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CHAPTER 1

INTRODUCTION

This Report is the product of a process that began with a request to the Commission from the Ethics Committee of Winnipeg's Golden West Centennial Lodge Personal Care Home in 1992. Workers in the home were having difficulty determining whether elderly residents were mentally competent to make decisions about themselves, and were looking for some assistance in that process. Ultimately, the Commission established an Advisory Committee in 1996 to consider the issue, and to advise on the appropriate response.[1]

The Advisory Committee informed the Commission that the problem raised by the Golden West Ethics Committee was also being encountered by professionals in other settings. Service providers and other persons in positions of trust must regularly make determinations regarding the competence of customers and clients, including their ability to give instructions, make decisions, or enter into particular transactions. Since people in such positions are rarely trained to assess mental capacity, the determinations are often made intuitively, and there is no uniformity to the procedures followed after their suspicions are aroused. The Committee recommended developing a protocol that clarified when and how to assess competence, and what steps to take following the assessment. This would not only assist those who must assess capacity, but also protect vulnerable persons by ensuring that mental capacity is assessed more consistently.

The Commission, with the assistance of Susan P. Riley, a practising Winnipeg lawyer, drafted a Discussion Paper on *Informal Assessment of Competence*. The Discussion Paper was circulated, and comments from interested parties were solicited, in August of 1998, with November 15, 1998 set as the deadline for submitting responses. (The deadline was subsequently extended to December 15, 1998, and some additional responses were received after that date.) In all, the Commission received 22 responses to the Discussion Paper. This Report is based on the initial Discussion Paper, and reflects the Commission's consideration of the responses to that Discussion Paper.

A. OUTLINE OF REPORT

[1]The Advisory Committee members were: Dr. Hugh Andrew, Chief Provincial Psychiatrist, Manitoba Health; Irene Hamilton, Q.C., Public Trustee of Manitoba; Linda Beaupré, Social Worker, Ethics Committee, Golden West Centennial Lodge; Dr. David Murray, Medical Director, Deer Lodge Centre; Joan Drodoski, Program Director, Alzheimer Society of Manitoba; Patricia G. Ritchie, Q.C., Barrister and Solicitor; Annie Markman-Anderson, Manager, Operations Support, Royal Bank of Canada; Prof. John C. Irvine, Faculty of Law and a member of the Commission; and Jeffrey A. Schnoor, Q.C. and Iris C. Allen, the then Executive Director and Legal Counsel, respectively, of the Commission.

In this Report, the Commission will focus mainly on informal testing of competence by people who are not specially trained to conduct such assessments. Formal assessments of mental capacity, such as those required for Orders of Supervision or admission to psychiatric facilities, fall squarely within the ambit of *The Mental Health Act*[2] and are therefore outside the scope of this Report.[3]

Chapter 2 provides a general discussion of the fundamental concepts of mental capacity and competence, followed by an outline in Chapter 3 of those areas in which the law already prescribes standards of mental capacity. Chapter 4 discusses how individuals might determine whether to conduct an informal assessment, and how such an assessment might be performed. The issue of legal consequences arising from informal testing is covered in Chapter 5. Chapter 6 lists the questions the Commission set out for consideration in the Discussion Paper, and summarizes the responses received. Finally, Chapter 7 features the Commission's recommendations and proposes possible guidelines for adoption in Manitoba.

Two Appendices are attached to this Report. Appendix A is an example of a "mini-mental state" test presently in common use among mental health care professionals as a screening mechanism, which could serve as a model for an informal competence assessment test. Appendix B consists of a list of persons and organizations who responded to our Discussion Paper and those to whom copies were circulated.

B. NOTES REGARDING TERMINOLOGY

In its Discussion Paper, the Commission used the terms "competence" and "capacity" interchangeably. This was criticized by one of the respondents to the Discussion Paper, who suggested that the two terms refer to quite distinct (though related) concepts and should not be confused. The Commission agrees that there is a clear distinction to be drawn between the ability to function generally in a rational and purposeful way, on the one hand, and the more specific ability to perform particular transactions, on the other. The assignment to these respective concepts of the labels "competence" and "capacity" (or *vice versa*), however, seems to imply a consistency of usage not apparent in the literature the Commission has reviewed. Accordingly, we continue to use the two *terms* interchangeably in this Report, while recognizing that there is a distinction between the two *concepts*.

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[2]*The Mental Health Act*, C.C.S.M. c. M110.

[3]A special committee was established by the Minister of Health in June 1995 to review *The Mental Health Act*. Its Report was submitted to the Minister in 1997: *Report of the Mental Health Act Review Committee* (January 1997). A new *Mental Health Act* was enacted in 1998 based in large part on the Committee's recommendations; however, it has yet to be proclaimed: *The Mental Health Act*, S.M. 1998, c. 36. As a result, references to *The Mental Health Act* in this Report will be to the legislation currently in force unless otherwise noted.

C. ACKNOWLEDGMENTS

The Commission wishes to thank Mr. Jonathan G. Penner, an independent researcher, who prepared this Report, and Susan P. Riley and Marlaine Lindsay (a second year law student) who assisted in the preparation of the initial Discussion Paper that formed the basis for this Report. We also wish to acknowledge the work of the Advisory Committee and the research and writing which had been accomplished by our then permanent legal staff prior to the Commission's cutbacks in mid 1997.

We also thank the various Departments of the Government of Manitoba and The Manitoba Law Foundation for providing the Commission with the funds necessary to complete this project.

CHAPTER 2

THE LAW REGARDING COMPETENCE

The common law presumes that once one has attained the age of majority, one is competent. Only after a reasonable possibility of incompetence has been established does the law intervene, and even then the type or scope of its intervention is often uncertain or ill-defined. This lack of legal certainty raises concerns about possible infringement of personal autonomy.

While competence can become an issue in almost any context, it arises most commonly in the context of decisions regarding personal care, health care, finances, and legal rights. Although discussion concerning competence tends to focus on the elderly, it is important to bear in mind that members of *all* age groups may, from time to time, have their competence questioned, for a variety of reasons.

When the Commission decided to undertake this project, it did so with the realization that the law cannot provide all of the answers. This is an area that requires more flexibility and sensitivity to particular circumstances than can be delivered by a statute, and as most of our respondents recognized, what is needed is assistance and guidance for those who find themselves confronted with issues of apparently imperfect competence. Nevertheless, the law is capable of providing a framework that maximizes the protection of those whose competence is at issue.

A good example of a statute that provides such a framework is Manitoba's *Health Care Directives Act.*[1] That statute respects the individual's right to make decisions and allows wide flexibility in how this is done. Among other things, the Act allows a person to give direction regarding treatment, in anticipation of their own incompetence, by appointing a substitute decision maker. It cannot ensure, however, that the person in question was competent when they appointed the substitute decision maker.

A. PRESUMPTION OF COMPETENCE

Under the common law, adults are presumed to be competent to make decisions for themselves.[2] This has been codified in, for example, *The Health Care Directives Act* and the new *Mental Health Act*,[3] [yet to be proclaimed]; section 2 of each of those Acts provides that in the absence of evidence to the contrary, everyone who is 16 years of age or older is presumed to be mentally competent to make relevant decisions.

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[1] *The Health Care Directives Act*, C.C.S.M. c. H27.

[2] *Khan* v. *St. Thomas Psychiatric Hospital* (1992), 7 O.R. (3d) 303 at 313 (C.A.).

[3] *The Mental Health Act*, S.M. 1998, c. 36, s. 2 (not yet proclaimed).

The common law presumption of competence means that everyone is entitled to assume that any adult with whom he or she deals has decision making capacity. Indeed, unless there is a basis for believing otherwise, one is *required* to assume capacity: "… no one has a general right to question or assess another's competence purely speculatively however well-intentioned they may be."[4]

Generally, an individual's status should not affect the presumption that he or she is competent. The common law and some Manitoba statutes make it clear, however, that the presumption does not apply to those under sixteen years of age.[5] Moreover, quite apart from the position in point of law, it is a matter of common observation that in fact adult children are often able to exert influence over financial, property and health decisions relating to their aging parents. Physicians sometimes confer with adult children rather than with their aging patient who actually requires treatment,[6] despite the fact that the elderly are usually capable of making their own decisions.[7] Manitoba's *Mental Health Act* reflects this attitude toward seniors by authorizing the court to declare a person incapable of managing his or her affairs by reason of mental infirmity "arising from age" or other causes, and to appoint a committee of the person's estate.[8]

Some writers have suggested that the presumption of competence is frequently wrongly ignored on the basis of psychiatric illness, physical frailty, or difficult behaviour in an institutional setting.[9] Capacity can fluctuate, and those who deal with people in situations where mental capacity may be an issue must remain alert to changes in that capacity over time.[10]

In law, the presumption of competence can be rebutted only when there is clear evidence that a person lacks the capacity to make certain decisions for himself or herself.[11]

In sum, then, the common law presumes that adults are competent, unless the opposite is

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[4]K.V. Madigan, D. Checkland, and M. Silberfeld, "Presumptions Respecting Mental Competence" (1994), 39 Can. J. Psychiatry 147.

[5]*The Human Tissue Act*, C.C.S.M. c. H180, ss. 10(1), (2) and 11(1); *The Family Maintenance Act*, C.C.S.M. c. F20, s. 21(2); and *The Health Care Directives Act*, C.C.S.M. c. H27, s. 4(2).

[6]M.O. Hogstel (ed.), *Nursing Care of the Older Adult* (3rd ed., 1994) 320.

[7]D.N. Weisstub, *Enquiry on Mental Competency: Final Report* (Report submitted to the Minister of Health, Ontario, 1990) 158.

[8]*The Mental Health Act*, C.C.S.M. c. M110, s. 76(1).

[9]Working Group on Legal Issues, Committee on Guidelines for Comprehensive Services to Elderly Persons with Psychiatric Disorders, "Legal issues in the care of mentally impaired elderly persons: Competence, surrogate management, and protection of rights," (1987) Canada's Mental Health 6 at 7.

[10]*Khan* v. *St. Thomas Psychiatric Hospital*, *supra* n. 2, at 313, leave to appeal to S.C.C. refused (1992), 10 O.R. (3d) xv (note).

[11]*Mental Health* (Rel. 1995-1) 5-11 citing *Gordon* v. *Cameron*, [1994] O.J. 523 (March 4, 1994), Doc. Barrie G10359, Logan J. (Ont. Gen. Div.) with respect to decisions about medical treatment; K.V. Madigan and M. Silberfeld, "Clinical Application of the Least Restrictive Alternative in Competency Assessments" (1993), 12 Est. & Tr. J. 282 at 284.

proven on the basis of clear evidence, although this presumption is not always honoured in practice.

B. TASK OR DECISION SPECIFIC COMPETENCE

In the past, competence was often considered a global construct: either one possessed absolute mental capacity to make all legal, social, and medical decisions, or one lacked the capacity to make any such decision at all. However, competence is now widely recognized as being specific to certain types of problems, tasks, or decisions.[12] In other words, one may simultaneously be competent to make decisions about one thing and not competent to make decisions about another;[13] incapacity in one area does not necessarily imply incapacity in another area.

The English Law Commission recognized this principle in recently recommending the "functional approach" to determining capacity, which recommendation was accepted in principle by the Lord Chancellor:

> This approach focuses on the decision itself and the capability of the person concerned to understand at the time it is made the nature of the decision required and its implications. This approach is thus very specific and avoids generalisations which may involve unnecessary intrusion into the affairs of the individual. For example, a person may be able to decide that they want to have contact with a particular relative, but may not be able to understand the nature of a particular financial contract on which a decision is needed. The functional approach would indicate that the first decision is one for which the person had capacity, whereas the second decision is one for which s/he did not. The approach thus allows individuals to have the maximum decision-making powers possible. Restrictions would be dependent on the nature and complexity of the decision in hand and would not exclude the person from making decisions within their competence.[14]

Both the common law and certain statutes recognize competence as being specific to the task or decision. The Ontario Surrogate Court has held that a person may lack the capacity to execute

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[12]Weisstub, supra, n. 7, at 35 and 45; M. Silberfeld, "New Directions in Assessing Mental Competence" (1992), 38 Can. Fam. Physician 2365; W.M. Altman, P.A. Parmelee and M.A. Smyer, "Autonomy, Competence and Informed Consent in Long Term Care: Legal and Psychological Perspectives" (1992), 37 Villanova L. Rev. 1671 at 1679 citing the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *Making Health Care Decisions: The Ethical and Legal Implications of Informed Consent in the Patient-Practitioner Relationship* (1982) 3 and 55; M. Silberfeld, W.R.C. Harvey, B.M. Dickens and R.J. Pepper-Smith, "A Competency Clinic for the Elderly at Baycrest Centre" (1989), 10 Adv. Q. 23 at 24; D. Checkland and M. Silberfeld, "Competence and the Three A's: Autonomy, Authenticity, and Aging" (1993), 12 Can. J. Aging 453 at 454; D. Rutman and M. Silberfeld, "A Preliminary Report on the Discrepancy Between Clinical and Test Evaluations of Competence" (1992), 37 Can. J. Psychiatry 634; M. Silberfeld, "Competency Assessments" (1991), 11 Est. & Tr. J. 165. See also M. Silberfeld, D. Stevens, S. Lieff, D. Checkland and K. Madigan, "Legal Standards and the Threshold of Competence" (1993), 14 Adv. Q. 482 which compares ten types of competencies.

[13]Checkland and Silberfeld, *supra* n. 12, at 454; Silberfeld, "New Directions in Assessing Mental Competence", *supra* n. 12, at 2366.

[14]Lord Chancellor's Department, "Who Decides?: Making Decisions on Behalf of Mentally Incapacitated Adults" (Consultation Paper, December, 1997), ch. 3, para. 3.7.

a will but retain the capacity to marry.[15] Similarly, the Alberta Supreme Court has held that a person may be capable of transacting business of an intricate nature, but lack the capacity to make a will.[16] In Manitoba, *The Sale of Goods Act*[17] makes reference to a person's capacity "to buy and sell" and "to contract, and to transfer and acquire property," and *The Mental Health Act*[18] provides that individuals may have the capacity to "consent to a voluntary admission" and "instruct counsel". Other specific areas of capacity recognized in legislation or the common law include the capacity to: divorce; adopt a child; be a parent; sue or be sued; give a binding release or waiver; act in a fiduciary capacity (as trustee or executor); be responsible for a tort; operate a motor vehicle; vote; hold public office; be a juror; be a judge; and immigrate or emigrate.[19]

The Mental Health Act, however, does not consistently recognize competence as decision or task specific; it only provides for the appointment of a committee on a fairly comprehensive basis, to manage either a person's estate or the estate and all personal affairs.[20] The Act does not contemplate appointment on a limited basis for only those matters for which the individual does not have the required level of competence. By contrast, under Alberta's *Dependent Adults Act* a judge may appoint a limited guardian to make decisions on behalf of incapable persons with regard to only one or some of the following matters:

- where they live;
- with whom they consort and live;
- the nature and type of social activities they are involved in;
- the nature or type of work, or conditions of work, that they are permitted to do;
- the type of educational, vocational, or other training that they participate in;
- whether they are able to apply for any license, permit, approval, or other consent or authorization as required by law;
- whether they should commence, compromise, or settle any legal proceedings that do not relate to the estate;
- whether to consent to any health care that is in the best interests of the dependent adult; and
- any day-to-day matters, such as their diet and dress.

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[15] *Re McElroy* (1978), 93 D.L.R. (3d) 522 at 525 (Ont. Surr. Ct.).

[16] *Montreal Trust Co.* v. *McKay* (1957), 21 W.W.R. 611 (Alta. S.C.).

[17] *The Sale of Goods Act*, C.C.S.M. c. S10, s. 4(1).

[18] *The Mental Health Act*, C.C.S.M. c. M110, ss. 16(1.2) and 26.8(2).

[19] E. Stein, *Mental Competency Determinations and the Law* (1989) 26-27 citing Can. Mental Health Assoc., *The Law And Mental Disorder*, v. 7, pt. 2. Weisstub, supra n. 7, at 45, lists the following categories for decision making capacity (and suggests that they may be further subdivided in terms of the requirements of a particular decision): to make treatment decisions, to make decisions about property, to appoint a substitute decision maker, to make decisions about medical records, to care for self, to care for children, to waive legal rights such as right to counsel, to instruct counsel, and to knowingly commit a crime.

[20] *The Mental Health Act*, C.C.S.M. c. M110, s. 56.

Only when an individual needs a guardian in all of these areas will the judge grant total guardianship.[21]

The law relating to competence has thus evolved to recognize that competence need not be an "all-or-nothing" proposition; that it may be restricted in some way without the individual in question being entirely incompetent. This has not, however, been universally provided for in the relevant Manitoba legislation.

C. EXISTING STATUTORY PROVISIONS

There are at present a number of statutes in effect in Manitoba that deal in one way or another with competence. The following is a survey of some of the more significant ones.

The single most important statute is *The Mental Health Act*.[22] That Act allows the court to appoint a committee to manage the personal and/or financial affairs of a person who is mentally incapable of doing so on his or her own behalf. Under section 56, the court may declare a person to be "mentally disordered," which is defined by the Act as having:

> a substantial disorder of mood, thought, perception, orientation or memory that grossly impairs judgment, behaviour, capacity to recognize reality or ability to meet the ordinary demands of life but excludes a disorder due exclusively to a mental disability.

Under section 76, the court may declare a person to be incapable of managing his or her affairs by reason of mental infirmity arising from disease, age, habitual drunkenness, the use of drugs, or other cause; no declaration of mental disorder is necessary.

The Public Trustee automatically becomes the committee of anyone who does not already have a committee and is declared under section 56 to be mentally disordered, or under section 76 to be incapable of managing his or her affairs. As well, a physician may certify that a person is incapable of managing his or her affairs,[23] in which case the Public Trustee likewise automatically becomes that person's committee.

Another noteworthy statute is *The Vulnerable Persons Living with a Mental Disability Act*,[24] which provides a framework for protection of persons deemed to be vulnerable. The Act defines "vulnerable" persons as adults "living with a mental disability who [are] in need of

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[21] *Dependent Adults Act*, R.S.A. 1980, c. D-32.

[22] *The Mental Health Act*, C.C.S.M. c. M110.

[23] Under sections 26.11 or 26.12 of the Act for, respectively, persons who have or have not been admitted to a psychiatric facility.

[24] *The Vulnerable Persons Living with a Mental Disability Act*, C.C.S.M. c. V90.

assistance to meet [their] basic needs with regard to personal care or management of [their] property". The Act defines mental disability as:

> [S]ignificantly impaired intellectual functioning existing concurrently with impaired adaptive behaviour and manifested prior to the age of 18 years, but excludes a mental disability due exclusively to a mental disorder as defined in section 1 of *The Mental Health Act*.

Under *The Vulnerable Persons Living with a Mental Disability Act*, a substitute decision maker may be appointed to manage a vulnerable person's personal care, or property, if the person is incapable of managing those aspects of his or her life. The powers of the substitute decision maker are limited to those areas in which the person is incapable of managing without assistance.

Also noteworthy is *The Powers of Attorney Act*[25] which provides that a properly drafted power of attorney will survive subsequent incompetence, defined in that Act as "the inability of a person to manage his or her affairs by reason of mental infirmity arising from age or a disease, addiction or other cause". However, the appointment of a committee under *The Mental Health Act* terminates any powers of attorney then in effect.

The *Powers of Attorney Act* also provides for "springing" powers of attorney, which become effective on a date, or on the occurrence of an event, specified in the power of attorney.[26] This allows a person to have a power of attorney come into effect only in the event that they become incompetent.

Finally, *The Health Care Directives Act*[27] permits a person who has the capacity to make health care decisions to appoint, in writing, a proxy to make those decisions on his or her behalf in the event that he or she loses that capacity. The Act defines "capacity" as the ability to "understand the information that is relevant to making a [health care] decision and … to appreciate the reasonably foreseeable consequences of a decision or lack of decision". "Health care decisions" are decisions to consent, or refuse or withdraw consent, to anything done for a health-related purpose.

In short, while there are several statutes in Manitoba that deal with the issue of competence, each treats only one or more aspects of competence, and not necessarily consistently. The definition of "incompetence" in *The Powers of Attorney Act*, for example, is similar, but not identical, to the definition in section 76 of *The Mental Health Act*. *The Health Care Directives Act*, to take another example, contains a "task-specific" definition of capacity, while *The Mental Health Act*'s definition is an all-or-nothing proposition.

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[25] *The Powers of Attorney Act*, C.C.S.M. c. P97, ss. 10(1) and 1.

[26] *The Powers of Attorney Act*, C.C.S.M. c. P97, s. 6.

[27] *The Health Care Directives Act*, C.C.S.M. c. H27.

D. INTERESTS LINKED WITH DETERMINATION OF COMPETENCE

The law must balance three competing interests when dealing with determinations of individuals mental capacity:

1. Individual's rights, including the rights to dignity, autonomy and to self determination,

2. The individual's best interests as determined by the state in the exercise of its *parens patriae* powers, and

3. The interest of the community in the promotion of broader state concerns. These include the protection of all citizens and the state's legitimate interests in achieving administrative simplicity, efficacy and efficiency in the care of its members.[28]

The remainder of this Chapter will be devoted to consideration of these interests, and, finally, how they are currently balanced within society.

1. Dignity, Autonomy, and Self-determination

Canadian law generally provides that competent individuals are entitled to autonomy and to self-determination. Autonomy is a person's right to exercise free will; to be free from constraint and coercion in order to act according to his or her intentions, preferences, and values. Other people are not normally justified in interfering with the actions or choices of an autonomous individual.[29]

Self-determination, on the other hand, is the right to make decisions that affect one's self. Whereas the right to autonomy is the right to *act* toward the world in general in accordance with one's world view, the right to self-determination is the right to make *decisions* about oneself and about things that affect one.

The Canadian *Charter of Rights and Freedoms* confirms the importance of individual rights,[30] including the rights of autonomy and self-determination, and requires that all legislation conform with these rights as set out in the *Charter*, subject to the limiting and overriding provisions contained in sections 1 and 33.

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[28]Weisstub, *supra* n. 7, at 48.

[29]Madigan and Silberfeld, *supra* n. 11, at 282; Checkland and Silberfeld, *supra* n. 12, at 456.

[30]*Canadian Charter of Rights and Freedoms*, being Part I of the *Constitution Act, 1982*, being Schedule B of the *Canada Act 1982* (U.K.), 1982, c. 11; Weisstub, *supra* n. 7, at 48.

The preamble to *The Vulnerable Persons Living with a Mental Disability Act*[31] provides another example of the importance attached to individual rights in our society. It codifies the common law presumption of competence for vulnerable persons and affirms the right of individuals to make their own decisions, remain independent, and determine their own interests.

When an individual has been found to lack the necessary level of competence for a particular decision, the law deprives that person of the right to make the decision. To that extent, the person loses her or his autonomy and right to self-determination.

Planning ahead enables people to continue to exert some control over certain decisions should they lose their capacity to make those decisions. For example, a person's right to make their own health care decisions will be maintained if the person has either made a health care directive or appointed a health care proxy. *The Health Care Directives Act* requires the proxy to make health care decisions on behalf of the maker in accordance with his or her wishes, if they are known.[32] Similarly, prior to becoming incompetent, a person can exercise some measure of control over property decisions by appointing a substitute decision maker through a springing or enduring power of attorney. (Some decisions, of course, cannot be exercised by a substitute, such as the decision to make a will or to marry.)

Beyond these mechanisms, however, the effect of the common law and statutory regimes is that the right to make decisions for oneself ends when competence is lost. Thus, for example, a person who lacks testamentary capacity is not permitted to make, revoke, or alter a will. A person who lacks the required capacity to make health care decisions cannot make such decisions. A person who is not competent to marry will not be permitted to marry. A person who lacks the capacity to grant a power of attorney will not be allowed to do so.

When a person is judged to be incompetent to make a particular decision, a substitute is often required to make financial or health care decisions on his or her behalf. A committee may be appointed to look after the financial affairs of a person who lacks the capacity to make these decisions,[33] and the Public Trustee may be appointed as committee to handle their personal

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[31]*The Vulnerable Persons Living with a Mental Disability Act*, C.C.S.M. c. V90, enacted by S.M. 1993, c. 29, proclaimed October 4, 1996. The Act assists vulnerable persons, who are defined to be "adult[s] living with a mental disability who [are]...in need of assistance to meet [their]... basic needs with regard to personal care or management of [their]... property." Mental disability is defined as "significantly impaired intellectual functioning existing concurrently with impaired adaptive behaviour and manifested prior to the age of 18 years, but excludes a mental disability due exclusively to a mental disorder as defined in section 1 of *The Mental Health Act*;...": s. 1(1).

[32]*The Health Care Directives Act*, C.C.S.M. c. H27, s.13.

[33]*The Mental Health Act*, C.C.S.M. c. M110, ss. 56, 76, 80(1) provide for the court to appoint a committee for a person who has been found to be either "mentally disordered" or otherwise incapable of managing his or her own affairs due to "mental infirmity"; ss. 26.11, 26.12, and 80(1) provide for the appointment of a committee without a court hearing, where a doctor certifies that a patient in a psychiatric facility is incapable of managing his or her own affairs or where the provincial Director of Psychiatric Services makes an Order of Supervision concerning a person who is not in a psychiatric facility or a person who is about to be released from one. Under s. 80(1), the Public Trustee of Manitoba is the committee where none other exists.

affairs.[34] Along with losing the actual right to make the decision, the individual also loses some privacy due to the involvement in her or his life of other people or the state.

2. Protection of the Individual

Questioning another person's competence may rock the very foundation of that person's independence and dignity.[35]

> Denying that another person is competent challenges the foundation of that person's independence and dignity. It is wrong to question lightly another's mental competency: the challenge will certainly cause pain and may do even worse harm. But this raises a conflict for which there probably is no completely satisfactory resolution. People sometimes insist on doing something that they are incompetent to do (like driving a car although their eyesight is failing) and thereby present a real threat of harm to themselves and others. … The problem is to recognize two obligations simultaneously - on the one hand, the obligation to assist incompetent people who require help and, on the other, the obligation to respect the liberty of people, including the right of incompetent people to make those decisions that they are competent to make.[36]

Interference by the state in the affairs of an incompetent person is justified because it is needed to protect that person from the consequences of his or her own incapacities. The authority of the Manitoba Court of Queen's Bench to protect from harm or exploitation those who are incapable of looking after themselves (this includes mental incompetents and children) is called the *parens patriae* jurisdiction. This jurisdiction authorizes the Court to intervene where the common law or legislation is inadequate to protect people with intellectual or mental health disabilities, and to order what is in their best interests.[37]

Other statutory provisions require those in a position to make decisions for incompetent persons to take into account the person's best interests. A proxy appointed under *The Health Care Directives Act*, for example, must make health care decisions in the best interests of the person who appointed them, if they are not aware of that person's wishes with respect to the particular circumstances.[38] Similarly, a substitute decision maker appointed under *The Vulnerable Persons Living with a Mental Disability Act* must be guided by the best interests of

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[34]*The Mental Health Act*, C.C.S.M. c. M110, ss. 24-25 provide that the Public Trustee is authorized to make substituted decisions for incompetent adults in psychiatric facilities and, in doing so, is required to consult with the person's family, where reasonably possible, and must exercise its power in the best interests of the person having regard to certain specified statutory principles and criteria (ss. 80(1.4), 24.1(3) and (4)).

[35]M. Silberfeld and A. Fish, *When the Mind Fails: A guide to dealing with incompetency* (1994) 8.

[36]*Id.*, at 8-9 [emphasis in original].

[37]*Re Eve* (1986), 31 D.L.R. (4th) 1 at 5 and 29 (S.C.C.).

[38]*The Health Care Directives Act*, C.C.S.M. c. H27, s. 13.

the vulnerable person if they do not know what that person's wishes are, or if following those wishes would endanger anyone's health or safety.[39]

In sum, society has a perceived obligation to look after the best interests of those of its members who are incapable of doing so themselves. This is reflected both in the *parens patriae* jurisdiction and in certain statutory provisions.

3. Community Interests

In addition to the individual's right to self-determination and autonomy, and society's interest in protecting the best interests of incompetent persons, the state is also concerned with broader community interests, such as:

- avoiding uncertainty with respect to the determination of competence and its consequences;
- preventing unnecessary assessments of competence;
- avoiding the needless deprivation of rights as a result of a finding of incompetence;
- preventing individuals from acting in a manner that is contrary to their best interests, as a result of incompetence; and
- minimizing not only intervention in individuals' lives but also the transaction costs, both human and financial, that accompany such interventions.[40]

The community's interests go beyond those of the individual immediately affected, and must be taken into account whenever intervention is considered.

4. Resolution of Competing Interests

A determination of competence must balance the right to individual autonomy, on the one hand, and protective intervention on the other.[41] The problem has been aptly summarized as follows:

> Being labelled 'incompetent' is an extremely stigmatizing, and damaging experience.
>
> It implies that the whole person, and not just a small segment of one's character, isn't working properly. Such a stigma has severe consequences for the patient. This label not only facilitates interested family members in gaining ultimate control over one's personal

[39]*The Vulnerable Persons Living with a Mental Disability Act*, C.C.S.M. c. V90, s. 76(1).

[40]Weisstub, *supra* n. 7, at 54.

[41]Madigan and Silberfeld, *supra* n. 11, at 283.

> property and treatment decisions, it renders one as being somewhat of a less valuable member of the community.
>
> Alternatively, allowing an incapable individual to make decisions may be highly detrimental to his physical, mental, financial or social well being.[42]

It has been suggested that, at present, society gives greater weight to an individual's autonomy and right to self-determination than it does to the state's duty and power to protect the vulnerable and helpless: "The values to be maintained are concern for the sanctity, dignity and worth of the individual and the preservation of individual liberty and independence to the fullest degree possible."[43] This view is supported by the law's presumption of competence, by placing the burden of proof on the person alleging incapacity, and by requiring clear evidence of incompetence to rebut that presumption. In addition, it has been suggested that in cases of marginal capacity,

> it is … much easier to justify a policy exception in favor of *accepting* an *incompetent's* consent than it would be to justify an exception which would *nullify* a *competent's* choice. In the latter instance, an important right of freedom is being denied, whereas in the former the only right which may be in question is the incompetent's right to protection.[44]

The potential conflict between care and liberty may be minimized by the adoption of two fundamental guidelines. The first is that assessors should be very selective, and assess competence only in relation to a specific task or decision by considering what the person wants to achieve, and then determining what abilities that person needs to succeed on his or her terms.[45] Second, when intervention is necessary, the interference with the person's freedom to make decisions and take actions should be minimized. The least restrictive alternative should always be chosen,[46] and assessors need to bear in mind the serious implications of the results of their assessment; they may well hold someone's livelihood and sense of self-worth "in the palm of their hands".[47]

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[42]Weisstub, *supra* n. 7, at 57.

[43]Working Group on Legal Issues, Committee on Guidelines for Comprehensive Services to Elderly Persons with Psychiatric Disorders, *supra* n. 9, at 7.

[44]B. Freedman, "Competence, Marginal and Otherwise" (1981), 4 Int'l J. Law & Psychiatry 53 at 71 [emphasis in original].

[45]Silberfeld and Fish, *supra* n. 35, at 9.

[46]Madigan and Silberfeld, *supra* n. 11, at 284.

[47]Response to Discussion Paper from Foyer Valade (December, 1998).

CHAPTER 3

LEGAL STANDARDS OF COMPETENCE

A. ACCEPTED STANDARDS FOR DETERMINING COMPETENCE

The common law provides some guidance for determining competence on an informal basis in a number of specific circumstances. These circumstances include those requiring the capacity to:

- marry;
- make a will;
- execute an enduring power of attorney;
- enter into a financial contract; and
- consent to medical treatment.

Any discussion of a general test of competence must necessarily begin with a review of established standards of competence. The five areas the Commission has chosen to review are not, however, an exhaustive list of existing categories of standards.

1. Marriage

The common law standard for the mental capacity to marry is well established. At the date of the marriage, both parties must be capable of understanding the legal nature of the contract of marriage and the duties and responsibilities it creates. They must recognize and appreciate the obligations they are about to assume as a result of their change of status.

By section 92 of the *Constitution Act, 1867*,[1] the provinces have legislative jurisdiction over the solemnization of marriage. Manitoba has passed *The Marriage Act*,[2] which governs the formal and ceremonial requirements of marriage.

The Act establishes two different procedures. The first procedure permits solemnization of the marriage under the authority of a marriage licence issued at least 24 hours before the ceremony. The second procedure involves "banns," an announcement published within a church declaring the intention of the two persons who wish to marry. The publication of banns is done in accordance with particular church practices and involves a ceremony that takes place before

[1] *Constitution Act, 1867* (U.K.), 30 & 31 Vict., c. 3, s. 92(12).

[2] *The Marriage Act*, C.C.S.M. c. M50.

the marriage. Under this second procedure, a religious official may grant a dispensation of publication of banns that has the same effect as a marriage licence. Under either procedure, the parties must swear, among other things, that they believe that no legal impediment to their marriage exists, including lack of competence.

The Act also prohibits issuing a licence, publishing banns, granting dispensation of banns, or solemnizing a marriage if one of the parties has been certified as mentally disordered under *The Mental Health Act*, unless a psychiatrist has certified that the person is competent to understand the nature of the contract and the duties and responsibilities it creates.

If the person issuing the licence or publishing, or waiving the publishing of, the banns is unaware of any such psychiatrist's certification, he or she must determine, albeit on an informal basis, the parties' capacity. This is usually based on casual conversation. If there is any doubt as to competence, it may be necessary to turn to a professional assessor, such as a physician, psychiatrist, or psychologist, for a more formal assessment.

2. Making a Will

When assessing whether a person is competent to make a will, a lawyer must determine whether their client understands the nature of the legal act of a testamentary disposition. The most widely accepted test for testamentary capacity derives from the English case of *Banks* v. *Goodfellow*.[3] It requires that the client not only know what he or she owns and is bequeathing, but also understand and appreciate the nature of their obligations, and not suffer from any disorder or delusion which might affect the dispositions. The common law attempts to make the test specific to the task at hand. Persons who suffer from extreme mental difficulties have been judged competent to make wills; however, the more complex the disposition and extent of the property being disposed of, the higher the level of competence required. Neither a superficial appearance of lucidity nor an ability to answer simple questions in an apparently rational way are sufficient evidence of competence.

The duty imposed on a lawyer taking instructions for a will is onerous. He or she must be satisfied, by way of personal inquiry, not only that true testamentary capacity exists, but that the instructions are freely given and that the client understands the effect of the will. A solicitor cannot discharge this duty by asking perfunctory questions, receiving apparently rational answers, and simply recording the words expressed by the client in legal form. Instructions for a will have to be taken from the maker of the will, and full inquiry made as to his or her personal financial position and that of the family, the objects of his or her bounty, and the nature and extent of the property involved.

The lawyer's duty to substantiate competence is particularly important if there are suspicious circumstances, such as doubt being cast on the client's capacity to either make a will

[3] *Banks* v. *Goodfellow* (1870), L.R. 5 Q.B. 549.

or understand and approve the will's contents. For example, when dealing with clients whose competence may be in question, it is essential that the lawyer investigate any former wills, to discover the reasons for any contemplated variation or changes.[4]

Before drafting the will, the lawyer must satisfy himself or herself that the client:

- understands the nature and effect of making a will;
- understands the nature and extent of the disposition of his or her property;
- comprehends and appreciates the claims to which he or she ought to give effect; and
- suffers from no disorder of the mind or delusion that has influenced his or her disposition.[5]

If all four of the above requirements are satisfied, the lawyer may proceed to draft the will.

3. Executing an Enduring Power of Attorney

An enduring power of attorney is a legal document that allows one person (the donor) to give to another (the attorney) the power to act on the donor's behalf with respect to financial and property matters even if the donor subsequently becomes incapacitated or incompetent. This arrangement is used to assist donors when absence or disability prevents them from personally controlling their finances.

As with wills, the common law has set out a task specific test. A person is competent to give a power of attorney if he or she is capable of comprehending the nature and effect of the power being created.[6] The donor must understand that the attorney is being appointed to act on his or her behalf in all financial and property matters,[7] and that the power,

- is the complete authority to act in all financial matters;
- is similar to allowing the attorney to step into the financial shoes of the donor;
- will survive the donor's incompetence; and
- is irrevocable on incompetence.

If this kind of knowledge and understanding is absent at the time of execution, the power

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[4]*Re Collicutt Estate* (1994), 128 N.S.R. (2d) 81 at 96-98 (P. Ct.); *Murphy* v. *Lamphier* (1914), 31 O.L.R. 287 (H.C.).

[5]*Banks* v. *Goodfellow*, *supra* n. 3.

[6]*The Powers of Attorney Act*, C..C.S.M. c. P97, s. 10(3).

[7]*Godelie* v. *Ontario (Public Trustee)* (1990), 39 E.T.R. 40 (Ont. Dist. Ct.).

is invalid.[8] These types of documents are often signed at a time when the donor's health is in decline and, in some cases, when incompetence is imminent. As a result, lawyers who are asked to prepare a power of attorney have a professional responsibility to conduct an informal assessment of their client's competence.

If the lawyer has concerns about the donor's competence, it may be necessary (with the donor's permission) to arrange for a formal assessment by a physician, psychiatrist, or psychologist.

4. Entering into a Financial Contract

Bank employees often encounter the need for capacity assessment in the performance of their daily tasks. The promissory notes or guarantees that they ask their customers to sign are governed by the common law of contract. The common law provides that a contract is voidable (that is, liable to be set aside) if one party was incapable of understanding the terms and consequences of the contract and the other party knew, or ought to have known, of the incapacity.[9]

The test, again, is also quite task specific, and the required level of understanding varies with the complexity of the financial transaction. In general, the customer must understand the nature of the contract and its effects; for example, that a "promissory note" means that the bank can call the amount on demand and seize any pledged assets if they do not pay.

As a result of the common law of contract described above, bankers have a legal duty to test for competence where it is apparent, or they suspect, that the customer is incapable of understanding the transaction. Failure to make further inquiries will result in the bank being deemed to know of the customer's incompetence. As well, a bank has a fiduciary obligation to ensure that a customer's interests are being protected if the customer relied upon the advice of the bank, the bank was aware of the reliance, the bank had some interest in the transaction being concluded, and the relationship between the customer and the bank was confidential in nature (*i.e.*, the customer's decision was influenced by the confidence he or she placed in the bank).[10]

Bank employees are generally untrained in mental competence assessment, and tend to rely on intuition and hearsay to make decisions on competence, reverting to informal testing when they are suspicious.

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[8]*The Powers of Attorney Act*, C.C.S.M. c. P97 s. 10(3).

[9]*The Imperial Loan Co., Ltd.* v. *Stone*, (1892) 1 Q.B. 599 at 601 (C.A.); *Peters* v. *Rocher* (1982), 15 Man. R. 168 at 173 (Q.B.).

[10]*Vita Health Co. (1985) Ltd.* v. *Toronto-Dominion Bank*, [1993] 7 W.W.R. 242 at 250 (Man. Q.B.).

5. Making Medical Treatment Decisions

Health care workers, often more attuned to competence issues than those in the financial sector, must constantly decide whether patients are competent to consent to, or refuse, treatment. The stakes in medical treatment decisions are often high, such as where a cancer patient decides whether or not to undergo chemotherapy. Courts of law have been careful to tailor the competence test to the complexity of the decision and to the patient. For example, the level of competence required to decide whether or not to have one's tonsils out is lower than for the decision to undergo a triple coronary by-pass.

In making medical treatment decisions, the patient is once again presumed to be competent.[11] The treating physician is justified in going ahead if there is no outward sign of incapacity. She or he evaluates the capacity to make a reasoned decision about treatment, and to understand and appreciate the foreseeable risks and consequences of going ahead with, or refusing, the treatment.[12] Consequences include any likely benefits, risks, and discomforts, and the patient must understand any available alternative treatments. The diagnosis and the course of treatment must be explained to the patient in terms he or she can easily understand. The patient must be able to talk knowledgeably about the decision, and not simply repeat the information provided.

A precise legal definition of mental competence to make treatment decisions is contained in *The Mental Health Act*,[13] for the purposes of that Act. The test is set out there because competence is often in issue for patients in psychiatric facilities.

The test for competence should be conducted in terms of the actual decision to be made, and not in the abstract. The patient must be provided with all material details relating to the proposed treatment[14] and delusions should only be considered if they materially affect the patient's ability to decide.[15] If the patient does not have capacity at the time their consent is given, the consent is invalid and the treating physician may be liable to the patient in negligence or the tort of battery, and may even be charged with criminal assault.

B. A GENERAL STANDARD?

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[11]*Khan* v. *St. Thomas Psychiatric Hospital* (1992), 7 O.R. (3d) 303 at 313 (C.A.)

[12]B. Sneiderman, J.C. Irvine and P.H. Osborne, *Canadian Medical Law: An Introduction for Physicians, Nurses and other Health Care Professionals* (2nd ed., 1995) 34.

[13]*The Mental Health Act*, C.C.S.M. c. M110, s. 24(3).

[14]J. Arboleda-Florez, *Mental Health Law and Practice* (1994) 5-28.

[15]*Id.*, at 5-30, quoting D. Weisstub, *Enquiry on Mental Competency: Final Report* (Report submitted to the Minister of Health, Ontario, 1990).

In each of the situations involving capacity assessment discussed above, persons untrained in the task of assessing competence are nevertheless responsible for judging competence, with potentially serious consequences for both themselves and the people they serve. As each of these situations has already been addressed by the law, it is far easier to create "checklists" for informal assessments in these particular areas, but because of the delicate nature of questioning a client's or patient's mental capacity, a high level of skill is required. The assessor must often accomplish the task without the patient being aware that he or she is being tested: a skilled questioner can make the task of educating the client and concurrent assessment so seamless that the subject is not aware that he or she is being tested.

The scenarios reviewed in this Chapter are each of a particular nature, and arise out of specific circumstances. The common law has determined that when two people wish to marry, a certain level of capacity must be present. In the same vein, in order to be competent to make a will, execute a power of attorney, enter into a financial contract, or decide on medical treatment, a particular standard of competence must be met.

The difficulty when addressing the question of a common standard for all instances where competence becomes an issue is that the standard fluctuates even amongst the five examples discussed above. The person seeking solemnization of their marriage, testamentary powers, transfer of decision making, contractual authority, or the right to make medical decisions must demonstrate sufficient understanding of the nature of the request and its consequences. Beyond this similarity, however, there is significant variation in the level of competence required. For example, a person may lack testamentary capacity, and yet have the capacity to marry.[16] Even a person who has been declared incapable of managing his or her affairs, and has had a committee appointed to manage his or her estate, can still have the capacity necessary to marry.[17]

Despite this variation, it is in the interests of both the assessor and the subject to develop standardized testing even at the informal level. A subject could potentially be denied the right to exercise his or her free will, and an assessor could be held legally liable should competence later be proven. Conversely, someone lacking the appropriate capacity could be permitted to make decisions adversely affecting his or her own well-being because of an inadequate assessment. Either situation is undesirable. Further, those who perform the initial assessment required in these situations are often not fully trained in all aspects of such testing. A common standard setting out, on a very general basis, what is required could go a long way toward solving many of the problems inherent in such circumstances.

The next Chapter will discuss the legal duty to assess competence, and the potential consequences of such assessments.

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[16] *Re McElroy* (1978), 93 D.L.R. (3d) 522 (Ont. Surr. Ct.).

[17] *Demeyer v. Hudema* (1983), 24 Man. R. (2d) 157 (C.A.).

CHAPTER 4

DUTY TO DETERMINE COMPETENCE

A. INTRODUCTION

A legal duty to determine whether someone has a certain level of competence arises in many circumstances. When a customer wishes to open a bank account or withdraw a substantial amount of money, their banker may need to know whether they are capable of managing their finances. When a nursing home resident refuses prescribed medication, or wants to move out of the nursing home, a staff member may be uncertain whether the resident is competent to make such a decision. In addition to the scenarios discussed in Chapter 3, competence may become an issue when a person's consent is needed for participation in medical research, hospitalization, or the release of medical records, or when a person wants to carry on a profession, obtain a divorce, hold office, sue or be sued, drive a car, stand trial, parent a child, or give evidence. In fact, the issue of competence arises every day, in a myriad of situations, and in each situation someone may have a legal duty to assess the competence of someone else.

Unfortunately, bank tellers, nursing home employees, and other people faced with this duty have rarely had formal training in how to assess whether someone is competent to make particular decisions or perform particular tasks.

B. DUTY TO TEST

Sometimes the law imposes a duty to determine another's competence notwithstanding a lack of formal training to do so. For example, a lawyer who prepares a will has a duty to satisfy himself or herself that the maker of the will is legally competent to make a will.[1] While most lawyers involved in such transactions realize that a person wishing to make a will must be competent, they do not always take the appropriate steps to confirm that competence.[2]

Physicians have a similar obligation to determine competence whenever they administer treatment to a patient; the physician must not only obtain the patient's informed consent to a proposed treatment, but also be " satisfied that the patient is legally capable of providing that

[1] *Friesen and Holmberg* v. *Friesen Estate* (1985), 33 Man. R. (2d) 98 at 108 (Q.B.).

[2] *Id.*

consent.[3] Again, this professional responsibility is not always met. A submission to the Ontario *Enquiry on Mental Competency* stated:

> . . . the problem with the present practice [is that practitioners tend] . . . to follow the path of least resistance, treating all consenters and failing to treat refusers whether capable or not, thus resulting in incapable refusers being left alone until their condition deteriorates to an emergency status. To respond to the problem, . . . legislation encouraging early intervention for treating medical and surgical conditions of incapable refusers needs to be drafted. We expect that the mandatory screening of all involuntary patients, when coupled with the recognition of capacity assessment as a reimbursable procedure and greater education in this respect, will change this tendency and hopefully lead to the recognition that care givers have a professional duty to consider, and when necessary, assess the capacity of both consenters and refusers.[4]

Some people, for example bank tellers, are obligated to ensure that those with whom they interact are competent to make particular decisions. Regardless of whether there is a legal *duty* to assess competence, decisions are made daily in, for example, personal care homes based on someone's understanding of someone else's competence. Care workers and families are challenged to assess competence in such situations as how to provide care, dietary decisions, mobility, and control of finances.[5] The challenges are greatest when a client's condition is deteriorating, but has not yet reached the point where the client can be declared generally incompetent.[6] It is not uncommon for someone to have a prognosis that suggests their competence will improve, or that their incompetence is limited to only one or two aspects of their functioning.[7]

If those who do have a duty to assess another's competence are unaware of this responsibility or how to meet it, or simply fail to meet it, the result is inconsistency in the performance of assessments. Some individuals who lack competence to make particular decisions will nevertheless be permitted to make those decisions, to their detriment. In other cases, assessments of competence may be conducted on individuals without sufficient reason. Thus, while some people may be inadequately protected, others may be subject to an excessive

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[3]Every person who understands the nature and consequences of proposed medical treatment has a right to consent to or refuse that treatment: *Mulloy* v. *Hop Sang*, [1935] 1 W.W.R. 714 at 715 (Alta. S.C. App. Div.); *Malette* v. *Shulman* (1990), 67 D.L.R. (4th) 321 at 327 (Ont. C.A.). Persons who do not understand the nature and consequences of proposed treatment must rely on the decisions of a substitute decision maker: *Institut Philippe Pinel de Montréal* v. *Dion* (1983), 2 D.L.R. (4th) 234 at 236-237 (Que. S.C.).

[4]D.N. Weisstub, *Enquiry on Mental Competency: Final Report* (Report submitted to the Minister of Health, Ontario, 1990) 254 quoting Dr. F.M. Mai, Chief of Psychiatry, University of Ottawa-Ottawa General Hospital, submission to the Enquiry on Mental Competence, March 29, 1989.

[5]Responses to Discussion Paper from the Ethics Committee, Bethania Mennonite Personal Care Home (November, 1998), Extendicare (Canada) Inc. (November, 1998) and Salvation Army Golden West Centennial Lodge (December, 1998).

[6]Responses to Discussion Paper from Salvation Army Golden West Centennial Lodge (December, 1998) and Brandon Regional Health Authority (November, 1998).

[7]Response to Discussion Paper from Social Work Department, Health Sciences Centre (November, 1998).

invasion of their privacy**.** (This is further discussed in Chapter 5.)

In order to address the obverse problems of, on the one hand, failure to assess and, on the other, unnecessary assessment, guidance should be available to people who have a duty to determine competence, as well as to those who simply have concerns about the competence of a person with whom they contract or otherwise interact. This guidance should arguably be available not only to professionals, but to the general public. Relatives of people whose mental competence may be questionable must make judgments about that competence in many situations, including participation in elections, choosing helpers, and drafting a will or a health care directive.[8]

The duty to determine a person's competence will vary among different relationships, and remains a very malleable concept. An awareness of this duty is only the first step in the process of informal competence assessment.

C. INDICIA OF INCOMPETENCE

An informal assessment of competence is a process

> that recognizes the dangers of challenging another's competency and that encourages people to clarify and examine their reasons for doing so before they take any step (say, a psychiatric assessment of competency that may lead to a guardianship application) that may have drastic consequences for another person's well-being.[9]

Often the issue of competence is raised by a relative or friend in the context of committal or admission to a nursing home. Sometimes, an individual's behaviour may be so out of the ordinary that doubts are raised respecting his or her mental capacity.[10] For example, a "substantial and unexplained change in an individual's approach to the making of decisions" puts competence in issue, particularly for elderly people who have often developed settled preferences and patterns of behaviour.[11] Some medical conditions have also been associated with incompetence.

Simple observation may provide clues regarding a person's competence to perform a specific task or make a specific decision. Particular attention to the following characteristics or behaviours can provide clues to the person's level of competence:

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[8]Response to Discussion Paper from Alzheimer Society (November, 1998).

[9]M. Silberfeld and A. Fish, *When the Mind Fails: A guide to dealing with incompetency* (1994) 54.

[10]Weisstub, *supra* n. 4, at 233.

[11]Weisstub, *supra* n. 4, at 76.

- dress, grooming, posture, mobility, gestures, and facial expressions;
- the stated age of a person, in combination with their appearance;
- mental alertness;
- tone of voice, and the rate and wording of speech;
- coherence and relevance of language, use of unusual words, jargons and phrases, and the ability to articulate;
- mood, attitude about self, and feelings of depression or mania that significantly interfere with decision making;
- delusions or hallucinations; and
- symptoms, such as nervousness, tenseness, excessive worrying, and fear of impending disaster that significantly interfere with decision making.

Assessors must consciously avoid the tendency to treat these factors as determinative of the level of competence, particularly in the case of mental illness, developmental handicaps (mental impairment present or occurring during a person's formative years), advanced age, or persons who have been involuntarily committed.[12] The assessor must take into account the person's own experiences. For example, someone who survived a Nazi concentration camp may react atypically to people in positions of authority, or people wearing white lab coats, without that reflecting negatively on his or her competence.[13]

It must be kept in mind that,

> [o]ften acts that would be taken as a mark of eccentricity or independence in a young and vigorous person are wrongly taken as proof of incompetency in someone who is old or ill. A competency assessment must therefore ask what kind of person is being assessed and what sorts of things the person has generally held to be important. An incompetent person is so not merely because he or she fails to behave as others wish him or her to, but because he or she cannot behave in accordance with his or her *own* considered or habitual standards of behaviour.[14]

Thus, it is only behaviour that is unusual for the particular person that may be sufficient reason to consider an informal assessment of competence.[15]

Decisions are made on the basis of information. If an assessor is concerned about an apparent lack of understanding on the part of the person being tested, the assessor should consider how the relevant information has been presented to the subject. Studies have shown that comprehension and capacity can be facilitated by manipulating the manner in which

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[12]Weisstub, *supra* n. 4, at 116-118; Silberfeld and Fish, *supra* n. 9, at 44, 46 and 47.

[13]Response to Discussion Paper from Foyer Valade (December, 1998).

[14]Silberfeld and Fish, *supra* n. 9, at 47 [emphasis in original].

[15]M.J. Lucas, "Assessment of Mental Status" in C. Eliopoulos (ed.), *Health Assessment of the Older Adult* (2nd ed., 1990) 208-209.

information is presented.[16] The use of simpler wording, repetition, pictures, or drawings may increase understanding.

It is also important to consider a person's overall situation when assessing what action, if any, is appropriate. One respondent offered the example of an elderly couple living on their own with home care support. The wife is physically disabled, and thus incapable of managing activities of daily living independently; the husband is cognitively impaired, requiring constant cuing to carry out activities of daily living. If assessed on his own, the husband might be assessed as incompetent and removed from the home, with inevitable repercussions on his wife's ability to live on *her* own. In context, however, the couple might well be seen as fully functional, and allowed to continue to live together.[17]

Even if there are strong indicators of a lack of competence with respect to a particular decision, it is not always appropriate to conduct an informal assessment, which may embarrass or humiliate the person. This is the case with any determination of competence, as such testing is always an invasion of the person's privacy.[18] An assessment should generally only be conducted if the individual's behaviour has given rise to a strong suspicion of incompetence. An informal assessment of competence is called for only if:

- there is "good reason to raise the issue of the person's competence, but insufficient proof to conclude that a formal assessment of competency is called for";[19]
- the test is necessary, and is likely to result in the provision of assistance; *and*
- the test respects the individual's own choices, and focuses on the objective risks that the person may encounter.

Whether these goals are met is based on the answers to the following questions:[20]

- What is the problem? The answer to this question assists in determining whether competence needs to be informally assessed and may provide solutions that would avoid such testing.
- Will a competence assessment help to solve the problem? If the required assistance is not available, testing may provide no benefit.
- Is a voluntary solution practical? A voluntary solution is usually more successful,

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[16]W.M. Altman, P.A. Parmelee and M.A. Smyer, "Autonomy, Competence and Informed Consent in Long Term Care: Legal and Psychological Perspectives" (1992), 37 Villanova L. Rev. 1671 at 1692.

[17]Response to Discussion Paper from Foyer Valade (December, 1998).

[18]Weisstub, *supra* n. 4, at 64; Silberfeld and Fish, *supra* n. 9, at 54 *et seq.* See also M. Silberfeld, "Competency Assessments" (1991), 11 Est. & Trusts J. 165 at 170-171.

[19]Silberfeld and Fish, *supra* n. 9, at 54.

[20]The following discussion is drawn from Silberfeld and Fish, *supra* n. 9, at 54-64.

and less expensive and emotionally wearing, than compulsory arrangements, and respectful of the right to make decisions. An assessment may not be needed if a person who requires help will accept it voluntarily.

- What arrangements are already in place? A person's independence is maximized if an enduring power of attorney or health care directive has been executed. If an appropriate substitute `decision maker is not available, however, the benefit of a competence assessment may be diminished.
- Whose interest is being served? If a person has previously indicated that he or she would want his or her competence challenged in that particular circumstance, or if that person, or a reasonable individual in that person's position, would want to be assessed as to whether he or she could make that decision, then the person's best interests are being served.
- What risks are involved in the present situation? If the person merely plans to continue to do something that has been done for a long time without harm, there is probably insufficient risk to justify a competence assessment. Similarly, if harm is unlikely to occur in the circumstances of the person's life, or if the risk of harm is voluntarily assumed with recognition of the potential consequences, there is again little justification for an assessment. However, if a similar situation has resulted in real harm to that person, or will expose the person to harm that will make his or her life significantly worse than it is now, these would be intolerable risks. The more serious the anticipated risk, the more likely it is to be intolerable. It is even more likely to be intolerable when a person's actions threaten to harm others.

A final issue to be addressed is the connection, if any, between the assessor and the subject. This is especially true if the assessor has a vested interest in the subject, such as where adult children wish to make the decision regarding committal of their elderly parents to a long term care facility. When considering the appropriateness of an assessment in such a situation, the assessor must provide a reasonable explanation for believing that the subject faces an intolerable risk of harm, and then ask for the opinion of a sensible disinterested person, prior to proceeding to an informal test of competence.

Note that the difficulty of maintaining objectivity will be magnified if the assessor is not highly skilled; "even after many years of working with the elderly many professional staff of various disciplines still have difficulty understanding the topic of incompetence."[21]

It is important that assessors always appreciate the distinction between an informal assessment of competence, or screening process, and a more formal assessment, and that the former not become a substitute for the latter.[22]

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[21]Response to Discussion Paper from Deer Lodge Centre (November, 1998).

[22]Response to Discussion Paper from Manitoba Association on Gerontology (November, 1998).

D. CONCLUSION

While a legal duty to ensure that competence exists will arise in many different situations, those confronted on a day-to-day basis with the need to assess capacity generally lack the proper training to conduct such testing. This gap is further compounded by the fact that the existing legal tests for capacity vary depending on the circumstances, and what will trigger the need for assessment can also vary. It is therefore of paramount importance that assessors not act hastily, and remain aware that what may indicate a lack of competence in one person is mere eccentricity in another.

There are comparatively few situations in which the need for informal assessment will actually arise, and testing should not be applied wholesale to everyone who exhibits characteristics that may be considered "strange". The goals of competence assessment must also be kept in mind: if no purpose is served from testing because no remedy is available in any event, testing is not justified.

Chapter 5 will examine the legal consequences inherent in the process of informal competence assessment.

CHAPTER 5

LEGAL CONSEQUENCES

When contemplating guidelines that may ultimately result in the refusal of services or treatment, or conversely, the involuntary imposition of services or treatment, it is important to be aware of the legal consequences that may flow from such actions. While formal competence assessment may be conducted under the authority of *The Mental Health Act*, with its statutory liability and safeguards, the uncontrolled nature of a process lacking that formality necessarily raises concerns regarding obligations of confidentiality, defamation, the law of negligence, consent issues, and human rights. These areas will be briefly discussed in this Chapter.

A. OBLIGATIONS OF CONFIDENTIALITY

A person conducting an informal assessment may obtain, or already possess, confidential information from the person being assessed. He or she will have to exercise care in respect of how, when, and to whom that information is disclosed. When a person is entrusted with information that is not publicly known, in circumstances that impose an obligation not to disclose or use that information without the authority of the confider, it cannot be divulged unless the confider consents, or there is just cause for doing so. The obligation of confidentiality can arise in any one of several ways.

1. Statute

The Personal Health Information Act[1] governs the collection, retention, use, and disclosure of personal health information in Manitoba by health care facilities, public bodies, and health services agencies. The Act imposes a duty of confidentiality on the entities covered by its provisions. Any of those facilities, bodies, or agencies that has obtained personal health information concerning an individual (which includes information relating to the diagnosis of the individual's mental condition) is prohibited from disclosing the information except under certain circumstances, and to certain specified people. The Act makes it an offence to disclose such information in contravention of the Act's provisions, punishable by a fine of up to $50,000.

There are defences available to a charge under the Act, including that the person who disclosed the information reasonably believed that disclosure was authorized under the Act. The Act authorizes disclosure, for example, if the person disclosing the information reasonably believes that disclosure is necessary to prevent or lessen a serious and immediate threat to the

[1] *The Personal Health Information Act*, C.C.S.M. c. P33.5.

mental health of the individual, or to public health or public safety. And, of course, disclosure is permitted if the individual in question consents. Nevertheless, anyone governed by the Act must be extremely careful when disclosing someone else's personal health information.

It is worth noting that *The Freedom of Information and Protection of Privacy Act*[2] does not apply to records governed by *The Personal Health Information Act*, and *The Privacy Act*[3] does not apply to information obtained in confidence from the person in question.[4]

2. Contract

A duty of confidentiality may be created when a contract is entered into with another person and the contract contains an express or implied term regarding confidentiality.[5] This is true both for "formal" written contracts and for oral contracts. Usually, the obligation of confidentiality owed by professionals to their clients or patients is recognized in the Code of Ethics or Code of Conduct of those professions.[6] This duty extends to any confidential information acquired by a professional adviser from the confider. For example, when a physician refers a patient's case to a specialist, "the obligation of confidence owed by the doctor to his patient will cover not only the information which the patient imparts to his doctor but also any information relating to that patient which the doctor secures from the specialist."[7]

The law relating to the duty of confidentiality is exceedingly complex.[8] Obviously, it does not extend to any and all information, but even in the context of familiar commercial relationships such as that between banker and client, the extent and incidence of the duty of

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[2]*The Freedom of Information and Protection of Privacy Act*, C.C.S.M. c. F175.

[3]*The Privacy Act*, C.C.S.M. c. P125.

[4]*Bingo Enterprises Ltd.* v. *Price Waterhouse* (1986), 41 Man. R. (2d) 19 (C.A.).

[5]The Law Commission (Eng.), *Breach of Confidence* (Report #110, 1981) 12, n. 46 citing among other cases, *Tuck & Sons* v. *Priester* (1887), 19 Q.B.D. 629, and 18.

[6]See for example, The Law Society of Manitoba, *Code of Professional Conduct* (1991) 11-14; Association of Physiotherapists of Manitoba, *Bylaw, Article I: Code of Ethics* (1982) 2.3; Canadian Dental Association, *Code of Ethics*, Article 9; Canadian Psychological Association, "A Canadian Code of Ethics for Psychologists" (1986), published in "Handbook for Psychologists and Psychological Service Providers" (1990), 9 Manitoba Psychologist 49 at 56; Institute of Certified Management Consultants of Manitoba, *The Uniform Code of Professional Conduct for the Institute of Certified Management Consultants of Canada* (1989) 32; Canadian Association of Social Workers, *Code of Ethics* (1983) 4-5.

[7]The Law Commission (Eng.), *supra* n. 5, at 22.

[8]See F. Gurry, *Breach of Confidence* (1984). A helpful guide to the incidence of the duty of confidentiality is the analysis by Megarry J. in *Coco* v. *A.N. Clark (Engineers) Ltd.*, [1969] R.P.C. 41 (Ch.).

confidentiality has long remained contentious,[9] though that duty certainly endures even after the contractual banker-client relationships has itself come to an end.[10]

If a contractual duty of confidentiality is breached, the person at fault may be liable to pay damages to the affected individual. Alternatively, the contract itself may expressly or impliedly provide for the remedies available to the injured party.

3. Fiduciaries

A fiduciary owes an obligation of confidentiality as one of a number of duties.[11] Although certain relationships are fiduciary in their very nature, including the relationship of trustee and beneficiary, guardian and ward, and principal and agent, a fiduciary duty may arise in the context of other relationships as well.[12] In determining whether a relationship is one in which fiduciary duties are owed, the courts will consider whether it contains "common features discernible in the contexts in which fiduciary duties have been found to exist,"[13] such as:

(1) the fiduciary has scope for the exercise of some discretion or power.

(2) the fiduciary can unilaterally exercise that power or discretion so as to affect the beneficiary's legal or practical interests.

(3) the beneficiary is peculiarly vulnerable to or at the mercy of the fiduciary holding the discretion or power.[14]

In addition, in order to be deemed a "fiduciary" (with the resulting fiduciary duties), the person must have a direct relationship with the confider.[15]

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[9]It has been so ever since the English Court of Appeal, in *Tournier* v. *National Provincial and Union Bank of England*, [1924] 1 K.B. 461, divided on the issue as to whether the obligation of confidentiality might attach to information obtained from sources other than the customer's account. The opinion of Atkin L.J (in which Bankes L.J. concurred) was that it might, provided that the occasion in which the information was obtained arose out of the banking relations of the bank and its customers. A narrower view was taken by Scrutton L.J. in dissent on this issue. See Gurry, *supra* n. 8 at 144.

[10]*Tournier* v. *National Provincial and Union Bank of England*, *id*., at 473.

[11]*International Corona Resources Ltd.* v. *Lac Minerals Ltd.* (1987), 44 D.L.R. (4th) 592 at 638-639 (Ont. C.A.), cited by La Forest J. on appeal: *LAC Minerals Ltd.* v. *International Corona Resources Ltd.* (1989), 61 D.L.R. (4th) 14 (S.C.C.).

[12]*LAC Minerals Ltd.* v. *International Corona Resources Ltd, supra* n. 11, at 16.

[13]*Frame* v. *Smith* (1987), 42 D.L.R. (4th) 81 at 98-99 (S.C.C.) quoted in *LAC Minerals Ltd.* v. *International Corona Resources Ltd. supra* n. 11, at 27.

[14]*Frame* v. *Smith*, *supra* n. 13, at 99, quoted in *LAC Minerals Ltd.* v. *International Corona Resources Ltd.* , *supra* n. 11, at 27.

[15]*LAC Minerals Ltd.* v. *International Corona Resources Ltd.*, *supra* n. 11, at 36.

If a relationship is fiduciary, the confider can sue the confidant for a breach either of the duty of confidentiality[16] or fiduciary duty. [17] However, where the essence of the complaint is misuse of confidential information, the appropriate cause of action is breach of confidence.[18] The compensation payable by a fiduciary to an injured party can be substantial.

4. Outside Contract

An obligation of confidentiality can also arise in non-contractual situations when non-public information is communicated in confidence.[19] A duty may also be imposed on a person who is not in a direct relationship with the confider, as where confidential information is received from a confidant in breach of that confidant's obligation to the original confider.[20] An action in this situation will succeed only if the information has the necessary quality of confidence about it, was imparted in circumstances which demonstrated an obligation of confidence, and there is an unauthorized use of the information to the detriment of the confider.[21]

5. Exceptions to Duty of Confidentiality

No obligation of confidentiality is absolute. Disclosure of confidential information is justified in limited circumstances, such as where: there is an obligation to disclose at law; there is a duty to the public to disclose; disclosure is required in the confidant's interests; or the confider expressly or impliedly consents to disclosure.[22]

(a) Compulsion of law

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[16]The conventional remedies are an accounting of profits or damages and, in appropriate cases, an injunction. The focus in breach of confidence cases is the plaintiff's loss; the goal is restoration of the plaintiff to the monetary position he or she would have been in had the wrong not been committed: *LAC Minerals Ltd.* v. *International Corona Resources Ltd.*, *supra* n. 11, at 76-77. For a detailed discussion of the remedies for breach of confidence, see The Law Commission (Eng.), *supra* n. 5, at 64 *et seq.*

[17]An action for a breach of a fiduciary obligation is equitable; only equitable remedies are available for a breach: *LAC Minerals Ltd.* v. *International Corona Resources Ltd.*, *supra* n. 11, at 36. A restitutionary remedy is considered to be appropriate "because [fiduciaries]... are required to disgorge any benefits derived from the breach of trust.": at 76.

[18]*LAC Minerals Ltd.* v. *International Corona Resources Ltd.*, *supra* n. 11, at 64.

[19]*LAC Minerals Ltd.* v. *International Corona Resources Ltd.*, *supra* n. 11, at 20.

[20]*LAC Minerals Ltd.* v. *International Corona Resources Ltd.*, *supra* n. 11, at 36, citing *Liquid Veneer Co. Ltd.* v. *Scott* (1912), 29 R.P.C. 639 at 644 (Ch.).

[21]*LAC Minerals Ltd.* v. *International Corona Resources Ltd.*, *supra* n. 11, at 20, quoting Megarry J. in *Coco* v. *A.N. Clark (Engineers) Ltd.*, *supra* n. 8, at 47; *Malone* v. *Metropolitan Police Commissioner*, [1979] 2 W.L.R. 700 at 728-729 (Ch. D.).

[22]*Tournier* v. *National Provincial and Union Bank of England*, *supra* n. 9, at 473, applied by *Canadian Imperial Bank of Commerce* v. *Sayani*, [1994] 2 W.W.R. 260 at 265-267 (B.C.C.A.).

The common law and statute law sometimes require disclosure of confidential information.[23] The law does so whenever a public good or public interest supersedes the private duty to maintain a confidence. For example, a physician who believes that a patient should no longer be permitted to drive a motor vehicle must report this to the Registrar of Motor Vehicles.[24] Bankers are required to report suspicious financial transactions to certain government departments,[25] and individuals may be required to disclose confidential information in a court of law.[26]

(b) Duty to the public

The duty of a physician, journalist, accountant, or other person to maintain a confidence may also be overridden where there is a public interest in disclosure.[27] Although previously disclosure of confidential information on the basis of public interest was justified only to prevent a future crime or fraud or a breach of the country's security,[28] recent case law has expanded the criteria for disclosure in the public interest.[29]

The public interest exception is not limited to fraud in the criminal sense, but includes misrepresentations that fall short of what the law defines as "fraud" or "deceit". The duty to disclose on the basis of the public interest is actually part of an implied term respecting, for example, the bank's obligation of confidentiality in the contract between the banker and the customer, as it is "inconceivable that an honest banker would ever be willing to do business on

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[23]*Parry-Jones* v. *Law Society*, [1969] 1 Ch. 1 at 9 (C.A.).

[24]*The Highway Traffic Act*, C.C.S.M. c. H60, s.157(1).

[25]See F. Neate and R. McCormick, *Bank Confidentiality* (1990) 67-68. A bank is encouraged or required to disclose: records in its possession which could serve as evidence whether or not the legal proceedings involve the bank, by the *Canada Evidence Act*, R.S.C. 1985, c. C-5 (s. 29 (5) and (6)); records of transactions, including private information of the bank's customers who are not themselves under investigation, by the *Income Tax Act*, R.S.C. 1985 (1st Supp.) (to Revenue Canada,) and suspicious financial activity, by the *Criminal Code*, S.C. 1988, c. 51, the *Food and Drugs Act*, R.S.C. 1985, c. F-27 (s. 44.3) and the *Narcotic Control Act*, R.S.C. 1985, c. N-1 (s. 19.2). The legislation also establishes that there is no civil or criminal liability for disclosing to the authorities facts upon which a person suspects that certain property may be the proceeds of crime.

[26]*Tournier* v. *National Provincial and Union Bank of England*, *supra* n. 9, at 481. For example, see the *Inquiries Act*, R.S.C. 1985, c. I-13, which provides that in the course of an inquiry, any person can be subpoenaed to appear, testify and produce any documents in his or her possession which relate to the subject matter of the inquiry. There are more than 47 federal statutes which confer powers of inquiry by reference to the *Inquiries Act*, and which could be used to impose a duty of disclosure: Neate and McCormick, *supra* n. 25, at 68, n. 16. See also, *Canada Evidence Act*, R.S.C. c. C-5, ss. 29(5) and (6).

[27]*Jones.* v. *Smith*, (25 March 1999), No. 26500 (S.C.C.).

[28]*Weld-Blundell* v. *Stephens*, [1919] 1 K.B. 520 at 527 (C.A.). For a recent case in which disclosure was justified to prevent a future crime, see *Jones.* v. *Smith*, *supra* n. 27. See also *Tournier* v. *National Provincial and Union Bank of England*, *supra* n. 9, at 473 and 481, applied by *Canadian Imperial Bank of Commerce* v. *Sayani*, *supra* n. 22, at 265-267. See also, *Beloff* v. *Pressdram Ltd.*, [1973] 1 All E.R. 241 at 260 (Ch. D.).

[29]*Lion Laboratories Ltd.* v. *Evans*, [1984] 3 W.L.R. 539 at 546 and 558 (C.A.).

terms obliging the bank to remain silent in order to facilitate its customer in deceiving a third party."[30] Disclosure is limited to those persons who have a proper interest in receiving the information, such as the police when a crime has been committed. There may also be cases where the misdeed is of such a character that the public interest may require or excuse a broader disclosure, perhaps even to the media.[31]

(c) Interest of confidant

The confidant's own interests may also justify disclosure of confidential information. As an example, a banker is justified in disclosing information about a customer's account and affairs, to a reasonable extent, for the bank's own protection in collecting or suing for an overdraft or in giving a reason for declining to honour cheques drawn or bills accepted by the customer, when the customer has insufficient assets on deposit with the bank.[32]

(d) Express or implied consent

Of course, a confider may also expressly or impliedly consent to the disclosure of confidential information. A bank customer, for example, may impliedly consent to disclosure by authorizing a reference to his banker.[33]

However, disclosure of confidential information in a customer's interests is probably not excusable where there is reasonable time to consult the customer to obtain an express consent or refusal to disclosure.[34]

6. Can Incompetence Justify Disclosure of Confidential Information?

If a banker suspects that another person is trying to defraud the bank's customer and the customer appears to be incompetent, can the banker disclose information about that person in order to prevent the fraud? Or, if a lawyer suspects that someone is trying to influence his or her client, as a testator, and the lawyer believes that the client lacks testamentary capacity, is it enough simply to refuse to draw up the will: can confidential information be used to prevent an

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[30]*Canadian Imperial Bank of Commerce* v. *Sayani*, *supra* n. 22, at 266.

[31]*Initial Services Ltd.* v. *Putterill*, [1968] 1 Q.B. 396 at 405-406.

[32]*Tournier* v. *National Provincial and Union Bank of England*, *supra* n. 9, at 473, applied by *Canadian Imperial Bank of Commerce* v. *Sayani*, *supra* n. 22, at 265-267. See also *Tournier*, at 481.

[33]*Tournier* v. *National Provincial and Union Bank of England*, *supra* n. 9, at 473, applied by *Canadian Imperial Bank of Commerce* v. *Sayani*, *supra* n. 22, at 265-267.

[34]*Tournier* v. *National Provincial and Union Bank of England*, *supra* n. 9, at 481.

injustice being done? After all, if the client goes to another, possibly less observant, lawyer to draw up the will, a new will may result, without regard to the testator's level of competence. Or, if the person solemnizing a marriage suspects that a person wants to marry someone who seems to be incompetent in order to gain access to the incompetent person's wealth, can confidential information be used to assist the potentially incapable person? Can the Public Trustee be contacted to try to ensure that the person's financial affairs are protected?

The case law defining the circumstances in which disclosure of confidential information is justified is general in nature, and does not deal specifically with these circumstances. As such, there is no definitive answer as to whether persons in these or similar positions are justified in overriding their obligation of confidentiality. Whether a person is justified in contacting the Public Trustee or the police or another individual in order to prevent a crime or misdeed depends on the facts of the particular case.

As previously noted, there is presently a lack of consistency in the manner in which professionals deal with the issue of competence. For example, some bankers who are concerned about a customer's competence to make a financial decision contact the Public Trustee's Office, while others try to resolve the problem informally by contacting a relative of the customer.

These two approaches reflect the dilemma faced by bankers. Raising the issue of mental incapacity with a customer might cause offence or embarrassment and result in that customer choosing to deal with a different bank. At the same time there is at the very least a moral obligation, and sometimes, as noted above, a legal duty, to protect customers from mismanagement or fraud with respect to their financial resources. In addition, bankers remain unclear about the duty of confidentiality to their customers and whether they are justified in reporting their concerns to the Public Trustee, the police, or relatives**.** Similar concerns are faced by lawyers and other professionals confronted with clients, patients, parishioners, or customers who may be taken advantage of if not provided with assistance.

A number of provincial and federal statutes compel or encourage the reporting of information for public interest reasons,[35] and some statutes even *require* the reporting of confidential information.[36] The enactment of these provisions clearly indicates that in some circumstances, the Manitoba Legislature and the Parliament of Canada consider certain public

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[35]For example, *The Animal Care Act*, C.C.S.M. c. A84 s. 8; *The Discriminatory Business Practices Act*, C.C.S.M. c. D80, s. 5; *The Legislative Assembly and Executive Council Conflict of Interest Act*, C.C.S.M. c. L112, s. 17; *The Municipal Council Conflict of Interest Act*, C.C.S.M. c. M255, s. 6(5); *The Public Schools Act*, C.C.S.M. c. P250, s. 39(4); *The Veterinary Medicine Act*, C.C.S.M. c. V30, s. 14(1); *The Fires Prevention Act*, C.C.S.M. c. F80, s. 38(3); *The Highway Traffic Act*, C.C.S.M. c. H60, s. 155(1); *The Heritage Resources Act*, C.C.S.M. c. H39.1, s. 46; *The Physiotherapists Act*, C.C.S.M. c. P65, s. 48(1); *The Occupational Therapists Act*, C.C.S.M. c. O5, s. 47(1); *The Registered Nurses Act*, C.C.S.M. c. R40, s. 46(1); *The Psychiatric Nurses Act*, C.C.S.M. c. P170, s. 47(1); *The Practical Nurses Act*, C.C.S.M. c. P100, s. 46(1); *The Registered Dietitians Act*, C.C.S.M. c. D75, s. 44(1); *The Registered Respiratory Therapists Act*, C.C.S.M. c. R115, s. 49(1); *The Chiropractic Act*, C.C.S.M. c. C100, s. 30(1); *The Medical Act*, C.C.S.M. c. M90, s. 39(1); *The Pharmaceutical Act*, C.C.S.M. c. P60, s. 63; *The Law Society Act*, C.C.S.M. c. L100, s.76(1).

[36]For example, *The Highway Traffic Act*, C.C.S.M. c. H60, s.157(1); *The Mental Health Act*, C.C.S.M. c. M110, s. 26.11(2); *Canada Evidence Act*, R.S.C. 1985, c. C-5, ss. 29(5) and (6); *Income Tax Act*, R.S.C. 1985 (1st Supp.) (to Revenue Canada); *Narcotic Control Act*, R.S.C. 1985, c. N-1, s. 19.2; and *Inquiries Act*, R.S.C. 1985, c. I-13.

interests to be of greater importance than the private interest of confidentiality, including the protection of the administration of justice, the prevention of crime, and the protection of pedestrians and motorists.

These provisions are also beneficial to individuals and organizations who must decide whether they are justified in reporting certain confidential information, and eliminates the guesswork about whether certain particular public interests are important enough to override the obligation to keep the information confidential. For example,

> [t]he legislated duty relieves the bank of having to decide whether a sufficiently high public good would be served by disclosure so as to supersede the private duty to maintain confidentiality. This difficult judgment, combined with the ever broadening legislative requirements, may explain why this [the public duty to disclose (apart from legislation or common law)] has been a little used exception.[37]

However, the duty of confidentiality is a fundamental principle to members of many professions, and sometimes prevails even over an important public interest. For example, legislation mandating reporting of information for the protection of children and vulnerable persons applies to confidential communications to most professionals, but not to communications between a solicitor and his or her client.[38]

There is, then, no short answer to the question whether incompetence can justify disclosure of confidential information. It all depends on the facts of the case. Although legislation, and the common law, permit and even require disclosure under certain circumstances, sometimes the answer will simply have to depend on common sense and good judgment.

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[37]Neate and McCormick, *supra* n. 25, at 69. The legislated duty referred to is derived from the *Evidence Act*, R.S.C. 1985, c. C-5, s. 462.31.

[38]*The Child and Family Services Act*, C.C.S.M. c. C80, s. 18; *The Vulnerable Persons Living with a Mental Disability Act*, C.C.S.M. c.V90, ss. 21 and 24. A number of statutes also provide that the duty to report a disorder that prevents a colleague from practicing their profession does not apply to information obtained by a member which is confidential due to the professional-patient relationship: *The Physiotherapists Act*, C.C.S.M. c. P65, s. 48(2); *The Occupational Therapists Act*, C.C.S.M. c. O5, s. 47(2); *The Registered Nurses Act*, C.C.S.M. c. R40, s. 46(2); *The Psychiatric Nurses Act*, C.C.S.M. c. P170, s. 47(2); *The Licensed Practical Nurses Act*, C.C.S.M. c. P100, s. 46(2); *The Registered Dietitians Act*, C.C.S.M. c. D75, s. 44(2); *The Registered Respiratory Therapists Act*, C.C.S.M. c. R115, s. 49(2). See, however, the recent Supreme Court of Canada decision in *Jones* v. *Smith*, *supra* n. 27.

B. PRIVACY AND DEFAMATION

While the issue of confidentiality necessarily includes consideration of the right to privacy, a separate discussion of the right to privacy is also in order. Unlike most Canadian jurisdictions, Manitoba has enacted legislation to protect privacy rights. Under *The Privacy Act*,[39] an unreasonable and substantial violation of the privacy of another person is actionable in the Court of Queen's Bench.[40] The Act does not include an exhaustive definition of privacy. It does, however, provide examples of what can constitute a violation of privacy, including the use of personal documents without consent. Several defences to an action are outlined: consent; reasonable actions without constructive knowledge of the violation; protection of lawful rights; acting under legal authority; and acting within the public interest.[41] Because people conducting informal assessments do not have the statutory protections available to those conducting assessments under *The Mental Health Act*, anyone conducting an informal test of competence is potentially susceptible to an action under *The Privacy Act*. Proof of damages is not required, and the remedies available under the Act include a monetary award and an injunction.[42]

Linked with privacy is the concept of defamation. Defamation is the publication of a statement that tends to lower a person in the estimation of right-thinking members of society generally, or that tends to make them shun or avoid that person. Discrimination on the basis of "mental disability" is prohibited by the *Charter*, as well as by Manitoba's *Human Rights Code*, suggesting that a certain stigma attaches to such a label. Persons administering an informal competence test must be aware of the consequences of the testing and the subsequent release of the results of an assessment: as soon as third parties become recipients of potentially damaging information, the possibility of a defamation action against the assessor arises**.**

As with any civil action, there are defences to a defamation claim. If the information published is completely true, the assessor is exonerated. An apology to the wronged person may also mitigate the situation, but it must be as widespread as the original information, and must be a complete apology. Specifically with respect to releasing the results of an informal assessment, the defence of "qualified privilege" exists where one person has defamed another while acting under a perceived duty, without a "wrongful" motive.

Assessors must always consider not only how their informal testing is conducted, but what is done with the results of the assessment. If they fail to respect the subject's privacy rights, they can find themselves being sued for defaming that subject.

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[39]*The Privacy Act*, C.C.S.M. c. P125.

[40]*The Privacy Act*, C.C.S.M. c. P125, s. 2(1).

[41]*The Privacy Act*, C.C.S.M. c. P125, s. 5.

[42]*The Privacy Act*, C.C.S.M. c. P125, ss. 2(2) and 4(1).

C. NEGLIGENCE

The tort of negligence has expanded its scope to the point where it now encompasses almost every human activity. It may be committed concurrently with other torts and breaches of contract, and is often used instead of other, more complex forms of action, or as a residual mode of complaint, addressing wrongs not covered by other torts.

The law of negligence imposes liability on anyone who causes damage by failing to show "due care" in circumstances where a duty exists to do so. This duty will ordinarily arise whenever a reasonable person in the particular circumstances would foresee that another's safety or interests will be at risk unless appropriate care is taken. The "activity" may be physical (*e.g.* operating machinery), or verbal (*e.g.* giving advice). It may also, in exceptional cases, consist of a *failure* to act in circumstances where a reasonable person would be expected to take action.

Negligence law has not yet been successfully used to redress claims for harm to reputation, such as might arise from the careless release of confidential information. Except in extreme cases, accompanied by actual physical or psychological illness, a negligence claim cannot be used to recover damages for the infliction of emotional distress, but claims against persons who negligently cause purely monetary loss to others are common.

One can imagine circumstances in which the careless or unskillful conduct of an informal competence assessment might cause serious economic harm; for example, the loss of a job, or of a promotion. It is equally possible that *failure* to perform such an informal assessment on a person who was obviously incompetent might result in devastating losses to that person. The bank teller, called upon by a clearly confused client to disburse that client's life savings to an apparent stranger, could be liable to the client under the law of negligence, if she or he simply follows the client's instructions without question. Both action and inaction, conducting an informal assessment and failing to conduct one where common sense requires it, can result in liability for a breach of the obligation of due care. Such a breach could result in liability for damages to the affected individual.

D. CONSENT

One method often used to reduce or restrict liability is obtaining a waiver from the person who could potentially initiate a lawsuit. By signing the waiver, the person agrees not to sue.

If legal consequences are to flow from the use of non-legislated guidelines, many assessors will quite reasonably want to protect themselves against liability, and waivers may suggest themselves as a means of accomplishing this.

There are a series of generally accepted doctrines used when determining the validity of

waivers, including the concept of reasonable notice: a waiver is not enforceable unless the person signing it is given reasonable notice of it, in order to ensure that they are cognizant of its effect. This creates a problem when competence is in issue: can a person being tested for their level of mental capacity be legally bound by a document that they lack the ability to comprehend?

1. Lack of Capacity to Consent to Testing

As discussed in Chapter 3, in the current legal climate, task-specific competence has superseded the idea of general competence. Therefore, those required to determine others' capacity on a day-to-day basis must maintain a particular focus in their testing. The purpose of an assessment is to "decide the capacity of the client in the particular domain giving rise to the assessment."[43] If the assessor wants to avoid potential liability, consent of the subject provides a complete defence. Of course, the difficulty lies in the questionable quality of such consent:

> In order to get a valid consent from a patient whose competency is to be assessed, it seems that one would first have to assess whether the individual has the requisite abilities for such consent, an assessment which in turn seems to require consent.[44]

This is a paradox with which the medical community, in particular, has been struggling for some time. Can damage resulting from an informal competence test be vitiated by consent to the test, or a waiver of rights, by the subject of the assessment?

Combating this problem requires preparedness and training on the part of the assessor, as well as informing the person being tested of the reasons for assessment and of the test itself. The need to ensure that the person being tested is informed was emphasized by one of the respondents to the Discussion Paper:

> Today's society reinforces the importance of informed consent to treatment. … [The] practice [of not requiring informed consent] may have serious repercussions from a liability perspective.[45]

There is certainly no easy answer to the problem. It is entirely possible, however, that obtaining consent to assessment from a subject may not insulate the assessor from liability for what happens as a result of carrying out the assessment.

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[43]R. Abramovitch, M. Finstad, and M. Silberfeld, "Preliminary Report on Informed Consent for Mental Capacity Assessments" (1993) 12 Can. J. Aging 373 at 374.

[44]R. Pepper-Smith, W.R.C. Harvey, M. Silberfeld, E. Stein, and D. Rutman, "Consent to a Competency Assessment" (1992) 15 Int'l J.L. & Psychiatry 13 at 13.

[45]Response to Discussion Paper from Foyer Valade (December, 1998).

E. HUMAN RIGHTS ISSUES

Canadian human rights legislation could play a large part in the implementation of government-mandated guidelines for competence determination. Because they are government-initiated and sanctioned, any such guidelines would be subject to both the *Charter*[46] and *The Human Rights Code*,[47] and all the relevant actions and remedies. For example, section 15(1) of the *Charter* and section 9 of *The Human Rights Code* prohibit discrimination based on physical or mental disability. Those who, in the process of administering an informal competence test using government-sanctioned guidelines, fail to respect the rights of the person being tested may violate that person's legally protected rights. This would be especially true where the assessment is improperly administered, with no thought given to the interests of the person being tested. Great care must be taken to adhere to the objectives of assessment, and to avoid testing where no benefit to the subject can result.

The nature of the testing must also be considered: issues such as mandatory assessment, testing based on the discretion of the assessor, and the evidentiary requirements for initiating and completing competence testing, as well as the results of the assessment. Are rights infringed when a service is refused based on an informal competence assessment? What about the imposition of treatment on an unwilling patient that is justified by the use of informal competence guidelines? This latter situation could constitute a violation of the *Charter* right to "security of the person."[48]

The *Charter* permits courts to redress breaches of *Charter* rights by whatever remedies they consider "appropriate and just in the circumstances".[49]

Those administering any kind of competence test need to be aware of the possibility of serious consequences to the civil liberties of the people being tested. As will be discussed, this awareness can only be achieved through the training of assessors in not only the testing itself, but also its possible legal consequences.

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[46] *Canadian Charter of Rights and Freedoms*, being Part I of the *Constitution Act, 1982*, being Schedule B of the *Canada Act 1982* (U.K.), 1982, c. 11.

[47] *The Human Rights Code*, C.C.S.M. c. H175.

[48] *Canadian Charter of Rights and Freedoms*, being Part I of the *Constitution Act, 1982*, being Schedule B of the *Canada Act 1982* (U.K.), 1982, c. 11, s.7.

[49] *Canadian Charter of Rights and Freedoms*, being Part I of the *Constitution Act, 1982*, being Schedule B of the *Canada Act 1982* (U.K.), 1982, c. 11, s.24(1).

F. CONCLUSION

It is clear that there are many potential risks run by anyone conducting an informal competence assessment. These range from a possible obligation to keep confidential the information obtained from the assessment, to a duty to take due care in deciding to administer, and administering, any assessment. Whatever steps are taken to clarify informal assessment procedures, these risks ought to be borne in mind.

CHAPTER 6

DISCUSSION QUESTIONS AND ANSWERS

The Discussion Paper included a list of 10 questions to which the Commission sought responses from interested parties. The following is a list of those questions, accompanied by summaries of the responses received. A list of the 22 parties who responded to the Discussion Paper can be found in Appendix B.

A. FORMAL EDUCATION

1. Is there a need for formal education in the area of competence assessment?

All respondents who addressed this question agreed that there is a need for formal education of one kind or another. One respondent suggested that a brochure detailing definitions of competence and the elements of assessment would suffice,[1] while another endorsed both undergraduate and continuing education in the area of competence assessment for all professionals whose clients' competence may be put in issue.[2] Education "should not only provide tools for more effective assessment, but also make the assessor aware of the issues and complexities of the assessment".[3]

One respondent identified potential "target markets for education [as] family members, the general public, policy analysts, administrators and service providers in the private, public and volunteer sectors".[4] It is not at all clear, however, that formal education would be supported for *all* individuals who might be in a position to administer informal assessments of competence. One respondent took issue with the idea that "just anyone can be trained to become an assessor of competence,"[5] while another pointed out that broad-based training might in fact be counter-productive:[6]

We agree that formal education is a prerequisite for those professionals charged under the

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[1]Family Dispute Services, Province of Manitoba (November, 1998).

[2]Riverview Health Centre (November, 1998).

[3]Ethics Committee, Bethania Mennonite Personal Care Home (November, 1998).

[4]Alzheimer Society (November, 1998).

[5]Manitoba Association on Gerontology (November, 1998).

[6]Deer Lodge Centre (November, 1998).

> Mental Health Act to carry out assessments of competence. It would also be helpful to have at least some basic education in the fundamentals for those lay persons who are now carrying out screenings on a routine basis. In practical terms, however, it would be very difficult if not impossible to implement for the latter group - and probably could not be made mandatory. This is a situation where a little knowledge could be quite dangerous - and may lead to encouraging the lay person to take inappropriate actions that might be contrary to the best interest of the client and his/her family.

Other respondents' endorsement of the value of formal education appeared to focus on education of professional staff involved in personal care situations, rather than a broader-based training of anyone who might be in a position to have to make an informal assessment. One noted that "education of service providers and administrators … will ultimately result in improved standards of care".[7] Another suggested training selected personnel from given facilities, who would then pass their training along to their colleagues.[8]

Respondents noted that any training would have to be tailored to the particular situation of the trainee; for example, "education for the health sector would vary from that of the banking industry".[9] One expressed concern that "a 'cookiecutter' approach, as a result of a formalized education, may be detrimental to the individuals being assessed, as well as limiting the focus of the assessor."[10]

One respondent suggested that anyone working within the "human services industry," broadly defined, should have a basic understanding of the degrees of competence.[11]

Finally, in a somewhat different vein, one respondent recommended that the public ought to be educated as to the options that presently exist to protect themselves should competence become a concern. These options include the springing power of attorney, enduring power of attorney, and advance treatment directive.[12]

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[7]Alzheimer Society (November, 1998).

[8]Extendicare (Canada) Inc. (November, 1998).

[9]Extendicare (Canada) Inc. (November, 1998).

[10]Manitoba Medical Association Ethics Committee (December, 1998).

[11]Manitoba Association of Gerontology (November, 1998).

[12]Social Work Department, Health Sciences Centre (November, 1998).

B. FORMAL ASSESSMENT TRAINING

2. Should people who administer these tests be required to take formal training which at least raises the issues and makes them aware of some of the complexities of the assessment?

A number of respondents supported requiring persons who administer informal assessments to undergo formal training. Some felt that this was absolutely necessary:[13]

> [We] would support the continuation of limiting "informal assessments" to those who currently already have some guidelines to dictate what is expected of them, *i.e.* lawyers, bankers, those who perform marriages. Others who work with individuals who at times appear 'incompetent' must have training to ensure that they can make informed decisions to request 'formal' assessments.

Another suggested that "[p]eople who are put in the position of having to make informal assessments of capacity should have as much training and as many tools at their disposal as possible."[14]

Others were less optimistic about the possibility of imposing such a requirement. One stated: "I am not sure that a requirement for formal training of all people to whom this knowledge could apply would be realistic or practical given the numbers, turnover, variability in frequency of use, etc.," and recommended that educational materials would be more helpful.[15]

Another respondent suggested:[16]

> Offering training on an as-requested basis would be valuable for the non-professional, providing the limitations of screening are clearly stated at the outset and the [concern about encouraging lay persons to take inappropriate actions is] taken into account.

Another respondent felt that formal training would only be necessary for those who administer such tests with regularity and who are primarily responsible for the outcome of the assessments.[17] One raised the issue of who would be responsible for monitoring training, and

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[13]Manitoba Association of Gerontology (November, 1998).

[14]Office the Public Trustee, Province of Manitoba (December, 1998).

[15]Dr. H.G. Andew, Director of Psychiatric Services, Chief Provincial Psychiatrist, Province of Manitoba (November, 1998).

[16]Deer Lodge Centre (November, 1998).

[17]Family Dispute Services, Province of Manitoba (November, 1998).

ensuring that standards are maintained.[18]

One respondent suggested that the difficulties involved in implementing formal education in the workplace could be overcome by using an "inservice" approach.[19]

C. OVERRIDING CONFIDENTIALITY

3. Do assessors need guidance on when they can override confidentiality in ordering a formal test of competence?

All of the respondents who addressed this question were agreed that guidance was needed. Such guidance, it was suggested, could be provided by way of an educational package.[20] Particular areas of concern that were identified included: when to release financial information to, *e.g.*, the Public Trustee when there are concerns of financial abuse; and how to deal with situations where the competence of the family or substitute decision maker is in question.[21]

One respondent expressed concern regarding the lack of professional codes of ethics to guide the conduct of many of the people charged with carrying out informal assessments, and pointed out that provisions of *The Personal Health Information Act* and *The Privacy Act* may be relevant to the issue of overriding client confidentiality.[22] Another queried how guidelines could be enforced.[23]

Finally, one respondent suggested a "readily accessible mechanism where an assessor could review the facts of the case (while preserving the [confidentiality of the] person in question) with a trained consultant or team". Such a team could include a psychologist and/or psychiatrist, an ethicist, a social worker, a lawyer, and a speech-language pathologist and audiologist.[24]

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[18]Foyer Valade (December, 1998).

[19]Social Work Department, Health Sciences Centre (November, 1998).

[20]Family Dispute Services, Province of Manitoba (November, 1998).

[21]Extendicare (Canada) Inc. (November, 1998).

[22]Deer Lodge Centre (November, 1998).

[23]Manitoba Association of Gerontology (November, 1998).

[24]The Manitoba Speech and Hearing Association (February, 1999).

D. EXISTING TESTS

4. Do you currently use any test for competence? Do you find it objectionable or demeaning, or accurate and helpful?

A number of respondents indicated that they currently use one or more informal assessment tests. The test most commonly mentioned was the Mini-Mental State test, also referred to as the Folstein Mini-Mental State Exam or the MMSE;[25] other means of testing included interviews and direct observation. Some noted that such tests are used primarily to contribute to effective care planning, and not to determine competence.[26]

Overall, the respondents did not feel that the administration of such tests is demeaning to the participants, *provided* that they are conducted correctly:

> Though not inherently objectionable or demeaning, in insensitive hands [the MMSE test] may be perceived as such by some clients. Any of the screening tools require sensitivity, skill and professionalism if they are to be administered appropriately.[27]

E. LEGAL CONCERNS

5. Do you have any legal concerns about assessing competence in your workplace? Would changes in legislation help?

Few respondents addressed this issue directly, and none of those who did had any legal concerns about assessing competence. One respondent did suggest some concern with the concepts of situational competence and fluctuating capacity, but pointed out that legal concerns arise more often in the context of clients' families.[28]

One respondent suggested that changes in legislation would be of assistance when determining whether to refer a client for assessment, and that meaningful changes would enhance clarity and direction with respect to ordering competence assessments.[29] Another noted that existing legislation does not take into account and specify the various areas or domains of

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[25]M.F. Folstein, S.E. Folstein and P.R. McHugh, "'Mini-Mental State': A Practical Method for Grading the Cognitive State of Patients for the Clinician" (1975), 12 J. Psychiat. Res. 189 at 196 *et seq.*

[26]Extendicare (Canada) Inc. (November, 1998).

[27]Deer Lodge Centre (November, 1998).

[28]Extendicare (Canada) Inc. (November, 1998).

[29]Family Dispute Services, Province of Manitoba (November, 1998).

competence, and that changes to recognize these distinctions are probably needed.[30] Yet another pointed out that some provinces have a Consent to Medical Treatment Act that addresses problematic areas.[31]

F. GUIDELINES, PROCEDURES, AND PROTOCOLS

6. At this time, do you favour the setting up of a form, namely a series of published Guidelines, Procedures and Protocols, for an informal assessment?

Virtually every respondent supported the publication of some sort of guidelines, procedures, and/or protocols dealing with the conduct of informal assessments.[32] Some felt that general guidelines would be preferable to standardized protocols, to ensure that the informal assessment process could be used in a variety of settings,[33] or that the focus must remain on the competence to make a specific decision at a specific time, with a clear distinction between informal assessments and formal declarations of incompetence.[34] Other respondents suggested that educational materials would be helpful,[35] and that such materials in the form of an educational kit, should be distributed as widely as possible.[36]

One respondent recommended legislating a requirement that the guidelines be followed, along with an enforcement mechanism, lest the guidelines be disregarded.[37] Another noted, however, that "the more formalized an informal competency assessment becomes, the more difficult the distinction between 'informal' and 'formal' (legal) assessments of competence" becomes.[38]

Finally, it was noted that if policies and procedures are to be established, input from pastoral services, ethicists, health professionals directly involved in assessing client care, and

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[30]Salvation Army Golden West Centennial Lodge (December, 1998); Deer Lodge Centre (November, 1998).

[31]Manitoba Medical Association Ethics Committee (December, 1998).

[32]Except that the Manitoba Medical Association did not support the setting up of formal protocols that would apply to the medical profession: Manitoba Medical Association Ethics Committee.

[33]Manitoba Society of Occupational Therapists (December, 1998).

[34]Extendicare (Canada) Inc. (November, 1998).

[35]Dr. H.G. Andrew, Chief Provincial Psychiatrist, Province of Manitoba (November, 1998).

[36]Office of the Public Trustee, Province of Manitoba (December, 1998).

[37]Manitoba Association of Gerontology (November, 1998).

[38]Dr. H.G. Andrew, Chief Provincial Psychiatrist, Province of Manitoba (November, 1998).

lawyers would be essential.[39]

G. PROPOSED GUIDELINES

7. If so, have you any specific comments on the discussion in Chapter [7]?

Response to the guidelines set out by the Commission in the Discussion Paper was uniformly positive. Respondents described the guidelines as "comprehensive and accurate,"[40] "in logical sequence, stated in precise terms and easily understood,"[41] and "a useful reference".[42] One suggested that a glossary or definition of terms would be helpful, as would the use of plain language rather than legal terminology,[43] and another felt that the process must be as clear and straightforward as possible to encourage appropriate and meaningful use in the field.[44]

One respondent, as noted above, did not support the setting up of an informal assessment procedure at all.[45] Otherwise, the Commission is persuaded that the proposals that formed the core of the Discussion Paper, and which constitute the basis for the Commission's recommendations in this Report, have widespread support in the relevant community.

H. INFORMATION BOOKLETS

8. Would booklet forms of information, similar to the summaries of competence to marry, make a will, etc. found in Chapter 3, be of any assistance in your profession or workplace?

The responses to this query were, again, universally positive. All of the respondents who responded to this question agreed that booklet forms of information would be a helpful resource. Such booklets should be, it was suggested, in lay language at a grade 8-10 reading level.[46]

One respondent suggested that the most relevant summaries would relate to the

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[39]Foyer Valade (December, 1998).

[40]Social Work Department, Health Sciences Centre (November, 1998).

[41]Manitoba Society of Occupational Therapists (December, 1998).

[42]Riverview Health Centre (November, 1998).

[43]Extendicare (Canada) Inc. (November, 1998).

[44]Dr. H.G. Andrew, Chief Provincial Psychiatrist, Province of Manitoba (November, 1998).

[45]Manitoba Medical Association Ethics Committee (December, 1998).

[46]Deer Lodge Centre (November, 1998).

determination of a need for medical assistance, and to signatures to release information, waive confidentiality, and sign financial papers.[47] One suggested incorporating guidance on issues relating to confidentiality, legal rights, and personal privacy.[48] Another recommended the provision of brochures that are system-specific, dealing with issues such as health care, banking, and legal documents.[49]

I. LEGISLATION VERSUS EDUCATION

9. Is your profession or workplace looking for legislation or simply education in the area of competence assessment?

This question provoked a considerable amount of discussion by respondents. The majority generally preferred education to legislation, but the variety of responses is noteworthy. One respondent did recommend legislation, albeit in conjunction with education, as the most effective method of protecting those who administer informal assessments or refer for more formal assessments.[50] Another expressed a preference for education, but was concerned that without legislation it may not be possible to provide immunity to persons acting in good faith in conducting an informal assessment.[51] Another suggested an education program, followed by an assessment of its effectiveness, before considering legislation.[52]

Other respondents suggested that education is more likely than legislation to succeed in clarifying appropriate methods and increasing consistency,[53] that the enactment of legislation may encumber a process that has not to date presented substantial difficulties,[54] and that legislation would be more detrimental than helpful.[55]

> Legislation may serve to substitute one set of problems for another. For example, formalized structured guidelines may threaten the competing need for flexibility and choice. This is a significant threat since most, if not all, distinct intervention by a service

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[47]Family Dispute Services, Province of Manitoba. (November, 1998).

[48]Dr. H.G. Andrew, Chief Provincial Ppsychiatrist, Province of Manitoba (November, 1998).

[49]Social Work Department, Health Sciences Centre (November, 1998).

[50]Family Dispute Services, Province of Manitoba (November, 1998).

[51]Dr. H.G. Andrew, Chief Provincial Psychiatrist, Province of Manitoba (November, 1998).

[52]Fred Douglas Society Inc. (November, 1998).

[53]Extendicare (Canada) Inc. (November, 1998).

[54]Riverview Health Centre (November, 1998).

[55]Ethics Committee, Bethania Mennonite Personal Care Home (November, 1998).

provider necessarily requires some degree of innovation and uniqueness.

> Legislation may actually reinforce existing fear of malpractice - thus promoting the misuse of assessment tools. Further, legislation regarding competency assessment would be difficult, time consuming and costly.[56]

Two respondents did note that existing legislation is inadequate, in that it fails to recognize the possibility that incompetence may be decision- or task-specific.[57] One recommended three statutes that may provide guidance in this area: Alberta's *Dependent Adult Act*, Ontario's *Health Care Consent Act*, and Manitoba's *Vulnerable Persons Living with a Mental Disability Act*, the last of which could be extended to apply to persons who are found to be mentally disabled after the age of 18.[58] Another respondent suggested amending *The Mental Health Act* to provide for time-limited Orders of Supervision, which would be of assistance in circumstances where a person is expected to regain competence, as, for example, in cases of head injury.[59]

One respondent suggested that family physicians be provided with additional education and information, to assist them in making decisions in this area.[60] Another respondent recommended formal education by speech-language pathology and audiology professionals about communication disorders.[61]

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[56]Alzheimer Society (November, 1998).

[57]Salvation Army Golden West Centennial Lodge (December, 1998); Deer Lodge Centr (November, 1998). This issue is discussed above at p. 6.

[58]Salvation Army Golden West Centennial Lodge (December, 1998); the Alzheimer Society (November, 1998) echoed the last of these recommendations.

[59]Social Work Department, Health Sciences Centre (November, 1998).

[60]Manitoba Association of Gerontology (November, 1998).

[61]The Manitoba Speech and Hearing Association (February 1999).

J. GOOD FAITH IMMUNITY EXCEPTION

10. If legislation is favoured, should a provision be included to grant immunity to persons acting in good faith when conducting an informal assessment?

This question elicited few responses, but most of those provided were in favour of an immunity-granting provision. One respondent went so far as to say that if legislation is favoured, immunity *must* be granted to those acting in good faith, and only clear evidence of a lack of good faith should result in legal liability.[62]

One respondent, however, suggested that immunity was unnecessary:

> Provided the screener is acting in good faith and as a reasonable person, no immunity should be necessary. In fact, if a protection of immunity is given, it may be sufficient to convince an unscrupulous person who is in a conflict of interest situation to act inappropriately.[63]

Another suggested that, at least in the field of health care, adequate mechanisms already exist.[64]

Another respondent felt that immunity was advisable, but that before the protection of the legislation would apply, specific triggers would have to be present and documented.[65]

K. CONCLUSION

The responses received indicate that there is a strong demand for education and assistance on the topic of informal competence assessment. The vast majority of respondents are of the view that the government should provide guidelines, training, and informational materials to assist health care workers, and the public in general, in dealing appropriately with persons whose competence appears to be questionable.

The following Chapter sets out the Commission's recommendations, which flow in large part from these responses to the Discussion Paper.

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[62]Manitoba Association of Gerontology (November, 1998).

[63]Deer Lodge Centre (November, 1998).

[64]Extendicare (Canada) Inc. (November, 1998).

[65]Social Work Department, Health Sciences Centre (November, 1998).

CHAPTER 7

AN INFORMAL COMPETENCE ASSESSMENT PROCESS

There are many ways to assess the competence of individuals who may have some appearances of mental incapacity, several of which methods have been examined by the Commission. As it is unlikely that one particular form will be universally suitable for all of the differing circumstances in which questions of competence may arise, this Chapter will focus on a discussion of the possible structure of a general assessment of mental competence. It will also set out the Commission's recommendations, based in large part on the responses to the Discussion Paper.

A. PURPOSE

As indicated in previous chapters, while a person's level of competence is judged daily in a variety of situations, there is no common standard against which the level of competence is judged. When considering the potential seriousness of the consequences arising from such assessments, the introduction of "shared criteria for the various competencies would help to ensure shared standards of practice."[1] The Commission shares this view and supports the creation of a set of guidelines that would be applicable to most circumstances in which questions of competence arise. As a matter of public and private concern, the standardization of competence assessment would address the problem of substantive differences among current methods of assessment, even amongst persons in the same field of expertise, and provide direction and methodology to a vague area of the law.

By providing one basic technique to determine the required level of competence, a standardized assessment would accomplish a number of goals not met under the present system.

First, those who are required to determine competence levels on a day-to-day basis would have an established guide. Many such persons do not possess any training in psychiatric assessment, yet must decide whether to accept the decisions made by members of the populace. For example, the bank teller asked to withdraw large sums of money may wonder whether the customer truly understands the consequences of the decision being made, but has no way of determining the customer's level of comprehension.

Second, the provision of competence guidelines would also help to ensure that the civil rights of persons subject to such determinations would be adequately protected. Currently, such

[1]D. Checkland and M. Silberfield, "Competence and the Three A's: Autonomy, Authenticity, and Aging" (1993), 12 Can. J. Aging 453 at 455.

testing is often arbitrary in nature: there is, in fact, no uniform system for informally testing competence. The courts, professional codes of ethics, and societal norms combine to establish tests that vary from circumstance to circumstance, yet there is no basic informal method to determine whether people are competent to make decisions. This is not to say that the *level* of competence is the same regardless of the decision to be made – quite the contrary. Any guidelines to be put in place must not only be mindful of the right to autonomy and the right to protection, but also of the sliding scale of competence.

One of the respondents to the Discussion Paper recommended describing the process as a "screening" rather than an "informal assessment":

> A screening process identifies individuals at risk for a given condition without attempting a definitive diagnosis. This appears to be the main issue of concern in the discussion paper and is sufficiently removed from the term "formal assessment of competence" so as not to confuse people as to the nature of the investigation.[2]

While the Commission concurs that a screening process is what is intended by the "informal assessment" recommended in this Report, it will nevertheless continue to refer to this preliminary process as an informal assessment, as this appears to be the practice in the relevant literature.

RECOMMENDATION 1

Manitoba should adopt guidelines to assist those who are required to determine competence levels on a regular basis.

RECOMMENDATION 2

The guidelines should be made available, in the form of an educational kit, to everyone who may need them.

RECOMMENDATION 3

The guidelines should provide guidance on when duties of confidentiality may be overridden in special circumstances.

B. A COMMON LEGAL STANDARD

It is clear that current standards of competence, as developed through the common law and existing statutes, adhere to the ideal of testing competence with respect to the specific task in question. However, as discussed, consistency is the key to protecting not only the assessor, but

[2]Response to Discussion Paper from the Riverview Health Centre (November, 1998).

also the civil rights of the subject of any informal competence test. Accordingly, the Commission advocates the implementation of a single set of guidelines that recognizes that the threshold of competence will vary according to the decision to be made.[3]

The Commission is of the opinion that the rigid application of guidelines is to be avoided: it is not possible to introduce narrow guidelines for the determination of competence, to be widely applicable, when the current legal climate favours transaction-specific standards, as such a recommendation would result in over-inclusive testing.

In addition to the examples discussed in Chapter 3, the literature has identified several others in which competence is task-specific. These include the ability to choose a place of residence, retain and instruct counsel, make personal care decisions, and testify.[4] The threshold of competence is different in each situation and any test should allow for these and similar variations.

RECOMMENDATION 4

The guidelines should reflect the fact that standards of competence vary from situation to situation, and that only capacity to perform a specific task, or make a specific decision, need be present.

1. Triggering an Assessment

Prior to initiating a determination of competence, there must be something that precipitates an assessment, and testing should only be done if both a "trigger" and the need to test are present. The assessment should not be conducted unless both steps, the trigger and the need to test, indicate that it should be.

A "trigger" is an event that precipitates a challenge of competence. A valid trigger must be *prima facie* evidence strongly suggesting incompetence, *and* represent a real risk of significant harm to either (a) the person; or (b) property.[5] In other words, it is not simply enough to suspect that a person may be incompetent – there must be some actual danger arising from that suspicion.

For example, testing the capacity of a banking customer is not justified if the only result of the incompetence would be the deposit of monies into a savings account instead of a chequing

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[3]Checkland and Silberfield, *supra* n. 1, at 455.

[4]M. Silberfeld, D. Stevens, S. Lieff, D. Checkland, and K. Madigan, "Legal Standards and the Threshold of Competence" (1993), 14 Advocates' Quarterly 482.

[5]D.W. Molloy, "Capacity Assessment: To What Standard and By Whom?" (address to the Canadian Bar Association - Ontario, 21 October 1994) [unpublished].

account; there is no real risk of significant harm. However, if the transaction involves the withdrawal of all the savings of a previously frugal client, and the client appears to be confused or disoriented, an informal assessment may be called for. Thus, if the trigger requirement is sufficiently fulfilled, the first step is complete.

RECOMMENDATION 5

The guidelines should only permit testing if there is a demonstrated "trigger".

2. Need to Test

The need for assessment must then be determined by asking:

1. Would this person benefit from intervention?; and
2. Is the proposed intervention the least restrictive alternative?[6]

Simply put, the justification for competence assessment does not exist unless some benefit will arise from such testing. A bank teller should only initiate a test if the customer can be assisted by the intervention of the bank, and if that intervention will intrude on the subject's rights less than any other reasonable alternative. Only after these two elements of the "need to test" step are satisfied should the competence assessment be initiated.

RECOMMENDATION 6

The guidelines should only permit testing if the subject will benefit from intervention, and if such intervention would be the least restrictive alternative.

3. Choosing the Standard of Competence - The Sliding Scale

Once a decision is made to conduct an informal assessment, the assessor must employ the appropriate standard of competence for the specific circumstances. A sliding scale of three standards of competence has been suggested, specifically in the context of medical procedures and treatment. The choice of which standard to use is dependent on the seriousness of the consequences of the decision to be made: low, mid, and high level.[7]

Low level consequences are present where the decision is not dangerous and is

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[6] *Id.*

[7] J. F. Drane, "Competency to Give an Informed Consent: A Model for Making Clinical Assessments" (1984), 252 JAMA 925 at 926-927.

objectively in the subject's best interests.[8] The level of competence required in the face of such consequences is simply the ability to assent to what is considered to be the rational expectation. As long as the subject is aware of what is happening, they are viewed as informed and capable of making the decision.

Mid-level consequences occur where the condition is ongoing, and the proposed solution is either dangerous or of a less definite benefit.[9] The subject must understand the risks and outcomes of the different options, and choose a course of action based on this understanding. It is the "capacity for an understanding choice"[10] which is of paramount importance: the ability to articulate the understanding verbally is not relevant unless there is no other way to determine this capacity.

High level consequences arise where the decision to be made is dangerous, and the actual decision may objectively be considered irrational.[11] In this case, the capacity to appreciate the nature and consequences of the decision is required: the subject must be able to reason and demonstrate the thought processes that resulted in the decision.

RECOMMENDATION 7

The guidelines should set out options as to the appropriate standard of competence to be demonstrated in any given situation.

4. Testing for Competence: A Variety of Tests

Once the standard of competence has been chosen, the testing must begin. The Commission has considered five categories of tests introduced by Roth, Meisel, and Lidz: evidencing a choice, reasonable outcome of choice, choice based on rational reasons, ability to understand and actual understanding.[12] A brief explanation of each test follows, and we conclude with a proposal for a general assessment technique.

The evaluation that requires only the evidencing of a choice maintains that the competent person is one who evidences a preference for or against something. What is important is the presence or absence of a decision. While very respectful of the autonomy of the subject, this is only low-level testing, suitable for very few decisions.

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[8] *Id.* at 926.

[9] Drane, *supra* n. 7, at 926.

[10] Drane, *supra* n. 7, at 926.

[11] Drane, *supra* n. 7, at 927.

[12] L.H. Roth, A. Meisel and C.W. Lidz, "Tests of Competency to Consent to Treatment" (1977), 134 Am. J. Psychiatry 279 at 280-282.

An evaluation of a person's capacity to reach the reasonable decision comprises the test of reasonable outcome of choice. Emphasis is placed on the result of the decision, and not on how that decision has been reached. In this case, personal autonomy suffers while social goals and individual protection benefit.

If the decision is due to or is a product of mental illness, it is considered to be a choice not based on rational reasons. Such a test examines the quality of the subject's thinking. While clinicians may rely upon such a determination, this is not a good legal test. It is far too difficult to distinguish what may be considered *irrational* reasons from *rational* reasons, and whether in fact mental illness has any effect on the rationality of a task-specific decision.

The test requiring actual understanding is extremely difficult to satisfy. There is an obligation on the assessor to educate the subject, and to directly ascertain whether the subject has achieved understanding. Not only is a very high level of competence required, but it is difficult to determine what is "adequate" understanding, and how much impact the assessor's behaviour has on the subject's comprehension level.

Finally, the determination of competence can be based on the subject's ability to understand the risks, benefits, and available alternatives. The subject must demonstrate understanding of the elements that the law has determined are critical to decision making. It does not matter how the subject uses these elements. Not as demanding as the requirement for actual understanding, but flexible enough to apply to almost every decision, this test of *ability to understand* has the greatest appeal to the Commission as the logical choice for a general assessment of competence. This test best accords with the goals of informal competence assessment.

RECOMMENDATION 8

The guidelines should be directed to enabling the assessor to determine the subject's ability to understand the relevant risks and benefits, and available alternatives.

5. Testing for Competence

The test of ability to understand consists of several specific subtests. For a subject to demonstrate an ability to understand, and thus be considered competent, in the context of a particular setting, he or she must:

1. Be able to receive and appreciate information necessary for making a decision, and about the issues that must be decided;
2. Be willing to make a decision;
3. Be able in some way to communicate (or implement) the decision;
4. Be able to manipulate the information in some way to produce the decision. This

requires:

a. Memory sufficient to retain relevant information long enough to make a decision;
b. The ability to assess or recognize facts (not opinions), and in some instances, the ability to obtain factual data independently;
c. The ability for functional logic.[13]

These different steps are discussed in greater detail below.

Step 1

Be able to receive and appreciate information necessary for making a decision, and about the issues that must be decided.

The person must know that there is a decision to be made, and must be able to tell the assessor what that decision is. For example, the bank customer who wants to deposit money in her or his account must understand and appreciate the teller's question as to which account the deposit is to go into.

Step 2

Be willing to make a decision.

The person must want to make the decision. If someone is more than indecisive, and he or she actually refuses to make a choice, this could be an indication of lack of understanding of that decision. To revisit the banking scenario, if the customer is asked to choose between depositing into their chequing or savings accounts, and refuses to make that simple choice, the teller may be alerted to potential incompetence to make that transaction.

Step 3

Be able in some way to communicate (or implement) the decision.

Any type of communication (written, oral, or non-verbal) may be used, as long as the person is able to convey their ideas, or carry out the decision. Disability is *not* an indication of incompetence: as long as a person can indicate their choice in some form, the decision has been communicated. If the banking customer is unable to speak or write, body language must suffice to indicate choice. However, a customer who simply nods in response to all questions may be exhibiting behaviour that suggests incompetence.

Step 4

[13]S.R. Smith and R.G. Meyer, *Law, Behavior, and Mental Health: Policy and Practice* (1987) 661.

Be able to manipulate the information in some way to produce the decision.

This is where the assessor will determine the level of mental processing that the subject is capable of. It is very important to remember that a decision is not "irrational" simply because it is not in keeping with, or contradicts, generally held opinions or beliefs. For example, if a customer chooses to remove all of their money from their banking institution based on the belief that all bankers are corrupt, this is not sufficient evidence to prove incompetence. There must be something more to justify removing the right to make decisions about his or her financial affairs from that customer.

The following steps are subsets of the manipulation requirement:

Step 4a

Memory sufficient to retain relevant information long enough to make a decision.

This ability is directly related to the type of decision to be made. The memory required for one task will be greater or smaller than that required for another task. The banking customer who makes a simple deposit will only need to remember a small number of details, whereas the person who wishes to request a loan from their financial institution must be capable of remembering a relatively large quantity of information.

Step 4b

The ability to assess or recognize facts (not opinions), and in some instances, the ability to obtain factual data independently.

Smith and Meyer define "facts" as belonging to three different categories:

1. Those facts completely indisputable and established beyond all question. An example is the existence of gravity. The failure to accept these facts may be the basis for determining someone's incompetence if material to the decision making in question.
2. Those facts generally accepted as true, but not *absolutes*. For example, it is generally recognized that it is healthy to eat a balanced diet. Someone may reject the benefits of one food group and still be considered competent, provided he is able to recognize that he is rejecting a fact generally accepted by most people.
3. Matters about which reasonable people may disagree. These are not facts at all, although they are sometimes incorrectly labeled as such. They often contain an element of opinion, belief, or prediction about the future. Examples of these "facts" are that IBM is currently a good investment or that saccharin causes cancer. The rejection of such "facts," of course, does not mean that someone is

incompetent.[14]

It is of paramount importance that the assessor recognizes these different categories of "fact", and does not allow their own version of the facts to be clouded by opinion.

Step 4c

The ability for functional logic.

This is the ability "to engage in basic reasoning processes."[15] An assessor must focus on whether the subject is *able* to look at a situation critically and come to a reasoned conclusion, and not whether the actual decision is logical. People have different beliefs, value systems, and emotions, and the process of making a decision will necessarily involve all of these factors. A subject should have the right to reject the "logical" course, as long as the ability to engage in functional logic is present.

RECOMMENDATION 9

The guidelines should reflect the fact that a subject may be considered competent within a task-specific setting, if he or she is:

(a) able to receive and appreciate information necessary for making a decision, and about the issues that must be decided;
(b) willing to make a decision;
(c) able in some way to communicate (or implement) the decision; and
(d) able to manipulate the information in some way to produce the decision.

C. TESTING FORMAT

When formal assessments are conducted, they are often done in environments designed specifically for that purpose. A psychiatrist examining a patient will do so in the psychiatrist's office, which is organized and designed specifically for such purposes. Assessors who conduct informal assessments rarely have the luxury of purpose-designed surroundings. Questions of competence arise in a myriad of situations, making it unrealistic to require assessors to adhere to one single format. In cases where formality is not necessary, the Commission proposes assessment through a semi-structured interview in which questions are directed to the subject.

It is important that several practical issues be addressed during the interview. The test must be done in a quiet, and preferably private, setting where the assessor is relaxed and

[14]*Id.*, at 662.

[15]Smith and Meyer, *supra* n. 13, at 663.

comfortable with the testing procedures and materials.[16] Ideally, the subject of the test should be seated and comfortable. As well, testing should be done by those educated in the testing procedures, not by laypersons without any applicable training.

The Commission raised in the Discussion Paper the question of whether or not the subject should be informed that his or her competence was being assessed. The only respondent who specifically discussed this issue suggested that *not* informing the subject could have serious liability implications for the assessor.[17] (See page 33 for a discussion of this issue.) The Commission agrees that, as a general rule, informal assessments ought to be conducted only with the knowledge of the person being assessed.

RECOMMENDATION 10

The guidelines should not permit informal assessments to be conducted unless the subject of the assessment is aware of the assessment process.

D. TRAINING REQUIREMENTS

Proper training of assessors is absolutely essential to ensure the fair and appropriate application of any competence evaluation. It is recommended that any profession, workplace, or field of expertise in which persons may be required to assess the competence of people with whom they interact initiate educational programs outlining the application of the guidelines that the Commission has recommended. It is also worth noting that when an unskilled or untrained person assesses another's competence, the latter's autonomy may be threatened.[18]

RECOMMENDATION 11

Organizations whose employees may reasonably be expected to be in a position to informally assess others' mental capacity should be required to provide for appropriate training of those employees.

1. Misapplication of Standards

The misapplication of existing standards presents a problem. Misapplication occurs when the assessor either chooses to deviate from the standards or is unable to adhere to the standards due to their vagueness or the assessor's lack of comprehension. While this issue may be addressed in part by the introduction of a single set of guidelines, people who are required to

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[16]M.J. Lucas, "Assessment of Mental Status" in C. Eliopoulos, *Health Assessment of the Older Adult* (2nd ed., 1990) 207.

[17]Response to Discussion Paper from Foyer Valade (December, 1998).

[18]Response to Discussion Paper from The Manitoba Speech and Hearing Association (February, 1999).

make determinations according to any manual must be instructed in the proper application of those guidelines. Even the most precise theory will not be fully understood until its practical application is demonstrated.

RECOMMENDATION 12

Use of the informal assessment procedure should be restricted to those who have undergone formal training in its use.

2. Communication Issues

One of the respondents to the Discussion Paper noted that Manitobans with communication disorders represent a particular challenge to assessors:[19]

> Competence can be viewed along a continuum related to communication. At one end of the spectrum may be an individual who *appears to be incompetent* but can demonstrate competence if the communicative partner understands how to facilitate the person's communication. At the other end of the spectrum may be a person who *appears to be competent* to make a decision, but has comprehension difficulties that are [masked] by good communication skills.

Clearly, assessors must be trained to recognize and allow for communication disorders, and comprehension difficulties masked by good communication skills, that might negatively affect the accuracy of an assessment.

RECOMMENDATION 13

Any training regime should include training in the recognition of, and dealing with, communication disorders.

[19]Response to Discussion Paper from The Manitoba Speech and Hearing Association (February, 1999).

3. Vulnerable Groups

Another respondent noted[20] that although the focus of much of the discussion of competence is the elderly, other vulnerable groups exist. These include, for example, those with mental disabilities, head injuries, or fetal alcohol syndrome. It is these groups who are most likely to be the subjects of informal competence assessment, and whatever testing regime is eventually adopted must treat all such groups consistently.

RECOMMENDATION 14

Any informal test of competence should be drafted so as to be equally applicable to all vulnerable groups who may be subject to such tests.

4. Cultural Issues

Two respondents[21] identified a further issue: that of the applicability of any specific test to persons whose first language differs from the language in which the assessment is conducted. Language difficulties may easily be misinterpreted as a lack of competence, and the informal assessment test should be sensitive to this fact and applicable across languages and cultures.

RECOMMENDATION 15

Whatever test is eventually adopted should be sensitive to the needs of persons whose first language differs from the language in which the test is conducted.

5. Neutrality

Neutrality of the assessor is absolutely essential to an accurate assessment of competence. The "formulation of decision-making capacity focuses upon the ability to exercise certain mental skills. It specifically avoids judging beliefs, values, preferences, feelings, and emotions."[22] A biased assessor will taint the results of any test, especially where the procedures rely heavily on the personal and technical judgment of that assessor.

One respondent suggested[23] that serious consideration must be given to the nature of the

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[20]Response to Discussion Paper from Association for Community Living - Manitoba (December, 1998).

[21]Responses to Discussion Paper from The Manitoba Speech and Hearing Association (February, 1999) and Foyer Valade (December 1998).

[22]Smith and Meyer, *supra* n. 13, at 663.

[23]Respone to Discussion Paper from Riverview Health Centre (November, 1998).

relationship between the assessor and the client. If the assessor is someone who has an ongoing relationship with the client, he or she may be placed in a conflict of interest when assessing the client's competence, and as a result may lack the neutrality necessary to make an objective determination of competence.

Anyone conducting informal competence assessments must learn to be aware of and subsequently overcome any biases that may affect the outcome of the assessment. In situations where a potential bias is identified, arrangements must be made to have the assessment conducted by a properly qualified person who will not be biased.

RECOMMENDATION 16

Any training regime should enable assessors to recognize, and deal appropriately with, their own potential biases.

6. Legal Consequences

As with any testing procedure, those responsible for administering informal competence assessments must be educated in not only testing procedures, but also the potential consequences. As outlined in Chapter 5, the legal ramifications of informal testing can be widespread and serious, both for the assessor and for the subject. Informing assessors of these potential consequences will benefit both parties to the assessment.

RECOMMENDATION 17

Any training regime should inform assessors of the potential legal consequences of conducting, or failing to conduct, an informal assessment.

As noted at page 52 above, most respondents to the Discussion Paper favoured granting immunity to persons acting in good faith when conducting an informal assessment. Although the Commission does not recommend the creation of legislation to deal with the issue of informal assessments of competence, it is convinced that this type of immunity ought to be embodied in statutory form. As *The Mental Health Act* presently deals with *formal* assessments of competence, the Commission considers that it would be most appropriate to include an immunity provision in that Act.

RECOMMENDATION 18

The Mental Health Act ***should be amended to provide that persons conducting an informal assessment of competence, in good faith and in accordance with the guidelines recommended in this Report, be immune from any civil suit arising out of***

the conduct of that assessment.

7. Availability

Devising a standard test for informal competence assessments and a training program to accompany it will be of little assistance if those in need of the training do not receive it. As was pointed out by one respondent:[24]

> Banks and financial institutions may be able to distribute such a test and train individuals through their organizations. There will always be individuals, however, who are more isolated or who do not have a large structured organization behind them to provide them with the tools and training available. For example, caretakers in apartment buildings are often called upon to make a preliminary assessment as to whether a tenant has the capacity to continue to live alone, or whether he/she is merely eccentric.

It will be necessary to consider how a standard test will be disseminated, and how those who will be administering it will be trained to do so. This issue is important, because the illusory protection of individual rights can be more dangerous than a complete lack of protection. Individuals who mistakenly believe their rights to be protected are more vulnerable to infringements of those rights.

RECOMMENDATION 19

Appropriate methods of disseminating the guidelines, and training assessors, should be developed.

8. Ongoing Monitoring

Once a training regime has been established and implemented, it will be necessary continually to monitor the expertise of the people who have been trained to administer the informal assessments. Ongoing training and monitoring of expertise are generally recognized as important components of most professions in contemporary society. Without them, standards are inevitably susceptible to erosion, and the benefits of introducing guidelines and training will eventually be lost, to the detriment of the vulnerable groups identified in this Report.

RECOMMENDATION 20

An adequate method of monitoring assessors' expertise and abilities should be established, along with ongoing refresher training where required.

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[24]Response to Discussion Paper from the Office of the Public Trustee, Province of Manitoba (December, 1998).

E. ADVISORY PANEL

Although the Commission lacks the requisite expertise to design or recommend a specific test for use by those conducting informal assessments, it is convinced that the preparation and/or dissemination of such a test by an officially accredited body would be of immense assistance to those faced with the difficult task of informally assessing competence.

Several respondents to the Discussion Paper indicated that they currently administer the "MiniMental State" test when screening for competence. The version of that test appended to "'Mini-Mental State': A Practical Method for Grading the Cognitive State of Patients for the Clinician"[25] (which appears as Appendix A to this Report) is an example of a test that might be recommended or adapted for use in the context of informal competence assessment.

The Commission is of the opinion that the most appropriate body to adopt or adapt a screening test for informal competence assessment would be an independent body of qualified professionals, similar in concept to the Advisory Committee that assisted the Commission in the preparation of the Discussion Paper. Such a body could review existing tests and either recommend one for adoption, or draft its own designed for use in the kind of situations the Commission has identified. The advisory panel might include physicians, psychiatrists, psychologists, ethicists, lawyers, pastoral service providers, speech pathologists and audiologists, and/or social workers.

In addition to developing the test, the advisory panel should be asked to undertake, or assist in, implementing some of the Commission's other recommendations. It would be appropriate, for example, for that body to develop the guidelines, formal training program, and series of brochures that the Commission has recommended.

RECOMMENDATION 21

An advisory panel of experts and interested parties should be established to:

(a) recommend a screening test for use in informal assessments;
(b) develop the recommended guidelines;
(c) design a formal training program; and
(d) develop a series of informational brochures.

F. CONCLUSION

The responses to the Commission's Discussion Paper have made it clear that guidelines, training, and pertinent information would be welcomed by assessors and subjects of assessments alike. The Commission is persuaded that there is a need for guidelines to assist in the informal

[25] M.F. Folstein, S.E. Folstein, and P.R. McHugh, "'Mini-mental State': A Practical Method for Grading the Cognitive State of Patients for the Clinician, (1975) 12 J. Psychiat. Res. 189.

assessment of competence. While the necessity of conducting informal assessments of competence presents itself in many different situations, on a daily basis, such assessments are frequently carried out by people who have little or no training and guidance. The rights of people who are subject to such assessments are continually in danger of being infringed, and assessors are often at risk of liability for infringing those rights.

For these reasons the Commission recommends the establishment without undue delay of an Advisory Panel, an obvious and necessary first step in dealing with issues around the informal assessment of competence. The balance of the Commission's recommendations will, it is hoped, assist the Panel in addressing the most difficult issues that it will face.

CHAPTER 8

LIST OF RECOMMENDATIONS

The following are the recommendations contained in this Report.

1. Manitoba should adopt guidelines to assist those who are required to determine competence levels on a regular basis. (p. 54)

2. The guidelines should be made available, in the form of an educational kit, to everyone who may need them. (p. 54)

3. The guidelines should provide guidance on when duties of confidentiality may be overridden in special circumstances. (p. 54)

4. The guidelines should reflect the fact that standards of competence vary from situation to situation, and that only capacity to perform a specific task, or make a specific decision, need be present.(p. 55)

5. The guidelines should only permit testing if there is a demonstrated "trigger". (p. 56)

6. The guidelines should only permit testing if the subject will benefit from intervention, and if such intervention would be the least restrictive alternative. (p. 56)

7. The guidelines should set out options as to the appropriate standard of competence to be demonstrated in any given situation. (p. 57)

8. The guidelines should be directed to enabling the assessor to determine the subject's ability to understand the relevant risks and benefits, and available alternatives. (p. 58)

9. The guidelines should reflect the fact that a subject may be considered competent within a task-specific setting, if he or she is:

   (a) able to receive and appreciate information necessary for making a decision, and about the issues that must be decided;
   (b) willing to make a decision;
   (c) able in some way to communicate (or implement) the decision; and
   (d) able to manipulate the information in some way to produce the decision. (p. 61)

10. The guidelines should not permit informal assessments to be conducted unless the subject of the

assessment is aware of the assessment process. (p. 62)

11. Organizations whose employees may reasonably be expected to be in a position to informally assess others' mental capacity should be required to provide for appropriate training of those employees. (p. 62)

12. Use of the informal assessment procedure should be restricted to those who have undergone formal training in its use. (p. 63)

13. Any training regime should include training in the recognition of, and dealing with, communication disorders. (p. 63)

14. Any informal test of competence should be drafted so as to be equally applicable to all vulnerable groups who may be subject to such tests. (p. 64)

15. Whatever test is eventually adopted should be sensitive to the needs of persons whose first language differs from the language in which the test is conducted. (p. 64)

16. Any training regime should enable assessors to recognize, and deal appropriately with, their own potential biases. (p. 65)

17. Any training regime should inform assessors of the potential legal consequences of conducting, or failing to conduct, an informal assessment. (p. 65)

18. *The Mental Health Act* should be amended to provide that persons conducting an informal assessment of competence, in good faith and in accordance with the guidelines recommended in this Report, be immune from any civil suit arising out of the conduct of that assessment. (p. 66)

19. Appropriate methods of disseminating the guidelines, and training assessors, should be developed. (p. 66)

20. An adequate method of monitoring assessors' expertise and abilities should be established, along with ongoing refresher training where required. (p. 67)

21. An advisory panel of experts and interested parties should be established to:
    (a) recommend a screening test for use in informal assessments;
    (b) develop the recommended guidelines;
    (c) design a formal training program; and
    (d) develop a series of informational brochures. (p. 67)

This is a Report pursuant to section 15 of *The Law Reform Commission Act*, C.C.S.M. c. L95, signed this 8th day of September 1999.

Clifford H.C. Edwards, President

John C. Irvine, Commissioner

Gerald O. Jewers, Commissioner

Eleanor R. Dawson, Commissioner

Pearl K. McGonigal, Commissioner

APPENDIX A

THE 'MINI-MENTAL STATE' TEST[1]

Patient.....
Examiner.....
Date.....

"MINI-MENTAL STATE"

Maximum Score	Score	
		ORIENTATION
5	( )	What is the (year) (season) (date) (day) (month)?
5	( )	Where are we: (state) (county) (town) (hospital) (floor).
		REGISTRATION
3	( )	Name 3 objects: 1 second to say each. Then ask the patient after you have said them. Give 1 point for each correct answer. Then repeat them until he learns all 3. Count trials and record. Trials
		ATTENTION AND CALCULATION
5	( )	Serial 7's. 1 point for each correct. Stop after 5 answers. Alternatively spell "world" backwards.
		RECALL
3	( )	Ask for the 3 objects repeated above. Give 1 point for each correct.
		LANGUAGE
9	( )	Name a pencil, and watch (2 points) Repeat the following "No ifs, ands or buts." (1 point) Follow a 3-stage command: "Take a paper in your right hand, fold it in half, and put it on the floor" (3 points) Read and obey the following: CLOSE YOUR EYES (1 point)

[1]M.F. Folstein, S.E. Folstein and P.R. McHugh, "'Mini-mental State': A Practical Method for Grading the Cognitive State of Patients for the Clinician", (1975) 12 J. Psychiat. Res. 189 at 196 *et seq.*

Write a sentence (1 point)
Copy design (1 point)
_____ Total score

ASSESS level of consciousness along a continuum_____
Alert Drowsy Stupor Coma

INSTRUCTIONS FOR ADMINISTRATION OF
MINI-MENTAL STATE EXAMINATION

ORIENTATION

(1) Ask for the date. Then ask specifically for parts omitted, e.g., "Can you also tell me what season it is?" One point for each correct.

(2) Ask in turn "Can you tell me the name of this hospital?" (town, county, etc.). One point for each correct.

REGISTRATION

Ask the patient if you may test his memory. Then say the names of 3 unrelated objects, clearly and slowly, about one second for each. After you have said all 3, ask him to repeat them. This first repetition determines his score (0-3) but keep saying them until he can repeat all 3, up to 6 trials. If he does not eventually learn all 3, recall cannot be meaningfully tested.

ATTENTION AND CALCULATION

Ask the patient to begin with 100 and count backwards by 7. Stop after 5 subtractions (93, 86, 79, 72, 65). Score the total number of correct answers.

If the patient cannot or will not perform this task, ask him to spell the word "world" backwards. The score is the number of letters in correct order. E.g. dlrow = 5, dlorw = 3.

RECALL

Ask the patient if he can recall the 3 words you previously asked him to remember. Score 0-3.

LANGUAGE

Naming: Show the patient a wrist watch and ask him what it is. Repeat for pencil. Score 0-2.

Repetition: Ask the patient to repeat the sentence after you. Allow only one trial. Score 0 or 1.

3-Stage command: Give the patient a piece of plain blank paper and repeat the command. Score 1 point for each part correctly executed.

Reading: On a blank piece of paper print the sentence “Close your eyes”, in letters large enough for the patient to see clearly. Ask him to read it and do what it says. Score 1 point only if he actually closes his eyes.

Writing: Give the patient a blank piece of paper and ask him to write a sentence for you. Do not dictate a sentence, it is to be written spontaneously. It must contain a subject and verb and be sensible. Correct grammar and punctuation are not necessary.

Copying: On a clean piece of paper, draw intersecting pentagons, each side about 1 in., And ask him to copy it exactly as it is. All 10 angles must be present and 2 must intersect to score 1 point. Tremor and rotation are ignored.

Estimate the patient’s level of sensorium along a continuum, from alert on the left to coma on the right.

APPENDIX B

LIST OF PERSONS/ORGANIZATIONS WHO RESPONDED TO THE DISCUSSION PAPER ON *INFORMAL ASSESSMENT OF COMPETENCE*

Gerontological Social Work Interest Group, Deer Lodge Centre
Family Dispute Services, Department of Family Services, Manitoba
Extendicare (Canada) Inc., Edmonton, AB
Helen Godkin, Morris, MB
Community and Mental Health, Public & Mental Health Services, Brandon, MB
Ethics Committee, Bethania Mennonite Personal Care Home
Deer Lodge Centre
Manitoba Naturopathic Association
Policy & Procedures Committee, Manitoba Association on Gerontology
Fred Douglas Society Inc.
Alzheimer Society
Dr. Hugh Andrew, Director of Psychiatric Services, Chief Provincial Psychiatrist, Manitoba
Riverview Health Centre
Manitoba Society of Occupational Therapists
Foyer Valade
Public Trustee of Manitoba
Social Work Department, Health Sciences Centre
Occupational Therapists, Geriatric Services, St. Boniface General Hospital
Ethics Committee, Salvation Army Golden West Centennial Lodge
Ethics Committee, Manitoba Medical Association
Association for Community Living - Manitoba
The Manitoba Speech and Hearing Association
Harvey Bostrom, Native Affairs Secretariat, Department of Northern Affairs, Manitoba

PERSONS TO WHOM COPIES OF THE DISCUSSION PAPER WERE DISTRIBUTED

Advisory Committee

Dr. Hugh Andrew - Chief Provincial Psychiatrist, Manitoba Health
Irene Hamilton, Q.C. - Public Trustee of Manitoba
Dr. David Murray - Medical Director, Deer Lodge Centre
Joan Drodoski - Program Director, Alzheimer Society of Manitoba
Linda Beaupre, c/o Ethics Committee, Golden West Centennial Lodge
Patricia G. Ritchie, Q.C. - Barrister and Solicitor

Annie Markman-Anderson - Manager, Operations Support, Royal Bank of Canada
Jeffrey A. Schnoor, Q.C. - Director, Criminal Justic Policy Branch

Iris C. Allen - Former Legal Counsel, Manitoba Law Reform Commission

Cabinet Members

Hon. Gary Filmon - Premier
Hon. Vic Toews, Q.C.- Minister of Justice & Attorney General
Hon. Harry Enns - Minister of Agriculture
Hon. James Downey - Deputy Premier
Hon. James Cummings - Minister of Natural Resources
Hon. James McCrae - Minister of Environment
Hon. Glen Findlay - Minister of Highways and Transportation
Hon. Leonard Derkach - Minister of Rural Development
Hon. Bonnie Mitchelson - Minister of Family Services
Hon. Harold Gilleshammer - Minister of Labour
Hon. Darren Praznik - Minister of Health
Hon. Eric Stefanson - Minister of Finance
Hon. Linda McIntosh - Minister of Education and Training
Hon. Rosemary Vodrey - Minister of Culture, Heritage and Citizenship
Hon. Jack Reimer - Minister of Urban Affairs
Hon. David Newman - Minister of Energy and Mines
Hon. Franklin Pitura - Minister of Government Services
Hon. Michael Radcliffe, Q.C. - Minister of Consumer and Corporate Affairs

Members of the Legislative Assembly

Steve Ashton
Becky Barrett
Marianne Cerilli
Dave Chomiak
Hon. Louise M. Dacquay
Gregory Dewar
Gary Doer
Albert Driedger
Peter George Dyck
James Ernst
Clif Evans
Leonard Evans
David Faurschow
Jean Friesen
Neil Gaudry
Ed Helwer
George Hickes
Gerard Jennissen

Gary Kowalski
Kevin Lamoureux
Oscar Lathlin
Marcel Laurendeau
Gord Mackintosh
Jim Maloway
Doug Martindale
Gerry McAlpine
Diane McGifford
MaryAnn Mihychuk
Jack Penner
Daryl Reid
Shirley Render
Eric Robinson
Denis Rocan
Tim Sale
Conrad Santos
Stan Struthers
Ben Sveinson
Mervin Tweed
Rosann Wowchuk

The Court of Queen's Bench - General Division

Hon. B. Hewak - Chief Justice
Hon. J. Oliphant - Associate Chief Justice
Hon. G.J. Barkman
Hon. H. Beard
Hon. A.L. Clearwater
Hon. W.M. Darichuk
Hon. W.R. DeGraves
Hon. A. Dureault
Hon. L. Duval
Hon. K.J. Galanchuk
Hon. T.M. Glowacki
Hon. B.M. Hamilton
Hon. K.R. Hanssen
Hon. A.A. Hirshfield
Hon. D.P. Kennedy
Hon. B. Keyser
Hon. R. Krindle
Hon. D.J. McCawley
Hon. A. MacInnes

Hon. M.M. Monnin
Hon. P.S. Norse
Hon. N. Nurgitz
Hon. P. Schulman
Hon. J.A. Scollin
Hon. J.G. Smith
Hon. F. Steel
Hon. W.S. Wright

The Court of Queen's Bench - Family Division

Hon. G. Mercier - Associate Chief Justice
Hon. C.M. Bowman
Hon. R. Carr
Hon. R.M. Diamond
Hon. J.S. Duncan
Hon. J.A. Menzies
Hon. G.R. Goodman
Hon. S. Guertin-Riley
Hon. J.A. Mullally
Hon. K. Stefanson

Department of Justice

Bruce MacFarlane, Q.C. - Deputy Minister of Justice
Public Trustee's Office
J. Dupont - Supervisor, Women's Advocacy Program
D. Harvey - Senior Crown Attorney, Family Violence Unit, Criminal Justice Division
J. MacPhail - Director, Family Law, Civil Justice Division
Tom Hague - Director, Civil Legal Services, Civil Justice Division
Margaret Bilash - Coordinator, Victim/Witness Assistance Program
Rob Finlayson - Director, Prosecutions
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Ann Lemieux - President, Manitoba Gerontological Nursing Association

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Irene Crowe - Health Policy Consultant, Manitoba Association of Registered Nurses
Ron Sharegan - President, Manitoba Association of Social Workers
Dr. Kenneth Brown - Registrar, College of Physicians and Surgeons
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Verna Holgate - Executive Director, Manitoba Association of Licensed Practical Nurses
Ross McIntyre - Executive Director, Manitoba Dental Association
Manitoba Athletic Therapists Association
Dr. Donald Stewart - Editor, Newsletter, Psychological Assocation of Manitoba
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Valerie Price - Executive Director, Manitoba Association for Rights and Liberties
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Agencies and Associations

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Catherine Place
John Zacharuk - Centre Facilitator, Main Street Senior Centre
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Barbara Russell - Administrator, Selkirk Avenue Senior Centre
Susan Sader - Centre Facilitator, Stradbrook Senior Centre
Murielle Gagner-Ouellette - Executive Director, Pluri-Elles
David Merasty - Executive Director, Cree Nation Child & Family Caring Agency
Maria Wasylkewycz - Age and Opportunity
Ms. J. Edwards - Winnipeg Community and Long Term Care
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Arlene Jones - Seniors Wellness Centre, St. James-Assiniboia Senior Centre Inc.
James E. Read - Executive Director, Salvation Army Ethics Centre
Ramon Kopas - Director of Planning and Development, Manitoba Society of Seniors
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David Martin - Provincial Coordinator, Manitoba League of Persons with Disabilities Inc.
Suzanne Rutledge - Secretary, Manitoba Gerontological Social Workers Interest Group

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Hospitals

Winnipeg
Concordia Hospital - Paul Redekop, Chair, Ethics Committee
Grace General Hospital - Major John McFarlane, Executive Director
Health Sciences Centre - Michelle Augert, Secretary, Ethics Committee
Manitoba Adolescent Treatment Centre - Peter Dubienski, Director
Misericordia General Hospital - Elizabeth Grover, Chair, Ethics Committee
Riverview Health Centre - M. Conner, Ethics Resource
St. Boniface General Hospital - Pat Murphy, Clinical Ethicist
Harvey Sector - Chair, St. Boniface Hospital Committee on Aging
Seven Oaks General Hospital - Ellen Karr, Ethics Committee
Victoria General Hospital - Vera Derenchuk, Chair, Ethics Committee
Winnipeg Hospital Authority - Gordon Webster, Chief Executive Officer

Manitoba
Brandon General Hospital - Executive Director
Brandon Mental Health Centre - Executive Director
Burntwood Regional Health Authority, Thompson MB - Executive Director
Eden Mental Health Centre, Winkler MB - Executive Director
Flin Flon General Hospital - Executive Director
Johnson Memorial Hospital, Gimli MB - Executive Director
Selkirk & District General Hospital - Executive Director
Selkirk Mental Health Centre - Executive Director
The Pas Health Complex - Executive Director

Personal Care and Nursing Homes

Beacon Hill Lodge - Phyllis Boryskiewich, Administrator
Bethania Mennonite Personal Care Home - Helmut Epp, Administrator
Central Park Lodges - Don Solar, Administrator
Deer Lodge Centre - Tim Duprey, Administrator
Donwood Manor Personal Care Home - Herta Janzen, Administrator
Extendicare/Oakview Place - Debbie Senychych, Administrator
Extendicare/Tuxedo Villa - Mrs. King, Administrator
Fort Garry Care Centre - Gerald Kalef, Executive Director
Fred Douglas Lodge - Marilyn Robinson, Executive Director
Golden Door Geriatric Centre - L. LeBlanc, Administrator
The Golden Links Lodge - Doreen Rosmus, Administrator
Heritage Lodge Personal Care Home - Linda Norton, Administrator

Holiday Haven Nursing Home - Joanne Sarraino, Administrator
Holy Family Home - Jack Kifil, Administrator
Life Care Centre - W. Ouellet, Owner
Luther Home - James Gessner, Administrator
M.B. Lodge - Mrs. Garcia, Administrator
Maples Personal Care Home - Robert Beaudin, Administrator
Meadowood Manor Personal Care Home - Charles Kunze, Administrator
Middlechurch Home of Winnipeg - L. Holgate, Executive Director
Park Manor Personal Care Home - Charles Toop, Executive Director
River East Personal Care Home - Ron Baron, Administrator
St. Adolphe Nursing Home - Mrs. Cramp, Director of Nursing
St. Joseph's Residence - Marianna Muzyka
St. Norbert Nursing Home - Robert Brousseau, Administrator
Sharon Home - Audrey Arlinsky, Chief Executive Officer
Tache Nursing Centre - Tache Nursing Centre
Vista Park Lodge - Joe McKee, Administrator
West Park Manor Personal Care Home - Ken Reimche
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Central Manitoba Inc, Portage la Prairie, MB
Churchill Regional Health Authority Inc., Churchill MB
Interlake Regional Health Authority Inc., Stonewall, MB
Marquette Regional Health Authority Inc., Shoal Lake, MB
NOR-MAN Regional Health Authority Inc., Flin Flon, MB
North Eastman Health Authority Inc., Pinawa

Parkland Regional Health Authority Inc., Dauphin, MB
South Westman Regional Health Authority Inc., Souris, MB
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REPORT ON

INFORMAL ASSESSMENT OF COMPETENCE

EXECUTIVE SUMMARY

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INTRODUCTION

This Report is the product of a process that began with a request from the Ethics Committee of Winnipeg's Golden West Centennial Lodge Personal Care Home. Staff members were having difficulty determining whether elderly residents were mentally competent to make decisions about themselves, and looked to the Commission for assistance in this regard. In turn, the Commission established an Advisory Committee, which learned that other people who were regularly required to assess the competence of customers and clients were experiencing the same difficulty. The Advisory Committee recommended developing a protocol that would clarify when and how to assess competence, and the appropriate course of action to take following the assessment. Such a protocol would not only assist those required to assess competence, but also protect vulnerable people who may not be competent to make a particular decision.

The Commission prepared a Discussion Paper on the issue of the "informal" assessment of mental competence, and circulated it to interested parties for comment. This Report reflects the Commission's consideration of the responses to that Discussion Paper.

THE LAW REGARDING COMPETENCE

The common law presumes that a person is competent once he or she has attained the age of majority. Only after a reasonable possibility of incompetence has been established does the law intervene, and even then often in uncertain or ill-defined ways. This lack of legal certainty raises concerns about possible infringement of personal autonomy.

In the past, the law often considered competence to be a global construct: either one possessed absolute mental capacity, or one lacked the capacity to make any decisions at all. However, it is now widely recognized that a person may simultaneously be competent to make decisions about one matter and not competent to make decisions about another; incapacity in one area does not necessarily imply incapacity in another area. This understanding of competence is not, however, recognized in Manitoba's existing statutes.

The law must balance three competing interests when dealing with determinations of individuals' mental capacity: the individual's rights to dignity, autonomy, and self-determination; the individual's best interests as determined by the state; and the community's interests in the promotion of broader state concerns. The potential conflict between care and liberty may be minimized by the adoption of two fundamental guidelines. First, assessors should be very selective, assessing competence only in relation to a specific task or decision. Second, when intervention is necessary, the interference with the person's freedom should be minimized; that is, the least restrictive alternative should always be adopted.

LEGAL STANDARDS OF COMPETENCE

The common law provides some guidance for determining competence on an informal basis in a number of specific circumstances, including those requiring the capacity to: marry; make a will; execute an enduring power of attorney; enter into a financial contract; or consent to medical treatment. The difficulty when discussing a common standard for all instances where competence becomes an issue is that the standard fluctuates even amongst those five examples. For instance, a person may lack testamentary capacity, and yet have the capacity to marry, and a person who has been declared incapable of managing his or her affairs, and has had a committee appointed to manage his or her estate, may still have the requisite capacity to marry.

Despite the variation in existing legal standards for competence, it is in the interests of both the assessor and the person whose competence is in question to develop standardized testing at the informal level. A common standard setting out, on a very general basis, what is required for someone to be considered "competent" could minimize the problems created by inconsistent assessments by different people in similar circumstances.

DUTY TO DETERMINE COMPETENCE

A legal duty to determine whether someone has a certain level of competence arises every day, in a myriad of situations. Unfortunately, people confronted on a day-to-day basis with the need to assess capacity generally lack the proper training to conduct such testing. This problem is compounded by the fact that the existing legal tests for capacity vary depending on the circumstances, and what will trigger the need for assessment can also vary.

It is therefore important that assessors not act hastily in judging competence, and bear in mind that what may indicate a lack of competence in one person is mere eccentricity in another. Testing should not be applied wholesale to everyone who exhibits characteristics that may be considered peculiar. As well, an important tenet of competence assessment must be kept in mind: if no purpose is served from testing because no remedy is available in any event, testing is not justified.

LEGAL CONSEQUENCES

When contemplating guidelines that may ultimately result in the refusal of services or treatment, or conversely, the involuntary imposition of services or treatment, it is important to be aware of the legal consequences that may flow from such actions. The uncontrolled nature of an informal process raises concerns regarding obligations of confidentiality, defamation, the law of negligence, consent issues, and human rights. The potential risks assumed by those conducting informal competence assessments must be considered when deciding what steps to take to clarify informal assessment procedures.

DISCUSSION QUESTIONS AND ANSWERS

The responses to the Discussion Paper indicated that there is a strong demand for education and assistance on the topic of informal competence assessment. The vast majority of respondents were of the view that the government should provide guidelines, training, and informational materials to assist health care workers, and the public in general, in dealing appropriately with persons whose competence may become an issue.

AN INFORMAL COMPETENCE ASSESSMENT PROCESS

There are many ways to assess the competence of individuals who may have exhibited signs of mental incapacity, several of which have been examined by the Commission. As no one particular form will be universally suitable for all circumstances in which questions of competence may arise, the Commission focused on the possible structure of a general assessment of mental competence.

Given the potential seriousness of the consequences arising from informal competence assessments, the Commission considers that the introduction of shared criteria for the various competencies would help to ensure shared standards of practice. The Commission therefore supports the creation of a set of guidelines that would be applicable to most circumstances in which questions of competence arise.

Guidelines should only permit testing if there is a demonstrated "trigger" and should only permit testing if the subject will benefit from intervention, and if such intervention would be the least restrictive alternative. Options should be set out as to the appropriate standard of competence to be demonstrated in any given situation and should be directed to enabling the assessor to determine the subject's ability to understand the relevant risks and benefits and available alternatives.

Organizations whose employees may reasonably be expected to be in a position to informally assess others' mental capacity should be required to provide for appropriate training of those employees. Any training regime should inform assessors of the potential legal consequences of conducting, or failing to conduct, an informal assessment. As well, *The Mental Health Act* should be amended to provide that persons conducting an informal assessment of competence, in good faith and in accordance with the guidelines recommended, be immune from any civil suit arising out of the conduct of that assessment.

The Commission also recommends the prompt establishment of an Advisory Panel, comprised of independent qualified professionals and interested persons, which it considers to be a necessary first step in developing such guidelines. It is hoped that the Commission's recommendations will assist the panel in addressing the most difficult issues concerning the informal assessment of competence.

RAPPORT SUR

ÉVALUATION INFORMELLE DE LA CAPACITÉ MENTALE

RÉSUMÉ

RÉSUMÉ

INTRODUCTION

Ce rapport remonte à une demande formulée par la commission d'éthique du foyer de soins personnels Golden West Centennial Lodge de Winnipeg. Les membres du personnel avaient du mal à déterminer la capacité mentale des personnes âgées résidant dans l'établissement en ce qui concerne la prise de décisions les touchant. C'est pour cette raison qu'ils se sont tournés vers la Commission pour de l'aide relativement à ce dossier. La Commission, pour sa part, a mis sur pied un comité consultatif qui a pu constater qu'il existait d'autres personnes auxquelles l'on faisait régulièrement appel pour évaluer la capacité mentale de clients qui souffraient du même problème. Le comité consultatif a suggéré l'établissement d'un protocole permettant de déterminer plus clairement le moment et la façon d'évaluer la capacité mentale, ainsi que d'indiquer la marche à suivre après l'évaluation. Un tel protocole permettrait non seulement de venir en aide à ceux et celles qui en ont besoin, mais aussi de protéger les personnes vulnérables qui pourraient ne pas être en mesure de prendre une certaine décision.

La Commission a rédigé un document de travail sur le dossier de l'évaluation informelle de la capacité mentale et en a distribué des copies aux intervenants afin que ceux-ci puissent exprimer leur commentaires. Le présent rapport est le fruit de l'examen par la Commission des réactions au document de travail.

LA CAPACITÉ MENTALE AU SENS DE LA LOI

En vertu de la *common law*, une personne est censée être habile à prendre des décisions une fois qu'elle a atteint l'âge de la majorité. Aucune intervention légale ne peut avoir lieu avant que l'on n'ait réussi à déterminer une possibilité d'inhabilité raisonnable; même dans ces cas, les critères sont souvent flous ou mal définis. Ce manque de certitude sur le plan légal suscite des préoccupations quant à une éventuelle violation du droit des personnes à l'autonomie.

Dans le passé, la loi avait souvent tendance à considérer la capacité mentale comme étant un concept global : soit une personne possédait la capacité mentale de prendre des décisions, soit celle-ci ne la possédait pas du tout. De nos jours, cependant, il est généralement reconnu qu'une personne peut, à la fois, avoir la capacité de prendre des décisions dans un domaine tout en n'étant pas en mesure d'en prendre dans un autre. L'incapacité de prendre des décisions dans un domaine ne suppose pas nécessairement une incapacité dans un autre domaine. Les lois du Manitoba actuellement en vigueur ne reconnaissent toutefois pas cette interprétation de la capacité mentale.

La loi doit donc trouver un équilibre entre trois intérêts opposés lorsqu'il s'agit de déterminer la capacité mentale d'une personne : les droits de cette dernière à la dignité, à

l'autonomie et à l'autodétermination, les intérêts primordiaux de cette personne tels que définis par l'État et les intérêts de la communauté en ce qui a trait à la promotion d'une plus vaste intervention de la part de l'État. Il serait possible de minimiser les effets du conflit potentiel entre assistance et liberté en adoptant deux lignes directrices fondamentales. En premier lieu, les évaluateurs devraient être très sélectifs et n'évaluer la capacité mentale qu'en fonction d'une décision ou d'une tâche précise. En deuxième lieu, dans les cas où il est nécessaire d'intervenir, il faudrait réduire au minimum toute interférence avec les droits de cette personne à la liberté. En somme, il faudrait toujours adopter la solution la moins restrictive.

LES CRITÈRES JURIDIQUES QUI DÉTERMINENT LA CAPACITÉ MENTALE

La *common law* prévoit certaines directives permettant de déterminer la capacité mentale de façon informelle dans un bon nombre de circonstances précises, y compris les aptitudes nécessaires pour prendre les décisions suivantes : se marier, rédiger un testament, s'engager à une procuration durable, conclure un contrat financier ou consentir à des traitements médicaux. La difficulté qui se présente lorsqu'il s'agit de discuter de la mise en place de normes communes s'appliquant à toutes les circonstances dans lesquelles la capacité mentale devient un facteur est que les normes ont tendance à varier même au sein des cinq situations mentionnées ci-dessus. Une personne peut, par exemple, ne pas posséder les facultés nécessaires pour tester, tout en possédant les capacités requises pour se marier. Une autre, dont il aurait été déterminé qu'elle n'était plus en mesure de gérer ses affaires et à l'intention de laquelle un comité aurait été nommé pour assurer la gestion de sa succession, peut néanmoins toujours posséder la capacité mentale requise pour se marier.

En dépit des variations au sein des normes légales qui permettent actuellement de définir la capacité mentale, il est dans les meilleurs intérêts, tant de l'évaluateur que de la personne dont la capacité est mise en question, que l'on mette au point un méthode d'évaluation informelle normalisée. L'élaboration d'une norme commune qui permettrait de définir, de façon très générale, les capacités requises pour qu'une personne soit considérée « habile » à prendre des décisions, pourrait minimiser les problèmes provoqués par les évaluations inconsistantes effectuées par différents évaluateurs dans des situations du même genre.

L'OBLIGATION JURIDIQUE DE DÉTERMINER LA CAPACITÉ MENTALE

L'obligation juridique de déterminer si une personne possède un niveau de capacité mentale quelconque se manifeste chaque jour, et ce, dans une myriade de situations. Malheureusement, les personnes qui sont confrontées de jour en jour à la nécessité d'évaluer la capacité mentale n'ont généralement pas reçu la formation nécessaire pour procéder à de telles évaluations. Ce problème est aggravé par le fait que les tests de capacité actuellement en usage varient en fonction des circonstances, ce qui signifie que les situations qui pourraient donner lieu à une évaluation peuvent aussi varier.

Il est donc important que les évaluateurs prennent leur temps lorsqu'il s'agit de déterminer la capacité mentale et tiennent compte qu'un comportement qui indique une insuffisance de capacité chez une personne peut n'être que de l'excentricité chez une autre. Il ne faudrait pas évaluer d'emblée quiconque fait preuve d'une comportement qui semblerait bizarre. De plus, il faut prendre en considération un principe important lors de toute évaluation : si l'évaluation ne sert à aucun but, parce qu'il n'y a de toute façon pas de remède, celle-ci n'est pas justifiable.

LES CONSÉQUENCES JURIDIQUES

En examinant les lignes directrices qui pourraient, à la limite, entraîner un refus d'offrir des services ou des traitements, ou, dans le cas contraire, l'imposition obligatoire de services ou de traitements, il est important de tenir compte des conséquences juridiques pouvant émaner de telles actions. La nature incontrôlée du processus d'évaluation informelle suscite des inquiétudes quant aux règles de droit en matière de confidentialité, de diffamation, de négligence, de consentement et de droits de la personne. Les personnes qui procèdent aux évaluations informelles de la capacité mentale doivent tenir compte des risques potentiels auxquels ils s'exposent lorsqu'elles décident de la marche à suivre pour clarifier les processus d'évaluation informelle.

QUESTIONS À DÉBATTRE ET RÉPONSES

Les réactions au document de discussion indiquent d'importants besoins au niveau de l'éducation et de l'aide en matière d'évaluation informelle de la capacité mentale. La vaste majorité des personnes qui nous ont répondu sont d'avis que le gouvernement devrait fournir des lignes directrices, de la formation et du matériel éducatif afin d'aider les travailleurs du secteur des soins de santé, ainsi que le grand public, à composer de façon adéquate avec les personnes pour lesquelles la capacité mentale pourrait devenir un problème.

UN PROCESSUS D'ÉVALUATION INFORMELLE DE LA CAPACITÉ MENTALE

Il existe de nombreuses façons d'évaluer les aptitudes de personnes qui ont manifesté des signes d'incapacité mentale et la Commission en a déjà étudié plusieurs. Étant donné qu'aucune méthode particulière ne saurait être universellement adaptée à toutes les situations dans lesquelles des problèmes reliés à la capacité mentale pourraient surgir, la Commission a concentré ses efforts sur l'éventuelle mise en place d'un processus général d'évaluation de la capacité mentale.

Vu la gravité potentielle des conséquences pouvant être entraînées par les évaluations informelles de la capacité mentale, la Commission est d'avis que l'élaboration de critères communs pour répondre aux divers degrés de capacité mentale pourrait encourager la mise en

oeuvre de normes de pratique communes. La Commission favorise donc l'établissement d'un ensemble de lignes directrices que l'on pourrait appliquer dans la majorité des situations où il est question de capacité mentale.

Selon les lignes directrices, l'évaluation ne serait permise que si l'on constate un « élément de déclenchement » ou que l'on estime que le sujet profitera de l'intervention, ou encore qu'une telle intervention constitue la solution la moins restrictive. Il faudrait proposer diverses solutions afin d'établir une norme appropriée permettant de définir la capacité mentale et d'aider les évaluateurs à déterminer à quel point le sujet est en mesure de comprendre les risques et les avantages pertinents et les solutions de rechange qui s'offrent à lui.

Les organisations qui peuvent raisonnablement s'attendre à ce que certains de leurs employés soient en mesure de procéder à une évaluation informelle de la capacité mentale d'autres personnes devraient être tenus de fournir aux employés en question une formation appropriée. Dans le cadre de tout système de formation, les évaluateurs devraient être informés des éventuelles conséquences juridiques émanant du fait de procéder ou de négliger de procéder à une évaluation informelle. De plus, il faudrait apporter des modifications à la *Loi sur la santé mentale* afin que les personnes qui procèdent, de bonne foi et conformément aux lignes directrices proposées, à une évaluation informelle, ne fassent pas l'objet de poursuites judiciaires.

La Commission propose aussi la mise en place, dans les plus brefs délais, d'un conseil consultatif composé d'experts indépendants qualifiés et d'intervenants concernés, car elle est d'avis que ceci constitue la première étape de l'élaboration des lignes directrices. Il est à espérer que les recommandations de la Commission aideront le comité consultatif à s'attaquer aux dossiers les plus épineux dans le domaine de l'évaluation informelle de la capacité mentale.