are Not Enough: Therapeutic Jurisprudence Lessons for Law Reformers” (2002) 18 *Touro L Rev* 443 at 446-47; Margaret Brazier, “Do No Harm—Do Patients Have Responsibilities Too?” (July 2006) 65:2 *Cambridge LJ* 397 at 398.

become deeply embedded in our psyche¹⁶ and law.¹⁷ But when we take into account the maladaptive cognitive effects of loneliness, it would be irresponsible to abandon this group of symptomatic refusers.¹⁸

Given the recent explosion of strategies to combat loneliness, why am I suggesting a legal response? The answer is simple: interventions assume a consenting participant. Even the most effective strategy (i.e., cognitive behavioural therapy [CBT]) is meaningless if a symptomatic refuser does not consent. Unfortunately, our traditional understanding of the law only gives us two undesirable ways out of this legal intervention dilemma: either we use the incapacity label or mental health legislation to justify interference with the lonely older man's decision-making rights. Using a superior court's protective jurisdiction offers a third—and less intrusive—option. As I discuss below, practical challenges may remain, but from a legal standpoint, intervention attempts are no longer stymied by the fictional notion of capacity.

This thesis is divided into five chapters. Chapter I sets out the theoretical framework. In particular, I discuss therapeutic jurisprudence, which is a psychologically-sensitive way to look at the law, and the concept of universal legal capacity. While universal legal capacity has most often been invoked to reclaim and protect the decision-making rights of people traditionally labelled as incapable, I argue that dissolving the capacity dichotomy may also benefit those who suffer from internal decision-making constraints such as loneliness which fall short of the incapacity threshold.

Chapter II outlines why loneliness matters. I first define the condition, and then distinguish it from objective isolation. I also outline the evolutionary approach to loneliness, which provides one explanation for why people feel lonely. Next, I identify five factors which, alone or in combination, increase one's risk for the emotional condition. In particular, I discuss age, gender, living alone, health status and personality. I conclude the chapter by outlining the negative consequences associated with loneliness, including its effects on mental and physical health, service utilisation and social cognition.

¹⁶ The phrase appears to be a popular catchphrase, not the precise language used in case law. At the time of writing, basic searches in CanLII and Quicklaw for “right to live at risk” returned no cases. “Dignity of risk” returned three cases in CanLII: two in relation to wheelchair accessibility and one in relation to child custody. A basic search in HeinOnline's Law Journal Library for “dignity of risk” returned 46 law articles, mostly in relation to disability rights and mental health law. “Live at risk” returned five results, none directly on point.

¹⁷ See *Koch*, *supra* note 10 at para 21.

¹⁸ See e.g. Emily White, *Lonely: Learning to Live with Solitude* (Toronto: McClelland & Stewart, 2011) (leaving lonely people to fend for themselves tends to result in little change and therefore, we should not walk away but take active measures to help them, at 277).

Chapter III addresses my rationale for focusing on older men. First, I identify what I mean by “older adult.” Second, I explain the four factors which have compelled me to write about older men: the feminisation of elder advocacy; men’s less help-seeking behaviour; the family-oriented approach to law and policy; and the marginalising effects of the active aging approach.

Chapter IV demonstrates the recent evolution of the *parens patriae* jurisdiction in Canada. In particular, I argue that some courts have departed from the strict understanding that the jurisdiction can only be exercised when they make a formal finding of incapacity. I begin the chapter with a general discussion of “first generation” *parens patriae* in Canada, and then explore the terminological confusion surrounding the concept of inherent jurisdiction. I argue that inherent jurisdiction is something more than a source of procedural powers; that is, it can be invoked to affect substantive matters. Next, I discuss several cases in which the English High Court has exercised its protective jurisdiction over vulnerable adults who do not lack capacity. I then turn to a line of Canadian cases which have laid the groundwork for what I refer to as “second generation” *parens patriae*, or the superior courts’ protective jurisdiction over vulnerable adults.

Chapter V sets out my proposed framework for invoking a superior court’s protective jurisdiction over lonely older men who do not lack capacity but are symptomatically refusing objectively needed home-based services. First, I outline the general circumstances in which a court may be justified in exercising its protective jurisdiction. While some situations may be classified as “self-neglect,” I explain that I am referring more generally to the rejection of services which purport to facilitate aging-in-place. Second, I suggest that dignity ought to serve as the guiding principle. Third, I identify the legislative gap which currently exists in adult guardianship/protection and mental health laws. To provide structure, I conduct my gap analysis with reference to B.C.’s legislation. Fourth, I review the general nature of protective jurisdiction orders. Fifth, I propose that the protective jurisdiction ought to be exercised in the most effective, less intrusive manner. Too often “most effective, less intrusive” language is merely rhetoric; invoking the superior court’s protective jurisdiction has the potential to result in more effective and less intrusive intervention than currently happens when an older adult is refusing in-home services. I conclude the chapter with a discussion of three practical challenges of effectively using the protective jurisdiction: limited resources; enforceability; and service provider safety.

CHAPTER I: THEORETICAL FRAMEWORK

This chapter sets out the theoretical framework of my thesis. First, I discuss therapeutic jurisprudence, which embraces the use of psychological research in legal writing, and ultimately seeks more therapeutic applications of the law. Second, I discuss universal legal capacity, and the benefits of dissolving the capacity dichotomy for those who suffer from internal decision-making constraints such as loneliness which fall short of the incapacity threshold.

1. Therapeutic jurisprudence

Developed by American scholars David Wexler and Bruce Winick, therapeutic jurisprudence is a thoroughly interdisciplinary field of study that examines the law's often overlooked impact on psychological well-being.¹⁹ It broadly defines "the law" to include legal rules, legal procedures, and the roles and behaviours of legal actors (e.g., lawyers and judges).²⁰ Unlike traditional doctrinal analysis, which typically involves precedent and analogical reasoning, TJ draws upon empirical-based social science research to explore how the law, as a potential instrument of healing, may be developed, reformed and applied in a manner which produces positive therapeutic outcomes (and minimises anti-therapeutic consequences).²¹ Rather than viewing the law as something that inevitably makes people's lives worse, TJ sees the law as having potential therapeutic value.²² That is, the law has the potential to positively affect the emotional lives of people who bump into "sharp legal things."²³ By improving the law's role as a therapeutic agent,²⁴ TJ can help find ways to blunt those edges.

¹⁹ David B. Wexler, "Putting Mental Health into Mental Health Law: Therapeutic Jurisprudence" in David B. Wexler & Bruce J. Winick, *Essays in Therapeutic Jurisprudence* (Durham, North Carolina: Carolina Academic Press, 1991) [Wexler & Winick, *Essays*] at 8 [Wexler, "Putting"].

²⁰ David B. Wexler, "From theory to practice and back again in therapeutic jurisprudence: now comes the hard part" (March 2011) 37:1 *Monash UL Rev* 33 at 33 [Wexler, "Theory"].

²¹ Wexler, "Putting", *supra* note 19 at 8 & 13; Bruce J. Winick, "Therapeutic Jurisprudence and Victims of Crime" in Edna Erez, Michael Kichling & Jo-Anne Wemmers, eds, *Therapeutic Jurisprudence and Victim Participation in Justice: International Perspectives* (Durham, NC: Carolina Academic Press, 2011), 3 at 3. TJ shares similarities with the public health concept of "the social determinants of health" (SDOH), which are the conditions, forces, policies and systems that shape people's health. While law is rarely identified as a SDOH, it is arguable that it is one of the social forces or living conditions (social determinants) in society which impact people's well-being.

²² See e.g. David B. Wexler, "Therapeutic Jurisprudence in a Comparative Law Context" (1997) 15 *Behav Sci & L* 233 at 234.

²³ I borrow this phrase from Stephen Wexler, "Practicing Law for Poor People" (1970) 79 *Yale L J* 1049 at 1050.

²⁴ See e.g. David B. Wexler, "Putting Mental Health into Mental Health Law: Therapeutic Jurisprudence" (February 1992) 16:1 *Law & Human Behav* 27 at 32 [Wexler, "Mental Health"].

When TJ first emerged about 25 years ago,²⁵ it was initially applied to mental health law.²⁶ Since then, the approach has been used in many other legal areas, and it is now understood to be “a psychologically sensitive way to look at virtually all aspects of law and justice.”²⁷ Within law and aging, TJ has been applied to professional ethics in elder law practice;²⁸ theoretical approaches to elder law;²⁹ clinical legal education;³⁰ the medicalization of aging;³¹ older drivers, public health and community safety;³² end-of-life decision-making;³³ testamentary capacity and undue influence;³⁴ adult protective proceedings;³⁵ tort liability and Alzheimer’s disease;³⁶ and nursing home regulation.³⁷ There is a dearth of law and aging literature on loneliness and the legal significance of its paradoxically self-defeating behaviour.

Rooted in a realist law reform agenda,³⁸ TJ analyses whether positive psychological outcomes can be achieved through the creative (i.e., more therapeutic) application of existing laws, or if new laws are needed to produce therapeutic effects.³⁹ Wexler argues that reforms aimed at applying existing laws more therapeutically are likely to be “far easier” to advance and less controversial than formal legislative reform, and consequently, there may be a greater chance that

²⁵ *Ibid* at 33.

²⁶ See Wexler, “Putting”, *supra* note 19 at 8.

²⁷ Edna Erez, Michael Kilchling & Jo-Anne Wemmers, “Therapeutic Jurisprudence and Victim Participation in Justice: An Introduction” in Erez, Kichling & Wemmers, *supra* note 21, ix at x. See also David B. Wexler, “The Development of Therapeutic Jurisprudence: From Theory to Practice” (1999) 68:3 *Revista Juridica UPR* 691 at 696.

²⁸ Dennis P. Stolle, “Professional Responsibility in Elder Law: A Synthesis of Preventive Law and Therapeutic Jurisprudence” (Fall 1996) 14:4 *Behav Sci & L* 459.

²⁹ Marshall B. Kapp, “A Therapeutic Approach” in Doron, *Theories*, *supra* note 11, 31 [Kapp, “Therapeutic”].

³⁰ Cindy E. Faulkner, “Therapeutic Jurisprudence and Preventive Law in the Thomas M. Cooley Sixty Plus, Inc., Elder Law Clinic” (Spring 2005) 17:3 *St. Thomas Law Rev* 685.

³¹ Winsor C. Schmidt, “Medicalization of Aging: The Upside and the Downside” (Fall 2011) 13:1 *Marquette Elder’s Advisor* 55.

³² Bruce J. Winick & Alina M. Perez, “Aging, Driving, and Public Health: A Therapeutic Approach” (Winter 2010) 11:2 *Fla Coastal L Rev* 189.

³³ Thomas L. Hafemeister, “End-of-Life Decision Making, Therapeutic Jurisprudence, and Preventive Law: Hierarchical v. Consensus-Based Decision-Making Model” (1999) 41:2 *Ariz L Rev* 329.

³⁴ Daniel C. Marson, Justin S. Huthwaite & Katina Herbert, “Testamentary Capacity and Undue Influence in the Elderly: A Jurisprudent Theory Perspective” (2004) 28 *Law & Psychol Rev* 71.

³⁵ Jennifer L. Wright, “Protecting Who From What, And Why, And How?: A Proposal for An Integrative Approach to Adult Protective Proceedings” (2004) 12 *Elder LJ* 53 [Wright, “Protecting”].

³⁶ Edward P. Richards, “Public Policy Implications of Liability Regimes for Injuries caused by Persons with Alzheimer’s Disease” (Winter 2001) 35:2 *Ga L Rev* 621.

³⁷ Marshall B. Kapp, “Quality of Care and Quality of Life in Nursing Facilities: What’s Regulation Got to Do with It” (Spring 2000) 31:3 *McGeorge L Rev* 707.

³⁸ Kapp, “Therapeutic”, *supra* note 29 at 31.

³⁹ David B. Wexler, “Applying the Law Therapeutically” in Wexler & Winick, *Therapeutic Key*, *supra* note 11, 831 at 841 [Wexler, “Applying”]; David B. Wexler & Bruce J. Winick, “Introduction” in Wexler & Winick, *Therapeutic Key*, *ibid*, xvii at xvii; Des Rosiers, *supra* note 15.

such proposals will achieve the desired change.⁴⁰ Therefore, Wexler urges TJ proponents to explicitly discuss, research and write about the ways in which existing laws can possibly be applied in a more creative and therapeutic manner.⁴¹ While not uncontroversial, this is the approach I have taken in this thesis. Rather than proposing legislative reform, I argue that, through the combined effect of the evolution of the *parens patriae* jurisdiction and the emerging line of English protective jurisdiction case law, superior courts in Canada have an existing jurisdiction to intervene in the lives of capable lonely older men who are symptomatically refusing objectively needed home-based services. Exercising this jurisdiction has the potential to improve their quality of life.

TJ is not without its critics. John Petrla argues that the approach suffers from the underlying assumption that researchers and lawyers (as opposed to mental health patients, etc.) decide whether a particular law has therapeutic value.⁴² Similarly, Dennis Roderick and Susan Krumholz question how TJ defines and determines what is therapeutic;⁴³ they observe that TJ's preferred therapeutic outcomes have no independent, inherent basis, but instead, are socially constructed by the approach's proponents.⁴⁴ These criticisms have merit. Take the example of the alleged therapeutic value of patient "voice" in civil commitment hearings.⁴⁵ Enhancing procedural practices to allow for greater patient participation may satiate legal professionals, but the changes may make little difference to those who experience the same end result: involuntary detention.⁴⁶ In response to these critiques, Wexler and Winick emphasize that nothing in their work suggests that lawyers, researchers or other professionals should propose law reform without regard to the patient perspective.⁴⁷

⁴⁰ Wexler, "Applying", *ibid* at 841.

⁴¹ *Ibid.*

⁴² John Petrla, "Book Review of *Essays in Therapeutic Jurisprudence: A Review of Essays in Therapeutic Jurisprudence*" (1993) 10 NYL Sch J Hum Rts 890.

⁴³ Dennis Roderick & Susan T. Krumholz, "Much Ado About Nothing? A Critical Examination of Therapeutic Jurisprudence" (2006) 1 S New Eng Roundtable Symposium LJ 201.

⁴⁴ *Ibid* at 208. See also Stolle, *supra* note 28.

⁴⁵ See e.g. Tom R. Tyler, "The Psychological Consequences of Judicial Procedures: Implications for Civil Commitment Hearings" (1992) 46 SMU L Rev 433 at 439-40. See also Bruce J. Winick, "On Autonomy: Legal and Psychological Perspectives" (1992) 37:6 Vill L Rev 1705 at 1755-68 (psychological value of patient choice).

⁴⁶ Compare Jack Susman, "Resolving hospital conflicts: a study on therapeutic jurisprudence" (1994) 22 J Psychiatry & L 107 (patients could judge procedures fair even when the result was unfavourable from their standpoint, at 121).

⁴⁷ David B. Wexler, "Patients, Professionals, and the Path of Therapeutic Jurisprudence: A Response to Petrla" (1993) 10 New York Law School Journal of Human Rights 907 at 908 [Wexler, "Patients"]; Bruce J. Winick, "The Jurisprudence of Therapeutic Jurisprudence" (1997) 3:1 Psychol Pub Pol'y & L 184 at 195 [Winick, "Jurisprudence"].

Further, Wexler and Winick argue that therapeutic outcomes must not be achieved at the expense of traditional legal principles such as autonomy.⁴⁸ But if autonomy always trumps, then TJ provides little help in resolving the tension between achieving therapeutic goals (e.g., protection) and safeguarding other values (e.g., autonomy), unless one takes the fashionable position of arguing that the law's unwavering commitment to autonomy is therapeutic.⁴⁹ Winick concedes that when values conflict, TJ is not a way to resolve the dilemma; rather, one must go outside of the approach and look to an ethical or political theory which sets out a hierarchy of values.⁵⁰ In Chapter V, I explore the perennial conflict between protection and autonomy, and propose that we overcome the tension by using dignity as the guiding principle when a court is determining whether to exercise its protective jurisdiction over a lonely older man.

Another criticism of TJ is that it has poor theoretical quality because it is not presented in a manner which allows it to be refuted, and therefore, it difficult to empirically study the application of its therapeutic constructs.⁵¹ However, TJ scholars have tended to “retreat” from the suggestion that TJ is a theory.⁵² For instance, Wexler observes:

[TJ] is not and never pretended to be a full-blown ‘theory.’ More properly, and more modestly, it is simply a ‘field of inquiry’—in essence a research agenda—focusing attention on the often overlooked area of the impact of the law on psychological wellbeing and the like. From the very beginning, however, TJ has sought to work with frameworks or heuristics to organise and guide thought.⁵³

Therefore, rather than characterising TJ as a theory, it is preferable to describe it as a psycho-legal “lens” or perspective through which one examines the law’s potential therapeutic effectiveness.⁵⁴

2. Universal legal capacity

The capacity dichotomy assumes a bright line between those with and without capacity. This assumption is not remedied by replacing the global capacity model with the functional approach, which recognizes task-specific decision-making (e.g., you may be capable of making some

⁴⁸ Wexler, “Mental Health”, *supra* note 24 at 32; Winick, “Jurisprudence”, *ibid* at 191-92; David B. Wexler, “Therapeutic Justice” (1972) 57 Minn L Rev 289 at 294-95; Wexler, “Patients”, *ibid* at 907-08.

⁴⁹ See Winick, “Jurisprudence”, *ibid* at 191-92.

⁵⁰ *Ibid* at 197-98.

⁵¹ Roderick & Krumholz, *supra* note 43 at 205-07 & 214-15.

⁵² Nigel Stobbs, “The Nature of Juristic Paradigms: Exploring the Theoretical and Conceptual Relationship between Adversarialism and Therapeutic Jurisprudence” (2011) 4:1 Wash U Jurisprudence Rev 97 at 106.

⁵³ Wexler, “Theory”, *supra* note 20 at 33 [footnotes omitted].

⁵⁴ See e.g. Winick, “Jurisprudence”, *supra* note 47.

decisions but not others) and capacity’s fluctuating nature (e.g., you may have capacity to instruct counsel in the morning but not in the late afternoon).⁵⁵ While the functional approach is preferable to the global model, people still fall on either side of the capacity dichotomy, albeit in a more nuanced, decision-specific way. There remains a binary division between those with and without capacity; individuals on the “wrong” side are still labeled as incompetent—an outcome which has several potential adverse effects such as stigmatisation and the deprivation of liberty.⁵⁶ Unsurprisingly, the dominant understanding of capacity is increasingly being viewed as arbitrary, outdated,⁵⁷ and from a TJ perspective, anti-therapeutic.⁵⁸ In its place, there is emerging support for the concept of universal legal capacity, which views capacity as an intrinsic characteristic that applies universally to all individuals, regardless of the nature and level of their impairment.⁵⁹ Under this approach, legal capacity is not something to be taken away; rather, it is an inalienable right for everyone, including persons with disabilities.

The notion of universal legal capacity is most often invoked to reclaim and safeguard the decision-making rights of adults traditionally labelled as incapable. For instance, the concept is captured in Article 12 of the United Nations *Convention on the Rights of Persons with Disabilities*, which calls on state parties to “recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life,” and to “take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity.”⁶⁰ Article 12 is considered a key driver behind the establishment of domestic supported decision-

⁵⁵ See e.g. *CD (Re)*, 2014 CanLII 32644 (ON CCB) (“It is trite to say that capacity to consent is not fixed in time or context. A person may be capable of consenting to one kind of treatment, but not to another, and may be capable of consenting at one time but not at another, even within relatively short intervals” at 11).

⁵⁶ See Winick, “Side Effects”, *supra* note 11 at 38; *WA-D (Re)*, 2011 CanLII 59065 (ON CCB) (involuntary patient with delusional disorder expressed outrage at being labelled as a psychiatric patient, refused to cooperate with care and confined himself to bed for 23 hours per day).

⁵⁷ See Doug Surtees, “Constructing Incapacity: Deconstructing Capacity in Adult Guardianship” in A. Kimberley Dayton, ed, *Comparative Perspectives on Adult Guardianship* (Durham, NC: Carolina Academic Press, 2014), 273 at 273.

⁵⁸ Winick, “Side Effects”, *supra* note 11 at 27 & 37; David B. Wexler, “Practising Therapeutic Jurisprudence: Psycholegal Soft Spots and Strategies” in Dennis P. Stolle, David B. Wexler & Bruce J. Winick, eds, *Practising Therapeutic Jurisprudence: Law as a Helping Profession* (Durham, NC: Carolina Academic Press, 2000), 45 at 53.

⁵⁹ Camilla Kong, “The *Convention for the Rights of Persons with Disabilities* and Article 12: Prospective Feminist Lessons against the ‘Will and Preferences’ Paradigm” (2015) 4 *Laws* 709 at 710. See also Amita Dhandu, “Universal Legal Capacity as a Universal Human Right” in Michael Dudley, Derrick Silove & Fran Gale, eds, *Mental Health and Human Rights: Vision, Praxis and Courage* (Oxford: Oxford University Press, 2012), 177.

⁶⁰ 13 December 2006, GA Res A/RES/61/106, UNGAOR, 61st Sess, arts 12(2)-(3) (ratified by Canada 11 March 2010, reserving the right to continue to use substitute decision-making).

making regimes,⁶¹ which allow traditionally-labelled “incapable” adults to receive assistance from another person so they can make and communicate their own decisions.⁶² This approach differs from the draconian nature of substitute decision-making, which usurps an adult’s right to make decisions and hands that power to someone else.⁶³ Further, supported decision-making abandons the stigmatising outcome of labelling a person as incapable;⁶⁴ instead of viewing the individual as incapable, it places the source of incapacity within the decision-making process itself.⁶⁵ This approach is rooted in the social model of disability; the question is whether the surrounding environment, as opposed to the person, is “capable” of supporting the individual make and communicate a decision. If not, the environment must be changed so the person has the appropriate decision-making supports.⁶⁶

While dissolving the capacity dichotomy has its obvious benefits for adults traditionally labelled as incapable, it may also improve the law’s response to adults who suffer from internal decision-making constraints such as loneliness which fall short of the incapacity threshold. Without an arbitrary line dividing those with and without capacity, it becomes difficult to justify non-intervention (abandonment) simply on the grounds that a person possesses the fictional notion of capacity. Something more is needed. Libertarians might argue that a lonely older man is making an autonomous free choice, but as relational theorists observe, this perspective mistakenly assumes that people are independent—as opposed to interdependent—beings.⁶⁷ In rejecting the overly individualistic liberal actor, the relational theory of autonomy acknowledges that social situations

⁶¹ Shih-Nigh Then, “Evolution and Innovation in Guardianship Laws: Assisted Decision-Making” (2013) 35 *Sydney L Rev* 133 at 146. For examples of supported decision-making in Canada, see *Adult Guardianship and Trusteeship Act*, SA 2008, c A-4.2; *Representation Agreement Act*, RSBC 1996, c 405 [RAA]; *The Adult Guardianship and Co-decision-making Act*, SS 2000, c A-5.3; *Adult Protection and Decision Making Act*, SY 2003, c 21, Sch A.

⁶² See Robert M. Gordon, “The Emergence of Assisted (Supported) Decision-Making in the Canadian Law of Adult Guardianship and Substitute Decision-Making” (2000) 23:1 *Intl J L & Psychiatry* 61 at 69.

⁶³ Surtees, *supra* note 57 at 275.

⁶⁴ See Sarah Burningham, “Developments in Canadian Adult Guardianship and Co-Decision-Making Law” (2009) 18 *Dal J Leg Stud* 119 at 123.

⁶⁵ See Surtees, *supra* note 57 at 279 & 282; Office of the High Commissioner for Human Rights, “Monitoring the *Convention on the Rights of Persons with Disabilities*: Guidance for Human Rights Monitors” (New York: United Nations, 2010) at 8.

⁶⁶ See Surtees, *ibid* at 282.

⁶⁷ See Françoise Baylis, “The Self *in Situ*: A Relational Account of Personal Identity” in Jocelyn Downie & Jennifer L. Llewellyn, eds, *Being Relational: Reflections on Relational Theory and Health Law* (Vancouver: UBC Press, 2012), 109 at 109 & 112; Jennifer L. Llewellyn, “Restorative Justice: Thinking Relationally about Justice” in Downie & Llewellyn, *ibid*, 89 at 90; Janet E. Lord & Michael Ashley Stein, “Contingent participation and coercive care: Feminist and communitarian theories of disability and legal capacity” in Bernadette McSherry & Ian Freckelton, eds, *Coercive Care: Rights, Law and Policy* (New York: Routledge, 2013), 31 at 34.

(including relationships and pressures) affect personal decision-making.⁶⁸ A classic example is the capable woman who decides to remain in an abusive spousal relationship, and refuses offers of support (e.g., help with obtaining a restraining order).⁶⁹ Her decisions may be objectively unwise, but from the liberal individualist perspective, they are considered to be freely made choices.⁷⁰ This approach fails to appreciate that her decisions may actually arise from her contextual or situational vulnerability, which stem from the relationship itself.⁷¹ It is problematic to exclude her from protective action simply because she retains capacity in the traditional sense. As Martha Minow writes about the concept of constrained choice:

A recent threat to individual freedoms and human rights, perhaps ironically, stems from a tendency among many judges and officials to assert that someone has a choice. While laudable for the respect it seems to accord individuals, the legal rhetoric of choice—including discussions of voluntariness—is too often used to assign responsibility to someone who had little power to choose....⁷²

Contextual decision-making constraints may be external (e.g., an abusive spouse), but in some cases, the predator may be found within the person. In this thesis, I present loneliness as an internal decision-making constraint that may justify a court to intervene in a “capable” adult’s life.

⁶⁸ See Llewellyn & Downie, *ibid* at 7; Lucy-Ann Buckley, “Relational Theory and Choice Rhetoric in the Supreme Court of Canada” (2015) 29 Can J Fam L 251 at 253; Lord & Stein, *ibid* at 31-34.

⁶⁹ See Margaret Hall, “Material Exploitation and the Autonomy Ideal: The Role of Equity Theory in Adult Protection Legislation” (2008) 5 Elder L Rev 9.

⁷⁰ *Ibid.*

⁷¹ *Ibid.*

⁷² Martha Minow, “Choices and Constraints: For Justice Thurgood Marshall” (1991) 80 Geo LJ 2093 at 2093-94.

CHAPTER II: LONELINESS MATTERS

Loneliness is an emotional pain that few of us have escaped. For most, the experience is fleeting. We may feel a pang of loneliness after moving to a new city or when travelling alone. Feelings of loneliness may surge after losing a spouse, outliving close friends or residing far from family. For others, the condition is chronic. In its unrelenting form, loneliness has been associated with several serious health conditions; its damage is comparable to smoking 15 cigarettes a day.⁷³ Loneliness has also been linked to increased service utilisation, and paradoxically self-defeating behaviour.⁷⁴ Given the high personal, societal and financial toll of loneliness, it is no surprise that the condition has become a topic du jure.⁷⁵ As the population ages, governments and advocacy groups have placed particular emphasis on later life loneliness,⁷⁶ with British Health Secretary Jeremy Hunt calling the epidemic of lonely older adults a “national shame.”⁷⁷ Yet many of the well-intentioned

⁷³ Julianne Holt-Lunstad, Timothy B. Smith & J. Bradley Layton, “Social Relationships and Mortality Risk: A Meta-Analytic Review” (2010) 7:7 PLoS Med doi:10.1371/journal.pmed.1000316 at Figure 6. See *below*, Chapter II.4 (Negative associations).

⁷⁴ See *below*, Chapter II.4 (Negative associations).

⁷⁵ Loneliness received relatively ample attention from social scientists in the 1970s and 80s. The recent surge of interest is likely due in part to newer studies linking loneliness to serious health problems. Examples from the earlier period include Robert S. Weiss, *Loneliness: The Experience of Emotional and Social Isolation* (Cambridge, MA: The MIT Press, 1973) (loneliness is a “chronic disease without redeeming features” at 15); Letitia Anne Peplau & Daniel Perlman, eds, *Loneliness: A Sourcebook of Current Theory, Research and Therapy* (Toronto: John Wiley & Sons, Inc., 1982); Mohammadreza Hojat & Rick Crandall, eds, *Loneliness: Theory, Research, and Applications* (Newbury Park: Select Press, 1989). See also U.S. President’s Commission on Mental Health (1978) cited in Stephanie Cacioppo et al, “Loneliness: Clinical Import and Interventions” (2015) 10:2 Perspectives on Psychol Sci 238 at 239 & 244 (importance of easing the pain of those suffering from loneliness).

⁷⁶ See National Seniors Council, “Report on the Social Isolation of Seniors 2013-2014” (October 2014), online: Government of Canada <www.seniorscouncil.gc.ca> (social isolation increases likelihood of loneliness, at 1); Government of Canada, News Release, “National Seniors Council to further examine social isolation of seniors” (12 March 2015), online: <<http://news.gc.ca>>; Employment and Social Development Canada, Seniors, “Funding: Pan-Canadian Projects”, online: <www.esdc.gc.ca> (call for proposals for pan-Canadian projects that address social isolation among older adults); B.C. Ministry of Health, Children’s, Women’s and Seniors Health Branch, “Social Isolation Among Seniors: An Emerging Issue” (March 2004), online: <<http://www.health.gov.bc.ca>>; Age-Friendly Manitoba, “Let No One Be Alone Week—A Time to Reach Out to Isolated Seniors, May 5-11” (15 April 2013), online: <<http://www.agefriendlymanitoba.ca>>; Knowledge Networks & Insight Policy Research, “Loneliness among Older Adults: A National Survey of Adults 45+” (September 2010), online: AARP <www.aarp.org> (AARP-commissioned national survey on loneliness and social isolation in the U.S.); Campaign to End Loneliness, “About the campaign”, online: <www.campaigntoendloneliness.org/> (joint campaign in the U.K. to end later life loneliness); The Sporting Memories Foundation, “The Foundation”, online: <www.sportingmemoriesnetwork.com> (tackling dementia, depression and loneliness by engaging older adults in social activities and helping them recall sporting memories); Statistics New Zealand, *Loneliness in New Zealand: Findings from the 2010 NZ General Social Survey* (April 2013), online: <www.stats.govt.nz> (11 percent of older people feel lonely all, most or some of the time, at 5); Talia Shadwell, “Funding for study to compare aged New Zealanders’ loneliness with rest of world” *Stuff* (15 March 2016), online: <www.stuff.co.nz> (New Zealand to fund study comparing loneliness among older New Zealanders with data from 29 European countries).

⁷⁷ Jeremy Hunt quoted in Oliver Wright, “Jeremy Hunt blasts British society’s neglect of its elderly” *Independent* (17 October 2013), online: <<http://www.independent.co.uk>>.

initiatives to tackle loneliness do not address the maladaptive social cognition which plagues chronic sufferers, and imprisons them in a vicious cycle. Instead, loneliness interventions typically aim to increase social contact, enhance social support or improve social skills, but evidence of their effectiveness is limited, if not weak.⁷⁸ For example, consistent with the active aging approach,⁷⁹ volunteering is often touted as a loneliness remedy. But this activity is no antidote.⁸⁰ While it may work for some, it can leave others “feeling doubly alone.”⁸¹ As Robert Weiss observed in his seminal book on the emotional affliction, only the non-lonely suppose that loneliness can be cured by “random sociability;” advising lonely people to “be pleasant, outgoing, interested in others” seems “oddly beside the point.”⁸² Unsurprisingly, a recent meta-analysis of loneliness interventions found that the most effective interventions address the lonely person’s

⁷⁸ See e.g. Gavin J. Andrews et al, “Assisting friendships, combating loneliness: users’ view on a ‘befriending’ scheme” (2003) 23:3 *Ageing & Society* 349 at 360 (befriending scheme demonstrating some value, at 355); R. Honigh-de Vlaming et al, “Acceptability of the Components of a Loneliness Intervention Among Elderly Dutch People: A Qualitative Study” (May/June 2013) 44:3 *American J Health Ed* 136 (limited evidence on home visits is mostly weak or confined to specific groups, such as older Moroccan immigrants or older adults living in dispersed rural settings, at 144); British Geriatrics Society, Newsletter, “GP loneliness scheme cuts fifth of consultations with older patients” (June 2015), online: <www.bgs.org.uk> (older lonely patients participated in social events such as tea parties; family doctors reported a 20 percent drop in office visits, at 32); Age UK & the Isles of Scilly, “People, Place, Purpose: Shaping services around people and communities through the Newquay Pathfinder” (2014), online: <www.ageuk.org.uk> (older adults at high risk of being admitted to hospital were visited by volunteers; early results included a 30 percent reduction in emergency admissions); Chris Dayson, Nadia Bashir & Sarah Pearson, “From dependence to independence: emerging lessons from the Rotherham Social Prescribing Pilot – Summary Report” (December 2013), online: <www.shu.ac.uk/> (patients at risk of unplanned hospital admission and in need of non-medical home support were provided time-limited services such as befriending; emergency department visits fell by up to 20 percent, at 1); Kali S. Thomas, Ucheoma Akobundu & David Dosa, “More than a Meal? A Randomized Control Trial Comparing the Effects of Home-Delivered Meals Programs on Participants’ Feelings of Loneliness” (26 November 2015) *J Gerontol B Psychol Sci Soc Sci* doi: 10.1093/geronb/gbv111 (homebound older adults receiving meals on wheels had lower loneliness scores than those who remained on the waiting list). There is also limited research on pet-based interventions: see e.g. Jitka Pikhartova, Ann Bowling & Christina Victor, “Does owning a pet protect older people against loneliness?” (20 September 2014) 14 *BMC Geriatrics* 106 (compared to women, men may find pet-based interventions less appropriate, at 110). But see Sarah Knapton, “Lonely elderly given hens to keep them company” *The Telegraph* (20 July 2015), online: <www.telegraph.co.uk>.

⁷⁹ See *below*, Chapter III.2 (Why older men?).

⁸⁰ See e.g. Weiss, *supra* note 75 at 17; Warren H. Jones, “Loneliness and Social Behavior” in Peplau & Perlman, *supra* note 75, 238 at 246. Compare John T. Cacioppo & William Patrick, *Loneliness: Human Nature and the Need for Social Connection* (New York: W.W. Norton, 2008) (volunteering benefits older adults’ health and well-being, and adds to the purpose, meaning and satisfaction of their lives, at 233).

⁸¹ White, *supra* note 18 at 308.

⁸² Weiss, *supra* note 75 at 13 & 17.

maladaptive social cognition, by directly targeting the negative feedback loop perpetuating the condition.⁸³ The results suggest that interventions which use CBT can reduce loneliness.⁸⁴

This chapter is divided into four sections. First, I define loneliness, and then distinguish it from objective isolation. Second, I outline the evolutionary approach to loneliness, which provides one explanation for why people feel lonely. Third, I identify five factors which increase one's risk for the emotional pain: age, gender, living alone, health status and personality. Fourth, I discuss the negative consequences associated with loneliness, including its effects on mental and physical health, service utilisation and social cognition.

1. What is loneliness?

While there are several definitions of loneliness, it is generally understood to be an unpleasant and distressing personal experience of unwanted discrepancies between existing and preferred relationships.⁸⁵ The mismatch between actual and desired connections is a subjective phenomenon; that is, it is based on the lonely person's own perceptions of his or her social world.⁸⁶ While loneliness is a near-universal experience, it is often situational,⁸⁷ sometimes surging after stressful life events such as the death of a spouse or close friend.⁸⁸ The feeling is usually time-limited, subsiding once the person reconnects with others.⁸⁹ But for some people, loneliness is unrelenting. Chronic loneliness has been defined as having a lack of satisfying relationships for two or more consecutive years.⁹⁰

⁸³ Masi et al, *supra* note 1 at 259. See also Megan L. Knowles et al, "Choking Under Social Pressure: Social Monitoring Among the Lonely" (June 2015) 41:6 *Personality & Soc Psychol Bulletin* 805 at 806. Compare Andy P. Dickens et al, "Interventions targeting social isolation in older people: a systematic review" (2011) 11 *BMC Pub Health* 647 at 666 (effective isolation and loneliness interventions offer social activity and/or support within a group format).

⁸⁴ Masi, *ibid* at 256.

⁸⁵ Brita Nilsson, Unni A. Lindstrom & Dagfinn Naden, "Is loneliness a psychological dysfunction? A literary study of the phenomenon of loneliness" (March 2006) 20:1 *Scandinavian J Caring Sci* 93 at 94; Pikhartova, Bowling & Victor, *supra* note 78 at 106; Ye Luo et al, "Loneliness, health, and mortality in old age: A national longitudinal study" (2012) 74 *Social Science & Medicine* 907 at 907; Dickens et al, *supra* note 83 at 648. See generally Peplau & Perlman, *supra* note 75.

⁸⁶ Keming Yang & Christina R. Victor, "The prevalence of and risk factors for loneliness among older people in China" (April 2008) 28:3 *Ageing & Society* 305 at 306.

⁸⁷ Pamela Qualter et al, "Loneliness Across the Life Span" (2015) 10:2 *Perspectives on Psychol Sci* 250 at 250.

⁸⁸ Sharon Shiovitz-Ezra & Liat Ayalon, "Situational versus chronic loneliness as risk factors for all-cause mortality" (2010) 22:3 *Intl Psychogeriatrics* 455 at 456.

⁸⁹ Qualter et al, *supra* note 87 at 250; Shiovitz-Ezra & Ayalon, *ibid* at 456.

⁹⁰ Jeffrey E. Young, "Loneliness, Depression and Cognitive Therapy: Theory and Application" in Peplau & Perlman, *supra* note 75, 379 at 382.

The subjective aspect of loneliness distinguishes it from objective isolation, which refers to the actual number of social contacts.⁹¹ Loneliness is about the quality of relationships; isolation is about quantity. Therefore, a person can be alone without being lonely, and an individual in a group setting (e.g., residential care) can experience loneliness.⁹² Compared to isolation, loneliness is difficult to measure because it is a self-reported subjective feeling.⁹³ Another difference between loneliness and isolation is that while individuals may want to have a small number of social contacts, they do not choose to be lonely—loneliness is always involuntary.⁹⁴

2. Why do we feel lonely?

According to an emerging evolutionary approach, loneliness might feel like a blight without any redeeming features, but it may play an important role in human evolution.⁹⁵ The theory posits that the painful feelings of loneliness motivate people to reconnect with others, thereby increasing their chances of survival and reproduction.⁹⁶ It suggests that the emotional pain triggers an “aversive signal” which warns us that our social connection to others is in jeopardy, and that we must change our behaviour to survive, prosper and procreate.⁹⁷ Similar to hunger and thirst, which motivate us to find food and water, loneliness drives us to repair broken relationships and maintain existing ones which are needed for health and well-being, as well as ensuring a genetic legacy.⁹⁸

⁹¹ Nilsson, Lindstrom & Naden, *supra* note 85; Luo et al, *supra* note 85; Dellmar Walker & Roy E. Beauchene, “The Relationship of Loneliness, Social Isolation, and Physical Health to Dietary Adequacy of Independently Living Elderly” in Lawrence A. Frolik, ed, *Aging and the Law: An Interdisciplinary Reader* (Philadelphia: Temple University Press, 1999), 568 at 568; Hawkey & Cacioppo, “Loneliness Matters”, *supra* note 1 at 218.

⁹² See Christina R. Victor, “Loneliness in care homes: a neglected area of research?” (2012) 8:6 *Aging Health* 637 (prevalence of severe loneliness among care home residents is at least double that of community-dwelling older adults).

⁹³ Liesl M. Heinrich & Eleonora Gullone, “The clinical significance of loneliness: A literature review” (October 2006) 26:6 *Clinical Psychol Rev* 695 at 711. While there are several loneliness scales, the most commonly used is the UCLA Loneliness Scale: *ibid* at 700.

⁹⁴ Luo et al, *supra* note 85 at 907; Dickens et al, *supra* note 83 at 648; Ethel Mannin, *Loneliness: A Study of the Human Condition* (Toronto: Hutchinson & Co. Publishers Ltd., 1966) at 11.

⁹⁵ J Cacioppo, S Cacioppo & Boomsma, *supra* note 1 at 3 & 7; Luc Goossens et al, “The Genetics of Loneliness: Linking Evolutionary Theory to Genome-Wide Genetics, Epigenetics, and Social Science” (2015) 10:2 *Perspectives on Psychol Sci* 213 at 214; Gillian A. Matthews et al, “Dorsal Raphe Dopamine Neurons Represent the Experience of Social Isolation” (2016) 164:4 *Cell* 617.

⁹⁶ J Cacioppo, S Cacioppo & Boomsma, *ibid* at 7.

⁹⁷ *Ibid* at 3, 7 & 14.

⁹⁸ *Ibid* at 7-8.

3. Risk factors

Humans are social animals, and the need to belong is present across the lifespan.⁹⁹ Therefore, it is unsurprising that loneliness can affect anyone; it does not discriminate.¹⁰⁰ However, several factors alone and in combination increase one's risk for the affliction. In this section, I briefly look at five risk factors for loneliness: age, gender, living alone, health status and personality.

Contrary to popular belief, loneliness is not restricted to old age.¹⁰¹ Children as young as five have reported feeling lonely.¹⁰² The age distribution of the emotional condition has been described as U-shaped, with rates peaking among adolescents and young adults, and then again among the oldest-old (often described as those aged 80 and over).¹⁰³ The distribution may be partly explained by the unrealistic relationship expectations of adolescents and young adults, and then late-life generally being characterised by the loss of partners and friends, as well as lower income levels and higher functional limitations.¹⁰⁴ A recent review of several studies found that 40 to 50 percent of people aged 80 and over reported that they “often” felt lonely (which is defined as moderate or serious loneliness); this compares to 20 to 30 percent of their younger counterparts aged 45 to 79.¹⁰⁵ The National Seniors Council of Canada also reports that approximately 50 percent of people over age 80 report feeling lonely.¹⁰⁶ Loneliness is felt by older adults with intact and reduced cognitive function, although a Swedish study found a higher frequency among people

⁹⁹ John T. Cacioppo et al, “Lonely traits and concomitant physiological processes: the MacArthur social neuroscience studies” (2000) 35 *Intl J Psychophysiology* 143 at 144; J Cacioppo, S Cacioppo & Boomsma, *ibid* at 6.

¹⁰⁰ S Cacioppo et al, *supra* note 75 at 239; Weiss, *supra* note 75 at 71-72.

¹⁰¹ Maike Luhmann & Lousie C. Hawkey, “Age Differences in Loneliness From Late Adolescence to Oldest Old Age” (2016) *Developmental Psychology* doi: 10.1037/dev0000117; Pearl A. Dykstra, “Older adult loneliness: myths and realities” (2009) 6 *Eur J Ageing* 91 at 92-93 (respondents of all ages overestimated the rate of loneliness among the older population).

¹⁰² Jude Cassidy & Steven R. Asher, “Loneliness and Peer Relations in Young Children” (1992) 63:2 *Child Development* 350.

¹⁰³ Karen Christensen & David Levinson, eds, *Encyclopedia of Community: From the Village to the Virtual World*, vol 1 (Thousand Oaks: Sage Publications, Inc., 2003) at 874; Leehu Zysberg, “Loneliness and Emotional Intelligence” in Ami Rokach, ed, *Loneliness Updated: Recent research on loneliness and how it affects our lives* (New York: Routledge, 2013), 39 at 39; Hawkey & J Cacioppo, “Loneliness Matters” *supra* note 1 at 218. But see Reuven P. Bulka, “Loneliness: Causes, Consequences, and Cure” (1996) 20 *Legal Med Q* 9 (“People in their late 60s, 70s, and 80s are invariably less lonely than younger adults” at 10 [emphasis added]).

¹⁰⁴ See Randy M. Page & Galen E. Cole, “Demographics Predictors of Self-Reported Loneliness in Adults” (1991) 68 *Psychol Reports* 939 at 944; Jiska Cohen-Mansfield & Aleksandra Parpura-Gill, “Loneliness in older persons: a theoretical model and empirical findings” (2007) 19:2 *Intl Psychogeriatrics* 279 at 280; Luhmann & Hawkey, *supra* note 101.

¹⁰⁵ Dykstra, *supra* note 101 at 92. See also Jen Beaumont, “Measuring National Well-being – Older people and loneliness, 2013” (11 April 2013) Office of National Statistics, online: <www.ons.gov.uk> (2009/10 English Longitudinal Study of Ageing showed that 34 percent of respondents aged 52 and over, and 46 percent of those aged 80 and over, felt lonely “some of the time” or “often,” at 1).

¹⁰⁶ National Seniors Council, *supra* note 76 at 8.

aged 75 and older who had slight cognitive difficulties: 48 percent of subjects with slight cognitive reduction experienced loneliness, compared to 34 percent of subjects with strongly reduced function and 31 percent with intact function.¹⁰⁷

Gender is a potential risk factor for loneliness, although studies on gender differences have produced inconsistent results.¹⁰⁸ A recent study of older adults in Canada found that men were lonelier than woman.¹⁰⁹ Men who are unmarried or have lost a spouse may be at an even greater risk of loneliness.¹¹⁰ If a spouse was their confidant, losing them may cause widowers to feel extremely lonely.¹¹¹ In studies which have found women to be lonelier, observers have pointed out that men may be less likely to admit (i.e., self-report) feeling lonely.¹¹² The stigma associated with loneliness may also make it susceptible to underreporting, especially by men.¹¹³

Living alone is also a risk factor associated with loneliness.¹¹⁴ Canadian census data from 2011 shows that the prevalence of living alone increases in later life. Among men aged 65 and over, 16 percent lived alone; this number rose to 21.8 percent among men aged 85 and older.¹¹⁵ For women, the numbers were 31.5 and 36.6 percent, respectively.¹¹⁶ The link between loneliness and living alone might be strongest among older adults from more “collectivist” societies, such as

¹⁰⁷ Karin Holmén et al, “Loneliness among elderly people living in Stockholm: a population study” (1992) 17 J Adv Nursing 43 at 46-47 (it is hard to judge the results of people with strong cognitive reduction because they may have difficulty communicating their subjective experience of loneliness, at 52). See also Lisa Boss, Duck-Hee Kang & Sandy Branson, “Loneliness and cognitive function in the older adult: a systematic review” (April 2015) 27:4 Intl Psychogeriatrics 541 (greater loneliness is associated with lower cognitive function).

¹⁰⁸ Louise C. Hawkley et al, “The Mental Representations of Social Connections: Generalizability Extended to Beijing Adults” (2012) 7:9 PLOS One doi:10.1371/journal.pone.0044065 at 9; Jiong Yang, *Relationship between Gender Traits and Loneliness: The Role of Self-Esteem* (MA Thesis, Brandeis University, Psychology Department, 2009) [unpublished] at 3-5 & 21.

¹⁰⁹ Jenny de Jong Gierveld, Norah Keating & Janet E. Fast, “Determinants of Loneliness among Older Adults in Canada” (June 2015) 34:2 Can J Aging 125 at 133.

¹¹⁰ Letitia Anne Peplau et al, “Being Old and Living Alone” in Peplau & Perlman, *supra* note 75, 327 at 339; Mannin, *supra* note 94 at 135; Lars Andersson, “Loneliness research and interventions: a review of the literature” (1998) 2:4 Aging & Mental Health 264 at 267.

¹¹¹ Kosberg, *supra* note 2 at 13.

¹¹² Andersson, *supra* note 110 at 267.

¹¹³ *Ibid.* See also Anthea Tinker, *Older People in Modern Society* (New York: Addison Wesley, 1997) at 232; Myer D. Mendelson, “Reflections on Loneliness” (1990) 26:2 Contemporary Psychoanalysis 330; Mannin, *supra* note 94 at 139; Jacqueline Olds & Richard S. Schwartz, *The Lonely American: Drifting Apart in the Twenty-first Century* (Boston: Beacon Press, 2010) at c 1.

¹¹⁴ Tineke Fokkema, Jenny de Jong Gierveld & Pearl A. Dykstra, “Cross-National Differences in Older Adult Loneliness” in Rokach, *supra* note 103, 200 at 202.

¹¹⁵ Statistics Canada, Census in Brief, *Living arrangements of seniors* (2011), online: <https://www12.statcan.gc.ca/census-recensement/2011/as-sa/98-312-x/98-312-x2011003_4-eng.cfm>.

¹¹⁶ *Ibid.*

Italy, where very high expectations of relationships may not be fulfilled.¹¹⁷ In comparison, older adults from “individualist” societies may view living alone as an achievement, rather than as a sign of rejection.¹¹⁸ A recent cross-national analysis found that older adults in Canada had the lowest loneliness scores when compared to their counterparts in seven other countries (France, Germany, Netherlands, Russia, Bulgaria, Georgia and Japan).¹¹⁹

Further, loneliness levels tend to be higher among older adults in poor health.¹²⁰ Some specific ailments associated with loneliness are urinary incontinence,¹²¹ rheumatic diseases (e.g., osteoarthritis, fibromyalgia),¹²² and Charles Bonnet syndrome (complex visual hallucinations in the visually impaired).¹²³ Older adults with these and other similar conditions may avoid or minimise social interaction to protect themselves against perceived stigma and embarrassment.

Certain personality characteristics may also increase one’s risk for loneliness. Low self-esteem, shyness, social phobia, continuous apprehension and fear of embarrassment in public have been linked to loneliness.¹²⁴ There is also a strong relationship between loneliness and anxiety.¹²⁵

¹¹⁷ Fokkema, de Jong Gierveld & Dykstra, *supra* note 114 at 220; Laura Alejandra Rico-Urbe et al, “Loneliness, Social Networks, and Health: A Cross-Sectional Study in Three Countries” (13 January 2016) 11:1 PLoS ONE doi: 10.1371/journal.pone.0145264 (people from southern and central European countries such as Italy, Spain and Poland tend to be lonelier than those from northern countries such as Finland, at 10); Dykstra, *supra* note 101 at 93 & 95; Mannin, *supra* note 94 at 135; *BS (Re)*, 2011 CanLII 37922 (ON CCB) at 4-5 [*BS*] (lawyer argued that client’s unwillingness to consider information related to long-term care was informed by a cultural overlay, not mental incapacity; as an Italian, she had a cultural expectation that she would be cared for by her children until it was no longer possible).

¹¹⁸ Letitia Anne Peplau et al, “Being Old and Living Alone” in Peplau & Perlman, *supra* note 75, 327 at 329. But these assertions are generally speculative, as existing research rarely distinguishes between people for whom living alone is an established pattern and those for whom it is a result of a recent traumatic life event such as losing a spouse: Christina Victor, Sasha Scambler & John Bond, *The Social World of Older People: Understanding Loneliness and Social Isolation in Later Life* (Berkshire: Open University Press, 2009) at 27. Compare Philip Elliot Slater, *The Pursuit of Loneliness: American Culture at the Breaking Point* (Boston: Beacon Press, 1970) at 11-12 (one might expect higher loneliness levels in Anglo-American societies, given their individualistic dimensions).

¹¹⁹ de Jong Gierveld, Keating & Fast, *supra* note 109 at 133.

¹²⁰ *Ibid* at 127; Elin Taube et al, “Being in a Bubble: the experience of loneliness among frail older people” (March 2016) 72:3 J Adv Nursing 631 at 632-33.

¹²¹ Pamela L. Ramage-Morin & Heather Gilmour, “Urinary incontinence and loneliness in Canadian seniors” Statistics Canada (October 2013), online: <<http://www.statcan.gc.ca>> at 5.

¹²² Marianne B. Kool & Rinie Geenen, “Loneliness in Patients with Rheumatic Diseases: The Significance of Invalidation and Lack of Social Support” in Rokach, *supra* note 103, 231 at 231.

¹²³ Robert J. Teunisse et al, “Social and Psychological Characteristics of Elderly Visually Handicapped Patients with the Charles Bonnet Syndrome” (July-August 1999) 40:4 Comprehensive Psychiatry 315.

¹²⁴ Bronwyn S. Fees, Peter Martin & Leonard W. Poon, “A Model of Loneliness in Older Adults” (1999) 54B:4 J Gerontology 231 at 232; Duck, Pond & Leatham, *supra* note 5 at 255.

¹²⁵ Fees, Martin & Poon, *ibid*; Wendi L. Gardner, “On the Outside Looking In: Loneliness and Society Monitoring” (November 2005) 31:11 Pers Soc Psychol Bull 1549 at 1551.

Similar to people with stigmatised health conditions, socially anxious people may withdraw from interaction as a defence mechanism, and unwittingly perpetuate the cycle of loneliness.¹²⁶

4. Negative associations

Loneliness is linked to serious personal, societal and financial costs. First, it may have long-lasting negative effects on mental and physical health.¹²⁷ Although the causal relationship is not clear-cut,¹²⁸ loneliness has been associated with heart disease and stroke;¹²⁹ depression, suicide and alcoholism;¹³⁰ accelerated cognitive decline, Alzheimer's disease and other dementias;¹³¹ decreased food intake;¹³² obesity and diabetes;¹³³ and increased mortality.¹³⁴ As life expectancies increase, these consequences are taking on greater significance. That is, while the short-term benefits of loneliness (e.g., increased motivation to reconnect) are realised across the lifespan, the cognitive and physiological effects (e.g., dementia, hypertension) are incurred in later life.¹³⁵ Throughout much of human history, people simply did not live long enough for the negative health effects of loneliness to be of much consequence.¹³⁶

¹²⁶ Duck, Pond & Leatham, *supra* note 5 at 255.

¹²⁷ Qualter et al, *supra* note 87 at 250.

¹²⁸ Julianne Holt-Lunstad et al, "Loneliness and Social Isolation as Risk Factors for Mortality: A Meta-Analytic Review" (2015) 10:2 *Perspectives on Psychol Sci* 277 (unadjusted data fail to account for research subjects' health status, which contributes to reverse causality, such as when individuals with poor health report increased loneliness because their medical condition limits their social contacts, at 233).

¹²⁹ Trisha Pettite et al, "A Systematic Review of Loneliness and Common Chronic Physical Conditions in Adults" (2015) 8 *The Open Psychol J* 113 at 130; Nilsson, Lindstrom & Naden, *supra* note 85 at 94; Nicole K. Valtorta et al, "Loneliness and social isolation as risk factors for coronary heart disease and stroke: systematic review and meta-analysis of longitudinal observational studies" (18 April 2016) *Heart* doi:10.1136/heartjnl-2015-308790 at 1. But see Briana Mezuk et al, "Loneliness, Depression, and Inflammation: Evidence from the Multi-Ethnic Study of Atherosclerosis" (2016) 11:7 *PLoS ONE* doi:10.1371/journal.pone.0158056 (loneliness is not positively associated with fibrinogen or C-reactive protein among relatively healthy middle-aged adults).

¹³⁰ Ken J. Rotenberg, "Loneliness and Interpersonal Trust" (1994) 13:2 *J Soc & Clinical Psychol* 152 at 152; Laurence C. Nolan, "Dimensions of Aging and Belonging for the Older Person and the Effects of Ageism" (2011) 25 *BYU J Pub L* 317 at 322-23; Pikhartova, Bowling & Victor, *supra* note 78 at 106.

¹³¹ Pikhartova, Bowling & Victor, *ibid*; Tjalling Jan Holwerda et al, "Feelings of loneliness, but not social isolation, predict dementia onset: results from the Amsterdam Study of the Elderly (AMSTEL)" (2014) 85 *J Neurol Neurosurg Psychiatry* 135. Compare Ellen Kathryn Rozek, *The Effect of Loneliness on Executive Functioning in Young and Older Adults* (PhD Thesis, University of Kansas, Faculties of Psychology and Gerontology, 2013) [unpublished] (findings provide limited support for hypothesis that loneliness impairs executive function, at 54).

¹³² Walker & Beauchene, *supra* note 91 at 568.

¹³³ Pettite et al, *supra* note 129 at 130; Nilsson, Lindstrom & Naden, *supra* note 85 at 94.

¹³⁴ Luo et al, *supra* note 85 at 907; JoAnn Grif Alspach, "Loneliness and Social Isolation: Risk Factors Long Overdue for Surveillance" (December 2013) 33:6 *Crit Care Nurse* 8 at 9-10; Max L. Stek et al, "Is Depression in Old Age Fatal Only When People Feel Lonely?" (January 2005) 162:1 *The American J Psychiatry* 178.

¹³⁵ J Cacioppo, S Cacioppo & Boomsma, *supra* note 1 at 6.

¹³⁶ *Ibid*.

Loneliness may lead to early and increased service utilisation. Among older adults, the emotional malady has been linked to early institutionalisation.¹³⁷ Studies also show that lonely older people visit their doctor more often than the non-lonely.¹³⁸ This pattern is said to reflect lonely people's "tendency to substitute physician support for social support."¹³⁹ Lonely individuals also make more frequent trips to the emergency department.¹⁴⁰ These self-coping mechanisms are understandable, and costly. British researchers estimate that increased service usage by chronically lonely older adults costs the public sector an average of £12,000 (\$23,300 CAD) per person over 15 years.¹⁴¹ For a local authority with 5,000 lonely older people, the total estimated cost over a 15-year period is £60m (\$116.5M CAD).¹⁴²

Loneliness is also associated with maladaptive social cognition. According to an evolutionary model, loneliness makes people feel unsafe and this triggers an automatic hypervigilance for social threats.¹⁴³ This "unconscious surveillance" produces cognitive biases; in particular, compared to non-lonely people, lonely individuals are more likely to expect rejection from others and remember negative social information.¹⁴⁴ This maladaptive social cognition leads to lonely people behaving in self-protective ways, in which they push people away, despite

¹³⁷ Morley D. Glicker, *Evidence-Based Counseling and Psychotherapy for an Aging Population* (Burlington, MA: Academic Press, 2009) at 164.

¹³⁸ Kerstin Gerst-Emerson & Jayani Jayawardhana, "Loneliness as a Public Health Issue: The Impact of Loneliness on Health Care Utilization Among Older Adults" (May 2015) 105:5 *American J Pub Health* 1013 at 1017; Jeffrey Geller et al, "Loneliness as a Predictor of Hospital Emergency Department Use" (October 1999) 48:10 *J Family Practice* 801 at 804.

¹³⁹ Sheung-Tak Cheng, "Loneliness-Distress and Physician Utilization in Well-Elderly Females" (January 1992) 20 *J Community Psychol* 43 at 54.

¹⁴⁰ Gerard J. Molloy et al, "Loneliness and Emergency and Planned Hospitalizations in a Community Sample of Older Adults" (2010) 58:8 *J Am Geriatrics Society* 1538 at 1538; Geller et al, *supra* note 138 at 804 (lonely people use the emergency department 60 percent more than the average non-lonely person).

¹⁴¹ Social Finance, "Investing to Tackle Loneliness: A Discussion Paper" (June 2015), online: <www.socialfinance.org.uk> at 10.

¹⁴² *Ibid* at 12.

¹⁴³ Hawley & J Cacioppo, "Loneliness Matters", *supra* note 1 at 220; Louise C. Hawley, John T. Cacioppo & Joshua Correll, "Perceived Social Isolation within Personal and Evolutionary Timescales" in C. Nathan DeWall, ed, *The Oxford Handbook of Social Exclusion* (New York: Oxford University Press, 2013) at 182-83; John T. Cacioppo & Louise C. Hawley, "People Thinking About People: The Vicious Cycle of Being a Social Outcast in One's Own Mind" in Kipling D. Williams, Joseph P. Forgas & William von Hippel, eds, *The Social Outcast: Ostracism, Social Exclusion, Rejection, and Bullying* (New York: Psychology Press, 2005) at 94, 98, 100 & 103 [J Cacioppo & Hawley, "People"]; Stephanie Cacioppo, Stephen Balogh & John T. Cacioppo, "Implicit attention to negative social, in contrast to nonsocial, words in the Stroop task differs between individuals high and low in loneliness: Evidence from event-related brain microstates" (July 2015) *Cortex* doi:10.1016/j.cortex.2015.05.032; Kool & Geenen, *supra* note 122 at 241.

¹⁴⁴ Hawley & J Cacioppo, "Loneliness Matters", *ibid*; Hawley, J Cacioppo & Correll, *ibid* at 182-83; J Cacioppo & Hawley, "People", *ibid* at 94, 98, 100 & 103; S Cacioppo, Balogh & J Cacioppo, *ibid*; Kool & Geenen, *ibid* at 241.

simultaneously desiring that social contact.¹⁴⁵ This behaviour tends to elicit negative responses from others, which validates the lonely person’s pessimistic expectations and fuels the likelihood of them again distancing themselves from potential social partners.¹⁴⁶ John Cacioppo and Louise Hawkley illustrate this self-reinforcing loneliness loop as follows:

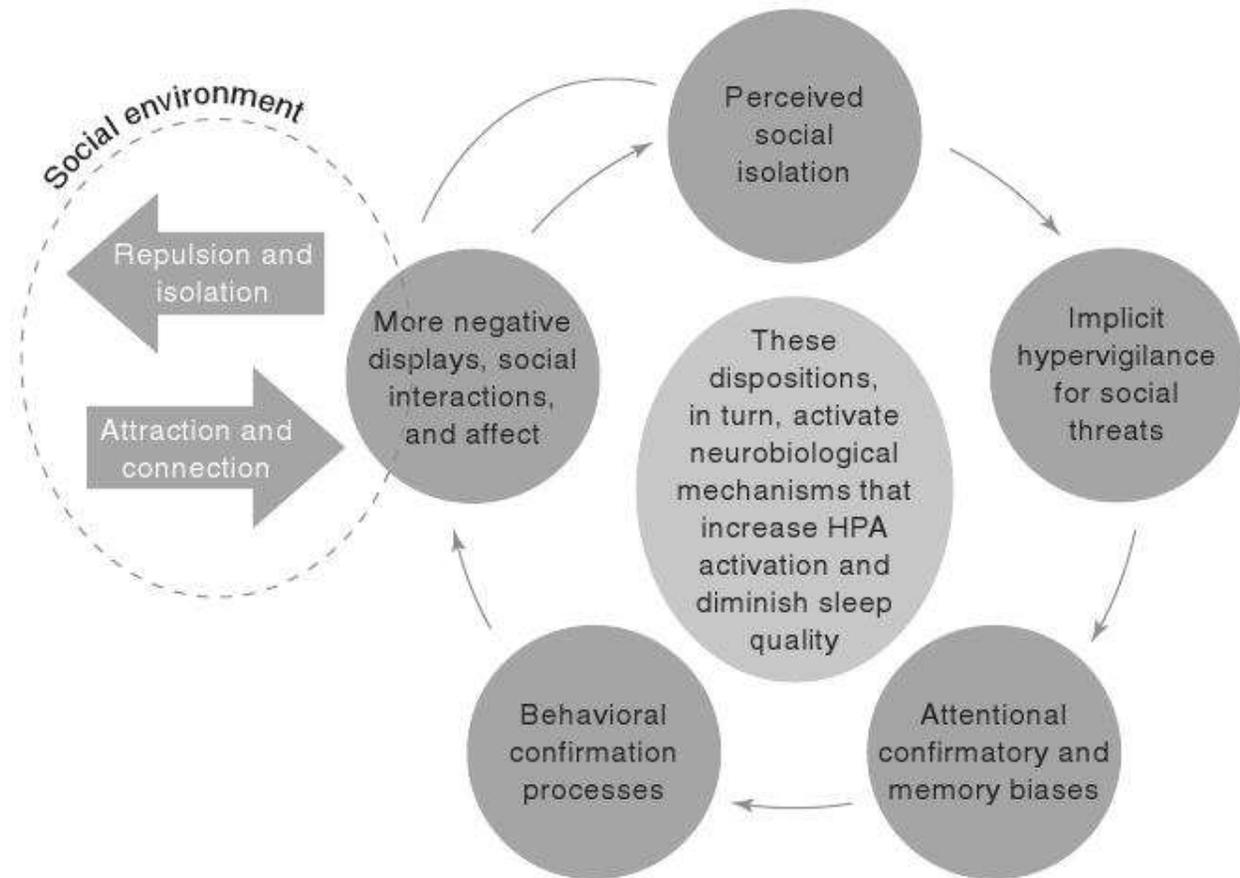


Figure 1: The effects of loneliness on human cognition.¹⁴⁷ Reprinted with permission.

¹⁴⁵ Hawkley & J Cacioppo, “Loneliness Matters”, *ibid*; J Cacioppo, S Cacioppo & Boomsma, *supra* note 1 at 9 (does not distinguish between pushing away casual acquaintances [e.g. friends and family] versus formal supports [e.g. social workers or volunteer befrienders]). See also J Cacioppo & Patrick, *supra* note 80 (“The sad irony is that these poorly regulated behaviors, prompted by fearful sensations, often elicit the very rejections that we all dread the most” at 16).

¹⁴⁶ Hawkley & J Cacioppo, “Loneliness Matters”, *ibid*; Louise C. Hawkley & John T. Cacioppo, “Loneliness” (2009) University of Chicago, online: <<http://psychology.uchicago.edu/people/faculty/cacioppo/jtcreprints/hc09.pdf>> at 6; Duck, Pond & Leatham, *supra* note 5 at 254-55; J Cacioppo, S Cacioppo & Boomsma, *ibid* at 9.

¹⁴⁷ J Cacioppo & Hawkley, “Perceived”, *supra* note 7 at 451 (“HPA” means hypothalamic pituitary adrenal. The HPA axis plays a central role in responding to stress). For another helpful figure, see Qualter et al, *supra* note 87 at 255.

Given that people who are stuck in the vicious cycle of loneliness tend to reject opportunities for social contact, it is unsurprising that popular interventions which encourage activities such as volunteering have little effectiveness. These initiatives do not directly target the negative feedback loop. It takes cognitive behavioural-based approaches to modify a chronically lonely person's maladaptive social cognition, and release them from the perpetual downward cascade. CBT achieves this change by helping individuals identify and challenge their automatic negative thoughts, beliefs and behaviours (e.g., expecting rejection from others).¹⁴⁸

¹⁴⁸ S Cacioppo et al, *supra* note 75 at 239 at 244; Ken Laidlaw & Larry W. Thompson, "Cognitive behaviour therapy with depressed older people" in Ken Laidlaw & Bob Knight, eds, *Handbook of Emotional Disorders in Later Life: Assessment and Treatment* (New York: Oxford University Press, 2008), 91 at 92 [reference omitted]; J Cacioppo & Patrick, *supra* note 80 at 235; Forrest Scogin & Avani Shah, "Introduction to Evidence-Based Psychological Treatments for Older Adults" in Forrest Scogin & Avani Shah, eds, *Making Evidence-Based Psychological Treatments Work with Older Adults* (Washington: American Psychological Association, 2012), 3 at 11; Kool & Geenen, *supra* note 122 at 241.

CHAPTER III: OLDER MEN – A FORGOTTEN POPULATION

This chapter sets out my rationale for focusing on older men. Or to put it more transparently, I explain why I am not following the current trend of framing aging as a women’s issue.¹⁴⁹ By writing about older men, I am not claiming that their challenges are bigger or more important than those faced by older women; rather, I am responding to their invisible suffering. For instance, Canadian men aged 85 and over have had the highest suicide rate of any age group in the country,¹⁵⁰ yet this epidemic has attracted little widespread concern. They were only recently surpassed by men in their 50s, not because older men’s suicide rate has significantly dropped, but because the rate among middle-aged men’s has risen.¹⁵¹

This chapter is divided into two sections. First, I discuss the initial terminology issues which often pose a conundrum in law and aging literature: who is an older adult? And what terms should be used when referring to this heterogeneous group? For brevity purposes, I only address the questions briefly; my conciseness is not meant to undermine the importance of finding and using non-ageist language. Second, I identify the four factors which have compelled me to write about older men. The points can be summarised as the feminisation of elder advocacy; men’s less help-seeking behaviour; the family-oriented approach to law and policy; and the marginalising effects of the active aging approach.

1. Who is an older adult?

Older people (and older men) are more different than they are alike. People have intersectional identities which shape their experiences—age is just one component. Therefore, it is difficult to settle on the appropriate terminology to use when discussing this diverse group. Such efforts are often controversial. In this thesis, I interchangeably use the terms “older person,” “older adult,” and “elder” to refer to all older people in a general sense. I understand that some individuals have

¹⁴⁹ See e.g. A.K. Dayton, “A Feminist Approach to Elder Law” in Doron, *Theories, supra* note 11 (“One important truth about global aging is that it is a ‘women’s issue’” at 45); Alzheimer Society of Canada’s, Media Release, “Alzheimer Awareness Month targets women with ‘The 72%’ campaign” (January 2015), online: <www.alzheimer.ca> (Alzheimer’s disease is “a women’s issue”).

¹⁵⁰ Statistics Canada, “Suicides and suicide rate, by sex and by age group” (10 December 2015), online: <<http://www.statcan.gc.ca/tables-tableaux/sum-som/l01/cst01/hlth66e-eng.htm>>.

¹⁵¹ One explanation for the rising suicide rate among middle-aged men is that they were disproportionately affected by the economic downturn in 2007-2009: see Katherine A. Hempstead & Julie A. Phillips, “Rising Suicide Among Adults Aged 40-64 Years” (May 2015) 48:5 *Am J Preventive Medicine* 491.

expressed discomfort with “elder” because of its close ties to “elderly,” which conjures stereotypical images of older people as frail, weak and dependent. However, as I discuss below in relation to my critique of the active aging approach, I fear that the modern battle cry to age “successfully” has further marginalised older people who are in fact frail, weak and dependent. I also use “elder” because of its respectful undertones, although I am sensitive to the fact that Aboriginal and faith communities may have criteria other than age which contribute to recognition as an Elder. At times, I also use the term “senior,” which has largely fallen out of fashion in academic writing. I use the word mostly when referring to various government initiatives, which continue to frequently describe members of the older population as “seniors.”

My discussion of older people is not confined to a specific age bracket. I am loosely referring to individuals in later life, generally those aged 80 and above. That said, people with undue hardships in life (e.g., homelessness, addictions, severe mental health issues, incarceration) may be physically older than their chronological age. “Old age” in these populations may start among those who are in their late 40s or early 50s. My focus on chronologically older people is for convenience and managing scope; younger vulnerable adults are not excluded on any principled basis. Moreover, I place little importance on age 65, which is the arbitrary number often associated with becoming a “senior.” I appreciate that age 65 (or sometimes 60, etc.) still carries some legal and practical relevance, as it continues to be the eligibility age for some programs and benefits (e.g., Old Age Security); however, for the purposes of this thesis, such defined ages amount to little more than convenient chronological markers.

2. Why older men?

Four factors have compelled me to focus on older men. First, older men have largely been forgotten.¹⁵² There are several possible explanations for this lack of attention, including the feminisation of elder advocacy:

¹⁵² Kosberg, *supra* note 2 at 15; Brian Beach & Sally-Marie Bamford, “Isolation: The emerging crisis for older men” *Independent Age* (2014), online: <www.ilcuk.org.uk> (when ageing policy and practice is explored from a gendered-perspective, the focus is usually on women, at 1); Peggy Edwards, Report prepared for the Division of Aging and Seniors, Public Health Agency of Canada, “Elder Abuse in Canada: A Gender-Based Analysis” Public Health Agency of Canada (2012) (the author made a special attempt to find recent studies on older men and abuse; however, the majority of reports generalized their findings to all older people, at 6). But see Kate Davidson, Tom Daly & Sara Arber, “Older Men, Social Integration and Organisational Activities” (2003) 2:2 *Soc Pol’y & Soc’y* 81; Christine Milligan et al, “Men’s Sheds and other gendered interventions for older men: improving health and wellbeing through social activity: A systematic review and scoping of the evidence base” Liverpool-Lancaster

Whereas older women have taken advantage of the successful advocacy efforts of feminists, older men have not benefited from efforts of those in the men's movement and there are few, if any, groups or organizations that advocate on behalf of their welfare. There are (faulty) assumptions regarding the superior quality of older men's lives, compared to older women.¹⁵³

To be sure, feminist advocacy has corrected the historic invisibility of women in classic liberal legal analysis (in which the legal actor is male). Parts of my theoretical framework are indebted to feminist scholarship.¹⁵⁴ However, older men, like women of all ages, are generally not reflected in the neutral liberal actor, who is male, but not old.¹⁵⁵ Some might argue that "older adult" is a euphemism for "older man," just as the "reasonable person" in law is really just the "reasonable man." According to this line of thought, there would need to be concerted attention on older women because any discussion of "older adult" is actually characterised by implicit male norms. This argument may carry some weight, but on a whole, it is problematic. If the liberal individualist actor does not grow old, some men (e.g., white, heterosexual, able-bodied) will age into the unfamiliar position of "other."¹⁵⁶ Women are "others" throughout their lives; older men may be experiencing marginalisation for the first time. Physical changes may also catch men off guard, or be met with resistance or denial. It is arguable that many women have a lifetime of bodily changes that are largely outside of their control (e.g., menstruation, child birth, lactation).¹⁵⁷ Aging can be seen as a continuation of those experiences. For older men, the loss of bodily control may be new (e.g., age-related incontinence, impotence).¹⁵⁸ From this perspective, it is possible that men may be less psychologically prepared for or accepting of the transition into old age.

The women-centred lens in elder advocacy has failed to respond to the particular needs and challenges of older men. For instance, the proliferation of rudimentary financial elder abuse prevention programs held in community centres and church basements do not effectively reach

Collaborative & Age UK (April 2013); Robert L. Rubinstein, *Singular Paths: Older Men Living Alone* (New York: Columbia University Press, 1986); Vacha-Haase, Wester & Christianson, *supra* note 2.

¹⁵³ Kosberg, *ibid* at 15 [reference omitted].

¹⁵⁴ See e.g. Chapter I.2 (Universal legal capacity), *above*, for my discussion of the relational theory of autonomy.

¹⁵⁵ See Margaret Isabel Hall, "Old Age (or, Do We Need a Critical Theory of Law and Aging)" (2014) 35 Windsor Rev Legal & Soc Issues 1 ("the normative liberal legal actor is not old" at 2) [Hall, "Old Age"]; Martha Albertson Fineman, "'Elderly' as Vulnerable: Rethinking the Nature of Individual and Societal Responsibility" (2012) 20:1 Elder LJ 71 at 118 [Fineman, "Elderly"].

¹⁵⁶ See Sarah Harper, "Constructing later life/constructing the body: some thoughts from feminist theory" in Anne Jamieson, Sarah Harper & Christina R. Victor, eds, *Critical Approaches to Ageing and Later Life* (Philadelphia: Open University Press, 1997), 160 at 169, referenced in Hall, "Old Age", *supra* note 155 at 8-9.

¹⁵⁷ Harper, *ibid* at 166.

¹⁵⁸ *Ibid.*

many older men, yet studies show that they are often victims. In a recent examination of the Ottawa Police Service's elder abuse files, researchers found that the most common type of elder abuse was financial, and that men were victimized more often than women.¹⁵⁹ Research on securities fraud also reveals that among older adults, the main victims are men, especially financially-literate, college-educated, married older men with self-reliant and self-deterministic personalities.¹⁶⁰ Such individuals do not fit the typical profile of "financial elder abuse 101" attendees. As Jayne Barnard astutely observes, "the type of person who is most likely to make an irrational investment decision—a stubborn, self-reliant, risk-seeking seventy-five-year-old man—is precisely the type of person least likely to seek out or internalize cautionary educational messages."¹⁶¹

As funders shift dollars to loneliness and isolation interventions, the trend of women-oriented programming has continued. Many initiatives have been designed without older men in mind, and unsurprisingly, we see very low participation rates among this cohort, especially among older men who are widowed, unmarried or otherwise unattached. For instance, in the 2014-2015 Ontario-based pilot project, "Living Life to the Full for Older Adults," older women accounted for 89 percent of participants, and of the handful of men who did attend, some were spouses of the women attendees.¹⁶² Low attendance among older men can be partly explained by demographics; since women on average live longer, there are simply more older women than older men.¹⁶³ But statistics are only part of the story. Another explanation for low turnout among older men is that some of them may eschew traditionally-run organisations aimed at older people, in part because they are not male-friendly.¹⁶⁴ Some researchers suggest that programs and clubs geared toward older adults might attract more men by having amenities such as a pool table and beer.¹⁶⁵ Changing

¹⁵⁹ See e.g. Lisa Ha & Ruth Code, "An Empirical Examination of Elder Abuse: A Review of Files from the Elder Abuse Section of the Ottawa Police Service" Department of Justice Canada (2013), online: <http://www.justice.gc.ca/eng/rp-pr/cj-jp/fv-vf/tr13_1/tr13_1.pdf> at 9.

¹⁶⁰ Jayne W. Barnard, "Deception, Decisions and Investor Education" (2009) 17 *Elder LJ* 201 at 210.

¹⁶¹ *Ibid* at 231.

¹⁶² Jenny Hardy & Nasreen Khatri, "Living Life to the Full: Breaking the Ice(olation) of Aging" (Presentation delivered at the Annual NICE Knowledge Exchange, Toronto, May 28, 2015).

¹⁶³ In Canada, the average life expectancy is 84 years for females and 80 for males: World Health Organization, Countries, "Canada", online: <<http://www.who.int/countries/can/en/>> (for people born in 2013). Among the Canadian population in 2010, women accounted for 56 percent of people aged 65 and older, 67 percent of those aged 85 and older, and 80 percent of centenarians. However, as the gender gap in life expectancies narrows between men and women, we can expect a more balanced distribution: Covadonga Robles Urquijo & Anne Milan, "Female population" Statistics Canada (July 2011), online: Statistics Canada <<http://www.statcan.gc.ca/pub/89-503-x/2010001/article/11475-eng.pdf>> at 8.

¹⁶⁴ Davidson, Daly & Arber, *supra* note 152 at 83 & 88.

¹⁶⁵ *Ibid*.

the location might also help. Instead of community centres and church basements, programming could take place at other trusted venues such as the Legion, golf club or barbershop.¹⁶⁶ Such an approach has been applied to prostate cancer education efforts in the U.S., where African-American barbershops disseminate customized information to patrons.¹⁶⁷ In terms of loneliness and isolation initiatives, very few programs specifically target older men. There are only a handful of exceptions. For instance, Men's Sheds are a promising example of "male-friendly" programming. Described as the modern version of "the shed in the backyard," Men's Sheds give men a safe and busy environment where they can find a sense of community and connection to friends "in an atmosphere of old-fashioned mateship."¹⁶⁸ In the "sheds," men might be found restoring furniture, fixing bicycles, making bird feeders or learning to cook for themselves. Others might just come for a cup of coffee. The program started in Australia, expanded to the U.K. and now has some traction in Canada.¹⁶⁹ But as with the vast majority of loneliness strategies, it assumes a consenting participant.

This brings me to the second factor justifying my focus on older men: men have a general tendency to be less help-seeking, making them a difficult group to find and engage. In particular, when compared to women, men are less likely to admit to having life problems, to seek help for those issues and, if they do reach out, they are less likely to actively participate or remain in programs.¹⁷⁰ Absent an emergency, older men without concerned children or close friends may have very little contact with service providers. A recent study of a U.K. home-visiting befriending service found that initial contact with the program was made on behalf of the older person, not through self-referral, and most often the contact was made by a female relative or friend.¹⁷¹

Third, I am focusing on older men because many laws, policies and awareness campaigns in relation to elders (e.g., advance care planning) place considerable significance on the notion of

¹⁶⁶ Changing the location might also improve uptake generally, not just among men: see e.g. Cohen-Mansfield & Parpura-Gill, *supra* note 104 (less than 20 percent of older Americans participate in senior centre activities, at 289).

¹⁶⁷ See generally John S. Luque et al, "Barbershop Communications on Prostate Cancer Screening Using Barber Health Advisors" (2011) 5:2 Am J of Men's Health 129.

¹⁶⁸ Australian Men's Shed Association, "Home", online: <<http://www.mensshed.org>>.

¹⁶⁹ See e.g. Okanagan Men's Shed, "About", online: <<http://mensshed.ca/>>.

¹⁷⁰ Kosberg, *supra* note 2 at 18-19; Addis & Mahalik, *supra* note 2; Vacha-Haase, Wester & Christianson, *supra* note 2 at 35-36.

¹⁷¹ Andrews et al, *supra* note 78 at 360.

family.¹⁷² This emphasis may result in approaches which are unresponsive to the needs and challenges of those without family or other social networks—an outcome which may disproportionately affect men, since they tend to have smaller support networks than women.¹⁷³ The consequences may be particularly acute among the oldest-old, as late life is a period generally characterised by fading social networks and sometimes the loss of a life-long spouse.¹⁷⁴ To be sure, at least one government has partly responded to the recognition that some individuals do not have (trusted) family members. In recent years, B.C. amended its *Health Care (Consent) and Care Facility (Admission) Act* to include “close friends” as potential temporary substitute decision-makers for health care.¹⁷⁵ The Act defines a close friend as an “adult who has a long-term, close personal relationship involving frequent personal contact with the [patient], but does not include a person who receives compensation for providing personal care or health care to [the patient].”¹⁷⁶ For individuals without friends or family, the Public Guardian and Trustee (PGT) is available, but it becomes involved if there is concern that the person is incapable.¹⁷⁷ Vulnerable adults who do not lack capacity are excluded from the ambit of the PGT’s protective powers.¹⁷⁸

When there is an external predator (i.e., a third party), the doctrines of undue influence and unconscionability may help bridge this protective gap which leaves out vulnerable adults who do not lack capacity.¹⁷⁹ For example, in *Juzumas v Baron*, Lang J.A. (*ad hoc*) of the Ontario Superior Court found that a 65-year-old housekeeper had exercised undue influence over Mr. Juzumas, a “vulnerable and completely dependent” 89-year-old man whom she “dominated.”¹⁸⁰ The

¹⁷² See Adam P. Romero, “Living alone: New demographic research” in Martha Albertson Fineman, ed, *Transcending the Boundaries of Law: Generations of feminism and legal theory* (New York: Routledge, 2011), 258 at 258 & 269-72.

¹⁷³ See Pearl A. Dykstra & Tineke Fokkema, “Social and Emotional Loneliness Among Divorced and Married Men and Women: Comparing the Deficit and Cognitive Perspectives” (2007) 29:1 Basic & Applied Soc Psychology 1 at 10.

¹⁷⁴ See Page & Cole, *supra* note 104 at 944; Cohen-Mansfield & Parpura-Gill, *supra* note 104 at 280.

¹⁷⁵ RSBC 1996, c 181, s 16(1) [BC HCCCFA Act]. See also *Mental Health Act*, RSBC 1996, c 288, s 1 (“near relative” includes friends) [BC MHA].

¹⁷⁶ BC HCCCFA Act, *ibid*, s 1 (“close friend”).

¹⁷⁷ See *Public Guardian and Trustee Act*, RSBC 1996, c 383, ss 17(1)(b) & (c) [BC PGT Act]; Public Guardian and Trustee of British Columbia, Services to Adults, “Assessment and Investigation Services”, online: <www.trustee.bc.ca>.

¹⁷⁸ See David Freedman, “Elder Law in Canada: A Country Without A Flag” (Paper presented to the 5th Canadian Conference on Elder Law, 29 October 2010) [unpublished] (“clients often appear annoyed that state actors like the Public Guardian and Trustee or the police don’t more vigorously protect older adults who are vulnerable to exploitation and neglect” at 5-6).

¹⁷⁹ See Hall, “Equity”, *supra* note 11 at 110-15.

¹⁸⁰ 2012 ONSC 7220, [2012] OJ No 6159 at paras 1-2 & 50 [*Juzumas*]. But see *Ross-Scott v Potvin*, 2014 BCSC 435, 2014 CarswellBC 684 at para 11 [*Ross-Scott*] (upholding a marriage that “was a quiet and discreet affair in

housekeeper persistently threatened that she would abandon him to a nursing home; fearing this outcome, Mr. Juzumas married her and transferred her his house.¹⁸¹ Mr. Juzumas did not present with dementia, although he was “at times muddled, confused, despondent [and] disoriented.”¹⁸² In granting a divorce and setting aside the transfer, Lang J.A. described Mr. Juzumas as “an elderly person who was both psychologically and physically vulnerable.”¹⁸³ Lang J.A. concluded that the transfer was tainted by unconscionability, as well as “undue influence of a vulnerable elder.”¹⁸⁴

But in the absence of a third party, we are again left with a protective gap when the influential factor is internal but does not render the person incapable. Under our traditional approach, constraints such as loneliness are legally irrelevant, yet loneliness, which has been described as a “hidden fox gnawing at the vitals,”¹⁸⁵ is associated with maladaptive social cognition which may heighten one’s propensity to reject objectively needed support, despite simultaneously desiring it. In appropriate cases, this emotional predator should matter in law. Using a superior court’s protective jurisdiction not only fills this protective gap, but it also has the potential to flexibly respond to situations in which a lonely older man has no family or close friends. Notably, the B.C. Court of Appeal has found that anyone can ask a superior court to invoke its *parens patriae* jurisdiction.¹⁸⁶

Fourth, I am writing about older men because they face the stereotypical image of masculinity in which they are expected to behave independently,¹⁸⁷ and the internalisation of this expectation may contribute to their resistance to care. In recent years, the stereotype has been intensified by the active aging approach, which tells older men (and women) that independence is a key to so-called “successful aging.”¹⁸⁸ The active aging narrative emphasizes the importance of leading an active, participatory and productive lifestyle in old age (e.g., we should all strive to be a tracksuit-wearing 90-year-old marathon runner). Unfortunately, the active aging approach drives

which a lonely, non-social 77 year old man wished to form a union with the [56-year-old] defendant and to remain in his home until he died” at para 284).

¹⁸¹ *Juzumas*, *ibid* at paras 1-2.

¹⁸² *Ibid* at para 70.

¹⁸³ *Ibid* at para 12.

¹⁸⁴ *Ibid* at paras 2 & 105.

¹⁸⁵ Mannin, *supra* note 94 at 11.

¹⁸⁶ *L.S. and S.S. v British Columbia (Ministry of Children and Family Development)*, 2004 BCCA 244, 238 DLR (4th) 655 at para 51 (including strangers).

¹⁸⁷ See e.g. James A. Smith et al, “‘I’ve been independent for so damn long!’: Independence, masculinity and aging in a help seeking context” (2007) 21 *J Aging Studies* 325 at 325.

¹⁸⁸ For a critique of the active aging approach, see e.g. Martha B. Holstein & Meredith Minkler, “Self, Society, and the ‘New Gerontology’” (2003) 43:6 *The Gerontologist* 787 at 792.

many modern-day policy agendas, with the federal government recently boasting: “A large majority of seniors are ... active later in life: 80 percent of seniors participate frequently (at least monthly) in at least one social activity, 36 percent perform volunteer work and 13 percent participate in the work force.”¹⁸⁹ The B.C. Seniors Advocate also has a tendency to reinforce the active aging message. For instance, on National Seniors Day 2015, the Advocate wrote:

Today I urge you to celebrate the courage of seniors. The 80-year-old woman with severe arthritis who braves driving rain, but still walks several kilometres to and from the grocery store to get supplies for dinner. The father who decides to become a university student for the first time at 70. The widowed grandparent who steps up to parent a grandchild after raising five kids of her own.

Today is a day to celebrate the selflessness of seniors. In virtually every sector of society it’s easy to see this in action. Individual seniors want to help in the diverse communities they live in. According to StatsCan, Canadians 65 and over, volunteer on average 220 hours per year, higher than any age group.¹⁹⁰

This statement further marginalises the homebound older man slouched in a worn chair drinking a can of beer, eating a TV dinner and watching Wheel of Fortune. The effects of diabetes make him unable to shuffle to the grocery store; deteriorating vision makes it difficult to read; he cannot “step up” to care for his grandchildren, because he has none; he stopped going to church years ago; and after decades of working long hours at a manufacturing plant, he does not have the will or energy to volunteer. From an active aging perspective, he is aging “unsuccessfully.” He has “failed” because he is not youthful, healthy and independent. He is old, sick and dependent. Unsurprisingly, the societal expectations associated with the active aging approach (i.e., staying youthful and independent) may contribute to a frail lonely older person’s feeling of loneliness.¹⁹¹

“Unsuccessfulness” is not unique. For example, 50 percent of older people in the U.K. consider the television to be their main form of company,¹⁹² and in Canada, fewer than two percent of post-secondary students are over age 60.¹⁹³ Volunteering rates also drop off among older cohorts. Less than one third of Canadians aged 75 and over volunteer, the lowest among all age

¹⁸⁹ Government of Canada, *Action for Seniors Report* (2014), online: <<http://www.seniors.gc.ca/eng/report/index.shtml#tc2a>>.

¹⁹⁰ Isobel Mackenzie, “Celebrating National Seniors Day Op-Ed” (1 October 2015), online: <<https://www.seniorsadvocatebc.ca/osa-reports/celebrating-national-seniors-day/>>.

¹⁹¹ Taube et al, *supra* note 120 at 637.

¹⁹² Age UK, “Evidence Review: Loneliness in Later Life” (Revised July 2014), online: <www.ageuk.org.uk> at 3.

¹⁹³ Meghan Dale, *Trends in the Age Composition of College and University Students and Graduates*, Statistics Canada, online: <<http://www.statcan.gc.ca/pub/81-004-x/2010005/article/11386-eng.htm>> at Charts 1 & 2.

groups.¹⁹⁴ It is also arguable that active aging benchmarks such as volunteering implicitly reflect privileged-class norms: individuals with less education and lower incomes are less likely to volunteer than those with higher education and incomes.¹⁹⁵ Further, the idea of volunteering may not resonate with everyone, including some older men. As the U.K. Men's Sheds Association chair candidly observes, "If you want a man to do something, don't ask him to volunteer, tell him there is a problem and it needs fixing."¹⁹⁶ The active aging message can also lead people to believe that everyone except them is aging "successfully." But again, the numbers suggest otherwise. Take running as an example. In the 2015 Boston Marathon, only 11 out of 27,167 starters were in the 80+ age group.¹⁹⁷ As Ethel Mannin similarly observed in 1966, "air-borne centenarians prove nothing except that some people wear better than others."¹⁹⁸

My critique of the active aging approach is not an endorsement of disengagement theory. According to this highly-criticised perspective,¹⁹⁹ social withdrawal is a voluntary, universal and natural part of aging.²⁰⁰ It has recently been suggested that older men's internalisation of disengagement theory might explain why their psychological suffering remains undetected and untreated, in part because they "mistakenly blame symptoms on the aging process."²⁰¹ I do not suggest that we harken back to the days when disengagement theory dominated, but it is my view that the active aging approach has set many older men up for "failure" because its standards are unattainable. The consequences of framing age-related decline as a failure are not just symbolic. Research suggests that men may be more likely to reach out for help if their problem is considered "normal;"²⁰² but the active aging approach does not normalise problems men may experience in old age. It stigmatises them. If they recoil, it becomes even harder to find and engage them.

¹⁹⁴ Mireille Vézina & Susan Crompton, *Volunteering in Canada*, Statistics Canada (16 April 2012), online: <<http://www.statcan.gc.ca/pub/11-008-x/2012001/article/11638-eng.pdf>> at Table 2.

¹⁹⁵ *Ibid* at 42.

¹⁹⁶ Mike Jenn cited in Emma Howard, "If I didn't come to the shed, I'd be alone, watching TV" *The Guardian* (7 October 2014), online: <www.theguardian.com>.

¹⁹⁷ Boston Athletic Association, "2015 Boston Marathon Statistics" (2015), online: <<http://raceday.baa.org/statistics.html>>.

¹⁹⁸ *Supra* note 94 at 140.

¹⁹⁹ For a critique of disengagement theory, see e.g. Eleanor O'Leary, *Counselling Older Adults: Perspectives, Approaches and Research* (New York: Chapman & Hill USA, 1996) at 23.

²⁰⁰ See Elaine Cumming & William Earl Henry, *Growing Old: The Process of Disengagement* (New York: Basic Books, 1961) cited in Ann Rathburn, "Psychosocial Parameters of Aging" in Gari Lesnoff-Caravaglia, ed, *Aging and Public Health: Technology and Demography: Parallel Evolutions* (Springfield: Charles C Thomas Publisher Ltd., 2001), 51 at 53.

²⁰¹ Vacha-Haase, Wester & Christianson, *supra* note 2 at 35.

²⁰² Kosberg, *supra* note 2 at 19.

CHAPTER IV: EVOLUTION OF THE *PARENS PATRIAE* JURISDICTION

This chapter sets out the recent evolution of the *parens patriae* jurisdiction in Canada, in which some courts have departed from the strict understanding that the jurisdiction can only be exercised when they make a formal finding of incapacity. I begin with a general discussion of “first generation” *parens patriae* in Canada. I then explore the terminological confusion surrounding the concept of inherent jurisdiction. I argue that inherent jurisdiction is something more than a source of procedural powers; that is, it can be invoked to affect substantive matters. Next, I discuss the emergence of the English High Court’s protective jurisdiction, which has been extended to vulnerable adults who do not lack capacity. I conclude the chapter with an overview of some Canadian cases which have laid the groundwork for what I refer to as “second generation” *parens patriae*, or the superior courts’ protective jurisdiction over vulnerable adults.

1. First generation *parens patriae* in Canada

The *parens patriae* jurisdiction has traditionally allowed superior courts to protect children and mentally incompetent persons who are unable to look after themselves.²⁰³ The courts’ authority is derived from the Crown’s power and duty to protect as *parens patriae* (a term derived from the English concept of the King’s role as a father of the country).²⁰⁴ The Crown does not exercise this protective role directly; it has been delegated to the superior courts.²⁰⁵ The jurisdiction is founded on necessity, namely “that the law should place somewhere the care of individuals who cannot take care of themselves, particularly in cases where it is clear that some care should be thrown

²⁰³ *E. (Mrs.) v Eve*, [1986] 2 SCR 388, 1986 CanLII 36 at para 35 [*Eve*] (non-therapeutic sterilisation of a mentally incompetent young adult woman not authorised under the *parens patriae* jurisdiction); *Seaman (Re)* (1997), 151 DLR (4th) 337, [1998] 1 WWR 353 paras 15-16 [*Seaman*]. For a detailed discussion of the *parens patriae* jurisdiction’s genesis, see *Eve*, *ibid* at paras 31-71.

²⁰⁴ *F v West Berkshire HA*, [1990] 2 AC 1, [1991] UKHL 1 (*sub nom In Re F*) at 6 [*F*], aff’g [1990] 2 AC 1, [1989] 2 WLR 1025 (Eng CA) [*F CA*].

²⁰⁵ *Eve*, *supra* note 203 at paras 33 & 72; *The Queen v Gynghall*, [1893] 2 QB 232 (Eng CA) at 225, cited with approval in *Adoption of Infant Registration No. 78-09-024190 (Re)* (1990), 66 DLR (4th) 154, 1990 CanLII 993 (BCSC) [*Adoption*]; *Butler v Freeman*, [1756] Amb 302 (per Lord Hardwicke), cited with approval in *In Re A*, [2003] EWHC 2746 (Fam), [2004] 1 All ER 480 (*sub nom Local Authority v Health Authority & Anor*) at para 62 [A].

around them.”²⁰⁶ The *Charter* has not limited the jurisdiction;²⁰⁷ however, it cannot be invoked to abrogate a person’s *Charter* rights.²⁰⁸

It is a flexible and adaptable remedy with a theoretically unlimited scope, in that the courts have declined to strictly define the matters in which it can be exercised to protect a child or mentally incompetent person.²⁰⁹ For instance, it has been invoked in such matters as custody, protection of property, medical treatment, as well as questions of residence and contact.²¹⁰ Traditionally, there are three situations in which the exercise of the *parens patriae* jurisdiction may be justified: emergency situations in which a child or incompetent adult is considered to be in need of protection; judicial review of an exercise of statutory power; or when there is a legislative gap which results in the child’s or incompetent adult’s best interests not being met.²¹¹

The legislative gap approach was established by Wilson J. of the Supreme Court of Canada in *Beson v Newfoundland (Director of Child Welfare)*.²¹² In that case, the Director of Child Welfare removed a child from a prospective adoptive home because of child abuse allegations, which were ultimately unfounded.²¹³ The potentially applicable legislation did not provide the adopting parents with a right of appeal.²¹⁴ Writing for the Court, Wilson J. found a legislative gap which the lower court could have filled by exercising its *parens patriae* jurisdiction in a manner that it considered to be in the child’s best interests, which was that the child be returned to the adoptive home.²¹⁵

The legislative gap approach has sometimes been incorrectly interpreted to mean that there must be an absence of legislation on the matter;²¹⁶ but as La Forest J. of the Supreme Court of Canada stated in *E. (Mrs.) v Eve*, “even where there is legislation in the area, the courts will continue to use the *parens patriae* jurisdiction to deal with unanticipated situations where it appears necessary to do so for the protection of those who fall within its ambit.”²¹⁷ The jurisdiction “is a

²⁰⁶ *Wellesley v Duke of Beaufort* (1827), 2 Russ 1 at 20, cited in *Eve*, *supra* note 203 at para 41.

²⁰⁷ *Perino v Perino* (2009), 99 OR (3d) 575, 2009 CanLII 82009 (SC) at para 42 [*Perino*].

²⁰⁸ *A.M. v Benes* (1998), 166 DLR (4th) 658, 57 CRR (2d) 120 (ON SC) at paras 46 & 51, rev’d on other grounds (1999), 180 DLR (4th) 72, 46 OR (3d) 271 (CA).

²⁰⁹ *Eve*, *supra* note 203 at para 43; *A*, *supra* note 205 at para 96.

²¹⁰ *Eve*, *ibid* at para 74; *A*, *ibid*.

²¹¹ *Adoption*, *supra* note 205.

²¹² [1982] 2 SCR 716, [1982] SCJ No 95 (cited to WL Canada).

²¹³ *Ibid* at paras 2-3.

²¹⁴ *Ibid* at para 14.

²¹⁵ *Ibid*.

²¹⁶ See e.g. *E.S.C. v D.A.P.* (1997), 152 DLR (4th) 439, 53 Alta LR (3d) 329 (CA) at para 17. But see *Nafie v Badawy*, 2015 ABCA 36, [2015] AJ No 85 at paras 91-92.

²¹⁷ *Eve*, *supra* note 203 at para 42.

carefully guarded one” and “[t]he courts will not readily assume that it has been removed by legislation where a necessity arises to protect a person who cannot protect himself.”²¹⁸ Further, as the Alberta Surrogate Court stated in *Seaman (Re)*, courts are bound to enforce the legislative will, but “they may also have a duty to exercise their inherent powers for the protection of children or mentally incompetent adults.”²¹⁹ Similarly, in a 2012 Ontario Superior Court decision, Harper J. observed that while the traditional view has been that *parens patriae* can only be exercised if there is a legislative gap, some recent Ontario cases suggest that there may be other exceptional circumstances which justify use of the jurisdiction.²²⁰ For example, in *Perino v Perino*, a mentally disabled adult witness was in need of independent legal representation, but legal aid services did not extend to her situation.²²¹ The matter did not affect the witness’s physical integrity; however, it was central to her well-being.²²² Corbett J. invoked the Court’s *parens patriae* jurisdiction to order that the witness be provided state-funded legal services. He also exercised the Court’s inherent jurisdiction, which he said provided it with the jurisdiction to control its own process.²²³

2. Inherent jurisdiction: terminological confusion

In *Perino*, Corbett J. defined inherent jurisdiction as a procedural concept. However, such a limited description is controversial. There are cases in which inherent jurisdiction is also characterised as a substantive concept,²²⁴ and adding to the linguistic bewilderment, the *parens patriae* jurisdiction itself is referred to an inherent jurisdiction.²²⁵ Recognising the superior courts’ inherent jurisdiction as something more than a source of procedural powers is important for the approach I am proposing in this thesis because, as I discuss below, the English courts have ventured outside the *parens*

²¹⁸ *Ibid* at para 75.

²¹⁹ *Supra* note 203 at para 15.

²²⁰ *Children’s Aid Society of London and Middlesex v C.D.B.*, 2012 ONSC 5474 at para 37.

²²¹ *Supra* note 207. See also *Walton v Sommerville*, 2010 ONSC 2765, [2010] OJ No 2043 at para 26 (per Corbett J.).

²²² *Perino*, *ibid* at para 39.

²²³ *Ibid* at paras 14 & 26.

²²⁴ See *Ziebenhause v Bahlieda*, 2014 ONSC 138, 119 OR (3d) 275 at para 48 [*Ziebenhause SC*], *aff’d* 2015 ONCA 471, 126 OR (3d) 541 [*Ziebenhause CA*] (CA possibly collapsed the distinction between inherent and general jurisdiction). *Contra* *Bea v The Owners, Strata Plan LMS 2138*, 2015 BCCA 31, [2015] BCJ No 111 at para 30; *Lymer (Re)*, 2015 ABQB 347, [2015] AJ No 591 at para 21, *aff’d* 2016 ABCA 76, [2016] AJ No 270 at para 10; *Goodwin v Rodgerson*, 2002 NSCA 137, 210 NSR (2d) 42 at para 17 [*Goodwin*].

²²⁵ *Nielsen v Pierce* (1983), 27 Alta LR (2d) 355, 48 AR 274 (QB) (“A superior court in the jurisdiction where a child is resident has an inherent jurisdiction to act where the situation is gravely prejudicial to the child or where a matter of dire emergency arises. This inherent jurisdiction is usually referred to as the *parens patriae* power of the court” at para 10).

patriae doctrine and into the wider “jurisdictional hinterland”²²⁶ of inherent jurisdiction to justify intervening in the lives of vulnerable adults who do not lack capacity. Narrowly interpreting inherent jurisdiction as a procedural concept would significantly undermine, if not prohibit, such interventions, as they undoubtedly affect the adults’ substantive rights.

Canadian courts have described the superior courts’ inherent jurisdiction as having an “amorphous nature,” although it “does not operate without limits.”²²⁷ It is a special and extraordinary power which should “be exercised sparingly and with caution.”²²⁸ Government can remove the court’s inherent jurisdiction over a particular matter, but only by “clear and precise [statutory] language.”²²⁹ Thus, even if a matter is regulated by statute, a court can still exercise its inherent jurisdiction as long as doing so would not conflict with any legislative provision.²³⁰ The mere existence of legislation does not oust the court’s inherent jurisdiction; the jurisdiction remains as long as it is exercised in a manner which does not contravene the legislative will.

Given these loose descriptions, the doctrine of inherent jurisdiction has been characterised as vague and difficult to pin down.²³¹ The modern starting point for the confusion is I.H. Jacob’s seminal and frequently cited article, “The Inherent Jurisdiction of the Court.”²³² Jacob stated that the jurisdiction is part of procedural law, not substantive law.²³³ He defined it as:

the reserve or fund of powers, a residual source of powers, which the court may draw upon as necessary whenever it is just or equitable to do so, and in particular to ensure the observance of the due process of law, to prevent improper vexation or oppression, to do justice between the parties and to secure a fair trial between them.²³⁴

Jacob also differentiated between a court’s inherent and general jurisdictions. He stated that:

the two terms are not interchangeable, for the “inherent” jurisdiction of the court is only a part or an aspect of its general jurisdiction. The general jurisdiction of the

²²⁶ *DL v A Local Authority & Ors*, [2012] EWCA Civ 253, [2012] 3 FCR 200 at para 1 [*DL*].

²²⁷ *Ontario v Criminal Lawyers’ Association of Ontario*, 2013 SCC 43, [2013] 3 SCR 3 at paras 19 & 22 [*Criminal Lawyers*].

²²⁸ *R v Caron*, 2011 SCC 5, [2011] 1 SCR 78 at para 30.

²²⁹ *Ziebenhaus SC*, *supra* note 224 at paras 57-58, citing with approval *R v Rose*, [1998] 3 SCR 262, 166 DLR (4th) 385 at para 133.

²³⁰ *Criminal Lawyers*, *supra* note 227 at para 23.

²³¹ *Goodwin*, *supra* note 224 at para 17; *MacMillan Bloedel Ltd. v Simpson*, [1995] 4 SCR 725, 1995 CanLII 57 at para 30 [*MacMillan*].

²³² (1970) 23 Curr Legal Probs 23.

²³³ *Ibid* at 24.

²³⁴ *Ibid* at 51, cited approvingly in *Criminal Lawyers*, *supra* note 227 at para 20. See also *Grobbelaar v News Group Newspapers Ltd and Another*, [2002] UKHL 40, [2002] WLR 3024 at para 25 (“a definition which has never perhaps been bettered”, per Lord Bingham of Cornhill).

High Court as a superior court of record is, broadly speaking, unrestricted and unlimited in all matters of substantive law, both civil and criminal, except in so far as that has been taken away in unequivocal terms by statutory enactment. The High Court is not subject to supervisory control by any other court except by due process of appeal, and it exercises the full plenitude of judicial power in all matters concerning the general administration of justice within its area. Its general jurisdiction thus includes the exercise of an inherent jurisdiction.²³⁵

In the recent case of *Reznik v Matty*, the B.C. Supreme Court discussed the conceptual confusion between inherent and general jurisdictions.²³⁶ The petitioners, as residuary beneficiaries of an estate, sought an order directing the executor to immediately distribute some of the funds.²³⁷ Their counsel argued that the Court's authority to make the order flowed from its inherent jurisdiction.²³⁸ The respondent's counsel disagreed, and argued that its inherent jurisdiction was limited to controlling its own process.²³⁹ Relying on Jacob's article, Funt J. stated that "the phrase 'inherent jurisdiction' may have created confusion," and that it did not have the same meaning as general jurisdiction.²⁴⁰ He concluded that "[i]n sum, the court is a court of general jurisdiction, with 'all of the powers that are necessary to do justice between the parties.'" ²⁴¹ Appearing to rely on the Court's general (not inherent) jurisdiction, Funt J. ordered the distribution.²⁴²

The ambiguity surrounding the scope of a superior court's inherent jurisdiction is further complicated by the fact that appellate and inferior (statutory) courts, as well as administrative tribunals, also claim to invoke an inherent jurisdiction to control their own process.²⁴³ In these contexts, however, the jurisdiction is exclusively considered to be a procedural concept. Some judges have stated that it might be preferable and less confusing to describe an inferior court's control over its own procedure as an implied jurisdiction, since inherent jurisdiction is used by

²³⁵ Jacob, *ibid* at 23.

²³⁶ 2013 BCSC 1346, [2013] BCJ No 1651 at para 18.

²³⁷ *Ibid* at para 2.

²³⁸ *Ibid* at para 11.

²³⁹ *Ibid* at para 13.

²⁴⁰ *Ibid* at paras 18-22.

²⁴¹ *Ibid* at para 23.

²⁴² *Ibid* at 51. See *below*, fn 255.

²⁴³ See *L.L.C. v P.G.*, [1994] BCJ No 1591 at para 28 (Prov Ct), quoting *Cocker v Tempess* (1841), 151 ER 864 (Exh) ("The power of each court over its own process is unlimited; it is a power incident to all courts, inferior as well as superior; were it not so, the court would be obliged to sit still and (to) see its own process abused for the purpose of injustice"). But see Jacob, *supra* note 232 ("It may well be that these [inferior court's] powers, although exercised under the inherent jurisdiction of the court, are not original, but derived from the powers of the High Court conferred on the county court by statute" at 50).

superior courts.²⁴⁴ Similarly, a tribunal's procedural powers may be better described as implied or equitable,²⁴⁵ or as Member Groarke of the Canadian Human Rights Tribunal suggested in relation to arbitrators, "I cannot help but feel that a term like 'ancillary jurisdiction' or 'incidental jurisdiction' would be more accurate and less provocative than the term 'inherent jurisdiction.'"²⁴⁶ These observations suggest that the inherent jurisdiction of superior courts is something more than procedural; otherwise, it would not be confusing to also use it in relation to appellate and inferior courts' control over their own process. Unfortunately, the Supreme Court of Canada has not helped clarify matters. In *United States of America v Shulman*, Arbour J., writing for the Court, stated that "[an appellate court] has, like all courts, an implied, if not inherent, jurisdiction to control its own process."²⁴⁷ Using the word "inherent" is needlessly confusing because, as the Supreme Court of Canada itself has unequivocally stated, "there is no inherent jurisdiction in any appeal court."²⁴⁸

Others have suggested that the problem rests less with the terms "inherent" and "implied," and more so with the mistaken conflation of the words "jurisdiction" and "power." The High Court of New Zealand made the following distinction between inherent jurisdiction and inherent power:

The former connotes an original and universal jurisdiction not derived from any other sources, whereas the latter connotes an implied power such as the power to prevent abuse of process, which is necessary for the due administration of justice under powers already conferred. Thus the High Court has an inherent jurisdiction as confirmed by s16 of the Judicature Act 1908 whereas the District Court has an implied power within that jurisdiction as conferred by statute. It is not an inherent jurisdiction but a power which exists within that statutory jurisdiction.²⁴⁹

Similarly, the Supreme Court of New Zealand has observed that "[s]ome confusion may arise because the term 'inherent jurisdiction' is applied both to substantive and procedural powers."²⁵⁰ It states that courts' inherent powers to regulate their own process arise out of either statutory and common law substantive jurisdictions; "courts which do not possess an inherent substantive

²⁴⁴ *Davison v Canadian Artists Syndicate Inc.*, 2011 NSSM 28, [2011] NSJ No 249 at para 31 (Sm Ct Ct); *R v Gunn*, 2003 ABQB 314, 15 Alta LR (4th) 109 at paras 25 & 28.

²⁴⁵ See e.g. *Zutter v British Columbia (Council of Human Rights)* (1995), 122 DLR (4th) 665, 3 BCLR (3d) 321 (CA) (equitable jurisdiction to reconsider).

²⁴⁶ *Day v Canada (Department of National Defence)*, 2002 CanLII 45923 (CHRT) at para 20.

²⁴⁷ 2001 SCC 21, [2001] 1 SCR 616 at para 33.

²⁴⁸ *Kourtessis v M.N.R.*, [1993] 2 SCR 53, 102 DLR (4th) 456 at 69-70, cited with approval in *R v W. (G.)*, [1999] 3 SCR 597, 178 DLR (4th) 76 at para 8.

²⁴⁹ *Watson v Clarke*, [1988] NZHC 561, [1990] 1 NZLR 715 at 9.

²⁵⁰ *Zaoui v The Attorney General*, [2004] NZSC 31 at para 35 (High Court had the inherent jurisdiction to grant bail as a remedy in an immigration matter on a direct application, even though it was not seized of any substantive issue challenging the detention).

jurisdiction (as is the case where their substantive powers are entirely statutory) nevertheless have inherent or implied procedural powers necessary to enable them to give effect to their statutory substantive jurisdiction.”²⁵¹ From this perspective, Jacob’s description of inherent jurisdiction may be better captured by the phrase “inherent procedural powers” (as opposed to statutory procedural powers of appellate and inferior courts), in that they are incidental procedural devices which enable superior courts to control their own process.²⁵² On this understanding, the inherent jurisdiction is simply a descriptor of where a superior court’s inherent procedural powers originate; the inherent jurisdiction (as opposed to statute) is the source of a superior court’s procedural devices.²⁵³

But this interpretation of inherent jurisdiction is narrow. Others describe the concept as something more than a source of procedural powers. For example, Goh Yihan argues that inherent jurisdiction refers to a superior court’s inherent authority to hear a matter,²⁵⁴ although this description closely resembles Jacob’s definition of general jurisdiction.²⁵⁵ Yihan identifies a few examples of the High Court of Singapore exercising its inherent authority, including *Re LP (adult patient: medical treatment)*.²⁵⁶ In that case, a hospital brought an urgent application asking the Court to declare that a proposed amputation was in a patient’s best interests.²⁵⁷ Initially, the patient refused surgery and said she wanted her legs saved at all costs, but then her condition worsened and she went into a coma before doctors made it known to her that she would die if her legs were not amputated.²⁵⁸ Given the urgency of the situation, there was no time to appoint a substitute decision-maker.²⁵⁹ Since the patient was not “mentally disordered,” the mental health legislation did not apply and the Court seemed to implicitly decline to invoke its *parens patriae* jurisdiction.²⁶⁰

²⁵¹ *Ibid.*

²⁵² See Goh Yihan, “The Inherent Jurisdiction and Inherent Powers of the Singapore Courts: Rethinking the Limits of their Exercise” (2011) *Sing JLS* 178 at 197; Jessica Liang, “The Inherent Jurisdiction and Inherent Powers of International Criminal Courts and Tribunals: An Appraisal of their Application” (2012) 15 *New Crim L Rev* 375 at 379.

²⁵³ See Marcelo Rodriguez Ferrere, “The Inherent Jurisdiction and its Limits” (2013) 13:1 *Ota LR* 107 at 111-12.

²⁵⁴ Goh, *supra* note 252 at 197.

²⁵⁵ Because of Canada’s constitutional framework, the term “inherent jurisdiction” of a superior court is preferable to “general jurisdiction.” Section 101 of the *Constitution Act, 1867*, 30 & 31 Vict, c 3 empowers Parliament to create a federal court with general jurisdiction over the administration of all federal law, although Parliament has chosen not to do so. As a result, unlike superior courts, federal courts are not presumed to have jurisdiction over a substantive matter in the absence of an express statutory enactment. But if they did, their general jurisdiction would flow from statute, not an inherent jurisdiction: *Canada (Human Rights Commission) v Canadian Liberty Net*, [1998] 1 SCR 626, 157 DLR (4th) 385 at paras 28-29 [*Liberty Net*].

²⁵⁶ [2006] SGHC 13 [*Re LP*].

²⁵⁷ *Ibid* at para 1.

²⁵⁸ *Ibid* at para 2.

²⁵⁹ *Ibid* at para 1.

²⁶⁰ *Ibid* at paras 4-5.

Instead, it relied upon its inherent jurisdiction to grant the order.²⁶¹ The Court was concerned that if it failed to provide a solution to the problem, “the common law would be seriously defective.”²⁶² The Court emphasized that by finding that the amputation was in the patient’s best interests, it was not altering the underlying substantive law; it was merely providing a forum to adjudicate a problem that did not fall within statutory or *parens patriae* jurisdiction.²⁶³ The Supreme Court of Canada expressed a similar sentiment in *Canada (Human Rights Commission) v Canadian Liberty Net*.²⁶⁴ Bastarache J., writing for the majority, stated that if a person has a justiciable right, there must be a court competent to enforce it: the purpose of the inherent “residual” or “remedial” jurisdiction “is simply to ensure that a right will not be without a superior court forum in which it can be recognized.”²⁶⁵ Further, the Nova Scotia Court of Appeal has stated that a superior court’s inherent jurisdiction “should not be used to effect changes in substantive law.”²⁶⁶ This passage was recently cited with approval by the B.C. Court of Appeal.²⁶⁷

But Yihan identifies cases in which the superior court (in Singapore) has exercised its inherent jurisdiction in matters which affect substantive matters.²⁶⁸ For conceptual clarity, he states that in these cases, the court is invoking its “inherent substantive powers,” which are distinguishable from a court’s inherent jurisdiction and inherent procedural powers.²⁶⁹ Yihan acknowledges that the idea of inherent substantive powers may “be a startling one,” especially since the Singaporean Court of Appeal has stated that the doctrine of inherent jurisdiction can only be invoked for procedural matters.²⁷⁰ However, the suggestion aligns with a judge’s important (albeit controversial) role to develop and adapt the common law to meet the changing needs of society. As Lord Donaldson of Lynton MR stated in the Court of Appeal’s decision in *F*, “the common law is the great safety net which lies behind all statute law and is capable of filling gaps left by that law, if and in so far as those gaps have to be filled in the interests of society as a whole. This process of using the common law to fill gaps is one of the most important duties of the

²⁶¹ *Ibid* at paras 4 & 11.

²⁶² *Ibid* at para 5, quoting *F*, *supra* note 204 at 55.

²⁶³ *Re LP*, *ibid*.

²⁶⁴ *Liberty Net*, *supra* note 255.

²⁶⁵ *Ibid* at 32.

²⁶⁶ *Goodwin*, *supra* note 224 at para 17.

²⁶⁷ *Kriegman v Wilson*, 2016 BCCA 122, 2016 CarswellBC 681 at para 73.

²⁶⁸ Yihan, *supra* note 252 at 197-98.

²⁶⁹ *Ibid* at 197.

²⁷⁰ *Ibid*.

judges.”²⁷¹ And as Lord Griffiths of the House of Lords stated on further appeal, “judges can and should accept responsibility to recognize the need and to adapt the common law to meet [the public interest].”²⁷² Doing so may even make new law; however, if such a development is not met with public approval, it is always be open to the government to reverse or alter it.²⁷³

3. Protective jurisdiction: the English experience

In England, the *parens patriae* jurisdiction as it relates to mentally incompetent adults is no longer available; instead, the courts now (controversially) use what has been described as an inherent “protective jurisdiction.” It has been suggested that the “inadvertent loss”²⁷⁴ of *parens patriae* lead to the “rediscovery”²⁷⁵ of the protective jurisdiction in *F*,²⁷⁶ although even one of its biggest proponents (Munby J.) has more recently acknowledged that the jurisdiction was invented.²⁷⁷ The practical difference between the protective jurisdiction and the *parens patriae* jurisdiction has been described as “a distinction without a difference.”²⁷⁸ But substantively, the English courts have extended the scope of the protective jurisdiction to vulnerable adults who do not lack capacity.

a. Inadvertent loss of *parens patriae*

In *F*, the House of Lords considered whether the High Court had the jurisdiction to order the proposed sterilisation of *F*, a 36-year-old woman with a serious mental disability who lacked capacity to consent to the operation.²⁷⁹ From age 14, *F* had been a voluntary in-patient at a mental hospital.²⁸⁰ The sterilisation issue arose because of a sexual relationship she had developed with a male patient, and because of her mental disability, it was believed that it would be psychologically disastrous for her to conceive a child (other contraception methods such as the pill and an

²⁷¹ *F* CA, *supra* note 204 at 13. See also *Spencer v Anderson (Paternity Testing: Jurisdiction)*, [2016] EWHC 851 (Fam) at para 55 [*Spencer*]; *A*, *supra* note 205 at para 87.

²⁷² *F*, *supra* note 204 at para 19.

²⁷³ *Ibid.*

²⁷⁴ *E v Channel Four & Anor*, [2005] EWHC 1144, [2005] 2 FLR 913 at para 55 [*E*], per Munby J.

²⁷⁵ *St Helens Borough Council v PE & Anor*, [2006] EWHC 3460 at para 10, per Munby J (inherent declaratory jurisdiction in relation to adults).

²⁷⁶ *Supra* note 204.

²⁷⁷ James Munby, “Protecting the rights of vulnerable and incapacitous adults—the role of the courts: an example of judicial law making” (2014) 26 *Child & Fam LQ* 64 at 64 & 77.

²⁷⁸ *SL v SL*, [2000] EWCA Civ 162 at para 6, per Lord Justice Thorpe.

²⁷⁹ *F*, *supra* note 204 at 1-2.

²⁸⁰ *Ibid* at 2.

intrauterine device had been ruled out).²⁸¹ The High Court found that sterilisation would be in F's best interests, and the Court of Appeal unanimously affirmed that conclusion.²⁸² On further appeal, the House of Lords faced three issues: whether it was necessary or desirable for the High Court to have become involved in the matter; if so, what jurisdiction the High Court had to deal with the matter; and if the Court had jurisdiction, the procedure it should have used to exercise it.²⁸³

On the first question, Lord Brandon of Oakbrook found that the statutory vacuum made it necessary for the High Court to become involved. The mental capacity legislation did not apply to the proposed sterilisation because its provisions only governed treatment for a patient's mental disorder (e.g., anti-psychotic medications), not treatment for conditions other than a mental disorder (e.g., sterilisation to prevent conception).²⁸⁴ Lord Brandon found that the common law filled the gap because, in his view, the existing common law allowed doctors to lawfully treat incapable adults without their consent if treatment was in the best interests of the patient.²⁸⁵ He found that treatment would only be in the best interests of incapable patients if it was carried out to save their lives, or to ensure or prevent deterioration of their physical or mental health.²⁸⁶ Since Lord Brandon viewed the existing law as already permitting the sterilisation (if it was in F's best interests), he found that the doctors did not need court approval to carry out it out; doing so would make medical care for incapable persons "grind to a halt."²⁸⁷ Nevertheless, given the serious, irreversible and controversial nature of the proposed sterilisation, he stated that it was "highly desirable" for the High Court to become involved "as a matter of good practice."²⁸⁸

Lord Brandon then turned to the second question: the jurisdiction of the High Court to deal with the matter. He found that the *parens patriae* jurisdiction as it related to minors continued to survive in the form of the High Court's wardship jurisdiction, but the *parens patriae* jurisdiction as it related to mentally incompetent adults had ceased to exist.²⁸⁹ The Court contrasted this situation with other jurisdictions, including Canada, where the *parens patriae* jurisdiction in

²⁸¹ *Ibid.*

²⁸² *Ibid* at 3.

²⁸³ *Ibid.*

²⁸⁴ *F*, *ibid* at 4. See also *ibid* at 21, per Lord Goff of Chieveley.

²⁸⁵ *Ibid* at 4. *Contra Eve*, *supra* note 203 at para 89.

²⁸⁶ *F*, *ibid.*

²⁸⁷ *Ibid* at 5.

²⁸⁸ *Ibid* (In their separate concurring judgments, Lords Goff and Griffiths went a step further than Lord Brandon on this point, and stated that doctors should be required to go to court before sterilising a mentally incompetent adult, at 19 & 28).

²⁸⁹ *Ibid* at 6 & 21.

relation to incompetent adults was “still alive and available for exercise by their courts.”²⁹⁰ Lord Brandon explained that the *parens patriae* jurisdiction no longer existed in England because of two events which occurred in November 1960.²⁹¹ First, the *Mental Health Act 1959* came into force, and second, the instrument authorising the High Court’s jurisdiction over persons of unsound mind was revoked.²⁹² Since the *parens patriae* jurisdiction was unavailable and the mental capacity legislation did not apply, Lord Brandon relied upon the common law, although in his view, it did not confer a jurisdiction to approve or disapprove the operation, but simply confirmed that the procedure was already lawful.²⁹³

On the third question, Lord Brandon stated that the High Court had the jurisdiction to make a declaration regarding the lawfulness of the proposed sterilisation.²⁹⁴ He found that this declaratory jurisdiction was part of the High Court’s inherent jurisdiction.²⁹⁵ He reiterated that by exercising its declaratory jurisdiction, the High Court would not be changing the substantive law, since again, it was his view that the existing common law in England allowed doctors to perform the surgery.²⁹⁶ According to Lord Brandon, the High Court’s declaration was not making the unlawful lawful; the proposed sterilisation, by operation of the common law, was already lawful. The High Court was simply providing a judicial “third opinion” that the proposed sterilisation was in F’s best interests and therefore lawful.²⁹⁷

Since *F*, the English courts have continued to justify using the protective jurisdiction on the grounds that it fills gaps in statutory law. Initially, the new jurisdiction was invoked in relation to mentally incompetent adults whose situations did not fall precisely within mental capacity legislation.²⁹⁸ The scope of the jurisdiction is broad, applying to surgery and matters unconnected to medical treatment.²⁹⁹ As Munby J. asserted, “the court can regulate everything that conduces to

²⁹⁰ *Ibid* at 15. The Supreme Court of Canada has held that the *parens patriae* jurisdiction should not be used to authorise non-consensual non-therapeutic sterilisation: *Eve*, *supra* note 203 at 89.

²⁹¹ *F*, *ibid* at 6.

²⁹² *Ibid*.

²⁹³ *Ibid* at 7 & 12.

²⁹⁴ *Ibid* at 13.

²⁹⁵ *Ibid* at 12-13.

²⁹⁶ *Ibid* at 13.

²⁹⁷ *Ibid*. Compare *Eve*, *supra* note 203 (the superior court was being asked to consent to the sterilisation on behalf of the patient, at 21).

²⁹⁸ *DL*, *supra* note 226; *London Borough of Ealing v KS & Ors*, [2008] EWHC 636 at para 67 [KS].

²⁹⁹ *A*, *supra* note 205 at para 88.

the incompetent adult's welfare and happiness."³⁰⁰ One of the largest threats to the English courts' continued use of the protective jurisdiction in relation to incompetent adults was the passage of the *Mental Capacity Act 2005* (MCA 2005), which came into force in 2007.³⁰¹ However, several cases have confirmed that the jurisdiction survived the legislation's implementation.³⁰² Even more, in *DL v A Local Authority & Ors*, Davis LJ of the English Court of Appeal rejected the argument that the mental capacity legislation had completely ousted the High Court's protective jurisdiction in relation to adults, whether incapacitated or not: "there simply is no such provision to that effect contained in the MCA 2005—which, as I read it, is concerned only with adults who lack capacity (as defined in the statute)."³⁰³ Thus as Munby J. observed in *E v Channel Four & Anor*, the English courts have "come a long way since the decision in [F]."³⁰⁴ They are not only invoking the protective jurisdiction in relation to incompetent adults, but also in relation to a wider category of individuals classified as "vulnerable adults" who do not lack capacity.³⁰⁵ Jackson J. of the English High Court recently confirmed this in unequivocal terms; he stated that "the jurisdiction has been developed to provide remedies for the protection of vulnerable but not legally incapable adults."³⁰⁶

b. Expansion to vulnerable adults

This section chronologically outlines some of the seminal English cases in which the High Court has exercised its protective jurisdiction over vulnerable adults—a category which Munby J. first described in *Re SA (Vulnerable Adult with Capacity: Marriage)*.³⁰⁷ In that case, he addressed whether the High Court could exercise its inherent jurisdiction to protect SA, a young woman who had just turned 18 (the age of majority) and was therefore an adult.³⁰⁸ When SA was a child, the Court had exercised its *parens patriae* and wardship jurisdictions to protect her from the risk of an unsuitable arranged marriage in Pakistan; the current question was whether the Court had the

³⁰⁰ *Re SA (Vulnerable Adult with Capacity: Marriage)*, [2005] EWHC 2942 (Fam), [2006] 1 FLR 867 (*sub nom A Local Authority v MA & Ors*) at para 45 [*Re SA*].

³⁰¹ Jonathan Herring, *Vulnerable Adults and the Law* (Oxford: Oxford University Press, 2016) at 76-77; *KS*, *supra* note 298 at paras 63-66 (capacity to marry and consent to sexual relations).

³⁰² Herring, *ibid* at 77.

³⁰³ *DL*, *supra* note 226 at para 72.

³⁰⁴ *E*, *supra* note 274 at para 55.

³⁰⁵ *Re SA*, *supra* note 300 at para 76.

³⁰⁶ *Spencer*, *supra* note 271 at para 57 [emphasis added].

³⁰⁷ *Re SA*, *supra* note 300 at para 1.

³⁰⁸ *Ibid*.

jurisdiction to continue that protection now that she was an adult.³⁰⁹ SA had capacity to marry, but she was “undoubtedly vulnerable.”³¹⁰ She functioned at the intellectual level of a 13- or 14-year-old, had a reading age of about 7 or 8, was deaf and could not speak.³¹¹ She communicated by British Sign Language (BSL), which her parents did not use.³¹² She could not understand, lip read or sign in her family’s first language, Punjabi.³¹³ As a result, it was doubtful that SA and her parents understood each other’s plans and wishes.³¹⁴ If SA was placed outside the U.K. and surrounded by people who did not communicate in BSL, it was highly likely that she would become extremely distressed, develop psychological difficulties and feel extremely isolated, which would pose a significant risk to her mental health and well-being.³¹⁵ SA’s wishes were clear: she wanted to eventually marry a Muslim man, but she did not want to live in Pakistan so he would have to speak English and be prepared to live in the U.K.³¹⁶ The specific issue was whether, despite SA’s capacity to marry, the Court could put in place protective measures (e.g., require that marriage arrangements be made through BSL) which would enable SA to understand and give informed consent to the terms of the arranged marriage she would eventually face.³¹⁷ Munby J. concluded that the Court had the jurisdiction to grant this relief.³¹⁸ He found that SA was a vulnerable adult who had disabilities which may impair her ability to make a free choice and form real and genuine consent—even in the absence of any undue influence or misinformation.³¹⁹

Munby J. declined to define who might fall into the vulnerable adult category; instead, he identified three non-exhaustive categories of vulnerability, namely constraint; coercion or undue influence; and other disabling circumstances:

[T]he inherent jurisdiction can be exercised in relation to a vulnerable adult who, even if not incapacitated by mental disorder or mental illness, is, or is reasonably believed to be, either (i) under constraint or (ii) subject to coercion or undue influence or (iii) for some other reason deprived of the capacity to make the relevant

³⁰⁹ *Ibid.*

³¹⁰ *Ibid* at para 2.

³¹¹ *Ibid* at paras 3, 6 & 114.

³¹² *Ibid* at para 4.

³¹³ *Ibid.*

³¹⁴ *Ibid* at paras 4 & 115.

³¹⁵ *Ibid* at para 15.

³¹⁶ *Ibid* at para 24.

³¹⁷ *Ibid* at para 28.

³¹⁸ *Ibid* at para 34.

³¹⁹ *Ibid* at para 124.

decision, or disabled from making a free choice, or incapacitated or disabled from giving or expressing a real and genuine consent.³²⁰

Munby J. described constraint as referring to situations in which a person is incarcerated, confined, controlled or under a restraint which significantly curtails his freedom.³²¹ Coercion or undue influence relates to the improper influence of another person.³²² The third category of other disabling circumstances includes:

the many other circumstances that may so reduce a vulnerable adult's understanding and reasoning powers as to prevent him forming or expressing a real and genuine consent, for example, the effects of deception, misinformation, physical disability, illness, weakness (physical, mental or moral), tiredness, shock, fatigue, depression, pain or drugs. No doubt there are others.³²³

Another example may be the maladaptive cognitive effects of loneliness.

In *Re SK*, Singer J. exercised the protective jurisdiction on an interim basis to ascertain whether an adult was in a situation which would justify the Court's intervention.³²⁴ In that case, the proposed plaintiff (SK) was a young adult British citizen whose family was from Bangladesh.³²⁵ It was believed that she was being held against her will in her family's home country and that she was at risk of a forced marriage, which would grossly interfere with her human rights and possibly result in criminal offences against her as her capacity to consent (e.g., to sexual relations) would have been "overborne by fear, duress or threat."³²⁶ Singer J. also noted that if SK was forced to marry, she may experience "irreparable and severe physical and emotional consequences."³²⁷ While the High Court's wardship jurisdiction could not be invoked because SK was an adult, Singer J. held that the Court's inherent jurisdiction could be used to provide a remedy. He found that the "declaratory jurisdiction" could be invoked to ascertain whether SK had been able to exercise her free will when making decisions about her civil status and country of residence.³²⁸ The judge hoped that this determination could be made by arranging for SK to be seen by a British consular official in Bangladesh, who could evaluate her circumstances and

³²⁰ *Ibid* at para 77.

³²¹ *Ibid* at para 78.

³²² *Ibid*.

³²³ *Ibid*.

³²⁴ [2004] EWHC 3202 (Fam), [2005] 3 All ER 421 at para 2.

³²⁵ *Ibid*.

³²⁶ *Ibid* at paras 1 & 4.

³²⁷ *Ibid* at para 4.

³²⁸ *Ibid* at para 9.

ascertain her wishes in an unconstrained environment.³²⁹ To determine the precise whereabouts of SK, Singer J. ordered several relatives to appear before the Court to give information about her location.³³⁰ In a postscript, Singer J. states that SK was promptly interviewed by a consular official, and then she returned to England where she expressed her wish that the court proceeding be discontinued.³³¹ Nevertheless, Singer J. expressed no reservations about invoking the jurisdiction; he stated that while the anxieties giving rise to the proceeding may have turned out to be “ill-founded,” the situation made it appropriate for the Court to investigate SK’s circumstances.³³²

In *Re G (An Adult) (Mental Capacity: Court’s Jurisdiction)*,³³³ Bennett J. used the jurisdiction as a pre-emptive measure to protect a capable adult.³³⁴ The case involved a 29-year-old woman (G) with a history of mental illness whose father had been violent towards her, and having contact with him appeared to worsen her mental state.³³⁵ When G was incapable, an interim order had been put in place to limit contact between her and her father.³³⁶ At the time of the final hearing, G’s mental condition had improved and she was considered to be capable of making decisions about the nature and extent of contact with her father.³³⁷ However, Bennett J. was concerned that if the Court removed the protective framework that had been put in place when G was incapable, her mental state would likely deteriorate again, and he did not think that the jurisdiction should be “entirely dependent on the shifting sands” of G’s capacity at the time of the final hearing—the “focal point” should be the situation which resulted in her mental deterioration.³³⁸ Therefore, Bennett J. exercised the Court’s inherent jurisdiction, and he did so in a manner which scholars have described as a preventative measure to stop the “revolving door” scenario of mental illness.³³⁹

Further, in *Local Authority X v MM & Anor (No. 1)*, Munby J. stated that courts can intervene to protect vulnerable adults from the risk of future harm as long as “there is a real

³²⁹ *Ibid* at para 10.

³³⁰ *Ibid* at para 12.

³³¹ *Ibid* at para 15.

³³² *Ibid* at para 16.

³³³ [2004] EWHC 222 (Fam) [G]. See Michael C. Dunn, Isabel C.H. Clare & Anthony J. Holland, “To empower or protect? Constructing the ‘vulnerable adult’ in English law and public policy” (June 2008) 28:2 Leg Stud (Soc Leg Scholars) 234.

³³⁴ Dunn, Clare & Holland, *ibid*.

³³⁵ *G*, *supra* note 333 at paras 1, 69 & 79.

³³⁶ *Ibid* at para 64.

³³⁷ *Ibid* at para 87.

³³⁸ *Ibid* at paras 91, 105 & 112.

³³⁹ Dunn, Clare & Holland, *supra* note 333.

possibility, rather than a merely fanciful risk, of such harm.”³⁴⁰ He noted that such intervention ought to be exercised with a view to the vulnerable person’s happiness:

[J]ust as wise parents resist the temptation to keep their children metaphorically wrapped up in cotton wool, so too we must avoid the temptation always to put the physical health and safety of the elderly and the vulnerable before everything else. Often it will be appropriate to do so, but not always. Physical health and safety can sometimes be bought at too high a price in happiness and emotional welfare. The emphasis must be on sensible risk appraisal, not striving to avoid all risk, whatever the price, but instead seeking a proper balance and being willing to tolerate manageable or acceptable risks as the price appropriately to be paid in order to achieve some other good – in particular to achieve the vital good of the elderly or vulnerable person’s *happiness*. What good is it making someone safer if it merely makes them miserable?³⁴¹

And from the reverse angle, the right to live at risk can be a hollow victory if it does not translate into a better quality of life for lonely older men.

The final case I address in this section is *DL*.³⁴² It provides strong authority for the proposition that the English High Court may exercise its protective jurisdiction in relation to older adults “who plainly [have] mental capacity to make decisions for themselves.”³⁴³ In that case, the Court of Appeal considered whether the High Court properly exercised its jurisdiction to protect “an elderly married couple” from their adult son (DL), even though neither parent lacked mental capacity.³⁴⁴ The father (Mr. L) was 86-years-old; Mrs. L was 90.³⁴⁵ All three parties lived together in a house owned by Mr. L.³⁴⁶ DL was aggressive towards his parents, sometimes resulting in physical violence.³⁴⁷ His behaviour also included making verbal threats; restricting his parents’ visitors, including professional caregivers; trying to coerce his father to transfer him ownership of the house; and pressuring his parents to have Mrs. L moved into a care home against her wishes.³⁴⁸ The local authority brought the proceedings to protect Mr. and Mrs. L from DL; however, Mrs. L wished to preserve her relationship with her son and she did not want any proceedings to be taken

³⁴⁰ [2007] EWHC 2003 (Fam), [2008] Fam Law 213 at para 119.

³⁴¹ *Ibid* at para 20 [emphasis original].

³⁴² *Supra* note 226.

³⁴³ *Ibid* at para 3.

³⁴⁴ *Ibid* at para 9.

³⁴⁵ *Ibid*.

³⁴⁶ *Ibid*.

³⁴⁷ *Ibid*.

³⁴⁸ *Ibid*.

against him.³⁴⁹ Mr. L's wishes remained unclear.³⁵⁰ The High Court made interim injunction orders restraining DL's aggressive and coercive behaviour towards his parents.³⁵¹ On appeal, McFarlane LJ observed that the protective jurisdiction articulated by Munby J. clearly applies to adults who are vulnerable for reasons other than mental incompetence.³⁵² Appearing to anticipate criticism, McFarlane LJ stated that the jurisdiction was not so extensive and all-encompassing that it would threaten the autonomy of every English adult; it was limited to adults with compromised decision-making.³⁵³ Like Munby J., McFarlane LJ declined to delineate which adults may fall into the vulnerable adult category. Instead, he preferred to recognize "the ability of the common law to develop and adapt its jurisdiction, on a case by case basis, as may be required."³⁵⁴

In a concurring judgment, Maurice Kay LJ suggested that it would be "most unfortunate" if the law did not protect vulnerable adults merely because they have capacity:

Where a person lacks capacity [under] the MCA 2005, he has the protection provided by that statute. A person at the other end of the scale, who has that capacity and is not otherwise vulnerable, is able to protect himself against unscrupulous manipulation, if necessary by obtaining an injunction against his oppressor. This case is concerned with a category of people who, in reality, have neither of those remedies available for their protection. It would be most unfortunate if, by reference to their personal autonomy, they were to be beyond the reach of judicial protection. For the reasons given by my Lords, they are not.³⁵⁵

The Court of Appeal upheld the High Court's injunctions which protected Mr. and Mrs. L.³⁵⁶

A common thread in the vulnerable adult decisions is the existence of a third party villain,³⁵⁷ which is similar to cases in which the doctrines of undue influence or unconscionability are applied. As the High Court noted in *Spencer*, the protective jurisdiction has been invoked when a vulnerable adult is at risk of coercion or abuse.³⁵⁸ Indeed, as the cases above demonstrate, there is "a judicial appetite for increased intervention [into] the lives of vulnerable people"³⁵⁹ who are

³⁴⁹ *Ibid.*

³⁵⁰ *Ibid.*

³⁵¹ *Ibid.* Because Mr. L had become incapacitated by the time of the hearing, the High Court exercised its authority under the MCA 2005 to protect him; it used its inherent jurisdiction in relation to Mrs. L: *ibid* at para 5.

³⁵² *Ibid* at para 15.

³⁵³ *Ibid* at paras 53-54.

³⁵⁴ *Ibid* at para 64.

³⁵⁵ *Ibid* at para 79 [emphasis added].

³⁵⁶ *Ibid* at para 80.

³⁵⁷ Dunn, Clare & Holland, *supra* note at 333.

³⁵⁸ *Supra* note 271 at para 58.

³⁵⁹ Kirsty Keywood, "Vulnerable Adults, Mental Capacity and Social Care Refusal" (2010) 18 Med L Rev 103 at 110.

subjected to a third party predator. I suggest that it may also be justifiable to invoke the protective jurisdiction when there is an internal predator—loneliness—which compromises an adult’s exercise of free choice.

4. Protective jurisdiction: the Canadian potential

Through the combined effect of the evolution of the *parens patriae* jurisdiction and the emerging line of English protective jurisdiction case law, I argue that superior courts in Canada have an existing jurisdiction to intervene in the lives of capable lonely older men who are symptomatically refusing objectively needed home-based services. An initial objection would likely be that, unlike in England, the *parens patriae* jurisdiction has not disappeared in relation to incompetent adults; the jurisdiction remains alive and well. In England, it was the disappearance of *parens patriae* which triggered the courts to discover the protective jurisdiction. In Canada, such an inadvertent loss is unlikely. As the Newfoundland and Labrador Court of Appeal recently observed, it is arguable that the *parens patriae* jurisdiction is part of the provincial superior court’s “core” jurisdiction in s 96 of the *Constitution Act, 1867*,³⁶⁰ and therefore, cannot be eliminated without a constitutional amendment.³⁶¹ Section 96 states, “The Governor General shall appoint the Judges of the Superior, District, and County Courts in each Province, except those of the Courts of Probate in Nova Scotia and New Brunswick.”³⁶² This section appears to be nothing more than a “staffing provision” (i.e., conferring the power to appoint judges); however, through judicial interpretation and the recognition of unwritten constitutional norms, it has come to constitutionally protect the superior courts’ inherent jurisdiction.³⁶³ Therefore, it can only be removed by constitutional amendment.³⁶⁴

If *parens patriae* had remained available to the English courts, it is possible that the protective jurisdiction would have never emerged; but it is also possible that the courts may have extended the underlying concept of the *parens patriae* jurisdiction (i.e., necessity) to respond to the needs of vulnerable adults who do not lack capacity. As I discuss below, there are indications

³⁶⁰ *Supra* note 255, s 96.

³⁶¹ *J.T. v Newfoundland and Labrador (Child, Youth and Family Services)*, 2015 NLCA 55, [2015] NJ No 390 at para 15.

³⁶² *Constitution Act, 1867*, *supra* note 255, s 96.

³⁶³ *Ref re Remuneration of Judges of the Prov. Court of P.E.I.; Ref re Independence and Impartiality of Judges of the Prov. Court of P.E.I.*, [1997] 3 SCR 3, 1997 CanLII 317 at paras 88-95.

³⁶⁴ *Criminal Lawyers*, *supra* note 227 at para 18; *MacMillan*, *supra* note 231 at para 15.

that the start of such an evolution is occurring in Canada, namely that some courts have loosened the *parens patriae* jurisdiction's traditional "proof of incompetence" requirement. These cases have laid the groundwork for the second generation of *parens patriae*, or for conceptual clarity, the superior courts' protective jurisdiction over vulnerable adults. Bringing vulnerable adults under the courts' protective arm can be seen as an expansion of the traditional *parens patriae* jurisdiction, or as a new jurisdiction within the superior courts' broader inherent jurisdiction (i.e., another category of inherent jurisdiction).

In *Eve*, La Forest J. stated that when using the *parens patriae* jurisdiction over adults, "proof of incompetence must, of course, be made."³⁶⁵ However, as Fisher J. of the B.C. Supreme Court recently observed in *Temoin v Martin*, "*Eve* is not instructive about what 'proof of incompetence' means."³⁶⁶ While the Alberta Court of Appeal has stated that there must be "compelling evidence of incompetence,"³⁶⁷ a line of cases suggest that something below this standard may be sufficient to justify the use of *parens patriae*. First, recall that in *Perino*, Corbett J. exercised the Ontario superior court's *parens patriae* jurisdiction and inherent procedural powers to order that state-funded legal services be provided to a mentally disabled adult witness.³⁶⁸ Corbett J. did not make a formal finding of incapacity; rather, he described the witness as "a vulnerable person ... whose capacity to make decisions for herself [was] in question."³⁶⁹

Second, in *Temoin*, a daughter petitioned for a declaration that her 87-year-old father, Mr. Martin, was incapable of managing his personal and financial affairs.³⁷⁰ Under the applicable legislation, a precondition of the hearing was that the daughter must provide affidavits from two medical practitioners setting out their opinion that Mr. Martin was incapable.³⁷¹ Mr. Martin refused to see the doctors for a capacity assessment.³⁷² Fisher J. found that there was a legislative gap with respect to individuals who needed the protection of the applicable statute, but would not cooperate in obtaining the required medical evidence.³⁷³ The gap was "particularly acute" because the adult's

³⁶⁵ *Eve*, *supra* note 203 at para 36.

³⁶⁶ 2011 BCSC 1727, 2011 CarswellBC 3377 at para 64 [*Temoin*], *aff'd* 2012 BCCA 250, [2012] BCJ No 1174 [*Temoin* CA].

³⁶⁷ *U. (J.) v Alberta (Director of Child Welfare)*, 2001 ABCA 125, 281 AR 396 at para 5, leave to appeal to SCC refused [2001] SCCA No 381.

³⁶⁸ *Supra* note 207.

³⁶⁹ *Ibid* at para 42 [emphasis added].

³⁷⁰ *Temoin* CA, *supra* note 366 at paras 1 & 4.

³⁷¹ *Ibid* at para 2.

³⁷² *Ibid*.

³⁷³ *Ibid* at paras 48-49.

refusal flowed from his apparent incapability: “In these cases, the requirement of two medical opinions, designed to protect individual autonomy, become an impediment that places individuals who are incapable of making free choices beyond assistance.”³⁷⁴ Despite the legal presumption of capacity, Fisher J. found that the “proof of incompetence” standard would be met if there was evidence that the person was *prima facie* incompetent.³⁷⁵ The standard would be “something less than the court being satisfied that the person is incapable.”³⁷⁶ In Mr. Martin’s case, there was some evidence that he lacked testamentary capacity, but in accordance with the functional approach to capacity, Fisher J. held that it was of little assistance to the determination of whether he lacked capacity to manage his personal and financial affairs.³⁷⁷ Ultimately, Fisher J. found that there was insufficient evidence to establish that Mr. Martin was *prima facie* incompetent, and therefore, she declined to exercise the *parens patriae* jurisdiction to order a medical examination.³⁷⁸

Third, in *Seaman*, the Alberta Surrogate Court exercised its *parens patriae* jurisdiction over two proposed—but not formally declared—incapable adults.³⁷⁹ In that case, two daughters were seeking guardianship of their mothers, and applied to have the Court waive the service requirement because there was medical and other evidence that service would be detrimental to their mothers’ health and therefore not in their best interests.³⁸⁰ Under the applicable legislation, both the Court and the Public Guardian had to consent to the dispensation, but in the case at bar, the Public Guardian would not consent.³⁸¹ The Court found that the legislation did not contemplate a situation in which the Public Guardian was acting unreasonably, thereby causing an unacceptable delay and potentially causing harm to proposed dependent adults.³⁸² The Court held that its *parens patriae* jurisdiction could be invoked to dispense with service on the proposed dependent adults, if service would not be in their best interests, and when the Public Guardian was unreasonably refusing to consent to the dispensation.³⁸³

³⁷⁴ *Ibid* at para 51.

³⁷⁵ *Temoin*, *supra* note 366 at para 64.

³⁷⁶ *Ibid* [emphasis added].

³⁷⁷ *Ibid* at paras 66-69.

³⁷⁸ *Ibid* at paras 56 & 65.

³⁷⁹ *Supra* note 203.

³⁸⁰ *Ibid* at para 1.

³⁸¹ *Ibid* at para 4.

³⁸² *Ibid* at para 17.

³⁸³ *Ibid* at para 20.

Similarly, in *McMaster v McMaster*, the Ontario Superior Court exercised its *parens patriae* jurisdiction over an older woman without making a formal finding of incapacity.³⁸⁴ In that case, an affluent 80-year-old woman (Ms. McMaster) granted her two sons (Graeme and Malcolm) a general continuing power of attorney.³⁸⁵ Over time, Ms. McMaster’s health deteriorated, as did her finances.³⁸⁶ Graeme was unaware that he was an attorney, until he sought a passing of accounts from Malcolm.³⁸⁷ Concerned about Malcolm’s financial mismanagement, Graeme sought to have Malcolm removed as a property attorney.³⁸⁸ Under the applicable legislation, the Court had the authority to terminate, on its own initiative, an attorney’s power under an incapable person’s continuing power of attorney; however, the statute applied to people with general overall incapacity (as opposed to just financial incapacity).³⁸⁹ The evidence suggested that Ms. McMaster may have had financial incapacity, which could exist without a formal “legal diagnosis of incapacity.”³⁹⁰ Whitten J. found that there was a legislative gap since the provision protected people with general overall incapacity, but not financial incapacity (a difference he said was “practically speaking academic”).³⁹¹ He relied upon the *parens patriae* jurisdiction to fill the gap and protect Ms. McMaster by removing Malcolm as her property attorney.³⁹² Notably, it appears that Whitten J. even declined to conclude that Ms. McMaster was financially incapable; he did, however, find her to be vulnerable:

Even if it were necessary in order to declare [Ms. McMaster] fiscally incapable, more detailed medical evidence is necessary, what evidence exists is clearly that of an elderly vulnerable person who because of her memory deficits and her “dementia”... is the embodiment of an individual who needs protection of the court, otherwise she is a pawn in the investment schemes of her son.³⁹³

Taken together, *Perino*, *Temoin*, *Seaman* and *McMaster* challenge the strict understanding of the *parens patriae* jurisdiction’s “proof of incompetence” requirement. In these cases, the jurisdiction was invoked without a formal finding of incapacity. Indeed, in *McMaster*, Whitten J. extended the protection to a vulnerable older adult whose incapacity had not been established.

³⁸⁴ 2013 ONSC 1115, [2013] OJ No 877 [*McMaster*].

³⁸⁵ *Ibid* at para 1.

³⁸⁶ *Ibid* at para 2.

³⁸⁷ *Ibid* at para 3.

³⁸⁸ *Ibid*.

³⁸⁹ *Ibid* at paras 3 & 21.

³⁹⁰ *Ibid* at paras 10 & 53.

³⁹¹ *Ibid* at paras 28 & 55.

³⁹² *Ibid* at paras 56 & 63.

³⁹³ *Ibid* at para 56 [emphasis added].

CHAPTER V: *PARENS PATRIAE* 2.0 – PROTECTIVE JURISDICTION

In case law and mainstream narratives about older people, loneliness is usually presented as an emotion that makes one vulnerable to financial abuse.³⁹⁴ A classic story involves an older man who falls victim to a younger woman who preys on his lonely heart and drains his bank account. “Right to live at risk” advocates defend his objectively unwise decisions on the grounds that he can do what he wants; if having someone in his life fills a void in his heart, who are we to judge? But this feel-good account presents loneliness in a colloquial sense; it glosses over the clinical or evidence-based understanding of loneliness which suggests that lonely people tend to behave in paradoxically self-defeating ways, such as unwittingly pushing people away, despite simultaneously desiring social connection.

Lonely older men’s maladaptive social cognition has the potential to negatively affect a range of relationships, including those with concerned third parties such as social workers who offer them objectively needed home-based services. Rather than simply viewing their refusal of services as an assertion of their right to live at risk, it may be more appropriate to view the rejection as a symptom of their loneliness. They are symptomatic refusers, not libertarian flag-bearers.

While in many cases, social workers and other concerned parties can skillfully overcome such hostility, there may be situations in which a lonely older man does not relent. Or he may initially accept help, and then change his mind. Abandoning him risks confirming his negative expectations of others, and thus further cementing his maladaptive social cognition. Yet labelling him as incapable or using mental health legislation to force intervention is too heavy-handed, and it places him at considerable risk of unnecessary institutionalisation. Invoking the superior courts’ protection jurisdiction offers a less intrusive solution.

This chapter sets out my proposed framework for invoking a superior court’s protective jurisdiction to respond to the needs of lonely older men who do not lack capacity but are symptomatically refusing objectively needed home-based services. First, I identify the general

³⁹⁴ See e.g. *Ross-Scott, supra* note 180; Nathalie Martin, “Consumer Scams and the Elderly: Preserving Independence Through Shifting Default Rules” (2009) 17:1 *Elder LJ* 1 at 5; Jessica Coombs, “Scamming the Elderly: An Increased Susceptibility to Financial Exploitation Within and Outside of the Family” (2014) 7 *Alb Gov’t L Rev* 243 at 248; Kerri Griffin, “Safeguarding Against Golden Opportunities” (2010) 2 *Est Plan & Cmty Prop LJ* 441 at 448 & 454; Jeffrey L. Bratkiewicz, “‘Here’s A Quarter, Call Someone Who Cares’; Who Is Answering the Elderly’s Call for Protection from Telemarketing Fraud?” (2000) 45 *SD L Rev* 586 at 589; Shelby A.D. Moore & Jeanette Schaefer, “Remembering the Forgotten Ones: Protecting the Elderly from Financial Abuse” (2004) 41 *San Diego L Rev* 505 at 517-18 & fn 55.

circumstances in which a court may be justified in exercising its protective jurisdiction. While some situations may be classified as “self-neglect,” I explain that I am referring more generally to the rejection of services which purport to facilitate aging-in-place. Second, I suggest that dignity ought to serve as the guiding principle. Third, using B.C.’s legislation as a point of reference, I discuss the legislative gap which currently exists in its adult guardianship/protection and mental health laws. Fourth, I review the general nature of protective jurisdiction orders. Fifth, I propose that the protective jurisdiction ought to be exercised in the most effective, less intrusive manner. “Most effective, less intrusive” language guides statutory interventions,³⁹⁵ but as a line of cases demonstrate, it is often just rhetoric, especially when an older adult is refusing in-home services and is subsequently deemed incapable of making a care home admission decision. I conclude the chapter with a discussion of three practical challenges of effectively using the protective jurisdiction: limited resources; enforceability; and service provider safety.

1. Proposed framework

a. Circumstances justifying intervention

There may be various circumstances in which a court may be justified in exercising its protective jurisdiction over a symptomatic refuser. Each situation needs to be determined on a case-by-case basis, and therefore, it would be unwise to provide a list of refusals which may trigger the jurisdiction. Refusing meals on wheels and nursing care may be enough in one case, but not another. I am particularly concerned with situations in which a lonely older man refuses home-based services and is then deemed incapable so third parties can simply institutionalise him.

Generally speaking, I am referring to the rejection of services that purport to facilitate aging-in-place; that is, services which aim to help older adults delay or avoid institutionalisation and remain in their own home for as long as possible. For better or worse, aging-in-place has emerged as the common policy response to the aging population. The approach is consistent with the dominant narrative which says that most older adults wish to remain in their current home and intergenerational community for as long as possible.³⁹⁶ It also aligns with the recognition that housing older adults in institutional settings is an expensive and potentially unsustainable endeavour. While numbers vary across jurisdictions, it is commonly reported that home care is a

³⁹⁵ See *Adult Guardianship Act*, RSBC 1996, c 6, s 56(5) [BC AGA].

³⁹⁶ See e.g. Petra de Jong et al, “Housing Preferences of an Ageing Population: Investigation in the Diversity Among Dutch Older Adults” (2012) Netspar Discussion Paper 07/2012-024 at 25.

less costly alternative to institutionalisation. For example, the North East Ontario Local Health Integration Network found that the average daily cost of a long-term care bed was \$126, while home care was \$42.³⁹⁷ Providing care in a hospital bed was the most expensive, at \$842 per day.³⁹⁸ Coupled with the active aging approach, this economic reality has pushed governments of all levels to announce, and occasionally implement, a number of fiscal and public policy changes to facilitate aging-in-place.³⁹⁹ While the aging-in-place movement will positively impact many Canadians, the concept may be oversold, with many older adults “now occupying inappropriate residential environments.”⁴⁰⁰ Driven by a highly libertarian approach, the shift from institutionalisation to community care may not translate into a better quality of life for lonely older men who fall on the “right” side of the fictitious capacity dichotomy, and paradoxically reject services.

In some cases, the lonely older man’s circumstances may be classified as “self-neglect.” Interestingly, loneliness has been linked to Diogenes syndrome, an extreme form of elder self-neglect that is generally characterised by hoarding, domestic squalor and the refusal of external help.⁴⁰¹ However, we must proceed with caution when invoking the term “self-neglect,” which has an “almost bewildering” number of manifestations and is a difficult concept to define.⁴⁰² B.C.’s *Adult Guardianship Act* defines “self-neglect” as:

³⁹⁷ Home Care Ontario, Home Care Services, “Facts & Figures - Publicly Funded Home Care”, online: <www.homecareontario.ca>.

³⁹⁸ *Ibid.*

³⁹⁹ See Liberal Party of Canada, “A New Plan for a Strong Middle Class” (2015), online: <www.liberal.ca> at 9 (campaign promise to invest \$3 billion over four years to improve the quality and accessibility of home care); Susan Lunn, “Home care money still to come, Health Minister Jane Philpott promises” *CBC News* (26 March 2016), online: <<http://www.cbc.ca/news/politics/federal-budget-home-care-philpott-1.3506472>> (home care campaign promise part of larger, ongoing negotiations with the provinces and territories around health funding); B.C. Government, News Release, “\$2 million helps support seniors to stay at home longer” (13 June 2014), online: <<https://news.gov.bc.ca/stories/2-million-helps-support-seniors-to-stay-at-home-longer>> (United Way program providing non-medical home support to older adults); *Income Tax Act*, RSBC 1996, c 215, Part 11 & *Income Tax Act*, RSC 1985, c 1 (5th Supp), s 118.04(3) (tax credits helping seniors with the cost of home modifications); City of Winnipeg, “Age-Friendly Winnipeg: Action Plan” (May 2014), online: <www.winnipeg.ca> at 8 (creating age-friendly communities through initiatives such as low-floor buses which improve accessibility).

⁴⁰⁰ See e.g. Stephen M. Golant quoted in Fredrick Kunkle, “Aging in place concept has been oversold, professor argues” *The Washington Post* (5 March 2015), online: <www.washingtonpost.com>.

⁴⁰¹ Alejandra Saldarriaga-Cantillo & Juan Carlos Rivas Nieto, “Noah Syndrome: A Variant of Diogenes Syndrome Accompanied by Animal Hoarding Practices” (2015) 27 *J Elder Abuse & Neglect* 270; Benjamin Boynton, *Indicators of Diogenes Syndrome in Community Dwelling Elderly* (PhD Thesis, Walden University, College of Social and Behavioral Sciences, 2014) [unpublished]. The causal relationship between loneliness and Diogenes syndrome is not clear cut.

⁴⁰² Suzy Braye, David Orr & Michael Preston-Shoot, “Self-neglect and adult safeguarding: findings from research”, Final Report to the Department of Health, Adults’ Services SCIE Report 46 (September 2011), online: <http://sro.sussex.ac.uk/22841/1/Self_neglect_report.pdf> at 8.

any failure of an adult to take care of himself or herself that causes, or is reasonably likely to cause within a short period of time, serious physical or mental harm or substantial damage or loss in respect of the adult's financial affairs, and includes

- (a) living in grossly unsanitary conditions,
- (b) suffering from an untreated illness, disease or injury,
- (c) suffering from malnutrition to such an extent that, without intervention, the adult's physical or mental health is likely to be severely impaired,
- (d) creating a hazardous situation that will likely cause serious physical harm to the adult or others or cause substantial damage to or loss of property, and
- (e) suffering from an illness, disease or injury that results in the adult dealing with his or her financial affairs in a manner that is likely to cause substantial damage or loss in respect of those financial affairs.⁴⁰³

This definition applies to adults with and without capacity; that is, the statutory meaning of "self-neglect" in B.C. is not contingent upon the adult being incapable.⁴⁰⁴ As a result, a support and assistance plan may be offered to a capable adult, although he can refuse to accept it.⁴⁰⁵

B.C.'s definition of "self-neglect" can be contrasted with the one in Newfoundland and Labrador. In that province, the statutory definition only applies to people who lack capacity.⁴⁰⁶ Thus, vulnerable adults with capacity fall outside the scope of the province's statutory adult protective services; in other words, statutory service plans are only offered to those who lack capacity.

"Self-neglect" is also a problematic term because it is a value-laden social construct, influenced by the socio-economic status and cultural values of assessors.⁴⁰⁷ Compare the Ontario

⁴⁰³ BC AGA, *supra* note 395, s 1("self-neglect").

⁴⁰⁴ *Ibid.* See also British Columbia, Legislative Assembly, *Official Report of Debates (Hansard)*, 35th Parl, 2nd Sess, Vol 12 No 7 (15 July 1993) at 8757 (C Serwa).

⁴⁰⁵ BC AGA, *ibid.*, ss 1("self-neglect") & 53(4)-(5). The different approaches may be partly explained by the provinces' reporting regimes for the general public. Newfoundland and Labrador has mandatory reporting; that is, a person who reasonably believes that an adult is self-neglected (or abused or neglected) must immediately report the information (*Adult Protection Act*, SNL 2011, c A-4.01, s 12 [NL APA]). In B.C., reporting is discretionary (BC AGA, *ibid.*, s 46(1)).

⁴⁰⁶ NL APA, *ibid.*, s 2(p)("self-neglect").

⁴⁰⁷ See generally William Lauder, "The utility of self-care theory as a theoretical basis for self-neglect" (2001) 34:4 J Adv Nursing 545. Geographic location may also affect perceptions; rural communities may have a higher level of tolerance for self-neglect: see J. Harbison et al, "Offering the help that's needed: responses to the mistreatment and neglect of older people in a rural Canadian context" (2004) 9:2 Rural Social Work 147.

cases of *M.G. (Re)*⁴⁰⁸ and *AP (Re)*.⁴⁰⁹ Since Ontario does not have adult protection legislation,⁴¹⁰ they are not statutory self-neglect cases *per se*. Both were decided under the province's *Health Care Consent Act, 1996*,⁴¹¹ and addressed whether the older adults lacked capacity to make a care home admission decision. *M.G.* involved a 77-year-old woman with multiple serious medical conditions, including but not limited to diabetes, hypertension, osteoporosis and possible schizoid personality.⁴¹² Her leg had been amputated, which confined her to a wheelchair.⁴¹³ Over a two year period, she had been admitted to the hospital nine times (due to pain from sores), and these episodes involved a pattern of behaviour in which she would be discharged with her agreeing to accept community care support, but once she returned to home, she would cancel the services.⁴¹⁴ *M.G.* would tell authorities that she would be away visiting a friend, but in fact she remained in her supportive housing unit.⁴¹⁵ In her apartment, there were plastic bags filled with garbage and infested with cockroaches; there was rotting food in the refrigerator; and her wheelchair was covered in urine and feces.⁴¹⁶ Because of her situation, she was at high risk of eviction.⁴¹⁷ *M.G.* attended the Ontario Consent and Capacity Board (CCB) hearing to challenge her doctor's assessment that she was incapable. In upholding the incapacity finding, the panel member (a lawyer) stated:

Ms. *M.G.* brought a blue recycling garbage bag to the hearing. She had packages of paper in the bag, and spent much of her time sorting through the materials. Because of the concern about infection, Ms. *M.G.* was at a separate table from the panel members. She seemed content with her isolated position.⁴¹⁸

The panel member further stated that *M.G.*'s "constant assertions that she was not sick, and that she could take care of herself, when added to her obvious preference for isolation and pattern of socially avoidant behaviour, prevented her from passing [the capacity test]."⁴¹⁹

⁴⁰⁸ 2008 CanLII 28425 (ON CCB) [*M.G.*].

⁴⁰⁹ 2011 CanLII 29197 (ON CCB) [*AP*].

⁴¹⁰ There has been at least one attempt to have adult protection legislation in Ontario: see Bill 30, *An Act to protect adults from abuse and neglect*, 4th Sess, 37th Leg, Ontario, 2003 (first reading 21 May 2003).

⁴¹¹ SO 1996, c 2, Sch A [ON HCCA].

⁴¹² *M.G.*, *supra* note 408 at 4.

⁴¹³ *Ibid* at 3.

⁴¹⁴ *Ibid*.

⁴¹⁵ *Ibid*.

⁴¹⁶ *Ibid* at 5.

⁴¹⁷ *Ibid*.

⁴¹⁸ *Ibid* at 7.

⁴¹⁹ *Ibid*.

Similar to M.G., A.P. was a single 86-year-old woman who lived alone in her rented apartment.⁴²⁰ She had poor vision and hearing, but no mobility issues.⁴²¹ Unlike M.G., A.P. was described as “‘spry’ for her age” and “‘fiercely independent.’”⁴²² She did her own shopping and cooking, and refused community supports such as meals on wheels.⁴²³ A.P. believed she could receive the internet through a connection in her head, although this delusion did not relate to the matter at hand; that is, she was not hearing voices that counselled her against admission.⁴²⁴ In finding her capable, the panel member stated that throughout her testimony, A.P. was “articulate and eloquent” and that “[i]t was clear that her opposition to admission arose from her fierce spirit of independence.”⁴²⁵ Recall that in *M.G.*, the panel member made a point of noting that M.G. had brought a garbage bag to the hearing, was placed at a separate table with those bags and exhibited socially avoidant behaviour. M.G. was found incapable; A.P., on the other hand, was found capable.⁴²⁶ A.P. fit the privileged-class narrative; M.G. and her garbage bags did not.

ARC (Re) is another case characterised by underlying value-judgments that implicitly associate, if not equate, the “right” appearance with capacity.⁴²⁷ In that case, a 76-year-old farmer suffered from several physical conditions, a personality disorder and dementia.⁴²⁸ He was admitted to a psychiatric facility because he uttered threats against his family, was depressed and had suicidal ideation.⁴²⁹ He was eventually transferred to a medical ward for his physical ailments, and a registered nurse assessed him as being incapable of making a care home admission decision and managing his property.⁴³⁰ In finding Mr. ARC capable, the CCB panel member stated:

Although Mr. ARC did not testify, he was present and I had the opportunity to observe him and to watch his interactions with others during the hearing. There was nothing to suggest to me that on the day of the hearing, he lacked the cognitive ability to comprehend information relevant to admission to a care facility.

For example, this was not a situation where the patient had been wheeled into the hearing prone on a hospital bed and without any discernible interaction with others

⁴²⁰ *AP*, *supra* note 409 at 3.

⁴²¹ *Ibid.*

⁴²² *Ibid.*

⁴²³ *Ibid.*

⁴²⁴ *Ibid* at 7.

⁴²⁵ *Ibid.*

⁴²⁶ *Ibid* at 9.

⁴²⁷ 2013 CanLII 47109 (ON CCB).

⁴²⁸ *Ibid* at 3.

⁴²⁹ *Ibid.*

⁴³⁰ *Ibid* at 1 & 4.

or comprehension of the hearing proceedings. He spoke several sentences in my presence, and presented as a pleasant, active and concerned senior citizen.⁴³¹

There are exceptions to these value-laden decisions, including *Koch (Re)*, which is a leading authority supporting the proposition that a third party's value judgments and personal beliefs are irrelevant to capacity evaluations.⁴³² Koch was a 37-year-old woman who suffered from multiple sclerosis and was mostly confined to a wheelchair.⁴³³ During separation agreement negotiations, her husband alleged that she was incapable of making a care home admission decision and managing her financial affairs.⁴³⁴ An evaluator who found Koch incapable noted that her home was ““very cluttered, disorganized, [with] food in all rooms.””⁴³⁵ However, Quinn J. of the Ontario Court of Justice largely dismissed these observations: “Although I have great difficulty in elevating an untidy apartment to the point where it is an indicia of mental incapacity, in fairness, before so concluding, [the evaluator] should have given [Koch] an opportunity to explain the state of the premises. A perfectly logical explanation might have been forthcoming.”⁴³⁶ Quinn J. found that Koch had in fact given such an explanation when responding to her lawyer's questions during the capacity hearing:

Q. Now, we've heard some discussion about your apartment being cluttered.

A. It's worse than that.

Q. So, it was worse than that...

A. Well, you can't do much from a wheelchair, your legs don't walk. I wash my own dishes, do my laundry. I'm very embarrassed, okay?⁴³⁷

Quinn J. also took issue with the evaluator's reliance on the fact that during the capacity assessment, Koch pulled a bra out of a bag and needed help putting it on:

[The evaluator] never afforded the appellant the opportunity to explain the bra incident. The explanation might have been entirely logical. Perhaps the appellant, if she is physically unable to put on her bra, as appears to be the case, decided that morning to have her bra handy since she was expecting a female visitor whose

⁴³¹ *Ibid* at 6 [emphasis added].

⁴³² *Supra* note 10 at para 54. See also Jennifer L. Wright, “Guardianship for your own good: Improving the well-being of respondents and wards in the USA” (2010) 33 *Intl J L & Psychiatry* 350 at 360:

[T]he portrayal of the elder's capacity in the guardianship hearing is not necessarily either honest or accurate. Petitioners scrutinize every action and expression of the elder for possible signs of incapacity, and not surprisingly, find them. How many of our daily actions and statements could be presented, especially out of context, as signs of diminishing mental capacity?

⁴³³ *Koch, ibid* at para 1.

⁴³⁴ *Ibid*.

⁴³⁵ *Ibid* at para 39.

⁴³⁶ *Ibid*.

⁴³⁷ *Ibid*.

assistance she could enlist. This is but one of many examples of [the evaluator] injecting her own value judgments into the process; [the evaluator] does not carry her bra in a bag and so anyone who does must be mentally incapacitated.⁴³⁸

In finding Koch capable, Quinn J. reiterated that the Court did not care “a whit” about evaluators’ personal beliefs and values, which are “anathema” to the capacity assessment process.⁴³⁹

BS (Re) is another exception to the line of value-laden cases. In that case, an 85-year-old Italian immigrant with Alzheimer’s disease needed 24-hour care to remain at home.⁴⁴⁰ B.S. did not want to move into long-term care, but capacity evaluators found her incapable of making an admission decision.⁴⁴¹ When weighing the evidence, the CCB panel member proceeded cautiously:

In my consideration of the evidence in this hearing, I have had to be very careful with much of it.... Evidence of poor hygiene or excessive alcohol consumption or inadequate nutrition, for example, is only relevant insofar as it speaks to whether the applicant is capable of making admissions decisions. An applicant who is capable of making his/her own admissions decisions may remain in his/her own home, not cleaning adequately, eating poorly and drinking to excess.⁴⁴²

Nevertheless, the panel member found B.S. to be incapable.⁴⁴³

As I conclude this section, it is important to note that I am not arguing that loneliness itself is “self-neglect” or an independent “problem” that would trigger the protective jurisdiction on its own. I am proposing that loneliness is an internal constraint on a lonely person’s exercise of free choice in relation to a decision about objectively needed in-home services such as home care.

b. Dignity as the guiding principle

The principles of autonomy and protection are frequently invoked as competing interests. In relation to patients’ decision-making rights, the Supreme Court of Canada has consistently treated autonomy (i.e., the right to decide what happens to one’s body and life) as a fundamental interest that trumps all others.⁴⁴⁴ As a result, the right to medical self-determination is not vitiated by the

⁴³⁸ *Ibid* at para 41.

⁴³⁹ *Ibid* at paras 54 & 70.

⁴⁴⁰ *BS*, *supra* note 117 at 4-5.

⁴⁴¹ *Ibid* at 5.

⁴⁴² *Ibid* at 18. See also *Russell v Calgary General Hospital*, 2004 ABQB 102, 352 AR 168 (“The mere fact that a person conducts herself in a manner which is unhealthy or fails to accept treatment recommended by a physician, does not justify ... detention [under the *Mental Health Act*]” at para 49).

⁴⁴³ *BS*, *ibid* at 20.

⁴⁴⁴ See *Cuthbertson v Rasouli*, 2013 SCC 53, [2013] 3 SCR 341 at para 19 (withdrawal of life support requires patient consent in Ontario); *Carter v Canada (Attorney General)*, 2015 SCC 5, [2015] 1 SCR 331 at para 67 [*Carter*] (unconstitutionality of criminal prohibition on doctor-assisted dying). See also Timothy Caulfield,

seriousness of the risks or consequences that may flow from the patient's decision.⁴⁴⁵ Hence the courts have found that capable adults have the right to refuse life-saving treatment,⁴⁴⁶ and more recently, the right to doctor-assisted death if they have a grievous and irremediable medical condition that causes enduring suffering that is subjectively intolerable.⁴⁴⁷ While I do not intend to debate the controversial issue of doctor-assisted death, I will make one observation in relation to loneliness. A recent study from the Netherlands shows that nearly 50 percent of people whose request for assisted dying was approved identified loneliness as a reason for wanting to die.⁴⁴⁸ In response to these findings, bioethicists Barron Lerner and Arthur Caplan observe, "Loneliness, even if accompanied by other symptoms, hardly seems a condition best addressed by offering death."⁴⁴⁹ Yet loneliness is not mentioned by the *Carter* trial judge, Court of Appeal or Supreme Court of Canada.⁴⁵⁰ To be sure, the trial judge addresses depression and cognitive impairment (e.g., dementia, delirium, delusions), but she does so under the rubric of capacity.⁴⁵¹ If these conditions impair a person's ability to make authentic decisions, it may render them incapable.⁴⁵² However, as one of the plaintiff's expert witnesses testified, most people with depression will not be cognitively impaired to the point of being incompetent.⁴⁵³ Similarly, it is likely that most people suffering from loneliness will not be cognitively impaired to the point that they are incapable. Thus if the person is capable, internal vulnerabilities such as loneliness are irrelevant. The trial judge also addresses voluntariness, which could theoretically include an analysis of loneliness as an

"Revisiting Core Principles: Autonomy, Consent, and the Biobanking Challenge" in Jocelyn Downie & Elaine Gibson, eds, *Health Law at the Supreme Court of Canada* (Toronto: Irwin Law, 2007), 169 at 169 & 172. Putting aside the complexities of public health risks (e.g., communicable disease) and circumstances where there is no time to ascertain a patient's wishes (e.g., emergencies).

⁴⁴⁵ *Carter*, *ibid* at para 67; *Fleming v Reid* (1991), 82 DLR (4th) 298, 4 OR (3d) 74 (CA) at para 33 (cited to WL Canada) (doctor must respect preferences of two involuntary mental health patients with schizophrenia to not take anti-psychotic drugs) [*Fleming*].

⁴⁴⁶ *Malette v Shulman* (1990), 67 DLR (4th) 321, [1990] OJ No 450 (CA) (doctor liable for battery because he gave an unconscious Jehovah's Witness a blood transfusion despite her signed card stating she would not consent to a transfusion).

⁴⁴⁷ *Carter*, *supra* note 444 at para 127.

⁴⁴⁸ Marianne C. Snijdwind et al, "A Study of the First Year of the End-of-Life Clinic for Physician-Assisted Dying in the Netherlands" (10 August 2015) JAMA Intern Med doi:10.1001/jamainternmed.2015.3978 at Table 3. Among those whose request was denied, 71.5 percent identified loneliness as a reason for wanting to die.

⁴⁴⁹ Barron H. Lerner & Arthur L. Caplan, "Euthanasia in Belgium and the Netherlands: On a Slippery Slope?" (10 August 2015) JAMA Intern Med doi:10.1001/jamainternmed.2015.4086.

⁴⁵⁰ *Carter v Canada (Attorney General)*, 2012 BCSC 886, [2012] BCJ No 1196 [*Carter BCSC*], rev'd 2013 BCCA 435, 365 DLR (4th) 351, aff'd *Carter*, *supra* note 444 (the terms loneliness and lonely do not appear; isolated is mentioned but in another context, e.g., an isolated incident).

⁴⁵¹ *Carter BCSC*, *ibid* at paras 770-98.

⁴⁵² *Ibid* at para 789.

⁴⁵³ *Ibid* at para 787.

internal constraint that falls below the incapacity threshold, but the judge’s discussion is limited to “outside forces” that influence decision-making (e.g., coercion, undue influence).⁴⁵⁴ There is recognition that a capable person can act involuntarily due to external factors (and thus vitiate consent), but it appears that internal factors have to rise to the level of incapacity—an unlikely outcome in the case of loneliness. The combined effect of the trial judge’s analysis is the perpetuation of the artificial distinction between capable adults and internally vulnerable adults. Capable adults with internal vulnerabilities (e.g., loneliness) fall through the cracks. Similar to Maurice Kay LJ’s observation in *DL*, it would be most unfortunate if, by reference to their capacity, internally vulnerable adults were left to their own maladaptive devices. Yet given the premium our courts have placed on autonomy, this is precisely the situation in which lonely older men find themselves.

There are at least three approaches to remedying this lopsided problem. First, if we frame the challenge as a tension between two competing values, the straightforward solution is to place more emphasis on protection and less on autonomy. But simply pitting these interests against one another will inevitably result in outcomes that are either too libertarian or too paternalistic. This is the current situation, with autonomy trumping all other interests. An overly protectionist environment is also undesirable. Second, if we replace the liberal individualist actor with the vulnerable subject,⁴⁵⁵ the once competing interests of autonomy and protection are no longer oppositional. The apparent tension between the interests can be reconciled because truly fostering a symptomatic refuser’s individualistic autonomy requires that we first release him from decision-making constraints. Thus interventions that create room for unencumbered decision-making are justified on the grounds that they actually facilitate the person’s autonomy. This position has merit; however, I prefer a third approach that moves away from the autonomy/protection debate.

When a court is determining whether to exercise its protective jurisdiction, I propose that dignity serve as the guiding principle. While the concept has been defined in various ways, dignity essentially means that every human being has intrinsic value, merely by being human.⁴⁵⁶ The

⁴⁵⁴ *Ibid* at para 799.

⁴⁵⁵ See Martha Albertson Fineman, “The Vulnerable Subject: Anchoring Equality in the Human Condition” (2008) 20 *Yale JL & Feminism* 1 (vulnerability is inherent in the human condition); Martha Albertson Fineman, “The Vulnerable Subject and the Responsive State” (2010) 60 *Emory LJ* 251; Fineman, “Elderly”, *supra* note 155.

⁴⁵⁶ *Quebec (Public Curator) v Syndicat national des employés de l’hôpital St-Ferdinand*, [1996] 3 SCR 211, 1996 CanLII 172 at para 104; Christopher McCrudden, “Human Dignity and Judicial Interpretation of Human Rights” (2008) 19:4 *Euro J Intl L* 655 at 679. *Cf* Freedman, *supra* note 178 (dignity as the “flag for [elder law] supporters to rally around” at 9).

problem is that dignity has become strongly and solely associated with the concept of autonomy, and thus in opposition to protection. Outside of the equality rights context, the courts consistently put “autonomy and dignity” on one side, and “protection” on the other. In *Carter*, the Court states, “This is a question that asks us to balance competing values of great importance. On the one hand stands the autonomy and dignity of a competent adult who seeks death as a response to a grievous and irremediable medical condition. On the other stands the sanctity of life and the need to protect the vulnerable.”⁴⁵⁷ When autonomy and protection are in issue, courts invoke dignity to shield people against state intrusion, but dignity ought to be given equal consideration on the protection side of the equation. What is being protected may well be a lonely older man’s dignity. At a minimum, putting “protection and dignity” together allows us to explore this possibility.

c. Legislative gap: lonely older men with capacity

For the court to invoke its protective jurisdiction, there must be a legislative gap which results in lonely older men’s best interests not being met. In B.C., the adult guardianship and protection laws (collectively referred to as the “adult guardianship regime”) and the *Mental Health Act (MHA)*⁴⁵⁸ do not protect lonely older men who are symptomatically refusing home-based services; nor has the provincial government ousted the superior court’s protective jurisdiction over these vulnerable adults by clear and precise statutory language.

i. Adult guardianship/protection regime

The statutes governing the adult guardianship regime do not provide a mechanism to protect vulnerable adults who do not lack capacity but are refusing objectively needed home-based services; instead, the right to live at risk prevails. Critics may argue that the gap is intentional; that is, the legislature specifically designed the adult guardianship regime to ensure all capable adults can refuse support, assistance or protection. From this perspective, using the protective jurisdiction would be contrary to the legislative will. However, this argument becomes less convincing when the legal environment in which the legislation was designed is taken into account. When the B.C. legislature introduced reforms to the province’s adult guardianship regime in 1993,⁴⁵⁹ the existing

⁴⁵⁷ *Carter*, *supra* note 444 at para 2 [emphasis added].

⁴⁵⁸ BC *MHA*, *supra* note 175.

⁴⁵⁹ British Columbia, Legislative Assembly, *Official Report of Debates (Hansard)*, 35th Parl, 2nd Sess, Vol 11 No 7 (17 June 1993) at 7369 (Hon C Gabelmann) [Gabelmann, 17 June 1993].

substitute decision-making legislation was highly paternalistic and out of step with the functional approach to capacity. In particular, the *Patients Property Act* was criticised for perpetuating a global incapacity model, in which an adult either had capacity or not; the Act failed to recognize that an adult may be capable of making some decisions but not others.⁴⁶⁰ After extensive community consultation,⁴⁶¹ the legislature unanimously passed four pieces of legislation to modernise the adult guardianship system: the *Adult Guardianship Act (AGA)*,⁴⁶² the *Health Care (Consent) and Care Facility (Admission) Act (HCCCFA Act)*,⁴⁶³ the *Representation Agreement Act (RAA)*⁴⁶⁴ and the *Public Guardian and Trustee Act*.⁴⁶⁵ When introducing the reforms, the government implicitly referred to the problems with the all-or-nothing approach to incapacity, namely that adults subjected to, or at risk of becoming subjected to, the existing regime lost control over all personal and/or property decisions:

The existing legislative scheme can no longer respond to the needs and wishes of individuals directly affected by the legislation, their families and the professionals who provide support and services. Individuals who are directly affected by this package of legislation want the right to make their own decisions to the greatest extent possible, often relying on the support and assistance of family members and friends. These ... bills clearly establish an adult's right to make his or her own decisions....⁴⁶⁶

The new system was intended to “provide a balance between an adult’s right to make his or her own decisions and society’s obligation to protect individuals who are unable to make decisions because of diminished mental capacity.”⁴⁶⁷ The reforms would allow adults, who would otherwise be deemed incapable, to make as many of their own decisions as possible, and allow adults to arrange in advance who would make decisions on their behalf if they lost capacity in the future. In large part, the government was proposing the changes to better respect the decision-making rights of adults who fell or were at risk of falling within an archaic guardianship model; adults who

⁴⁶⁰ B.C. Law Institute, “A Comparative Analysis of Adult Guardianship Laws in BC, New Zealand and Ontario” BCLI Report No 46 (October 2006), online: <www.bcli.org> at 23; Heather Aase, *Women with Developmental Disabilities and Sexual Abuse: An Analysis of the (Draft) Practice Guidelines for Part 3 of the Adult Guardianship Act* (MSW Thesis, University of Northern British Columbia. 2003) [unpublished] at 37.

⁴⁶¹ British Columbia, Legislative Assembly, *Official Report of Debates (Hansard)*, 36th Parl, 3rd Sess, Vol 16 No 22 (12 July 1999) at 1500 (Hon U Dosanjh).

⁴⁶² *Supra* note 395.

⁴⁶³ *Supra* note 175.

⁴⁶⁴ *Supra* note 61.

⁴⁶⁵ *Supra* note 177.

⁴⁶⁶ Gabelmann, 17 June 1993, *supra* note 459 at 7369.

⁴⁶⁷ *Ibid.*

remained capable were already sheltered from the overly paternalistic regime. As such, the strong liberal-individualistic tone of the legislative debates and new guardianship system ought to be read in part as a response to the annihilation of “incapable” adult’s decision-making rights. The existing climate demanded a forceful remedy, and the legislature pushed the pendulum very far in favour of autonomy. It was an understandable action given the legal environment, but sadly, it has left us with a situation in which symptomatic refusers with “sub-incapacity” constraints such as loneliness are condemned to needless suffering.

To be sure, capable older adults were also beneficiaries of the reforms. Compared to younger adults, it is well-documented that society has traditionally been less tolerant of older adults’ “unwise” and “risky” decisions, especially if their choices are not in accordance with their doctor’s proposed course of action or adult children’s preferences.⁴⁶⁸ Take the case of *Bartoszek v Ontario (Consent and Capacity Board)*.⁴⁶⁹ Mrs. Bartoszek was a 76-year-old widow living alone in a rented apartment.⁴⁷⁰ She was less than five feet tall and therefore struggled to get into and out of her bed which was too high.⁴⁷¹ Given some of her physical difficulties, neighbours and family helped her out by taking her bill payments to the bank and delivering groceries.⁴⁷² One day she fell and injured her hip, although she was able to independently make her way to the hospital.⁴⁷³ While hospitalised, a social worker conducted a capacity assessment; during the assessment, Mrs. Bartoszek’s daughter was present and “had expressed the desire that her mother ought to be admitted into a care facility.”⁴⁷⁴ The social worker determined that Mrs. Bartoszek was incapable of making a care home admission decision, and as a result, she was institutionalised against her will.⁴⁷⁵ Mrs. Bartoszek’s daughter then terminated her mother’s rental agreement and told the care home that, if her mother left, she would not provide any support services.⁴⁷⁶ In agreeing with the social worker’s capacity assessment, the CCB panel member identified several risks if Mrs.

⁴⁶⁸ See Law Commission of England, “Mental Incapacity” Law Com No 231 (28 February 1995), online: <www.gov.uk> at 33; Wright, “Protecting”, *supra* note 35 at 71; Kenneth Sakauye, *Geriatric Psychiatry Basics* (New York: W.W. Norton & Company, 2008) at 60-61 (daughter sought guardianship over her 83-year-old mother because she was “horrified” by her mother’s intimate relationship with a man in his 70s).

⁴⁶⁹ [2002] OJ No 3800, 117 ACWS (3d) 155 at para 20 [*Bartoszek*].

⁴⁷⁰ *Ibid* at para 2.

⁴⁷¹ *Ibid* at para 8.

⁴⁷² *Ibid* at paras 2-3.

⁴⁷³ *Ibid* at para 4.

⁴⁷⁴ *Ibid* at para 6.

⁴⁷⁵ *Ibid* at para 5.

⁴⁷⁶ *Ibid* at para 7.

Bartoszek returned home, such as possibly having no apartment, potentially having no one around if she fell and being unable to escape if a fire started in another unit.⁴⁷⁷ On appeal, however, Harris J. of the Ontario Superior Court described these risks as a “litany of possible perils” that were “speculative” and “applied against ... the misty notion that there were insufficient community resources to tend to her reasonable specific needs.”⁴⁷⁸ In finding Mrs. Bartoszek capable, Harris J. reminded the respondents that:

[i]t is mental capacity, not wisdom, that is at issue here. The appellant, Mrs. Bartoszek carries with her, like all citizens, the right to be wrong.

...

Now that the appellant’s apartment is gone, she has lost her neighbourhood support system that was effective, given willingly, and integral to her independence and dignity. That turn of events however is not relevant to the requirement of [the capacity test].⁴⁷⁹

Harris J. ordered the respondents to assist Mrs. Bartoszek in obtaining an independent living unit, a hearing aid device, home care and a lower bed.⁴⁸⁰

Bartoszek raises legitimate concerns about capable older adults’ decisions not being respected, but it can be distinguished from vulnerable adult cases in which a court may be justified in exercising its protective jurisdiction. On the stated facts, *Bartoszek* did not involve an older adult whose decision-making abilities were compromised by constraint, undue influence or other disabling circumstance. Unlike a lonely older man stuck in the vicious cycle of loneliness, Mrs. Bartoszek appeared to be making an unencumbered decision to “live at risk.” Unconstrained by maladaptive social cognition, it was a voluntary assumption of risk.

Similarly, *Koch*⁴⁸¹ can be distinguished from vulnerable adult situations. Recall that *Koch* involved a woman with multiple sclerosis, and the impugned capacity evaluation inappropriately took into account her untidy home and the fact that she pulled a bra out of a bag. This case is frequently cited as a leading common law authority for the proposition that adults have the right to make “unwise” and “risky” decisions. In finding Koch capable, Quinn J. underscored the importance of personal autonomy:

The right to be foolish is an incident of living in a free and democratic society.

...

⁴⁷⁷ *Ibid* at para 22.

⁴⁷⁸ *Ibid*.

⁴⁷⁹ *Ibid* at paras 20 & 23.

⁴⁸⁰ *Ibid* at para 26.

⁴⁸¹ *Supra* note 10.

The right knowingly to be foolish is not unimportant; the right to voluntarily assume risks is to be respected. The State has no business meddling with either. The dignity of the individual is at stake.⁴⁸²

There was insufficient evidence that Koch was unable to understand and appreciate the risks and consequences of her decisions.⁴⁸³ She more closely resembled the “otherwise incapable” adults who were subjected to, or at risk of being subjected to, outdated decision-making regimes that historically usurped the rights of people with intellectual, mental and physical disabilities. Like the B.C. legislature’s law reform efforts in 1993, *Koch* placed a premium on autonomy to correct the historical mistreatment of people with disabilities. This again pushed the pendulum very far.

Koch and the B.C. legislative reforms can be viewed as a response to disability rights advocacy which urged stakeholders to allow people with disabilities to live with the “dignity of risk.” The “dignity of risk” concept was introduced in 1972 by Robert Perske in relation to people with intellectual disabilities.⁴⁸⁴ Perske argued that people with intellectual disabilities were being denied the ability to experience a reasonable and necessary amount of risk which was necessary for normal human growth and development.⁴⁸⁵ He gave three examples of normal human risk-taking that ought to be extended to people with intellectual disabilities: operating heavy machinery; engaging in romantic relationships; and instead of being housed in “super-safe” facilities, living in homes that were designed for “normal, happy human beings” and had “plenty of glass, many doors to the outside, and lots of brightly colored fixtures.”⁴⁸⁶

Since its emergence over 40 years ago, the “dignity of risk” philosophy has also been applied to people with mental and physical disabilities, as well as older adults, although in the elder advocacy context, it tends to be captured by slightly different wording (i.e., the right to live at risk). Legitimate concerns about overprotection drive the “dignity of risk” movement; however, it is problematic to simply apply the philosophy to capable older adults as a *carte blanche* justification for non-intervention. The concept makes sense in the context of remedying environments which are too paternalistic in that they prevent individuals from participating in and experiencing the real world. When a category of people have become so “smothered” with protection, it is appropriate to build in some reasonable and normal risk. For example, care home

⁴⁸² *Ibid* at paras 54 & 69.

⁴⁸³ *Ibid* at para 13.

⁴⁸⁴ Robert Perske, “The Dignity of Risk and the Mentally Retarded” (February 1972) 10:1 *Ment Retard* 24.

⁴⁸⁵ *Ibid*.

⁴⁸⁶ *Ibid*.

residents should be allowed to engage in intimate relationships and move around without wheelchairs. For overprotected groups, the “dignity of risk” concept is a sword which lets them experience normal risk-taking activities of everyday life; it serves to change the status quo. However, for lonely older men, the “right to live at risk” approach has morphed into a shield which obstructs attempts to intervene in his unwanted and involuntary status quo (recall that loneliness is not a choice). The non-interventionist result is troubling because research shows that people tend to go along with the current state of affairs and perceive any change as a loss, even if maintaining the status quo is an inferior choice.⁴⁸⁷

While status quo bias was initially a behavioural economics concept, it has subsequently been studied in other contexts, including healthcare decision-making.⁴⁸⁸ In the elder care context, the bias is arguably on display in Denmark’s preventive home visit program. Under that initiative, the country’s municipalities are required by law to offer two annual home visits to all people aged 75 and over.⁴⁸⁹ The program is often praised as an example of innovative elder care, but acceptance rates have been low. In a recent study, 75 percent of men and 63 percent of women did not take up the offer.⁴⁹⁰ Part of the problem may be attributed to poor invitation procedures such as generic letters with no proposed visit date.⁴⁹¹ But low participation rates may also be linked to the system’s opt-in design; that is, if an individual does not respond to the invitation (and maintains the status quo), they are treated as not wanting a visit. Reversing the default option (i.e., making a visit the pre-selected choice) may result in more individuals participating in the program; if they do not want a visit, they can always take an active step to decline the offer.

Combined with the maladaptive cognitive effects of loneliness, a lonely older man may be especially prone to preserving the status quo and thus more likely to refuse objectively needed services. His resistance may be further reinforced by his declining realm of independence and less help-seeking behaviour. Yet advocates hide his symptomatic refusals under the intellectual veneer of the “right to live at risk.”

⁴⁸⁷ See Samuelson & Zeckhauser, *supra* note 3.

⁴⁸⁸ See e.g. Gaurav Suri et al, “Patient Inertia and the Status Quo Bias: When an Inferior Option is Preferred” (2013) 24:9 *Psychological Science* 1763.

⁴⁸⁹ See generally Ekman, Vass & Avlund, *supra* note 2 (noting that the evidence on the beneficial effects of the visits is contradictory).

⁴⁹⁰ *Ibid* at 566.

⁴⁹¹ *Ibid* at 566-67.

In a similar vein, the statutory presumption of capacity serves to perpetuate the status quo.⁴⁹² I am not suggesting that the presumption should be reversed; it plays a vital role in ensuring that people are not considered incapable simply because they are old or have difficulty communicating decisions.⁴⁹³ The presumption makes sure that these adults are not stripped of their decision-making rights.⁴⁹⁴ But replacing the capacity/incapacity dichotomy with the concept of universal legal capacity exposes the arbitrary exclusion of symptomatic (yet capable) refusers from the law's protective safety net.

To be sure, the state cannot help everyone and must draw the line somewhere. The B.C. government has chosen to use "incapacity" as the qualifying criteria, although doctrines such as undue influence suggest that persons with capacity may not be operating as a free agent.⁴⁹⁵ The *Adult Guardianship Act* appears to implicitly acknowledge a range of "sub-incapacity" decision-making constraints, but it then relies upon the presumption of capacity to justify non-intervention in relation to vulnerable adults. Section 44 of the AGA states:

The purpose of [the support and assistance provisions] is to provide for support and assistance for adults who are abused or neglected [or self-neglected] and who are unable to seek support and assistance because of

- (a) physical restraint,
- (b) a physical handicap that limits their ability to seek help, or
- (c) an illness, disease, injury or other condition that affects their ability to make decisions about the abuse or neglect [or self-neglect].⁴⁹⁶

Yet if an abused, neglected or self-neglected adult refuses a support and assistance plan, it must not be provided unless there is a finding of incapacity.⁴⁹⁷ The Act states that a designated agency can only apply for a court order authorising the services if the adult appears to be incapable and a subsequent assessment arranged by the PGT determines that the adult is incapable.⁴⁹⁸ It is possible to read the AGA as allowing the court to order non-medical services without the court itself making

⁴⁹² See Keywood, *supra* note 359 at 108-10.

⁴⁹³ RAA, *supra* note 61, s 3(2); British Columbia, Legislative Assembly, *Official Report of Debates (Hansard)*, 35th Parl, 2nd Sess, Vol 11 No 24 (7 July 1993) at 8366-67 (V Anderson).

⁴⁹⁴ See British Columbia, Legislative Assembly, *Official Report of Debates (Hansard)*, 36th Parl, 3rd Sess, Vol 16 No 15 (29 June 1999) at 1415 (Hon P Priddy).

⁴⁹⁵ See e.g. *Quinlan v Caron*, 2011 ONSC 1391, 2011 CarswellOnt 1271 (*Vout v Hay*, [1995] SCJ No 58 "does not stand for the principle that once testamentary capacity has been proved, a person may not attack a will on the basis of undue influence" at para 8).

⁴⁹⁶ BC AGA, *supra* note 395, s 44. See also British Columbia, Legislative Assembly, *Official Report of Debates (Hansard)*, 35th Parl, 2nd Sess, Vol 11 No 24 (7 July 1993) at 8364 (Hon C Gabelmann).

⁴⁹⁷ BC AGA, *ibid*, ss 53(4)-(5) & 54(1).

⁴⁹⁸ *Ibid*, ss 53(5) & 54(1).

a finding of incapacity, although given the combined effect of the legislative intent and the current state of the common law, a court would likely find that incapacity is a prerequisite.

On hearing an application for the provision of a support and assistance plan, the Act states that a court must consider whether the adult is abused, neglected or self-neglected; is unable to seek support and assistance because of an illness, disease, injury or other condition that affects his ability to make decisions about the abuse, neglect or self-neglect; and needs and would benefit from the proposed services.⁴⁹⁹ This is the same language used to describe the purpose of the Act, and recall that incapacity is not integral to the statutory definitions of abuse, neglect and self-neglect (unlike jurisdictions such as Newfoundland and Labrador). When considering the criteria, the court must take into account the information contained in the incapacity assessment,⁵⁰⁰ but the Act does not explicitly state that the court must find the adult to be incapable.

To be sure, the *AGA* is clear that the support and assistance provisions do not override a capable adult's consent rights in s 4 of the *HCCCCFA Act*,⁵⁰¹ but that section applies to health care, which is defined as "anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other purpose related to health."⁵⁰² It is possible that an objectively needed home-based service does not fall squarely within that definition, and may be more appropriately categorised as psychosocial, personal or basic care, although the result would likely be the same.

In *Bentley v Maplewood Seniors Care Society*, Greyell J. of the B.C. Supreme Court "found that adults have a common law right to consent or refuse consent to personal care services."⁵⁰³ Greyell J. turned to the common law because he did not find any B.C. statute which established the legislative standard for informed consent to personal or basic care.⁵⁰⁴ In *Bentley*, an 83-year-old woman with advanced Alzheimer's disease lived in a care home, had very few physical movements and was unable to eat independently.⁵⁰⁵ Care home staff assisted "her with eating and drinking by placing a spoon or glass on her lower lip," and when she opened her mouth, they placed the nourishment or liquid in her mouth and she swallowed it.⁵⁰⁶ If she kept her mouth

⁴⁹⁹ *Ibid*, s 56(1).

⁵⁰⁰ *Ibid*, s 56(2).

⁵⁰¹ *Ibid*, s 45(2)(a), citing *HCCCCFA Act*, *supra* note 175, s 4.

⁵⁰² *HCCCCFA Act*, *ibid*, ss 1("health care") & 4.

⁵⁰³ 2014 BCSC 165, [2014] BCJ No 181 at para 121 [*Bentley*], *aff'd* 2015 BCCA 91, [2015] BCJ No 367 [*Bentley CA*] (appealed on the narrow issue of consent in relation to the common law tort of battery; appeal dismissed on the grounds that Greyell J. had found that Mrs. Bentley was consenting to the assisted eating and drinking).

⁵⁰⁴ *Bentley*, *ibid* at paras 46 & 77.

⁵⁰⁵ *Ibid* at paras 8 & 18-19; *Bentley CA*, *supra* note 503 at para 1.

⁵⁰⁶ *Bentley*, *ibid* at para 19.

closed, staff did not force her to eat or drink.⁵⁰⁷ While capable, Mrs. Bentley had signed a “statement of wishes” that she not be given nourishment or liquids if she became unable to take part in decisions and if there was no reasonable expectation of her recovery.⁵⁰⁸ Her family members sought a declaration to end the assisted eating and drinking.⁵⁰⁹ The first issue Greyell J. considered was whether Mrs. Bentley was currently capable of making the decision to accept nourishment and liquids with assistance.⁵¹⁰ Greyell J. found that the *Patients Property Act* did not apply to this task-specific question because the Court was not being asked to make a global finding of incapacity (i.e., whether Mrs. Bentley was “incapable of managing herself”).⁵¹¹ Greyell J. also declined to apply the *HCCCFA Act* because it governed health care, not personal or basic care.⁵¹² Greyell J. noted that the *RAA* defined “personal care” as matters respecting:

- (a) the shelter, employment, diet and dress of an adult,
- (b) participation by an adult in social, educational, vocational and other activities,
- (c) contact or association by an adult with other persons, and
- (d) licences permits, approvals or other authorizations of an adult to do something.⁵¹³

In the absence of legislation governing consent to personal or basic care, Greyell J. turned to the common law and found that it provided authority for the proposition that it is necessary to obtain a capable adult’s informed consent before providing personal or basic care.⁵¹⁴ He observed that, for the consent to be meaningful, the adult must be “capable of understanding the proposed care and free from undue influence or coercion.”⁵¹⁵ If we apply this analysis to the *AGA*, which does not explicitly state that the court must make an incapacity finding, it seems possible that the court could order the provision of services in relation to a capable adult on the basis of undue influence or coercion. Taken an incremental step further, the order could be made in relation to capable adults who are vulnerable due to internal “disabling circumstances” such as loneliness.

Nevertheless, the interpretation that a court may make a statutory support and assistance order without finding the person incapable would likely be deemed contrary to the legislative

⁵⁰⁷ *Ibid.*

⁵⁰⁸ *Ibid* at para 5.

⁵⁰⁹ *Ibid* at para 1.

⁵¹⁰ *Ibid* at para 3.

⁵¹¹ *Ibid* at para 44.

⁵¹² *Ibid* at para 46.

⁵¹³ *Supra* note 61, s 1 (“personal care”).

⁵¹⁴ *Bentley*, *supra* note 503 at para 46.

⁵¹⁵ *Ibid* at para 47 [emphasis added].

will.⁵¹⁶ The *AGA*'s first guiding principle states that "all adults are entitled to live in the manner they wish and to accept or refuse support, assistance or protection as long as they do not harm others and they are capable of making decisions about those matters."⁵¹⁷ This guiding principle is considerably more "autonomy-preserving" than jurisdictions which also include harm to self. For instance, Saskatchewan's *Adult Guardianship and Co-decision-making Act* states, in part, that adults can refuse support, assistance or protection "as long as they do not harm themselves or others."⁵¹⁸ Similar language appears in Newfoundland and Labrador's *Adult Protection Act*: "an adult is entitled to live in the manner he or she wishes as long as that adult ... does not harm himself, herself or others."⁵¹⁹ As a result, upon hearing an application under the *AGA*, there is a strong likelihood that a court would only order the provision of services if the court found the adult to be incapable.

With no *AGA* remedy available, there is no statutory protection for capable older men whose decision-making is compromised by loneliness. In appropriate cases, the superior court's protective jurisdiction ought to fill this legislative gap. Notably, both the *AGA* and *HCCCFA Act* explicitly preserve a superior court's *parens patriae* jurisdiction. Section 62.2(1) of the *AGA* states:

Nothing in this Act

- (a) limits the inherent jurisdiction of the court to act in a *parens patriae* capacity, or
- (b) deprives a person of the right to ask the court to exercise that jurisdiction.⁵²⁰

The *HCCCFA Act* contains substantially similar wording.⁵²¹ There is legitimacy to the argument that the legislature did not anticipate that the *parens patriae* jurisdiction might evolve to include vulnerable adults who do not lack capacity. That said, I prefer the comments by Lord Griffiths in *F*. As discussed above, he urged his fellow judges to develop the common law in accordance with the public interest, and if it was met with public disapproval, the government could always change it.⁵²² If the superior courts exercise their protective jurisdiction over lonely older men who are

⁵¹⁶ See e.g. British Columbia, Legislative Assembly, *Official Report of Debates (Hansard)*, 35th Parl, 2nd Sess, Vol 11 No 24 (7 July 1993) (Hon C Gabelmann) ("should the adult refuse such assistance, there is provision for the [designated agency] to seek a court order to require the incapable adult to avail himself or herself of services that have been designed to resolve the abuse or neglectful situation" at 8364 [emphasis added]).

⁵¹⁷ *BC AGA*, *supra* note 395, s 2(a).

⁵¹⁸ *Supra* note 61, s 3(c).

⁵¹⁹ *Supra* note 405, s 8(1)(ii).

⁵²⁰ *Supra* note 395, s 62.2(1).

⁵²¹ *Supra* note 175, s 33.4 (4).

⁵²² Compare *Winnipeg Child and Family Services (Northwest Area) v D.F.G.*, [1997] 3 SCR 925, [1997] SCJ No 96: The *parens patriae* jurisdiction has never been used to permit a court to make such decisions for competent women, whether pregnant or not. Such a change would not be an incremental change [in

refusing objectively needed services, it is open to the legislature to explicitly remove the court's ability to do so with clear and precise statutory language.

ii. Mental health legislation

It is arguable, but problematic, that the *Mental Health Act* could potentially be applied to capable lonely older men who are refusing objectively needed home-based services, leading to the conclusion that the legislature has occupied the field and thus ousted the court's protective jurisdiction. While loneliness is not a mental illness,⁵²³ the *MHA* applies more broadly to a "person with a mental disorder," which the Act defines as "a person who has a disorder of the mind that requires treatment and seriously impairs the person's ability (a) to react appropriately to the person's environment, or (b) to associate with others."⁵²⁴ Applying a broad and liberal interpretation, it is possible that the maladaptive social cognitions associated with loneliness may be a "disorder of the mind." If so, the authorities could certify a capable lonely older man as an involuntary patient under the *MHA* and force psychiatric treatment. Under the psychiatric facility leave provisions, the treatment could occur in the community (including in a care home).⁵²⁵

Under B.C.'s mental health legislation, there is no requirement that the authorities find the person to be incapable of consenting to treatment.⁵²⁶ The requirement for treatment is integral to the statutory definition of "person with a mental disorder;" the person's capacity to consent to treatment is irrelevant. The *MHA* explicitly states that treatment is deemed to be given with an involuntary patient's consent,⁵²⁷ and the *HCCCCFA Act* further clarifies that its health care consent provisions do not apply to the psychiatric treatment of involuntary patients.⁵²⁸ Controversially, the

line with authority], but a generic change of major impact and consequence.... If anything is to be done, the legislature is in a much better position to weigh the competing interests and arrive at a solution that is principled and minimally intrusive to pregnant women (at para 56).

⁵²³ Cacioppo & Patrick, *supra* note 80 at 230; Ron L. Evans & C. Mary Dingus, "Serving the Vulnerable: Models for Treatment of Loneliness" in Hojat & Crandall, *supra* note 75, 249 at 249. Compare White, *supra* note 18 (author says that adding loneliness to the *Diagnostic and Statistical Manual of Mental Disorders* "would be an important first step in seeing the state as a legitimate, recognizable affliction" at 306).

⁵²⁴ BC *MHA*, *supra* note 175, s 1("person with a mental disorder").

⁵²⁵ *Ibid*, ss 31(1) & 37.

⁵²⁶ But see *Interpretation Act*, RSBC 1996, c 238, s 29 ("'mentally disordered person', 'mentally incompetent person', 'mentally ill person', or 'person with a mental disorder' means a person with a mental disorder as defined in section 1 of the *Mental Health Act*" [emphasis added]). Compare *The Mental Health Services Act*, SS 1984-85-86, c M-13.1 (criteria for involuntary commitment includes a finding that the patient is incapable of making treatment decisions, at s 24(2)(a)(ii)); *Saskatoon Regional Health Authority v A. B.*, 2005 SKQB 153, [2005] SJ No 187 at para 27.

⁵²⁷ BC *MHA*, *supra* note 175, s 31(1).

⁵²⁸ *Supra* note 175, ss 2(a)-(d).

involuntary treatment provisions were upheld in 1993 as constitutionally valid,⁵²⁹ although it remains to be seen whether a court would reach a similar finding today, especially in light of the Supreme Court of Canada’s decision in *Starson v Swayze*.⁵³⁰ In that case, Major J., writing for the majority, stated that “[t]he right to refuse unwanted medical treatment is fundamental to a person’s dignity and autonomy,” and that “[t]his right is equally important in the context of treatment for mental illness.”⁵³¹ However, *Starson* arises out of Ontario, where involuntary patients retain the right to refuse treatment, unless they are found incapable under the *Health Care Consent Act*’s general consent provisions.⁵³² That proposition was confirmed by the Ontario Court of Appeal in *Fleming v Reid*, in which it was held that the determination of involuntary status “is independent of any assessment of a patient’s mental competency [to refuse psychiatric treatment].”⁵³³ The Court confirmed that capable involuntary patients in Ontario have a constitutionally protected right to refuse psychiatric treatment.⁵³⁴

Even if we classify a lonely older man as “a person with a mental disorder,” the *MHA* would have limited application in resolving the intervention dilemma because the Act applies to the provision of psychiatric treatment,⁵³⁵ which likely includes the delivery of cognitive behavioural therapy but not the social or personal care services the person is resisting.⁵³⁶ Further, using the archaic and potentially unconstitutional *MHA* to compel a capable lonely older man to receive home-based services would be highly controversial and, as we have seen in relation to care home admissions, subject to abuse. It is not uncommon for health authorities to use the *MHA* to place an older adult in a care home when he or she is refusing to consent,⁵³⁷ and to also forcibly medicate them against their will.⁵³⁸ In 2012, the B.C. Ombudsperson reported that at least 100

⁵²⁹ *McCorkell v Riverview Hospital* (1993), 104 DLR (4th) 391, 81 BCLR (2d) 273 (SC) (WL Canada) (“The purpose of the Act is manifestly plain: the treatment of the mentally disordered who need protection and care in a provincial psychiatric hospital” at para 99 [emphasis added]).

⁵³⁰ 2003 SCC 32, [2003] 1 SCR 722 [*Starson*].

⁵³¹ *Ibid* at 759.

⁵³² ON *HCCA*, *supra* note 410, s 4(1).

⁵³³ *Fleming*, *supra* note 445 at para 8.

⁵³⁴ *Ibid* at paras 8, 33 & 35.

⁵³⁵ BC *MHA*, *supra* note 175, s 1 (“treatment”).

⁵³⁶ Compare Louise Holland, *Abandonment or Autonomy: How Do Social Workers Know the Difference?* (MSW Thesis, The University of Northern British Columbia, 2010) [unpublished] at 87-88 (anecdotal evidence that B.C. health authorities have used the *MHA* to force older adults living at home to receive services); *Jewish General Hospital c S.U.*, 2015 QCCS 4351 at 28 (authorizing at-home care for outpatient diagnosed with schizophrenia).

⁵³⁷ See e.g. Holland, *ibid* at 46, 80 & 117.

⁵³⁸ British Columbia, Legislative Assembly, *Official Report of Debates (Hansard)*, 39th Parl, 4th Sess, Vol 38 No 2 (14 May 2012) at 1440 (B Simpson).

older adults living in residential care were involuntary patients detained under the *MHA*.⁵³⁹ The practice of using the *MHA* as a backdoor admissions mechanism is troubling because involuntary detention carries serious implications for older adults. For instance, involuntary patients in residential care can be given anti-psychotic medications without consent, even outside of emergency situations. The *MHA* was not enacted for that express purpose.⁵⁴⁰ Indeed, the government has acknowledged this inappropriate use and may be developing a clear policy on the matter.⁵⁴¹

d. The orders

When a superior court invokes its protective jurisdiction over a lonely older man, it has the potential to make flexible, responsive remedies. For example, it could simultaneously authorise the provision of home support services such as meals on wheels, and cognitive behavioural therapy to address the underlying maladaptive social cognition which may be contributing to the refusal. Over time, the therapy may help lift the lonely older man out of the behavioural confirmation loop of loneliness, thus removing at least one decision-making constraint on his willingness to accept the objectively needed in-home services. Therefore, like the orders made under s 54 of the *Adult Guardianship Act*, the protective jurisdiction orders should terminate one year after they are made or on an earlier date specified by the court.⁵⁴² They could also be changed, canceled or renewed to reflect the changing or ongoing needs of the lonely older man.

e. Most effective, less intrusive measures

While the protective jurisdiction allows for flexible orders, the courts must choose the most effective, less intrusive measures. This aspect of the proposed framework warrants discussion because case law reveals that this principle is not consistently applied in analogous situations in which older adults refuse home-based services. In particular, a line of Ontario cases demonstrate that refusers are often deemed incapable of making a care home admission decision, which means

⁵³⁹ B.C. Ombudsperson, Public Report No 47, “The Best of Care: Getting it Right for Seniors in British Columbia (Part 2)” vol 2 (February 2012), online: <<https://www.bcombudsperson.ca>> at 265.

⁵⁴⁰ *Ibid* at 270.

⁵⁴¹ B.C. Ombudsperson, “Update on Status of Recommendations: Public Report No 47, The Best of Care: Getting it Right for Seniors in British Columbia (Part 2)” (June 2015), online: <<https://www.bcombudsperson.ca>> at 31.

⁵⁴² BC AGA, *supra* note 395, s 56(7).

they can be institutionalised against their will. The less intrusive option of providing the home-based services to the non-consenting adult is missed.

For jurisdictional consistency, I would have ideally analysed B.C. case law, specifically in relation to applications under s 54(1) of the *Adult Guardianship Act* for an order authorising the provision of services for adults aged 65 and over who had refused a statutory support and assistance plan and were assessed as incapable of making that decision. However, there is a dearth of applications. Searching legal databases (for all adult ages) returned only one result, and in any event, the authorities in that case did not pursue an application under s 54(1).⁵⁴³ I also confirmed this lack of case law through information requests I made to the local health authorities, in which I asked for data from 2013 and 2014. In response, three of the five authorities stated that they had made no s 54(1) applications in relation to adults aged 65 and over who had refused a support and assistance plan and were assessed as incapable of making that decision.⁵⁴⁴ Among the remaining two authorities, one stated that it did not record the information as requested,⁵⁴⁵ and the other did not respond to my questions. B.C. also lacks a statutory care home admissions process for “incapable” adults who do not have a substitute decision-maker already in place,⁵⁴⁶ so unlike Ontario, there is not a clear group of cases on this discrete matter.

I will now turn to the Ontario cases. *J.W. (Re)* involved an 88-year-old divorced man with a history of medical problems.⁵⁴⁷ He lived alone, and his children reported that he was losing weight, eating poorly and “the only foods on hand were cookies and some canned foods.”⁵⁴⁸ They also discovered that his fridge had stopped working.⁵⁴⁹ While in hospital after a medical emergency, J.W. saved all of his menus which included instructions on his nutritional needs; he said that once he was home, he would use the menus and buy the necessary groceries to make a meal.⁵⁵⁰ His doctor had concerns about this occurring, as J.W. had not previously done his own shopping and he required assistance with activities of daily living.⁵⁵¹ His daughter testified that he did not cook, was difficult to access because he did not like to wear his hearing aid and thus did

⁵⁴³ *Bentley*, *supra* note 503 at paras 32 & 137.

⁵⁴⁴ Email from Vancouver Coastal Health Authority to author (10 September 2015); letter from Fraser Health Authority to author (10 September 2015); email from Island Health to author (8 September 2015).

⁵⁴⁵ Letter from Northern Health to author (15 September 2015).

⁵⁴⁶ Part 3 of the *HCCCF Act*, *supra* note 175 creates a process, but the provisions are unproclaimed.

⁵⁴⁷ 2005 CanLII 57810 (ON CCB) at 3.

⁵⁴⁸ *Ibid* at 4.

⁵⁴⁹ *Ibid*.

⁵⁵⁰ *Ibid* at 6.

⁵⁵¹ *Ibid* at 6-7.

not hear the phone, and that he got agitated and angry when she attempted to explain to him that he was getting more forgetful.⁵⁵² J.W. expressed frustration with his doctor; he was clearly annoyed that his doctor had written to the Ministry of Transportation regarding concerns about him continuing to drive.⁵⁵³ J.W. refused to consider suggestions for home support, including meals on wheels and cleaning, cooking and laundry services.⁵⁵⁴ He told his family that under no circumstances would he allow any outside helpers into his home, and called the suggestion of a home care nurse “ridiculous” and “completely unnecessary.”⁵⁵⁵ He also refused to discuss long-term care options, and said going into a nursing home was “almost like solitary confinement,” and that he would lose his independence and not be able to do the things he enjoyed such as playing golf, driving and swimming at his cottage.⁵⁵⁶ In finding J.W. incapable of making a care home admission decision, the CCB panel member stated:

There is little doubt that throughout his life Mr. W. has been a very talented man, including in his professional life. However, he now faces some challenges regarding his activities of daily living and medical care that he is unable to appreciate or acknowledge.... He is unable to appreciate the benefits of any alternative courses of action, including assistance through the provision of home care services. This is not as a result of any failure on the part of the medical team to adequately inform Mr. W. of the options proposed, and the risks, benefits and consequences of any decision in this regard. Rather, it is directly related to limitations associated with Mr. W.’s mental capabilities.⁵⁵⁷

Yet he was not compelled to receive home-based supports; instead, the decision allowed a third party to force him into long-term care against his will. Such an outcome is hardly less intrusive. Using the superior courts’ protective jurisdiction has the potential to result in less intrusive intervention than currently happens.

Further, recall the case of *M.G.*⁵⁵⁸ *M.G.* was the 77-year-old woman who brought the garbage bag with her to the capacity hearing. She would initially accept and then cancel community care support. In finding her incapable of making a care home admission decision, the panel member noted that community resources had been made available to her on multiple occasions, but that she had shown “a pattern of rejecting the assistance which [was] consistently offered to

⁵⁵² *Ibid* at 7.

⁵⁵³ *Ibid* at 8.

⁵⁵⁴ *Ibid* at 5.

⁵⁵⁵ *Ibid* at 5 & 8.

⁵⁵⁶ *Ibid*.

⁵⁵⁷ *Ibid* at 13 [emphasis added].

⁵⁵⁸ *Supra* note 408.

her.”⁵⁵⁹ Yet she was not compelled to receive the community supports; instead, the decision allowed her to be institutionalised against her will.

A string of other cases reflect a similar pattern. In *R.L. (Re)*, an 80-year-old woman who lived alone “was not permitting any assistance whatsoever except for some once weekly help from a neighbor;” she was found incapable of making a care home admission decision.⁵⁶⁰ The same result occurred in *NK (Re)*, which involved a 79-year-old woman who lived living alone “in a state of squalor” and refused to let care providers change her soiled undergarments.⁵⁶¹ It is arguable that institutionalising her against her will may not resolve her unwillingness to let others change her undergarments.⁵⁶² It may be more convenient for care providers, but convenience should never be a justification for trampling someone’s decision-making rights over their own body.⁵⁶³ Further, in *Z (Re)*, an 86-year-old widow who lived alone was found incapable; she refused meals on meals and would not use a pill organizer or wear a Lifeline bracelet which would quickly summon help if she fell.⁵⁶⁴ The panel member noted:

She needed to be monitored and she had no realistic plan for that to happen. There were steps that a capable person who appreciated the risks could have taken. She could have applied for more in-home nursing care, she could have had all of her meals prepared and delivered, she could have worn a bracelet that would summon help immediately if she fell, she could have used a pill organizer.⁵⁶⁵

These cases can be contrasted with *RH (Re)*.⁵⁶⁶ In that case, a 68-year-old divorced man who lived alone was found incapable, but he was already receiving the maximum available home and community supports, including meals on wheels and help with cleaning and bathing.⁵⁶⁷

In fairness to the panel members, it is important to point out that their hands were tied. They were tasked with determining whether the adults were incapable of making a care home admission decision, not whether they were incapable of refusing in-home services. While the CCB has jurisdiction over “personal assistance services,” these services are limited to those which are provided in long-term care settings, not an adult’s own home.⁵⁶⁸ Nevertheless, there are a few cases

⁵⁵⁹ *Ibid* at 8.

⁵⁶⁰ 2004 CanLII 57258 (ON CCB) at 3 & 9.

⁵⁶¹ 2014 CanLII 51744 (ON CCB) at 2 & 8.

⁵⁶² *Ibid* at 12.

⁵⁶³ See e.g., *F*, *supra* note 204 at 571 (per Lord Jauncey).

⁵⁶⁴ 2008 CanLII 49567 (ON CCB) at 3 & 5-6.

⁵⁶⁵ *Ibid* at 6.

⁵⁶⁶ 2014 CanLII 49869 (ON CCB).

⁵⁶⁷ *Ibid* at 4 & 8.

⁵⁶⁸ ON *HCCA*, *supra* note 410, ss 2(1)(“recipient”) & 57.

in which the panel member explicitly acknowledges options less intrusive than involuntary institutionalisation. For instance, recall the case of *BS*, which involved an 85-year-old Italian woman who needed 24-hour care to remain at home.⁵⁶⁹ The panel member found the woman incapable, but encouraged her children to explore alternatives short of involuntary placement: “As a matter purely of *obiter*..., I would encourage B.S.’s offspring to consider exploring all available means of maintaining her in her own home with live-in care (including some novel financial instruments designed expressly to assist elderly homeowners with no income).”⁵⁷⁰ A panel member made a similar observation in *W.Mc. (Re)*.⁵⁷¹ In that case, the authorities believed that an incapable 83-year-old man (*W.Mc.*) with several health conditions should be in long-term care, not his own home; however, his substitute decision-maker would not consent to placement.⁵⁷² *W.Mc.* was “very resistant to care,” although he received assistance with activities such as bathing, dressing and foot care.⁵⁷³ Care workers reported concerns such as “lack of food, client naked on couch, soiled incontinent product and clothes, dried blood and feces in bath tub, dog feces throughout the house and bruising on *W.Mc.*’s face.”⁵⁷⁴ The panel member noted that if he was institutionalised, he would be unable to do many of the things he enjoyed such as looking at the lake and watching television all through the night.⁵⁷⁵ While there were some benefits of being in a care home (e.g., efficient medication administration), the panel member concluded that admission would not improve his quality of life; in fact, it may well have had the opposite effect in that he could have become depressed and/or aggressive when dealing with the changes.⁵⁷⁶ Keeping him at home with 24-hour professional care was “clearly” a course of action which was available, appropriate and less restrictive, although the panel member acknowledged that she had no mechanism to enforce this outcome.⁵⁷⁷

⁵⁶⁹ *Supra* note 117.

⁵⁷⁰ *Ibid* at 9.

⁵⁷¹ 2007 CanLII 22329 (ON CCB).

⁵⁷² *Ibid* at 4 & 5.

⁵⁷³ *Ibid* at 6-7.

⁵⁷⁴ *Ibid* at 6.

⁵⁷⁵ *Ibid* at 22.

⁵⁷⁶ *Ibid* at 22-23.

⁵⁷⁷ *Ibid* at 24.

2. Practical challenges

Effectively invoking the superior courts' protective jurisdiction has potential practical challenges. I will address three of the most pressing difficulties.

a. Limited resources

The first challenge is one of limited resources, especially in relation to home care and mental health services such as CBT. Court orders are only as effective as the services under it, so authorizing care, support and therapies for refusers may overwhelm an already overburdened system. Going to court can also be cumbersome.⁵⁷⁸ Resource scarcity may be most acute in rural and remote areas, although creative delivery mechanisms such as telepsychiatry have the potential to open up geographic boundaries at least in relation to mental health services.⁵⁷⁹ There is also promising evidence of some increased interest in older adults' mental health,⁵⁸⁰ which are challenging the outdated belief that conditions such as depression and loneliness are inevitable parts of aging. Further, the shortage of services may be overstated. For example, in *D.R. (re)*, a doctor found that a 61-year-old involuntary patient was incapable of making a care home admission decision.⁵⁸¹ The witness testified that care home placement was appropriate for D.R. because, *inter alia*, "she needed help with some activities of daily living such as shopping, meal preparation and cooking, and that assistance could not be sufficiently provided by publicly funded community-based services, or by her family."⁵⁸² The witness said that apart from care home admission, the authorities could provide a social worker and limited nursing services about once or twice a week, but not daily or twice daily as D.R. required.⁵⁸³ However, when pressed further, the witness testified that it was possible that a publicly-funded nurse could come in to monitor her medications twice daily,

⁵⁷⁸ *A.M.S., Re*, 1993 CanLII 8329 (NL SCTD) ("there may be merit in devising a scheme, with built in safeguards, for the provision of consents to medical treatment for mentally incompetent persons even where no advance directive exists, so as to avoid the cumbersome application in every case to court for exercise of the *parens patriae* jurisdiction" at para 40 in *obiter*).

⁵⁷⁹ See e.g. O'Leary, *supra* note 199 at 98; Gretchen A. Brenes et al, "Telephone-Delivered Cognitive Behavioral Therapy and Telephone-Delivered Nondirective Supportive Therapy for Rural Older Adults With Generalized Anxiety Disorder: A Randomized Clinical Trial" (August 2015) *JAMA Psychiatry* doi:10.1001/jamapsychiatry.2015.1154.

⁵⁸⁰ Laidlaw & Thompson, *supra* note 148 at 93; Mary Beth M. Cresci, "Challenges of aging: The impact of loneliness" in Brent Willock, Lori C. Bohm & Rebecca Coleman Curtis, eds, *Loneliness and Longing: Conscious and Unconscious Aspects* (New York: Routledge, 2012), 135 at 135.

⁵⁸¹ 2005 CanLII 57904 (ON CCB) at 1.

⁵⁸² *Ibid* at 13.

⁵⁸³ *Ibid*.

and that the Canadian Mental Health Association could possibly get involved by having psychiatric nurses visit once or twice a week.⁵⁸⁴

b. Enforceability

The second challenge relates to enforceability. Even if the services are available, a lonely older man may still be unwilling to receive the home support or participate in CBT. Unlike an involuntary patient under a community treatment order, the lonely older man is not faced with the prospect of being returned to the psychiatric ward if he does not comply with the provision of services, and unlike incapable adults, he does not face the threat of being placed in a care home. Without “consequences,” it may be difficult to make him comply. He may simply refuse to open his door. Breaking it down to deliver his meals on wheels is overly drastic. So is finding him in contempt of court. This practical dilemma is a legitimate concern, because if it cannot be resolved, situations may either escalate or fizzle out to the point that service providers eventually give-up. It also ties back to the limited resources challenge. Gaining a lonely older man’s trust and cooperation may be particularly difficult if the same workers are not always be available. This problem was evident in *HH (Re)*, where an 88-year-old woman was only comfortable with certain nurses and would refuse to let others into her house.⁵⁸⁵

c. Service provider safety

The third challenge relates to service provider safety. A symptomatic refuser’s reaction to court ordered services could be extreme, including physical aggression. In *L.M. (Re)*, the authorities wanted to keep a 79-year-old woman with chronic paranoid schizophrenia, Parkinson’s disease and hypertension as an involuntary patient in part because home care was no longer suitable.⁵⁸⁶ She was often non-compliant with her medication, and had been found “malnourished, naked and psychotic.”⁵⁸⁷ The nurse involved with supervising her home care testified that the woman’s home was unsafe for service providers: she had pushed a worker, was verbally abusive and the nurse had exhausted four agencies in search for a home care worker because none of those who had initially

⁵⁸⁴ *Ibid.*

⁵⁸⁵ 2013 CanLII 54408 (ON CCB).

⁵⁸⁶ 2005 CanLII 57705 (ON CCB) at 4 [*L.M.*].

⁵⁸⁷ *Ibid.*

taken the assignment would return.⁵⁸⁸ In maintaining her involuntary status, the panel member noted that no home care services would be available because she had exhausted those community resources, and therefore, she would be in great danger.⁵⁸⁹ Similarly, *LD (Re)* involved a 66-year-old man who lived alone and was initially assessed as being incapable of making a care home admission decision.⁵⁹⁰ While the panel member ultimately disagreed with this finding, the assessor noted that LD had a history of conflict with and resistance to personal support workers, especially in relation to his inability or refusal to refrain from smoking when they visited, and this resulted in a care provider organization saying that it would reduce and withdraw services.⁵⁹¹

⁵⁸⁸ *Ibid* at 6. See also *E.G. (Re)*, 2007 CanLII 46902 (ON CCB) (home care client would get angry and uncooperative when attempts were made to help her).

⁵⁸⁹ *L.M.*, *ibid* at 11.

⁵⁹⁰ 2013 CanLII 48970 (ON CCB) at 3.

⁵⁹¹ *Ibid* at 5 & 15.

CONCLUSION

In this thesis, I proposed an intervention approach to loneliness which overcomes the legal fiction of capacity, and responds to the paradoxically self-defeating behaviour associated with the emotional condition. In particular, I argued that a superior court's protective jurisdiction may be invoked to help lonely older men age-in-place by ordering objectively needed in-home services. Using the law to respond to loneliness may seem heavy-handed, but other intervention approaches assume a consenting participant. Even the most effective cognitive behavioural-based strategies proceed on this assumption. Legal interventions are not inherently oppressive; the law can be applied in therapeutic ways which improve people's well-being. However, current legal approaches to symptomatic refusals do not realise this potential. Instead, lonely older men are either categorised as incapable—an outcome which can lead to unnecessary institutionalisation, or abandoned in the name of the “right to live at risk.” From active aging and libertarian perspectives, their refusals are celebrated as an exercise of free choice. But this reduces lonely older men to pawns, unwittingly serving someone else's agenda and thus suffering needlessly. In contrast to this approach, invoking a superior court's protective jurisdiction extends a supportive hand to those stuck in the vicious cycle of loneliness. In my view, this is the preferred way forward.

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