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MEMORANDUM
PRIVATE & CONFIDENTIAL

To: Chris Beesley - Community Living Ontario
Cc: Ursula Redner – Co-chair of Sector Pandemic Planning Initiative
From: Brendon Pooran, Cheryl Wiles Pooran & Madison Pearlman
Re: COVID-19 Vaccination Policies Applicable to People Supported by Agencies in the Developmental Services Sector
Date: January 25, 2021

OVERVIEW

On behalf of the Sector Pandemic Planning Initiative ("SPPI"), Community Living Ontario ("CLO") has asked us to provide an opinion with respect to developing COVID-19 vaccination policies for people supported (referred to as "people supported", "people" and "person") by agencies in the Developmental Services ("DS") sector. Specifically, this memorandum provides a legal analysis with respect to the following issues:

1. What are the legal considerations related to agencies supporting people in the vaccination process by providing information and obtaining consent to vaccination?

   and

2. Can agencies require that a person be vaccinated as a condition of:

   a. Entering into a new support relationship with the agency;

   b. Continuing an existing support relationship; or

   c. Visiting people supported at an agency's residential support locations?

In answering the foregoing questions, we have considered publicly available case law, secondary resources, current legislation and regulations, policy directives, ministerial and public health guidelines and recommendations. We note that the case law, legislation, regulations, ministerial policy and public health guidelines are constantly evolving, as is scientific knowledge related to the COVID-19 virus and vaccination for same.

This analysis is based on the law as it relates to services and support settings that are typical of "service agencies" as defined under the *Supports and Services for the Social Inclusion of Persons with Developmental Disabilities Act*[1] ("SIPDDA") and may not be applicable to other types of supports or

[1] *Social Inclusion of Persons with Developmental Disabilities Act* 2008 SO 2008, c. 14.

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PART 1: SHORT CONCLUSIONS

A. What are the legal considerations related to agencies supporting people in the vaccination process by providing information and obtaining consent to vaccination?

A health care practitioner administering vaccines to people supported is responsible for assessing capacity and confirming that consent has been obtained in compliance with the *Health Care Consent Act*[2] ("HCCA"). Agency personnel should not be assessing capacity or consenting on behalf of people supported, however, they may play a valuable role in supporting people to understand and appreciate the decision they will be called upon to make in relation to a COVID-19 vaccine. Where the health care practitioner administering a vaccination finds that a person lacks capacity to consent, the agency can also play an important role in facilitating communications between the health care practitioner and the person's Substitute Decision Maker ("SDM") or the Office of the Public Guardian and Trustee (the "PGT").

Agencies should refrain from any actions which could make the consent involuntary (i.e. imposing policies that may leave the person with no choice but to consent) or uninformed (i.e. by persuading a person to consent by providing false, misleading, or incomplete information). Such actions could result in liability for an agency, particularly if a person has an adverse reaction.

B. Can any agency require that people be vaccinated as a condition of:

1. Entering into a new service relationship with the agency?

Yes, an agency can likely require vaccination as a condition of entering into a new service relationship for direct in-person supports. However, any such conditions should be subject to accommodations to the point of undue hardship for people unable to vaccinate for human rights-related reasons. Furthermore, we recommend that vaccination protocols include a case-by-case assessment for considering new service relationships involving people who decline vaccination for reasons that may not technically be protected by human rights law.

2. Continuing an existing service relationship?

We do not recommend implementing a policy for people supported that makes vaccination a condition of continuing service. The necessary implication of such a policy is that failure to vaccinate would result in withdrawal of service. Such a policy creates a significant risk for agencies from a legal, regulatory compliance and public relations perspective. Instead, we recommend a policy that encourages vaccination and addresses vaccination refusal with protocols that involves a spectrum of alternative measures that are responsive to the relative risk involved in each type of service and situation. Such a policy should also provide for accommodations for human rights-based vaccination refusals.

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[2] *Health Care Consent Act* SO 1996, c 2, Schedule A.

3. Visiting a person supported within an agency's residential support locations?

We recommend that agencies develop visitation policies or protocols that are consistent with public health and ministerial guidance. These policies or protocols should include provisions for assessing exceptions on a case-by-case basis, at which point vaccination status of the visitor may be a reasonable consideration, along with other factors for determining the risk associated with the proposed visit(s), which may include the setting, the services, the needs and risks to other stakeholders in the location, among other things.

PART 2: BACKGROUND

This section summarizes considerations related to (A) COVID-19 and COVID-19 vaccines; (B) vaccination requirements and practices in other sectors; and (C) the various areas of law that are relevant to COVID-19 vaccination policies for people supported in the DS sector.

A. COVID-19

1. COVID-19 and the DS Sector

It is well-established that COVID-19 is a highly infectious, deadly virus posing serious health and safety risks to all Canadians. It is also well-known that certain populations, most notably the elderly, individuals with underlying health conditions, and those living in congregate care settings, are considered particularly vulnerable to COVID-19. Congregate care settings, including residential locations supported by DS agencies, are also more prone to outbreaks owing to the pre-existing vulnerabilities of residents, communal spaces and number of staff entering and exiting residences.

In response to the pandemic, the government has issued a number of emergency orders related to the DS sector, including regulations that require and authorize agencies to implement any measures reasonably necessary to prevent, respond to and alleviate the outbreak of COVID-19,[3] and to follow all guidelines issued by the Ministry of Health and Long-Term Care ("MOH") and the Chief Medical Officer of Health.[4] The Ministry of Children, Community and Social Services ("MCCSS") and the MOH have also issued directives, guidelines and recommendations for DS sector agencies related to infection control and visitation.[5]

The province has also implemented a Response Framework that implements a spectrum of protective measures based on risk in the community on a regional basis (by public health unit region) (the "Response Framework"). This Response Framework can be accessed here: https://www.ontario.ca/page/covid-19-response-framework-keeping-ontario-safe-and-open.

Neither the Response Framework, nor any of the regulations, directives, or guidelines issued to date address the issue of vaccination for people supported. Furthermore, select guidelines that initially imposed restrictions and requirements related to testing and access for visitors, have since been dialled back in the face of pressure from families and the media and legal challenges.

2. COVID-19 Vaccines

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[3] *Emergency Order - Service Agencies Providing Services and Supports to Adults with Developmental Disabilities and Service Providers Providing Intervenor Services,* O Reg 121/20.
[4] *Emergency Order - Congregate Care Settings,* O Reg 177/20.
[5] Ontario Ministry of Health, "COVID-19 Guidance: Congregate Living for Vulnerable Populations" (May2020); Ontario Ministry of Children, Community and Social Services, "Visitor's Guidelines: Re-Opening of Congregate Living Settings" (July 2020).

Canada has currently approved two vaccines, Moderna and Pfizer/BioNTech ("Pfizer"), each requiring two doses respectively. Health officials expect that both vaccines are effective against the original strain of COVID-19 and the UK variant which has been confirmed in Ontario. The vaccine will be made available to the public for free, but not all at once. In the future, additional vaccines may be approved and administered throughout Canada. Ontario has developed its *Ethical Framework for COVID-19 Vaccine Distribution* prioritizing vulnerable populations in phases:

- Phase 1: health care workers and essential caregivers in long term care and retirement homes, hospitals and other congregate care settings for seniors and residents in these homes;
- Phase 2: workers and residents of other at-risk congregate care settings including community living settings.[6]

We know anecdotally that some people supported and workers in DS sector residential support locations have already been vaccinated and it appears that residences operated by DS sector agencies will be prioritized in Phase 2 (expected to begin in March 2021).

The Moderna vaccine will be available for people 18 years old and older and Pfizer will be available for people 16 and older. Based on current studies, the vaccines are roughly 94.1% effective shortly after the second dose is given. At this time, it is unknown whether the vaccines prevent transmission of the virus from person to person. More studies and time are needed to gain a better understanding of the impact of these and other COVID-19 vaccines.[7] At this time, the government has indicated it does not have any intention to mandate COVID-19 vaccinations in general or for any particular segment of the population.

B. VACCINATION IN OTHER CONTEXTS

1. Childcare and Education

The provincial and federal governments recommend but have not mandated that adults "be routinely immunized for vaccine-preventable diseases." However, the Ontario government has legislatively mandated vaccination for certain types of diseases among certain populations, most notably vaccinations for childhood diseases as a pre-condition for school and childcare programming.[8] The legislative framework requiring children to be vaccinated is subject to exemptions for religious and medical restrictions, in the absence of which the framework prescribes specific consequences for students who fail to produce evidence of vaccination. The public policy rationale that has been found to justify mandatory vaccination in the school and childcare context is the "importance of protecting the health of

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[6] Government of Ontario, [Getting a COVID-19 vaccine in Ontario | COVID-19 (coronavirus) in Ontario]

[7] National Advisory Committee on Immunizations (Government of Canada), [Recommendations on the use of COVID-19 vaccines - Canada.ca]

[8] Under *General,* O Reg *137/15* under the *Child Care and Early Years Act*, 2014, SO 2014, c 11, Schedule 1 admission to a child-care centre is contingent on the centre confirming that a child under school-age has received the prescribed immunizations in accordance with public health directives. Importantly, this immunization requirement also applies when a child-care licensee is overseeing the provision of home child care.[8] This requirement is subject to religious and medical exceptions.

children."[9] While it is tempting to point to mandatory vaccination policies implemented by school boards and childcare centres as a precedent for DS agencies doing the same, the legislation that underlies education and childcare sector policies makes these policies distinguishable and therefore not terribly helpful in determining what will be justifiable for DS agencies.

2. Long-term Care and Retirement Homes

While specific vaccines are not legislatively required for admission into long-term care or retirement homes, the legislation that governs such homes provides greater authority and obligation to develop infection prevention and control programs. These service providers have obligations to follow public health directives, ensure information about diseases and vaccines are available to residents, have documentation and reporting protocols, and screen all residents for tuberculosis within 14 days of admission. Additionally, long term care homes must offer all residents prescribed vaccines including the influenza vaccine each year.[10] Similar requirements and obligations apply to retirement homes.[11] The legislative and regulatory obligations on DS agencies in this respect are much more limited.

C. LEGAL CONSIDERATIONS APPLICABLE TO DS SECTOR AGENCIES

The following legal issues are applicable to DS sector agencies seeking to implement vaccination policies for people supported:

1. Human Rights and Charter Values

Vaccination policies that have an adverse impact on a person who declines vaccination for disability or religious related reasons may be challenged as discriminatory and contrary to human rights law, specifically the *Ontario Human Rights Code* (the "Code").[12] There is no question that agencies will be obliged to accommodate people who are unable to vaccinate for such human rights protected reasons up to the point of undue hardship and any policy implemented by an agency should include a commitment to same. Undue hardship should be assessed based on risk to health and safety of people supported and other stakeholders, the cost, efficacy of vaccines, and availability of reasonable alternatives measures, among other things.

Leaving aside the issue of protected grounds of discrimination, mandatory vaccination policies can also come with the risk of challenges based on alleged breach of the right to life, liberty and security of person under the *Canadian Charter of Rights and Freedoms.*[13] While DS agencies are not technically subject to the *Charter* as they are not generally considered to be "public sector" entities, DS agency vaccination policies could still attract *Charter* scrutiny and as such vaccination policies and protocols should be crafted

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[9] *I.B. v Kyle*, 2018 CanLII 30998 (ON HSARB)
[10] *General,* O Reg 79/10 under the *Long Term Care Homes Act*, SO. 2007, c 8, section 229.
[11] *General,* O Reg 166/11 under the *Retirement Homes Act*, 2010, SO 2010, c 11, section 27.
[12] *Ontario Human Rights Code* RSO 1990, c 19.
[13] *Canadian Charter of Rights and Freedoms,* Part 1 of the *Constitution Act,* 1982, being Schedule B to the *Canada Act 1982* (UK), 1982 c 11.

in a manner that does not unreasonably interfere with the personal autonomy and bodily integrity of people supported.[14]

2. Consent and the Health Care Consent Act (HCCA)

In Ontario, the *HCCA* sets out that voluntary and informed consent is a general requirement for medical treatment. Section 11(1) identifies the elements of consent to medical treatment:

- The consent must relate to the treatment;
- The consent must be informed;
- The consent must be given voluntarily; and
- The consent must not be obtained through misrepresentation or fraud.

The courts have repeatedly emphasized the inherent right to bodily integrity and the importance of free and informed consent to treatment of any kind, particularly when it comes to the injection of medication.[15]

Absent *HCCA* consistent consent, vaccinations could be viewed as assault or battery and be the subject of a civil claim to damages. Conceivably, an agency that imposes mandatory vaccination could face claims where a person consents to vaccination because they were under duress (threatened with withdrawal of service if they refused). In some situations, particularly residential support relationships, the choice between vaccination and withdrawal of service will not be a true choice, rendering consent involuntary. Agencies could also face tort claims (as further described below) in relation to providing false, misleading or incomplete information to a person in order to obtain their consent. Liability in such cases could be substantial, particularly where a person suffers a serious adverse reaction.

3. Services and Supports for the Social Inclusion of People with Developmental Disabilities Act (SIPDDA)[16]

SIPDDA requires service agencies to provide services and supports in accordance with the terms and conditions specified in a funding agreement and consistent with any policy directive.[17] SIPDDA does not speak directly to the issue of immunization or infectious disease control, nor does any policy directive. Furthermore, funding agreements do not typically include a bases on which an agency may choose to decline to provide service. They may however speak to how and under what circumstances funding and supports may be discontinued. Each agency should review their funding agreements to determine whether there may be restrictions on their ability to decline or discontinue services in certain circumstances.

[14] *Fleming v Reid* [1991] OJ No. 1083 at 18; See also *Manitoba (Director of Child and Family Services) v C(A),* 2009 SCC 30 at para 39.
[15] *Fleming v Reid supra* note 14.
[16] *SIPPDA supra* note 1.
[17] *Ibid,* section 23.

4. Quality Assurance Measures Regulation (QAM)[18]

The matter of voluntary, informed consent dovetails with the obligations that DS agencies have under *QAM. QAM* requires DS Sector agencies to:

- promote social inclusion, individual choice, independence and rights.[19]
- develop policies and procedures with respect to "health promotion, medical services and medication", which includes:
    - providing people with public health information that is accessible and understandable so that they can make informed decisions about their health, and
    - developing documentation protocols with respect to a person's refusal to receive medical services recommended by a medical professional, medical services a person supported is receiving and any health concerns of people supported.[20]
- provide information with respect to prescription medication, diet and nutrition, personal hygiene, personal fitness, sexual health, behaviour that may pose a threat to the person's health, safety or well-being, self-esteem and well-being, communication skills, and developing relationships.[21]
- provide assistance to people supported in attending medical appointments.[22]
- have policies and procedures that protect the personal safety and security of people they support,[23] the wellbeing of people they support (i.e. food and nutrition, care of personal property, bathing/showering support, scalding prevention and pets and service animals).[24]

On balance, these obligations do not provide a statutory obligation to implement a widespread mandatory COVID-19 vaccination policy and in fact *QAM*'s recognition of individual choice, independence and rights may in fact preclude such a policy. Together with the duties to provide information, *QAM* favours policies that educate, encourage, and support vaccination and take a balanced and reasonable approach to safely continuing supports for people who choose to exercise their right to decline vaccination.

5. Privacy Considerations

It is widely accepted that personal privacy is a basic right and a central tenant of Canadian common law. It is also well-established that people have a high expectation of privacy in their own homes.[25] From a legal perspective, vaccination is understood to engage privacy interests associated with bodily integrity and personal autonomy. As such, people supported may claim that a mandatory vaccination policy and the collection of information about their vaccination status is a breach of their individual privacy rights. Recent developments related to the tort of "intrusion upon seclusion" could be raised as grounds for a

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[18] *Quality Assurance Measures* O Reg 299/10.
[19] *Ibid,* section 4.
[20] *Ibid,* section 7(1).
[21] *Ibid,* section 24 (applicable to agencies providing residential services and supports).
[22] *Ibid.*
[23] *Ibid,* section 12(1)(a).
[24] *QAM, supra* note 18, section 25 (applicable to agencies providing residential services and supports)
[25] *Jones v Tsige* 2012 ONCA 32, paragraphs 38-44.

claim by a person who objects to being asked for information about their vaccination status or being required to vaccinate as a condition of service. However, given the legitimate health and safety concerns underlying any such requests or requirements, at least in direct support settings, we believe the legal risk associated with any such claims to be relatively low.

Although many DS sector agencies may not be subject to the limits and obligations under the *Personal Health Information Protection Act*[26], it will still be important to ensure that vaccination related information is managed in a manner that is consistent with existing agency policies related to the collection, use and disclosure of personal health information.

6. Contract Law

In addition to the legislative and regulatory regimes applicable to DS sector, DS agencies and their relationships with the people they support may be subject to contract law.[27] This may be the case, even where there is no formal "service agreement" in place with a person. The impact of contract law will depend on the terms of any service agreement that is in place, existing policies and commitments, implied or express, that an agency has made to a person related to the service relationship. Contractual obligations may also be implied into the service relationship by the common law.

Key contract law considerations in the context of the imposition of a new vaccination policy would include:

a) **Reasonableness.** If a contractual relationship exists an agency may have a duty to perform services honesty, fairly, reasonably, and in a manner that is not "capricious or arbitrary." As such, there may be a contractual obligation to ensure that any vaccination policies are reasonably necessary, not arbitrary and that the restrictions are proportional to the risk.

b) **Termination and Notice of Termination.** Courts have held that agreements involving elements of trust, confidence, delegation of authority or personal relations between the parties are more likely to give rise to an implied right to terminate on reasonable notice. In the DS sector, given the very serious personal interests and trust at play, it's likely that absent a contractual term to the contrary an agency may have an obligation to provide "reasonable notice" if it intends to withdraw service for failure to vaccinate. The amount of notice is required will turn on the particular agreement under consideration and the circumstances surrounding it. The range of what has constituted 'reasonable notice' in these types of agreements under Canadian case law is generally between 30 days and two years.

c) **Breach of Contract.** Agencies may face allegations of repudiation or breach of contract (and associated claims to monetary damages) where they fundamentally change, modify, suspend or terminate service. We note, however, that in the context of COVID-19 an agency may be able to

[26] *Personal Health Information Protection Act,* 2004 SO 2004, c 3 Schedule A.

[27] Note that contract law would only apply to people supported who are currently receiving service and not to any prospective people supported who have not already entered into a service relationship with an agency.

raise a defence reasonable necessity, "frustration of contract" or "*force majeure*". The availability of these defences will depend on the terms of the contract, any existing policies, the terms of the new vaccination policy, the degree of risk associated with the particular circumstances, the reasonably necessity of the agency's actions and the circumstances being unforeseeable and/or beyond the control of the agency.

7. Tort Lability

In addition to breach of contract, an agency could also be held liable for damages in tort by a person supported, a family member, employees or others who suffer harm as a result of acts or omissions in relation to COVID-19. For instance, claims could be raised by any individual who contracts COVID-19 from a person supported or staff member on the agency's premises. This risk has been cited as grounds for more aggressive vaccination requirements by agencies.

Fortunately, the government has passed legislation that limits liability for not-for-profit agencies and their personnel related to COVID-19 entitled Bill 218, *Supporting Ontario's Recovery and Municipal Elections Act, 2020* ("Bill 218"). Specifically, Bill 218 prohibits any action against a person (or agency) arising directly or indirectly as a result of an individual's exposure to or infection with COVID-19 due to an act or omission of that person as long as at the relevant time, the person acted or made a good faith effort to act in accordance applicable public health guidance relating to COVID-19 and any applicable federal, provincial or municipal law relating to COVID-19 that applied to the person. We note, however, that this liability protection does not apply to claims by employees or others providing services and as such it remains imperative that agencies take all reasonable measures to protect the health and safety of these personnel, including implementing reasonably vaccination policies for people supported.

Leaving aside liability related to actual infection with COVID-19, there is also the risk of claims from a person supported and/or their family in the event that the person suffers an adverse reaction from vaccination after being "mandated" by an agency to be vaccinated or in reliance on advice or information provided by the agency, as further discussed above in relation to consent and capacity. There is no protection from this form of liability under Bill 218.

8. Tenancy Rights under the Residential Tenancies Act (the RTA)[28]

DS agencies which own, lease and/or operate residential properties (including group homes, supported independent living units, etc.) must contemplate that people effectively have tenancy rights which may restrict agencies from imposing mandatory vaccination policies in residential programs. The *RTA* contains provisions that protect the rights of tenants living in a "residential complex" and "care homes" from unlawful evictions and only permits evictions in certain circumstances. The legislation applies to agencies operating residential homes in units they own and may also apply in respect of units for which they hold a head lease. These rights may limit the options an agency has when it comes to enforcing a mandatory vaccination policy.

[28] *Residential Tenancies Act* 2006, SO 2006 c 17.

While the RTA does allow a landlord to terminate a lease on grounds of "impairing safety", the safety provision of the *RTA* typically only applies in situations where tenants are violating existing mandatory laws and regulations.[29] We believe it is unlikely that these grounds would be read to include a refusal to vaccinate.

9. Labour and Employment Law

Finally, mandatory vaccination policies have been mostly explored in the labour and employment law context, with a particular focus on the reasonableness of mandatory influenza vaccines for staff. While this jurisprudence is not analogous to mandatory vaccination policies for people supported, courts have generally upheld modified vaccine policies with limited exceptions that demonstrate a balance of the bodily integrity and privacy interests of an individual along with human rights and the health and safety considerations. These cases also demonstrate that each policy must be assessed individually, on a case-by-case basis. We understand that SPPI has provided information and direction to DS sector agencies in relation to mandatory vaccination policies affecting staff.

Employer duties to provide a healthy and safe working environment[30] and to establish policies and procedures related to inoculation for infectious disease,[31] all support DS agencies taking reasonable measures to ensure people supported are vaccinated. These obligations, however, are based on a standard of "reasonable necessity". Whether or not a "mandatory vaccination policy" for people supported is reasonably necessary to protect staff will depend on numerous factors, including the risks in the community, the risks within the agency, the types of support and the support setting, the interests of other stakeholders, and the availability of reasonable alternative measures. Practically speaking, given that by far the greatest risk of infection in DS agencies comes from staff themselves, we believe it unlikely that workplace health and safety obligations would be found to justify a mandatory vaccination policy for people supported.

[29] See: TEL-07722, Re, 2007 CarswellOnt 9634. See also: *2276761 Ontario Inc. v Overall* 2018 ONSC 3264.
[30] *Occupational Health and Safety Act*, RSO 1990, c 0.1.
[31] *Health Care and Residential Facilities,* O Reg 67/93.

PART 3: ANALYSIS AND DISCUSSION

The following discussion and analysis applies the previously outlined legal considerations to the specific questions posed by Community Living Ontario on behalf of SPPI and provides recommendations in relation to best practices for vaccination policies and protocols for people supported.

A. CONSENT AND CAPACITY ISSUES WHEN SUPPORTING CONSENT TO VACCINATION

Consent and capacity are paramount considerations when developing and implementing a plan or protocol for encouraging vaccination, providing information to, and obtaining consent for vaccination from people supported. Consistent with *QAM* obligations, policies related to health and safety should be written in a way that is accessible and DS sector staff should explain the policy in a way that people understand, providing additional support when needed.

Assessing Capacity

A person who is sixteen years or older is presumed to be capable of making decisions about personal care matters which includes consenting to health care treatment and therefore by extension, to being treated with a COVID-19 vaccine. Health care practitioners should rely upon this presumption of capacity <u>unless</u>: (i) there has been a formal finding of incapacity with respect to the decision or type of decision in question; <u>or</u> (ii) there are reasonable grounds to believe that the person is incapable of making a decision related to the provision of the COVID-19 vaccine.

Capacity must be assessed by an appropriate health care professional. In the case of vaccinations, the health care professional administering the vaccine must assess for capacity and obtain the necessary consent to vaccinate from the person supported or their SDM. Specifically, under the section 4 of the *HCCA,* "a person is capable with respect to a treatment […] if the person is able to <u>understand the information</u> that is relevant to making a decision about the treatment […] and able to <u>appreciate the reasonably foreseeable consequences of a decision or lack of decision</u> (our emphasis)."

It is important to note that, notwithstanding the presumption of capacity related to personal care matters at age sixteen, there is no stipulated age of health care consent to treatment in Ontario. Capacity is determined based on the test referred to above and considers the child's age, maturity and general understanding of the proposed treatment. Although there is no vaccine currently available for people under the age of sixteen, agency policies should proactively address the age of people supported or update such policies once vaccinations become available.

The Role of the DS Agency in Facilitating Consent

Many agencies will be responsible for supporting people in the vaccination process, including with physical, behavioural and/or emotional supports. Nonetheless, it is important that the health care practitioner administering the vaccine ultimately remains responsible for assessing capacity and confirming that consent has been obtained in compliance with the *HCCA.*

For the purposes of *HCCA* consent to vaccination, DS agency staff should not be assessing capacity or consenting on behalf of people supported, however, they may play a valuable role in supporting people to understand the decision they will be called upon to make and the impact of giving or refusing consent. Some steps agencies can take include:

- Providing current public health information to people supported and their families about COVID-19 and vaccinations;
- Familiarize people and families with the consent forms and other vaccine guidance from the MOH;
- Document notes and observations about capacity that can assist health care professionals make their formal assessments;
- Document people supported who have a legally authorized SDMs, those who have another SDM based on the hierarchy set out in the *HCCA* and those who do not have someone in their lives that could serve as an SDM in accordance with the SDM hierarchy set out in the *HCCA*;
- Document whether there may be the need to engage the PGT in the consent process if DS sector staff have concerns about a person supported's capacity to consent to a vaccine.

Substitute Decision Makers

In some cases, people supported will not be capable of consenting to receive the COVID-19 vaccine for themselves. Consent will need to be obtained from their SDM. The *HCCA* sets out a hierarchy of SDMs:

1. A statutory or court appointed guardian, if the guardian has the authority to give or refuse consent to the treatment;
2. A Power of Attorney for person care;
3. A representative appointed by the Consent and Capacity Board under section 33 of the *Substitute Decisions Act* if the representative has authority to give or refuse consent to the treatment;
4. A spouse or partner;
5. A child or parent or a children's aid society or other person who is lawfully entitled to give or refuse consent to the treatment in the place of the parent;
6. A parent who has only a right of access;
7. A brother or sister;
8. Any other relative.

Absent an SDM, the PGT's office is required to provide consent.

Where there is reason to suspect that the health care practitioner may find a person supported to be incapable of consenting to vaccination, it may be advisable for the agency to make arrangements to involve the SDM (or the PGT) in the process of providing consent directly to the health care practitioner.

B. POLICIES REQUIRING VACCINATION FOR PEOPLE SUPPORTED:

1. As a Condition of Entering Service

DS Sector agencies can likely mandate vaccination as a condition of eligibility for direct in-person services for people not currently receiving services, subject to human rights-related accommodation obligations as further described above. Absent a previously executed service agreement or existing service relationship, an agency has the right to decline service to a person based on non-discriminatory criteria they establish given their operational capabilities and legitimate business interests, which may include the health and safety of their staff and other people they support. COVID-19 would likely provide sufficient rationale for requiring vaccination as a pre-condition for most in-person services requiring close contact with others during the pandemic.

At the same time, we are in unprecedented circumstances and agency policies mandating vaccinations have not been tested in the law. No government authority has yet taken the step of mandating or even recommending mandatory vaccinations for the DS sector or at all. Therefore, policies mandating vaccination run the risk of legal challenge and liability, may damage relationships with families and people supported, are unlikely to have the support of MCCSS and could face significant public relations backlash.

Policy Recommendations for Prospective Persons Supported

We recommend developing a policy that requires vaccination as a condition of entering into a new service relationship for direct in-person supports. Such policies should be subject to accommodations to the point of undue hardship for people unable to vaccinate for human rights related reasons. Furthermore, we recommend adopting a protocol that includes a case-by-case assessment for considering new service relationships involving people who decline vaccination for reasons that may not technically be protected by human rights law.

Specific recommendations for the development of such policies include:

1. Review funding agreements and corporate governance documents (i.e. letters patent, bylaws, etc.) to ensure there are no limitations on the agency's ability to independently determine eligibility criteria for service.

2. For people seeking services and supports by way of on online or virtual means only, do not require vaccination or gather information related to vaccination status – doing so is not reasonably necessary to ensure the health and safety of any person. However, where a service is being delivered virtually on a temporary basis, inform people about the vaccination requirements in place upon the resumption of in-person services and supports.

3. Clearly communicate vaccination requirements in any enrollment materials for the service/setting in question, along with information on the benefits of vaccination, the rationale for the requirement and how a person can become vaccinated in an accessible manner.

4. Ensure that service agreements are in place with people supported entering service or their representatives and that such agreements include provisions related to the agency's vaccination policy.

5. Develop and make available a policy that clearly articulates the agency's policy and eligibility criteria related to vaccination. This policy should address the following:

   a. Articulate the agency's commitment to human rights accommodation up to the point of undue hardship. Provide accommodation up to the point of undue hardship to people who have a bona fide and substantiated human rights reason for declining vaccination.

   b. Protocols for assessing vaccination refusals (whether human rights related or not) on a case-by-base basis considering the type of service, the setting, the needs of the person, the interests of other stakeholders, and the present risks in the community, among other things.

   c. Where a person is admitted into service without vaccination, communicate any alternative measures that will be imposed and communicate that service may be interrupted, modified or suspended as necessary to respond to changes related to COVID-19, including but not limited to changes in the law, recommendations from public health, risk levels within the agency or the community.

   d. Ensure that any alternative measures that are implemented for a person who is unvaccinated are reasonable in the circumstances.

   e. Ensure that any policy requiring evidence of vaccination addresses the secure collection, use, disclosure and retention of such information.

6. Review and update existing policies (including but not limited to privacy and confidentiality policies) to ensure consistency with any new vaccination policies or protocols developed in response to the COVID-19 pandemic.

7. Review and update vaccination policies from time to time to ensure they reflect current public health information and any changes to legislation and government guidelines.

2. As a Condition of Continuing with Service

It being understood that human rights accommodation obligations must be addressed in every policy related to vaccination (see above), the discussion below deals with vaccination refusals that are unrelated to human rights protected grounds.

Vaccination Refusal for Non-Human Rights Related Reasons

Mandating vaccination as a condition of continuing service implies that service will be terminated if a person declines vaccination. As such, it comes with the risk of liability in relation to breach of contract or tort, as well as privacy law and legislative and regulatory compliance issues. The degree of risk will depend on the terms of any service contract or funding agreement, whether the person supported has a real choice based on the types of supports in question and the availability of alternatives, whether the measure is "reasonably necessary" based on the degree of risk given the supports in question, the setting in which supports and services are being provided, and the interests of other stake holders, among other things.

As noted above, certain types of service settings come with added complexity from a legal perspective. Residential supports in settings that are owned, leased or controlled by an agency may be subject to eviction related restrictions under the *RTA* (see above). Furthermore, such arrangements are typically subject to service agreements creating contractual obligations and expectations of permanency or longevity that can make exclusion from service and removal from an agency home challenging. It goes without saying that withdrawing service in such contexts would also be a public relations nightmare.

Ultimately, while agencies generally have the authority to establish their own policies and discontinue services to a person where it deems necessary, that authority should be exercised reasonably and in good faith and may require advance notice depending on the circumstances. As such, we recommend an approach that encourages vaccination and addresses vaccination refusal with a spectrum of measures that are responsive to the relative risk involved on a case-by-case basis and provides accommodation where any refusal is related to a bona fide human rights related reason. This is not only a legal best practice, but also advisable from a risk management, relationship management and public relations perspective.

Determining Consequences for Refusal to Vaccinate

There is a wide spectrum of consequences that may flow from a person's choice to refuse vaccination. These consequences range from permanent exclusion from services on the high-risk end of the spectrum to ongoing support to comply with public health recommended PPE and social distancing precautions on the low-risk end of the spectrum. The more intrusive (restrictive or negative) the consequence for the person supported, the more difficult it will be to justify. The spectrum of consequences and their degree of intrusiveness and corresponding risk is set out at Figure 1 below.

Figure 1 - Spectrum of Consequences

Intrusive - High Risk					Non-Intrusive - No Risk	
Permanent Withdrawal of Service	Temporary withdrawal of service	Reduction in Service	Changes to physical interactions and spaces	Modifications to Service	Enhanced PPE	Status Quo

The factors that will determine what consequences can reasonably be justified are discussed further below in Figure 2.

Figure 2 – Factors for Assessing Justification for Intrusive Consequences

Factor	Justifying More Intrusive Consequences	Justifying Less Intrusive Consequences
Community Risk Level	At present, when the entire province is in the Grey Level of risk according to the Provincial Framework it will be easier to justify more intrusive measures.[32]	Where the risk level is very low (such as in communities in the green or yellow risk level) it may be more difficult to justify intrusive measures.
Types of Support	Services in which social distancing is not possible and involving close contact. This could range from companionship for a person who cannot comply with social distancing, to personal/intimate care, and aerosol generating procedures.	Services that can be performed while maintaining social distancing or services that can be delivered virtually.
Congregate vs. Individualized Supports	Congregated supports where the person will be interacting with a number of other people supported and/or support workers will increase the risk associated with the person refusing to vaccinate and as such imposing more intrusive consequences (particularly during periods of elevated community risk) for such settings may be justifiable.	Individualized supports where there is no interaction or very limited interaction with other people supported or staff will make it harder to justify harsh consequences.
Ability/ willingness to follow alternative protocols	Where a person supported is unable or unwilling to comply with health and safety protocols, this will justify more intrusive measures.	Ability and willingness to comply with measures that are equally effective but less intrusive.

[32] Note: Agencies may wish to integrate the **Provincial Framework,** or other public health indicators of community risk as a component indicator of consequences for refusal to vaccinate into their policy.

Factor	Justifying More Intrusive Consequences	Justifying Less Intrusive Consequences
Viability of Alternative Measures	Where there are no reasonable measures that are as effective as vaccination, vaccination is more likely to be justified. For instance, if outbreaks continue to happen within the agency's group homes, despite strict adherence to PPE, cleaning and distancing protocols, more intrusive measures may be justified.	Where PPE, cleaning and physical distancing measures have been effective (ex. outbreaks have been limited to a single individual and not spread to others in the workplace), less intrusive measures should be considered.
Timing and Stakeholder Immunity	When vaccines are available to people support in the program but not in the community at large and therefore risk of contagion remains high, more intrusive measures are more likely to be justified. When other people with whom the person will be interacting are unvaccinated and cannot be vaccinated for human rights protected reasons, more intrusive measures may be easier to justify.	Imposing negative consequences on a person for refusing vaccination when they do not reasonably have access to vaccination will obviously be difficult to justify. Given that access to vaccination is in part tied to age and that no vaccines have been approved for Canadian under the age of 16, more intrusive measures for people in this category would be high risk. In addition, once vaccines are widely available requiring a person supported to be vaccinated ostensibly on the basis that it is reasonably necessary for their own safety and the safety of others will be harder to demonstrate if all staff and other participants in their service cohort have been vaccinated and therefore are not at risk.
Needs of Person Supported	Where the services in question are not essential to the life and health and safety of the person supported and the consequences of withdrawal of service or restriction of service are therefore not serious for the person supported, then more serious consequences for refusal to vaccinate may be justified	Where the services are essential due to the needs of the person supported and therefore restriction or withdrawal of service would have very serious negative repercussions for the person, then less intrusive measures should be considered where possible.

Ultimately, even where factors generally support more intrusive consequences for refusal to vaccinate, there are some situations where permanent or even temporary withdrawal of services will not be advisable as indicated in the last row of Figure 2 above. For instance, withdrawal of service (tantamount to eviction) from a group home for a person refusing vaccination will be very difficult to justify and may in fact be unlawful under the *RTA*. In this scenario, we strongly recommend that alternative measures be implemented, which, depending on the factors outlined above, may include treating the person as COVID-19 positive, enhanced PPE, restrictions on access within the home, and other precautionary measures.

Vaccination Policy Recommendations for People Currently Receiving Service

We recommend that agencies develop vaccination policies that encourages vaccination and addresses vaccination refusals with a spectrum of measures that are responsive to the relative risk involved on a case-by-case basis. These policies should provide accommodation up to the point of undue hardship where refusal is related to a bona fide human rights related reason.

Recommendations for the development of such policies are as follows:

1. Adopt a vaccination policy that encourages and sets an expectation that all people currently receiving in-person service be vaccinated.

2. Develop a communication strategy for engaging people supported, family of people supported, and staff to increase support for an agency's approach to vaccinations.

3. Ensure the policy clearly articulates the agency's commitment to human rights accommodation up to the point of undue hardship where a person is unable to vaccinate for human rights protected reasons.

4. Ensure that any policy addresses the secure collection, use, disclosure and retention of such information.

5. Include a protocol that includes a spectrum of consequences that will flow from refusal to vaccinate for each service-type based on:

    a. service agreements applicable to people currently receiving the service in question,
    b. current advice from public health,
    c. the nature of the services,
    d. the service setting,
    e. the viability of reasonable alternative precautionary measures,
    f. the interests of other stakeholders in the setting, and
    g. the relative risks in the agency and community at large based on information from public health (consider integrating the Response Framework).

    These factors are discussed in greater detail in the chart above (Figure 2). Consequences prescribed in the policy will likely need to be re-evaluated from time to time based on changes in data related to the virus, vaccination and risk and recommendations from public health.

6. Address non-human rights related vaccination refusals on a case-by-case basis using the protocol and considering the particular circumstances and needs of the person in question.

7. Review and update existing policies to ensure consistency with any new vaccination policies or protocols developed in response to the Covid-19 pandemic.

8. Review and update vaccination policies from time to time to ensure they reflect current public health information and any changes to legislation and government guidelines.

3. As a Condition of Access as a Visitor

Restrictions on visitation to congregate care settings during the pandemic have been fraught with legal and public relations challenges. As most agencies will be aware, guidelines from the MOH and MCCSS initially required COVID-19 testing as a condition for visitation in congregate care settings. However, in response to legal and media challenges these guidelines were amended by the government, removing the testing requirement and leaving it to agencies to independently address visitation related risks. These risks include human rights challenges, RTA-based challenges, consent and capacity considerations, as well as contractual and tort-based claims for harm caused by visitation restrictions.

Based on the foregoing, we would recommend that DS sector agencies continue to follow current public health and ministerial guidance for restricting visitation, screening, use of PPE and physical distancing for essential visitors to congregate care settings. Vaccination status should not be a screening factor for visitation that is otherwise permissible consistent with these guidelines, unless otherwise directed or recommended by public health.

However, where exceptions to the visitation protocols are being considered (either to deny visitation due to perceived risks or to grant visitation that would not otherwise be permissible), we recommend assessing the risks associated with the proposed visit(s) on a case-by-case basis considering the various factors identified in Figure 2 above. At this point, vaccination status may be a reasonable consideration for deviating from otherwise prescribed protocols. In addition, agencies should consider the types of interactions and contact that the visitor will have with a person supported and other stakeholders, the degree of vaccination of people supported and staff in the location of the proposed visit, the need and rationale for the visit, the duration and location of the visit, the ability and willingness of the visitor and others within the location to follow social distancing, the use of PPE and hand and respiratory hygiene, among other things.

Recommendations for Policies on Vaccination for Visitors

We recommend that agencies develop visitation policies or protocols that are consistent with public health and ministerial guidance. These policies or protocols should include provisions for assessing exceptions on a case-by-case basis, at which point vaccination status of the visitor may be a reasonable consideration, along with other factors for determining the risk associated with the proposed visit(s) as outlined above.

PART 4: CONCLUSION

COVID-19 vaccination for agencies, staff and people supported remains unchartered territory and is subject to scientific and legal variables that are changing on a daily basis. Vaccination protocols therefore need to be approached with caution to ensure that: (a) people supported (or their SDMs) have the ability to make informed and voluntary choices about vaccination; (b) any consequences imposed by agencies in relation to a person's choice not to be vaccinated respect the person's human rights; and (c) any consequences imposed by agencies in relation to a person's choice not to be vaccinated be responsive to the risk and reasonable based the circumstances of the case.

Should you require any further assistance with developing vaccination policies for agencies operating in the DS sector, please do not hesitate to contact us.