

Guardianship final report background paper: Legislative schemes regulating deprivation of liberty in residential care settings

Introduction

- 1.1 A number of jurisdictions have introduced legislative schemes which allow a designated person, or a combination of people, to authorise another person's deprivation of liberty in a residential care setting thereby permitting actions that would otherwise constitute assault and false imprisonment.
- 1.2 This background paper contains brief descriptions of some of those legislative schemes.

England and Wales

Overview of the Deprivation of Liberty Safeguards under the *Mental Capacity Act 2005* (UK)

- 1.3 As indicated in Chapter 15 of the Guardianship final report, the *Mental Capacity Act 2005* (UK) was amended in 2007 in response to the European Court of Human Rights' decision in *HL v United Kingdom* (the *Bournewood* case)¹ in which it was found that HL's living arrangements at Bournewood Hospital, where he was effectively detained as an informal patient, were an unauthorised deprivation of liberty in contravention of his right to liberty in article 5(1) of the *European Convention for the Protection of Human Rights and Fundamental Freedoms* (European Convention).²
- 1.4 The Deprivation of Liberty Safeguards (the Safeguards), which came into effect on 1 April 2009, seek to ensure that individuals who are or who

¹ *HL v United Kingdom* (2005) 40 EHRR 32 [1].

² *Convention for the Protection of Human Rights and Fundamental Freedoms*, 10 December 1948, Council of Europe, ETS No 005, (entered into force generally on 3 September 1953).

may be deprived of their liberty in a hospital or care home are identified and that any restraint is externally reviewed and authorised, even if the person is not actively seeking liberty. Once a person in this situation is identified, an assessment process is carried out by between two and six assessors who each report separately to the supervisory body that commissions the assessments. If all the requirements are met, an authorisation must be issued. The Safeguards are unusual because authority for a person's deprivation of liberty is provided by a combination of various clinicians rather than by a court, tribunal or statutory official.

- 1.5 The Safeguards aim to ensure compliance with article 5(1) of the European Convention³ by requiring that any deprivation of liberty of a person of 'unsound mind' is in accordance with a procedure prescribed by law. It is also possible to apply to the Court of Protection about the applicability of the Safeguards in a particular case thereby providing a right to judicial review of a detention's lawfulness in compliance with article 5(4) of the European Convention.⁴
- 1.6 The *Mental Capacity Act 2005* (UK) applies in England and Wales.⁵ The Deprivation of Liberty Safeguards made under the Act apply to people living in care homes as well as hospitals.⁶ They apply to people who:
- lack capacity specifically to consent to treatment or care in either a hospital or care home that, in their own best interests, can only be provided in circumstances that amount to a deprivation of liberty, and where detention under the *Mental Health Act 1983* is not appropriate for the person at that time.⁷
- 1.7 The Safeguards seek to 'provide a proper legal process and suitable protection in those circumstances where deprivation appears to be unavoidable, in a person's own best interests'.⁸ They do not cover deprivations of liberty in supported accommodation,⁹ a private

³ Ibid art 5(1).

⁴ Ibid art 5(4).

⁵ We note that the safeguards apply slightly differently in England and Wales due to varying regulations. Chapter 17 of the Guardianship final report deals primarily with the scheme as it operates in England.

⁶ In contrast, the *Mental Health Act 1983* (UK) c 20 only allows detention for psychiatric health purposes: see *GJ v The Foundation Trust* [2009] EWHC 2972 (Fam).

⁷ Ministry of Justice (United Kingdom), *Deprivation of Liberty Safeguards: Code of Practice to Supplement the Main Mental Capacity Act 2005 Code of Practice* (2008) 9 ('*Deprivation of Liberty Safeguards: Code of Practice*').

⁸ Ibid 9–10.

⁹ See *Salford City Council v BJ* [2009] EWHC 3310 (Fam).

residence,¹⁰ or for people under the age of 18.¹¹ They do not apply to people detained under the *Mental Health Act 1983* (UK).¹²

- 1.8 The Safeguards provide for two types of authorisations for a deprivation of liberty—a standard authorisation¹³ and an urgent authorisation.¹⁴

What is a deprivation of liberty?

- 1.9 The *Mental Capacity Act 2005* (UK) provides little guidance about what constitutes a 'deprivation of liberty', merely indicating that the term has the 'same meaning as in Article 5(1) of the Human Rights Convention'.¹⁵ *The Deprivation of Liberty Safeguards: Code of Practice to Supplement the Main Mental Capacity Act 2005 Code of Practice* (the Deprivation of Liberty Safeguards Code) echoes the point made in *Bournewood* that it is impossible to lay down a rigid formula for determining when there is a deprivation of liberty:

[T]o determine whether there has been a deprivation of liberty, the starting-point must be the specific situation of the individual concerned and account must be taken of a whole range of factors arising in a particular case such as the type, duration, effects and manner of implementation of the measure in question. The distinction between a deprivation of, and restriction upon, liberty is merely one of degree or intensity and not one of nature or substance.¹⁶

- 1.10 The Deprivation of Liberty Safeguards Code suggests that it may be helpful to imagine a scale that moves from a restraint (or restriction) to

¹⁰ See *Deprivation of Liberty Safeguards: Code of Practice*, above n 7, 14: 'It will only be lawful to deprive somebody of their liberty elsewhere ... when following an order of the Court of Protection on a personal welfare matter. In such a case, the Court of Protection Order itself provides a legal basis for the deprivation of liberty. This means that a separate deprivation of liberty authorisation under the processes set out in the Code of Practice is not required'.

¹¹ This situation would generally fall under the *Children Act 1989* (UK) c 41, s 25. In some situations it would be appropriate to use the *Mental Health Act 1983* (UK) c 20: see *Deprivation of Liberty Safeguards: Code of Practice*, above n 7, 12.

¹² *Mental Health Act 1983* (UK) c 20. The determination of whether someone is ineligible for the safeguards is made under *Mental Capacity Act 2005* (UK) c 9, sch 1A. For a recent discussion of the problematic relationship between the *Mental Health Act 1983* (UK) c 20 and the ineligibility provisions for the Deprivation of Liberty Safeguards contained in the *Mental Capacity Act 2005* (UK) c 9, sch 1A, see Neil Allen, 'The Bournewood Gap (As Amended?)' (2010) 18 *Medical Law Review* 78.

¹³ *Mental Capacity Act 2005* (UK) c 9, sch A1 pt 4. For guidance on how to apply the standard authorisation process in practice, see *Deprivation of Liberty Safeguards: Code of Practice*, above n 7, 28–66.

¹⁴ *Mental Capacity Act 2005* (UK) c 9, sch A1 pt 5. For guidance on how to apply the urgent authorisation process in practice, see *Deprivation of Liberty Safeguards: Code of Practice*, above n 7, 67–75.

¹⁵ *Mental Capacity Act 2005* (UK) c 9, s 64(5).

¹⁶ *HL v United Kingdom* (2005) 40 EHRR 32, 791; *Deprivation of Liberty Safeguards: Code of Practice*, above n 7, 16–17.

a deprivation of liberty. It notes that an individual's position on the scale 'will depend on the concrete circumstances of the individual and may change over time'.¹⁷

1.11 In *Bournemouth*, the Court observed that a person may be deprived of liberty even if a hospital ward is not locked or lockable.¹⁸ The Deprivation of Liberty Safeguards Code refers to a range of factors from United Kingdom and European Court of Human Rights case law that are relevant in determining if the line between restriction upon liberty and deprivation of liberty has been crossed. These include factors such as:

- physical control (eg restraint, including sedation)
- mental control (eg the exercise of complete and effective control over the care and movement of a person for a significant period by staff)
- a combination of mental and physical control (eg the refusal of a request by carers for a person to be released into their care).¹⁹

The Deprivation of Liberty Safeguards Code emphasises that the list is not exhaustive and the particular circumstances of each case must be considered.

1.12 The lack of any definitive statements about what constitutes a deprivation of liberty and what is merely a restriction of liberty may make it extremely difficult for hospitals and care homes to determine whether particular residents are being deprived of their liberty.

What are the Safeguards?

1.13 The Safeguards fall into two categories—those that operate during the process for the issue of an authorisation, and those that apply once an authorisation is in place.

Prior to authorisation

1.14 The main features of the Safeguards that protect individuals prior to or during the process for the issue of an authorisation are:

- A duty on hospitals and care homes to identify people who are, or are likely to be deprived of their liberty in the hospital or care home in the next 28 days and to meet all the qualifying requirements for a Deprivation of Liberty Safeguards standard authorisation.²⁰

¹⁷ *Deprivation of Liberty Safeguards: Code of Practice*, above n 7, 17.

¹⁸ *HL v United Kingdom* (2005) 40 EHRR 32, 793.

¹⁹ *Deprivation of Liberty Safeguards: Code of Practice*, above n 7, 17.

²⁰ *Mental Capacity Act 2005* (UK) c 9, sch A1 para 24.

- A duty on the managing authority²¹ of the hospital or care home to apply for a standard authorisation from its supervisory body²² to detain the person.²³
- A duty on the supervisory body of the hospital or care home to ensure that assessments are carried out to see if the person meets the six qualifying requirements for a standard authorisation. The six qualifying requirements are:
 - i. age requirement
 - ii. mental health requirement
 - iii. mental capacity requirement
 - iv. best interests requirement
 - v. eligibility requirement
 - vi. no refusal requirement.²⁴
- A duty on the supervisory body to instruct an Independent Mental Capacity Advocate to represent and support the person²⁵ if there is an application for a deprivation of liberty authorisation and there is no one other than people engaged in providing care or treatment for the person to consult in determining what would be in the person's best interests.²⁶
- The ability for a third party to ask the supervisory body to determine if there is an unauthorised deprivation of liberty.²⁷ Provided the

²¹ The managing authority of hospitals and care homes is defined in the *Mental Capacity Act 2005* (UK) c 9, sch A1 paras 176–9. The Ministry of Justice (United Kingdom), *Deprivation of Liberty Safeguards: Code of Practice*, above n 7, 28–9 summarises these provisions as follows: 'In the case of an NHS (public) hospital, the managing authority is the NHS body responsible for the running of the hospital in which the relevant person is, or is to be, a resident. In the case of a care home or private hospital, the managing authority will be the person registered, or required to be registered under Part 2 of the *Care Standards Act 2000* (UK) in respect of the hospital or care home'.

²² A supervisory body of hospitals and care homes is defined in the *Mental Capacity Act 2005* (UK) c 9, sch A1 paras 180–3 as one of the following: a Primary Care Trust, a local authority, the Welsh Ministers or a local health board. For a more comprehensive explanation, see *Deprivation of Liberty Safeguards: Code of Practice*, above n 7, 28–30.

²³ *Mental Capacity Act 2005* (UK) c 9, sch A1 para 24. The duty also applies if a standard authorisation has been given and is in force and there is, or is to be, a change in the place of detention: at para 25.

²⁴ *Mental Capacity Act 2005* (UK) c 9, sch A1 paras 13–20.

²⁵ The general role and duties of an Independent Mental Capacity Advocate are detailed in the *Mental Capacity Act 2005* (UK) c 9, s 35. See also *Deprivation of Liberty Safeguards: Code of Practice*, above n 7, 36–8; Department for Constitutional Affairs (United Kingdom), *Mental Capacity Act 2005 Code of Practice* (2007) 178–201.

²⁶ *Mental Capacity Act 2005* (UK) c 9, s 39A. The managing authority has a duty to notify the supervisory body of this when it submits the application for the deprivation of liberty authorisation: at s 39A(2).

²⁷ *Mental Capacity Act 2005* (UK) c 9, sch A1 para 68.

request is not vexatious or frivolous and the matter has not been decided already with no change in circumstances, the supervisory body must appoint an assessor to determine if the person is a detained resident.²⁸ The assessment must be completed within seven days from the date that the supervisory body receives the request.²⁹ If the assessment determines that the person is a detained resident and the detention is unauthorised, a full assessment must be carried out.

After authorisation

1.15 After an authorisation is issued, the main features of the Safeguards are:

- A duty on the supervisory body to appoint a representative for the person if a standard authorisation for deprivation of liberty is issued.³⁰ The representative must maintain contact with the relevant person, and represent and support the relevant person in all matters relating to the Safeguards.³¹
- A duty on the supervisory body to instruct an Independent Mental Capacity Advocate to represent the person during any gaps in the appointment of a representative.³²
- A duty on the supervisory body to instruct an Independent Mental Capacity Advocate if the relevant person does not have a paid representative and:
 - they or the representative requests that an Independent Mental Capacity Advocate is appointed, or
 - the supervisory body believes that instructing an Independent Mental Capacity Advocate will help ensure that the person's rights are protected.³³
- A duty on the supervisory body to review a standard authorisation if a review is requested by the relevant person, their representative or the managing authority.³⁴ The managing authority must request a review if it believes that one or more of the qualifying requirements is reviewable.³⁵

²⁸ Ibid sch A1 para 69.

²⁹ *Mental Capacity (Deprivation of Liberty: Standard Authorisations, Assessments and Ordinary Residence) Regulations 2008* (UK) SI 2008/1858, reg 14.

³⁰ *Mental Capacity Act 2005* (UK) c 9, sch A1 para 139.

³¹ Ibid sch A1 para 140.

³² Ibid s 39C.

³³ Ibid s 39D.

³⁴ Ibid sch A1, paras 102(2)–(3). The supervisory body may also carry out a review at any time on its own initiative: at para 102(1).

³⁵ *Mental Capacity Act 2005* (UK) c 9, sch A1 para 103(2).

- A maximum period of 12 months duration for an authorisation.³⁶
- A right to apply to the Court of Protection to determine questions about the lawfulness of the detention.³⁷

Types of authorisation

1.16 There are two types of authorisation—a standard authorisation³⁸ and an urgent authorisation.³⁹

Standard authorisation

1.17 As the name indicates, a standard authorisation should be used in most instances and should be sought before a deprivation of liberty commences. A managing authority must request a standard authorisation if it appears likely that during the next 28 days, someone is likely to be accommodated in its hospital or care home in circumstances that amount to a deprivation of liberty and that person is likely to meet all the qualifying requirements for an authorisation.⁴⁰

1.18 Once a supervisory body receives a request for a standard authorisation it is required to ensure that six assessments⁴¹ are carried out to determine if the qualifying requirements are met.⁴² If all six qualifying requirements are met, the supervisory body must give a standard authorisation.⁴³ The written authorisation must contain:

- the duration of the authorisation
- the purpose of the deprivation of liberty
- the conditions imposed on the authorisation
- the reasons why each qualifying requirement is met.⁴⁴

³⁶ Ibid sch A1 paras 42, 51.

³⁷ Ibid s 21A.

³⁸ Ibid sch A1 pt 4. For details of how to apply the standard authorisation process in practice, see *Deprivation of Liberty Safeguards: Code of Practice*, above n 7, 39–66.

³⁹ *Mental Capacity Act 2005* (UK) c 9, sch A1 pt 5. For details of how to apply the urgent authorisation process in practice, see *Deprivation of Liberty Safeguards: Code of Practice*, above n 7, 67–75.

⁴⁰ *Mental Capacity Act 2005* (UK) c 9, sch A1 para 24. In some cases, a third party may request the supervisory body to determine whether there is an unauthorised deprivation of liberty. If an assessment has determined that the person is a detained resident and the detention is not authorised under s 4A, the standard authorisation procedure is followed as if the managing authority had applied: at sch A1 paras 67–73 for details of this process.

⁴¹ The six assessments are discussed at [1.23]–[1.29].

⁴² *Mental Capacity Act 2005* (UK) c 9, sch A1 para 33(2).

⁴³ Ibid sch A1 para 50.

⁴⁴ Ibid sch A1 para 55(1).

- 1.19 A deprivation of liberty authorisation should last for the shortest time possible and may not be issued for longer than 12 months.⁴⁵

Urgent authorisation

- 1.20 An urgent authorisation is used if a deprivation of liberty needs to occur before a standard authorisation can be completed. It authorises deprivation of liberty for a maximum period of 14 days.⁴⁶
- 1.21 Only the managing authority may issue an urgent authorisation.⁴⁷ It can only be issued if a request for a standard authorisation has been made. This means that a managing authority should not issue itself an urgent authorisation unless it has a reasonable expectation that the six qualifying requirements will be met.⁴⁸

Assessments

- 1.22 The six-part assessment process is both detailed and rigorous. The mental health assessor and the 'best interests' assessor must be different people and there must be a minimum of two assessors.⁴⁹
- 1.23 The assessments must be carried out within 21 days from the date on which the supervisory body receives a request from the managing authority for a standard authorisation.⁵⁰

⁴⁵ Ibid sch A1 paras 42, 51.

⁴⁶ It is issued for a maximum period of seven days and can be extended once for a maximum of another seven days for exceptional reasons: *Mental Capacity Act 2005* (UK) c 9, sch A1 paras 77, 78(2), 84–6.

⁴⁷ *Mental Capacity Act 2005* (UK) c 9, sch A1 para 74. It must make an urgent authorisation in situations where it is either required to make a request to, or has already made a request to the supervisory body for a standard authorisation and it believes that the need for the person to be deprived of their liberty is so urgent that deprivation needs to begin before the request is made, or dealt with by the supervisory body: at sch A1 para 76.

⁴⁸ This is because the duty to request a standard authorisation only arises where the person is likely to meet the qualifying requirements: see *Mental Capacity Act 2005* (UK) c 9, sch 1A paras 24, 25. See also *Deprivation of Liberty Safeguards: Code of Practice*, above n 7, 67.

⁴⁹ *Mental Capacity (Deprivation of Liberty: Standard Authorisations, Assessments and Ordinary Residence) Regulations 2008* (UK) SI 2008/1858, regs 4, 5; *Deprivation of Liberty Safeguards: Code of Practice*, above n 7, 41. The requirements for eligibility to be an assessor are rigorous. For example, in England a mental health assessment must be carried out by a registered doctor, who has completed standard training for deprivation of liberty safeguards and additional training relevant to their role as mental health assessor in the 12 months prior to selection (except in the 12-month period beginning with the date the doctor has successfully completed the standard training). The eligibility and selection requirements for assessors are detailed in the *Mental Capacity (Deprivation of Liberty: Standard Authorisations, Assessments and Ordinary Residence) Regulations 2008* (UK) SI 2008/1858, pts 2, 3.

⁵⁰ *Mental Capacity (Deprivation of Liberty: Standard Authorisations, Assessments and Ordinary Residence) Regulations 2008* (UK) SI 2008/1858, reg 13. But note that the period for assessment is reduced if an urgent authorisation is in place under the *Mental Capacity Act 2005* (UK) c 9, sch A1 para 76. In this case, the assessments required for the standard authorisation must be

- 1.24 The age assessment confirms whether the person is 18 years or older.⁵¹
- 1.25 The 'no refusals' assessment seeks to ensure that there is no relevant refusal of assistance in place.⁵² There is a refusal if the person has made a valid advanced decision to refuse treatment.⁵³ There is also a refusal if the accommodation of the person in the relevant hospital or care home would conflict with a valid decision of either a court appointed substitute decision maker or substitute decision maker personally appointed by the person.⁵⁴
- 1.26 The mental health assessment establishes whether the person has a mental disorder within the meaning of the *Mental Health Act 1983* (UK) thereby permitting various actions under that legislation.⁵⁵ A mental disorder is any disorder or disability of the mind excluding dependence on alcohol or drugs.⁵⁶ It includes all learning disabilities.⁵⁷ The mental health assessor must consider how the relevant person's mental health is likely to be affected by being a detained resident and report these conclusions to the 'best interests' assessor.⁵⁸
- 1.27 The mental capacity assessment establishes whether the person lacks capacity to make decisions about their own accommodation, treatment and care.⁵⁹

completed within the period during which the urgent authorisation is in force: *Mental Capacity (Deprivation of Liberty: Standard Authorisations, Assessments and Ordinary Residence) Regulations 2008* (UK) SI 2008/1858, reg 13(2).

⁵¹ *Mental Capacity Act 2005* (UK) c 9, *ibid* sch A1 paras 13, 34.

⁵² *ibid* sch A1 paras 18–20, 48.

⁵³ *ibid* sch A1 para 19(1). Advance decisions are dealt with at ss 24–6.

⁵⁴ *Mental Capacity Act 2005* (UK) c 9, sch A1 para 20(1). See: at ss 9, 16 for the appointment provisions relating to a donee or a deputy. In this context, a donee corresponds to an enduring guardian appointed under the *Guardianship and Administration Act 1986* (Vic) s 35A. A deputy corresponds to a guardian appointed under the *Guardianship and Administration Act 1986* (Vic) s 22.

⁵⁵ *Mental Capacity Act 2005* (UK) c 9, sch A1 paras 14, 36.

⁵⁶ *Mental Health Act 1983* (UK) c 20 s 1.

⁵⁷ *Mental Capacity Act 2005* (UK) c 9, sch A1 para 14 provides that the exclusions in the *Mental Health Act 1983* (UK) c 20 for a person with a learning disability not to be regarded as suffering from a mental disorder do not apply.

⁵⁸ *Mental Capacity Act 2005* (UK) c 9, sch A1 para 36.

⁵⁹ *ibid* sch A1 paras 15, 37.

- 1.28 The eligibility assessment determines if the person is eligible for an authorisation under the Deprivation of Liberty Safeguards.⁶⁰ A person is ineligible if their treatment is regulated by the *Mental Health Act 1983* (UK). The assessment concerns the person's potential status under the *Mental Health Act 1983* (UK), not just their actual status.⁶¹ If the *Mental Health Act 1983* (UK) is applicable, it must be used in preference to the *Mental Capacity Act 2005* (UK).⁶² In general, a person will be eligible for an authorisation if the proposed deprivation is in a care home or in a hospital for non-mental health treatment.⁶³
- 1.29 The best interests assessment requires findings that:
- the person is, or is to be, a detained resident
 - it is in the best interests of the person to be a detained resident
 - it is necessary for the person to be a detained resident to prevent harm to them
 - detaining the person is a proportionate response to the likelihood of the person suffering harm and the seriousness of that harm.⁶⁴
- 1.30 The 'best interests' assessment is extremely detailed. The Code of Practice recommends that the 'best interests' assessment is undertaken last, once there is a reasonable expectation that the other five qualifying requirements will be met, because it is likely to be the most time-consuming.⁶⁵ It requires the assessor to consider:

⁶⁰ Ibid sch A1 paras 17, 46–8, sch 1A.

⁶¹ Ibid sch 1A.

⁶² Justice Charles stated that 'the MHA 1983 is to have primacy when it applies ... medical practitioners cannot pick and choose between the two statutory regimes as they think fit having regard to general considerations (eg the preservation or promotion of a therapeutic relationship with P) that they consider render one regime preferable to the other': *GJ v The Foundation Trust* [2009] EWHC 2972 (Fam) [45]. For a critique of this judgment's interpretation of the ineligibility assessment, and the primacy of mental health over mental capacity law see Neil Allen, 'The Bournemouth Gap (As Amended?)' (2010) 18 *Medical Law Review* 78. Allen notes that it is likely that the Deprivation of Liberty Safeguards could not have been used for HL in the paradigmatic case for which they were designed because it is likely that he would have been ineligible as an objecting mental health patient under the *Mental Capacity Act 2005* (UK) c 9 sch 1A para 2 (Case E). This means it is probable that his detention could only be authorised by the *Mental Health Act 1983* (UK) c 20.

⁶³ See *Deprivation of Liberty Safeguards: Code of Practice*, above n 7, 48. But note there are circumstances in which a person is ineligible in these circumstances if the authorisation would be inconsistent with an obligation under the *Mental Health Act 1983* (UK) c 20, for example a requirement to reside in a particular place: see *Mental Capacity Act 2005* (UK) c 9, sch 1A paras 2 (Cases B, C, D), 3.

⁶⁴ *Mental Capacity Act 2005* (UK) c 9, sch A1 paras 16, 38.

⁶⁵ *Deprivation of Liberty Safeguards: Code of Practice*, above n 7, 44.

- the mental health assessor's conclusions about how the relevant person's mental health is likely to be affected by being a detained resident
- any relevant needs assessment
- any relevant care plan
- the views of the relevant managing authority⁶⁶
- the views of interested persons.⁶⁷

Queensland

- 1.31 In Queensland, an automatically appointed substitute decision maker known as a 'statutory health attorney' can make decisions about health care matters, including residence in some forms of supported accommodation, for a person who is unable to make their own decisions.⁶⁸
- 1.32 Like the 'person responsible' provisions of the *Guardianship and Administration Act 1986* (Vic) (the G&A Act), the Queensland legislation sets out a hierarchy of people who may act as an automatically appointed statutory health attorney. These are, in order, the person's spouse, their unpaid carer, a close friend or relative (who is not a paid carer).⁶⁹ If none of these people are available and culturally appropriate to exercise power, the Adult Guardian is the statutory health attorney for the matter.⁷⁰
- 1.33 An automatic appointment of a statutory health attorney will only take effect if there is:
- no relevant advance health directive giving a direction about the matter
 - the tribunal has not appointed a guardian to deal with the matter or made an order about the matter
 - the adult has not appointed an attorney for the matter.⁷¹

⁶⁶ *Mental Capacity Act 2005* (UK) c 9, sch A1 paras 38, 39. The requirements are in addition to the best interests principles in s 4, such as the requirement to consider the person's past and present wishes and feelings.

⁶⁷ *Ibid* s 4(7).

⁶⁸ *Powers of Attorney Act 1998* (Qld) s 62.

⁶⁹ *Ibid* s 63(1).

⁷⁰ *Ibid* s 63(2).

⁷¹ *Guardianship and Administration Act 2000* (Qld) s 66. There are also some situations where no consent is required—these are detailed at ss 62–4.

- 1.34 In Queensland, admission to high-level care in aged care facilities has been characterised as a health care decision.⁷² This means that an automatically appointed statutory health attorney can consent to living arrangements of this nature.⁷³ The extent of a statutory health attorney's power to authorise deprivations of liberty as part of these living arrangements is not clear.

Ontario

- 1.35 In the Canadian province of Ontario, the *Health Care Consent Act*⁷⁴ provides that where a person has been found to be incapable of consenting to admission to a health care facility a substitute decision maker may authorise admission.⁷⁵ Sections not yet in force will govern admission to secure units within care facilities.⁷⁶ The *Health Care Consent Act* provides that before a substitute decision maker can consent to or refuse admission on behalf of a person an evaluator must find that the person is incapable with respect to the admission.⁷⁷
- 1.36 The Ontario legislation contains a hierarchical list of people who may act as substitute decision maker for medical treatment.⁷⁸ The same people may authorise admission to a care facility, if consent is required by law.⁷⁹

⁷² See Department of Justice and Attorney-General, Government of Queensland, *Health Care Decisions for Others* (31 October 2011) <<http://www.justice.qld.gov.au/justice-services/guardianship/making-health-care-decisions/healthcare-decisions-for-someone-else>>. See also *Powers of Attorney Act 1998* (Qld) sch 2 ss 4–5, which defines 'health matter' and 'health care'.

⁷³ *Powers of Attorney Act 1998* (Qld) s 62.

⁷⁴ *Health Care Consent Act*, SO 1996, c 2, sch A.

⁷⁵ The *Health Care Consent Act*, SO 1996, c 2, sch A s 40(1). The *Long-Term Care Homes Act*, SO 2007, c 8, s 207(5) will repeal and substitute s 40(1) on a day to be named by proclamation of the Lieutenant Governor. The *Health Care Consent Act*, SO 1996, c 2, sch A, s 2(1) defines a care facility as a long-term care home as defined in the *Long-Term Care Homes Act, 2007*, or a facility prescribed by the regulations as a care facility. The *Long-Term Care Homes Act*, SO 2007, c 8, s 2(1) defines a long-term care home as a place that is licensed as a long-term care home under this Act, and includes a municipal home, joint home or First Nations home approved under Part VIII.

⁷⁶ *Long-Term Care Homes Act*, SO 2007, c 8, s 207(2) repealing and substituting *Health Care Consent Act*, SO 1996, c 2, sch A, s 38.

⁷⁷ *Health Care Consent Act*, SO 1996, c 2, sch A, s 40(1). The *Health Care Consent Act*, SO 1996, c 2, sch A, s 2(1) provides a range of people who may act as an evaluator, in the circumstances provided by the regulations.

⁷⁸ *Health Care Consent Act*, SO 1996, c 2, sch A, ss 20(1).

⁷⁹ *Ibid* sch A, ss 20(1), 41.

- 1.37 The legislation is similar to the 'person responsible' provisions of the G & A Act.⁸⁰ Like the G & A Act, the list prioritises appointed decision makers over automatically appointed decision makers. It gives priority first to court appointed guardians with relevant decision-making authority,⁸¹ followed by personally appointed attorneys for personal care with relevant decision making authority,⁸² and thirdly a representative appointed by the Consent and Capacity Board.⁸³
- 1.38 A person may give or refuse consent only if he or she is: capable with respect to the treatment; at least 16 years old (unless the parent of the incapable person); not prohibited by court order or separation agreement from having access to the incapable person or giving or refusing consent on his or her behalf; and is available and willing to assume the responsibility of giving or refusing consent.⁸⁴ The substitute decision maker is the highest-ranking person on this list who is available, capable and willing to make the decision.⁸⁵
- 1.39 The Act provides for the Public Guardian and Trustee to act as a substitute decision maker of last resort if no one on the list is available, capable and willing to make the decision.⁸⁶ The Public Guardian and Trustee also makes the decision if there are two or more eligible people of equal rank on the hierarchical list whose claims rank above all others and who disagree about whether to give or refuse consent.⁸⁷
- 1.40 If the substitute decision maker knows of a wish applicable to the circumstances that the person expressed after turning the age of 16 and during a period of capacity, the substitute decision maker must give or refuse consent in accordance with the wish.⁸⁸ If there is no known wish applicable to the circumstances, or it is impossible to comply with the wish, the substitute decision maker must act in the person's best interests.⁸⁹

⁸⁰ *Guardianship and Administration Act 1986 (Vic) s 37.*

⁸¹ A guardian of the person is appointed by the Superior Court of Ontario under the *Substitute Decisions Act*, SO 1992, c 30, s 55.

⁸² An attorney for personal care may be appointed by the person under the *Substitute Decisions Act*, SO 1992, c 30, s 46.

⁸³ A representative may be appointed by the Consent and Capacity Board under the *Health Care Consent Act*, SO 1996, c 2, sch A, s 33.

⁸⁴ *Health Care Consent Act*, SO 1996, c 2, sch A, s 20(2).

⁸⁵ *Ibid* sch A, s 20(3).

⁸⁶ *Ibid* sch A, s 20(5).

⁸⁷ *Ibid* sch A, s 20(6).

⁸⁸ *Ibid* sch A, s 42(1)(1).

⁸⁹ *Ibid* sch A, s 42(1)(2).

- 1.41 When determining what is in the best interests of the person, the substitute decision maker must consider the following matters:
- the values and beliefs that the person knows the incapable person held when capable and believes he or she would still act on if capable
 - any wishes expressed by the incapable person with respect to admission to a care facility that are not required to be followed under the 'wishes applicable to the circumstance' provision
 - whether admission to the care facility is likely to improve the quality of the incapable person's life, prevent the quality of the incapable person's life from deteriorating, or reduce the extent to which, or the rate at which the quality of the incapable person's life is likely to deteriorate
 - whether the quality of the incapable person's life is likely to improve, remain the same or deteriorate without admission to the care facility
 - whether the benefit the incapable person is expected to obtain from admission to the care facility outweighs the risk of negative consequences to him or her
 - whether a course of action that is less restrictive than admission to the care facility is available and is appropriate in the circumstances.⁹⁰
- 1.42 An additional provision will govern substituted consent to admission to a secure unit. It provides that the substitute decision maker must not give consent to the person's admission to a secure unit of a care facility unless the admission is essential to prevent serious bodily harm to the person or to others, or allows the incapable person greater freedom or enjoyment.⁹¹ Exceptions will apply for crisis admissions.⁹²
- 1.43 Additional regulation of admissions to a secure unit will also be provided under the *Long-Term Care Homes Act*.⁹³ These sections are not yet in force but will require a 'placement co-ordinator' for the geographic area where the home is located to authorise the admission of the person to a secure unit within the home only if all of the following are satisfied:

⁹⁰ Ibid sch A, s 42(2).

⁹¹ *Long-Term Care Homes Act*, SO 2007, c 8. S 207(6) amending *Health Care Consent Act*, SO 1996, c 2, sch A, s 42 to add subsection (3).

⁹² *Health Care Consent Act*, SO 1996, c 2, sch A, s 47.

⁹³ *Long-Term Care Homes Act*, SO 2007, c 8, s 45. This section comes into force on a day to be named by proclamation of the Lieutenant Governor: at s 232(2).

- there is a significant risk that the person or another person would suffer serious bodily harm if the person were not admitted to a secure unit
- alternatives to admitting the person to a secure unit have been considered but would not be effective to address the risk referred to above
- admitting the person to a secure unit is reasonable, in light of the person's physical and mental condition and personal history
- a physician, registered nurse in the extended class or other person provided for in the regulations has recommended the admission to a secure unit
- the admission of the person to a secure unit has been consented to by the person or, if the person is incapable, a substitute decision-maker of the person with authority to give that consent.⁹⁴

1.44 The legislation will also require the placement co-ordinator to give the person a written notice of their rights⁹⁵ and to notify a rights adviser who must seek to see the person in question.⁹⁶

1.45 The *Long-Term Care Homes Act* provides extensive legislative regulation on the use of restraints. It requires long-term care homes to establish and comply with a written policy directed to minimizing restraint of residents.⁹⁷ The Act requires a written plan of care for each resident.⁹⁸ It describes activities which are and which are not considered restraint of a resident.⁹⁹ It covers situations where restraints must not be used, for

⁹⁴ *Long-Term Care Homes Act*, SO 2007, c 8, s 45(1). This section comes into force on a day to be named by proclamation of the Lieutenant Governor: at s 232(2).

⁹⁵ *Long-Term Care Homes Act*, SO 2007, c 8, s 45(6) requires that the written notice given to the person is in accordance with the requirements provided for in the regulations and must inform the person, (a) of the reasons for the admission; (b) that the person is entitled to apply to the Consent and Capacity Board for a determination as to whether the substitute decision-maker complied with section 42 of the *Health Care Consent Act*, 1996, (c) that the person has the right to retain and instruct counsel without delay; and (d) of any other matters provided for in the regulations. This section comes into force on a day to be named by proclamation of the Lieutenant Governor: at s 232(2).

⁹⁶ *Long-Term Care Homes Act*, SO 2007, c 8, s 45(2). This section comes into force on a day to be named by proclamation of the Lieutenant Governor: at s 232(2).

⁹⁷ *Long-Term Care Homes Act*, SO 2007, c 8, s 29(1).

⁹⁸ *Ibid* s 6(1).

⁹⁹ *Ibid* s 30.

example for the convenience of staff or as a disciplinary measure.¹⁰⁰ It also provides conditions under which restraining may be used.¹⁰¹

1.46 The *Long-Term Care Homes Act* provides that a resident may be restrained by a physical device only if it is included in the resident's plan of care, or done when immediate action is necessary to prevent serious bodily harm to the person or to others.¹⁰² It may only be included in a resident's plan of care if all of the following are satisfied:

- there is a significant risk that the resident or another person would suffer serious bodily harm if the resident were not restrained
- alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the significant risk
- the method of restraining is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable methods that would be effective to address the significant risk
- a physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining
- the restraining of the resident has been consented to by the resident or, if the resident is incapable, authorised by a substitute decision-maker of the resident with authority to give that consent
- the plan of care provides for everything required under the Act if a resident is being restrained by a physical device.¹⁰³

1.47 The requirements that apply to the use of restraints include: compliance with regulations; monitoring; reassessment of the resident's condition including an evaluation of the effectiveness of the restraining; and an obligation to discontinue the method of restraining if, as a result of reassessment, an alternative to restraining is identified that would address the risk, or a less restrictive method of restraining is identified that would be reasonable in light of the resident's physical and mental condition and would address the risk.¹⁰⁴

¹⁰⁰ Ibid s 30(1).

¹⁰¹ Ibid ss 31–32. Section 32, which relates to restraining using barriers, locks etc comes into force on a day to be named by proclamation of the Lieutenant Governor: at s 232(2).

¹⁰² *Long-Term Care Homes Act*, SO 2007, c 8, ss 30(1)(3), s 31. A resident may be restrained in accordance with the common law duty to restrain or confine a person when immediate action is necessary to prevent serious bodily harm to the person or to others: at s 36.

¹⁰³ *Long-Term Care Homes Act*, SO 2007, c 8, s 31(2). Section 31(3) sets out the requirements that must be provided for in the plan of care if a resident is being restrained by a physical device.

¹⁰⁴ *Long-Term Care Homes Act*, SO 2007, c 8, s 31(3).

- 1.48 The *Long-Term Care Homes Act* also regulates restraining a resident by the use of barriers, locks or other devices or controls from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents.¹⁰⁵ The common law duty of a caregiver to restrain or confine a person when immediate action is necessary to prevent serious bodily harm to the person is a statutorily recognised exception to these provisions.¹⁰⁶
- 1.49 Sections not yet in force will provide a further exception to the requirement that a resident should not be restrained in this way. The sections require the restraint to be included in a care plan under similar conditions to those required for restraining by the use of physical devices.¹⁰⁷ The conditions include a requirement of significant risk, consideration of alternatives and whether the method of restraining is both reasonable and the least restrictive alternative, a recommendation about the method of restraining by a health professional, consent or substitute consent and checking whether the plan of care provides for everything required under the Act if a resident is being restrained by a physical device.¹⁰⁸
- 1.50 The Act also provides: for reassessment of the resident's condition and evaluation of the effectiveness of restraining; that the restraining is only used for the minimum time necessary to address the risk; and a requirement that the method of restraining used is discontinued if, as a result of reassessment, an alternative to restraining is identified that would address the risk, or a less restrictive method of restraining is identified that would be reasonable in light of the resident's physical and mental condition and would address the risk.¹⁰⁹

¹⁰⁵ Ibid s 30(1)5.

¹⁰⁶ Ibid s 36(1).

¹⁰⁷ Ibid s 32. Section 32 comes into force on a day to be named by proclamation of the Lieutenant Governor: at s 232(2).

¹⁰⁸ *Long-Term Care Homes Act*, SO 2007, c 8, s 32(2). Section 32 comes into force on a day to be named by proclamation of the Lieutenant Governor: at s 232(2).

¹⁰⁹ *Long-Term Care Homes Act*, SO 2007, c 8, s 32(3). Section 32 comes into force on a day to be named by proclamation of the Lieutenant Governor: at s 232(2).

British Columbia

- 1.51 In British Columbia, provisions in the *Health Care (Consent) and Care Facility (Admission) Act* not yet in force will provide for substitute decision makers to consent to admission to a care facility.¹¹⁰
- 1.52 The provisions are similar to those in Ontario providing for a range of people to give substitute consent to admission.¹¹¹ Priority is given to a court appointed decision maker with authority to consent to the admission (personal guardian).¹¹² The next person in the hierarchy is a personally appointed decision maker with authority to consent to the admission (representative).¹¹³ If no appropriate court appointed or personally appointed substitute decision maker is available, a range of automatically appointed decision makers may provide consent. The hierarchy of automatically appointed substitute decision makers is: 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 close friend of the adult; a person immediately related to the adult by marriage.¹¹⁴
- 1.53 A personally appointed substitute decision maker, or any of the list of automatically appointed decision makers, may not provide substitute consent unless a medical practitioner or a prescribed health care provider has determined that the person is incapable of giving or refusing consent.¹¹⁵

¹¹⁰ *Health Care (Consent) and Care Facility (Admission) Act*, RSBC 1996, c 181. The provisions, which are not yet in force, providing for admission to a care facility will be in pt 3, ss 20–26. See the *Health Statutes Amendment Act*, SBC 2007, c 19, s 8. Section 8 comes into force by regulation of the Lieutenant Governor in Council: at s 40.

¹¹¹ *Health Care (Consent) and Care Facility (Admission) Act*, RSBC 1996, c 181. The provisions providing for substitute consent will be s 22. See the *Health Statutes Amendment Act*, SBC 2007, c 19, s 8.

¹¹² *Health Care (Consent) and Care Facility (Admission) Act*, RSBC 1996, c 181. The provision providing for substitute consent by a personal guardian will be s 22(1)(a). See the *Health Statutes Amendment Act*, SBC 2007, c 19, s 8.

¹¹³ *Health Care (Consent) and Care Facility (Admission) Act*, RSBC 1996, c 181. The provision providing for substitute consent by a representative will be s 22(2)(a). See the *Health Statutes Amendment Act*, SBC 2007, c 19, s 8.

¹¹⁴ *Health Care (Consent) and Care Facility (Admission) Act*, RSBC 1996, c 181. The provision providing for substitute consent by a range of automatically appointed decision makers is 22(2)(b)–(j). See the *Health Statutes Amendment Act*, SBC 2007, c 19, s 8.

¹¹⁵ *Health Care (Consent) and Care Facility (Admission) Act*, RSBC 1996, c 181. The provisions providing that a determination must be made that the person is incapable to consent or refuse on their own behalf will be ss 22(1)(b), s 26. See the *Health Statutes Amendment Act*, SBC 2007, c 19, s 8.

- 1.54 In order to give or refuse substitute consent for admission to a care facility the person must be at least 19, have been in contact with the adult during the preceding 12 months, have no dispute with the adult, be capable of giving or refusing consent and willing to comply with the duties for giving or refusing consent.¹¹⁶
- 1.55 A personally appointed or automatically appointed decision maker who is a manager of a care facility is not eligible to give substitute consent to admission to the manager's own care facility.¹¹⁷
- 1.56 If none of the appointed or automatic decision makers are available or qualified, or there is a dispute about who is to be chosen, the Public Guardian and Trustee must be notified and must choose a person to give or refuse substitute consent. This may be a person employed in the office of the Public Guardian and Trustee.¹¹⁸
- 1.57 Before giving or refusing consent, the substitute decision maker is required to consult, or make reasonable efforts to consult with, the adult and any spouse, friend or relative of the adult who asks to assist.¹¹⁹
- 1.58 The standard for decision making is 'the adult's best interests', which requires the substitute decision maker to consider:
- the adult's current wishes and any pre-expressed wishes, values and beliefs
 - whether the adult could benefit from admission to a care facility

¹¹⁶ *Health Care (Consent) and Care Facility (Admission) Act*, RSBC 1996, c 181. The provision providing qualifications to give or refuse substitute consent will be s 22(4). See the *Health Statutes Amendment Act*, SBC 2007, c 19, s 8.

¹¹⁷ *Health Care (Consent) and Care Facility (Admission) Act*, RSBC 1996, c 181. The provision providing that a manager may not give consent in these circumstances will be s 22(3). See the *Health Statutes Amendment Act*, SBC 2007, c 19, s 8.

¹¹⁸ *Health Care (Consent) and Care Facility (Admission) Act*, RSBC 1996, c 181. The provision providing for the Public Guardian and Trustee to choose a person to give or refuse consent in these circumstances will be s 22(5). See the *Health Statutes Amendment Act*, SBC 2007, c 19, s 8.

¹¹⁹ *Health Care (Consent) and Care Facility (Admission) Act*, RSBC 1996, c 181. The provision providing that a substitute must consult will be s 23(2)(a). See the *Health Statutes Amendment Act*, SBC 2007, c 19, s 8.

- whether a course of action other than admission to a care facility, or a less restrictive type of care facility, is available and appropriate in the circumstances.¹²⁰

1.59 There is an exception for emergency admissions.¹²¹

1.60 The new legislation does not deal specifically with admissions to secure units but regulations require a care plan¹²² and govern any use of restraints.¹²³

Yukon

1.61 In Yukon, the *Care Consent Act* provides a hierarchical list of people who may provide substitute consent to admission to a care facility if the person is not capable of consenting or refusing admission.¹²⁴ It is the care provider who determines that the person is incapable of giving or refusing consent.¹²⁵

1.62 The *Care Consent Act* gives priority to a court appointed guardian with appropriate authority for the decision,¹²⁶ followed by a personally appointed decision maker with appropriate authority for the decision.¹²⁷ If there is not an appointed decision maker with appropriate authority, a range of automatically appointed decision makers who have a personal relationship with the person may provide consent to admission.¹²⁸ The first person on the automatically appointed list of people is the person's spouse¹²⁹ and the last person is a close friend who gives the care

¹²⁰ *Health Care (Consent) and Care Facility (Admission) Act*, RSBC 1996, c 181. The provisions on best interests will be ss 23(2)(b),(3). See the *Health Statutes Amendment Act*, SBC 2007, c 19, s 8.

¹²¹ *Health Care (Consent) and Care Facility (Admission) Act*, RSBC 1996, c 181. The provisions providing for emergency admissions will be s 24. See the *Health Statutes Amendment Act*, SBC 2007, c 19, s 8.

¹²² *Residential Care Regulation*, BC Reg 96/2009 ss 80, 81.

¹²³ *Ibid* ss 73, 74, 75. *Health Care (Consent) and Care Facility (Admission) Act*, RSBC 1996, c 181. The provision on use of restraints will be s 26.1. See the *Health Statutes Amendment Act*, SBC 2007, c 19, s 8.

¹²⁴ *Care Consent Act*, SY 2003, c 21, sch B, s1 defines 'care' to include admission to a care facility.

¹²⁵ *Care Consent Act*, SY 2003, c 21, sch B, s 6.

¹²⁶ *Ibid* sch B, s 12(1)(a).

¹²⁷ *Ibid* sch B, s 12(1)(b).

¹²⁸ *Ibid* sch B, s 12(1)(c)–(i).

¹²⁹ *Ibid* sch B, s 12(1)(c).

provider a signed statement setting out prescribed information regarding their relationship with the care recipient.¹³⁰

- 1.63 A number of conditions apply to the ability to give substitute consent. These relate to: the substitute decision maker's own capability;¹³¹ their age;¹³² lack of a conflict with the person that raises a reasonable doubt about their ability to comply with their statutory duties for decision making;¹³³ a requirement that they are not prevented from making a decision by a court order;¹³⁴ their availability;¹³⁵ and their willingness to comply with the statutory duties for decision making.¹³⁶ There is also a requirement that the proposed substitute decision maker has been in contact with the person during the preceding 12 months.¹³⁷
- 1.64 If there is no qualified person from the hierarchical list available to give consent, the *Care Consent Act* provides for a substitute decision maker of last resort.¹³⁸ In this situation, consent may be given by the care provider and one other person who is a health provider.¹³⁹ A person is only eligible to give consent as a substitute decision maker of last resort if they: do not have a conflict with the care recipient that raises a reasonable doubt whether the person will comply with the statutory duties for decision making;¹⁴⁰ are not prevented by a court order;¹⁴¹ and are willing to comply with the statutory duties for decision making.¹⁴²
- 1.65 The statutory duties of a substitute decision maker providing consent or refusal are a duty to consult with the person the decision relates to, to

¹³⁰ Ibid sch B, s 12(1)(i). A 'close friend' is defined as 'a person who is 19 years of age or older with whom the care recipient maintains both a long-term close personal relationship through frequent personal contact and a personal interest in the care recipient's welfare, but does not include a person who receives remuneration for providing care or other services to the care recipient': at s 12(7).

¹³¹ *Care Consent Act*, SY 2003, c 21, sch B, s 12(2)(a).

¹³² Ibid sch B, s 12(2)(b). The person must be 19 or older unless they are the person's spouse or parent.

¹³³ *Care Consent Act*, SY 2003, c 21, Sch B, s 12(2)(d).

¹³⁴ Ibid sch B, s 12(2)(e).

¹³⁵ Ibid sch B, s 12(2)(f).

¹³⁶ Ibid sch B, s 12(2)(g).

¹³⁷ Ibid sch B, s 12(2)(c).

¹³⁸ Ibid sch B, s 13(1).

¹³⁹ Ibid sch B, s 13(1).

¹⁴⁰ Ibid sch B, s 13(2)(a).

¹⁴¹ Ibid sch B, s 13(2)(b).

¹⁴² Ibid sch B, s 13(2)(c).

the extent that is reasonable¹⁴³ and a duty to ascertain the wishes, beliefs and values of the person.¹⁴⁴

- 1.66 The Act requires a substitute decision maker to give or refuse consent in accordance with the wishes of the person to whom the decision relates.¹⁴⁵ This requirement is displaced if: the wish was not expressed when the person was capable and had reached the age of 16;¹⁴⁶ compliance with the wish is impossible;¹⁴⁷ or the substitute decision maker believes the person would not still act on the wish if capable because of changes in knowledge, technology, or practice in the provision of care not foreseen by the person.¹⁴⁸
- 1.67 Consent or refusal is to be given in accordance with the person's values and beliefs if it cannot be made in accordance with their wishes.¹⁴⁹ If an expressed wish does not clearly anticipate the circumstances that exist, it is to be used as guidance to the values and beliefs of the person.¹⁵⁰
- 1.68 If it is not possible to make a decision in accordance with the person's wishes and their values and beliefs are not known the substitute decision maker must give or refuse consent in accordance with the person's best interests.¹⁵¹ In determining the person's best interests, the substitute decision maker must consider the following matters:¹⁵² the person's current wishes;¹⁵³ whether the person's condition or well-being is likely to be improved by the proposed care or will not deteriorate because of it; whether the person's condition or well-being is likely to improve without the proposed care or is not likely to deteriorate without it; whether the benefit the care recipient is expected to obtain from the proposed care is greater than the risk of harm or other negative consequences; and whether the benefit of a less restrictive or less intrusive form of available care is greater than the risk of harm or other negative consequences.

¹⁴³ Ibid sch B, s 18.

¹⁴⁴ Ibid sch B, s 19.

¹⁴⁵ Ibid sch B, s 20(1).

¹⁴⁶ Ibid sch B, s 20(2)(a).

¹⁴⁷ Ibid sch B, s 20(2)(b).

¹⁴⁸ Ibid sch B, s 20(2)(c).

¹⁴⁹ Ibid sch B, s 20(4).

¹⁵⁰ Ibid sch B, s 20(3).

¹⁵¹ Ibid sch B, s 20 (5).

¹⁵² Ibid sch B, s 20(6)(a)–(e).

¹⁵³ Ibid sch B, s 20(6).