Study Paper on

Health Care Consent and Capacity Assessment Tribunals

BCLI Study Paper 12
CCEL Study Paper 10

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INTRODUCTORY NOTE

Study Paper on Health Care Consent and Capacity Assessment Tribunals

A finding of mental incapacity to give informed consent to health care, or to decide whether to accept or refuse admission to a care facility, results in a very significant loss of personal autonomy. A mature legal system must provide a readily accessible means to obtain review of a finding of incapacity by an independent decision-making body. This imperative has been accentuated by Canada's ratification of the UN *Convention on the Rights of Persons with Disabilities*.

British Columbia once experimented with an administrative tribunal as a forum for review of decisions about mental capacity to consent to health care, and for resolution of disputes connected with substitute decision-making. The experiment was aborted well before reliable conclusions could be drawn about its merits.

At the present time, British Columbia nominally provides a mechanism for review of incapacity assessments, and of health care or care facility admission decisions of substitute decision makers, by application to the Supreme Court. In the course of the Canadian Centre for Elder Law's project on Health Care Consent, Aging and Dementia: Mapping Law and Practice in British Columbia, it came to light that the court-based remedy is not utilized to any extent. In all likelihood, this is because it is inaccessible as a practical matter to most persons whose mental capacity is in question and their supporters.

A recommendation by the Advisory Committee on Health Care, Consent, Aging and Dementia called on government to consider the restoration of a non-court review mechanism, and for robust research to shed light on a model that would be appropriate for British Columbia.

This study paper is a response to that call for research. It examines existing tribunals in Canada and Australia that deal with mental capacity and consent to health care, and analyzes issues and considerations that would enter into the design of a tribunal suited to British Columbia. In so doing, the study paper lays groundwork for the public policy exercise that it is hoped will follow to bring a truly accessible non-court review mechanism into being in the health sector.

Emily Clough
Chair
British Columbia Law Institute and
Canadian Centre for Elder Law

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EXECUTIVE SUMMARY

This study paper originated with a call made by an interdisciplinary advisory committee for research and consultation concerning a quasi-judicial review mechanism for findings of incapability to consent to health care, and for resolving disputes surrounding health care substitute decision-making. It is intended to lay an informational foundation for a public policy debate and governmental action.

The call for research and consultation was made in one of 34 recommendations contained in *Conversations About Care: The Law and Practice of Health Care Consent for People Living with Dementia in British Columbia*, published in 2019 by the Canadian Centre for Elder Law. The project leading to that report revealed strong concerns in the community about the barriers faced by persons living with a dementia diagnosis in securing independent review of incapacity assessments and health care decisions concerning them made by others. Current law provides for an application to the Supreme Court of British Columbia, but for numerous reasons explained in the study paper, this is not a practical or accessible means of obtaining independent review for most who desire it.

The right to exercise control over one's own health care through giving or refusing informed consent goes to the essence of personal autonomy. The importance of this right is emphasized by the fact that the Supreme Court of Canada has held it to be comprised in the guarantee of liberty and security of the person under section 7 of the *Canadian Charter of Rights and Freedoms*.

A finding of mental incapacity to give or refuse consent to health care, or to admission to a care facility, entails a serious loss of personal autonomy leading to conferral of decision-making authority on others. Substitute decision-makers exercising this authority are required to be guided by the known wishes, beliefs, and values that an incapable person held while capacity was still retained, and with present wishes if the incapable person is able to make them known. Nevertheless, a clear and accessible pathway to independent review of incapacity findings and of substitute decision-making on behalf of an incapable individual is a minimum requirement of access to justice in light of the significance accorded by Canadian law to the rights involved.

The importance of ensuring that a realistic review mechanism is in place is all the greater in light of Canadian ratification of the UN *Convention on the Rights of Persons with Disabilities*. Article 12 of this Convention stipulates that measures relating to the exercise of legal capacity intended to safeguard those with disabilities must be subject to review by a "competent, independent and impartial authority or judicial body."

While the study paper is an informational document rather than a positional one, it proceeds from the premise that the obligation under the Convention to provide a review mechanism cannot be fulfilled by merely having one available in law, but which is unusable in practice.

The study paper examines non-court review mechanisms existing in other jurisdictions with systems of administrative law and legislation relating to health care consent that resemble those of British Columbia. It discusses the potential adaptability of these mechanisms in British Columbia, and means of maximizing the accessibility of a specialized review tribunal for health care consent and mental capacity matters.

Chapter 1 provides background information on the recommendation that led to the study paper and outlines the contents of each chapter. Chapter 2 explains the legal regime governing consent to health care and admission to care facilities in British Columbia, much of which consists of rules found in the *Health Care (Consent) and Care Facility (Admission) Act* (HCCCFA Act). A review tribunal established to function in place of the court review now contemplated by section 33.4 of the HCCCFA Act would work within this regime and apply its rules in performing its mandate.

Chapter 3 recounts the short-lived experiment in this province with a Health Care and Care Facility Review Board, which was never fully implemented and was terminated before any reliable conclusions could be drawn about the merits of a specialized review tribunal to adjudicate matters relating to capacity and consent in the health sector.

Canadian examples of health care consent and capacity tribunals are examined in Chapter 4. These tribunals are found in Ontario and Yukon. The jurisdictional mandate, procedure, membership, budget, caseload, general track record and reputation of each of these bodies are reviewed.

Australian tribunals are the subject of Chapter 5. Each Australian state has an administrative tribunal that exercises jurisdiction in matters of consent to health care, mental capacity, and substitute decision-making for the mentally incapable. In all but one state, this function is carried out by the guardianship division or "list" of a multifunctional state civil tribunal. The guardianship division or "list" functions much as a tribunal within a tribunal, however, with members specializing in hearing matters dealing with mental capacity and adult guardianship. The remaining state retains a specialized board with this jurisdiction, but will soon join the other states in converting its specialized board into a division of a unified civil and administrative tribunal. As with the Ontario and Yukon tribunals, the mandate, procedure, membership, funding, caseload, etc. are examined and contrasted.

Chapter 6 evaluates the merits of the quasi-judicial tribunal as a means of delivering access to justice in matters of capacity and health care consent, comparing it to the existing court-based review mechanism and a hypothetical specialized court. Recognizing that the question of whether the caseload volume arising under the HCCCFA Act alone would be large enough to justify the formation of a separate tribunal will arise once again, various jurisdictional combinations with mental capacity matters as the common denominator are discussed as alternatives for implementing the tribunal model. The chapter goes on to identify considerations for policymakers in configuring a consent and capacity assessment review tribunal in this province with emphasis on accessibility.

Chapter 7 is a general conclusion.

LIST OF ABBREVIATIONS

ACAT	Australian Capital Territory Civil and Administrative Tribunal
CCA	*Care and Consent Act*, R.S.Y. 2003, c. 21, Sch. B
CCB	Consent and Capacity Board (Ontario)
CRPD Convention	*United Nations Convention on the Rights of Persons with Disabilities*, CTS 2010/8
GAB	Tasmanian Guardianship and Administration Board
HCCA 1996	*Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sch. A (Ontario)
HCCCFA Act	*Health Care (Consent) and Care Facility (Admission) Act*, R.S.B.C. 1996, c. 181
NCAT	New South Wales Civil and Administrative Tribunal
NTCAT	Northern Territory Civil and Administrative Tribunal
QCAT	Queensland Civil and Administrative Tribunal (QCAT)
SACAT	South Australian Civil and Administrative Tribunal
SAT	Western Australia State Administrative Tribunal
SDA 1992	*Substitute Decisions Act, 1992*, S.O. 1992, c. 30 (Ontario)
SDM	Substitute decision maker
TSDM	Temporary substitute decision maker
VCAT	Victorian Civil and Administrative Tribunal
Yukon CCB	Capability and Consent Board (Yukon)

CHAPTER 1. BACKGROUND

A. Introduction

The freedom to control what happens with regard to one's body is at the root of personal independence and quality of life. Among the aspects of life in which this freedom is most overtly exercised are decisions to accept or refuse various forms of health care. The freedom to make decisions about one's own bodily integrity in the context of health and personal care is sufficiently significant in Canadian law to be comprised in the guarantee of liberty and security of the person under section 7 of the *Canadian Charter of Rights and Freedoms*.[1]

While the law presumes initially that every adult has the mental capacity to make decisions about the adult's own health and living circumstances, it takes account of the reality that decision-making capacity can be diminished or lost through causes such as mental disorder, traumatic injury, or degenerative neurological diseases to an extent that rational choice is no longer possible. Mechanisms exist in law for conferring temporary or permanent authority on others to make decisions on behalf of persons who have lost the capacity to make them on their own behalf. The trigger for this transfer of decision-making authority is a determination that an individual lacks the mental capacity to make the type of decision in question.

A finding of mental incapacity can result in a serious loss of personal autonomy. Recent legislation in the area of consent to health care and admission to long-term care facilities has been designed to ameliorate those effects in the interests of preserving the self-determination and personal dignity of persons with diminished mental capacity. These have been directed in part at ensuring that decision-making on behalf of an incapable person is carried out insofar as possible with the known wishes, beliefs, and values that the person expressed or held while capacity was still retained, or with present wishes if the incapable person is able to make them known.

Nevertheless, given the serious loss of personal autonomy that can flow from an assessment of mental incapacity to consent or refuse health care or admission to a long-term care facility, fairness and the interests of access to justice demand that findings of this kind be open to independent review. So too must be the acts of substitute

1. *Carter v. Canada (Attorney General)*, 2015 SCC 5, [1015] 1 S.C.R. 331 at para. 67.

decision makers. The path to obtaining independent review must also be clear and accessible.

B. Reasons for This Study Paper

In British Columbia at the present time, anyone seeking independent review of an assessment of mental incapability to consent to health care, or of a health care decision made on behalf of someone who has been assessed as incapable of giving consent, must apply to the Supreme Court. The same is true with respect to findings of incapacity to decide on acceptance or refusal of admission to a care facility to receive residential or other long-term care.

Reliance on court processes for review of matters of mental capability assessment in connection with health care and care facility admission raises issues of accessibility, timeliness, and cost. The cost of legal representation, court fees, and potential liability for the costs of an opponent, are generally acknowledged in recent years to be barriers to access to justice for people of ordinary means in all situations. They are especially formidable barriers for those whose financial affairs may have been placed under the control of someone else due to their mental status, or whose impecuniosity may be partly related to a mental or physical disability. Others who might legitimately seek review of a health care consent or care facility admission matter, such as representatives and temporary substitute decision-makers who have been improperly passed over when consent for provision of care is sought, face the same cost barriers.

Decisions regarding health care and care facility admission must often be made on an urgent basis. The court system and court calendars are notoriously overcrowded, and hearing dates may not be obtainable within a feasible timeframe.

Court procedures are generally conducted in public, and most court documents are available for public inspection. Much of the evidence in matters of mental capacity, guardianship, and health care, however, consists of highly private and personal information that people do not want to have revealed to the world at large. The public nature of court applications can make vulnerable individuals and those concerned with their care or well-being reluctant to seek a fair and proper resolution of a dispute.

The regular civil courts are generalist by necessity, and there is a question of whether a specialized decision-making body would be better-adapted to deciding matters of mental capacity and health care as well as more accessible.

In 2019 the Canadian Centre for Elder Law completed a project on dementia and the law of consent to health care and issued a report entitled *Conversations About Care*.[2] The project involved extensive consultation amongst health care professionals, persons living with dementia and their advocates (lay and professional), their caregivers, and other stakeholders. The consultations revealed strong concerns about access to justice in terms of the barriers faced by persons living with a dementia diagnosis in securing independent review of incapacity assessments and health care decisions that affect them in profound ways.

Research carried out in connection with the project culminating in the *Conversations About Care* report revealed *no instances* of court review, despite the fact that the relevant statutory provision, namely section 33.4 of the *Health Care (Consent) and Care Facility (Admission) Act*, had been in effect for nearly a decade.[3] The absence of evidence that the process was being used at all reinforced concerns that review by the Supreme Court is effectively inaccessible for those who need it. These concerns are not limited by reference to provincial law alone, as access to independent review of incapacity findings is a requirement of Article 12 of the *United Nations Convention on the Rights of Persons with Disabilities* (CRPD Convention), which Canada ratified a decade ago.[4]

In addressing these concerns, the report identified a need for a more readily accessible and expeditious mechanism in British Columbia to deal with challenges to incapability findings and disputes surrounding substitute decision making in health care. One of the 34 recommendations developed by the project's interdisciplinary Advisory Committee and set out in *Conversations About Care* stated:

> Recommendation 30
> The Government of British Columbia should implement an independent non-court review mechanism to enable people to challenge:
>
> - Findings of incapability to consent to health care treatment;
> - Choice of temporary substitute decision makers;
> - Care facility admission decisions; and
> - Decisions made by substitute decision makers with respect to the person's health care, including the use of restraints.

2. Canadian Centre for Elder Law, *Conversations About Care: The Law and Practice of Health Care Consent for People Living with Dementia in British Columbia* (Vancouver: Canadian Centre for Elder Law, 2019).

3. *Ibid.*, at 232.

4. United Nations, *Treaty Series*, vol. 2515, p. 3; CTS 2010/8. Canada ratified the CRPD Convention on 11 March 2010 and the Optional Protocol on 2 January 2019.

> The Provincial Government should engage in robust research and consultation to determine the most appropriate and effective mechanism, and undertake education of health care professionals and staff, and the general public, when the process is implemented.

As is explained later in this study paper, British Columbia had a review tribunal of the kind described in the above recommendation in place for a short period early in this century, but it was quickly abolished for primarily fiscal reasons before it could exercise its full statutory mandate.

The present study paper flows from this call made by the Advisory Committee for research to determine an appropriate and effective review mechanism. It is based on comparative legal research and consultation on non-court review mechanisms that exist in other jurisdictions with systems of administrative law and legislation pertaining to health care consent that resemble those of British Columbia. The study paper does not make specific recommendations for legislative action or endorse any particular model for a review mechanism. Its purpose is to provide an informational foundation for policymakers, legislators, and the general public to consider the merits of re-introducing a review tribunal in this province.

C. Outline of the Study Paper

Chapter 1 is a general introduction describing the background and purpose of the study paper.

Chapter 2 explains the body of law currently in effect that a health care consent and capacity review tribunal in this province would have to apply in carrying out its adjudicative role.

The history of the short-lived British Columbia Health Care and Care Facility Review Board and how its function came to be superseded by the current review powers of the Supreme Court of British Columbia are the subjects of Chapter 3.

Chapters 4 and 5 examine, respectively, the existing Canadian and Australian tribunals exercising jurisdiction in matters of health care consent and mental incapacity.

Chapter 6 considers the possible adaptation in British Columbia of the existing Canadian and Australian models, or features of them, and delineates policy considerations that would need to be taken into account in the design of a non-court review mechanism in this province. Chapter 7 is a general conclusion.

D. Funding of the Study Paper

Funding of the project leading to this study paper was generously provided by the Law Foundation of British Columbia.

CHAPTER 2. CONSENT TO HEALTH CARE AND CARE FACILITY ADMISSION IN BRITISH COLUMBIA

This chapter contains an overview of the law of consent to health care and admission to care facilities in British Columbia. It is intended to provide a basic explanation of the legislation that a review board would need to apply in carrying out its review function.

A. The Principle of Informed Consent

In the 1980's, Canadian courts embraced the principle that mentally capable individuals are entitled to determine voluntarily whether to consent to receive medical treatment or refuse it, and to be informed beforehand of the nature of the proposed treatment, its benefits and risks, and any alternatives that may be available. This principle is known as *informed consent*, and is part of the common law in the provinces and territories that have a common law system, including British Columbia. A similar principle is applied under the civil law system of Québec.

A physician or other health care provider is obliged to obtain the patient's consent, after disclosure of the nature and gravity of the proposed treatment, any material risks and any special or unusual risks associated with the proposed treatment.[5] A material risk is one that carries serious consequences for the patient.[6] The health care provider must ensure that the patient comprehends the information being communicated.[7]

The test in the common law jurisdictions for determining the adequacy of risk disclosure by a health care provider is whether a patient has been given the information that a reasonable person in the patient's position would want to know in order to make a decision to undergo the proposed treatment.[8] Ordinarily, a mere possibility

5. *Hopp v. Lepp*, [1980] 2 S.C.R. 192 at 210; *Fleming v Reid* [1990] 4 O.R. (3d) 74 (C.A.).

6. *Reibl v. Hughes*, [1980] 2 S.C.R. 880, at 884-885.

7. *Ibid.* See *also Lue v. St. Michael's Hospital*, [1997] O.J. No. 255 at para 114.

8. *Ciarlariello v. Schacter*, [1993] 2 S.C.R. 119 at para. 54.

of risk does not need to be disclosed unless it carries serious consequences for the patient. In the latter case, it is then a material risk that requires disclosure.[9]

In Québec, articles 10 and 11 of the *Civil Code* are interpreted to require a different and more subjective test for the adequacy of disclosure, namely whether the care provider has supplied the information that the particular patient, rather than a hypothetical reasonable person, would want to have in order to make a decision to consent or refuse the proposed treatment.[10]

The right to informed consent implies the right of a mentally capable individual to refuse consent to treatment, regardless of the consequences of that choice. A patient may refuse specific or all treatment, or choose an alternate form of care, regardless of whether the choice is misguided in the opinion of the health care provider.[11] The right to self-determination in relation to health care may be exercised by a mentally capable patient despite serious and even mortal risks that may arise as a consequence.[12]

The principle of informed consent, and the right of a patient to self-determination regarding the patient's own care extends to the withdrawal of consent to treatment as well, either before or after treatment has begun.[13] Once consent is withdrawn, treatment may only resume with informed consent given anew, with disclosure by the care provider of what a patient would want to know about the risks attendant on the continuation of a treatment or procedure.[14]

Common law exceptions to the principle of informed consent are few. They include emergency care necessary to preserve life or prevent serious harm that is given to a mentally capable adult who is unable to give consent due to the adult's condition, and cases in which a patient consciously waives the right to self -determination and places complete reliance on the care provider's professional judgment. Some authorities recognize a narrow exception for "therapeutic privilege," under which a health care provider is justified in withholding information to prevent causing psychological harm to a patient.[15]

9. *Supra*, note 6.

10. *Drolet v. Parenteau*, [1994] R.J.Q. 689 (C.A.); *M.G. v. Pinsonneault*, 2017 QCCA 607.

11. *Manitoba (Director of Child and Family Services) v. A.*, 2009 SCC 30, at para. 199, citing *Malette v. Shulman* (1990), 72 O.R. (2d) 417.

12. *Fleming v. Reid* (1991), 4 O.R. (3d) 74 (C.A.); *Malette v. Shulman*, *supra*, note 11.

13. *Supra*, note 8.

14. *Ibid.*

15. See *Layton v. Wescott* (1992), 6 Alta. L.R. (3d) 91 at 102 (Q.B.).

B. Consent to Health Care Under Provincial Legislation

British Columbia is one of several jurisdictions in Canada that regulate consent to health care by legislation. The other jurisdictions are Ontario,[16] Québec,[17] Prince Edward Island,[18] and Yukon.[19] The principle of informed consent underlies all the legislation, although its expression and application are modified by the terms of the enactments. The legislation is broadly similar apart from that of Québec, where the Civil Code contains a general requirement of consent to health care that in recent years is judicially interpreted as implicitly incorporating the principle of informed consent.[20]

C. British Columbia's Health Care Consent Legislation

1. General

The general legal rules in British Columbia regarding consent by adults to their own health care are found in the *Health Care (Consent) and Care Facility (Admission) Act* ("HCCCFA Act").[21] This Act applies to most, but not all, forms of adult health care. The rules governing health care provided to minors are found in other legislation, and are significantly different.[22]

"Health care" is defined in the HCCCFA Act as "anything done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other purpose related to health."[23]
Health care is classified as major or minor under the Act. Major health care means major surgery, any treatment involving a general anaesthetic, major diagnostic or

16. *Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sch.A.

17. *Civil Code of Québec*, CQLR c CCQ-1991, arts. 11-25. See also *Act respecting end of life care*, R.S.Q. c. S-32.0001.

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

19. *Care Consent Act*, S.Y. 2003, c. 21, Sch. B.

20. *Supra*, note 10.

21. R.S.B.C. 1996, c. 181 ("HCCCFA Act").

22. See the *Family Law Act*, S.B.C. 2011, c. 25, s. 41(f) that includes giving, refusing or withdrawing consent to health treatment of a child as being among the responsibilities of parents. Section 17 of the *Infants Act*, R.S.B.C. 1996, c. 223, addresses the circumstances in which a minor ("infant" in the terminology of the Act) may consent to receive health care without the involvement of a parent or guardian.

23. *Supra*, note 21, s. 1 ("health care").

investigative procedures, or care that is prescribed by regulation as major health care.[24] Minor health care means health care that is not major health care, and includes routine tests and routine dental treatment.[25]

2. The Right to Consent to Health Care and Requirements for Valid Consent

The HCCCFA Act declares that every adult capable of giving or refusing consent to health care has the right to:

- voluntarily give/refuse consent to health care on any grounds;
- select a particular form of available health care on any grounds;
- revoke consent;
- expect that the decision will be respected;
- be involved to greatest degree possible in case planning and decision-making.[26]

In order for a consent given by a capable adult to be legally valid, the Act requires that it must be given voluntarily to the health care provider, in the absence of fraud or misrepresentation, and in reference to particular health care that is proposed.[27] In addition, the health care provider must have given the adult the information a reasonable person would need in order to understand the care that is proposed and decide whether to undergo it.[28] This includes information about the

24. *Supra*, note 21, s. 1 ("major health care"). The *Health Care Consent Regulation*, BC Reg. 20/2000, s. 4 prescribers the following as major health care: radiotherapy, intravenous chemotherapy, kidney dialysis, electroconvulsive therapy, laser surgery.

25. *Supra*, note 21, s.1 ("minor health care").

26. *Supra*, note 21, s. 4.

27. *Supra*, note 21, ss. 6(a)-(d). The term "health care provider" applies to persons licensed, certified or registered to provide health care under a prescribed Act. The only currently prescribed Acts are the *Health Professions Act*, R.S.B.C. 1996, c. 183 and the *Social Workers Act*, S.B.C. 2008, c. 31: *Health Care Consent Regulation*, *supra*, note 24, s. 3. Among the occupational groups covered by this definition are physicians, dentists, pharmacists, nurses, physiotherapists, occupational therapists, dietitians, naturopaths, chiropractors, opticians, audiologists, psychologists, speech pathologists, podiatrists, acupuncturists, and practitioners of traditional Chinese medicine, and social workers.

28. *Supra*, note 21, s. 6(e). The informational requirements do not apply when consent is given by way of an advance directive: s. 9(1.1).

- condition for which the health care is proposed;
- the nature of the health care;
- the risks and benefits of the proposed health care about which a reasonable person would expect to be told;
- alternative courses of health care.[29]

A further requirement of valid consent is that the adult must have had an opportunity to ask questions and receive answers about the proposed health care.[30]

A health care provider must communicate the information the HCCCFA Act requires to be given to an adult before the adult's consent is sought in a manner appropriate to the adult's skills and abilities.[31] The health care provider may also allow the adult's spouse, near relatives, or close friends that accompany the adult and offer their assistance to help the adult understand or demonstrate understanding.[32] These provisions regarding communication between the health care provider and the adult for whom health care is proposed also apply to any communications made in connection with determining whether the adult has the capacity to consent, as discussed later in this chapter.

It is important to note that unlike the requirements concerning the nature of the information that must be provided to an intended recipient of health care, the manner in which a health care provider must communicate the information is not based on the "reasonable person" standard. Instead, communication must be geared to the abilities of the particular care recipient, and carried out with assistance if necessary. This is especially important for care recipients facing a language barrier, or displaying some degree of cognitive impairment, or whose capacity to comprehend and evaluate the information being given by the health care provider is otherwise in question.[33]

29. *Ibid.*
30. *Ibid.*, s. 6(f).
31. *Ibid.*, s. 8.
32. *Ibid.*
33. Canadian Centre for Elder Law, *Conversations About Care: The Law and Practice of Health Care Consent for People Living with Dementia in British Columbia*, CCEL Report 10 (Vancouver: CCEL, 2019) at 79.

A consent is effective only with respect to the specific health care for which it was given.[34] It can extend to a course of similar treatments or a series of procedures, however. As defined in the HCCCFA Act, health care can include a series or sequence of similar treatments or forms of care administered over a period of time for a particular health problem.[35] It also extends to a plan for minor health care intended to deal with one or more health problems that an adult has or is likely to have in light of a present condition, and which will expire not more than 12 months from the date consent was given to the plan.[36]

Consent may be given orally or in writing, including by way of an advance directive, or it may be inferred from conduct.[37]

3. Presumption of Capacity to Consent to Health Care and Determining Incapacity

The HCCCFA Act presumes that every adult is capable of giving, refusing, or revoking consent to health care until the contrary is demonstrated.[38] Before turning to a substitute decision maker, a health care provider is required to make every reasonable effort to obtain a decision from the adult.[39]

The HCCCFA Act requires a health care provider to base a decision that an adult is incapable to give, refuse, or revoke consent to care on whether or not the adult demonstrates understanding of the information relevant to consent that the Act obliges the care provider to give, and that the information applies to the adult's own situation.[40] If that understanding is present, capacity is present for the purposes of the Act and the adult's prior, informed consent is a prerequisite to the administration of care.[41] If that understanding is absent, the adult lacks capacity and the care provider must obtain substitute consent from someone legally authorized to decide to give or refuse it.

34. *Supra*, note 21, s. 9(2).

35. *Supra*, note 21, s.1 ("health care").

36. *Ibid.*

37. *Ibid.*, s. 9(1).

38. *Ibid.*, s. 3(a).

39. *Ibid.*, s. 5(2).

40. *Ibid.*, s. 7.

41. The terms "capacity" and "capability" are each used in different provincial enactments in reference to what is in essence the same concept. "Capacity" is used in this study paper to denote the state of being mentally capable of making decisions with legal effect, and "capable" as the adjective to denote the possession of capacity.

The test of incapacity under the HCCCFA Act does not expressly recognize that the ability to understand the relevant information and relate it to one's own situation may vary from day to day and at different times of day, and may also vary with respect to the nature of the decision that is in question. While skilled assessors may take variability of capacity in a particular individual into account when conducting assessments, it is not a feature of our law at the present time. The Canadian Centre for Elder Law has recommended that the HCCCFA Act be amended to recognize the possibility that capacity may vary in this manner.[42]

A determination of incapability cannot be based solely on the adult's way of communicating with others.[43]

4. Obtaining Substitute Consent When Adult Patient Lacks Capacity

When seeking substitute consent, health care providers have the same obligations concerning the provision of information and communication vis-à-vis a substitute decision maker (SDM) as they do towards a capable adult who is a proposed care recipient.[44] Substitute consent, like that given directly by an adult with capacity, must be voluntary and informed in order to have legal effect.

The HCCCFA Act specifies who may provide substitute consent for persons incapable of consenting to health care for themselves, and creates a hierarchy of SDMs.

At the top of the hierarchy is a court-appointed personal guardian or a representative appointed by the adult in question in a representation agreement, provided that they have authority under their terms of appointment to consent or refuse health care on behalf of the adult in question.[45] Of course, personal guardians and representatives can only serve as SDMs if they are themselves mentally capable of making a health

42. *Supra*, note 2, at 187.

43. *Ibid.*, s. 3(2).

44. *Ibid.*, s. 10.

45. *Ibid.*, ss. 11(a), (b)(i), (iii). "Personal guardian" is the term used in the HCCCFA Act to refer to a committee of the person appointed by the court under the *Patients Property Act*, R.S.B.C. 1996, c. 349. "Representative" is defined in s. 1 of the HCCCFA Act as "a person authorized by a representation agreement to make or help in making decisions on behalf of another and includes an alternate representative." Representation agreements are governed by the *Representation Agreement Act*, R.S.B.C. 1996, c. 405. Unless the court orders otherwise, a representation agreement is terminated if a committee is appointed: *Patients Property Act*, *supra*, s. 19.

care decision under the test of incapacity in the HCCCFA Act that was explained earlier in the chapter.[46]

If the adult who is the proposed care recipient has a personal guardian or a representative who is available and meets these criteria, then the SDM for the adult is the personal guardian or representative, as the case may be. A health care provider may provide health care to an incapable adult if the personal guardian or representative gives informed consent.[47]

If there is no personal guardian or representative, or if one is not available, a health care provider may obtain substitute consent from a "temporary substitute decision maker" (TSDM) listed in section 16 of the HCCCFA Act. The potential TSDMs, in ranked order, are:

- the adult's spouse;
- the adult's child;
- the adult's parent;
- the adult's brother or sister;
- the adult's grandparent;
- the adult's grandchild;
- anyone else related by birth or adoption to the adult;
- a person immediately related to the adult by marriage.[48]

The care provider must select as a TSDM the first person in this ranked list who is available and qualified to give, refuse, or revoke consent to the proposed health care. In order to qualify, the person must be at least 19 years old, have been in contact with the adult during the preceding 12 months, have no dispute with the adult, be capable

46. *Ibid.*, s. 11(b)(ii).

47. *Ibid.*, s. 11.

48. *Ibid.*, s. 16(1).

of giving, refusing, or revoking substitute consent, and be willing to comply with the duties of a TSDM.[49]

If there is no one in the list of potential TSDMs who is available or qualified, or if there is a dispute about who should be selected as a TSDM, the health care provider must choose a person authorized by the Public Guardian and Trustee.[50] This may include an employee of the Office of the Public Guardian and Trustee.[51]

If consent to major health care is provided by a TSDM, the health care provider must inform the adult who is the intended care recipient and any spouse, near relative or close friend accompanying the adult of the assessment of incapacity, the name of the TSDM, and the decision to give or refuse substitute consent.[52] A prescribed form of written notice is used for this purpose.[53] Minor health care may be provided to an incapable adult with substitute consent given by a TSDM without the requirement to inform a spouse or other supporters accompanying the adult of the identity of the TSDM.[54]

Not more than 21 days before health care authorized by consent of a TSDM begins, the health care provider must confirm in writing that the adult is still incapable and that the TSDM who gave the consent confirms that it should begin.[55] If the health care provider has reason to believe before or after the health care begins that the adult who is to receive it has recovered the capacity to consent, a further determination of capacity is required at that point.[56] If capacity is recovered at any time after substitute

49. *Ibid.*, s. 16(2).

50. *Ibid.*, s. 16(3). In the event of a dispute amongst family members over who should be the decision maker for an incapable relative, it is common for a regional health authority or an individual health care practitioner to contact the Office of the Public Guardian and Trustee to designate a TSDM.

51. *Ibid.*

52. *Ibid.*, s. 14(4). Section 14(4) speaks only of giving or refusing consent. It omits reference to revocation of consent. The provision of the HCCCFA Act empowering a TSDM to make a health care decision, namely s. 17(1), likewise refers only to giving or refusing consent. By contrast, s. 16(2) refers to giving, refusing, or revoking consent in addressing the qualifications of a TSDM to make a health care decision. This creates some uncertainty about the ability of a TSDM to revoke a consent to health care that was previously given, whether by the same TSDM or another decision maker.

53. *Health Care Consent Regulation*, *supra*, note 24, s. 6.

54. *Supra*, note 21, s. 15.

55. *Ibid.*, s. 17(2).

56. *Ibid.*, s. 17(2.1).

consent was given, the substitute consent is automatically rescinded and before any health care is begun or continued, consent must be sought from the now capable adult.[57]

5. Obligations of SDMs and Limitations on Their Authority

Due to the fact that the different categories of SDMs derive their authority from different legislation, they have similar but finely nuanced legal obligations vis-à-vis the incapable adult in giving, refusing, or revoking health care consent. They also have differing limitations on their authority.[58]

Representatives are required by the *Representation Agreement Act* to consult with the adults who appointed them to the extent reasonable in making decisions on their behalf, and to comply with their wishes "if it is reasonable to do so."[59] If it is not possible to determine the adult's current wishes or it is not reasonable to comply with them, the representative must comply with any instructions or wishes the adult expressed while capable.[60] If, however, the relevant representation agreement is one made under section 9 of that Act and states that the representative needs only to comply with instructions the adult gave before losing mental capacity, the representative does not need to consult the adult and ascertain the adult's current wishes before making a health care decision.[61]

If the adult's instructions or expressed wishes are not known, the representative must decide on the basis of the adult's known beliefs and values, and if they are not known, in the adult's best interests.[62] When a health care decision by a representative must be made on the basis of the adult's best interests, the representative must take into account the same considerations that a TSDM must bear in mind when determining an adult's best interests do under section 19(3) of the HCCCFA Act.[63] These considerations are described below.

57. *Ibid.*, s. 17(2.2).

58. The Canadian Centre for Elder Law has recommended that the statutory obligations of SDMs concerning health care be harmonized to a greater extent by amendment of relevant statutes: *supra*, note 2 at 196.

59. R.S.B.C. 1996, c. 405, s. 16(2).

60. *Ibid.*, s. 16(3).

61. *Ibid.*, s. 16(2.1).

62. *Ibid.*, s. 16(4).

63. *Ibid.*, s. 16(7).

Representatives are prohibited from consenting to the same kinds of prescribed health care that lie outside the authority of TSDMs, unless the representation agreements appointing them are made under section 9 of the *Representation Agreement Act* and expressly confer the power to consent to do so.[64]

TSDMs must consult with the incapable adult "to the greatest extent possible" before giving or refusing consent, and comply with any instructions or wishes the adult expressed while possessing capacity.[65] If the adult's instructions or wishes are not known, the TSDM must make the decision in the adult's best interests.[66] In determining the incapable adult's best interests, a TSDM (and representatives, as mentioned above) must consider the following:

- the adult's current wishes, and known beliefs and values;
- whether the adult's condition or well-being is likely to be improved by the proposed health care;
- whether the adult's condition or well-being is likely to improve without the proposed health care;
- whether the benefit the adult is expected to obtain from the proposed health care is greater than the risk of harm; and
- whether a less restrictive or less intrusive form of health care would be as beneficial as the proposed health care.[67]

A TSDM does not have authority to give or refuse substitute consent for an incapable adult to receive certain types of health care prescribed by regulation.[68] These are:

- abortion, unless it is recommended in writing by the treating physician and at least one other medical practitioner who has examined the adult;

64. *Ibid.*, s. 9(2)(a).
65. *Supra*, note 21, s. 19(1).
66. *Ibid.*, s. 19(2).
67. *Ibid.*, s. 19(3).
68. *Ibid.*, s. 18(1).

- electroconvulsive therapy, unless it is recommended in writing by the treating physician and at least one other medical practitioner who has examined the adult;

- psychosurgery;

- removal of tissue for implantation in another human body, or for medical education or research;

- experimental health care involving a foreseeable risk to the adult that is not outweighed by the expected therapeutic benefit;

- participation in a health care or medical research program that has not been approved by a committee referred to in section 2 of the HCCCFA Act (a listed ethics board)

- any treatment, procedure or therapy that involves using aversive stimuli to induce a change in behaviour.[69]

A TSDM is authorized, however, to refuse substitute consent to health care that is necessary to preserve life if the health care providers caring for the incapable adult agree that the refusal is medically appropriate, and if the TSDM complies with all the statutory duties applicable to TSDMs.[70]

Personal guardians are not currently under statutory obligations to consult or abide by the wishes or instructions of the adult for whom they are the decision maker. Instead, their powers are derived from the terms of the court orders appointing them. As fiduciaries, they are obliged to always act in the best interests of the person for whom they are responsible. Nevertheless, the Public Guardian and Trustee has published a handbook for personal guardians that urges them to be guided by the terms of the HCCCFA Act in making health care decisions and the same criteria that representatives and TSDMs are legally bound to follow. The handbook suggests personal guardians make health care decisions in accordance with this trilogy of guidelines:

- any known instructions or wishes made by the adult when the adult was capable;

69. *Health Care Consent Regulation*, *supra*, note 24, s. 5.

70. *Supra*, note 21, s. 18(2).

- if there are no known prior instructions or wishes made when the adult was capable, the decision is to be made in accordance with known applicable values and beliefs;

- if there are no such known values and beliefs then a decision is to be made in the adult's best interests as defined in the [HCCCFA] Act.[71]

6. Consent or Refusal by Advance Directive

Part 2.1 of the HCCCFA Act allows for advance directives that operate as consents or refusals of health care at a future time when the maker of the directive may have become incapable of making a health care decision. An "advance directive" is a written instruction made by a capable adult that gives or refuses consent to health care for the adult in the event of incapability to do so at the time the health care is required, and which complies with Part 2.1 of the Act.[72]

In addition to any content that may be prescribed by regulation, an advance directive must contain an indication that the maker knows a health care provider may not provide health care that the maker refuses in the advance directive, and also that a substitute decision maker will not be chosen in respect of health care for which consent is given or refused in it.[73]

The Act provides a special test of incapacity for the purpose of making an advance directive. An adult is incapable of making an advance directive if the adult cannot understand its nature and consequences in the sense of lacking understanding of the scope and effect of the health care instructions set out in it, and that no TSDM will be selected to make decisions on adult's behalf except in circumstances specified in section 19.8 of the Act.[74]

A health care provider may follow the advance care directive of a person lacking capacity to consent to health care, but only if the health care provider does not know of

71. Public Guardian and Trustee of British Columbia, *Private Committee Handbook* (Vancouver: PGTBC, 2014) at 24, online: https://www.trustee.bc.ca/documents/pcs/pcs%20handbook.pdf.

72. *Supra*, note 21, s. 1 ("advance directive"). An advance directive must be signed in the presence of two witnesses like a will: s. 19.5(1). If one witness is a lawyer or a notary public, however, only that one witness is required: s. 19.5(4). Like a will, alterations to an advance directive must be witnessed in the same manner. Part 2.1 of the HCCCFA Act also contains some requirements concerning the content of an advance directive.

73. *Ibid.*, s. 19.4(b).

74. *Ibid.*, s. 19.1(2).

any personal guardian or representative with authority to make decisions for adult in respect of the proposed health care.[75]

In a case where an incapable adult has made an advance directive and also a representation agreement, a health care provider generally must look to the representative for a health care decision in respect of any matter over which the representative has decision-making authority, regardless of the order in time which the directive and representation agreement were made.[76] The exception is when the representation agreement declares that a health care provider may act in accordance with an instruction in the advance directive without the representative's consent.[77]

If the health care provider is aware the adult has a personal guardian authorized to make health care decisions, the personal guardian must be consulted to obtain a consent or refusal of proposed care. The advance directive is not binding on the personal guardian under the law currently in effect.[78]

A health care provider is only required to make a "reasonable effort" to determine whether an adult has an advance directive, or a personal guardian or representative.[79]

Part 2.1 of the HCCCFA Act specifies a few circumstances in which an advance directive is not to be followed, and instead health care providers must consult an SDM to obtain consent or refusal. These circumstances are ones in which the health care provider reasonably believes that

- the instructions in an adult's advance directive do not address the health care decision to be made,

75. *Ibid.*, ss. 19.7(1), (2).

76. *Ibid.*, s. 19.3(1).

77. *Ibid.*, s. 19.3(2).

78. Portions of the *Adult Guardianship Act*, R.S.B.C. 1996, c. 6 that are not in force would repeal and supplant the *Patients Property Act*, *supra*, note 45, and impose obligations on personal guardians similar to those resting on representatives and TSDMs to be guided by wishes or instructions expressed by an incapable adult while capacity was still present, If no such wishes or instructions are known to have been expressed, personal guardians would be obliged to act in accordance with the best interests of the incapable adults for whom they are the decision makers, taking into account the beliefs and values of those adults insofar as they are known.

79. *Ibid.*, s. 19.7(3).

- in relation to a health care decision, the instructions in an adult's advance directive are so unclear that it cannot be determined whether the adult has given or refused consent to the health care,

- since the advance directive was made and while the adult was capable, the adult's wishes, values or beliefs in relation to a health care decision significantly changed, and the change is not reflected in the advance directive, or

- since the advance directive was made, there have been significant changes in medical knowledge, practice or technology that might substantially benefit the adult in relation to health care for which the adult has given or refused consent in an advance directive.[80]

It is obvious this list of circumstances in which the HCCCFA Act allows for an advance directive to be treated as ineffective leaves room for considerable difference of opinion and dispute. Even when all parties agree that an advance directive is valid and effective, there can be room for nuance and difference of opinion about its correct interpretation. While advance directives are a mechanism intended to further the principle of individual autonomy in health care, and to create certainty and comfort for patients, their families, and health care providers alike, they are also fodder for the kind of disputes that are sometimes only resolved through an impartial, disinterested decision-making body.

7. Exceptions to the Requirement for Informed Consent

(a) Urgent or emergency health care

The HCCCFA Act provides an exception to the requirement for informed consent when health care must be provided on an urgent or emergency basis, and consent is unobtainable from the adult who requires it. In order for this exception to apply, several conditions must be met.

The care in question must be necessary to preserve life, prevent serious physical or mental harm, or to alleviate severe pain.[81] The health care provider must have the opinion that the adult requiring the care is incapable of giving or refusing it, whether due to intoxication, unconsciousness, semi-consciousness, or any other reason.[82] The adult must not have a personal guardian or representative who is authorized to

80. *Ibid.*, s. 19.8.

81. *Ibid.*, s. 12(1)(a).

82 . *Ibid.*, s. 12(1)(b).

consent, capable of doing so, and available.[83] ("Availability" in this context means that it would be possible for the health care provider to determine whether the adult has a personal guardian or representative, and to communicate with the personal guardian or representative.[84]) The Act also requires that, "where practicable," the health care provider's opinion concerning the need for the health care and the incapability of the proposed care recipient to give or refuse consent must be confirmed by a second health care provider.[85]

A personal guardian or representative who becomes available after the emergency health care has begun, or a TSDM selected after that point, may refuse consent for continued care.[86] In that case, the health care initiated under the emergency exception must be withdrawn.[87]

If the health care provider believes, however, that a personal guardian or representative is not complying with their duties under the HCCCFA Act or any other Act in refusing health care for the incapable adult, emergency care necessary to preserve life, prevent serious physical or mental harm, or to alleviate severe pain may be provided despite the refusal.[88]

(b) Preliminary examination

Triage or another kind of preliminary examination, treatment or diagnosis may be performed on an adult without the requirement of a fully informed consent as along

83. *Ibid.*, s. 12(1)(c).

84. *Ibid.*, s. 12(2).

85. *Ibid.*, s. 12(1)(d).

86. *Ibid.*, s. 12(3).

87. *Ibid.* Even though the health care provider may be obliged in these circumstances to interrupt health care to an incapable adult initiated under the emergency exception in s. 12(1) of the HCCCFA Act , provider who believes that a personal guardian, representative, or TSDM has acted in breach of obligations legally owed to the incapable adult would have a right to apply to the Supreme Court of British Columbia under s. 33.4 for an order reversing or varying the decision to refuse continued care. See the text under the subheading "Court Review of Incapacity Assessments and Health Care Substitute Decision-Making" later in this chapter.

88. *Ibid.*, s. 12.2. In theory, the health care provider would have the alternative to apply for an order under s. 33.4 overruling the personal guardian's or representative's refusal, as mentioned in note 87, *supra*. Of course, this would be impractical when care must be supplied urgently to save lives or prevent serious harm.

as the adult indicates a desire to receive the preliminary care, or a spouse, near relative or close friend indicates a wish that the adult receive it.[89]

(c) Involuntary psychiatric treatment under the Mental Health Act

A further important exception to the consent requirements of the HCCCFA Act pertains to psychiatric treatment administered to persons involuntarily admitted to a designated facility under the *Mental Health Act*.[90] These persons are deemed under that Act to have consented to psychiatric treatment authorized by the director of the designated facility and any procedure necessarily related to the provision of psychiatric treatment.[91] Involuntary patients released on leave from a designated facility and those transferred from one to an approved home are also deemed to consent to any further authorized psychiatric treatment they receive.[92] The statutory deemed consent applies regardless of whether capacity to consent is present or absent. In this respect, British Columbia's mental health legislation differs from that of other Canadian jurisdictions.[93]

The HCCCFA Act applies to non-psychiatric health care administered to persons involuntarily admitted to designated facilities, but evidently this is not understood and observed in practice, possibly due in part to uncertainty over the extent of the deemed consent under the mental health statute to "procedures necessarily related to the involuntary psychiatric treatment." In a 2019 report, the Ombudsperson identified instances in which the directors of designated facilities assumed they could authorize non-psychiatric health care for involuntary patients using the same procedure as for

89. *Ibid.*, s. 13. A "near relative" is defined in s. 1 of the HCCCFA Act as "[a]n adult child, a parent, a grandparent, an adult brother or sister, any other adult relation by birth or adoption, or a spouse of any of these." A "close friend" is defined in s. 1 as "[a]nother adult who has a long-term, close personal relationship involving frequent personal contact with the adult, but does not include a person who receives compensation for providing personal care or health care to that adult."

90. R.S.B.C. 1996, c. 288.

91. *Ibid.*, ss. 1 (definition of "treatment") and 31. See also the definition of "treatment" in s. 1. An example of a procedure "necessarily related to the provision of psychiatric treatment" would include electroconvulsive therapy or the administration of antipsychotic medication.

92. *Ibid.* An "approved home" is one selected and approved under regulations made under the *Mental Health Act*, *supra*, note 90.

93. *Conversations About Care*, *supra*, note 2, contains a summary at pages 99-100 of the various approaches taken in other provinces and territories regarding consent to psychiatric treatment on the part of persons detained under mental health legislation.

psychiatric care.[94] The Ombudsperson made a recommendation that they cease doing this and instruct their staff that non-psychiatric treatment could only be given in accordance with the HCCCFA Act, or the *Infants Act*[95] in the case of minors.[96]

8. Consent to Health Care of Minors

In British Columbia, consent to health care administered to minors is governed by different legislation than consent to health care of adults.

Giving, refusing, or withdrawing consent to medical, dental, or other health-related treatments of minors is a parental responsibility under the *Family Law Act*.[97] This responsibility of parents (and by extension, a guardian) is subject, however, to section 17 of the *Infants Act*.[98] Under that provision, a minor may give a valid consent to receive health care, and it is unnecessary for the health care provider to obtain consent from the infant's parent or guardian.[99] "Health care" in the *Infants Act* has a definition similar to that under the HCCCFA Act.[100]

A minor's consent is valid only if the health care provider explains beforehand the nature, consequences, and reasonably foreseeable benefits and risks of the health care in question, and has concluded that it is in the infant's best interests, after making reasonable efforts to determine whether this is the case.[101]

If a minor has the capacity to understand the explanation that section 17 requires, the right of consent or refusal belongs only to the minor. The minor's parents or guardian

94. Office of the Ombudsperson, *Committed to Change: Protecting the Rights of Involuntary Patients under the Mental Health Act*, Special Report No. 42 (Victoria: Office of the Ombudsperson, 2019) at 60.

95. *Supra*, note 22.

96. *Supra*, note 94 at 60.

97. S.B.C. 2011, c. 41(f).

98. *Supra*, note 22. See *A.B. v. C.D.*, 2020 BCCA 11, at para. 215.

99. *Ibid.*, s. 17(2). This subsection has been held to codify the common law concerning health care consent by a "mature minor" who has the intelligence to appreciate the nature and consequences of proposed treatment: *Ney v. Canada (Attorney General)* (1993), 79 B.C.L.R. (2d) 47 (S.C.). See also *Van Mol v. Ashmore*, 1999 BCCA 6; leave to appeal refused [1997] S.C.C.A. No. 117.

100. *Ibid.*, s. 17(1) ("health care"). The *Infants Act*, however, does not distinguish between "major" and "minor" health care, unlike the HCCCFA Act. Regarding the definition of "health care" in the HCCCFA Act, see above the text in this chapter under the heading "C. British Columbia's Health Care Consent Legislation" and subheading "1. General."

101. *Ibid.*, s. 17(3).

do not have concurrent authority to consent or refuse on the minor's behalf.[102] The consent of a parent or guardian is only necessary if the minor does not have the capacity, as determined by the health care provider, to consent under section 17.

It has been held, however, that a Provincial Court order made under section 29 of the *Child, Family and Community Services Act*[103] on the application of the Director of Child, Family and Community Services prevails over a refusal of treatment by a minor or the minor's parents.[104] An order under section 29 of that Act may authorize health care to be provided to a minor without consent if, in the opinion of two medical practitioners, it is necessary to preserve the minor's life or prevent serious or permanent impairment of the minor's health.

B. Consent to Care Facility Admission

1. Part 3 of the HCCCFA Act and the Definition of "Care Facility"

Part 3 of the HCCCFA Act governs consent to admission and continued residence in a "care facility," which is defined to include facilities that provide long-term residential care, convalescent care, in-patient rehabilitative services, or extended care.[105] The term "care facility" as used in the HCCCFA Act does not include acute care facilities.

Although a version of Part 3 was included in the Act when first enacted, that Part was not brought into force until late 2019.[106] Until that point, British Columbia lacked a legislative framework for substitute decision-making in relation to admission to long-term care.[107]

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102. *Van Mol v. Ashmore*, *supra*, note 99, at para. 89; *A.B. v. C.D.*, 2020 BCCA 11, at para 215.

103. R.S.B.C. 1996, c. 46.

104. *B. (S.J.) v. British Columbia (Director of Child, Family and Community Services)*, 2005 BCSC 573.

105. *Supra,* note 21, s. 1 ("care facility"). The institutions comprised in the definition of "care facility" are a community care facility licensed or designated under the *Community Care and Assisted Living Act*, S.B.C. 2002, c. 75 that provides residential care to adults, a private hospital licensed under Part 2 of the *Hospital Act*, R.S.B.C. 1996, c. 200, and an institution designated as a hospital under that Act for the treatment of persons referred to in paragraph (b) or (c) of the definition of "hospital" in that Act. Persons referred to in paragraph (b) of the definition of "hospital" in the *Hospital Act* are those convalescing or being rehabilitated from acute illness or injury. Those referred to in paragraph (c) of that definition are persons requiring extended care at a higher level than that generally provided in a licensed private hospital.

106. See B.C. Reg. 114/2019.

107. *Conversations About Care, supra*, note 2 at 37.

A care facility admission decision relates to a long-term living arrangement that includes housing, personal care, and at least some forms of minor health care. It may and usually does involve contractual and financial commitments. The consent provisions under Part 3 resemble those in Part 2, but the mental capacity required to make a care facility admission decision is more multifaceted than the capacity required to receive or refuse specific medical or other health care treatment. Urged by a recommendation of the Ombudsperson, the provincial government has attempted to standardize the way in which an adult's capacity to give or refuse consent under Part 3 of the HCCCFA Act is assessed when there is some basis to suspect it is impaired or has been lost.[108] As a result, the *Health Care Consent Regulation* now contains mandatory protocols for assessing capacity to consent to care facility admission.[109]

2. Consent to Admission and Substitute Consent

Admission to a care facility requires an application by an adult or a person acting on the adult's behalf.[110] An application may be made on behalf of an adult only if the person making the same has reason to believe that the adult in question requires the type of care available in a care facility and that adult is incapable of giving or refusing consent to admission.[111]

The manager may only admit an adult to a care facility if:

- the adult consents, in the case of an adult with capacity to consent or refuse;[112]
- substitute consent is given, in the case of an adult incapable of giving or refusing consent;[113] or
- the emergency admissions provision applies.[114]

108. Office of the Ombudsperson, *The Best of Care: Getting it Right for Seniors in British Columbia (Part 2)* Public Report No 47 (Victoria: Queen's Printer, 2012) at 242-244 (Recommendation R115).

109. *Supra*, note 24 , Part 5, ss. 16-22.

110. *Supra*, note 21, s. 20(1).

111. *Ibid.*, s. 20(2).

112. *Ibid.*, s. 20(3)(a).

113. *Ibid.*, s. 20(3)(b).

114. *Ibid.*, s. 24(1).

Consent to care facility admission may be given orally or in writing, or inferred from conduct.[115] As with consent to health care, however, it is only valid if it is voluntary and informed, and obtained without fraud or misrepresentation.[116] This is true whether the consent is given directly by a capable adult seeking admission or by an SDM on behalf of an incapable adult.[117]

The information that must be supplied to the adult or an SDM is that which a reasonable person would need to understand that the adult will be admitted to the care facility and to decide whether to accept or refuse admission, including information about the care the adult will receive, the services available, and the circumstances under which the adult may leave the care facility.[118]

In communicating the information, the manager of a care facility is required to communicate in a manner appropriate to the adults (or SDM's) skills and abilities, and allow the adult's spouse, relatives or friends who accompany the adult to offer their assistance to help the adult understand or to demonstrate understanding of the information provided.[119]

3. Who May Give Substitute Consent

The persons who are eligible to give substitute consent for care facility admission are the same as those who can do so for health care. The manager of a care facility must look first to a personal guardian empowered to consent to the admission, if any.[120] If there is no personal guardian at hand with the requisite authority, substitute consent may be given or refused by a representative authorized to do so under a representation agreement.[121] Failing a personal guardian or a representative, the manager may seek consent from a person who could serve as a TSDM for the purpose of consenting to health care.[122]

115. *Ibid.*, s. 21(2). There is, however, no suggestion in Part 3 of the HCCCFA Act that consent may be inferred merely from the fact that an application for admission has been made. A manager of a care facility must make a positive effort to obtain consent to admission.

116. *Ibid.*, s. 21(1).

117. *Ibid.*, s. 22(6).

118. *Ibid.*, s. 21(1)(d).

119. *Ibid.*, s. 21(3).

120. *Ibid.*, s. 22(1)(a).

121. *Ibid.*, s. 22(1)(b).

122. *Ibid.*, s. 22(2). See the list of potential TDSMs earlier in this chapter under the subheading "Obtaining Substitute Consent When Adult Patient Lacks Capacity."

4. Duties of a Substitute Decision Maker

The duties of an SDM under Part 3 of the HCCCFA Act are similar to those relating to health care consent. Before giving or refusing consent, the SDM must make a reasonable effort to consult with the adult determined to be incapable and with any spouse, friend or relative who asks to assist.[123] The SDM must make the care facility admission decision in the adult's best interests, taking into account the adult's current wishes and any pre-expressed wishes, values and beliefs.[124] In determining the adult's best interests, the SDM must consider whether the adult could benefit from admission, and whether a different course of action or a less restrictive type of care facility is available and appropriate in the circumstances.[125]

5. Emergency Admission to a Care Facility Without Consent

An adult may be admitted to care facility without the adult's or a substitute decision maker's consent being first obtained if the adult has been determined to be incapable of giving or refusing consent and immediate admission is necessary to preserve life, to prevent serious physical or mental harm to the adult or serious physical harm to any person, or if the adult is the subject of an emergency measure taken under section 59 of the *Adult Guardianship Act*.[126]

Within 72 hours after an emergency admission, the manager of the care facility must obtain substitute consent for continued admission.[127]

6. Requests to Leave a Care Facility

A person in care who retains the capacity to give or refuse consent to admission (and continued residence by implication) may not be prevented or obstructed from leaving at any time.[128] If the SDM for a person in care who is incapable of giving or refusing

123. *Ibid.*, s. 23(2)(a).

124. *Ibid.*, s. 23(3)(a), (b).

125. *Ibid.*, s. 23(3)(c).

126. *Ibid.*, s. 24(1). Section 59 of the *Adult Guardianship Act*, *supra*, note 78, authorizes a designated agency to provide emergency health care to an adult who is apparently abused and neglected and take other necessary emergency measures to protect the adult from harm, if it is necessary to preserve the adult's life, prevent serious physical or mental harm to the adult, or protect the adult's property from significant damage or loss. Agreement by the adult is not a legal prerequisite for this emergency action.

127. *Supra*, note 21, s. 24(2).

128. *Ibid.*, s. 25(1)(a).

consent expresses a desire for the person to leave, the manager of the care facility is likewise obliged to allow the departure.[129]

If the manager of a care facility has reason to doubt the capacity of a person in care who expresses a desire to leave, the manager must have the person assessed in accordance with the procedure in Part 3 of the HCCCFA Act and the regulations under it.[130] An assessment is not necessary, however, if the person in care has a guardian.[131] A provision that is not in force as of the date of writing would also make an assessment unnecessary if the person in care has been assessed as incapable within the previous six months.[132]

7. Incapability Assessments Under Part 3 of the HCCCFA Act

Incapability assessments for the purpose of determining whether an adult is incapable of giving or refusing consent to admission or continued residence must be made only by a medical practitioner or a prescribed health provider.[133] The health providers in addition to medical practitioners who are prescribed as assessors for the purposes of the HCCCFA Act are: registered nurses and nurse practitioners, registered psychiatric nurses, social workers, occupational therapists, and psychologists, provided they are registrants of their respective professional colleges.[134]

A determination of incapacity to give or refuse consent to admission or continued residence must be based on whether the adult in question demonstrates understanding of the information that the manager of a care facility is obliged to provide to a prospective resident or the prospective resident's SDM.[135] The assessment leading to the determination must be made in accordance with the regulations under the HCCCFA Act.[136]

The protocols set out in the regulations for conducting incapacity assessments under Part 3 of the HCCCFA Act are procedural for the most part. With few exceptions, they do not extend to the methodology of assessment itself. The adult being assessed must

129. *Ibid.*, s. 25(1)(b).

130. *Ibid.*, s. 25(3).

131. *Ibid.*, s. 25(4)(a).

132. *Ibid.*, s. 25(4)(b).

133. *Ibid.*, s. 26(1).

134. *Health Care Consent Regulation*, *supra*, note 24, s. 16.

135. *Supra*, note 21, s. 26(2).

136. *Ibid.*

be informed of the purpose for which the assessment is being conducted, namely to determine whether the adult is incapable of giving or refusing consent to admission to, or continued residence in, a care facility.[137] The adult must also be informed that in the event of an incapacity finding, an SDM may give or refuse consent to those things for the adult.[138]

The assessor may permit persons other than the adult being assessed to be present during the assessment if the adult requests it or if it is necessary or advisable in order to communicate with the adult or conduct the assessment.[139]

The assessor may also prohibit a person from attending all or any part of an assessment over the objections of the adult being assessed if, in the assessor's opinion, that person's presence would disrupt or adversely affect the process.[140]

If the adult refuses or is not reasonably able to participate in the assessment or cannot reasonably be accessed, and the assessor has reason to believe the assessment can be completed accurately using available information, the assessment may be based on observational and other relevant information, and be conducted in whole or in part in the absence of the adult.[141]

The assessor may consult with persons having information relevant to the assessment, including persons who have provided social health care services to the adult in question, and with the adult's spouse, near relatives, and close friends.[142]

Before making a determination, the assessor must review all available relevant medical diagnoses and prognoses regarding any underlying or potentially reversible health conditions that may affect the ability to make decisions about admission to, or continued residence in, a care facility.[143]

On completing an assessment, the assessor must prepare an assessment report, which must include a description of the factors considered in making a determination of

137. *Health Care Consent Regulation*, *supra*, note 24, s. 17.

138. *Ibid.*

139. *Ibid.*, s. 18(1).

140. *Ibid.*, ss. 18(2), (3).

141. *Ibid.*, s. 20.

142. *Ibid.*, ss. 21(1), (2).

143. *Ibid.*, s. 19.

capacity or incapacity, a summary of information gathered from sources other than the adult, and the assessor's conclusions.[144] The adult normally must be informed of the determination and of the right to receive a copy of the assessment report on request.[145] If, however, the assessor has reason to believe that informing the adult of the determination or providing a copy of the assessment report would result in serious physical or mental harm to the adult or significant damage or loss to the adult's property, the assessor is not required to do so.[146]

An SDM is entitled to receive a copy of the assessment report on request if the adult was determined to be incapable.[147]

8. Use of Restraints

The HCCCFA Act prohibits the use of restraints for the purpose of punishment or discipline, or for the convenience of care facility staff, and allows their use only in accordance with regulations.[148] For the purpose of the Act, to "restrain" means to control or restrict the freedom of movement of a person in care by any physical means or any means that may be prescribed.[149] Additional prescribed means covered by the term "restrain" are chemical, electronic, mechanical or other means of controlling or restricting freedom of movement, and housing the person in a secure unit.[150] The inclusion of chemical means in the definition of "restrain" has the consequence that administration of mood-altering medication or heavy sedatives may amount to a restraint in certain circumstances.

The regulations under the HCCCFA Act make the provisions of the *Residential Care Regulation* on use of restraints applicable to persons in care.[151] They specify that a person in care may be restrained only in two circumstances. One is if the restraint is necessary to protect the person in care or others from "imminent serious physical

144. *Ibid.*, s. 22(1)(a).

145. *Ibid.*, ss. 22(1)(b), (d)(i).

146. *Ibid.*, s. 22(2).

147. *Ibid.*, s. 22(1)(d)(ii).

148. *Supra*, note 21, ss. 26.1(2), (3).

149. *Ibid.*, s. 26.1(1).

150. *Health Care Consent Regulation*, *supra*, note 24, s. 23.

151. *Ibid.*, s. 24(1). The *Residential Care Regulation*, B.C. Reg. 96/2009, is made under the *Community Care and Assisted Living Act*., *supra*, note 105. Section 24(1) of the *Health Care Consent Regulation*, *supra*, note 24, adopts Division 5 of Part 5 and s. 84 of the *Residential Care Regulation* for the purposes of s. 26.1 of the HCCCFA Act.

harm."[152] The other circumstance is if there is a written agreement governing the use of a restraint to which the person in care, or an SDM for that person, or a relative who is closest to and actively involved in the life of that person, is a party.[153] The medical practitioner or nurse practitioner responsible for the health of the person in care must also be a party to the agreement.[154] In effect, the legal use of a restraint in a care facility depends upon written consent except where it is necessary to prevent "imminent serious physical harm" to the person in care who is restrained or others.

The Canadian Centre for Elder Law has recommended that in non-emergency situations, consent to the use of a restraint in a care facility should have to be obtained in the same manner as consent to health care under the HCCCFA Act.[155] A further recommendation would require that consent of the person in care or an SDM be obtained in order to continue use of a restraint for more than 24 hours, and also require recognition of the right of the person in care or SDM to revoke the consent.[156]

C. Court Review of Capacity Assessments and Substitute Health Care Decision-Making

Section 33.4 of the HCCCFA Act provides a right to apply to the Supreme Court of British Columbia for review of an incapacity assessment and health care decisions made by SDMs on behalf of an adult:

> **Court directions and orders**
> **33.4** (1) The following people may apply to the court for an order under subsection (2):
>
> (a) a health care provider responsible for the care of an adult who is incapable of giving or refusing consent to health care;
>
> (b) an adult's representative or personal guardian;
>
> (c) a person chosen under this Act to give or refuse substitute consent to health care or admission to a care facility on behalf of an adult who is incapable;

152. *Residential Care Regulation*, *supra*, note 151, s. 74(1)(a).

153. *Ibid.*, s. 74(1)(b).

154. *Ibid.*

155. *Supra*, note 2 at 198.

156. *Ibid.*, at 199.

(d) an adult who is assessed as incapable of giving or refusing consent to health care or admission to a care facility.

(2) On application by a person described in subsection (1), the court may do one or more of the following:

(a) order the adult to attend at the time and place the court directs and submit to one or more assessments of incapability;

(b) give directions respecting

(i) the interpretation of a provision of an advance directive, or any other health care instruction or wish, made or expressed by an adult when capable, or

(ii) who should be chosen to provide substitute consent under this Act for an incapable adult;

(c) confirm, reverse or vary a decision by

(i) an adult's representative or personal guardian, or

(ii) a person chosen to provide substitute consent under this Act,

to give or refuse consent to health care or admission to a care facility;

(d) make any decision that a person chosen to provide substitute consent under this Act could make.

(3) Any person may apply to the court for an order voiding an advance directive on the basis that fraud, undue pressure or some other form of abuse or neglect was used to induce an adult to make the advance directive, or to change or revoke a previous advance directive.

(4) Nothing in this Act

(a) limits the inherent jurisdiction of the Supreme Court to act in a parens patriae capacity, or

(b) deprives a person of the right to ask the Supreme Court to exercise that jurisdiction.

An application may be made by an adult who has been assessed as incapable of consenting to or refusing health care, a guardian or representative, a TSDM chosen under

the HCCCFA Act, or a health care provider responsible for an incapable adult.[157] An application may also be made to the court for an authoritative interpretation of an advance directive, or any other health care wish or instruction made while capacity was still retained.[158]

When an application is made under section 33.4, the court is empowered to direct one or more re-assessments of capacity, and can order the adult whose capacity is in issue in the application to attend at a specified time and place to submit to them.[159] When the application concerns a decision by an SDM to give or refuse consent to health care or admission to a care facility, the court may confirm, reverse, or vary the decision, whether it is one made by a TSDM or by a personal guardian or representative.[160] The court may make any decision that a person chosen to provide substitute consent under the HCCCFA Act could make.[161]

The court is empowered to give directions regarding the interpretation of a provision in an advance directive or any other health care instruction or wish that an adult made or expressed while still capable of consenting or refusing health care.[162] It is also empowered to declare an advance directive void if it is shown that it was the product of fraud, undue pressure, or another form of abuse or neglect used to induce its making, or a change or revocation of a previous advance directive.[163]

Under section 33.4, the court may also give directions regarding who should be selected as a TSDM.[164]

Section 33.4 does not displace or limit the inherent *parens patriae* powers of the Supreme Court of British Columbia, nor prevent anyone from petitioning that court to exercise *parens patriae* jurisdiction in a particular situation.[165] *Parens patriae* powers are a part of the inherent jurisdiction of a superior court, allowing the court to act

157. *Supra*, note 21, s. 33.4(1).

158. *Ibid.*, s. 33.4(2)(b).

159. *Ibid.*, s. 33.4(2)(a).

160. *Ibid.*, s. 33.4(2)(c).

161. *Ibid.*, s. 33.4(2)(d).

162. *Ibid.*, s. 33.4(2)(b)(i).

163. *Ibid.*, s. 33.4(3).

164. *Ibid.*, s. 33.4(2)(b)(ii).

165. *Ibid.*, s. 33.4(4).

for the protection of minors and persons who lack mental capacity.[166] It is typically invoked when there is a gap in legislation or common law.[167] The full scope of *parens patriae* jurisdiction is not amenable to definition, but the jurisdiction may only be exercised in the interest of the person in need of protection, and in the case of adults its exercise is predicated on a finding of mental incapacity to manage oneself or one's affairs.[168]

There appear to be no decisions under section 33.4, even though the section has been in force for a decade. As it is highly unlikely that no incapacity findings were in dispute in that interval and no conflicts surrounding substitute decision-making in relation to health care arose, the lack of use of the provision suggests it is not feasible for those involved to apply to the Supreme Court for relief. For the reasons stated in Chapter 1, the court-based remedy under section 33.4 may be operating as a barrier to access to justice rather than a gateway.

166. *E. v. Eve*, [1986] 2 S.C.R. 388.

167. See, for example, *Forliti v. Forliti*, 2016 BCSC 743 at para. 306; *Re Senini*, 2016 BCSC 2299.

168. *E. v. Eve*., *supra*, note 166.

CHAPTER 3. THE BRIEF LIFE OF THE BRITISH COLUMBIA HEALTH CARE AND CARE FACILITY REVIEW BOARD

A. Regional Review Boards as Part of the Original Scheme

1. GENERAL

A review board was part of the original scheme of the HCCCFA Act. When first enacted in 1993, Part 4 of the HCCCFA Act contained provisions contemplating the creation of a Health Care and Care Facility Review Board in each health region of the province.[169] As was explained on second reading when introduced in the Legislative Assembly at the time, the purpose of the regional boards was to review and rule on any objection to health care decisions in a very expeditious timeframe, responding to a need for an informal, inexpensive, and timely procedure.[170] Opposition comments on second reading were to the effect that inclusion of a review process was seen as a useful aspect of the Act.[171]

Under the original Part 4, each regional review board was to consist of three members: a health care provider, a member of the Law Society, and a member who was not a health care provider nor a lawyer.[172] One member would be designated to chair board hearings and generally supervise the work of the board.[173]

2. JURISDICTION OF THE REVIEW BOARDS

The review boards were intended to have jurisdiction to review seven types of decisions within the scope of the HCCCFA Act:

169. S.B.C. 1993, c. 48, ss. 27-32.

170. British Columbia, Legislative Assembly, *Debates*, 2nd Sess., 35th Parliament, vol.11, no. 24, 7 July 1993 at 8319-8320 (Hon. E. Cull)

171. *Ibid.*, at 8321.

172. *Supra*, note 169 , s. 27(2).

173. *Ibid.*, s. 27(3).

- a decision that the adult to whom health care is provided or for whom health care is proposed is incapable of giving, refusing or revoking consent to health care,
- a decision to choose a TSDM under section 16 to give, refuse or revoke substitute consent to health care,
- a decision to give, refuse or revoke substitute consent to health care,
- a decision that an adult is incapable of rejecting a facility care proposal,
- a decision to accept or reject a facility care proposal,
- a decision to restrain an adult's freedom of movement within a care facility, or
- a decision that an adult is incapable of deciding to move out of a care facility.[174]

As is later explained, however, only the third head of jurisdiction listed above, namely "a decision to give, refuse or revoke substitute consent to health care," was ever brought into force.

The review boards were also authorized to give advice or directions on request to a health care provider, a committee ("guardian"), a representative, a TSDM, and the Public Trustee (as the Public Guardian and Trustee was then known).[175] The advice or directions that could be the subject of a request could cover the scope of authority under the Act, the classification of health care as major or minor, whether a representative or TSDM could consent to a particular type of health care, whether refusal of substitute consent to care necessary to preserve life was appropriate, or any other matter relating to health care to be provided to an incapable adult.[176]

3. Procedure – Request for Review and Hearing

A request to review a decision had to be delivered to the appropriate regional board within 72 hours after the decision was made.[177] A request could be made by a wide range of people besides an adult receiving or proposed to receive health care or who was a resident or proposed resident in a care facility, and whose capacity was in issue.

174. *Ibid.*, ss. 28(1)(a)-(g).

175. *Ibid.*, s. 31(1).

176. *Ibid.*, s. 31(1).

177. *Ibid.*, ss. 28(4), (5).

They included a spouse, relative or friend of such an adult, a guardian, representative, or TSDM of the adult, an advocacy organization prescribed by regulation, or the Public Trustee.[178] The parties to the review were the person who requested the review, the adult who was to receive health care, and the decision maker whose decision was the subject of the review.[179]

The review boards were to hold a hearing within seven days after receiving a request for a review, in keeping with the policy goal of expeditious resolution.[180] Parties had the right to be represented by counsel or an agent at a hearing.[181] The board could inform an "advocacy organization" prescribed by regulation if the board was of the opinion that the adult who was the subject of the review required assistance in a hearing.[182]

The parties were entitled to question witnesses and present any evidence that the board considered relevant.[183] Making relevance the only criterion for admissibility evinced an intent that the review boards would not be bound by the rules of evidence, although the legislation did not say so expressly. The standard of proof was expressly stated to be the balance of probabilities.[184]

A very significant provision in Part 4 of the HCCCFA Act stated that "the board must fully inform itself of the facts at the hearing."[185] This statutory language implied that the review board should follow an inquisitorial process, rather than imitating the adversarial process of regular courts. In other words, no onus of proof would rest on any party. [186] Instead, it would be the duty of the review board to inquire into the facts of

178. *Ibid.*, s. 28(2).

179. *Ibid.*, s. 28(7). The subparagraph (7)(b)(ii) referring to a current or prospective resident of a care facility as being a party to a review was never brought into force before its repeal in 2003.

180. *Ibid.*, ss. 29(1), (2). Section 6 of the *Health Care (Consent) and Care Facility (Admission) Amendment Act, 2002* would have amended s. 28 of the HCCCFA Act to allow the Board to confirm an SDM's decision to consent to minor health care without a hearing unless the review request raised a significant public policy issue or question about how the consent was obtained, but this amendment was never brought into force before the Board was abolished.

181. *Ibid.*, s. 29(3).

182. *Ibid.*, s. 29(4).

183. *Ibid.*, s. 29(6).

184. *Ibid.*, s. 29(7).

185. *Ibid.*, s. 29(8).

186. *Ruffo v. Conseil de la magistrature*, [1995] 4 S.C.R. 267, 1995 CanLII 49, at paras. 72-73; *Winko v. British Columbia (Forensic Psychiatric Institute)*, [1999] 2 S.C.R. 625, 1999 CanLII 694 at para. 54; *British Columbia (Assessor of Area No. 10 – Burnaby / New Westminster) v. Haggerty Equipment Co.*,

a matter, taking as active a role in eliciting those facts as was necessary, and make appropriate determinations without being limited to consideration of the evidence presented by the parties and the manner in which they framed their respective cases.[187] In keeping with an inquisitorial process, the review boards were expressly given the power to summon witnesses in addition to those called by the parties.[188] The boards were also given the powers of a commissioner under the former *Inquiry Act*[189] to compel attendance of witnesses and the production of documents, to examine witnesses on oath, and exercise contempt powers in the event of non-compliance.[190]

After the hearing, the boards could either confirm the decision under review or substitute their own decision.[191] If a review board substituted its own decision for that of the initial decision maker, it was required to be guided by and comply with the same substantive provisions of the HCCCFA Act that applied to the initial decision maker.[192]

4. Appeal From the Review Board

A decision of a review board could be appealed to the Supreme Court of British Columbia within 30 days on a question of law or fact, or both law and fact.[193] Lodging an appeal would operate as a stay of the decision being appealed, but the court could make an interim order authorizing provision of health care pending the appeal if it was necessary to prevent physical or mental harm.[194] The appeal would take the form of a re-hearing unless it involved only a question of law.[195] The court could substitute

1997 CanLII 2084 at para. 14 (B.C.S.C.). See also *Davidson v. British Columbia (Attorney General)* (1993), 87 C.C.C. (3d) 269, 1993 CanLII 6886 (B.C.C.A.); *Winko v. Forensic Psychiatric Institute* (1996), 112 C.C.C. (3d) 31 (B.C.C.A.), 1996 CanLII 8352 at para. 82.

187. This description is consistent with the characterization of an inquisitorial process by McLachlin, J. (as she then was) in *Winko v. British Columbia (Forensic Psychiatric Institute)*, [1999] 2 S.C.R. 625, 1999 CanLII 694.

188. *Supra*, note 169, s. 29(9).

189. R.S.B.C. 1996, c. 224, ss. 15 and 16.

190. *Supra*, note 169 , s. 29(9).

191. *Ibid.*, s. 30(1).

192. *Ibid.*, s. 30(2).

193. *Ibid.*, s. 32(1).

194. *Ibid.*, s. 32(4), (5).

195. *Ibid.*, s. 32(3). Section 7 of the *Health Care (Consent) and Care Facility (Admission) Amendment Act, 2002*, *supra*, note 180, would have changed the appeal procedure from a re-hearing to an appeal on the record, but this amendment did not come into force before abolition of the Review Board.

its decision for that of the board, but also was empowered to remit a matter to the board for rehearing with appropriate directions.[196]

B. Activation of a Unitary Health Care and Care Facility Review Board

1. Legislative Steps

Although passed in 1993, the HCCCFA Act was not brought into force until 2000.[197] Before this occurred, Part 4 of the Act was amended in 1999 to provide for a single Health Care and Care Facility Review Board ("Review Board") with multiple panels instead of regional boards.[198] Each panel could exercise all the powers of the full Board. The composition of the three-member panels would be the same as originally envisioned for a regional review board: one health care provider, one lawyer, and one person who was neither a lawyer nor a health care provider.

An important addition to the list of potential applicants for review was made in the same set of 1999 amendments, namely a health care provider caring for the adult who was the subject of the review.[199] The 1999 amendments to Part 4 also added language that restricted the ability of a prescribed advocacy organization to request a review to "prescribed circumstances."[200]

Only one of the seven heads of jurisdiction of the Review Board came into force with other portions of the Act in 2000, namely the power to review a decision to give, refuse, or revoke substitute consent to health care. It may be noted that the heads of Review Board jurisdiction relating to acceptance or rejection of a "facility care proposal," restraint within a care facility, and incapacity to make a decision to leave a care facility, could not have been implemented at that time in any case because Part 3 of the HCCCFA Act (Admission to a Care Facility) was not brought into force.[201] The provisions empowering the Review Board to give directions or advice on request never came into force.

196. *Ibid.*, s. 32(6).

197. B.C. Reg. 200/99, effective 28 January 2000.

198. *Adult Guardianship Statutes Amendment Act, 1999*, S.B.C. 1999, c. 25, s. 14, effective 27 February 2000: B.C. Reg. 12/00.

199. *Ibid.*, s. 15(a) adding s. 28(2)(d.1) to the HCCCFA Act..

200. *Ibid.*, s. 15(b).

201. Part 3 of the HCCCFA Act came into force only in late 2019.

At the same time as the Act came into force, the *Health Care Consent Regulation* did also.[202] Part 3 of this regulation addressed a number of matters connected with the process of the Health Care and Care Facility Review Board. The regulation declared that a Review Board hearing would not be open to the public unless the chair ordered otherwise.[203] Without opening the hearing to the public, however, the Review Board could allow a spouse, relative or friend of a putatively incapable adult to attend, or request a person to assist the board in communicating with the adult.[204] The regulation declared that the Board had the right to require disclosure to it of information in records in the custody of a health care provider or health care body that was necessary to enable the Board to perform its duties.[205] It declared also that legal counsel could represent an the adult who was the subject of a review hearing, regardless of whether the adult was capable of instructing counsel.[206]

The *Health Care Consent Regulation* designated the Community Legal Assistance Society (CLAS) as a prescribed advocacy organization for the purpose of Part 4 of the HCCCFA Act for a two-year period.[207] Pursuant to the amendment made in 1999 allowing for imposition of limits on the role of a prescribed advocacy organization, the regulation also restricted the circumstances in which CLAS could request a review to cases in which two physicians had made a written recommendation for abortion or electroconvulsive therapy for a person who was incapable of making a decision to request that the recommendation be reviewed.[208]

2. The Review Board In Operation

(a) Formation of the Review Board

The Minister of Health appointed 43 persons resident in various parts of the province to the Health Care and Care Facility Review Board in early 2000, and designated a member as Chair.[209] The appointments were for a term of one year. Many of these members were reappointed in 2001 for another one-year term.[210] A new Chair and

202. *Health Care Consent Regulation*, *supra*, note 24.

203. *Ibid.*, s. 11(1).

204. *Ibid.*, s. 11(2).

205. *Ibid.*, ss. 10(1),(2).

206. *Ibid.*, s. 13.

207. *Ibid.*, s. 8(2).

208. *Ibid.*, s. 9.

209. Minister's Orders M79-2000, M78-2000, M81-2000.

210. Minister's Order MO59-2001.

Deputy Chair were also appointed in 2001.[211] One-year appointments remained the pattern throughout the period in which the Review Board was in existence. Members were paid a *per diem* fee while engaged on Board business.

The Review Board originally had its own registry located in the Lower Mainland, with one of the members acting as registrar. In 2001 a central registry serving four health-related boards, including the Health Care and Care Facility Review Board, was created in Victoria.

Amendments to the HCCCFA Act passed in 2002 included a provision requiring that when a TSDM gave or refused consent to health care on behalf of an adult, the health care provider would have to provide written notice to the adult and any spouse, relative or friend accompanying the adult of the right to make a request within 72 hours for a review of the assessment that the adult was incapable of making the health care decision in question and of the TSDM's consent or refusal.[212]

(b) Review Board decisions 2000-2003

The Review Board decided eight review requests while it existed between 2000 and 2003.[213] The BCLI staff examined anonymized copies of the decisions. They are referred to here as Cases 1 to 8.

Three of the eight cases were reviews requested by CLAS, all of which concerned decisions by TSDMs consenting to electro-convulsive therapy. In two of the three cases the Review Board panel confirmed the TSDM's decision. In Case 1, CLAS had requested a review because the documentary record supplied was inadequate to allow CLAS to determine whether a review was warranted. In confirming the TSDM's decision, the panel agreed with CLAS that the documentation of the treatment decision and reasons for it had been inadequate. The panel noted it would have been unable to make a determination without the oral evidence given at the hearing.

In Case 2, the second review requested by CLAS, the challenge was to a decision of a TSDM to consent to electro-convulsive therapy. The Review Board confirmed the TSDM's decision as being in the best interests of the subject of the application. Despite

211. Minister's Order M059-2001 and Minister's Order M177-2001, respectively.

212. *Health Care (Consent) and Care Facility (Admission) Amendment Act, 2002*, S.B.C. 2002, c. 46, s. 4(b). The notice of the right to request a review by the Health Care and Care Facility Review Board was to be provided on the same form as the other information required to be given to the accompanying spouse, relative, or friend under s. 14(4) of the HCCCFA Act.

213. British Columbia, Legislative Assembly, *Debates*, 37th Parl. 4th Sess., vol. 19, no. 3, 27 Nov. 2003 at 8276, Hon. Geoff Plant.

his objections to this form of treatment, his medical history and other evidence showed that his anxiety and depressive symptoms improved when it was performed and deteriorated when it was not being performed, and that he was incapable of consenting for himself as he lacked insight into his condition.

In Case 3, another of the three reviews requested by CLAS, the Public Guardian and Trustee had consented to six electro-convulsive therapy treatments to commence not later than a certain date. At the initial hearing, the Board considered it required further evidence and adjourned in order that it could be provided. When the hearing reconvened, the date by which the treatments were to begin had passed. The Review Board panel considered that this made it impossible to confirm the decision under review, and so they looked to the provision in Part 4 of the HCCCFA Act allowing them to substitute their own decision.[214] The panel interpreted this provision to allow them to consent to electro-convulsive therapy for a different period and a different schedule. The panel also made "recommendations" to the treating physician of a clinical nature, including that alternate treatment by "the newest anti-psychotic medication" be considered. Although the panel referred to these as "recommendations," the panel clearly stated that they were terms of the consent being given by the Board in substitution for that given originally by the Public Guardian and Trustee.

Case 3 is highly problematic. The provision on which the panel relied empowered the Review Board to either confirm the decision under review or substitute its own. This provision would have allowed the Review Board to reverse the decision being reviewed, but it is highly questionable whether it extended to allowing a panel to consent to a health care proposal different from the one under review. The original Part 4 of the HCCCFA Act was entirely silent with regard to conferral of any authority on the Review Board to second-guess the clinical judgment of the treating physician. The panel gave consent to a revised course of electro-convulsive therapy treatments on conditional terms. In effect, the panel that decided Case 3 developed its own alternate health care proposal instead of confirming or reversing the decision under review. In so doing, the panel likely acted without jurisdiction.

Two of the requests resulting in a hearing were made by or on behalf of health care providers contending that a TSDM was not acting in compliance with the HCCCFA Act. In Case 4, where the dispute between the TSDM and the care providers arose because the TSDM was allegedly ignoring wishes expressed in an earlier, legally ineffective advance directive, the Review Board panel found that the health care recipient was

214. The Review Board was referring in this instance to s. 30(1) of the HCCCFA Act, as amended by S.B.C. 1999, c. 25, s. 16. This subsection empowered the board to either "confirm the decision under review or substitute its own decision."

capable of consenting and had changed her mind concerning continuance of life-sustaining treatment. In Case 5, a risk manager for a regional health authority applied as agent for the treatment team of an incapable adult whose TSDM had revoked consent for continuation of kidney dialysis. After making the procedural point that the request should have been made by the health care providers directly, the panel decided that the TSDM had complied with the patient's last known wishes and instructions in revoking the consent.

Two of the cases involved challenges by family members to consents given by court-appointed committees. In Case 6, the Public Guardian and Trustee as committee of the person had consented to a DNR (do not resuscitate) order concerning a woman whose physicians recommended only palliative treatment in the end-stage of her life in which she was unresponsive and lacked sensory awareness. Two of three immediate family members agreed with the DNR order and with restricting further treatment to palliative care. One family member demanded that life-sustaining treatment be continued, including tube feeding that had been interrupted because of the risk of aspiration. He sought to have the consent overruled by the Review Board. Initially, the registrar of the Review Board rejected the request for lack of jurisdiction on the basis that non-provision of active treatment was not "health care" within the meaning of the HCCCFA Act, and that the Review Board had no power to review a substitute consent given by a committee appointed by the court, but only one given by a TSDM whose authority derived from the Act.

At a hearing that subsequently took place despite the registrar's initial rejection of the request, the Public Guardian and Trustee took the same positions on the Review Board's jurisdiction as those initially taken by the registrar. The hearing panel concluded that the Review Board did have jurisdiction to review a substitute consent by a committee.[215] It also concluded that withholding of tube feeding in association with a DNR order was health care as defined in the HCCCFA Act because it was part of a palliative care plan, and palliative care was expressly included in the statutory definition of "health care." As the wishes or instructions of the adult in question could not be determined due to the internal disagreement in the adult's family, the panel held that the Public Guardian and Trustee had been correct in deciding whether to consent to the recommended health care on the basis of the adult's best interests. In view of the negligible likelihood of recovery and the fact that tube feeding would not have

215. A report prepared for the Office of the Public Guardian and Trustee and BCLI, and published by BCLI prior to the repeal of Part 4 of the HCCCFA Act, urged that consideration be given to clarifying the jurisdiction of the Health Care and Care Facility Review Board to review substitute health care decisions by a committee by express amendment: Stephan Salzburg, *Health Care Decisions and End-of-Life Issues: Terms of Reference for a Possible Project*, Report No. 21 (Vancouver: BCLI, 2002) at 31.

improved the adult's quality of life, the panel confirmed the consent given by the Public Guardian and Trustee to palliative care and the extension of the DNR order.

In the same matter, the panel gave intervenor status to the hospital in which the adult was being treated, because it considered the hospital's participation in the review would assist the panel. In doing so, the panel did not point to a source of authority to accord intervenor status to a non-party. Part 4 of the HCCCFA Act and the *Health Care Consent Regulation* made no mention of intervenors.

In Case 7, the other instance in which substitute consent by a committee was challenged by a family member, a sibling of the committee objected to the administration of anti-psychotic medication to their mother, who had been diagnosed with severe dementia. The other siblings supported the committee's consent and the mother's physicians. The panel proceeded on the basis that the presumption of capability had been rebutted by the fact that a superior court had appointed a committee, but also observed by its direct interview of the mother that she was incapable of consenting to health care. Based on the medical evidence it heard, the panel concluded the committee's substitute consent to treatment with anti-psychotic medication had been reasonable and confirmed it.

The Review Board declined to hear Case 8 on the ground that it only had jurisdiction to review a substitute health care decision, and no reviewable decision had been made. Instead, the request for review had been framed as an objection by a family member to the medical judgment of the attending physician.

3. Abolition of the Health Care and Care Facility Review Board

In 2002 the membership of the Review Board was reduced to 30, including a Chair and Deputy Chair.[216] In 2003 membership was reduced to nine, including the Chair and Deputy Chair.[217] At the time of the last reduction in the size of the Review Board, a governmental decision had already been made to abolish it in connection with a general overhaul of provincial administrative justice bodies, which saw the abolition of numerous other quasi-judicial tribunals that convened infrequently.

Reasons given in the Legislative Assembly for the abolition of the Review Board were:

216. Minister's Order M48-2002.

217. Minister's Order M188-2003.

- Abolition was consistent with the elimination of unnecessary government bureaucracy;[218]

- The Review Board had a narrow mandate and insufficient volume of cases;[219]

- Informal review processes existed within health authorities to protect rights of vulnerable patients;[220]

- Matters the Review Board handled were properly characterizable as intra-family disputes that would better be resolved through mediation or conciliation rather than an adjudicative process;[221]

- If alternate dispute procedures failed to resolve an intra-family dispute over substitute consent to health care for an incapable family member, a remedy still existed because it was possible to apply to court for appointment of a committee, which would involve judicial oversight.[222]

The legislation repealing Part 4 of the HCCCFA Act, and thereby abolishing the Review Board, was passed late in 2003 and took effect in March 2004.[223] Between then and 2011, there was no single adjudicative body in British Columbia with similar jurisdiction. In commenting on this gap in a 2006 study, the Canadian Centre for Elder Law stated:

> With the Board's demise, the capacity review void has only deepened. However ineffective, the Review Board did at least provide a forum in which one could challenge a specific finding of incapability or health care decision. After it was abolished, the system was left without a non-court capacity appeal process. This has added to the risk of substantive deprivation of Charter-protected procedural fairness rights for persons wishing to challenge a finding of incapability.[224]

218. British Columbia, Legislative Assembly, *Debates*, 37th Parl., 4th Sess., vol. 19, no. 3 (27 November 2003) at 8276 (Hon. Geoff Plant).

219. British Columbia, Legislative Assembly, *Debates*, 37th Parl., 4th Sess., vol. 19, no. 5 (1 December 2003) at 8338 (Hon. Geoff Plant).

220. *Ibid.*

221. *Ibid.*, at 8339.

222. *Ibid.*, at 8338.

223. *Miscellaneous Statutes Amendment Act (No. 3), 2003*, S.B.C. 2003, c. 96, s. 30, eff. 12 March 2004: B.C. Reg. 90/2004.

224. Canadian Centre for Elder Law, *A Comparative Analysis of Adult Guardianship Laws in BC, New Zealand and Ontario*, Report No. 4, (Vancouver: Canadian Centre for Elder Law, 2006) at 25.

In 2011, section 33.4 of the HCCCFA Act came into effect.[225] As explained in Chapter 2, section 33.4 allows applications to be made to the Supreme Court of British Columbia for review of incapacity assessments, decisions by SDMs, selection of TSDMs by a health care provider, and health care facility admission decisions. The Supreme Court also has the additional power to interpret advance directives and make determinations respecting their validity.

While the minimal caseload over the three years in which the Health Care and Care Facility Review Board was in existence raises a prominent and lingering question about the level of need for such a body, it must be remembered that the Review Board was not allowed to exercise its full statutory mandate. It was allowed only to deal with one narrow type of dispute. The restriction of the Review Board's operational mandate to only one of seven heads of jurisdiction listed under its constituting legislation had been a governmental choice, so the small volume of business coming before the Review Board in the time it was in existence was at least in part a self-fulfilling phenomenon. It should not determine the course of future public policy or preclude revisiting the question whether a quasi-judicial expert tribunal for resolving disputes about mental capacity and substitute consent to general health care is warranted. The Health Care and Care Facility Review Board was an experiment that was aborted well before any reliable conclusions could be drawn from it.

225. Section 33.4 was enacted by the *Adult Guardianship and Planning Statutes Amendment Act, 2007,* S.B.C. 2007, c. 34, s. 30, and was brought into force by B.C. Reg. 14/2011, s. 1(b).

CHAPTER 4. CANADIAN MODELS: ONTARIO AND YUKON

A. The Existing Health Care Capacity and Consent Tribunals in Canada

There are two existing models in Canada of quasi-judicial tribunals with jurisdiction to review assessments of incapacity to consent to health care and admission to long-term care facilities other than tribunals operating only under mental health legislation. These are the Consent and Capacity Board in Ontario and the Yukon Capability and Consent Board. This chapter examines these two tribunals in detail.

B. The Ontario Consent and Capacity Board

1. ORGANIZATION AND MANDATE

(a) Description of the Consent and Capacity Board

The Consent and Capacity Board of Ontario (CCB) is a quasi-judicial tribunal constituted under the *Health Care Consent Act, 1996* (HCCA 1996),[226] but it exercises adjudicative powers under several other statutes in addition. The CCB's self-description in its 2018-2019 Annual Report states:

> The CCB is an independent administrative tribunal with a mandate to adjudicate on matters of capacity, consent, civil committal, substitute decision making, disclosure of personal health information and mandatory blood testing.[227]

The CCB had 132 members throughout Ontario at the beginning of 2021, appointed for terms of two, three, and five years.[228] It has a full-time Chair, two full-time Vice-Chairs, and six part-time Vice-Chairs. [229] There are three categories of CCB members:

226. *Supra*, note 16.

227. Consent and Capacity Board, *Annual Report 2018-2019* (Toronto: CCB, 2019), online: http://www.ccboard.on.ca/english/publications/documents/annualreport20182019.pdf at 2.

228. Public Appointments Secretariat (Ontario), Consent and Capacity Board, online: https://www.pas.gov.on.ca/Home/Agency/263. Appointments to the CCB are made by the Lieutenant Governor in Council under s. 70(2) of the HCCA 1996, *supra*, note 16.

229. *Supra*, note 227 at 5.

lawyers, medical members (psychiatrists, non-psychiatrist physicians, and nurses), and "public members" drawn from the community at large.

The CCB has a staff of 15 to perform legal, registry and scheduling functions, public communications, and general administrative support.[230]

The annual budget of the CCB in 2018/19 was $9,082,300.[231]

(b) Jurisdiction

The CCB derives powers under the HCCA 1996,[232] the *Mental Health Act*,[233] the *Substitute Decisions Act*, *1992*[234] the *Personal Health Information Protection Act*, *2004*[235] and the *Mandatory Blood Testing Act*, *2006*.[236]

Under the *Health Care Consent Act, 1996*, a statute based on principles broadly similar to those reflected in the HCCCFA Act of British Columbia, the CCB is empowered to hold hearings and decide applications:

- for review of an assessment of incapacity to consent to health care, admission to a care facility, or to personal assistance services;[237]

- to determine if an SDM has complied with the statutory obligations of an SDM concerning the making of substitute health care decisions;[238]

230. *Ibid.*

231. *Ibid.*, at 19.

232. *Supra*, note 16.

233. R.S.O. 1990, c. M.7.

234. S.O. 1992, c. 30.

235. S.O. 2004, c. 3, Sch. A.

236. S.O. 2006, c. 26.

237. *Supra*, note 16, ss. 32, 50, 65. A "care facility" for the purposes of the HCCA 1996, *supra*, note 16, is a licensed long-term care home.

238. *Ibid.*, ss. 37, 54, 69.

- to appoint a "representative" to make decisions for an incapable person about health care, admission to a care facility, or a personal assistance service, or to terminate the appointment of a representative;[239]

- by a health practitioner, person responsible for admissions to a care facility, member of the staff of a personal service provider, or an SDM for directions when the wishes of an incapable person are unclear;[240]

- by an SDM or a health practitioner for authorization to depart from the wishes of an incapable person expressed while capacity was still retained, and consent to or provide treatment.[241]

Amendments to the HCCA 1996 that are not yet in force provide for similar applications to the CCB regarding capacity to consent and substitute decision-making in relation to "confining in a care facility" (restriction of movement within the facility).[242]

Applications other than ones by a putatively incapable person to review the finding of incapacity are deemed to include an application to review the incapacity finding, unless the CCB has previously ruled on the issue of that person's capacity to consent within the previous six months.[243] The purpose is to allow the CCB to determine if partial or complete recovery of capacity has taken place, rendering substitute decision-making arrangements unnecessary.

Under the *Mental Health Act* of Ontario, the CCB performs a role similar to that of the Mental Health Review Board in British Columbia. The CCB hears applications to review the involuntary detention of patients in a psychiatric facility, and may either renew or terminate their status as an involuntary patient.[244] The CCB also reviews community treatment orders for mandatory out-patient psychiatric care on application, and determines whether the order or any renewal of it should be confirmed or

239. *Ibid.*, ss. 33, 51, 66. The term "representative" has a different meaning in Ontario's health care consent legislation than under that of British Columbia. A "representative" in Ontario is an SDM who has been appointed under a CCB order to make health care, care facility admission, or personal assistance needs decisions on behalf of an incapable person who does not have a personal guardian or an attorney appointed under a power of attorney for personal care.

240. *Ibid.*, ss. 35, 52, 67.

241. *Ibid.*, s. 36.

242. *Ibid.*, ss. 54.3-54.21.

243. *Ibid.*, ss. 37.1, 54.1, 69.1.

244. *Supra*, note 233, s. 39(1).

revoked.[245] Mandatory reviews by the CCB of involuntary detention and community treatment orders take place at intervals specified in the Act.[246]

There is no presumption that a patient detained involuntarily in a psychiatric facility under the Ontario *Mental Health Act* is incapable of consenting or refusing psychiatric care for a mental disorder. This is a major difference between the health care consent and mental health legislation of Ontario and that of British Columbia. The matter of an involuntary patient's capacity to consent or refuse treatment is separate from the matter of involuntary status, and must be determined under the *Health Care Consent Act, 1996* according to the same statutory principles that apply to non-psychiatric health care. If an application to determine capacity to consent has been made to the CCB or while an appeal from the CCB is pending, treatment cannot be administered in the meantime.

Patients who have been found incapable of managing property under the *Mental Health Act* by reason of a mental disorder may apply to the CCB for review of that finding.[247] Children aged 12 to 15 who are admitted to a psychiatric facility as "informal patients" may apply to the CCB for a determination whether they require observation, care and treatment in the facility.[248] A mandatory review (deemed application) by the CCB is required after six months since a child's admission to the psychiatric facility or since the latest application by the child.[249]

Under the *Substitute Decisions Act, 1992*,[250] the CCB exercises review jurisdiction with respect to statutory guardianship respecting property. Statutory guardianship in Ontario, as in British Columbia, is a form of emergency or interim adult guardianship that arises pursuant to legislation without a court appointment in order to bridge a gap until a court appointment of a guardian is made for an adult determined to be mentally incapable of managing property.[251] In Ontario, when a patient in a psychiatric facility is determined under the *Mental Health Act* to be incapable of managing

245. *Ibid.*, s. 39.1(1).

246. *Ibid.*, ss. 39(4), 39.1(3).

247. *Ibid*., s. 60(1).

248. *Ibid.*, s. 13(1).

249. *Ibid.*, s. 13(2).

250. *Supra*, note 234.

251. In British Columbia, the term *committee* is still in use for a court-appointed guardian of an adult, although unproclaimed legislation will alter this to *guardian*, In Québec, a court-appointed adult guardian is either a *curator* or a *tutor*, depending on whether the guardianship authority conferred is plenary or partial.

property, the Public Guardian and Trustee automatically becomes the patient's statutory guardian of property.[252] Statutory guardianship may also arise through a person living in the community being certified by a trained assessor as mentally incapable of managing property. Upon receiving a certificate of incapability from the assessor, the Public Guardian and Trustee becomes the person's statutory guardian of property.[253]

Statutory guardianship in Ontario can end in various ways. It will end if a personal guardian is appointed by the court.[254] It also ends if a certificate of incapacity to manage property issued under the *Mental Health Act* is cancelled, or an assessor certifies that the person under statutory guardianship is no longer incapable.[255] It will also end if a valid continuing power of attorney made while capacity was still retained comes to light that gives the attorney authority over all the property of the incapable person, and the attorney certifies willingness to take over from the Public Guardian and Trustee in accordance with its terms.[256]

A person subject to statutory guardianship may apply to the CCB to review the initial finding of incapacity to manage property, or a subsequent finding that incapacity has continued.[257] The CCB may confirm the finding of incapacity or determine that the applicant is capable of managing property and in doing so, may substitute its opinion for that of the assessor or physician who made the incapacity finding.[258] An application to review a finding of incapacity to manage property that results in statutory guardianship may not be made if the applicant has applied for review of the incapacity finding within the previous six months.[259]

The CCB also exercises review jurisdiction under the Ontario *Personal Health Information Protection Act*.[260] If a health information custodian determines an individual is incapable of consenting to the collection, use or disclosure of personal health information, that individual may apply to the CCB for review of the determination unless there is someone entitled to act as that individual's SDM for the purpose of consenting

252. *Supra*, note 234, s. 15.

253. *Ibid.*, s. 16.

254. *Ibid.*, s. 20(1), para. 1.

255. *Ibid.*, paras. 3,4.

256. *Ibid.*, s. 16.1.

257. *Ibid.*, s. 20.2(1).

258. *Ibid.*, s. 20.2(5).

259. *Ibid.*, s. 20.2(2).

260. S.O. 2004, c. 3, Sch. A.

to health care.[261] A custodian of health information may apply to the CCB to determine whether an SDM has applied the considerations the SDM is obliged by the Act to apply in consenting, withholding, or withdrawing consent to the collection, use or disclosure of the incapable individual's personal health information, if the custodian is of the opinion that the SDM has not done so.[262] An application to the CCB by a custodian of health information is deemed to include an application to determine if the individual for whom the SDM acts has the capacity to consent to the collection, use or disclosure of personal health information, unless the CCB has made a determination about the individual's capacity to do so within the previous six months.[263]

The CCB has the power under the *Mandatory Blood Testing Act, 2006* to order a person to supply a blood sample if a person has not complied voluntarily with a demand by the medical officer for one within 48 hours of the demand.[264] The CCB may order the person to provide the blood sample following a hearing.[265] The CCB's powers under the *Mandatory Blood Testing Act, 2006* are unrelated to issues of mental capacity and consent.

The CCB's jurisdiction does not extend to considering and ruling upon the constitutional validity of an Act or regulation.[266]

2. Caseload of the CCB

The CCB receives and disposes of an impressive volume of business. It received 8239 applications in 2018/19 and held 4973 hearings.[267]

Reviews of involuntary patient status and community treatment orders under the *Mental Health Act* make up the largest share of the CCB caseload by far, accounting

261. *Ibid.*, s. 22(3).

262. *Ibid.*, s. 24(2). The considerations the SDM is obliged to apply are stated in s. 24(1)(a), and resemble in part those that apply in making a substitute health care decision. They are the wishes, values, and beliefs that the incapable individual held while retaining capacity, and which the SDM believes the individual would have wanted to be followed in decision-making about personal health care.

263. *Ibid.*, s. 24(2.1).

264. S.O. 2006, c. 26, ss. 3(3).

265. *Ibid.*, s. 5(1).

266. *Supra*, note 16, s. 70.1(1).

267. Consent and Capacity Board, *Annual Report 2018/19* (Toronto: CCB, 2020) at 16.

together for 66 per cent of all applications received in 2018/19.[268] Applications pertaining to capacity to consent to health care, admission to care facilities, or personal assistance services accounted for 26 per cent of application filings.[269] Applications for appointment of a representative and ones relating to the performance of an SDM represented only 1 per cent and 0.4 per cent, respectively.[270] The CCB's annual reports indicate this distribution of caseload between the various heads of the CCB's jurisdiction has tended to be relatively consistent between 2014-2019.

The volume of applications related to capacity to consent expressed as a percentage of the CCB's annual intake includes applications concerning the capacity of persons detained under the *Mental Health Act* of Ontario to consent or refuse psychiatric treatment for a mental disorder. Capacity-related applications are not segregated in the CCB's statistical tracking on the basis of the nature of treatment, so it is not possible to distinguish those relating to psychiatric treatment under the *Mental Health Act*[271] from the ones that arise in the context of capacity to consent to general health care. The CCB informed BCLI, however, that the vast majority of capacity-related applications that are made to the CCB concern psychiatric treatment.[272]

One of the factors influencing the caseload pattern may be whether a person affected by a reviewable determination or status is told of the right to seek review. There is no requirement for notification of the right to apply to the CCB when persons are assessed in a clinical setting or in a long-term care facility as incapable of consenting to health care.[273] Persons involuntarily admitted to a psychiatric facility or who are assessed under the *Substitute Decisions* Act, 1992 as incapable of managing property, however, and their SDMs if any, must receive notification of their right to apply to the CCB to seek review.[274] If patients detained in a psychiatric facility and found

268. *Ibid.*

269. *Ibid.*

270. *Ibid.*

271. Information provided by the Registrar of the CCB.

272. Information provided by the Registrar of the CCB.

273. Evaluators who assess persons in the community as being incapable of consenting to admission to a care facility are required to provide those persons with rights information specified in guidelines: *supra*, note 16, s. 47.1.

274. *Supra*, note 233, s. 38(2)(b) (review of detention as involuntary patients); s. 59(2) (review of finding of incapacity to manage property); R.R.O. 1990, Reg 741, s. 15(2) (review of incapacity finding concerning consent to psychiatric treatment); *supra*, note 234, s. 16(6) (assessment in the community of incapacity to manage property). Persons against whom a community treatment order is made under the *Mental Health Act* must also be given notice of their right to seek review: R.R.O. 1990, Reg 741, s. 14.3(2).

incapable of consenting to treatment wish to exercise the right to apply to the CCB regarding the finding of incapacity, a designated rights adviser must assist them to do so.[275]

3. CCB Procedure

The CCB is designed for rapid and informal decision-making. Timeliness is often crucial in a health care context, and very short mandatory timelines are a feature that distinguishes the CCB from most other quasi-judicial tribunals in Ontario and elsewhere.

The CCB is required to set a hearing within seven days after receiving an application, unless the parties agree to a later date.[276] The CCB must deliver its decision within one day after the end of the hearing.[277] Reasons for the decision must be delivered within four days after a party requests them, provided that the request is made within 30 days after the end of the hearing.[278]

CCB panels consist either of one member or three members, although the governing legislation also allows for five-member panels.[279] Three-member panels consist of a health professional, a lawyer, and a public member. The lawyer-member will preside at the hearing.

Only lawyers who have been CCB members for the preceding two years and members of the Law Society throughout the previous 10 years may sit alone to decide an application.[280] If the application concerns incapacity, the single member must also have experience in adjudicating capacity matters that the Chair considers to be relevant.[281]

275. R.R.O. 1990, Reg 741, s. 15(4).

276. *Supra*, note 16, s. 75(2).

277. *Ibid.*, s. 75(3).

278. *Ibid.*, s. 75(4).

279. *Ibid.*, s. 73(1).

280. *Ibid.*, s. 73(2)(a), (b). Applications under the *Mandatory Blood Testing Act, 2006*, *supra*, note 264, are an exception. Single members may decide an application under that Act if they have expertise in blood-borne pathogens and any other qualifications the Chair may set.

281. *Ibid.*, s. 73(2)(c). The Chair may also set additional qualifications a single member panel must possess: s. 71(3).

The CCB has set its own Rules of Practice.[282] The rules stipulate that if the subject of an application is an in-patient at a hospital, psychiatric facility, or resident in a long-term care home, hearings will be conducted at the care facility, etc. where that person is being treated or housed.[283] If the subject is living in the community, receives treatment at a health facility, and the application relates to treatment, the hearing will normally take place at that health facility.[284] If the subject is living in the community and the hearing relates to a matter other than treatment, the venue is flexible and will be determined on the basis of numerous factors, including the location of the person who is the subject of the application and the convenience of all the parties.[285] Bedside hearings in a hospital or care facility take place when necessary, and members will travel to wherever they are needed in the province.[286]

The parties to an application are identified in the HCCA 1996 and vary with the nature of the application. At a minimum, they include the applicant, the maker of the decision or finding which the applicant seeks to have reviewed, the health care provider or person responsible for authorizing admission to a care facility (if the health care provider or admissions supervisor is not also the maker of the decision under review), and any SDM sought to be appointed or removed in the application. The parties will also include any other person the CCB specifies as a party.[287] The CCB's expressly conferred power to add a party is apparently unrestricted. All the parties to an application may appear and take part in the hearing.

The CCB conducts hearings in both English and French.[288] Interpreters will be provided by the CCB if a party or witness requires one.[289] Hearings are generally limited to two-hour sessions, and matters that have not completed after two hours are rescheduled to a later session.[290] BCLI was told that the two-hour sessional time limit

282. Consent and Capacity Board, *Rules of Practice*, 19 June 2019, online: http://www.ccboard.on.ca/english/legal/documents/CCB_Rules_of_Practice_June_19_2019__FINAL-S.pdf

283. *Ibid.*, Rule 16.1.

284. *Ibid.*, Rule 16.2.

285. *Ibid.*, Rule 16.3.

286. Information provided in consultations with present and former CCB members, and by legal and medical practitioners with experience in CCB hearings.

287. *Supra*, note 16 , ss. 32(3), 33(4), 34(4), 35(2), 36(2), 37(2), 50(3), 51(4), 52(2), 53(2), 54(2).

288. *Ibid.*, Rule 22.1.

289. *Ibid.*, Rule 22.2.

290. *Ibid.*, Rule 25.6.

is frustrating for lawyers, but meets with more approval from physicians who appreciate the expeditiousness from a clinical standpoint. A high proportion of applications are resolved in the initial two-hour hearing.[291]

CCB hearings are conducted along primarily adversarial lines, although panels will at times take an active role in exploring the facts.[292] The CCB has stated in many decisions that because of the statutory presumption of capacity, the onus to establish incapacity always rests on a health professional or evaluator who has made or is defending an incapacity finding, never on the individual whose capacity is in question.[293] The civil standard of proof, i.e. the balance of probabilities, is applicable.[294] Parties have the right to call witnesses and cross-examine. Rules of evidence do not apply, and the panel may consider any evidence it considers relevant.[295]

CCB hearings are open to the public, despite the highly private health-related information given in evidence, because a provision of the Ontario *Statutory Powers Procedure Act* requires oral hearings held by Ontario tribunals to be public unless the tribunal orders otherwise. The CCB may do so on the ground that non-disclosure of sensitive evidence in the interests of parties outweighs the principle of open hearings, or because public security is involved.[296] While practitioners tend to hold the view that CCB hearings should be conducted in private, BCLI was told that the hearings generally attract little attention and in practice, the presiding panel member will usually ask parties and counsel if they object to the presence of observers, if any are in fact present.

In March 2020 the CCB suspended in-person hearings due to the coronavirus pandemic. It holds all hearings by teleconference and has experimented with videoconference. Parties are required to provide documents intended to be used in a hearing to the CCB and other parties a day ahead of the hearing. This temporary practice continues as of the date of publication.

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291. Information provided to BCLI in consultations with legal and medical practitioners and CCB members.

292. Paragraph 4.6 of the Consent and Capacity Board's *Policy Guideline No. 2*, 1 September 2017, directs panels to "take a proactive role during the course of the hearing when dealing with an unrepresented party."

293. *Re LC*, 2010 CanLII 67262 (ON CCB).

294. *Re OB*, 2017 CanLII 69993 (ON CCB); *Re DK*, 2013 CanLII 73959 (ON CCB).

295. *Statutory Powers Procedure Act*, R.S.O. 1990, c. S.22, s. 15(1).

296. *Ibid.*, s. 9(1).

Pre-hearing case conferences may be held in complex applications to simplify issues, explore settlement or the possibility of agreement concerning facts and evidence, and to deal with scheduling and other matters "that may assist in the just and most expeditious disposition of the hearing."[297] Case conferences are not open to the public.[298] A member who presides at a case conference may also preside at the hearing unless the case conference included an attempt at settlement, in which case that member may only preside at the hearing with the consent of all parties.[299]

4. Mediation

Mediation is adjunct to the CCB's normal operations, rather than a central part of them. The CCB Rules of Practice provide that mediation may take place with consent of all parties once an application has been filed in order to reach settlement of some or all of the issues in the application.[300] A member is designated to serve as a mediator, and that member will not participate in a subsequent case conference or hearing in the same application except by consent of all parties.[301]

Mediation takes place in private.[302] The mediation discussions are treated as privileged and confidential, and may not be disclosed in later hearings.[303] If the parties desire an order to formalize the results of a mediation, they may make a written request referencing the agreements and undertakings reached, and the CCB may issue an order at its discretion.[304]

5. Provision of Legal Aid Counsel in CCB Matters

The CCB may direct Legal Aid Ontario to provide legal representation in an application for anyone who is or may be mentally incapable, is the subject of the application, and is unrepresented. [305] Legal Aid Ontario is obliged to comply with the direction, but if the person for whom it arranges legal representation does not qualify to receive legal

297. *Supra*, note 282, Rule 19.1.

298. *Ibid.*, Rule 19.6.

299. *Ibid.*, Rule 19.9.

300. *Ibid.*, Rules 20.1, 20.2.

301. *Ibid.*, Rules 20.3, 20.4.

302. *Ibid.*, Rule 20.5.

303. *Ibid.*, Rule 20.6.

304. *Ibid.*, Rule 20.7.

305. *Supra*, note 16, s. 81(1)(a).

aid, the person is responsible for paying the legal fees.[306] A person for whom legal representation is arranged in this manner is conclusively deemed to have the capacity to instruct counsel, regardless of actual mental condition.[307]

The CCB's policy is to issue an order to Legal Aid Ontario to provide counsel whenever the subject of an application is unrepresented, unless that person insists on self-representation or has retained counsel independently.[308] If the subject of an application insists on self-representation, the CCB is not precluded from appointing counsel as an *amicus curiae*, and the Ontario Supreme Court of Justice has held that in some circumstances the CCB may be obliged to do so in order to ensure fairness in the proceeding.[309]

6. Appeal

A party to a CCB proceeding may appeal from the CCB's decision to the Ontario Superior Court of Justice on a question of law or fact, or both law and fact.[310] Short filing periods are prescribed for an appeal from the CCB, in keeping with the value of expeditious resolution reflected in the legislation and policies under which the CCB operates. A notice of appeal must be served and filed within seven days after receipt of the CCB decision.[311] The appellant's factum must be served and filed within 14 days after receipt of a copy of the record and transcript from the CCB.[312] The respondent's factum must be filed within 14 days following service of the appellant's.[313] The court must set the appeal hearing at "the earliest date compatible with its just disposition."[314]

In an appeal from the CCB, the Supreme Court of Justice may exercise all the powers of the CCB. It may substitute its opinion for that of a health practitioner, evaluator, SDM, or the CCB itself.[315]

306. *Ibid.*, s. 81(2).

307. *Ibid.*, s. 81(1)(b).

308. Consent and Capacity Board, *Policy Guideline No. 2*, 1 September 2017, para. 4.2.

309. *R.C. v. Dr. Klukach*, 2018 ONSC 7415.

310. *Supra*, note 16, s. 80(1).

311. *Ibid.*, s. 80(3).

312. *Ibid.*, s. 80(5).

313. *Ibid.*, s. 80(6).

314. *Ibid.*, s. 80(8).

315. *Ibid.*, s. 80(10).

The volume of appeals from the CCB is relatively small in relation to the caseload of the CCB. There were 73 notices of appeal received in calendar 2018, while the number of hearings held in 2018/19 was 4,973.[316]

BCLI was told that the court strives to schedule the hearing of appeals from the CCB as expeditiously as possible. As treatment cannot be initiated pending the disposition of an appeal from a decision that would have the effect of authorizing consent, however, an appeal can and sometimes does result in a considerable delay in commencing treatment, to the detriment of the patient's health in the meantime. The court can order, on application, that treatment commence if it is demonstrated that a person's condition will deteriorate substantially before disposition of the appeal and the treatment in question is the least intrusive one likely to benefit that person. [317]

7. Training of CCB Members

The CCB conducts extensive in-service training programs for its members. It provides comprehensive training for new members in legislation, rules and policies applied by the CCB, and pairs them with an experienced mentor.[318] It also provides supplemental training for new presiding members.[319] In 2018/19 the CCB implemented a supplemental training program for medical members.[320] Continuing in-service training of an issue-specific nature is provided to all members on matters such as community treatment orders, long-term care admission, end of life issues, and capacity to manage property.[321]

The CCB also has a performance evaluation program for all members to measure the quality of adjudication, and the evaluators in that program also receive specialized training.[322]

316. *Supra*, note 227, at 17-18.

317. *Supra*, note 16, ss. 18(3)(d), 19(1), (2).

318. *Supra*, note 227 at 11.

319. *Ibid.*

320. *Ibid.*

321. *Ibid.*, at 11-12

322. *Ibid.*.

8. Perceptions of the CCB and its Process

The CCB is generally seen as a comparatively accessible, expeditious, and inexpensive specialized decision-making body. Applications can be made on a standard form, and scheduling of a hearing within seven days after filing the application is mandated by law. The large membership of the CCB allows it to form panels quickly and deal with a heavy caseload within its statutory requirements. Single-member panels provide considerable flexibility in scheduling and fast response. The ability to hold hearings where the subject of the application is located, be it a hospital ward, a long-term care facility, or a residential living room, is viewed as especially praiseworthy. "The Board will come to you" is a refrain commonly heard when speaking with those familiar with the CCB.

The ability to order that legal aid counsel be made available for unrepresented persons whose mental capacity or freedom is in question in an application is a distinctive aspect of the CCB's statutory framework that is praised by patients' advocates as redressing what they would say is an inherent power imbalance between vulnerable patients and the health care establishment. Medical parties, however, consider that an imbalance flows from the fact that they generally are obliged to appear before the CCB without representation because hospitals and care facilities do not provide it, while patients can have access to legal aid counsel.

The CCB tends to be viewed very differently by lawyers and health professionals. This division between legal and medical attitudes toward the role of the CCB is most intense in relation to mental health matters, which dominate the CCB's docket and tend to characterize debate about the CCB's process. While mental health is the area in which the difference in the relative significance that lawyers and physicians attach to individual rights and freedoms on one hand and appropriate medical treatment for an individual's diagnosed condition on the other is most starkly reflected, the tension is not confined to that area.

The dichotomy between medical ethics and the law of health care consent in Ontario is brought to a head also in end of life situations, which are the subject of numerous CCB decisions. The typical scenario is one in which the treatment team has concluded further treatment and interventions to sustain life will be of no medical benefit and should be replaced with palliative care. The SDM for the incapable patient refuses to accept this medical advice and insists on all possible interventions to sustain life. In *Cuthbertson v. Rasouli*, the Supreme Court of Canada held that it is not open to physicians to bypass the CCB and unilaterally withdraw life support against the direction of an SDM on the ground that continuance of life support would be medically

unjustifiable.[323] Instead, the decision to overrule an SDM acting in accordance with what the SDM believes are the incapable adult's beliefs, values and wishes, or best interests, rests with the CCB. The CCB has shown on repeated occasions it is willing to order an SDM to consent to withdrawal of life support if it concludes this is in the best interests of an incapable adult in a terminal or vegetative state.[324] Nevertheless, the view was expressed to us that physicians rarely apply to the CCB to override an SDM who they believe is acting irrationally in insisting on medically unjustifiable interventions to prolong the life of an incapable patient, with the result that much needless suffering goes on to support a rights-based legal regime.

Our informants on the medical side tend to believe that rights-based legal considerations drive outcomes under the CCB framework to the detriment of patients' best interests, as treatment teams perceive them. This is also a position expressed strongly in some medico-legal literature by writers who decry the elevation of patient autonomy over medical judgment, although these writers' quarrel is actually with the underlying policy of the HCCA 1996, to which the CCB is obliged to give effect.[325]

Some physicians are highly experienced case presenters, particularly psychiatrists who are frequently called upon frequently to appear in reviews of involuntary in-patient status and community treatment orders. Other physicians who have to present cases or serve as witnesses only sporadically or on a single occasion consider themselves to be at a disadvantage, believe their clinical observations and professional judgment are under attack in a CCB hearing, and accordingly form a negative view of the CCB's process. Medical case presenters who concentrate on clinical diagnostic evidence, rather than focusing on the elements of the statutory test of capacity to consent to treatment under the HCCA 1996, may be left with the impression that the panel has disregarded medical expertise if it finds the presumption of capacity has not been overcome in the result. In recognition of this, the CCB has placed templates for medical reports on its website for the guidance of case presenters that are oriented to the statutory test the CCB is obliged to apply.

Another criticism voiced by physicians is that the way in which CCB hearings are conducted, combined with the typical lack of representation for physicians appearing

323. 2013 SCC 53, [2013] 3 S.C.R. 341.

324. See, for example, *Re CD*, 2007 CanLII 32892 (ON CCB); *Re SH*, 2019 CanLII 79248 (ON CCB).

325. See Joshua T. Landry et al., "Ethical failings of CPSO policy and the health care consent act: case review (2019) 20:20 *BMC Medical Ethics*, online: https://doi.org/10.1186/s12910-019-0357-y; Laura Hawryluck, "The Standard of Care and conflicts at the End of Life in critical care: Lessons from medical-legal crossroads and the role of a quasi-judicial tribunal in decision-making" (2013) 28 *Journal of Critical Care* 1055.

before CCB panels, makes the treating physician and the patient into adversaries and damages the physician-patient relationship by eroding trust and injecting or heightening antagonism. Cross-examination of a patient by the treating physician can exacerbate this effect.[326] One legal informant and former CCB panel member told BCLI he usually tried to discourage medical case presenters from doing so.

It was strongly suggested in our consultations that the case presenter defending a challenged medical finding or decision should not be the treating physician, as is usually the case, but instead an official of the hospital or health authority. Ideally, the case presenter would be in-house counsel or a risk management official not connected directly with the treatment team.

Scheduling of CCB hearings within the seven-day limit presents obvious challenges for clinicians and legal practitioners who are parties, witnesses, counsel for parties, or in some cases are CCB members themselves. Some informants clearly wished the CCB had more flexibility in scheduling, but the system nevertheless appears to function without much friction. When asked how clinicians cope with the CCB's compressed timelines, one medical informant commented, "We're used to it."

Lawyer informants maintained that physicians and evaluators succeed in a very high percentage of cases where capacity to consent is in issue, despite the onus resting on them in theory to prove incapacity and physicians' sense that their medical judgment is continually under attack in CCB proceedings. (Ninety per cent is the success rate typically mentioned.) Lawyers acting for patients tend to believe their clients whose capacity is in issue actually are the ones who face an uphill battle in contesting incapacity findings by their physicians or an evaluator.

Despite the relative informality of CCB hearings as compared to court proceedings, medical and patient participants have described them to researchers as objectionably legalistic.[327] Some informants told BCLI that single-member panels are preferable to three-member panels because they are less court-like. This observation is also reported in medicolegal literature as being one that is frequently voiced.[328]

326. Dhand notes an instance of this, complicated possibly by inter-cultural insensitivity: Ruby Dhand, "Access to Justice for Ethno-Racial Psychiatric Consumer/Survivors in Ontario" (2011), 29 Windsor Y.B. Access Just. 127 at 149.

327. Sayani Paul, Arash Nakhost *et al.*, "Perceptions of key stakeholders on procedural justice in the Consent and Capacity Board of Ontario's hearings" (2020), 68 Int'l J. of Law and Psychiatry 101515 at 5.

328. *Ibid.*

Paradoxically, some non-legal informants criticize the speed of the CCB's decision-making, which they say results in a rushed and cursory consideration of carefully compiled clinical evidence, inferior to the fuller hearing and vetting of evidence possible in a court. Another somewhat related criticism, but one primarily made by lawyers, is that the evidence on which the CCB confirms findings of incapacity can be very thin, often consisting of only a single medical report.

The CCB has been criticized for lacking what has come to be referred to as "cultural competence" in dealing with ethno-racial minorities. In other words, the criticism is that CCB panels follow a conscious or unconscious "colour-blind approach" and are insufficiently aware of how the experience of ethno-racial minorities and differing cultural norms play into health care decision-making and affect the interaction of individuals belonging to these minority groups with conventional medicine. Qualitative evidence pointing to a knowledge gap of this kind, or a perception of one, was elicited by Dhand in interviews with former participants in CCB processes.[329] If such a knowledge gap exists, however, it is unlikely to be unique to the CCB, but may well pervade the health care system of which the CCB is a part.

The Law Commission of Ontario observed that criticism of the CCB concentrated around what it described as "the inherent tension between promoting therapeutic outcomes and upholding fundamental rights."[330] This tension is inevitable, because fast resolution of exactly this kind of conflict is the raison d'être of the CCB. A very rapid and simple adjudication process will tend be a zero-sum game in which the unsuccessful party is left dissatisfied more often than not. Decisiveness and a capability for urgent response are nevertheless valuable qualities in the context of health care.

9. Proposals for Reform of the CCB

The Law Commission of Ontario recommended in a 2017 report on provincial adult guardianship laws that the jurisdiction the CCB now exercises should be combined with the statutory jurisdiction of the Superior Court of Justice under the *Substitute Decisions Act, 1992*[331] in a reconstituted administrative tribunal.[332] The tribunal that the Law Commission envisioned would have comprehensive jurisdiction over mental capacity and adult guardianship.

329. Dhand, *supra*, note 326.

330. Law Commission of Ontario, *Legal Capacity, Decision-Making, and Guardianship: Final Report* (Toronto: The Commission, 2017) at 199.

331. *Supra*, note 234.

332. *Supra*, note 330, at 215. See also 229 (Recommendation 29).

The Law Commission emphasized user-centred approaches and accessibility in all aspects.[333] The reconstituted tribunal would provide informational and referral services and supports, either as part of its own administrative framework or in partnership with other organizations, in order to "connect parties to accommodations and supports necessary to effectively access tribunal processes."[334] While noting the importance of timely adjudication, the Law Commission considered that the rigid statutory timelines under which the CCB now operates were not universally appropriate, and some greater flexibility in timeframe requirements would be desirable.[335] Adequate administrative support was seen as essential to enable a tribunal to meet timeframe pressures, and to allow parties access to required accommodations and services intended to assist them to prepare to take part in hearings.[336]

The Law Commission urged that legislators give consideration to empowering the tribunal to consider the constitutionality of the enactments that confer its powers and to grant remedies based on the *Canadian Charter of Rights and Freedoms* under section 24(1) of the *Constitution Act, 1982*.[337] These are powers that are normally exercised by courts and which few administrative tribunals have.[338] Without specifically recommending that a comprehensive guardianship tribunal be given the power to rule on the constitutionality of its enabling legislation and grant *Charter* remedies, the Law Commission suggested the justification for doing so is that the tribunal would constantly rule on matters involving Charter-protected rights, particularly those of liberty and the security of the person.[339] At the same time, the Law Commission noted there are constitutional limits on the extent to which powers akin to those of a provincial superior court may be vested in a statutory tribunal, and cautioned that remedial powers of a comprehensive tribunal would need to be fashioned within these limits.[340] Possibly in light of constitutional ramifications, the Law Commission also recommended that consideration be given to enabling the tribunal it envisioned to refer

333. *Ibid.*, at 226.

334. *Ibid.*, at 229 (Recommendation 29).

335. *Ibid.*, at 227-228.

336. *Ibid.*, at 228.

337. *Ibid.*, at 224.

338. The HCCA 1996 expressly prohibits the CCB from inquiring into the constitutional validity of an enactment or provision: *supra*, note 16, s. 70.1(1).

339. *Supra*, note 330 at 224.

340. *Ibid.*, at 223.

matters to the Superior Court of Justice for determination on its own motion or on the application of a party to an application.[341]

The Mental Health Legal Committee, a group of Ontario lawyers practising in the fields of mental health and mental capacity, proposed in a 2016 submission to the Law Commission of Ontario that the CCB should be placed under the aegis of the Attorney General rather than the Minister of Health.[342] The Committee supported most of the details that later found their way into the Law Commission's vision of a reconstituted capacity and adult guardianship tribunal, including an expanded mandate that would comprise the present statutory functions of the Superior Court of Justice in guardianship, more flexible time limits in guardianship matters, and power to consider constitutional issues and grant *Charter* remedies.[343]

10. Conclusion

Although the CCB has its critics, there is no groundswell of opinion in Ontario for abandoning the quasi-judicial, specialized tribunal model and reverting to the regular civil courts to decide disputes about mental capacity and consent to health care, substitute decision-making, and admission to long-term care. The Ontario CCB represents the most evolved administrative justice scheme at the present time in Canada for access to independent review of incapacity findings, decisions of SDMs, and the like, and has become an established feature in the legal landscape of the province.

C. The Yukon Capability and Consent Board

1. Organization and Mandate

(a) Description of the Capability and Consent Board

The Capability and Consent Board (Yukon CCB) is constituted under Part 3 of the *Care Consent Act* (CCA) of the Yukon Territory.[344] The *Care Consent Act* is based on principles of personal autonomy and informed consent, and is very similar to the HCCCFA Act of British Columbia and the Ontario HCCA 1996. The test of mental capacity under the CCA is very similar to that in the British Columbia HCCCFA Act. Like the HCCCFA Act but unlike the HCCA 1996, the Yukon CCA provides for advance directives.

341. *Ibid.*, at 224 and 229 (Recommendation 29).

342. Mental Health Legal Committee submission to the Law Commission of Ontario, 4 March 2016.

343. *Ibid.*

344. Supra, note 19.

The Yukon CCB consists of up to nine regular members and nine alternate members appointed by the territorial Commissioner in Executive Council.[345] Two regular members must be members of the Yukon Medical Association, two must be licensed "care providers" drawn from various other health professions designated by regulation, three must be members of the Law Society, and two must be persons who are neither physicians, care providers, or lawyers. Three of the alternate members must be lawyers, and two must be appointed from each of the three other membership categories.[346] A chair and two vice-chairs, all of whom must be members of the Law Society, are appointed from amongst the regular members of the Board.[347] Appointments are made for a maximum of three years.[348]

The CCA requires that in making appointments to the Yukon CCB, the Commissioner in Executive Council must attempt to give effect to these principles:

- the membership should reflect the cultural, regional and gender diversity of Yukon;

- the membership should include persons with knowledge or experience of people with

  (i) intellectual disabilities,
  (ii) mental illnesses,
  (iii) physical disabilities,
  (iv) people with brain injuries, or
  (v) diseases of aging or other degenerative illnesses that can lead to mental incapability.[349]

All members of the Yukon CCB are part-time. They are remunerated for time spent on Board business, and reimbursed for expenses incurred.

The Yukon CCB does not have a budgetary allocation separate from that of the Ministry of Health and Social Services. Information regarding the annual cost of the Yukon

345. *Ibid.*, s. 53(1).

346. *Ibid.* The care providers qualified to be Yukon CCB members are: nurse practitioners, registered nurses, psychologists, occupational therapists: *Care Consent Regulation,* YOIC 2005/80, s. 17(1) Social workers are also qualified by regulation to be appointed to the Yukon CCB: s. 17(2).

347. *Ibid.*, s. 54(1)

348. *Ibid.*, s. 55(1)

349. *Supra*, note 19, s. 53(3)(a),(c).

CCB's operations was sought from the Ministry, but was unavailable as of the time of publication.

(b) Jurisdiction

The Yukon CCB derives jurisdiction from the CCA and the *Mental Health Act.*[350]

The CCA describes the role of the Yukon CCB as being to "provide a forum for reviewing the decisions of care providers and substitute decision-makers, and for providing direction to substitute decision-makers, to ensure that the rights of care recipients are respected…careful consideration is given to the wishes, beliefs and values, or best interests of care recipients, and relatives and friends of the care recipient, and care providers, have an opportunity to be heard."[351]

Under the CCA, a request may be made to the Yukon CCB for a decision whether:

- a care provider has complied with the statutory test of capacity under the CCA in determining a person to be incapable of giving or refusing consent to care;
- a care provider has made a correct choice of an SDM in compliance with the statutory hierarchy of SDM's under the CCA;
- an SDM has complied with an SDM's statutory obligations under the CCA in giving or refusing substitute consent to major health care (as defined in the CCA) or admission to a care facility;
- a health care provider who has issued a certificate of need for financial protection has properly found that a care recipient is incapable of giving or refusing consent to care and had reasonable grounds to believe that, because of a health condition, the care recipient is incapable of making reasonable decisions regarding financial affairs.[352]

350. R.S.Y. 2002, c. 150.

351. *Supra*, note 19, s. 37.

352. *Ibid.*, s. 39(1). Issuance by a health care provider of a certificate of need for financial protection under s. 61(1) of the CCA is the initial step in a sequence that may lead to statutory guardianship of the individual and management of the individual's estate by the Public Guardian and Trustee: see ss. 61(1)-(3) and (5) of the CCA and s. 13 of the *Public Guardian and Trustee Act*, S.Y. 2003, c. 21, Sch. C.

The request to the Yukon CCB for a decision may be made by "any person having a substantial interest in the matter.[353]

In an application to determine if an SDM has complied with the CCA in giving or refusing consent to major health care or admission to a care facility, the Yukon CCB may confirm the SDM's decision, or set it aside and either refer it back to the original SDM for reconsideration, or choose another SDM and refer the matter to that SDM for decision.[354] If the Yukon CCB refers a matter to either the original or a replacement SDM, it may give directions with respect to compliance with the CCA or information the SDM must consider.[355]

SDM's may themselves apply to the Yukon CCB for directions before consenting or refusing health care for an incapable person if a wish concerning health care expressed by that person while capable is unclear, or if it is unclear whether the CCA requires the SDM to give effect to the wish or to make the health care decision on other grounds.[356]

The Yukon CCB may disqualify an SDM who fails to comply with a direction given by it, whether the direction was given in the context of a review in which the SDM's decision was challenged, or in an application for directions by the SDM in question.[357]

If there are one or more potential SDMs who qualify to be chosen as the SDM by a care provider, and who disagree whether consent should be given to proposed care for an incapable person, any of the SDMs may request the Yukon CCB to designate the SDM to make the health care decision.[358]

The CCA provides for automatic reviews of decisions and actions taken by so-called "last resort substitute decision makers." That term appears as the marginal subheading of the provision of the CCA that allows two health care providers, or three in the case of major health care, to give substitute consent to proposed health care or admission to live in a care facility if there is no qualified SDM to make the decision on behalf of a patient determined to be incapable of consenting. This may be done only if the care providers have no conflict of interest and follow the same principles regarding

353. *Ibid.*, s. 39(2).

354. *Ibid.*, s. 50(1).

355. *Ibid.* s. 50(2).

356. *Ibid.*, s. 40(1).

357. *Ibid.*, s. 50(4).

358. *Ibid.*, s. 14.

the previously expressed wishes of the patient and best interests considerations that other SDMs must apply under the CCA.[359] Whenever health care providers act as last resort substitute decision makers under this provision, the Yukon CCB must conduct a review of the circumstances without a hearing having to take place.[360]

Under the *Mental Health Act*, the Yukon CCB automatically reviews the circumstances of every involuntary admission or renewal of involuntary patient status under the Act within seven days of receiving a certificate of involuntary admission or renewal.[361] It also is required to review applications to transfer an involuntary patient normally resident in the Yukon to a hospital outside the Yukon within 48 hours after receiving the notification of intent to transfer.[362] The Yukon CCB is empowered to approve or disapprove a transfer.[363]

An application may be made to the Yukon CCB by any person having a substantial interest for a review of a certificate of involuntary admission or to transfer an involuntary patient outside the Yukon Territory.[364] A hearing need not be held if the patient consents to waive one and has the mental capacity to do so. If no hearing is held, the Yukon CCB may request information as it considers appropriate and determine whether the certificate or the intended transfer are in compliance with the Act and based on proper grounds.[365]

Provision of care under the *Mental Health Act* (as opposed to detention and involuntary admission) requires either consent of the patient or substitute consent in accordance with the CCA.[366] For certain treatments to be administered to an incapable patient, however, consent of the Yukon CCB is needed in addition to substitute consent. These treatments are chemotherapy lasting longer than three months, any procedure that removes, destroys, or interrupts the normal connections of the brain by direct access to the brain, or any form of care designated by regulation.[367]

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359. *Ibid.*, ss. 13(1), (2).

360. *Ibid.*, s. 38(1). The Yukon CCB may hold a hearing in an automatic review required by s. 38(1) if it is believed necessary: s. 38(2).

361. *Supra*, note 350 , s. 30(1).

362. *Ibid.*

363. *Ibid.*, s. 24(1).

364. *Ibid.*, ss. 31(1), (2).

365. *Ibid.*, s. 30(2).

366. *Ibid.*, s. 21(1).

367. *Ibid.*, ss. 21(2), (4).

2. Procedure of the Yukon CCB

The CCA gives the Board the ability to determine its own procedure, subject to the Act and any applicable regulations.[368] The Board is required to hold a hearing within seven days after hearing the request, subject to the matter being resolved by informal dispute resolution or postponed to allow informal dispute resolution to take place.[369]

A request for a review may be refused if the Chair is of the opinion that it involves questions of law that should be decided by a court, or that the request is premature, the decision sought to be reviewed is no longer in effect, or the request is frivolous or vexatious.[370] The request must be refused if it concerns a matter that is the subject of a court proceeding, or is one that has already been resolved by the court.[371]

The CCA provides for informal dispute resolution at the discretion of the Chair. If the Chair considers it appropriate, the Chair "shall ensure that a reasonable effort is made to resolve informally any differences between the person making the request and other persons interested in the matter."[372] As noted later, this provision is applied frequently.

The panels for a hearing under the CCA must include the chair or a vice-chair, a physician or other care provider, and a member who is neither a lawyer, physician, or other care provider.[373]

The parties entitled to participate in hearing under the CCA or one requested in relation to a finding of incapacity to consent or refuse care, are the care recipient, the care provider, the SDM or the candidate SDM proposed to be selected, and the applicant if the applicant is not one of the previous three.[374] Anyone who qualifies to be selected as an SDM may participate in a hearing of an application by an SDM for directions, and the parties may also include any other person whom the Yukon CCB specifies.[375]

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368. *Supra*, note 19, s. 58.

369. *Ibid.*, s. 42(2).

370. *Ibid.*, s. 42(3).

371. *Ibid.*, s. 42(4).

372. *Ibid.*, s. 44(1). The Chair may postpone a hearing in order that informal dispute resolution may take place: s. 44(2).

373. *Ibid.*, s. 57.

374. *Ibid.*, s. 45(1).

375 *Ibid.*, ss. 45(2), (3).

Hearings under the *Mental Health Act* require panels to be composed of the Chair or a Vice-chair, at least one physician-member, and at least one community member who is neither a physician nor a lawyer.[376]

The parties to a review of a certificate of involuntary admission or renewal, or a transfer, are the patient and the attending physician. The person in charge of the patient's hospital is also entitled to become a party, and the Yukon CCB may add as a party anyone who in the Board's opinion has a "substantial interest in the matter."

Yukon CCB procedures are not formalized beyond the extent of the procedural requirements expressly stated in the CCA and *Mental Health Act*. Hearings under the CCA are described as an "open forum" for the parties to communicate with the panel.[377] The rights of parties to cross-examination, inspection of documents relied upon by other parties, and having a supporter to the hearing to provide assistance or "to speak on their behalf" are provided in the CCA.[378] Legal aid counsel are provided to patients.[379]

The *Mental Health Act* contains more procedural detail and guidance than the CCA. It confers on the Yukon CCB the same powers as those of the Yukon Territory Supreme Court to compel attendance of witnesses and production of documents and records, and to examine witnesses under oath.[380] It allows the Yukon CCB the discretion to accept and act upon affidavit evidence.[381]

The *Mental Health Act* goes beyond these conventional powers courts have to compel evidence, however, in expressly requiring the Yukon CCB to "fully inform itself of the facts" and empowering it to summon witnesses and compel production of documents evidence in addition to those called and produced by the parties.[382] This enables the Yukon CCB to act in an investigative, inquisitorial manner in a *Mental Health Act* hearing to fill out the factual background to its own satisfaction, rather than being limited to considering the evidence provided by parties. There is no equivalent provision in the CCA.

376. *Ibid.*, s. 28.

377. Information provided by the Registrar of the Yukon CCB.

378. *Supra*, note 19, s. 45(4).

379. Information provided by the Registrar of the Yukon CCB.

380. *Supra*, note 350, s. 35(1).

381. *Ibid.*, s. 35(2).

382. *Ibid.*, s. 34.

3. Appeal

A decision of the Yukon CCB in a matter governed by the CCA may be appealed to the Yukon Territory Supreme Court on a question of law or fact within 30 days following the decision.[383] The right of appeal may be exercised by the care recipient, the care provider, an SDM, the applicant, the Public Guardian and Trustee, and any other person whom the Yukon CCB added as a party.[384] An appeal from the Yukon CCB does not operate as a stay of the decision being appealed unless the court orders otherwise.[385]

The powers of the court on appeal are to confirm or rescind the Yukon CCB decision, substitute its own decision exercising all the powers of the Yukon CCB, or refer the matter back to the Yukon CCB for rehearing in whole or in part with any directions the court considers proper.[386]

The appeal provisions of the *Mental Health Act* are extremely similar, but under them the court is additionally empowered, on application, to make an interim order authorizing treatment pending the disposition of the appeal if the decision appealed from authorized specific care.[387]

4. Caseload of the Yukon CCB

Virtually all matters dealt with by the Yukon CCB, and all the hearings that have been held, concern the *Mental Health Act.* There have been only 14 matters under the CCA since 2007. The majority of the 14 CCA matters consisted of reviews of decisions taken by health care providers acting as "last resort decision makers" to place patients in long-term care under the CCA provision referred to above that permits this step when there is no SDM available to make the decision.[388] One matter was a challenge by a divorced parent of the other parent's actions as SDM. Another was an application by health care providers for a ruling to determine whether an SDM was acting in the best interests of a patient. All but the last-mentioned matter were dealt with by

383. *Ibid.*, s. 52(1).

384. *Ibid.*

385. *Ibid.*, s. 52(3).

386. *Ibid.*, s. 52(2).

387. *Supra*, note 350, s. 37.

388. Information provided by the Registrar of the Yukon CCB.

informal resolution on the part of the Chair and did not proceed to a hearing.[389] The last-mentioned application was abandoned because the patient in question was transferred out of Yukon for psychiatric care.

D. Summary – Canadian Tribunals

The Ontario and Yukon quasi-judicial tribunals that deal with mental capacity and consent to health care exercise review jurisdiction in these matters under mental health legislation as well as under general health care consent legislation. Each functions under very short, statutorily mandated timeframes for hearing and decision. While they are specialized tribunals possessing legal and health care (not exclusively medical) expertise, their jurisdiction is not exclusive or final. Their findings and conclusions are not insulated by a privative clause against review by a court, as are those of some other tribunals with expert membership. Their decisions are fully subject to appeal to a superior court on questions of law and fact.

Other than in the context of detention and psychiatric treatment administered under mental health legislation, matters of capacity and consent to health care form a very small part of the caseload of each tribunal. A body of case authority exists only in Ontario, as due to its informal dispute resolution process, the Yukon CCB has not yet had to adjudicate a matter of this kind except ones arising under mental health legislation.

The administrative tribunal model combining expertise drawn from the health care sector, the legal profession, and lived experience appears to have been accepted as a functional aspect of health law in these two Canadian jurisdictions without generating significant controversy.

389. Information provided by the Registrar of the Yukon CCB.

CHAPTER 5. AUSTRALIAN TRIBUNALS

A. The Australian Civil and Administrative Tribunal System

Australia has a well-developed system of quasi-judicial tribunals that decide a very wide range of civil matters that in Canada would generally be dealt with by courts. The tribunals arose in order to increase access to justice, reduce system-wide delay, and allow for specialization by decision-makers.[390] Each state and territory in Australia has a civil and administrative tribunal with jurisdiction in guardianship matters.[391] Matters of mental capacity to consent to health care and issues surrounding substitute or supported consent are characterized under the general heading of "guardianship" in the Australian tribunal system whether the matters arise in an episodic context or in connection with other, broader issues of support or protection for adults with cognitive impairment.

It should be noted that a distinction is made in Australian legal systems between supportive and protective arrangements for personal affairs, including health care ("guardianship"), and for financial and legal affairs ("administration)." An appointment as a guardian does not confer authority over the financial and legal affairs of an adult under guardianship. This requires separate appointment as an administrator, even if the same individual is appointed as both guardian and administrator.[392] This chapter is only concerned with guardianship in the Australian sense of the term.

Guardianship orders are very seldom plenary, but are usually made to cover a limited range of decision-making, and are subject to mandatory periodic review by the tribunals or courts that made them.[393]

390. Anita Smith, "Tribunals and Statutory Authorities" in Sue Field, Karen Williams and Carolyn Sappideen, *Elder Law: A Guide to Working With Older Australians* (Alexandria, NSW: Federation Press, 2018) at 15.

391. Amalgamation of the Guardianship and Administration Board of Tasmania into the Tasmanian Civil and Administrative Tribunal (TasCAT) created by the *Tasmanian Civil and Administrative Tribunal Act 2020* (Tas.) is planned to take place in 2021. Schedule 3 of this Act creates the Protective Division of TasCAT , with a Guardianship Stream and Mental Health Stream.

392. Malcolm Schyvens, "The Australian Guardianship Tribunal System: Lessons to Share With Canada". Paper presented at 2017 Canadian Elder Law Conference, at 3.

393. *Ibid.*, at 5. Administration orders are also subject to mandatory periodic review, except in New South Wales.

The jurisdiction of the Australian tribunals in guardianship coexists with that of the superior courts, but in practice nearly all guardianship matters are dealt with by the tribunals.[394]

The state of Victoria was the first to confer statutory adult guardianship jurisdiction on an administrative tribunal, implementing a recommendation in the 1982 report of the Cocks Committee to allow for a more informal process that would better accommodate participation by persons with mental disabilities in the proceedings that concern them.[395] Other Australian states followed Victoria in creating guardianship boards.

At the end of the twentieth century and in the first two decades of the present one, the Australian states moved to amalgamate many specialized boards into super-tribunals. They are described as "multifunctional," exercising jurisdiction over a wide range of civil matters.[396] The multifunctional tribunals decide matters such as landlord-tenant, construction, and consumer-supplier disputes, professional discipline matters, and anti-discrimination complaints, in addition to guardianship and financial protection of persons with mental disabilities.

The tribunals also have a review jurisdiction in respect of administrative decisions that is more analogous to an appellate role than judicial review of administrative action as known in Canada. The review jurisdiction is conferred, and its parameters are defined, by subject-specific legislation rather than the framework statutes under which the tribunals are constituted.

The tribunals in the larger states possess a dedicated guardianship or protection "list" or division with tribunal members having relevant expertise, though tribunal members may sit in more than one list or division.[397]

The names and abbreviations of the Australian tribunals are listed here:

- New South Wales Civil and Administrative Tribunal (NCAT)

394. *Ibid.*

395. Errol Cocks, *Report of the Minister's Committee on Rights and Protective Legislation for Intellectually Handicapped persons* (Melbourne: Victorian Government Printer, 1982), cited in Anita Smith, "Developments in Australian incapacity legislation" (2018) 145 *Precedent* 4.

396. Smith, *supra*, note 390, at 18.

397. *Supra*, note 390 at 18.

- Victorian Civil and Administrative Tribunal (VCAT)
- South Australian Civil and Administrative Tribunal (SACAT)
- Queensland Civil and Administrative Tribunal (QCAT)
- Western Australia State Administrative Tribunal (SAT)
- Northern Territory Civil and Administrative Tribunal (NTCAT)
- Tasmanian Guardianship and Administration Board (GAB)[398]
- Australian Capital Territory Civil and Administrative Tribunal (ACAT)

Each of these tribunals is constituted by a statute that sets out the structure, membership qualifications, the manner in which members are appointed and removed, essential procedural powers, and other aspects of their operating framework. Like the *Civil Resolution Tribunal Act*[399] of British Columbia, the constituting statute contains a statement of generic principles which the tribunal is to follow in all cases. These focus on accessible, expeditious, and inexpensive justice, proportionality, and informality. For example, NCAT is constituted under the *Civil and Administrative Tribunal Act 2013* (NSW), which makes reference to a "guiding principle" in these terms:

> 36 Guiding principle to be applied to practice and procedure
> (1) The **"guiding principle"** for this Act and the procedural rules, in their application to proceedings in the Tribunal, is to facilitate the just, quick and cheap resolution of the real issues in the proceedings.
>
> (2) The Tribunal must seek to give effect to the guiding principle when it—
> (a) exercises any power given to it by this Act or the procedural rules, or
>
> (b) interprets any provision of this Act or the procedural rules.
> ……..
> (4) In addition, the practice and procedure of the Tribunal should be implemented so as to facilitate the resolution of the issues between the parties in such a way that the cost to the parties and the Tribunal is proportionate to the importance and complexity of the subject-matter of the proceedings.[400]

398. See *supra*, note 391.

399. S.B.C. 2012, c. 25, ss. 2(1), (2).

400. Act 2 of 2013, ss. 36(1), (2), (4).

The Queensland statute constituting QCAT says this regarding the principles to govern QCAT's operations:

> 4 Tribunal's functions relating to the objects
>
> To achieve the objects of this Act, the tribunal must—
>
> (a) facilitate access to its services throughout Queensland; and
>
> (b) encourage the early and economical resolution of disputes before the tribunal, including, if appropriate, through alternative dispute resolution processes; and
>
> (c) ensure proceedings are conducted in an informal way that minimises costs to parties, and is as quick as is consistent with achieving justice; and
>
> (d) ensure like cases are treated alike; and
>
> (e) ensure the tribunal is accessible and responsive to the diverse needs of persons who use the tribunal; and
>
> (f) maintain specialist knowledge, expertise and experience of members and adjudicators; and
>
> (g) ensure the appropriate use of the knowledge, expertise and experience of members and adjudicators; and
>
> (h) encourage members and adjudicators to act in a way that promotes the collegiate nature of the tribunal; and
>
> (i) maintain a cohesive organisational structure.[401]

The tribunal-constituting statutes are remarkably uniform, reflecting a common institutional model for dispensing civil justice and administrative law remedies that has been adopted throughout Australia. The subject-matter jurisdiction exercised by the tribunals is principally drawn from enabling provisions in other enactments. For example, in matters concerning mental capacity to consent to medical or dental treatment, NCAT exercises authority given to it by the *Guardianship Act 1987* (NSW) to decide those matters, and applies the Act's substantive provisions.[402] In deciding

401. *Queensland Civil and Administrative Tribunal Act 2009*, s. 4.

402. Act 257 of 1987.

landlord-tenant disputes, NCAT draws its subject-matter jurisdiction and the legal rules it applies from the *Residential Tenancies Act 2010* (NSW).[403]

In five states (New South Wales, Victoria, Queensland, South Australia and Western Australia), the president of the tribunal must be a superior court judge, and in the Northern Territory, a local court judge.[404] In Tasmania the president must be a lawyer of at least seven years' standing as an Australian legal practitioner.[405] In the Australian Capital Territory, the president of ACAT must meet the eligibility requirements for appointment as a magistrate.[406] Tribunal members, however, need not be lawyers, and diverse expertise and experience is reflected in their ranks.[407]

The multifunctional tribunals tend to be quite large, with many part-time sessional members. NCAT, for example, had 272 members in mid-2020.[408] SAT had 18 full-time members and 104 sessional members.[409]

The published annual cost of the multifunctional tribunals in Australian dollars, and the approximate Canadian dollar equivalents as of April 2021, is shown in the table below. It should be noted that the budget figures in the table represent the estimated annual cost of all the operations of the respective tribunals, not merely those of the guardianship lists or divisions within them that decide mental capacity matters:

403. No. 42 of 2010.

404. *Civil and Administrative Tribunal Act 2013* (NSW), s. 13(1); *Victorian Civil and Administrative Tribunal Act 1998* (Vic), s. 10(1); *Queensland Civil and Administrative Tribunal Act 2009*, s. 175(1); *South Australian Civil and Administrative Tribunal Act 2013*, s. 10(1); *State Administrative Tribunal Act* 2004 (WA), s. 108(3); *Northern Territory Civil and Administrative Tribunal Act 2014* (NT), s. 13(1).

405. *Guardianship and Administration Act 1995* (Tas), s. 7(2)(a).

406. *ACT Civil and Administrative Tribunal (Presidential Appointment Requirements) Determination 2016*, Notifiable Instrument NI2016-247, s. 4(1).

407. Smith, *supra*, note 390 at 17. Some of the states require that questions of law be decided by members with legal qualifications, or in the absence of such members from a panel, be referred to the President for decision, or alternatively to a court: see *State Administrative Tribunal Act 2004* (WA), s. 59; *Queensland Civil and Administrative Tribunal Act 2009*, ss. 116-118. Others give discretion to the tribunal to refer questions of law to a court, *e.g. Civil and Administrative Tribunal Act 2013* (NSW), s. 54.

408. New South Wales Civil and Administrative Tribunal (NCAT), *Annual Report 2019-20* (Sydney: NCAT, 2020) at 9.

409. Western Australia State Administrative Tribunal (SAT), *Annual Report 2020* (Perth: SAT, 2020) at 6.

Annual Budgets of Australian Tribunals

Tribunal	Fiscal period	A$	C$[410]	Source
ACAT	2019-20	----------	----------	Not published as a segregated cost
GAB (Tas.)	2019-20	1,520,000	1,451,600	Annual Report
NCAT	2019-20	55,500,000	52,525,500	Annual Report
NTCAT	2019-20	----------	----------	Not published as a segregated cost
SACAT	2019-20	----------	----------	Not published as a segregated cost
SAT (WA)	2019-20	14,200,000	13,561,000	Annual Report
QCAT	2019-20	23,200,000	22,156,000	Annual Report
VCAT	2018-19	56,300,000	53,766,500	Annual Report

B. Jurisdiction in Consent and Capacity Matters Relating to Health Care

As mentioned earlier, the Australian multifunctional tribunals exercise statutory jurisdiction in matters of health care consent and mental capacity. These are typically assigned to the division or "list" of the tribunal that deals with issues of guardianship and financial protection for persons with mental disability. In some states, the relevant provisions conferring jurisdiction on the tribunal are found in adult guardianship legislation. Victoria, South Australia, and the Northern Territory have separate

410. Based on the exchange rate of 0.955 published by the Bank of Canada on 1 April 2021.

enactments on health care consent and capacity and advance directives that are applied by the respective tribunals.[411]

One aspect of the tribunals' jurisdiction over this subject-matter is to authorize the guardians whom they appoint to make health care decisions for the incapable adult for whom the guardian will be responsible. This authority will be given expressly in the terms of the guardian's appointment in most cases, because guardianship orders are generally limited, and plenary guardianship orders are very rare.[412] This is in keeping with a principle pervading Australian guardianship legislation that the "least restrictive alternative" is to be taken whenever possible.[413]

Some of the Australian tribunals are empowered to consent to health care for a person incapable of giving or refusing consent in the absence of any another substitute decision-maker.[414] Applications for orders of this kind are sometimes made by a hospital or attending physician in order to obtain legal authority to proceed with a necessary treatment or to resolve a disagreement amongst family members over appropriate treatment of an incapable member in end of life situations.[415] Other states empower the tribunal to make a declaration about the capacity of the patient and designate an SDM to make a health care decision.[416] Certain kinds of treatment administered to a mentally incapable person, such as abortion, sterilization, or removal of tissue for transplant, may require the consent of the tribunal.[417]

In the Australian Capital Territory, any interested person may apply to ACAT for review of a health care decision by a "health attorney" (the equivalent of a TSDM in British Columbia) on behalf of a person incapable of giving consent to health care and who

411. *Medical Treatment Planning and Decisions Act 2016* (Vic); *Consent to Medical Treatment and Palliative Care Act 1995* (SA); *Advance Care Directives Act 2013* (SA); *Advance Personal Planning Act 2013* (NT).

412. Schyvens, *supra*, note 392 at 5.

413. Smith, *supra,* note 390 at 19-20. See *Guardianship Act 1987* (NSW), s. 15(4).

414. Smith, *supra*, note 390 at 27. See *Guardianship Act 1987* (NSW), ss. 42-44; *Guardianship and Administration Act 1993* (SA), s. 61 (re prescribed treatment); *Consent to Medical Treatment and Palliative Care Act 1995* (SA), s. 18E(4); *Guardianship and Administration Act 1995* (Tas), ss. 44-45; *Guardianship and Administration Act 2019* (Vic), ss. 141, 145 (re special medical procedure); *Medical Treatment Planning and Decisions Act 2016* (Vic), ss. 64-71; *Guardianship and Management of Property Act 2000* (Qld), s. 68 (special health care).

415. Information provided by the Deputy President and Division Head, Guardianship Division, NCAT.

416. *Powers of Attorney Act 1998* (Qld), ss. 109A, 111; *Guardianship and Administration Act 1990* (WA), ss. 110V-110ZA, 110ZG(1); *Guardianship and Administration Act 1991* (ACT), s. 69(2).

417. *Guardianship and Administration Act 2000* (Qld), s. 68(1).

has not appointed a health care decision-maker by enduring power of attorney.[418] A decision by an appointed guardian to consent or refuse participation in medical research may also be reviewed by ACAT on application by an interested person.[419] ACAT may revoke an advance health direction made by an individual while possessing capacity, if capacity was later lost and ACAT has appointed a guardian for the individual.[420]

VCAT has jurisdiction to rule on the eligibility and capacity of a person to choose voluntary medically assisted death.[421] Medically assisted death is not legal in Australian states other than Victoria, although it will be legalized in Western Australia in 2021.[422] When in force, the Western Australia legislation will empower SAT to make determinations on eligibility and capacity similar to those VCAT may make under the Victorian voluntary medically assisted death statute.[423]

C. Procedure

1. Overview

The Australian multifunctional tribunals are directed by their constituting statutes to act as informally as is consistent with just disposition of the matters that come before them.[424] The tribunals are not bound by rules of evidence, although they are required to observe the rules of natural justice in regard to procedural fairness.[425]

418. *Guardianship and Management of Property Act 1991* (ACT), s. 32JB. An "interested person" for the purpose of this provision is the incapable person, an attorney (appointed by power of attorney), a relative of the incapable person, the public advocate, the public trustee and guardian, an appointed guardian, a financial "manager" appointed to manage the financial and legal affairs of the incapable person, or a person prescribed by regulation: s. 37(2), incorporating by reference the definition of "interested person" in s. 74 of the *Powers of Attorney Act 2006* (ACT).

419. *Ibid.*, s. 37(1).

420. *Ibid.,* s. 68B.

421. *Voluntary Assisted Dying Act 2017* (Vic), ss. 68, 72.

422. See "End of life law in Australia," online: https://end-of-life.qut.edu.au/euthanasia.

423. *Voluntary Assisted Dying Act 2019* (WA), ss. 84, 88-90 (not yet in force).

424. See *Queensland Civil and Administrative Tribunal Act 2009* (Qld), s. 28(3)(c); *Civil and Administrative Tribunal Act 2013* (NSW), s. 38(4); *Victorian Civil and Administrative Tribunal Act 1998*, s. 98(1)(d); *South Australian Civil and Administrative Tribunal Act 2013* (SA), s. 39(1)(a); *Northern Territory Civil and Administrative Tribunal Act 2014* (NT), s. 53(2)(c); *ACT Civil and Administrative Tribunal Act 2008*, s. 7(a).

425. *Civil and Administrative Tribunal Act 2013* (NSW), s. 38(2); *Victorian Civil and Administrative Tribunal Act 1998* (Vic), ss. 98(1)(a), (b); *Queensland Civil and Administrative Tribunal Act 2009* (Qld), ss. 28(3)(a), (b); *South Australian Civil and Administrative Tribunal Act 2013* (SA), ss. 39(1)(b), (c);

Accessibility is one of the fundamental principles on which the tribunals were created. There are no filing fees in guardianship proceedings.[426] Costs are not awarded, except rarely in cases of abuse of process.[427] Rules of standing are very relaxed in the guardianship sphere. Applications may generally be brought by anyone with an interest in the well-being of the person who is the subject of the application.[428] In larger tribunals, registry staff in the guardianship division or list may take an active pre-hearing role in quickly determining the proper parties to receive notice of an application, contacting them and explaining the process, and gathering information in order to triage applications for priority on the basis of the risk to the person who is the subject of the application, or that person's property.[429]

Requirements for panel composition in guardianship matters vary between the tribunals, but will usually include at least one member with legal qualifications and others with relevant expertise. NCAT requires a three-member panel consisting of an Australian lawyer who will preside, a health care professional or social worker with experience in assessing or treating persons with mental disability, and a community member with relevant experience in dealing with mental disability.[430]

In guardianship matters especially, the procedure of Australian tribunals is inquisitorial.[431] The constituting statutes direct the tribunals, or permit them, to inform themselves by means the tribunals consider appropriate.[432] This mandate entails that the

State Administrative Tribunal Act 2004 (WA), ss. 32(1), (2); *Guardianship and Administration Act 1995* (Tas), ss. 11(2), (4); *Northern Territory Civil and Administrative Tribunal Act 2014* (NT), ss. 53(2)(a), (b); *ACT Civil and Administrative Tribunal Act 2008*, s. 7(b). See also Schyvens, *supra*, note 392 at 7.

426. *Ibid.*, at 4.

427. An example of a rare costs award in a guardianship case is *Re Oll*, [2014] NSWCATGD 40. Costs were awarded against an applicant who sought review of the appointment of a guardian based on unsupported allegations that were ultimately withdrawn.

428. Schyvens, *supra*, note 392 at 4.

429. Robertson Wright, "The NSW Civil and Administrative Tribunal," seminar paper given at the NSW Supreme Court Seminar, Sydney, 16 March 2016 at 21.

430. *Civil and Administrative Tribunal Act 2013* (NSW), Sch. 6, s. 4. See also Schyvens, *supra*, note 392 at 7.

431. Schyvens, *supra*, note 392 at 7. See also Robyn Caroll and Anita Smith, "Mediation in Guardianship Proceedings for the Elderly: An Australian Perspective" (2010) 28 Windsor Y.B. Access Just. 53 at 55.

432. See *Queensland Civil and Administrative Tribunal Act 2009* (Qld), ss. 28(3)(c),(e); *Civil and Administrative Tribunal Act 2013* (NSW), s. 38(6)(a); *Victorian Civil and Administrative Tribunal Act* 1998, s. 98(1)(c); *South Australian Civil and Administrative Tribunal Act 2013* (SA), ss. 39(1)(b),

tribunal panels are not limited by the evidence presented by the parties in a hearing. They will elicit additional oral evidence by questioning parties and witnesses, probe expert evidence in the same manner, and may obtain additional expert evidence on their own initiative if the evidence provided by the parties is inadequate to enable them to reach a decision.[433]

In keeping with informality as a value in the tribunal model, oral evidence is normally not given under oath in tribunal hearings.[434] Written evidence, including medical and other expert reports, need not be in affidavit form.[435] Unlike a court proceeding, there may not be a sharp distinction in a hearing between parties giving oral evidence and making submissions.[436] Cross-examination is permitted in some tribunals and in others it requires leave. Under the inquisitorial model, however, most of the questions are asked by the members of the hearing panel.[437] In addition to the evidence presented, the tribunals are required to take into account the views and wishes of a person who is the subject of an application for an order or direction.[438]

Most matters are resolved in a single hearing that seldom extends more than two hours unless the matter is exceptionally complex.[439] In some cases adjournments take place to obtain further evidence or production of documents.[440] In complex cases, a pre-hearing case conference may be held to refine the issues and ensure the hearing will proceed in an orderly manner without the need for adjournments.

The guardianship lists or divisions of the tribunals prioritize matters for hearing on the basis of the degree of risk to the individual who is the subject of the application, and are flexible regarding hearing venues and use of audiovisual technology. NTCAT is statutorily obliged to decide an application by a medical practitioner for a health

43(2)(a), (b); *Guardianship and Administration Act 1995* (Tas), s. 11(4); *ACT Civil and Administrative Tribunal Act 2008* (ACT), s. 8.

433. Information provided by Deputy President and Division Head, Guardianship, NCAT. See also Caroll and Smith, *supra*, note 431 at 64.

434. Smith, *supra*, note 390 at 31.

435. Schyvens, *supra*, note 392 at 7.

436. Smith, *supra*, note 390 at 31.

437. *Ibid.*

438. Schyvens, *supra*, note 392 at 7. See *Guardianship Act 1987* (NSW), ss. 4(d), 14(2)(a)(i), 44(2)(a)(i); *Guardianship and Administration Act 2019* (Vic), s. 8.

439. Smith, *supra*, note 390 at 31. See also Schyvens, *supra*, note 392 at 7.

440. Information provided by Deputy President and Division Head, Guardianship, NCAT. See also Smith, *supra*, note 390 at 31.

care consent within 24 hours after the application is lodged, if the application contains a statement that the applicant reasonably believes a decision is necessary on an urgent basis.[441]

2. Representation in Tribunal Proceedings

(a) General

The Australian multifunctional tribunals were designed for self-representation, and in most proceedings, a party requires leave of the tribunal to have legal representation at a hearing. In guardianship matters, the expectation of self-representation is less strong. Where allowed, representation is not necessarily restricted to representation by legal counsel. The relevant state legislation may allow for representation by advocates and supporters other than legal practitioners. There are some legislative differences between the states in this regard, and in the practice of the different state tribunals.

Leave of the tribunal is required for legal representation in NCAT guardianship proceedings.[442] Self-representation is still the norm in most proceedings in the Guardianship Division.[443] Leave is granted increasingly often for representation of the person who is the subject of an application for an order within the guardianship jurisdiction when the panel has confidence that the person has capacity to instruct counsel, but it is a matter within the discretion of each hearing panel.[444] NCAT guardianship division panels, however, also have the ability to appoint "separate representation" for the subject of an application when that person may lack capacity to instruct counsel. The concept of separate representation is explained below.

The Australian Capital Territory, South Australia, the Northern Territory, and Western Australia allow representation of the subject of the proceeding by legal counsel as of right.[445] In medical consent matters in South Australia, the person who is the

441. *Advance Personal Planning Act 2013* (NT), s. 63. NTCAT can refuse and treat the application as an ordinary rather than an urgent application under s. 44 of the Act if it is satisfied that, despite the applicant practitioner's assertion of urgency, a decision is not urgently required.

442. *Civil and Administrative Tribunal Act 2013*, s. 45(1).

443. NCAT Guardianship Division Guideline: Representation, para. 6. The Guideline indicates legal counsel may attend guardianship hearings without leave as a "McKenzie Friend" of the subject of the application to provide support, but not representation.

444. Information provided by the Deputy President and Division Head, Guardianship, NCAT.

445. *ACT Civil and Administrative Tribunal Act 2008* (ACT), s. 30; *South Australian Civil and Administrative Tribunal Act 2013* (SA), s. 56(1); *Northern Territory Civil and Administrative Tribunal Act 2014* (NT), s. 130(1); *State Administrative Tribunal Act 2004* (WA), s. 39(1).

subject of the proceeding may alternatively appear by the Public Advocate or by a "recognized" advocate, i.e. a person recognized by SACAT as being qualified to act on behalf of the person.[446]

Queensland allows a person with impaired mental capacity to be represented by an Australian legal practitioner as of right, or by another person with leave of QCAT.[447] QCAT is also empowered to appoint a representative for an unrepresented person in a guardianship proceeding.[448] The representative need not be a lawyer. The appointed representative is required to have regard to any expressed views or wishes of the person so represented, present that person's views and wishes to the tribunal, and promote and safeguard that person's rights, interests, and opportunities.[449]

In Victoria, there is no general exception from the ground rule of self-representation in Guardianship List proceedings, but a VCAT practice note provides that in "more complex matters" it will ordinarily permit representation by a professional advocate who is a legal practitioner, or another professional advocate who has professional experience relevant to the proceeding, such as a social worker or health professional in a guardianship matter.[450] If VCAT has given leave to a party to be represented by a professional advocate, any other party may be represented as of right.[451]

The Tasmanian GAB posts on its website that in a hearing "the proposed represented person [i.e., the subject of the application] can be accompanied by anybody they choose, such as a lawyer, a friend, a relative, an advocate."[452] A GAB practice directive contemplates that legal representatives may be present at a hearing.[453]

446. *Consent to Medical Treatment and Palliative Care Act 1995* (SA), s. 18K(1). Similar representation is possible in other matters coming within SACAT's guardianship jurisdiction: *Guardianship and Administration Act 1993* (SA), s. 68.

447. *Queensland Civil and Administrative Tribunal Act* (Qld), s. 43(2).

448. *Guardianship and Administration Act 2000* (Qld), s. 125(1).

449. *Ibid.*, s. 125(3).

450. VCAT Practice Note 1 at para. 21, online: file:///C:/Users/gblue/Downloads/practice-note-pnvcat1-common-procedures%20(1).pdf.

451. *Victorian Civil and Administrative Tribunal Act 1998* (Vic), s. 62(1)(b)(iii).

452. Online: https://www.guardianship.tas.gov.au/process/processes.

453. Guardianship and Administration Board Practice Direction No. 2 at 2, online: https://www.guardianship.tas.gov.au/data/assets/pdf_file/0003/586506/Guardianship-and-Administration-Board-Practice-Direction-2-of-2020-Hearing-Process-and-Procedure.pdf.

(b) Separate (uninstructed) representation

NCAT has the power to order "separate representation" for an unrepresented party who is or may have impaired mental capacity in order to ensure procedural fairness and protect the interests of that person in the proceeding. Counsel appointed by an order for separate representation may consult with the unrepresented person whose interests they are to protect, and may be expected to do so, but are not bound by that person's instructions. Instead, separate representation counsel are required to make submissions to the tribunal as to what outcome, in counsel's opinion, would "give paramount consideration to the welfare and interests of the subject person" in keeping with the terms of relevant legislation conferring jurisdiction on the tribunal.[454]

NCAT's criteria for separate representation are set out here:

> The Tribunal may decide to appoint a separate representative for the subject person if:
>
> - There is a serious doubt about the subject person's capacity to give legal instructions but there is a clear need for the person's interests to be independently represented at the Tribunal hearing or they wish to be represented
> - There is an intense level of conflict between the parties about what is in the best interests of the subject person
> - The subject person is vulnerable to or has been subject to duress or intimidation by others involved in the proceedings
> - There are serious allegations about exploitation, neglect or abuse of the subject person
> - Other parties to the proceeding have been granted leave to be legally represented
> - The proceedings involve serious and /or complex issues likely to have a profound impact on the interests and welfare of the person with a disability, such as end of life decision-making or proposed sterilisation treatment.[455]

454. NCAT Guardianship Division Guideline: Representation (August 2017), para. 48.

455. *Ibid.*, para. 43.

Legal Aid NSW is notified when NCAT makes an order for separate representation.[456] This does not entitle the subject of the application to legal aid, but in practice Legal Aid NSW provides counsel.[457]

D. Appeals From Tribunals

Appeal provisions vary between the Australian states. Victoria and Western Australia allow for an appeal to the superior trial court of the state or territory on a question of law alone with leave of the court.[458]

New South Wales provides for an appeal from the hearing panel's decision to an appeal panel of the tribunal.[459] A further appeal may be taken from the appeal panel to the superior trial court of the state on a question of law, or on other grounds with leave of the court.[460] The Australian Capital Territory follows the same pattern.[461]

Queensland, South Australia, and the Northern Territory provide, as alternate remedies, an appeal to an internal appeal panel of the tribunal and an appeal to a court on a question of law.[462] Queensland also provides that a decision of an appeal panel may be appealed to the state's Court of Appeal on a question of law alone with leave of that court.[463]

456. New South Wales Law Reform Commission, *Review of the Guardianship Act 1987*, Report 145 (Sydney, NSWLRC, 2018) at 260.

457. *Ibid*. The NSW Law Reform Commission notes that provision of separate representation counsel by Legal Aid NSW is not means-tested, and the issue of funding for it is controversial. The Commission was urged by Legal Aid NSW to recommend an amendment requiring NCAT to order the cost of separate representation counsel be paid by the person for whose benefit separate representation was ordered. The Commission declined to make this recommendation because it considered that a person should not be compelled to pay the fees of counsel who is not retained or instructed by that person, and who would not be bound by instructions that person might give.

458. *Victorian Civil and Administrative Tribunal Act 1998* (Vic), s. 148(1); *State Administrative Tribunal Act 2004* (WA), ss. 105(1), (2);

459. *Civil and Administrative Tribunal Act 2013* (NSW), ss. 80(1), (2).

460. *Civil and Administrative Tribunal Act 2013* (NSW), s. 83(1).

461. *ACT Civil and Administrative Tribunal Act 2008* (ACT), ss. 79(3), 86.

462. *Queensland Civil and Administrative Tribunal Act 2009*, ss. 142(1), 149; *South Australian Civil and Administrative Tribunal Act 2013*, ss. 70(1), 71.

463. *Queensland Civil and Administrative Tribunal Act 2009*, s. 150.

E. Caseload of the Australian Tribunals and Volume of Matters Related to Health Care

The Australian tribunals deal with a very high caseload with impressive speed. The caseload of their guardianship lists or divisions is enlarged by periodic statutory reviews of guardianship orders as well as original applications for orders and reviews of orders at the instance of third parties, because all guardianship orders are time-limited and face regular review. NCAT and VCAT, the two largest tribunals in the most populous Australian states, publish breakdowns of the annual caseload that afford a glimpse into the volume of health care-related matters that come before them in a year.

In 2019/20, NCAT's Guardianship Division received 12,850 applications for orders and reviews, and resolved 12,716 of them, with a clearance rate of 99 per cent.[464] Of these, 461 applications related to substitute consent for medical or dental treatment (including capacity determinations) and 20 to consent for participation in a clinical trial. The portion of the caseload relating to health care thus represented somewhat less than four per cent of the total caseload for the NCAT Guardianship Division. Health care matters have historically accounted for five per cent or less of the division's total annual caseload.[465]

VCAT's Guardianship List received 12,981 applications in 2019/20 and resolved 12,920. Of these, 78 were related to health care consent, or less than one per cent of the intake.[466] In 2018/19, the Guardianship List received 14,076 applications and finalized 12,981. There were 86 matters concerning health care consent in that year, approximately the same percentage of the total intake as in the year following.

F. Recommendations Made for Reform of the Australian Tribunal System

In recent years six Australian law reform agencies have reviewed guardianship laws, including the role of the tribunals in administering them. While the agencies made sweeping recommendations for reform of guardianship legislation generally, none

464. NCAT, *Annual Report 2019-2020* at 43, online: https://ncat.nsw.gov.au/documents/reports/ncat-annual-report-2019-2020.pdf.

465. Information provided by the Deputy President and Division Head, Guardianship, NCAT.

466. VCAT, Annual Report 2019-20 at 59, online: https://www.vcat.vic.gov.au/about-vcat/annual-reports-and-strategic-plan.

advocated abandonment of the tribunal system insofar as it applies to adult guardianship.[467]

The Law Reform Commissions of New South Wales, Queensland, and Victoria have all recommended that legal representation for the person who is the subject of an application should be allowed in all cases without leave.[468] The Victorian Law Reform Commission went further, recommending that the right to representation without leave should extend to all parties to a guardianship proceeding.[469]

In 2014 the federal Australian Law Reform Commission (ALRC) enunciated a set of National Decision-Making Principles based largely upon the *UN Convention on the Rights of Persons with Disabilities* (CRPD Convention)[470] and recommended that Australian guardianship legislation be reconfigured around them:

> *Principle 1: The equal right to make decisions*
>
> All adults have an equal right to make decisions that affect their lives and to have those decisions respected.
>
> *Principle 2: Support*
>
> Persons who require support in decision-making must be provided with access to the support necessary for them to make, communicate and participate in decisions that affect their lives.
>
> *Principle 3: Will, preferences and rights*
>
> The will, preferences and rights of persons who may require decision-making support must direct decisions that affect their lives.
>
> *Principle 4: Safeguards*
>
> Laws and legal frameworks must contain appropriate and effective safeguards in

467. Anita Smith, "Developments in Australian incapacity legislation" (2018) 145 *Precedent* 4 at 8.

468. New South Wales Law Reform Commission, *supra*, note 456 at 256; Queensland Law Reform Commission, *A Review of Queensland's Guardianship Laws*, Report No. 67, vol. 4 (Brisbane: QLRC, 2010) at 47; Victorian Law Reform Commission, *Guardianship*, Final Report 24 (Melbourne: VLRC, 2012) at 494.

469. Victorian Law Reform commission, *supra*, note 468, at 494.

470. *Supra*, note 4.

> relation to interventions for persons who may require decision-making support, including to prevent abuse and undue influence.[471]

Notably, this would require abandonment of the "welfare and best interests" of a person with impaired mental capacity as being the uppermost consideration in guardianship proceedings, and replacement by a focus on the "will, preferences, and rights" of the person.

In keeping with the thrust of the ALRC National Decision-Making Principles inspired by the CRPD Convention, the New South Wales Law Reform Commission recommended that the role of separate representation counsel be changed from one in which counsel makes submissions on the "welfare and interests" of the subject of the application to one in which counsel endeavours to give effect to that person's subjective will and preferences wherever possible.[472] This would include a clearly expressed decision to refuse health care contained in a valid advance care directive.[473]

The Queensland Law Reform Commission recommended that the role of a separate representative appointed by QCAT in an adult guardianship proceeding be defined to require the representative to present the adult's views and wishes to QCAT and "promote and safeguard the adult's rights, interests and opportunities."[474] This recommendation was implemented by a 2019 amendment to the Queensland *Guardianship and Administration Act 2000*.[475]

In addition to its recommendations on a right to representation without leave, the Victorian Law Reform Commission made recommendations to strengthen pre-hearing processes within VCAT, urging use of three-member rather than one-member panels in guardianship proceedings, and the establishment of an appeals division within VCAT.[476] The Commission also commented on the under-utilization of VCAT by indigenous communities, and recommended that VCAT create an indigenous liaison officer position.[477]

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471. Australian Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Laws*, Report 124 (Canberra: ALRC, 2014) at 64.

472. *Supra*, note 456 at 42-43 and 256.

473. *Ibid.*, at 48.

474. Queensland Law Reform Commission, *supra*, note 468 at 57.

475. *Guardianship and Administration and Other Legislation Amendment Act 2019* (Qld), s. 33(3).

476. Victorian Law Reform Commission, supra, note 468 at 487-491, 496, and 501.

477. *Ibid.*, at 503.

Apart from the recommendations concerning representation in guardianship proceedings and enhancing outreach to the indigenous population, the recommendations of the Australian law reform agencies call for only relatively minor change insofar as the tribunals are concerned. This reinforces the observation that in this as in other areas of law, the tribunal model for dispensing civil justice has become a well-established and distinctive feature of the Australian legal system.

CHAPTER 6. IS THE TRIBUNAL MODEL RIGHT FOR BC? CONSIDERATIONS FOR BC POLICYMAKERS

A. Introduction

This chapter deals with policy and structural considerations in meeting the perceived need for a more accessible review mechanism under the HCCCFA Act than the one the Act now provides, namely an application under section 33.4 to the Supreme Court. The extent to which the existing tribunals described in the previous chapters represent models capable of adaptation to meet that need is discussed, as are the considerations that policymakers and legislators would need to take into account in bringing a new non-court review mechanism into being.

B. The Problem: An Impractical Pathway to Independent Review

As noted in Chapter 2, section 33.4 of the HCCCFA Act is not being used to obtain review of incapacity assessments, or to resolve disputes in connection with substitute decision-making or to settle the meaning of advance directives. While there is no conclusive empirical evidence proving why that is the case, it is obvious that section 33.4 cannot be considered in isolation from the known barriers to access to the civil justice system: cost, delay, procedural complexity, and lack of legal aid.

Consider the situation of A, who granted an enduring power of attorney to B before the onset of A's dementia. A is a diabetic and is facing amputation of a leg below the knee to prevent necrosis that will eventually be fatal. A has been assessed as incapable of making the decision to accept or refuse the amputation, but disputes that assessment. A is refusing the amputation and discounts the risk in doing so. B has assumed the management of A's financial affairs under the power of attorney in good faith after A's dementia advanced to the point where A could no longer handle them. B is also the TSDM chosen by the treating physician. B agrees with the incapacity assessment, is prepared to consent as TSDM to the amputation as being in A's best interests, and is unwilling to assist A to contest the incapacity assessment by paying the expenses connected with making a s. 33.4 application to challenge the assessment of incapacity. In effect, A merely possesses an empty, theoretical statutory right to seek review of the incapacity assessment and is unable to invoke it.

There is significant cost associated with a statutory application to the Supreme Court. There is a practical need to retain counsel to pursue a section 33.4 application because of the formality of court procedure, which requires drafting, filing, and serving the petition stating the factual and legal basis for the application, affidavits in support, and a draft order. It would be extraordinary for someone like A, who suffers from dementia, to do this effectively without assistance. Legal aid is unavailable for an application under section 33.4 unless incapacity to consent or refuse health care is due to a mental disorder, in which case it may be provided on a discretionary basis. Impairment of mental capacity due to other causes, such as dementia, trauma, or developmental delay, does not suffice for legal aid. Even if A consults a lawyer, the lawyer may conclude it is not possible to accept instructions from A because of A's cognitive impairment.[478]

System delay can also operate as a barrier to access to justice. The proverb "justice delayed is justice denied" holds true with greater force in matters that concern health. Health care decisions often need to be taken urgently to prevent deterioration in one's condition. Normally, respondents to a petition have 21 days to file a response to an application in the Supreme Court.[479] This time for response may be abridged in an urgent matter, but a separate order must be obtained for this. The court would make an effort to hear and determine an urgent matter on an urgent basis, but may be unable to accommodate a long application (two hours or more) quickly enough. A chambers judge hearing a section 33.4 application quite likely would be doing so for the first time and would be unlikely to be familiar beforehand with the subject-matter of the expert evidence, so may find it necessary to reserve decision.

478. Rule 3.2-9 of the Law Society's *Code of Professional Conduct* states that where a client's mental capacity is impaired due to minority or a disability, a lawyer must maintain a normal lawyer-client relationship as far as possible. The Commentary to the rule states, however, that "when a client is, or comes to be, under a disability that impairs his or her ability to make decisions, the lawyer will have to assess whether the impairment is minor or whether it prevents the client from giving instructions or entering into binding legal relationships." The test of whether the client has the capacity to instruct the lawyer resembles the test of incapacity to make a health care decision under the HCCCFA Act. It is "whether the client has the ability to understand the information relative to the decision that has to be made and is able to appreciate the reasonably foreseeable consequences of the decision or lack of decision." If the lawyer's assessment is that the client is incapable of giving instructions, the lawyer may only take action necessary to protect the client until a legal representative (such as a committee) of the client is appointed, The Commentary states that a lawyer is then obliged to act on the legal representative's instructions as long as the legal representative is acting in good faith.

479. Assuming the respondent is served within Canada: *Supreme Court Civil Rules*, B.C. Reg., 168/2009, Rule 16-1(4)(c)(i).

Added to these known barriers of cost, delay, and procedural complexity is fact that court process is public. Evidence in a section 33.4 application will usually touch on mental and physical health and mental abilities of an individual. This is information of a kind that people typically do not want revealed to the world at large, and courts are reluctant to order that court records be sealed. The publicity of court proceedings in itself may have a tendency to discourage resort to section 33.4 on the part of persons who are the subject of an incapacity assessment, their families and other supporters.

For these reasons, the current section 33.4 could be described as ineffective in providing the opportunity within the legal system for independent review of incapacity assessments and resolution of disputes surrounding substitute decision-making in health care. It is not a remedy that is realistically accessible to most who would need it.

C. Significance of Article 12 of the CRPD Convention

The importance of having a realistically accessible review mechanism for assessments of mental incapacity to make health and care facility admission decisions is accentuated by Canadian ratification in 2010 of the CRPD Convention.[480] Article 12 of this Convention, which has been ratified or acceded to by 182 countries, declares that persons with disabilities have the right to exercise legal capacity and States Parties must ensure them adequate supports to allow them to exercise it.

Paragraph 4 of Article 12 states:

> 4. States Parties shall ensure that all measures that relate to the exercise of legal capacity provide for appropriate and effective safeguards to prevent abuse in accordance with international human rights law. Such safeguards shall ensure that measures relating to the exercise of legal capacity respect the rights, will and preferences of the person, are free of conflict of interest and undue influence, are proportional and tailored to the person's circumstances, apply for the shortest time possible and are *subject to regular review by a competent, independent and impartial authority or judicial body*. The safeguards shall be proportional to the degree to which such measures affect the person's rights and interests.[481]

480. *Supra*, note 4.

481. *Ibid.*

The term "safeguard" in paragraph 4 of Article 12 may be understood to apply to adult guardianship and substitute decision-making regimes, including the one created by the HCCCFA Act provisions relating to adults who are incapable under the legal test of capacity to make health care decisions.

Canada ratified the CRPD Convention with a reservation regarding Article 12, in particular with regard to the requirement of *regular* review of these measures in individual cases. The reservation stated that Canada reserved the right not to subject substitute decision-making arrangements to regular review by an independent authority where these measures were already subject to review or appeal.[482]

Nominally, section 33.4 of the HCCCFA Act provides the review by a competent, independent, and impartial authority or judicial body called for by Article 12 of the CRPD Convention. To the extent that s. 33.4 is inaccessible in practice, however, it falls short of fulfilling Canada's international obligation under the Convention, even to the degree to which Canada has circumscribed it.

D. Looking at Potential Solutions

1. A Specialized Court

While the Advisory Committee for Health Care Consent for People Living with Dementia rejected another court-based model for a review mechanism when it made the

482. See text of Canada's reservation concerning Article 12 of the CRPD Convention, online: https://treaties.un.org/pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-15&chapter=4&clang=_en#EndDec. Canada's reservation also declared its understanding that Article 12 permits supported and substituted decision-making arrangements in appropriate circumstances in accordance with law. In so doing, Canada rejected the interpretation of Article 12 espoused by the UN Committee on the Rights of Persons with Disabilities, which is that Article 12 makes the concept of adult guardianship illegal and requires repeal of all forms of guardianship and substitute-decision making legislation based on legal incapacity. This interpretation, reflected in *General comment No. 1 (2014): Article 12: Equal recognition before the law*, CRPD/C/GC/1 issued by the UN Committee has not been accepted by the majority of States Parties to the CRPD Convention, and has been expressly rejected by several States Parties in addition to Canada, including Germany, Norway, Denmark, and France, as well as by some national advocacy organizations. See Freeman et al, "Reversing hard won victories in the name of human rights: a critique of the General Comment on Article 12 of the UN Convention on the Rights of Persons with Disabilities" (2015) 2 *Lancet Psychiatry* 844 at 848-849. It is not the purpose of this study paper to venture into the international controversy over the interpretation of Article 12 in the non-binding General Comment. Instead, it is assumed here that any new tribunal created in British Columbia, or an existing one that may have its jurisdiction enlarged to comprise the present subject-matter of s. 33.4 of the HCCCFA Act would apply, at least initially, the existing terms of the HCCCFA Act and case law relating to mental incapacity and substitute decision-making..

recommendation on which this study paper is based, the concept of a specialized court model bears some brief examination.

It would be feasible in theory to create a specialized division of the Supreme Court like the Court of Protection in England and Wales. The Court of Protection decides guardianship and mental incapacity matters, including ones relating to health care consent and appropriate housing for mentally incapable persons.[483] The Court of Protection is composed of High Court, district and circuit judges, nominated to hear and decide matters of this kind.[484] Its hearings take place in private, unless the court otherwise orders.[485]

An advantage of a specialized court is that its judges develop subject-matter expertise. British Columbia has specialized courts organized under the aegis of the Provincial Court, such as the Vancouver Drug Treatment court, the Downtown Community Court, the Victoria Integrated Court, and Indigenous Courts.

A specialized court would likely be structured as a division of the Supreme Court of British Columbia for two reasons. The first is that guardianship and the protection of mentally incapable persons were historically dealt with by superior courts, and are likely part of the core jurisdiction of superior courts protected by section 96 of the *Constitution Act, 1867* against being vested in a provincially appointed decision-making body.[486] In order to avoid constitutional challenge to its jurisdiction, a specialized guardianship court should be comprised of federally appointed judges. The second reason is that forming a specialized division of the Supreme Court instead of a new specialized statutory court would avoid the need to establish a separate registry and administrative structure.

In order to have a large enough caseload to warrant creation of a specialized court, its jurisdiction would need to comprise committeeship matters under the *Patients*

483. *Mental Capacity Act 2005*, c. 9, ss. 15(1), 17(1)(a).

484. *Ibid.,* s. 46(2).

485. *Court of Protection Rules 2017*, S.I. 2017 No. 1035 (L. 16), Rule 4.1(1). Some decisions of the Court of Protection are now published in anonymized form.

486. Under the interpretation given to s. 96 of the *Constitution Act, 1867*, a provincial legislature cannot confer jurisdiction on a provincially appointed tribunal that is broadly conformable to an element of the jurisdiction exercised exclusively or predominantly by superior courts at the time of Confederation, unless the jurisdiction is non-judicial or the judicial powers so conferred are subsidiary or necessarily incidental to an otherwise constitutionally valid legislative or administrative scheme: *Reference re Amendments to the Residential Tenancies Act (N.S.)*, [1996] 1 S.C.R. 186.

Property Act,[487] and applications relating to statutory guardianship under Part 2.1 of the *Adult Guardianship Act*,[488] as well as applications under the present section 33.4 of the HCCCFA Act. Matters dealt with by the Provincial Court under Part 3 of the Adult Guardianship Act could also be heard by the specialized guardianship and mental capacity court, because under the *Provincial Court Act*, a Supreme Court judge may sit as a Provincial Court judge.[489]

Designating a cadre of Supreme Court judges to hear guardianship and mental capacity matters exclusively would be likely, nevertheless, to interfere with the assize system used outside the Lower Mainland, and deprive the Supreme Court of the flexibility to assign judges on circuit as needed. It is also by no means clear how the cost and complexity of Supreme Court process could be eliminated in the specialized division to the extent that the barriers to accessibility noted above could be overcome. It is possibly instructive that the Court of Protection in the United Kingdom has been the subject of the same criticisms raised in relation to the civil justice system generally, chiefly in relation to the length of time to obtain decisions and the general lack of understanding of its processes amongst the general public.[490] The specialized court model, though intriguing, is unlikely to afford a solution to the problem of accessibility.

2. The Tribunal Model

There has been a concerted effort in recent years to address the lack of proportionality between the nature of the matter requiring resolution on one hand and the cost and formality of court process on the other. Quasi-judicial tribunals have figured prominently in this effort. In British Columbia, smaller monetary claims and some other civil matters have been diverted from regular courts to the Civil Resolution Tribunal.

487. *Supra*, note 45.

488. *Supra*, note 78.

489. R.S.B.C. 1996, c. 379, s. 7.

490. See Amelia Hill, "The Court of Protection: defender of the vulnerable or shadowy and unjust?" (6 November 2011) *The Guardian*, online: https://www.theguardian.com/law/2011/nov/06/court-protection-defender-vulnerable-unjust; Rebecca Ley, "I'm still confused by the Court of Protection" (27 April 2013) *The Guardian*, online: https://www.theguardian.com/lifeandstyle/2013/apr/27/court-of-protection-dementia.

The perceived advantages of specialized, quasi-judicial tribunals are speed, informality, comparative inexpensiveness, greater privacy, and subject-matter expertise. All of these attributes are important in relation to matters of health and mental capacity. In particular, speed, privacy, and expertise are crucial.

Tribunals can be configured to render decisions quickly. Legislators have little reticence about imposing fixed timelines on statutory tribunals for hearing and decision once an application is filed. The Ontario CCB has been functioning for nearly three decades with a seven-day turnaround between filing of an application and hearing, and deals expeditiously with a large caseload. The process of the CCB is criticized by some informants as too rushed and cursory for some complex matters, but it is unquestionably decisive.

The procedure of tribunals may be as informal as their governing statutes and common law principles of procedural fairness allow. Applications to the Ontario CCB are made on a single form specific to the type of application being made. As the application form refers to the relief sought, the applicant is less likely to be confused as to which form to use. Applications to the Australian tribunals are made in a similar manner. Typically, tribunals are not bound by rules of evidence and the hearings can generally proceed without interruption to hear arguments and make rulings about the admissibility of pieces of evidence.

The setting in which hearings take place is of less importance for tribunals than for courts. The Ontario CCB will convene wherever it is needed, in a hospital or a long-term care facility, and the former British Columbia Health Care and Care Facility Review Board did likewise. In effect, a tribunal can be set up to go to the applicant rather than the reverse. This is particularly important in health care matters.

When hearings take place on tribunal premises, hearing rooms can be configured to place parties at greater ease.[491] This is particularly important insofar as older parties are concerned. The physical characteristics of courtrooms and hearing rooms can influence the quality of evidence given by aging persons whose visual acuity and hearing may be deteriorating and who may be living with dementia, and this could in turn affect the weight the court or tribunal gives their evidence.[492] Courtroom settings, by contrast, are rarely adaptable and are intrinsically stressful for most litigants and

491. Anne-Isabelle Cloutier, "La création d'une instance décisionelle specialisée au Québec: une voie à explorer pour une meillure protection des personnes inaptes" Steele Prize Paper, Canadian Conference on Elder Law, 2019 at 39.

492. Helene Love, "Seniors on the Stand: Accommodating Older Witnesses in Adversarial Trials" (2019), 97 Can. Bar Rev. 240 at 246.

witnesses, all the more so for individuals with dementia or other forms of cognitive impairment.

A much higher degree of privacy can attach to tribunal proceedings, which makes them a more amenable forum for hearing and deciding health and mental capacity matters. Tribunal proceedings need not be open to the public, as court proceedings are except in very rare circumstances. The legislation governing or empowering a statutory tribunal may stipulate that certain categories of evidence such as health information and capacity assessment reports be kept confidential except as between the parties. In New South Wales, information about NCAT Guardianship Division proceedings cannot be published without the consent of NCAT.[493] In the neighbouring state of Victoria, the VCAT Guardianship List restricts access to files or documents on a discretionary basis.[494] In both states, legislation prohibits the publication of the identity of parties to a Guardianship List or Division proceeding.[495]

Perhaps most importantly, a specialized tribunal may consist of decision-makers appointed for their expertise and experience in the subject-matter of the disputes the tribunal is to decide. The expertise represented in its membership may be interdisciplinary, allowing multiple fields of knowledge and experience to be brought to bear on the dispute before the tribunal. Diversity of qualifications and experience represented on tribunal panels would serve to dispel apprehensions of institutional bias and strengthen public confidence in the quality of decision-making.[496]

It is worth noting that six Australian law reform agencies have published reports on reform of state and territorial guardianship laws in recent years. All reviewed the role of the tribunals in the guardianship regime of their respective states. None urged abandonment of the tribunal system or even major changes to tribunals themselves, their powers, or jurisdiction. This is a fairly strong implicit endorsement of the quasi-judicial tribunal as a model for resolving disputes relating to mental capacity.

493. *Guardianship Act 1987* (NSW), s. 101.

494. VCAT Practice Note – PNG1 Guardianship List – General Procedures, online: https://www.vcat.vic.gov.au/documents/practice-notes/practice-note-png1-guardianship-list-general-procedures, paras. 41-42. See also *Victorian Civil and Administrative Tribunal Act 1998* (Vic), Sch.1, s. 37A.

495. *Civil and Administrative Tribunal Act 2013* (NSW), s. 65(2); *Victorian Civil and Administrative Tribunal Act 1998* (Vic) , Sch. 1, ss. 37, 50, 51AJ.

496. On the value of diversity of expertise and experience, see B. Ferres, "Personal Reflections of a Tribunal Member – The interface Between Medical Practice and Legal Decision making in Guardianship" (2007) 26 *Medicine & Law* 15 at 21.

In a comparison of the relative merits of a specialized court versus a specialized tribunal as a solution to the problem of increasing the accessibility of independent review, the tribunal model emerges as the more feasible and satisfactory solution.

E. Issues in Creating the Framework for a Review Tribunal

1. General

We attempt now to identify issues that should enter into the configuration of a specialized tribunal intended to serve as a more accessible, user-friendly review mechanism than the court-based one that section 33.4 of the HCCCFA Act currently provides.

2. Jurisdiction Under the HCCCFA Act

(a) Section 33.4 powers

At a minimum, a new tribunal would presumably have the statutory powers the Supreme Court now possesses under section 33.4 of the HCCCFA Act. In other words, it would have the power to:

- confirm, reverse or vary a decision by an SDM to give or refuse consent to health care or admission to a care facility;
- substitute its own decision for that of the SDM;
- direct a further assessment of the capacity of an adult who has been assessed as incapable of consenting or refusing health care or care facility admission, and order that person's attendance for the purpose of the re-assessment;
- interpret an advance directive or other health care instruction or wish made or expressed by an adult while capable, and make orders in accordance with the interpretation;
- determine who should be chosen as an SDM under the HCCCFA Act for an incapable adult.

(b) Authority to deal with incapacity finding on review with or without independent re-assessment

The legislation under which the former Health Care and Care Facility Review Board operated empowered the Board, in a review of an incapacity assessment, to substitute its own opinion of the capacity or incapacity of an adult for that of the original

assessor.[497] Under section 33.4(2)(a) of the HCCCFA Act, the Supreme Court is limited to directing a re-assessment on such a review application. The section is silent regarding what relief the court may grant if the original assessment and the court-ordered re-assessment conflict. The court's powers under the section appear limited to confirming, reversing, or varying a decision by an SDM, making a decision in place of an SDM, and determining who the SDM should be, interpreting advance directives and giving directions accordingly.

A new tribunal should be able to deal adequately with an application for review of an incapacity assessment, regardless if other relief is claimed, such as reversal of an SDM's decision. In other words, the tribunal should be empowered to confirm or set aside the assessment in the outcome, but should it be empowered to do so by forming its own opinion of the capacity of the adult in question based on the original assessment and evidence obtained in a hearing? Or should the tribunal be required to order a re-assessment by an independent assessor and make its decision based on the total weight of all the evidence? Either approach could be described as independent review of the original incapacity assessment.

Some of our medical informants were adamant that a review tribunal should invariably order a re-assessment when an original incapacity assessment is challenged, rather than forming its own view of an individual's capacity. The comment was offered that making a determination on capacity in the course of a hearing, if done properly, would prolong the hearing unduly. Existing tribunals in Ontario, Yukon, and Australia are not required to obtain an independent re-assessment before ruling on whether incapacity has been established, however.

The enabling legislation for a new review tribunal should be clear as to whether the tribunal has discretion to deal with a finding of incapacity on review with or without re-assessment, or must first direct re-assessment by another assessor.

(c) Review of decisions concerning continued residence in a care facility

Section 33.4 does not refer to decisions to consent to or refuse *continued* residence in a care facility, although other sections in the HCCCFA Act do deal with decisions regarding continued residence as opposed to admission decisions. Reviewing decisions on continued residence and assessments of incapacity to make them should be added to the catalogue of tribunal powers in order to cover situations in which an incapable adult and an SDM are at odds with regard to remaining in a care facility.

497. Part 4 of the HCCCFA Act, s. 30(1), as originally enacted.

(d) Review of decisions concerning use of restraints

Likewise, section 33.4 does not refer to review of decisions regarding consent to use of restraints in a care facility, as relevant provisions were not in force when the section was enacted. The enabling legislation for the former Health Care and Care Facility Review Board did provide for review of decisions to restrain an adult's freedom of movement within a care facility.[498] The scope of review of decisions within the purview of the HCCCFA Act would now be incomplete unless a decision to impose or consent to imposition of restraints is open to challenge before a new tribunal.

(e) Avoidance of advance directives on basis of fraud, undue influence, etc.

Section 33.4(3) allows for an application to have an advance directive declared void on the grounds of fraud, undue influence or other form of abuse or neglect. An application of this kind could require an extensive investigation of the factual background of an advance directive, possibly reaching many years into the past. It would likely require hearing evidence from multiple witnesses, and assessing their credibility. That kind of factual inquiry is one that a court is much better-adapted to undertake than a specialized tribunal. Including section 33.4(3) in the legislative framework of a tribunal would detract from the objective of timely resolution of disputes through use of a quasi-judicial tribunal.

Conferring jurisdiction over civil fraud and undue influence claims, albeit statutory ones, on a provincially created tribunal may invite constitutional challenge as well, as non-statutory claims in the nature of fraud and undue influence have traditionally been decided by superior courts.[499] Avoidance of advance directives on the basis of fraud, undue influence, or another form of abuse might best be left with the court system.

(f) Ability to decide constitutional questions and apply the Charter

As mentioned in Chapter 1, the matters that would come before a review tribunal exercising jurisdiction under the HCCCFA Act are ones that touch upon the right to liberty and security of the person under section 7 of the *Canadian Charter of Rights and Freedoms*. The question is whether the tribunal should be empowered to apply the *Charter* and decide other constitutional questions, potentially including ones relating to the constitutional validity of portions of its own governing Act.

498. Part 4 of the HCCCFA Act, s. 28(1)(f) as originally enacted.

499. See note 486, *supra*.

The submission was pressed on the Law Commission of Ontario that a provincial tribunal having comprehensive jurisdiction over guardianship should have these powers because its functions would concern Charter-protected rights to a significant extent. In recommending that Ontario create such a tribunal, the Law Commission took no definitive position on this point, but urged that consideration be given in the design of the tribunal to "the appropriateness of granting jurisdiction to consider constitutionality of its enabling statute and to grant remedies under the *Constitution Act, 1982*."[500] The Law Commission of Ontario also observed, however, that jurisdiction to hear Charter matters could interfere with expeditious adjudication.[501]

Few tribunals have the power to rule on constitutional questions, including ones relating to the *Charter*. This is generally a function of courts. The members of a tribunal are often appointed from disciplines other than law that have greater connection with the subject-matter of the tribunal's mandate, and cannot all be expected to have a thorough grasp of constitutional law.

The powers of many British Columbia tribunals are configured by reference to provisions of the *Administrative Tribunals Act*, which provides several gradations of adjudicative authority in relation to constitutional matters.[502] These range from having no jurisdiction over constitutional questions, to being able to decide constitutional questions except those relating to the *Charter*, and to having jurisdiction to determine all constitutional questions.[503] The gradation applicable to a tribunal depends on which provision of the *Administrative Tribunals Act* is made applicable to it by its enabling legislation. Tribunals that do have jurisdiction to determine constitutional questions by virtue of an *Administrative Tribunals Act* provision are also empowered to refer these questions to the Supreme Court of British Columbia.[504]

It is quite conceivable that the constitutionality of a provision of the HCCCFA Act or a *Charter* issue could be raised in an application to the review tribunal. Given that a panel of the review tribunal would include non-lawyers in order to bring an appropriate mix of knowledge to bear on the standard subject-matter of the tribunal's caseload, and that appeal of a panel ruling on a constitutional question is quite likely in any case, it may be doubted whether the review tribunal is the proper forum to decide questions of this kind. The observation of the Law Commission of Ontario that having

500. *Supra*, note 330 at 229.

501. *Ibid.*, at 224.

502. S.B.C. 2004, c. 45.

503. *Ibid.*, ss. 44(1), 45(1), 43(1).

504. *Ibid.*. ss. 43(2), 45(2).

to entertain constitutional arguments and rule upon them could derail the objective of speedy resolution is also apt, particularly in the health context where time may be a vital consideration.

An alternative to conferring jurisdiction to determine constitutional questions on a review tribunal is to give the tribunal a wide discretion to refer questions of law, not necessarily limited to constitutional ones, to the court. Australian tribunals generally have this power. The Law Commission of Ontario recommended it receive consideration in connection with the design of a guardianship tribunal, principally to maintain proportionality between the factual context of situations that call for timely and practical resolution and the procedures applied in resolving them.[505] It would allow important and complex legal questions to be elevated to a forum better equipped to deal with them, leaving the tribunal to deal with those aspects of a matter that directly engage its internal expertise.

(g) Ability to apply the Human Rights Code

The same considerations that apply to constitutional issues apply to the question whether the tribunal should have jurisdiction to apply the provincial *Human Rights Code*, a quasi-constitutional enactment.[506] A general power to refer questions of law to the court would cover questions relating to the *Code*.

Alternatively, one of sections 46.1 and 46.2 of the *Administrative Tribunals Act* could be made applicable to the tribunal. Both sections would give the tribunal the discretion to decline to apply the *Human Rights Code* in a matter before it if there is a more appropriate forum. The difference between the two provisions is that under section 46.1, the tribunal would have the jurisdiction to determine if there is a conflict between the *Human Rights Code* and another enactment, such as the HCCCFA Act. Under section 46.2, the tribunal would not have jurisdiction to determine if the other enactment is in conflict with the *Code*.

(h) Avoidance of conflict with orders made under Part 3 of the Adult Guardianship Act

Part 3 of the *Adult Guardianship Act* concerns adults suffering from abuse or neglect.[507] Under it, the Provincial Court may make orders under certain circumstances approving the provision of health care to an adult without the adult's consent if the adult has been assessed under that Act as incapable of consenting to a support and

505. *Supra*, note 330 at 226.

506. R.S.B.C. 1996, c. 210.

507. *Supra*, note 78, ss. 44-60.1.

assistance plan prepared by a designated agency (health authority). Such a plan may include health care. Under section 59 of the *Adult Guardianship Act*, also found in Part 3 of the Act, a designated agency taking emergency action under the section with respect to an abused or neglected adult who is apparently incapable of giving or refusing consent may provide emergency health care to the adult without the adult's consent.

An abused or neglected adult may be found incapable of consenting to a support and assistance plan for reasons other than impairment of cognitive ability alone, such as being in an abusive relationship of dependency in which the adult is unable to exercise free will with regard to accepting assistance.

The *Adult Guardianship Act* declares that Part 3 of that Act does not override rights under section 4 of the HCCCFA Act, which include the right of an adult who is capable of consenting or refusing health care to give, refuse, or revoke consent and have that decision respected.[508] In proposing a support and assistance plan that includes health care, a designated agency is required by Part 3 to ensure compliance with the HCCCFA Act.[509] The interaction of this requirement with the powers given to the Provincial Court and a designated agency to authorize health care without consent in certain circumstances under Part 3 is complex. Care would need to be taken in drafting the enabling legislation for a review tribunal under the HCCCFA Act to prevent a jurisdictional conflict from arising in specific cases between the powers of the review tribunal to make a determination concerning the capacity of an individual to consent or refuse health care and the powers of the Provincial Court and designated agencies acting under Part 3 of the *Adult Guardianship Act*.

3. Potential Combinations of Jurisdiction

(a) Whether caseload will support a self-standing review tribunal

The question of whether the re-establishment and maintenance of a review tribunal dealing exclusively with matters arising under the HCCCFA Act can be justified on the basis of the caseload that can be expected will undoubtedly rise again. The previous experience from 2000-2004 in British Columbia is not a reliable guide, because only one of the seven heads of jurisdiction of the former Health Care and Care Facility Review Board was ever brought into force.

The Office of the Ombudsperson informed us that of 705 complaints received concerning actions of health authorities between 2017 and 2019, 20 complaints related to matters that would be within the purview of the HCCCFA Act, namely the results of

508. *Ibid.*, s. 45(2).

509. *Ibid.*, s. 53(2).

a capacity assessment, the lack of an assessment, the identification of a TSDM by health authority staff following a finding of incapacity, the manner in which consent to health care was obtained, or the failure to obtain informed consent.

Drawing conclusions from the experience of the Ontario Consent and Capacity Board and Yukon Capability and Consent Board is complicated by the fact that these boards exercise review jurisdiction under both general health care consent legislation and mental health legislation, and do not distinguish between the two volumes of cases in compiling their caseload statistics. While capacity to consent cases amount to approximately 25 per cent of the caseload of the Ontario CCB, this percentage includes the cases relating to psychiatric care under mental health legislation, which we are told predominate by far.

The information available from the larger Australian tribunals examined in Chapter 5 points to a consistent percentage of health care consent cases in each year accounting for approximately five per cent (481 applications) of total Guardianship Division caseload in New South Wales and slightly under one per cent (86 applications) of total Guardianship List caseload in Victoria. Some of these applications, however, would not be reviews of decision-making, but ones in which the tribunal is asked to give substitute consent itself for medical or dental treatment in situations where there is no one with authority to consent on behalf of an incapable individual.

The possibility that numbers would be insufficient to justify a self-standing review tribunal that decides matters under the HCCCFA Act may lead policymakers to consider whether the lack of a realistically accessible review mechanism under that Act could be met by combining this function with another statutory review function or by adding it to the jurisdiction of an existing tribunal. Several possible alternatives are discussed below.

(b) Fusion of jurisdiction with Mental Health Review Board

As explained in Chapter 5, Ontario and Yukon have review boards exercising review jurisdiction under general health care consent legislation as well as performing a role corresponding to the Mental Health Review Board in British Columbia. British Columbia could follow this model. Among existing tribunals, the combination of legal, medical, and community expertise within the Mental Health Review Board probably coincides more closely with the expertise that a review tribunal under the HCCCFA Act would require than that of any other body.

The possibility of expanding the jurisdiction of the Mental Health Review Board to include review jurisdiction under the HCCCFA Act was discussed with the Chair of the Board, as well as the possibility of maintaining notionally separate boards with cross-

appointments and co-location. The outcome of the discussion was that both hypothetical combinations of jurisdiction were seen as feasible, provided that the resources of the Mental Health Review Board were expanded commensurately with the added role and caseload. This view was also taken by several other informants.

Although medical informants we consulted tended to be hostile to the suggestion of a single tribunal exercising review functions under the *Mental Health Act* and the HCCCFA Act, this combination seems to have the best prospects of being a conceptual and logistical fit.

(c) Combining review functions under HCCCFA Act and section 35 of the Adult Guardianship Act

Section 35 of the *Adult Guardianship Act* provides, in effect, that an adult who has been determined to be incapable of managing financial affairs under Part 2.1 of the Act and who has had that determination confirmed by reassessment may apply to the Supreme Court for review of the determination. The court may either confirm the determination or reject it and order that statutory guardianship of the adult must end. This is a similar review function to section 33.4 of the HCCCFA Act, and both could be assumed by the same review tribunal.

As the statutory guardianship regime under Part 2.1 of the *Adult Guardianship Act* is a modern statutory scheme for a temporary or emergency form of guardianship to prevent destitution or financial abuse of an adult with impaired mental capacity, rather than being based on the historical *parens patriae* powers that are part of the core jurisdiction of superior courts, there is less likelihood that transferring review powers under Part 2.1 from the Supreme Court to a provincially appointed tribunal would be found unconstitutional.

(d) Creation of a comprehensive adult guardianship tribunal

Believing that the CCB had demonstrated the efficacy of the administrative justice model in relation to mental capacity matters, the Law Commission of Ontario proposed the creation of a tribunal with comprehensive jurisdiction in the area of legal capacity and decision-making, covering property and financial management on behalf of mentally incapable individuals, personal care, health care, and guardianship of estates of persons admitted to psychiatric facilities. This would combine the jurisdiction of the Ontario CCB and the Superior Court of Justice in these matters, making the tribunal "the adjudicative forum for the vast majority of rights disputes in Ontario."[510]

510. *Supra*, note 330 at 215.

Transferred to British Columbia, this concept would call for unifying the jurisdiction exercised now by the Supreme Court under the *Patients Property Act*, the HCCCFA Act, and Part 2.1 of the *Adult Guardianship Act* (statutory guardianship) under the aegis of a single provincial tribunal. The concept is attractive in terms of increasing accessibility, establishing proportionality between the nature of disputes relating to mental capacity and the procedures to resolve them, and reducing cost barriers.

There would be significant constitutional pitfalls, however, in vesting the plenary authority in adult guardianship that the Supreme Court exercises under the *Patients Property Act* in a provincially appointed tribunal. The protection of mentally incapable adults is part of the historic core jurisdiction of superior courts, and it is not competent to provinces to move it to a decision-making body that is not another section 96 court, i.e. one with federally appointed judges.[511] The Law Commission of Ontario briefly alluded to this constitutional prohibition and said it was a factor to be considered in implementing a comprehensive guardianship tribunal of the kind it recommended for that province.[512]

Conferral of jurisdiction analogous to that of a superior court on a provincial tribunal can sometimes be upheld if it is necessarily incidental or subsidiary to an administrative scheme intended to achieve an otherwise valid legislative objective. Recently, however, the legislative objective of facilitating access to justice was held in this province to be inadequate to support the conferral of exclusive jurisdiction over low-value motor vehicle accident claims on the Civil Resolution Tribunal.[513]

Bringing plenary guardianship jurisdiction under the *Patients Property Act* into a provincial tribunal that also decides matters of capacity and consent to health care under the HCCCFA Act would help to alleviate the problem of low caseload numbers, if there indeed is one, but the constitutionality of that model would still be fragile. Maintaining concurrent jurisdiction under the *Patients Property Act* in the Supreme Court as well as *parens patriae* powers might go some distance to insulate the model against challenge, yet it is anyone's guess whether it would be sufficient.

511. See note 486, *supra*.

512. *Supra*, note 330, at 223.

513. *Trial Lawyers Association of British Columbia v. British Columbia (Attorney General)*, 2021 BCSC 348 at paras. 302, 372, 375.

4. Increasing the Accessibility of the Tribunal

(a) Ability to convene where needed

A health care review tribunal needs the ability to go to the applicants, rather than the applicants having to come to the tribunal. A major reason for the efficacy of the Ontario CCB is its ability to convene at any venue where the subject of an application is located, whether it be in a hospital, psychiatric facility, or long-term care centre, and at bedside when necessary. The former British Columbia Health Care and Care Facility Review Board was able to do the same. This requires a large, geographically dispersed membership that allows formation of panels quickly in different areas of the province. The Ontario CCB is able to use single-member panels as well as three-member ones, which allows it to deal with high volumes of cases and hold hearings on a very urgent basis when the need arises. Thought should be given to giving a review panel the option to use single-member panels.

(b) Regionalization vs. centralization

Regionalization of the review mechanism would increase accessibility. The original scheme for the British Columbia Health Care and Care Facility Review Board contemplated a board in each regional health authority. Full regionalization to this degree may make it difficult to standardize practice and procedures and achieve consistent interpretations, but an alternative could be to maintain standing panels of the tribunal in each health region or the ability to form them quickly from tribunal members resident in each region. Knowledge of local conditions and local populations, including familiarity with the different First Nations Communities, can have an important bearing on appropriate outcomes in matters that engage the beliefs and values of the communities concerned.

If centralization is unavoidable, the membership of the tribunal should still be as geographically diffuse as possible in order to allow formation of panels where needed in the province, including single-member panels.

(c) Rights of standing

A characteristic of all the tribunals examined in this study paper is that they give standing to a very broad range of persons in matters concerning health care consent and mental capacity in order to ensure as far as possible that any supporter can bring a matter affecting the interests of a mentally incapable person before them. The Yukon CCB will recognize as having standing "any person having a substantial interest in the matter." Whether or not this example is followed, standing to apply to the tribunal is usually accorded to at least these persons by existing tribunals of this kind:

- a person assessed as incapable or for whom consent to care or admission to a care facility has been given or refused;
- the substitute decision-maker, whatever that person's status (personal guardian, representative, TSDM, etc.);
- other eligible substitute decision-makers;
- the health care provider or official in charge of a care facility;
- a spouse, relative or close friend of the subject of the application;
- the Public Guardian and Trustee.

The tribunal could also be given the discretion to accord standing to anyone it believes should receive it, in order to meet the circumstances of any case. Most of the tribunals examined have this power.

(d) Representation

In order to take account of the reality that the subject of an application to a review tribunal may be incapable of instructing counsel, the enabling legislation of the tribunal should contain a provision stating that for the purpose of proceedings before the tribunal, that person is deemed capable of instructing counsel, as in the Ontario HCCA 1996. This would be intended only to ensure the possibility of representation, and not require counsel to receive or be bound by instructions that the incapable person may be unable to give or give competently.

It would be useful in addition for a review tribunal to have the power to designate an *amicus curiae* or uninstructed counsel when an incapable person is unrepresented to ensure that the person's interests are adequately protected, similar to the power of the Mental Health Review Board to appoint "discharge counsel" under its rules and that of NCAT in New South Wales to order "separate representation."

In some situations within the context of health care and prospective or current residence in a care facility, a close friend, family member or other supporter of an incapable person may be able to represent the interests of that person before a tribunal more effectively than legal counsel. These are cases where effective representation with respect to the matter in question, such as where the incapable person should be housed, would depend much more on familiarity with the incapable person's circumstances, beliefs, wishes and personality than on legal advocacy. Thought could be given to following the example of some of the Australian states and give the tribunal

the discretion to allow a lay supporter of an incapable person or a lay advocate to represent that person when it is clearly the wish of that person that the supporter or lay advocate do so, or when it is evident to the tribunal that the lay supporter or advocate has no conflict of interest and is best-placed to do so.

(e) Legal aid

Ideally, a review tribunal would be able to operate with a capability like that of the Ontario CCB to order the provincial legal aid organization to provide legal aid counsel for an unrepresented party unable to secure representation otherwise. Some of our informants expressed the view that the availability of legal aid has led to overuse of the CCB in Ontario. It is difficult nevertheless to envision how a review mechanism under the HCCCFA Act could be fully effective, accessible, procedurally balanced and fair without ready access to legal aid for otherwise unrepresented parties, especially but not exclusively for the individual who is the subject of an application.

(f) Education of the public and involved professions

If a review mechanism is to be effective and accessible, the public needs to be aware of it and the rights it protects, and professionals in the fields concerned need to be familiar with its process as well. A review tribunal needs some educational capability to familiarize the general public, health care providers, care facility operators, and the legal profession with its mandate and process.[514] Express mention of this adjunct educational function in the tribunal's enabling legislation as one of the tribunal's statutory powers should be considered to emphasize the importance of spreading awareness of the tribunal and ensure it is not neglected.

5. PROCEDURE

(a) Timeliness

It is obvious that elimination of unnecessary delay in decision-making is crucial in the context of health care. Short timelines are a feature of the Canadian examples of consent and capacity review tribunals. As mentioned in Chapter 4, the Ontario CCB and Yukon CCB operate under statutory requirements to hold a hearing within seven days after an application is made, unless the hearing is postponed by consent, and the Ontario CCB must render a decision within a day following the hearing. The former British Columbia Health Care and Care Facility Review Board was also required to conduct hearings within 7 days of a request being made.

514. Cloutier, *supra*, note 491 at 38.

Regardless of whether the timelines in these examples are seen as overly stringent, attention should be given in the enabling legislation for a review tribunal to speed of decision-making.

(b) User-friendly process

It goes without saying that the procedure for application to a review tribunal intended for greater accessibility should be as simple as possible. The tribunals studied generally require filing a single form, paper or electronic, to lodge an application.

The Ontario CCB makes a template available online for assessment and other reports that is designed to focus the attention of health care professionals on evidence relevant to the legal test of capacity that the Board must apply. These are techniques worth adopting in light of the fact that case presenters and expert witnesses will have varying degrees of familiarity with the legislation under which the review tribunal operates.

(c) Adversarial vs. Inquisitorial Procedure

The essentially conventional adversarial procedure employed in hearings by the Ontario CCB was criticized by some of our informants as pitting patients against their care providers, and family members against one another, with resulting harm to physician-patient and familial relationships.[515] A CCB member commented that he generally attempted to discourage physicians from cross-examining their patients in hearings for this reason.

The inquisitorial procedure used by Australian tribunals has the advantage of diffusing a confrontational atmosphere by placing the responsibility for eliciting evidence on the tribunal panel. It also allows the tribunal to obtain more and better evidence than what the parties provide. It is true that the inquisitorial model is in part a product of the fact that the Australian tribunals are designed for self-representation, but the power to go beyond the respective cases presented by the parties and obtain the best evidence available regarding an individual's mental capacity should in theory make for a better quality of decision-making. The former British Columbia Health Care and Care Facility Review Board was empowered and required, like the Australian tribunals, not merely to hear and decide but to "fully inform itself of the facts."

The inclusion of language allowing the review tribunal to adopt an inquisitorial process is well worth considering in drafting enabling legislation for a review tribunal.

515. See also Cloutier, *supra*, note 491 at 40-41 regarding exacerbation of intrafamilial friction by adversarial processes.

6. Tribunal Membership

(a) Qualifications

The tribunals surveyed in the study paper tend to follow the pattern of appointing three groups of members: a legally qualified group, a group qualified in a health care field or social work, and a group consisting neither of health care providers nor legally trained members. Members in the last-mentioned group are sometimes referred to as "community" members, and generally have some lived experience with mental incapacity or disability. This mix of qualifications is also typical of mental health review boards across the jurisdictions.

Ideally, members in both the health and legal groups should have knowledge and experience with assessment of mental capacity, be familiar with the conventional assessment techniques, and understand their limitations. Medical or nursing qualifications alone do not necessarily imply possession of extensive knowledge of, or experience with, capacity assessment.

In order to serve the entire province adequately even in the digital age, the membership needs to be large enough and geographically dispersed, so that panels can be formed quickly where they are needed and all regions represented. Knowledge of local conditions and populations would be important factors in the tribunal's decision-making, requiring ethnic, linguistic, and gender diversity in its membership. The tribunal should have insight, for example, into indigenous perspectives on dementia and decision-making within familial groups and communities. This can also be a focus in training of members, as mentioned below.

Drafters of the tribunal's enabling legislation should take note of the requirements in the Yukon *Care and Consent Act* that membership of the CCB "should reflect the cultural, regional and gender diversity of Yukon" and have knowledge or experience of people with mental impairment from different causes.[516] Inclusion of provisions like this would assist in guiding appointments to achieve the needed diversity in background and expertise.

(b) Training

Training of new members and in-service continuing training for those already serving is essential for a successful tribunal. Both aspects of training have been major components of the Ontario CCB's operations. Members need to become fully familiar with the governing legislation, the requirements of procedural fairness, some basic

516. *Supra*, note 19, s. 53(3)(c).

administrative law, and acquire an understanding of the theory and techniques of capacity assessment, their strengths and weaknesses.

Our professional and community informants stressed that training in dealing with intrafamilial disputes is important. Indigenous cultural, LGBTQ2+, and transgender sensitivity training is also essential for tribunal members, as these populations often have great distrust of the health care system and their reactions are not the same as those of non-marginalized groups in society.

CHAPTER 7. CONCLUSION

This study paper was not conceived to be a conclusory document, but an informational one. It was intended to shed light on structures and systems in place elsewhere that function with some success to increase access to justice in health care for members of the community who may have lost mental acuity, but who are still entitled to be accorded dignity and to retain personal autonomy to the greatest extent their condition permits. If this study paper has pointed to lessons from beyond our boundaries from which British Columbia could profit, it will have fulfilled its purpose.

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