
**Submission to NSW Law Reform Commission re its review of the Guardianship Act 1987**
**October 2016**

***Question Paper 1 – Preconditions for alternative decision-making arrangements***

## Preliminary matters

### *What is Capacity Australia?*

Capacity Australia is a not for profit medico-legal organisation led by senior legal, medical/psychiatric and social work academics and practitioners. We are committed to supporting the rights of people with decision-making disability.

### *Who are the authors of this paper?*

*Conjoint (UNSW) Professor Carmelle Peisah* is an old age psychiatrist with particular expertise in relation to decision-making capacity. She is the founder and President of Capacity Australia. She is a co-author of the ebook O'Neill and Peisah "Capacity and the Law", which is currently being updated. She has been a professional member of the NSW Guardianship Tribunal (now the Guardianship Division of NCAT).

*Nick O'Neill* is an Australian Lawyer currently a Professorial Visiting Fellow at the Faculty of Law, UNSW. He is a director of Capacity Australia and a co-author of the ebook O'Neill and Peisah "Capacity and the Law". He was the foundation Deputy President of the NSW Guardianship Board for five years and the President of the Board/Tribunal for 10 years.

*Jenna Macnab* currently works for the NSW Department of Justice and is reviewing the NSW Capacity Toolkit, which she authored in 2008. She is a Director of Capacity Australia, a NSW solicitor, and is undertaking a fulltime Ph D on the role of guardians and financial managers in supported decision-making for people with cognitive disability (via an Australia

Postgraduate Award scholarship and a La Trobe University scholarship). Jenna has worked in disability and the law for almost 20 years.

The ebook "Capacity and the Law" written by CP and N'ON deals not only with the issue of decision-making capacity but also deals in detail with the guardianship jurisdictions of all the Australian States and Territories. The update of the book, which is almost complete, will add to the existing book descriptions of all the considerable legislative developments and relevant case law from 2009 to late 2016.

***The context in which the Guardianship Act 1987 (NSW) operates.***

The overwhelming majority of people with decision-making disabilities in NSW do not, will not, and should not, need to be the subject of an application to what is now the Guardianship Division of NCAT. This fact, borne out by the history of the guardianship system established by the Guardianship Act 1987 (NSW), which came into force in August 1989, is consistent with an absolute imperative to make interventions in the life of persons with decision-making disabilities by the Guardianship Division a matter of last resort. Any changes made to the Act must be drafted to ensure that that remains the case.

Since it began operations in August 1989, it has been incumbent on what is now the Guardianship Division to ensure that it made guardianship and financial management orders only in circumstances in which they were needed. And, in relation to guardianship orders, at least, to ensure that they did not remain in place for longer than they are needed. The Act was designed, and indeed operationalised to achieve those goals.

The ability to appoint enduring guardians or enduring attorneys for personal matters was added to the ability to appoint enduring attorneys for financial matters. This served to extend the decision-making autonomy of those who had it, but might lose in the future or were in immediate risk of losing such autonomy because they had a diagnosis of dementia. This was done in one form or another in all the States and Territories from the 1990s to 2016, occasionally at least on the initiative of those holding office within the guardianship system. However, these mechanisms to extend a person's decision-making autonomy were promoted by the Guardianship Tribunal and Public Guardian in NSW and the Public Guardians/Advocates elsewhere together with other non-government organisations such as

Alzheimer's Australia. Now solicitors offer services, particularly to older people, to make such enduring documents for them.

There is a lot of effort from hospitals, various government agencies and non-government organisation to encourage people to make advance care directives or refusal of treatment documents.

All these activities have as their primary effect extending the decision-making autonomy of the person and the secondary effect of reducing the number applications to tribunals with guardianship jurisdiction. Always, autonomous self-appointment of substitute decision makers is to be preferred to tribunal appointment of such.

Another part of the context in which the NSW Act operates, is that many people with intellectual disabilities that affect their decision-making capacities to differing extents, live in the community in group homes or in the family home. A number of people with intellectual disabilities live in circumstances in which they are encouraged and supported to make or take part in making health, lifestyle and financial management decisions. With the impetus of UNCRPD beginning to take effect in Australia and encouraging greater efforts involving people with decision-making disabilities to make or take part in making decisions about their own lives and greater research about how to do that, there will be greater activity in relation to this matter. One of the outcomes of that activity will be a reduction of involvement with the guardianship jurisdiction.

So the guardianship system will continue to remain a small player in the world of people with decision-making disabilities. This role, however small, is an important role. Both tribunals with guardianship jurisdiction and courts with inherent parens patriae jurisdiction and statutory jurisdiction – as the NSW Supreme Court has and exercises as appropriate and not in rivalry with NCAT – will still be needed.

Why so? In the 27 years that a tribunal has had guardianship jurisdiction in NSW, there has been an apparent need for there to be a system by which applications can be made for guardianship orders to protect persons with decision-making disabilities from abuse,

exploitation or neglect by others. Such orders have been the only means available to some people with decision-making disabilities to meet their basic needs of shelter, food, medical or personal care. Always, (otherwise the pre-conditions for an order would not be met) there is an absence of alternative solutions, and such an outcome cannot be achieved without the intervention of a tribunal with statutory authority to make such orders. The same need for orders is currently present and will in the future be present for people who suffer from self- neglect, and/or neglect, abuse, or exploitation by others because of their decision-making disabilities and will become either seriously ill or will die unless alternative care and decision-making arrangements are made.

Notwithstanding the likelihood that the impetus provided by the UNCRPD will result in more people with decision-making disabilities being successfully supported in managing their own financial affairs, there will still be a need for NCAT to make financial management orders. This is because some people have decision-making disabilities that are so significant that they cannot manage their financial affairs and need someone else to do that for them. Sometimes the need for the order arises because the financial abuse and exploitation the person is suffering is caused by the activities of family members, including those appointed as attorneys under enduring powers of attorney, by “new found friends” or by others. There are many other examples where need for a financial management order will arise regardless of the efforts to get the person to play a role in handling their own financial affairs.

The authors of this submission make these assertions about the on-going need for a tribunal with guardianship jurisdiction the same as, or similar to, that currently exercised by NCAT, based on more than the more than two decades each of experience in fields of work related to that jurisdiction.

Also, as Capacity Australia noted in its submission to the Legislative Council’s Inquiry into elder abuse in NSW in January 2016, a number of studies show the prevalence of financial abuse in Australia generally and in NSW in particular. Capacity Australia stated that:

> *Perhaps the largest study of the nature and prevalence of elder abuse in Australia has been conducted on behalf of State Trustees Limited by Eastern Health Clinical School,*

*Monash University, Melbourne.[1] [2] A small qualitative study based in NSW to examine how financial abuse occurs, and what can be done to prevent or reduce its incidence, was conducted by Alzheimer's Australia NSW.[3] Such studies demonstrate that although figures vary – with certain cultural groups more vulnerable than others – financial abuse affects up to 5% of Australians over 65, such abuse being most often perpetrated by family members. This figure is likely to be an underestimate, as people do not easily and willingly report abuse. As well, cultural practises and beliefs often influence whether or not behaviour is considered abuse, and whether such behaviour abuse is even reported. Certain culturally and linguistically diverse (CALD) groups are at particular risk of abuse by virtue of isolation, "familism" which emphasizes the needs of the family over the needs of the individual, and shame or stigma which leads to concealing mistreatment and inhibiting formal help-seeking.[4]*

Capacity Australia acknowledges the need to revise the current legislation, particularly in regards to clarity in the area of capacity, its assessment, and the need to ensure that the role of NCAT is a small one as elucidated above. Notwithstanding this, Capacity Australia asserts that all the ills of capacity assessment – of which there are many – cannot be repaired or cured by legislation. Capacity assessment is not simple and should not be simple. It is an important process which, if done properly with maximization of every opportunity for promoting autonomy and identification of strengths and weaknesses, can serve to enhance the human rights of people with impaired decision making. On the other hand reductionist approaches can sabotage this. Having said this, there are a number of transgressions, or what we at Capacity Australia colloquially call "Capacity Crimes" that might be addressed with this opportunity to revise the legislation.

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[1] Wainer, J., Darzins, P., Owada, K., Prevalence of elder financial abuse in Victoria, Protecting elders' assets study, Monash University, Medicine Nursing and Health Sciences, State Trustees, 10th May, 2010,

[2] King C, Wainer J, Lowndes G, Darzins P, Owada K (2011) *For love or money: intergenerational management of older Victorians' assets,* Protecting Elders' Assets Study. Monash University, Eastern Health Clinical School, Melbourne; http://www.eapu.com.au/uploads/research_resources/VIC-For_Love_or_Money_JUN_2011-Monash.pdf

[3] https://nsw.fightdementia.org.au/sites/default/files/20140618-NSW-Pub-DiscussionPaperFinancialAbuse.pdf

[4] Wainer J., Owada K., Lowndes G., Darzins P (2011) Diversity and financial abuse in Victoria Protecting Elder's assets Study Monash University Eastern Health Clinical School , Melbourne.

We have, on behalf of Capacity Australia, confined our comments to those matters raised in Question Paper 1 about which we consider our expertise and experience allows us to make a useful contribution.

## The concept of "capacity"

### Question 3.1: Elaboration of decision-making capacity

*(1)Should the Guardianship Act provide further detail to explain what is involved in having, or not having, decision-making capacity?*

At present, the phrase "incapable of managing his or her person" has been interpreted as being synonymous with "lacking decision- making capacity". This ambiguity needs to be rectified.

Part 1 Section 2 of the Mental Capacity Act 2005 (England and Wales) states that:

> *For the purposes of this Act, a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.*

An explanation such as this should suffice in clarifying what is involved in having, or not having, decision-making capacity. While at face value this definition may appear overly simplistic, it encompasses a number of important elements. Firstly, there is reference to "lacks capacity in relation to a matter" not global capacity. It is paramount that no legislation refers to a person "lacking capacity" which would be antithetical to the task specific nature of capacity and indeed to Article 12, Convention Rights of Person with Disabilities (UNCRPD).[5] We note that a similar approach to the definition of capacity involving understanding the nature and effect of decisions about "the matter" is seen in Schedule 4 of Guardianship and Administration Act 2000 of Queensland.

Secondly, aetiologically linking inability to make decisions with an impairment of brain and mind immediately dismisses any link between decision making ability and "disability" per se (particularly physical disability) as it currently stands (see below), and between decision

[5] United Nations Convention on the Rights of Persons with Disabilities – UNCRPD. http://www.un.org/disabilities/convention/conventionfull.shtml

making ability and mere "bad decisions". By implication this reinforces the distinction between impaired decisions and bad decisions. This matter is discussed in more detail in our response to Question 3.7 below.

It is also important that disorders of both mind AND brain are referenced. Although dementia now exceeds intellectual disability as the most common context for contemporary NCAT applications, mental illness is now often overlooked as a potential cause of impaired decision-making, necessitating the inclusion of impairment of mind in the definition.

Notably, section 3 of the Mental Capacity Act 2005 (England and Wales) goes on to add:

> *(1) For the purposes of section 2, a person is unable to make a decision for himself if he is unable— (a) to understand the information relevant to the decision, (b) to retain that information, (c) to use or weigh that information as part of the process of making the decision, or (d) to communicate his decision (whether by talking, using sign language or any other means).*

The criteria (a) to (d) in the section, evolved from English common law and American capacity research on consent for medical treatment, represent the cognitive elements of decision making (particularly capacity for medical treatment) and not the test- specific aspects of capacity. These criteria, while useful, do not represent "the whole story" in regards to decision making capacity as it applies to the various decision making foci of the Guardianship Act (for example, financial capacity, see below) and thus belong in academic and scientific literature on capacity, not in guardianship legislation.[6]

As such, a simple statement such as; "a person lacks capacity in relation to a matter if at the material time he or she is unable to make a decision in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain" will suffice.

(2) *If the Guardianship Act were to provide further detail to explain what is involved in having, or not having, decision-making capacity, how should this be done?*

[6] O'Neill, N. & Peisah, C. (2011). *Capacity and the Law*. Sydney: Sydney University Press. Available at: http://www.austlii.edu.au/au/journals/SydUPLawBk/2011/1.html

There is a danger in being too prescriptive in legislation about the elements of decision-making capacity. However, there is a current need for guidelines or information regarding the contemporary context and understanding of decision-making capacity (and related concepts such as supported decision-making). This need is demonstrated by the number of continued requests for the Capacity Toolkit[7], which is universally liked across the ageing, disability, legal, financial, medical and allied health sectors; as well as in the community. A satisfaction survey of 200 recipients conducted by the Department of Justice found that recipients across disciplines found the Toolkit useful (97%) and also used the Toolkit in their work (93%). The survey was independently conducted by Rebound Research.

Such a resource would not only ensure that a 'universal capacity/supported decision-making language' could be utilised across sectors, it would provide some clarity in an emerging area. Case studies assisting users to operationalise complex concepts are also important, and are a key feature of the current Toolkit. Many recipients stipulated that these case studies were one of the most useful elements of the Toolkit.

Unlike in the United Kingdom, where the Code of Practice to the Mental Capacity Act 2005 (England and Wales)[8] has legal status, in that certain categories of people have a legal duty to have regard to it when working with or caring for adults who may lack capacity to make decisions, the NSW Capacity Toolkit is a non-statutory guideline. The benefit of this is the ability to amend the guideline commensurate with current practice and scientific knowledge, as medical research, law and practice in this area continues to be crystallised. Also, since the area of decision-making capacity is dynamic, currently the subject of much international debate, and the focus of considerable academic and practical research, a non-statutory guideline is less restrictive of the adoption of innovative and flexible ideas.

**Question 3.2: Disability and decision-making capacity**

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[7] NSW Attorney General Department. (2009). *NSW Capacity Toolkit* (2nd Edition) Sydney. Available at: http://www.justice.nsw.gov.au/diversityservices/Documents/capacity_toolkit0609.pdf

[8] Department for Constitutional Affairs. (2007). *Mental Capacity Act 2005: Code of Practice.* United Kingdom: The Stationery Office on behalf of the Department for Constitutional Affairs. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/497253/Mental-capacity-act-code-of-practice.pdf

*How, if at all, should a person's disability be linked to the question of his or her decision-making capacity?*

The International Classification of Functioning, Disability and Health (ICF) defines disability as an umbrella term for:-

(i) impairments (problems in body function or structure);

(ii) activity limitations (difficulties encountered in executing a task or action); and

(iii) participation restrictions (problems experienced in involvement in life situations).[9]

Accordingly, disability is the interaction between individuals with a health condition and personal and environmental factors. Lack of decision making capacity is per se a disability.

Currently, section 3 of the Guardianship Act 1987 (NSW) defines a person who has a disability as a reference to a person:

(a) who is intellectually, physically, psychologically or sensorily disabled,

(b) who is of advanced age,

(c) who is a mentally ill person within the meaning of the Mental Health Act 2007 , or

(d) who is otherwise disabled,

and who, by virtue of that fact, is restricted in one or more major life activities to such an extent that he or she requires supervision or social habilitation.

This definition is tautological i.e. people with a disability who have a disability by being restricted in activities.

As well, section 3 states that a "person in need of a guardian" means a person who, because of a disability, is totally or partially incapable of managing his or her person.

If we interpret "incapable of managing his or her person" as synonymous with "lacking decision- making capacity" as we currently do, then this statement is also tautological i.e. a "person in need of a guardian" means a person who, because of a disability, has a disability in decision making.

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[9] World Health Organisation Health topics Disabilities. http://www.who.int/topics/disabilities/en/ Accessed October 10, 2016.

It is the disorder (or the impairment in mind or brain), not the disability, that causes impairment in capacity. Moreover, the disorders which cause the disabilities referred to in section 3 do not all cause impairment in capacity. For example, neither physical, nor sensory disability, nor advanced age in and of themselves cause reduction or loss of decision making capacity. To approach the issue of decision making capacity or incapacity in this way undermines the presumption of capacity. For these reasons, disability per se should not be linked to decision making capacity.

**Question 3.3: Defining disability**

*If a link between disability and incapacity were to be retained, what terminology should be used when describing any disability and how should it be defined?*

For the reasons set out on the last paragraph, we recommend that the link with disability be broken.

**Question 3.4: Acknowledging variations in capacity**

*(1) Should the law acknowledge that decision-making capacity can vary over time and depend on the subject matter of the decision?*

*(2) How should such acknowledgements be made?*

*(3) If the definition of decision-making capacity were to include such an acknowledgement, how should it be expressed?*

*(4) If capacity assessment principles were to include such an acknowledgment, how should it be expressed?*

The statements articulated in Question 3.4.1 are important principles that govern capacity assessment, although this list is clearly not comprehensive. [10] When a valid trigger exists to rebut the presumption of capacity, capacity screening can, and should be performed by the full gamut of professionals who provide service or care, or are involved in decision making

[10] O'Neill, N. & Peisah, C. (2011). *Capacity and the Law*. Sydney: Sydney University Press. Available at: http://www.austlii.edu.au/au/journals/SydUPLawBk/2011/1.html; Peisah C, Forlenza O, Chiu E. Ethics, capacity, and decision-making in the practice of old age psychiatry: an emerging dialogue. Curr Opin Psychiatry. 2009 22 (6), pp. 519-521; Katona, c., et al (2009) World Psychiatric Association Section of Old Age Psychiatry Consensus Conference on Ethics and Capacity in old people with mental disorders International Journal Geriatric Psychiatry . 24(12):1319-24.

with people with cognitive and mental disorders, including health care professionals, lawyers and financial service professionals.[11] Capacity assessment should be performed by health care professionals with expertise in the performance of such. To legislate what is essentially a clinical determination is difficult. Moreover, as stated above, there are many other principles that govern capacity assessment, all of which, if we were to legislate capacity assessment principles, should be included namely:

1. Capacity is decision or task specific and cannot be extrapolated from one task to another
2. Capacity can vary within tasks depending on complexity
3. There is a presumption of capacity in relation to anyone 18 years and above. A valid "trigger" must exist to rebut the presumption of capacity.
4. Capacity is situation specific
5. Capacity is determined according to a risk threshold or hierarchy approach
6. Capacity is not diagnosis bound
7. Capacity cannot be extrapolated from cognitive performance alone
8. Capacity is dimensional, not categorical, i.e. not all or nothing - always consider supported decision making.

An example of a jurisdiction that has legislated capacity assessment comprehensively is California. Many of these basic capacity principles, namely the importance of the presumption of capacity, the acknowledgment that capacity is not status or diagnosis bound, and that it is task specific and it cannot be extrapolated from one task to the next, have statutory support in the Californian Due Process in Competency Determinations Act (DPCDA)(1996), Probate Code sections 810 – 813, and Civil Code section 39(b):

*810. The Legislature finds and declares the following:*

*(a) For purposes of this part, there shall exist a rebuttable presumption affecting the burden of proof that all persons have the capacity to make decisions and to be responsible for their acts or decisions.*

[11] NSW Capacity Toolkit http://www.justice.nsw.gov.au/diversityservices/Documents/capacity_toolkit0609.pdf.

*(b) A person who has a mental or physical disorder may still be capable of contracting, conveying, marrying, making medical decisions, executing wills or trusts, and performing other actions.*

*(c) A judicial determination that a person is totally without understanding, or is of unsound mind, or suffers from one or more mental deficits so substantial that, under the circumstances, the person should be deemed to lack the legal capacity to perform a specific act, should be based on evidence of a deficit in one or more of the person's mental functions rather than on a diagnosis of a person's mental or physical disorder.*

*811. (a) A determination that a person is of unsound mind or lacks the capacity to make a decision or do a certain act, including, but not limited to, the incapacity to contract, to make a conveyance, to marry, to make medical decisions, to execute wills, or to execute trusts, shall be supported by evidence of a deficit in at least one of the following mental functions, subject to subdivision (b), and evidence of a correlation between the deficit or deficits and the decision or acts in question:*

*(1) Alertness and attention, including, but not limited to, the following:*

*(A) Level of arousal or consciousness.*

*(B) Orientation to time, place, person, and situation.*

*(C) Ability to attend and concentrate.*

*(2) Information processing, including, but not limited to, the following:*

*(A) Short- and long-term memory, including immediate recall.*

*(B) Ability to understand or communicate with others, either verbally or otherwise.*

*(C) Recognition of familiar objects and familiar persons.*

*(D) Ability to understand and appreciate quantities.*

*(E) Ability to reason using abstract concepts.*

*(F) Ability to plan, organize, and carry out actions in one's own rational self-interest.*

*G) Ability to reason logically.*

*(3) Thought processes. Deficits in these functions may be demonstrated by the presence of the following:*

*(A) Severely disorganized thinking.*

*(B) Hallucinations.*

*(C) Delusions.*

*(D) Uncontrollable, repetitive, or intrusive thoughts.*

*(4) Ability to modulate mood and affect. Deficits in this ability may be demonstrated by the presence of a pervasive and persistent or recurrent state of euphoria, anger, anxiety, fear, panic, depression, hopelessness or despair, helplessness, apathy or indifference, that is inappropriate in degree to the individual's circumstances.*

*(b) A deficit in the mental functions listed above may be considered only if the deficit, by itself or in combination with one or more other mental function deficits, significantly impairs the person's ability to understand and appreciate the consequences of his or her actions with regard to the type of act or decision in question.*

*(c) In determining whether a person suffers from a deficit in mental function so substantial that the person lacks the capacity to do a certain act, the court may take into consideration the frequency, severity, and duration of periods of impairment.*

*(d) The mere diagnosis of a mental or physical disorder shall not be sufficient in and of itself to support a determination that a person is of unsound mind or lacks the capacity to do a certain act.*

*(e) This part applies only to the evidence that is presented to, and the findings that are made by, a court determining the capacity of a person to do a certain act or make a decision, including, but not limited to, making medical decisions. Nothing in this part shall affect the decision making process set forth in Section 1418.8 of the Health and Safety Code, nor increase or decrease the burdens of documentation on, or potential liability of, health care providers who, outside the judicial context, determine the capacity of patients to make a medical decision.*

*812. Except where otherwise provided by law, including, but not limited to, Section 813 and the statutory and decisional law of testamentary capacity, a person lacks the capacity to make a decision unless the person has the ability to communicate verbally, or by any other means, the decision, and to understand and appreciate, to the extent relevant, all of the following:*

*(a) The rights, duties, and responsibilities created by, or affected by the decision.*

*(b) The probable consequences for the decision maker and, where appropriate, the persons affected by the decision.*

*(c) The significant risks, benefits, and reasonable alternatives involved in the decision.*

*813. (a) For purposes of a judicial determination, a person has the capacity to give informed consent to a proposed medical treatment if the person is able to do all of the following:*

*(1) Respond knowingly and intelligently to queries about that medical treatment.*

*(2) Participate in that treatment decision by means of a rational thought process.*

*(3) Understand all of the following items of minimum basic medical treatment information with respect to that treatment:*

*(A) The nature and seriousness of the illness, disorder, or defect that the person has.*

*(B) The nature of the medical treatment that is being recommended by the person's health care providers.*

*(C) The probable degree and duration of any benefits and risks of any medical intervention that is being recommended by the person's health care providers, and the consequences of lack of treatment.*

*(D) The nature, risks, and benefits of any reasonable alternatives.*

*(b) A person who has the capacity to give informed consent to a proposed medical treatment also has the capacity to refuse consent to that treatment.*

Some 20 years on, the DPCDA was clearly groundbreaking and a phenomenal joint venture effort of the California State Bar Association and the California Medical Association.

However, it illustrates the complexity of capacity assessment and the difficulty legislating these principles. We put forward the Californian legislation and the Code of Practice to the UK Mental Capacity Act 2005 as examples, but not precedents to follow and discourage the legislation of capacity assessment principles. As stated previously, capacity assessment is a clinical process. It is not simple, should not be simple and human rights are not served by either prescriptive or reductionist statutory solutions.

As stated above in Question 3.1(2), information guidelines addressing the current decision-making capacity concepts will assist practitioners to understand principles of capacity and capacity assessment. Capacity assessment principles should not be conflated with general principles of decision-making or the right to make decisions with support, which may be contained within legislation as general principles (such as those in s. 4 of the Guardianship Act NSW or s. 39 of the Trustee and Guardian Act NSW) which apply to all or most decisions made under the legislation.

**Question 3.5: Should the definitions of decision-making capacity be consistent?**

*(1) Should the definitions of decision-making capacity within NSW law be aligned for the different alternative decision-making arrangements?*

International scientific consensual opinion is that definitions of capacity vary according to the decision at hand. This is the task, or decision–specific rule of capacity. The Guardianship Act NSW provides for alternative decision-making arrangements in regards to decisions about accommodation, health care, access, services, medical and dental consents, financial affairs. To align definitions of decision making capacity would be to undermine this basic capacity assessment principle. Consider the generic cognitive elements of capacity outlined above i.e:

(a) to understand the information relevant to the decision,

(b) to retain that information,

(c) to use or weigh that information as part of the process of making the decision, or

(d) to communicate his decision (whether by talking, using sign language or any other means).

As stated previously, this was designed for, and works well for medical and dental consents, using single decisions. However it doesn't work so well for financial capacity and administration orders. A plethora of instruments or methodologies have been developed to assess financial capacity.[12] There is no gold single standard instrument. However, forensic assessment scales such as the Financial Capacity Instrument [13] or the Financial Capacity Assessment Instrument[14] which specifically and comprehensively address financial capacity, provide more of a guide to the domains that should be considered, rather than more general daily living scales which assess individual tasks such as counting money or purchasing items. These domains include: Basic Monetary skills, Financial Conceptual knowledge, Cash transactions, Chequebook management, Bank statement management, Financial judgment including vulnerability to fraud and abuse, Bill payment, Knowledge of personal assets/estate arrangements, Investment Decision making. Questions geared to these domains include: Does the person know their assets and income? Can they read a bank statement? Do they pay their bills? Can they identify currency and its relative value?

On an entirely different note, capacity for intimate relationships (and potentially, an access function) can be operationalised as such:

- What is the person's understanding about what is involved in sexual intercourse?
- What is their knowledge of the nature of the relationship e.g. the identity of the other, emotional obligations of romantic relationships in general and in relation to the specific object of their affections?
- What is their knowledge (at a basic level) of the consequences of the relationship e.g. risks of pregnancy, sexually transmitted diseases, genital trauma, itch, anxiety?

[12] Sousa LB, Simões MR, Firmino H, Peisah C. (2014) Financial and testamentary capacity evaluations: procedures and assessment instruments underneath a functional approach. Int Psychogeriatr. 26(2):217-228.

[13] Marson, D.C., Sawrie, S.M., Snyder, S., McInturff, B., Stalvey T., Boothe A., Aldridge T., Chatterjee, A., Harrell, L.E. "Assessing financial capacity in patients with Alzheimer's disease" *Archives Neurology* 2000; 57; 877-884; Griffith HR, Belue K/., Sicola A., et al (2003) "Impaired financial abilities in mild cognitive impairment" *Neurology* 60: 449-457.

[14] Kershaw M.M. Webber L.S. (2008) Assessment of Financial Competence. Psychiatry Psychology and Law 15; 40-55

- Can they advocate for their interests, and terminate the relationship if they choose?[15]

Clearly the definition of decision-making capacity for both these types of capacity are tailored to the task at hand, often not a single decision. This also applies to other types of capacity, such as testamentary capacity, which also do not fit a single definition of capacity, albeit not relevant to the Guardianship Act. These ideas reflect international consensual medical and scientific opinion regarding decision- making capacity, as reflected in various academic publications [16] and consensual opinions of taskforces of both the International Psychogeriatric Association (the taskforce of which Professor Peisah chairs) and the World Psychiatric Association. [17]

Accordingly, it is neither possible nor appropriate to align the definitions of decision-making capacity within NSW law for the different alternative decision-making arrangements. Rather a simple over-arching statement defining capacity outlined in 3.1 should suffice, perhaps followed by a statement that capacity is task specific and as such the determination of capacity differs for each task.

(2) *If the definitions of decision-making capacity were to be aligned, how could this be achieved?*

Not appropriate as above.

**Question 3.6: Statutory presumption of capacity**

*Should there be a statutory presumption of capacity?*

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[15] O'Neill, N. & Peisah, C. (2011). *Capacity and the Law*. Sydney: Sydney University Press. Available at: http://www.austlii.edu.au/au/journals/SydUPLawBk/2011/1.html. Peisah C. Tiwana Benbow SM. Sexual expression, consent and capacity in residential care: a person-centred, human rights approach Book of Proceedings of the 1st Annual International Capacity Conference http://capacityaustralia.org.au/wp-content/uploads/2014/10/printed-Hong-kong-Booklet.pdf

[16] Peisah C, Forlenza O, Chiu E. Ethics, capacity, and decision-making in the practice of old age psychiatry: an emerging dialogue. Curr Opin Psychiatry. 2009 22 (6), pp. 519-521. Peisah C. (2016) Capacity Assessment in Chiu E. and Shulman K. Mental Health and Illness Worldwide. Mental Health and Illness of the Elderly. Springer Major Reference Work (in Press).

[17] Katona, c., et al (2009) World Psychiatric Association Section of Old Age Psychiatry Consensus Conference on Ethics and Capacity in old people with mental disorders International Journal Geriatric Psychiatry . 24(12):1319-24.

There is strong common law support for presumption of capacity. In the aforementioned examples of statutory support for such principles, the Mental Capacity Act 2005 (England and Wales) Part 1 Section 1 Principles states that a person must be assumed to have capacity unless it is established that he lacks capacity. In the Californian Due Process in Competency Determinations Act (DPCDA)(1996), Probate Code sections 810 – 813, and Civil Code section 39(b):

> *810. The Legislature finds and declares the following:*
>
> *(a) For purposes of this part, there shall exist a rebuttable presumption affecting the burden of proof that all persons have the capacity to make decisions and to be responsible for their acts or decisions*.

In the light of the common practice of presumption of NO capacity for people with various types of mental and physical illness and disability despite the common law presumption of capacity, there is practical value for an inclusion of this in the legislation.

**Question 3.7: What should not lead to a finding that a person lacks capacity**

(1) *Should capacity assessment principles state what should not lead to a conclusion that a person lacks capacity?*

Incapacity is not "status" or diagnosis bound [18]. This means that incapacity cannot be assumed because of a diagnosis, such as dementia or schizophrenia or Down's Syndrome, which means nothing in relation to decision making other than to raise a possible question as to capacity. The presumption may be rebutted by evidence to the contrary, but such evidence can only be derived when the person is given the opportunity to make the decision and appears to struggle as a result of a mental illness, disorder or intellectual disability. The question of whether or not a person has capacity is assessed in the context of their cognitive abilities and mental status in relation to the decision at hand.

In clinical settings the opposite occurs. People with mental illness, dementia or intellectual disability are usually presumed to lack capacity. Diagnoses per se are often sufficient to

[18] Peisah C, Forlenza O, Chiu E. Ethics, capacity, and decision-making in the practice of old age psychiatry: an emerging dialogue. Curr Opin Psychiatry. 2009 22 (6), pp. 519-521

prompt an application to NCAT, or recourse to family members to make substitute decisions. In a similar way, assumptions about capacity are made based on mere appearance or behaviour, which is specifically precluded in some jurisdictions (see below). The question is, can this be rectified by legislation?

(2) *If capacity assessment principles were to include such statements, how should they be expressed?*

Once again, models from other jurisdictions can be useful, particularly the recent Advance Personal Planning Act (Northern Territory). Part 1, Section 6 (5) of the Advance Personal Planning Act (NT) states that a person does not have impaired decision making capacity for a matter only because he or she:

*(a) has a disability, illness or other medical condition (whether physical or mental);or*
*(b) engages in unconventional behaviour or other form of personal expression; or*
*(c) chooses a living environment or lifestyle with which other people do not agree; or*
*(d) makes decisions with which other people do not agree; or*
*(e) does not speak English to a particular standard or at all; or*
*(f) does not have a particular level of literacy or education; or*
*(g) engages in particular cultural or religious practices; or*
*(h) does or does not express a particular religious, political or moral opinion; or*
*(i) is of a particular sexual orientation or identity or expresses particular sexual preferences; or*
*(j) takes or has taken, or is or has been dependent on, alcohol or drugs (but the effect of alcohol or drugs may be taken into account in determining whether the adult has impaired decision making; or*
*(k) engages or has engaged in illegal or immoral conduct*

The Mental Capacity Act 2005 (England and Wales) Part 1 section 1 Principles states:

*(2) A person must be assumed to have capacity unless it is established that he lacks capacity.*
*(3) A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.*

*(4) A person is not to be treated as unable to make a decision merely because he makes an unwise decision.*

Additionally, section 2 states

*(2) A lack of capacity cannot be established merely by reference to— (a) a person's age or appearance, or (b) a condition of his, or an aspect of his behaviour, which might lead others to make unjustified assumptions about his capacity.*

More simply uncoupling diagnosis from incapacity, the Californian Due Process in Competency Determinations Act (DPCDA)(1996), Probate Code sections 810 – 813, and Civil Code section 39(b):

*810. The Legislature finds and declares the following:*
*(c) A judicial determination that a person is totally without understanding, or is of unsound mind, or suffers from one or more mental deficits so substantial that, under the circumstances, the person should be deemed to lack the legal capacity to perform a specific act, should be based on evidence of a deficit in one or more of the person's mental functions rather than on a diagnosis of a person's mental or physical disorder*.

Unlike our statements above which specifically argue against legislating for "how to" assess capacity (which is a dynamic and ever evolving expertise- driven field), there may be value articulating in legislation a set of universally agreed transgressions in this area, perhaps best exemplified by the recent Northern Territory legislation.[19]

**Question 3.8: The relevance of support and assistance to assessing capacity**

*(1) Should the availability of appropriate support and assistance be relevant to assessing capacity?*

The availability of appropriate support must be part of capacity assessment, particularly for the purposes of application for orders for substitute decision making under the NSW Guardianship Act. As stated previously, disability is the interaction between individuals with a health condition and personal and environmental factors. [20] This means that provision of

[19] See *Guardianship of Adults Act (NT)* enacted in 2016 – s 5(6) in particular, but also s 5(5).
[20] World Health Organisation Health topics Disabilities. http://www.who.int/topics/disabilities/en/ Accessed October 10, 2016.

ramp for a person in a wheelchair negates their disability in regards to access. On a similar note, support for decision making may negate decision making disability, or negate the "need" for guardianship/administration, and preclude an application to NCAT.

*(2) If the availability of such support and assistance were to be relevant, how should this be reflected in the law?*

The Mental Capacity Act 2005 (England and Wales) Part 1 section 1 states:

> *A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.*

**Question 3.9: Professional assistance in assessing capacity**

*(1) Should special provision be made in NSW law for professional assistance to be available for those who must assess a person's decision-making capacity?*

As stated previously, capacity screening can, and should be performed by the full gamut of professionals who provide service or care, or are involved in decision making with people with cognitive and mental disorders, including health care professionals, lawyers and financial service professionals. Capacity assessment should be performed by health care professionals with expertise in the performance of such. One of the constraints to this is the lack of clear assessment processes.[21]

Capacity Australia was established in 2011 with the objective of providing education and training on capacity screening and assessment across health, legal and financial sectors, including capacity determination for the purposes of appointment of substitute decision making under the Guardianship Act. A range of resources have been provided for such including the textbook, our website and the State-specific legal minikits.[22] Beyond Capacity Australia and its affiliates there is a paucity of resources to provide assistance for those assessing capacity, despite an acknowledged need for such (e.g. by the NSW Health, Whole of Health Guardianship Project).[23]

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[21] Purser, K. "Assessing testamentary capacity in the 21st Century: Is *Banks v Goodfellow* still relevant?" (2015) 38(3) UNSW Law Journal 854

[22] http://capacityaustralia.org.au/

[23] http://www.health.nsw.gov.au/wohp/Pages/news.aspx

Making special provision in NSW law for professional assistance to be available for those who must assess a person's decision-making capacity is thus not feasible.

*(2) How should such a provision be framed?*

As indicated above - not appropriate.

**Question 3.10: Any other issues?**

*Are there any other issues you want to raise about decision-making capacity?*

No.

**Question 4.1: The need for an order**

*(1) Should there be a precondition before an order is made that the Tribunal be satisfied that the person is "in need" of an order?*

The use of the word "need" in the current Act is on the one hand extremely confusing in its currently drafted form, yet essential in its inclusion. As a result of poor drafting, in 1987, of some parts of the Act that, in s. 3, a definition of "a person in need of a guardian" means a person who, because of a disability, is totally or partially incapable of managing his or her person. That provision is followed by the statement in s. 14(1) that:

> If, after conducting a hearing into any application made to it for a guardianship order in respect of a person, [NCAT] is satisfied that the person is a person in need of a guardian, [NCAT] may make a guardianship order in respect of the person.

However before making a guardianship order, NCAT is required to have regard to the matters set out in s. 14(2) of the Act. In many cases you finish up with the contradictory situation in which a person who was "in need of a guardian" according to the s. 3 definition, did not need to have a guardian appointed for them after considering s. 14(2), particularly s. 14(2)(d) concerning the practicability of services provided without the need for an order, the s. 4 principles, the facts of the case and circumstances of the person.

Those regularly made decisions are confirmation of NCAT and its predecessors giving effect to the policy behind the Act, namely that the making of orders is a matter of last resort and

the need for a guardian must be apparent or very clearly foreseeable before an order is made. Simply stated, people who have a disability and who are unable to manage their person (i.e. lack capacity) do not require guardians. Impaired capacity per se is insufficient grounds for application for substitute decision making under the Act. This has been articulated in our teaching as:-

- DISABILITY ≠ grounds for GUARDIANSHIP
- DISABILITY + INCAPACITY ≠ grounds for GUARDIANSHIP

BUT ….

- DISABILITY + INCAPACITY + NEED = grounds for GUARDIANSHIP

Additionally, disability is irrelevant to this determination, as stated in our response to question 3.1. However, even if we replace the word disability with the preferred "impairment of, or a disturbance in the functioning of, the mind or brain", there must be established incapacity AND a need. While the drafting of the Act could do with a review, the requirement of need is an essential element of guardianship legislation to maximise autonomy in accordance with the CRPD.

*(2) If such a precondition were required, how should it be expressed?*

The need for guardian should not be distinguished from the need for an order. Put simply, an order (or guardian/financial manager appointment) is only required if there is:

(a) impairment of, or a disturbance in the functioning of, the mind or brain causing incapacity for a specific matter; and
(b) there is a need for an order such that no less restrictive alternative exists; and
(c) all practicable steps to help the person to make the decision have been taken without success.

**Question 4.2: A best interests precondition**

*(1) Should there be a precondition before an order is made that the Tribunal be satisfied that the order is in the person's "best interests"?*

As per s. 4, there has always been a mandate to give paramount consideration to the welfare and interests of subject persons. It has been suggested that as a matter of logic

that "welfare and interests" is the same as best interests. However the guardianship experience to date shows that this is not the case. In the context of the other principles in s. 4 as well as the considerations set out in s. 14(2), it is clear that there are many particular considerations that are to be considered. As a consequence, it is not accurate to equate "welfare and interests" with "best interests" when "best interests" is seen as a term operating at large and unaffected by at least the matters set out in ss. 4 and 14(2). If the concept of "best interests" is considered standing alone and not in the context of the legislation in which it is found, it simply becomes "best interests" as determined subjectively by the members of NCAT hearing the matter. Additionally, a subjective element is introduced by those providing reports/ evidence to the Tribunal in regards to "best interests". And that could lead to a patronising decision to appoint a guardian to protect the person the subject of the application from some of the vicissitudes of life by restricting their freedom of decision and action, discouraging them from living as far as possible a normal life in the community, not encouraging self-reliance and not considering the views of the person – all s. 4 principles.

As can be seen from the following in the paper given by Capacity Australia Director Nick O'Neill at the AGAC Conference 17 October 2016, the concept of "best interests" is highly nuanced in all the guardianship jurisdiction in Australia:

> *It is only the Western Australian tribunal (WASAT) that must make the best interests of the person the subject of the application its primary concern. Even then, it must not make an order if it is of the opinion that the needs of the person can be met by other means that are less restrictive of the person's freedom of decision and action. Also it must not appoint a plenary guardian where a limited guardian would be sufficient and, when appointing a limited guardian or an administrator, impose the least restrictions on the person's freedom of decision and action as is possible in the circumstances.* [24]
>
> *In clear contrast, the South Australian Act makes as the paramount consideration that SACAT has to put its mind to its opinion of what would be the wishes of the person if they were not mentally incapacitated – but, of course, only so far as there was reasonably ascertainable evidence on which to base that opinion. However other considerations required of SACAT are similar to those WASAT must put its mind to. When making either a guardianship or administration order or both, it must consider the adequacy of existing informal arrangements for the care of the person or the management of their financial affairs and to the desirability of not disturbing those*

[24] *Guardianship and Administration Act 1990 (WA)* s 4.

*arrangements. Any order that is made must be the one that is the least restrictive of the person's rights and personal autonomy as is consistent with their proper care and protection.*[25]

*In NSW, NCAT must give paramount consideration to the welfare and interests of the person they are considering making a guardianship or financial management order in relation to. However the order that it makes should restrict the freedom of decision and of action as little as possible. Consistent with that principle, the NSW Act provides that a plenary guardianship order shall not be made where a limited guardianship order would suffice.*[26]

*In Victoria and Tasmania there is a best interests requirement, but it is put differently from the WA provision. Neither VACT nor the Tasmanian Guardianship and Administration Board may make a guardianship or administration order unless it is satisfied that the order would be in the best interests the person. That is a different idea from the idea that the primary concern of the tribunal being the best interests of the person.*

*However, like in WA and NSW neither tribunal may make a plenary guardianship order unless it is satisfied that a limited guardianship order would be insufficient to meet the needs of the person who the application is about. Also any limited guardianship made shall be the least restrictive of the person's freedom of decision and action as is possible in the circumstances.*[27]

*The Queensland Act requires that before QCAT makes either a guardianship or an administration order, it must be satisfied that the person has impaired capacity for the matter and that there is a need for a decision about the matter or unreasonable risk in relation to the matter will or is likely to arise and, among other things, the person's interests will not be adequately protected. Again, this is a different concept from the best interests concept in the WA Act.*[28]

*The relevant provisions of the ACT Act are very similar to those of the Queensland Act. However in the ACT the wording is; "the person's interests will be significantly adversely affected".*[29]

*The NT Guardianship of Adults Act, which empowers NTCAT to appoint guardians as substitute decision-makers in relation to both personal and financial matters, was enacted and brought into force in 2016. Before it may appoint a guardian, NTCAT has to be satisfied that the person has impaired decision-making capacity, that the effect of that impairment is that the person is unable to exercise decision-making capacity in relation to some or all personal or financial matters and the person is in need of a guardian for some or all of those matters. When determining whether the person is in need of a guardian, NTCAT must take a range of matters into account,*

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[25] *Guardianship and Administration Act 1993 (SA)* s 5.
[26] *Guardianship Act 1987(NSW)* s 4.
[27] *Guardianship and Administration Act 191986(Vic)* s 22 and *Guardianship and Administration Act 1995 (Tas)* s 20.
[28] *Guardianship and Administration Act 2000 (Qld)* s 12.
[29] *Guardianship and Management of Property Act 1991 (ACT)* ss 7 and 8.

*including whether the person's needs could be adequately provided for in a way that is less restrictive of their freedom of decision and action than appointing a guardian.*[30]

*Mr Elferink the then Attorney-General and Minister for Justice in the NT pointed out in the second reading speech the Guardianship of Adults Bill 2016 sought to recognise the overall wellbeing, human rights and fundamental freedoms of persons with impaired decision-making capacity and align with the United Nations Convention on the Rights of Persons with Disabilities.*

*He said it was a contemporary piece of legislation drafted to maximise the participation of adults with impaired decision-making capacity in decisions affecting them, and also in everyday life, and to provide guardians with more guidance and certainty about their role.*[31]

*The Act does do all those things. However, he also noted that the legislation required NTCAT, like other decision-makers exercising authority under the legislation, to exercise that authority in a way that NTCAT believed was in the best interests of the person the subject of the application. But in order to determine the person's best interests, NTCAT had to seek and obtain the person's current views and wishes, so far as it was practicable to do so and to take into account all relevant considerations. The Act provides a long but non-exclusive list of relevant considerations that reflect the principles in the legislation of the other Australian jurisdictions.*[32] *Any consideration that NTCAT claimed was a matter of a person's best interests would have to be identified and an explanation given as to why it was in that particular person's best interests in relation to making a guardianship order.*

Even in relation to financial management orders where the elements of the test are, first incapacity to manage, second need for a manager and third, "it is in the person's best interests that the [financial management] order be made" the matter is much more nuanced in NSW. Again as Nick O'Neill pointed out in his 2016 paper referred to above:

*This is because as Lindsay J of the NSW Supreme Court sets out in some detail, the fact that tribunals considering whether a person lacks capacity to manage their own personal or financial affairs need to apply a holistic approach in applying the different concepts and requirements in the relevant legislation to the facts of each particular case with the result that; "an exhaustive definition of the concept, applicable to all cases at all times, is not … to be expected".*[33]

Later in his judgment Lindsay J went on to point out that:

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[30] *Guardianship of Adults Act (NT)* s 11.
[31] Northern Territory Legislative Assembly Debates 12th Assembly, 1st session, 19 March 2016, Parliamentary Record 28.
[32] *Guardianship of Adults Act (NT)* s 4.
[33] *P v NSW Trustee and Guardian* [2015] NSWSC 579. See [276] to [214] generally and [312] in particular.

*[T]he terms [the words and how they are stated] of the legislation must be viewed holistically, and bearing in mind that the concept of "capability" is directed to the reasonably foreseeable future as well as to the present time. This holistic approach also involved a consideration of the principles set out in the relevant legislation, particularly those provisions that placed a strong emphasis on a person's autonomy and dignity.*[34]

*H then noted that whether a person is to be found "capable of managing his or her own affairs", or not, ultimately requires a judgement-call grounded upon guidance available within the framework of the governing legislation and a close examination of the facts of the particular case.*[35]

Capacity Australia considers it appropriate either to drop the notion of "best interests" altogether or, noting that it has been a priority internationally in the light of a preference for will and preferences over the usually "other- defined", subjective notion of "best interests" to be applied, that the problem can be overcome by articulating clearly what is meant by best interests and include "will and preference" (including previous will and preferences or what we call "precedent autonomy") in the definition. We suggest that the provisions of the relevant legislation in the other States and Territories (except WA) could be considered, particularly the way it is dealt with in s. 4 of the Guardianship of Adults Act of the Northern Territory that came into force 29 July 2016.

It may also be useful to consider the Mental Capacity Act 2005 (England and Wales) which states in s. 4, in terminology still used in England and Wales:

*(1) In determining for the purposes of this Act what is in a person's best interests, the person making the determination must not make it merely on the basis of— (a) the person's age or appearance, or (b) a condition of his, or an aspect of his behaviour, which might lead others to make unjustified assumptions about what might be in his best interests.*

*(2) The person making the determination must consider all the relevant circumstances and, in particular, take the following steps.*

[34] Ibid. [311]
[35] Ibid. [312].

*(3) He must consider— (a) whether it is likely that the person will at some time have capacity in relation to the matter in question, and (b) if it appears likely that he will, when that is likely to be.*

*(4) He must, so far as reasonably practicable, permit and encourage the person to participate, or to improve his ability to participate, as fully as possible in any act done for him and any decision affecting him.*

*(5) Where the determination relates to life-sustaining treatment he must not, in considering whether the treatment is in the best interests of the person concerned, be motivated by a desire to bring about his death.*

*(6) He must consider, so far as is reasonably ascertainable— (a) the person's past and present wishes and feelings (and, in particular, any relevant written statement made by him when he had capacity), (b) the beliefs and values that would be likely to influence his decision if he had capacity, and (c) the other factors that he would be likely to consider if he were able to do so.*

*(7) He must take into account, if it is practicable and appropriate to consult them, the views of— (a) anyone named by the person as someone to be consulted on the matter in question or on matters of that kind, (b) anyone engaged in caring for the person or interested in his welfare, (c) any donee of a lasting power of attorney granted by the person, and (d)* any *deputy appointed for the person by the court, as to what would be in the person's best interests and, in particular, as to the matters mentioned in subsection (6).*

*(8) The duties imposed by subsections (1) to (7) also apply in relation to the exercise of any powers which— (a) are exercisable under a lasting power of attorney, or (b) are exercisable by a person under this Act where he reasonably believes that another person lacks capacity.*

*(9) In the case of an act done, or a decision made, by a person other than the court, there is sufficient compliance with this section if (having complied with the requirements of subsections (1) to (7)) he reasonably believes that what he does or decides is in the best interests of the person concerned.*

*(10) "Life-sustaining treatment" means treatment which in the view of a person providing health care for the person concerned is necessary to sustain life.*

*(11) "Relevant circumstances" are those— (a) of which the person making the determination is aware, and (b) which it would be reasonable to regard as relevant.*

(2) *If such a precondition were required, how should it be expressed?*

See (1) above.

(3) *What other precondition could be adopted in place of the "best interests" standard?*

See (1) above.

**Question 4.3: Should the preconditions be more closely aligned?**

*(1) Should the preconditions for different alternative decision-making orders or appointments in NSW be more closely aligned?*

The preconditions for different alternative decision-making orders should be aligned for the sake of clarity and understanding by those making applications under the Act and those making capacity assessments for the purposes of the Act. In particular, at present, need is a precondition for guardianship, while best interests is a precondition for financial management. Need should be a precondition for both. Best interests should be removed from financial management.

*(2) If so, in relation to what orders or appointments and in what way?*

As above.

**Question 4.4: Any other issues? Are there any other issues you want to raise about the preconditions for alternative decision-making arrangements?**

No

**Question 5.1: What factors should be taken into account?**

*(1) What considerations should the Tribunal take into account when making a decision in relation to:*

(a) a guardianship order

(b) a financial management order?

See below.

*(2) Should they be the same for all orders?*

The three requirements of (i) impairment of mind or brain; (ii) incapacity; and (iii) need should be a requirement for all orders.

*(3 ) Are there any other issues you want to raise about the factors to be taken into account when making an order?*

No. However we reserve the right to offer comment should changes to the s. 4 principles be suggested by the NSWLRC.