Health
Illawarra Shoalhaven
Local Health District

25 January 2017 JQ:kb

GPO Box 31
Sydney NSW 2001

Dear Sir/Madam

RE: NSW Law Reform Commission - Guardianship Act Review Update

I am a senior specialist in Rehabilitation Medicine working in the Illawarra.

Thank you for the opportunity to make some representations with regards your review of the NSW Guardianship Act.

Question Paper 2 – Decision Making Models
– my opinion is that the current Guardianship Act of 1987 has some areas of concern.

You have noted some of these concerns in your document, but briefly:

- The standard and method of capacity assessment in medical and legal settings are quite different. For example, a person who has had numerous assessments by medical consultants, allied health, nursing, family, community health workers, general practitioners, etc over a number of months, can have their decision "over-ruled" by a solicitor visiting the patient without any reference to the above practitioners, and deem the person to have/not have capacity for a particular question.

- A legal practitioner is also able to assess whether a person, who health professional have concluded does not have capacity to change an 'activated' enduring guardianship (which has not previously raised any concerns about due diligence of the enduring guardian), can change /rescind the enduring guardianship order. While legal oversight is necessary, there is a concern that a person with significant impairment (lack of capacity) could be prone to accept assurances of certain benefits of others, if the current enduring guardianship is rescinded. My understanding is that the whole idea of appointing an enduring guardian (to become active if and when needed) is that the person (s) that they trust with this important role, will become the enduring guardian. If there are concerns about the diligence of the appointed enduring guardian, this can be referred to the Tribunal for review.

- The strength of the 'legal assessment', in effect, makes the *"NSW Guardianship Application process for adult inpatients in NSW Health facilities",* (document number GL2016-026, publication date 4/11/2016) redundant. This document lists the responsibilities of health workers in 'NSW Health' facilities. In Section 2.3, the document outlines responsibilities of different medical teams, in Section 2.4 it outlines the roles of social workers, in Section 2.5 it outlines the roles of other health professionals, in Section 2.6 it outlines the roles of nurses and midwives. Often in the assessment of capacity, the team may request evidence from General Practitioners, family, community health care workers, etc.

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- With regard to 'capacity assessment' by the legal profession, I am unaware of any obligatory training to enable expertise in this area. The Law Society has expressed concern about this in the document 'When a client's mental capacity is in doubt (see attached).

- On a related matter, the current Guardianship legislation includes the right to appeal to the Supreme Court of NSW. I understand this can be an expensive, lengthy, and difficult process, possibly at times become impractical.

Section 2 What is a solicitor's role in mental capacity assessment?

A solicitor can be involved in carrying out a "legal" assessment of capacity. There is no single definition of legal capacity in New South Wales.

A solicitor may or may not have had any experience or training in what is involved in assessment capacity for a person to make a particular decision.

The position with regards the requirements for legal capacity assessment, I think, need to be clarified. The NSW Health guidelines (document number GL2016-026, publication date 4/11/2016) provide a rigorous framework in which capacity should be assessed in public hospitals. I have not been able to find a similar document with guidelines for the legal profession.

A practical concern is assessment of risk. NSW Health seems to be extremely risk averse –my area of work, rehabilitation, often involves people caring for people with dementia, brain injury, language impairment, frailty, etc. In NSW, there is a lack of guidance with regards 'risk' or 'acceptable risk', and vulnerability. For example, people who tend to fall are often advised, sometimes strongly, that nursing home level of care is the preferred (or even the 'only') option – at least some of these patients may have capacity to make such a decision.

There are a number of people kept in NSW public hospitals, despite requests to return home (bearing in mind the patient may have no concept of what or where 'home' is), because of a concern of risk and 'duty of care' to patients. In some circumstances, some of these patients may fall under the information provided in the *NCAT guardianship division factsheet on restrictive practices and guardianship* (attached). The application for an NCAT guardianship division hearing may take some time (months) during which time the legal status of the patient, and the hospital, are, I think, uncertain.

I would ask that some mechanism could be discussed, where people in this situation have more legal oversight/protection in a more efficient manner.

As in your introductory discussion, Article 12 of the Convention on the Rights of Persons with Disabilities should address this concern when implemented in Australia - the advancement of supported decision making represents excellent progress.

Yours faithfully

John Quinlan

Dr John Quinlan FAFRM

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CC: MR

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Attached:

Law Society of NSW document "When a client's mental capacity is in doubt" the *practical guide for solicitors (2016).*

NCAT Fact Sheet Guardianship Division - Restrictive practices and guardianship

References

Have your say: The role of guardians and financial managers
http://www.lawreform.justice.nsw.gov.au/Pages/lrc/lrc_current_projects/Guardianship/Have-your-say-the-role-of-guardians-and-financial-managers.aspx

Guardianship Act Review – Question Paper 2 and 3
http://being.org.au/2016/12/law-reform-of-guardianship-act-1987/

THE LAW SOCIETY
OF NEW SOUTH WALES

WHEN A CLIENT'S MENTAL CAPACITY IS IN DOUBT

A PRACTICAL GUIDE
FOR SOLICITORS

THE LAW SOCIETY
OF NEW SOUTH WALES

CONTENTS

1. INTRODUCTION

It is common to refer to capacity and mean only one of the three types of capacity, that being mental capacity. However, there are three different types of capacity: legal capacity, mental capacity and physical capacity. This is a short, practical guide for solicitors on what to do and what resources are available to assist them if they are concerned that their client may lack mental capacity to give instructions or make their own legal decisions.

While there is a basic common law presumption that every adult person has mental capacity to make their own decisions, in some cases solicitors may find they have doubts about whether their client does have the required legal level of mental capacity.

This may be for a range of reasons - the client may have an intellectual disability, an acquired brain injury or a mental illness. As the proportion of older people in the community increases, so does the likelihood that an older client may have an age related cognitive disability, such as Alzheimer's disease, which impairs their mental capacity to make decisions.

Dealing with a situation where a person's mental capacity is in issue is often a complex area however there are some basic principles which can guide solicitors in responding to these situations.

2. WHAT IS THE SOLICITOR'S ROLE IN MENTAL CAPACITY ASSESSMENT?

It is not the role of a solicitor to be an expert in mental capacity assessment of their client. However, a solicitor can be involved in carrying out a "legal" assessment of their client's mental capacity which involves:[1]

- Making an preliminary assessment of mental capacity - looking for warning signs or 'red flags' using basic questioning and observation of the client.[2]
- If doubts arise, seeking a clinical consultation or formal evaluation of the client's mental capacity by a clinician with expertise in cognitive capacity assessment.[3]
- Making a final legal judgment about mental capacity for the particular decision or transaction.[4]

People whose cognitive capacity is impaired may be vulnerable to exploitation by others and may not be able to protect their own legal interests. Solicitors have ethical duties to the court, their clients and to the administration of justice to ensure that the interests of their clients are promoted and protected at all times. Rule 8 of the *Legal Profession Uniform Law Australian Solicitors' Conduct Rules 2015* provides that a solicitor must follow a client's lawful, proper and competent instructions. This may suggest that a solicitor assess whether a client has the requisite mental capacity before either taking instructions or assisting them to make a legal decision which will affect their interests.

There are several cases in which the Supreme Court of NSW has considered the role of a solicitor when taking instructions from an older client where their mental capacity to understand a specific legal task is in question.[5]

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1 The American Bar Association Commission on Law and Aging and the American Psychological Association, *Assessment of Older Adults with Diminished Capacity: A Handbook for Lawyers* (2005) at p 3 http://www.apa.org/pi/aging/diminished_capacity.pdf

2 Ibid.

3 Ibid.

4 Ibid.

5 See *Anastasia Pates v Diane Craig and the Public Trustee: Estate of the Late Joyce Jean Cole No. 106306/94 Wills-Solicitors* [1995] NSWSC 87, *Winefield v Clarke* [2008] NSWSC 882 and *Edith White v Judith Liane Wills* [2014] NSWSC 1160.

3. WHAT IS "MENTAL CAPACITY"?

There is no single legal definition of mental capacity in New South Wales. Rather, the legal definition of mental capacity depends in each case on the type of decision which is being made or the type of transaction involved[6].

This means there are a variety of legal tests of mental capacity. Some are contained in legislation such as the *Guardianship Act 1987* (NSW) and others have been developed in common law, such as the test for testamentary capacity.

The different legal tests for mental capacity mean that a client may have the mental capacity to make some decisions, such as deciding whether to make small purchases like groceries, but may lack the mental capacity to make other decisions such as deciding whether to enter into more complicated financial arrangements.

A finding of incapacity in one area does not automatically mean that mental capacity is lacking in another area; for example, the Supreme Court of NSW has found that a person who is incapable of managing their financial affairs may still be mentally capable of making a will[7]. It has been suggested that the same mental capacity may not be necessary to revoke a will as to make one[8]. Similarly, lesser mental capacity may be needed for a codicil than a will[9]. A person may not be capable on managing their affairs but have the mental capacity to make an enduring power of attorney[10]. A person may not have the mental capacity to make a contract but have capacity to make a will[11]. Similar, if not greater, mental capacity is needed to make a power of attorney compared to that required for a will[12].

Appendix A to this Guide lists some of the more common tests for mental capacity in different legal areas but solicitors must ensure they keep up to date with the most recent statutory or common law mental capacity tests in the particular area involved.

Despite the many different legal tests for mental capacity, the fundamental issue is whether the client is able to understand the general nature of what they are doing[13].

If a client has ongoing difficulty in demonstrating this level of understanding then this may indicate a lack of mental capacity which warrants further exploration by the solicitor.

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6 *Gibbons v Wright* [1954] HCA 17.

7 *Re Estate of Margaret Bellew* [1992] Supreme Court of NSW, Probate Division (Unreported) McLelland J, 13 August 1992.

8 *d'Apice v Gutkovich - Estate of Abraham* (No. 2) [2010] NSWSC 1333, [96], Public *Trustee v Elderfield; estate of Poole* (Supreme Court of NSW, Young J, 26 April 1996, unreported).

9 *Hay v Simpson* (1890) 11 LR (NSW) Eq 109.

10 *Re K* [1988] 1 Ch 310.

11 *Banks v Goodfellow* (1870) LR 5 QB 549 citing *Stevens v Vancleve* (1822) 23 F. Cas. 35.

12 *Szozda v Szodza* [2010] NSWSC 804.

13 In *CJ v AKJ* [2015] NSWSC 498 at [32] the court stated: "The general law does not prescribe a fixed standard of "capacity" required for the transaction of business. The level of capacity required of a person is relative to the particular business to be transacted by him or her, and the purpose of the law served by an inquiry into the person's capacity: *Gibbons v Wright* (1954) 91 CLR 423 at 434-438".

4. KEY PRINCIPLES

Whenever a client's mental capacity may be in issue, it is important to remember and follow the following principles which are set out in *The Capacity ToolKit*[14] issued by the NSW Department of Justice:

- **Always presume a person has mental capacity**
  Under common law you must presume that a person has the mental capacity (sometimes called sanity) to make all their own decisions.
- **Mental capacity is decision-specific**
  Apply the presumption of mental capacity for every decision a person makes. If a client can make some but not all decisions, then they have a right to make as many decisions as possible.
- **Mental capacity is fluid**
  A person's mental capacity can fluctuate over time or in different situations, so you will need to assess their mental capacity for each decision whenever there is doubt about mental capacity. Even where a client lacked the ability to make a specific decision in the past, they might be able to make that decision later on. Clients might also regain, or increase their mental capacity, for example by learning new skills or taking medication. Other factors such as stress, grief, depression, reversible medical conditions or hearing or visual impairments may also affect a person's decision-making mental capacity.
- **Don't make assumptions that a person lacks capacity because of their age, appearance, disability or behaviour**
  A person's mental capacity should not be assessed solely on the basis of:
  - the way a person looks
  - the way a person presents
  - the way a person communicates
  - a person's impairment
  - the way a person acts or behaves
- **Assess a person's decision-making ability – not the decision they make**
  A client cannot be assessed as lacking mental capacity merely because they make a decision you think is unwise, reckless or wrong. Individuals have their own values, beliefs, likes and dislikes, and the majority of people take chances or make 'bad' decisions occasionally.
- **Respect a person's privacy**
  Assessing a person's mental capacity means dealing with personal information about them and there are a variety of legislative and ethically based privacy principles which are involved. In most cases, a client must consent to their personal information being provided to others.
- **Substitute decision-making is a last resort**
  A client may be able to make a particular decision at a certain time because they have support during the decision-making process (assisted decision- making). Before concluding lack of mental capacity, ensure that everything possible has been done to support the client to make a decision. Only seek the appointment of a substitute decision-maker such as a tutor, guardian or financial manager as a last resort.

These principles provide solicitors with a useful, practical and flexible approach to exploring issues of mental capacity according to the individual circumstances of each client. The *Capacity Toolkit* contains a wealth of information and guidance about mental capacity assessment and is available on-line or from the NSW Department of Justice or the Law Society.

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14 New South Wales Department of Justice *Capacity Toolkit: Information for government and community workers, professionals, families and carers in New South Wales*, (Sydney, 2008) at http://www.justice.nsw.gov.au/diversityservices/Pages/divserv/ds_capacity_tool/ds_capacity_tool.aspx

5. INDICATORS OF LACK OF MENTAL CAPACITY – WARNING BELLS AND RED FLAGS!

It will often be difficult to know when a client's mental capacity may be an issue. On the one hand, solicitors need to take great care to avoid making assumptions that a person lacks mental capacity because of their disability or their advanced age. As Gleeson CJ wrote in *Easter v Griffith* (1995) 217 ALR 284, at 290, in the context of testamentary mental capacity but seemingly applicable to all instances of challenged mental capacity: "a determination that a person lacked (or has not been shown to have possessed) a sound disposing mind, memory and understanding is a grave matter". This suggests that a conclusion about lack of mental capacity should not be "produced by inexact proofs, indefinite testimony, or indirect inferences": *Briginshaw v Briginshaw* [1938] HCA 34 per Dixon J.

On the other hand, there are certain indicators of a lack of mental capacity which should cause "warning bells to go off" if a solicitor becomes aware of them.

In some cases, the signs of a person's lack of mental capacity will be straightforward - they may be severely disoriented and confused about where they are and clearly unable to comprehend what is being said to them or to communicate in a rational way.

However, in other cases, it will not be obvious that a person may lack mental capacity. Many people with age-related cognitive disabilities may present extremely well to people who do not know them well and can appear capable.

It will only become apparent on closer, sometimes expert, examination that their mental capacity is impaired. A person with dementia may have excellent long term memory and be oriented in time and space but have poor short term memory with deficits in their judgment or ability to plan. They may be able to hold intelligent, lucid and entertaining conversations but not remember any details of that conversation a short period later.

There are some general warning signs or 'red flags' that point to the need for further investigation but they are not exhaustive and should not be used as grounds for a definite diagnosis.

These include[15]:

- A client demonstrates difficulty with recall or has memory loss
- A client has ongoing difficulty with communications
- A client demonstrates a lack of mental flexibility
- A client has problems with simple calculations which they did not have previously
- A client is disoriented
- There is a sense that "something about the client has changed", including deterioration in personal presentation, mood or social withdrawal
- A client is in hospital or a residential aged care facility when instructions are taken
- A client has changed solicitors several times over a short period, particularly if there has been a change from a solicitor who has advised the client for many years
- A client is accompanied by many other friends, family or carers to interviews with the solicitor but is not given the chance to speak for themselves
- A client shows a limited ability to interact with the solicitor
- A client shows a limited ability to repeat advice to the solicitor and ask key questions about the issues

Appendix B is a Capacity Worksheet developed in the United States which gives more examples of "warning signs" that mental capacity may be an issue.

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15 The American Bar Association Commission on Law and Aging and the American Psychological Association, *Assessment of Older Adults with Diminished Capacity: A Handbook for Lawyers* (2005) at above n1 at page v and pp13-16 at http://www.apa.org/pi/aging/diminished_capacity.pdf

6. COMMUNICATION WITH CLIENT

Communication with clients – approach and questions

It is vital that a solicitor approaches their consultation with their client in a way which will help the solicitor gain as much useful information as possible about whether the client has mental capacity to instruct a solicitor or make a legal decision.

There are a number of techniques which solicitors can use to provide a comfortable environment for clients which maximises their ability to understand the discussion and to accommodate any disabilities or impairments they may have[16]. These include giving clients more time to read documents, putting a client at ease and providing aids where the client has hearing or vision impairments.

Appendix C discusses some techniques which solicitors can use to assist clients to be at their best during a consultation with their solicitor.

The way in which questions are put to the client and their responses, both verbal and non-verbal, will also give a crucial indication of their ability to understand what is being discussed and how it affects them and their interests.

When asking questions, it is important to remember[17]:

- **Ask open-ended questions rather than questions which can be answered by "Yes" or "No"**
  Such as: What sort of decisions will your attorney be able to make for you?
- **Do not ask leading questions which suggest the answer**
  Such as: You probably would rather have someone in your family look after your money than a public official wouldn't you?
- **Frame your questions to quickly identify any areas of concern for which a person may need support or help, or require a substitute decision-maker**
  Such as: Will anyone else be affected by the contract or benefit from the contract? Who? Tell me about some of the important parts of the contract.
- **It is important to ensure it is the person being assessed who answers the questions**
  In some circumstances the person may need support from a neutral person such as an advocate or an interpreter.

7. SOLICITOR'S RECORDS OF INITIAL MENTAL CAPACITY ASSESSMENT

It is fundamental that solicitors take thorough, comprehensive and contemporaneous file notes of any consultation with clients where mental capacity is in issue or where the solicitor is exploring this issue through questioning and by observing the client.

These notes will be invaluable if the issue of mental capacity is subsequently raised in legal proceedings where the question of the client's mental capacity is challenged.

These challenges may not be made for some years after a solicitor has taken instructions, as is often the case when wills are disputed many years after they have been made.

A solicitor's notes may also be of assistance to any professional clinician who is engaged to undertake a professional assessment of the client's mental capacity.

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16 The American Bar Association Commission on Law and Aging and the American Psychological Association, *Assessment of Older Adults with Diminished Capacity: A Handbook for Lawyers* (2005) above n1 at pp27-30 at http://www.apa.org/pi/aging/diminished_capacity.pdf

17 The questions listed here and more can be found in the *Capacity Toolkit*, above n14 at pp110-137.

8. WHEN TO REFER AND TO WHOM

If there are still doubts about a client's mental capacity after the solicitor's "initial assessment", there may be a need to request a formal mental capacity assessment from a medical professional with experience in assessment of cognitive capacity.

There is a range of medical professionals whose role is to undertake mental capacity assessments and they use a variety of methods or tools to complete this task. A solicitor needs to consider the client's particular circumstances and possible disability before making a referral to an appropriate professional.

The crucial question in making a referral is how much experience does the medical professional have in the area of mental capacity assessment of older people or people with a possible mental illness/ intellectual disability/ acquired brain injury?

The following types of professionals may be able to carry out a mental capacity assessment:

PROFESSIONAL ASSESSOR	EXPERTISE
Psychiatrist	A medical doctor who specialises in the study, treatment and prevention of mental disorders.
Psychologist	A person engaged in the scientific study of the mind, mental processes and behaviour. They are not medical doctors and are not qualified to prescribe drugs.
Neuropsychologists	A psychologist skilled in conducting assessments that determine the presence or nature of brain dysfunction, for example after a head injury or where dementia is suspected. The assessment is conducted through interview, observation and psychological testing and generally involves the administration of tests of memory, concentration, other thinking skills and language.
Psychogeriatricians	A psychiatrist who specialises in the diagnosis, treatment and prevention of mental disorders occurring in the aged.
Geriatrician	A medical doctor specialising in the diagnosis and treatment of disorders that occur in old age, and with the care of the aged.
Gerontologist	A scientist who studies the changes in the mind and body that accompany ageing and the problems associated with them.
Neurologist	A scientist who specialises in the study of the structure, functioning and diseases of the nervous system.
ACAT (Aged Care Assessment Team)	A multi-disciplinary team of health care workers who assess people in their own home to determine the level of assistance the aged person needs to remain living there independently. The team is also responsible for assessing people for admission into nursing homes. The team is comprised of a nurse, social worker, occupational therapist and physiotherapist and may also include a geriatrician or psychogeriatrician. ACAT's are attached to major hospitals.

9. WHAT TO INCLUDE IN THE REFERRAL LETTER

A solicitor needs to take great care in drafting the referral letter for a mental capacity assessment. Many medical professionals will have a different approach to the task of mental capacity assessment than the legal approach and will not necessarily understand the specific legal tests which must be satisfied. A general request to provide a report about a client's "mental capacity" might elicit a report which addresses whether a person is able to remain at home and attend to their personal care needs but does not address the central issue about the client's mental capacity to make a particular legal decision.

It is therefore crucial that the referral letter sets out:

- The client's background
- The reason the client contacted the solicitor
- The purpose of the referral - what is the legal task or decision being considered
- The relevant legal standard of mental capacity to perform the task at hand
- Any known medical information about the client
- Information about the client's social or living circumstances
- The client's values and preferences if known

It may also be useful to invite the medical professional to telephone the solicitor for clarification if needed.

The Law Society is developing referral resources for solicitors. These resources will be made available on the Law Society's website.

10. HOW TO RAISE THE ISSUE WITH THE CLIENT

It will often be a sensitive, if not unpleasant, task to suggest to a client that there may be concerns they do not have mental capacity to make their own decisions. The loss of capacity is frightening and stigmatising to most people, and many clients will be offended, angry and defensive when this issue is raised.

However, it may make this task easier if it can be explained to the client in terms of the legal need to make sure that the client's mental capacity is adequate for the task at hand. The formal assessment could be suggested as a kind of "insurance" to protect against possible future legal challenges to the validity of the legal transaction involved.

11. MAKING THE FINAL LEGAL JUDGMENT WHEN THE CLINICAL MENTAL CAPACITY ASSESSMENT IS AVAILABLE

A mental capacity assessment report sent to a solicitor may conclude that the client is or is not capable of the particular legal task in issue, for example, that they have testamentary capacity. However it is important to remember that these findings are only clinical opinions which are distinct from a legal assessment about mental capacity. They are simply one source of evidence about the issue which the solicitor must consider before finally advising the client.

The solicitor must take time to thoroughly read and understand the report and to clarify any technical terms or language with the report's writer if necessary[18].

The clinical report could also be used to discuss clinical intervention or treatment options with the client or their family[19]. It may be possible that these interventions could improve the client's functioning and/or their mental capacity. For example, the client could be given antipsychotic medication to address psychiatric symptoms impairing understanding[20].

12. WHEN TO SEEK THE APPOINTMENT OF A SUBSTITUTE DECISION-MAKER

If a client is incapable of providing instructions or making a legal decision, it may be appropriate for a substitute decision-maker to be appointed who can stand in the client's place and ensure their best interests are protected.

Both the Supreme Court of NSW and the NSW Civil and Administrative Tribunal Guardianship Division can appoint a guardian and/or a financial manager to make substitute decisions for people with a decision-making disability. However, this should be pursued as a last resort when all other options have been explored.

A financial manager has the authority to give instructions to a solicitor and to initiate, continue or defend legal proceedings on behalf of an incapable person. However, it may not be necessary to seek the appointment of a financial manager if a tutor or guardian ad litem can be appointed under the rules of the particular court or tribunal involved.

There may be ethical issues involved when a solicitor makes an application for a financial manager or a guardian to be appointed for their client. The NSW Court of Appeal has commented that an application that a client is unable to manage his or her affairs should not be brought by solicitors if there is any reasonable alternative: *R v P* [2001] NSWCA 473 at [63]. However, in *P v R*, as no relative, church member or social worker was a reasonable alternative the solicitor was found to have properly brought the defendant's plight before the court and, in doing so, enabled the court to obtain an appreciation of the whole of the defendant's circumstances of disability and vulnerability: *P v R* [2003] NSWSC 819 at [82]. The solicitor was "a person who has gained a close appreciation of the defendant's circumstances and difficulties generally in the course of dealing with her": [81].

Issues of client confidentiality may arise when a solicitor is considering whether to provide information to a court or tribunal about a client's lack of mental capacity.

18 The American Bar Association Commission on Law and Aging and the American Psychological Association, above n1 at pp39-40.

19 Ibid.

20 Ibid.

The *Legal Profession Uniform Law Australian Solicitors' Conduct Rules 2015* provide as follows:

9. Confidentiality

9.1 A solicitor must not disclose any information which is confidential to a client and acquired by the solicitor during the client's engagement to any person who is not:

9.1.1 a solicitor who is a partner, principal, director, or employee of the solicitor's law practice or

9.1.2 a barrister or an employee of, or person otherwise engaged by, the solicitor's law practice or by an associated entity for the purposes of delivering or administering legal services in relation to the client,

EXCEPT as permitted in Rule 9.2.

9.2 A solicitor may disclose information which is confidential to a client if:

9.2.1 the client expressly or impliedly authorises disclosure,

9.2.2 the solicitor is permitted or is compelled by law to disclose,

9.2.3 the solicitor discloses the information in a confidential setting, for the sole purpose of obtaining advice in connection with the solicitor's legal or ethical obligations,

9.2.4 the solicitor discloses the information for the sole purpose of avoiding the probable commission of a serious criminal offence,

9.2.5 the solicitor discloses the information for the purpose of preventing imminent serious physical harm to the client or to another person, or

9.2.6 the information is disclosed to the insurer of the solicitor, law practice or associated entity.

13. CONCLUSION

It is fundamental to the solicitor/client relationship that a solicitor must rely and act on instructions of their client. However, where a solicitor considers that key indicators point clearly to a client's lack of mental capacity to give competent instructions, it is their responsibility to explore this issue further. This Guide aims to assist solicitors to take a principled approach to this task which is thorough, thoughtful and respectful of each client's particular circumstances. Solicitors who inform themselves of the issues surrounding client mental capacity and who are aware of the available resources in the area will be better equipped to face the challenges which often arise in this area of practice, while still providing a high standard of legal service to their client.

APPENDIX A
DIFFERENT MENTAL CAPACITY TESTS

Decision-specific test for mental capacity

In *Gibbons v Wright* [1954] HCA 17, (1954) 91 CLR 423, the High Court of Australia (at 437 per Dixon CJ, Kitto and Taylor JJ) defined a decision-specific test for mental capacity to enter into a contract:

"The law does not prescribe any fixed standard of sanity as requisite for the validity of all transactions. It requires, in relation to each particular matter or piece of business transacted, that each party shall have such soundness of mind as to be capable of understanding the general nature of what he [or she] is doing by his [or her] participation."

The same approach was explained as follows in *Scott v Scott* [2012] NSWSC 1541 at [205]:

"It is not, literally, a matter of imposing, or recognising, a different 'standard' of mental capacity in the evaluation of the validity of different transactions. What is required, rather, is an appreciation that the concept of 'mental capacity' must be assessed relative to the nature, terms, purpose and context of the particular transaction. Nothing more, or less, is required than a focus on whether the subject of inquiry had the capacity to do, or to refrain from doing, the particular thing under review".

Mental Capacity to give instructions to a solicitor

The *Uniform Civil Procedure Rules 2005* (NSW) have provisions regarding the appointment and removal of tutors and the manner in which those tutors will represent the person under legal incapacity. Rule 7.18 is the principal provision. It states that any person under legal incapacity may have a tutor appointed by the Court and the Court may remove a tutor and appoint another tutor.

Section 3 of the *Civil Procedure Act 2005* (NSW) defines "person under legal incapacity" as any person who is under a legal incapacity in relation to the conduct of legal proceedings (other than an incapacity arising under section 4 of the *Felons (Civil Proceedings) Act 1981)* and, in particular, includes:

(a) a child under the age of 18 years, and

(b) an involuntary patient or a forensic patient within the meaning of the *Mental Health Act 2007*, and

(c) a person under guardianship within the meaning of the *Guardianship Act 1987*, and

(d) a protected person within the meaning of the *NSW Trustee and Guardian Act 2009*, and

(e) an incommunicate person, being a person who has such a physical or mental disability that he or she is unable to receive communications, or express his or her will, with respect to his or her property or affairs.

The NSW Court of Appeal considered the need to appoint a tutor for litigation in *Murphy v Doman* [2003] NSWCA 249.

The Court noted at [35]:

"The cases do not consider the level of mental capacity required to be a "competent" litigant in person but it cannot be less than that required to instruct a solicitor. It should be greater because a litigant in person has to manage court proceedings in an unfamiliar and stressful situation."

In *Masterman-Lister v Brutton & Co* [2003] 3 All ER 162 Chadwick LJ described the issue when it was necessary to determine the mental capacity to give legal instructions in these terms:

"the test to be applied, as it seems to me, is whether the party to legal proceedings is capable of understanding, with the assistance of such proper explanation from legal advisers and experts in other disciplines as the case may require, the issues on which his consent or decision is likely to be necessary in the course of those proceedings. If he has capacity to understand that which he needs to understand in order to pursue or defend a claim, I can see no reason why the law – whether substantive or procedural – should require the interposition of a next friend or guardian ad litem."

In *Dalle-Molle by his Next Friend, Public Trustee v Manos and Anor* [2004] SASC 102, Debelle J reviewed the common law in this area and noted at 26:

"The level of understanding of legal proceedings must, I think, be greater than the mental competence to understand in broad terms what is involved in the decision to prosecute, defend or compromise those proceedings. The person must be able to understand the nature of the litigation, its purpose, its possible outcomes, and the risks in costs which of course is but one of the possible outcomes."

Mental capacity to manage affairs
(section 41 *NSW Trustee and Guardian Act 2009* and section 25G *Guardianship Act 1987*)

Originally courts adopted an objective test for inability "to manage his or her own affairs". For instance, in *PY v RJS & Ors* [1982] 2 NSWLR 700 at 702 Powell J stated that a person is not shown to be incapable of managing his or her own affairs unless, at the least, it appears:

(a) that he or she appears incapable of dealing in a reasonably competent fashion with the ordinary routine affairs of man; and

(b) that by reason of that lack of competence there is shown to be a real risk that either:

  (i) he or she may be disadvantaged in the conduct of such affairs, or
  (ii) that such monies or property which he or she shall possess may be dissipated or lost; it is not sufficient merely to demonstrate that the person lacks the higher level of ability needed to deal with complicated transactions or that he or she does not deal with even simple or routine transactions in the most efficient manner.

Later decisions appeared to move away from that approach: see *H v H* (Supreme Court of NSW, Young J, 20 March 2000, unreported) and *Re GHI* (a protected person) [2005] NSWSC 581. Most recently the courts have adopted a subjective approach which pays close attention to the text of the legislation: see *Re D* [2012] NSWSC 1006 at [46]- [62]; *PB v BB* [2013] NSWSC 1223 at [4]- [9]; *Re R* [2014] NSWSC 1810 at [84]-[94]; *CJ v AKJ* [2015] NSWSC 498 at [22]-[24]. This has been the approach consistently adopted by Victorian courts to the same issue: see *Re MacGregor* [1985] VicRp 85; [1985] VR 861. The subjective approach requires the examination of the particular person's affairs (meaning his or her legal and financial interests). An assessment is then made about whether that person can manage those affairs.

In *Ability One Financial Management Pty Limited v JB by his Tutor AB* [2014] NSWSC 245 at [144] Lindsay J stated that whichever approach is adopted "there must be a factual, functional deficiency in a person's capacity for self-management in order to qualify for an exercise of protective jurisdiction".

Testamentary capacity

The formula for determining testamentary capacity is stated in the judgment of the Court (Cockburn CJ, Blackburn, Mellor, and Hannen JJ) delivered by Sir Alexander Cockburn in *Banks v Goodfellow* (1870) LR 5 QB 549 at 565 as follows:

"It is essential to the exercise of such a power that a testator shall understand the nature of the act and its effects; shall understand the extent of the property of which he is disposing; shall be able to comprehend and appreciate the claims to which he ought to give effect; and, with a view to the latter object, that no disorder of the mind shall poison his affections, pervert his sense of right, or prevent the exercise of his natural faculties—that no insane delusion shall influence his will in disposing of his property and bring about a disposal of it which if the mind had been sound, would not have been made."

Mental capacity to make a power of attorney

In *Scott v Scott* [2012] NSWSC 1541 at [199] Lindsay J stated the following approach to the assessment of mental capacity to make a power of attorney:

"Attention must be focussed on all the circumstances of the case, including the identities of the donor and donee of a disputed power of attorney; their relationship; the terms of the instrument; the nature of the business that might be conducted pursuant to the power; the extent to which the donor might be affected in his or her person or property by an exercise of the power; the circumstances in which the instrument came to be prepared for execution, including any particular purpose for which it may ostensibly have been prepared; and the circumstances in which it was executed: [199].

"An exploration of all the circumstances of the case will, not uncommonly, call for consideration of events leading up to, and beyond, the time of execution of the disputed power of attorney, as well as on the focal point of the time of execution itself. A longitudinal assessment of mental capacity, along a time line extending either side of the focal point, may be necessary, or at least permissible, in order to examine the subject's mental capacity in context. Medicos and lawyers, alike, tend to embrace that approach. It is difficult to do otherwise. Context has a temporal as well as spacial and relational dimensions: [200].

...

"Where an Enduring Power of Attorney confers on an attorney power to dispose of the principal's property to or for the benefit of the attorney or third parties, the nature and degree of mental capacity required to grant such a power may approximate that required for the making of a valid will. In that event, the "standard" laid down by *Banks v Goodfellow* (1870) LR 5 QB 549 at 564-565 might apply or be approximated: [202].

...

"An Enduring Power of Attorney limited in its terms, or effect, to authorisation of acts for the benefit of the principal may require consideration of factors different from those considered upon an assessment of mental capacity for the making of a valid will": [204].

In the English case of *Re K* (1988) 1 Ch 310 at 316, the Court referred to the understanding which a person should have to be capable of making a power of attorney as follows:

"Firstly, (if such be the terms of the power) that the attorney will be able to assume complete authority over the donor's affairs. Secondly, (if such be the terms of the power) that the attorney will in general be able to do anything with the donor's property which he himself could have done. Thirdly, that the authority will continue if the donor should be or become mentally incapable. Fourthly, that if he should be or become mentally incapable, the power will be irrevocable without confirmation by the court."

Mental capacity to consent to medical treatment

The *Guardianship Act 1987* makes provision for substitute consent for medical treatment if an adult (over 16 years of age) is incapable of consenting to that treatment.

Section 33(2) of the *Guardianship Act 1987* states:

"... a person is incapable of giving consent to the carrying out of medical or dental treatment if the person:

(a) is incapable of understanding the general nature and effect of the proposed treatment, or

(b) is incapable of indicating whether or not he or she consents or does not consent to the treatment being carried out."

Mental capacity to make health-related privacy decisions under the *Health Records and Information Privacy Act 2002 (NSW)* (HRIPA)

The HRIPA establishes a test for mental incapacity as follows (section 7 HRIPA):

"(1) An individual is incapable of doing an act authorised, permitted or required by this Act if the individual is incapable (despite the provision of reasonable assistance by another person) by reason of age, injury, illness, physical or mental impairment of:

(a) understanding the general nature and effect of the act, or

(b) communicating the individual's intentions with respect to the act."

Mental capacity to consent to marriage

In *Babich & Sokur and Anor* [2007] FamCA 236, Justice Mullane stated: "the Australian test requiring that for a valid consent a person must be mentally capable of understanding the effect of the marriage ceremony as well as the nature of the ceremony [244] ... It is clear from the authorities that the law does not require the person to have such a detailed and specific understanding of the legal consequences [249] ... a valid consent involves either a general understanding of marriage and its consequences, or an understanding of the specific consequences of the marriage for the person whose consent is in issue [251]."

APPENDIX B
CAPACITY WORKSHEET FOR LAWYERS

Source: *Assessment of Older Adults with Diminished Capacity: A Handbook for Lawyers*, American Bar Association Commission on Law and Ageing & American Psychological Association (2005).

Please read and review the handbook prior to using the worksheet.

Client Name: _____

Date of Interview: _____

Attorney: _____

Place of Interview: _____

A. Observational signs

COGNITIVE FUNCTIONING	EXAMPLES
Short-term Memory Problems	• Repeats questions frequently • Forgets what is discussed within 15-30 min • Cannot remember events of past few days
Language Communication Problems	• Difficulty finding words frequently • Vague language • Trouble staying on topic • Disorganised • Bizarre statements or reasoning
Comprehension Problems	• Difficulty repeating simple concepts • Repeated questioning
Lack of Mental Flexibility	• Difficulty comparing alternatives • Difficulty adjusting to changes
Calculation/ Financial Management Problems	• Addition or subtraction that previously would have been easy for the client • Bill paying difficulty
Disorientation	• Trouble navigating office • Gets lost coming to office • Confused about day/time/year/season

EMOTIONAL FUNCTIONING	EXAMPLES
Emotional Distress	• Anxious • Tearful/distressed • Excited/pressured/manic
Emotional Lability	• Moves quickly between laughter and tears • Feelings inconsistent with topic

BEHAVIOURAL FUNCTIONING	EXAMPLES
Delusions	• Feels others out "to get" him/her, spying or organized against him/her • Fearful, feels unsafe
Hallucinations	• Appears to hear or talk to things not there • Appears to see things not there • Misperceives things
Poor Grooming/Hygiene	• Unusually unclean/unkempt in appearance • Inappropriately dressed
Other Observations/ Notes of Functional Behaviour	
Other Observations/ Notes on Potential Undue Influence	

MITIGATING/QUALIFYING FACTORS AFFECTING OBSERVATIONS	WAYS TO ADDRESS/ACCOMMODATE
Stress, Grief, Depression, Recent Events Affecting stability of client	• Ask about recent events, losses • Allow some time • Refer to a mental health professional
Medical Factors	• Ask about nutrition, medications, hydration • Refer to a physician
Time of Day Variability	• Ask if certain times of the day are best • Try mid-morning appointment
Hearing and Vision Loss	• Assess ability to read/repeat simple information • Adjust seating, lighting • Use visual and hearing aids • Refer for hearing and vision evaluation
Educational/Cultural/Ethnic Barriers	• Be aware of race and ethnicity, education, long- held values and traditions

B. Relevant legal elements

The legal elements of capacity vary somewhat among states and should be modified as needed for your particular state.

GENERAL LEGAL ELEMENTS OF CAPACITY FOR COMMON TASKS	NOTES ON CLIENT'S UNDERSTANDING/ APPRECIATING/FUNCTIONING UNDER ELEMENTS
Testamentary Capacity [Insert elements of relevant tests]	
Contractual Capacity [Insert elements of relevant tests]	
Mental Capacity to give gifts [Insert elements of relevant tests]	
Other Legal Tasks Being Evaluated & Capacity Elements	

C. Task-specific factors in preliminary evaluation of capacity

THE MORE SERIOUS THE CONCERNS ABOUT THE FOLLOWING FACTORS	THE HIGHER THE FUNCTION NEEDED IN THE FOLLOWING ABILITIES
Is decision consistent with client's known long-term values or commitments?	• Can client articulate reasoning leading to this decision?
Is the decision objectively fair? Will anyone be hurt by the decision?	• Is client's decision consistent over time? Are primary values client articulates consistent over time?
Is the decision irreversible?	• Can client appreciate consequences of his/her decision?

D. Preliminary conclusions about client capacity

After evaluating A, B and C above:

• **Intact** No or very minimal evidence of diminished mental capacity	**Action:** Proceed with representation and transaction
• **Mild problems** Some evidence of diminished capacity	**Action:** 1. Proceed with representation/transaction, or 2. Consider medical referral if medical oversight lacking, or 3. Consider consultation with mental health professional, or 4. Consider referral for formal clinical assessment to substantiate conclusion, with client consent
• **More than mild problems** Substantial evidence of diminished capacity	**Action:** 1. Proceed with representation/transaction with great caution, or 2. Consider medical referral if medical oversight lacking, or 3. Consider consultation with mental health professional, or 4. Refer for formal clinical assessment to substantiate conclusion, with client consent
• **Severe problems** Client lacks capacity to proceed with representation and transaction	**Action:** 1. Referral to mental health professional to confirm conclusion 2. Do not proceed with case; or withdraw, after careful consideration of how to protect client's interests 3. If an existing client, consider protective action consistent with MRPC 1.14(b)

Case notes

Summarize key observations, application of relevant legal criteria for capacity, conclusions and actions to be taken:

APPENDIX C
TECHNIQUES LAWYERS CAN USE TO ENHANCE CLIENT MENTAL CAPACITY

Source: *Assessment of Older Adults with Diminished Capacity: A Handbook for Lawyers*, American Bar Association Commission on Law and Ageing & American Psychological Association (2005). An excerpt from this publication is provided below.

Note: Attorneys should be read in the NSW setting as meaning lawyers.

V. Techniques lawyers can use to enhance client capacity

Clients with evidence of diminished capacity may still be able to make or participate in making a legal decision. The Comment to Model Rule 1.14 notes that "a client with diminished capacity often has the ability to understand, deliberate upon, and reach conclusions about matters affecting the client's own well-being." How can a lawyer maximize the capacity of an older client who may be limited by one or more of the cognitive, emotional, behavioral, or mitigating factors ....

This chapter highlights practical techniques that lawyers can use to accommodate sensory and cognitive changes that become more prevalent with age, and to engender the trust and confidence of older clients with diminished capacity.

This chapter describes an approach of "gradual counseling" by which the attorney may help the client to understand and make choices through a process of clarification, reflection, and feedback that is respectful of client values.

A key message of this chapter is that attorneys must be sensitive to age-related changes without losing sight of the individuality of each older person. Although functional limitations do increase with age, most older adults do not have physical, sensory, or cognitive impairments. Therefore, one must not assume impairments in older clients, but one must be prepared to address these issues when they arise. Moreover, attorneys should examine their own attitudes toward aging to ensure that "ageism" does not inadvertently influence their judgments about client capacity. Lawyers also should be alert to ethnic and cultural factors that might be a barrier to communication, subliminally affecting perceptions of client abilities and behavior.

Finally, attorneys should do everything possible to make their office and their counselling approach "elder friendly" and accessible to individuals with a range of disabilities. Under the Americans with Disabilities Act (ADA), law offices as "public accommodations" are required to make reasonable modifications to their policies, practices, and procedures to make services available to people with disabilities. Beyond this, many older clients whose impairments do not reach the level covered under the ADA will be aided by the kinds of techniques listed below to optimize their functioning.

A. Engendering client trust and confidence

Attorneys can take steps to build the trust of older clients, allowing them to be at their best during the interview process and bolstering their decision-making ability.

- Upon introduction, take time to **"break the ice"** and, if appropriate, make a few brief remarks about areas of common interest such as weather, sports, or mutual connections.
- **Interview the client alone** to ensure confidentiality and to build trust. However, consider the important role support persons can play. If the client is more at ease with a friend or family member in the room, **consider including the support person for a portion** of the interview or at least during an introductory phase. Be sure to talk *to the client rather than past the client* to the others.
- Stress the **confidentiality** of the relationship. Some older adults may be fearful of losing control of their affairs if they divulge information. Assure the client that information will not be shared with others, including family members, without prior consent.
- Encourage maximum **client participation** to increase a sense of investment in the process.
- Respond directly to the client's feelings and words, making the client **feel respected and valued**, which enhances trust.
- Use **encouragement** and verbal reinforcement liberally.

A. Engendering client trust and confidence (continued)

- Take **more time** with older clients so they are comfortable with the setting and the decision-making process to be undertaken.
- Conduct business over **multiple sessions** to increase familiarity and opportunities for trust building.

B. Accommodating sensory changes

While not all older adults have hearing and vision loss, these deficits are common for a substantial proportion of Americans over the age of 65. Sensory problems, particularly in hearing, sometimes result in older individuals pretending that they know what is under discussion, becoming socially withdrawn, and in some instances, depressed. As stated in Chapter IV, lawyers should not mistake sensory loss for mental confusion. Rather, sensory changes and the older adults' response to them are mitigating factors that should be taken into consideration when assessing signs of diminished capacity.

To address hearing loss

- Minimize **background noise** (e.g., close the office door, forward incoming calls) as individuals with hearing loss have difficulty discriminating between sounds in the environment.
- **Look at the client** when speaking. Many individuals with hearing loss read lips to compensate for hearing loss.
- **Speak slowly and distinctly**. Older adults may process information more slowly than younger adults.
- **Do not** over-articulate or **shout** as this can distort speech and facial gestures.
- Use a **lower pitch** of voice because the ability to hear high frequency tones is the first and most severe impairment experienced by many older adults with compromised hearing.
- Arrange seating to be conducive to conversation. **Sit close** to the client, face- to-face, at a table rather than on the far side of a desk.
- Focus more on written communication to compensate for problems in oral communication. Provide **written summaries** and follow-up material.
- Have auditory **amplifiers** available.

To address vision loss

- Increase **lighting**.
- **Reduce** the impact of **glare** from windows and lighting as older adults have increased sensitivity to glare. Have clients face away from a bright window.
- **Do not** use **glossy** print materials, as they are particularly vulnerable to glare. Format documents in **large print** (e.g., 14- or 16-point font) and double- spaced as presbyopia (blurred vision at normal reading distance) becomes more prevalent with age.
- Give clients **additional time** to read documents, as reading speed is often slower.
- Give the client adequate **time to refocus** his or her gaze when shifting between reading and viewing objects at a distance, as visual accommodation can be slowed.
- Be mindful of **narrowing field of vision**. A client may not be aware of your presence in the room until you are directly in front of him or her.
- Have **reading glasses** and magnifying glasses available on conference tables.
- Arrange furnishings so **pathways** are **clear** for those with visual or physical limitations.

To accommodate hearing/vision loss, address

- Background noise
- Seating position
- Lighting
- Large print materials
- Hearing and vision aids
- Speaking style and pace

C. Accommodating cognitive impairments

For clients with some evidence of cognitive impairment who may be in the murky gray area of "questionable capacity," the practical steps suggested below may offer significant support:

- Begin the interview with **simple questions** requiring brief responses to assess client understanding and optimal pace, as reaction time is often slower among older adults, particularly for more complex tasks.
- Conduct business at a **slower pace** to allow the client to process and digest information, as information-processing speed declines with age.
- Allow **extra time for responses** to questions, as "word-finding" can decline with age.
- **Break information** into smaller, manageable segments.
- Discuss **one issue at a time**, as divided attention between two simultaneous tasks, as well as the ability to shift attention rapidly, shows age-related decline.
- **Provide cues** to assist recall rather than expecting spontaneous retrieval of information.
- **Repeat**, **paraphrase**, **summarize**, and check periodically for accuracy of communication and comprehension. The importance of repeated testing for comprehension has been documented in research of informed consent procedures showing that comprehension is sometimes incomplete even when individuals state that they understand. This inconsistency is more pronounced among older adults, particularly those with low vocabulary and education levels.
- If information is not understood, incompletely understood, or misunderstood, **provide corrected feedback** and check again for comprehension.
- **Provide summary notes** and information sheets to facilitate later recall. Include key points, decisions to be made, and documents to bring to next meeting.
- Schedule appointments **for times of the day** when the client is at peak performance. Peak performance periods change with age and for many older adults **mornings** are often best.
- Provide time for **rest** and bathroom breaks.
- Schedule **multiple**, **shorter appointments** rather than one lengthy appointment, as older adults may tire more easily than younger adults. Multiple testing sessions can also assist in identifying the client's performance rhythms and cycles.
- Whenever possible, conduct business in the **client's residence**. This often makes the client more relaxed, optimizes decision-making, and provides the attorney with clues about "real-world" functioning.

D. Strengthening client engagement in the decision-making process

Linda F. Smith, in her seminal article "Elderlaw: Representing the Elderly Client and Addressing the Question of Competence," describes a technique of *gradual counselling* that is useful in compensating for age-related differences in memory and problem-solving ability, and when there are questions about capacity. It provides a method for inquiring into and understanding the client's decision-making process, and may assist such clients in thinking through their underlying concerns, goals and values, and choosing a consistent course of action.

"The attorney for the limited client should engage the client in a process of gradual decision-making, which will involve clarification, reflection, feedback, and further investigation .... Gradual counselling requires the attorney to repeatedly refer to the client's goals and values in assessing each alternative and in discussing the pros and cons of an alternative. This will involve a great deal of clarifying and reflecting of the clients' thoughts and feelings .... The attorney should proceed to explain each relevant option and elicit the client's reactions."

Smith outlines steps in the process of "gradual counselling" and maintains that if attorneys are vigilant in pursuing these steps with a client of questionable capacity, it may assist a limited client in reaching an informed decision.

Gradual counselling	• Identify goals • State problems • Ascertain values • Compare options to goals • Give feedback

- Confirm or reconfirm the client's basic **goal** or problem to be solved.
- **Get feedback** from the client to ensure he or she agrees with the lawyer's statement of the problem. Listen for important client values.
- Ascertain **the most important** values the client expresses. Restate these values and confirm with the client. Recognize that the values of an older client may differ from those of the attorney.

"For example, a young attorney may begin to doubt the competence of her elderly client who does not wish to contest a right to income or benefits or does not wish to take a relatively simple legal action to preserve his assets. However, if the particular client has a limited life expectancy, minimal need for assets, or an emotional focus upon internal or spiritual things, that client's decision may be quite reasonable. Because the underlying values are so important, throughout the counselling process the attorney should continue to reflect the feelings and thoughts that the client expresses . . . to understand the client's values as fully as possible."

- Describe the **best option** for attaining the client's goal. Ask for the client's feeling about that option.
- **Explain each relevant option**, and get the client's reaction. This will enable the attorney to see whether the client understands the information and how the client responds. It will also check for consistency of values. The attorney may need to "present fewer choices and only the most salient features for or against each alternative." This "weeding out" may allow a client of questionable capacity to reach a reasoned judgment.
- Give the client **feedback** that might be helpful. For example, if the client appears inconsistent in goals or decisions over time, pointing this out may help the client to remember and focus. If a client chooses a course that seems harmful, the attorney could express worry and concern, and get the client's reactions to this.
- Even when there is no clearly enunciated choice by the client, the lawyer still may be able to find capacity for the limited decision at hand from the **client's reactions** during the course of the session.

Such a "gradual counselling" approach is respectful of the client's autonomy. Moreover, an attorney taking these steps will be assured that he or she has made a thorough attempt to find client capacity before taking any more precipitous action. However, if despite all of these techniques and accommodations, the client's capacity for the decision or transaction is still questionable, the attorney may need assistance from a clinician.

APPENDIX D
RESOURCES

The American Bar Association Commission on Law and Aging and the American Psychological Association, *Assessment of Older Adults with Diminished Capacity: A Handbook for Lawyers* (2005) at http://www.apa.org/pi/aging/diminished_capacity.pdf

Darzins P, Molloy W and Strang D (eds) 2000 *Who Can Decide: The six step capacity assessment process*, Memory Australia Press: Adelaide

New South Wales Attorney General's Department, *Capacity Toolkit: Information for government and community workers, professionals, families and carers in New South Wales*, (2008) at http://www.justice.nsw.gov.au/diversityservices/Pages/divserv/ds_capacity_tool/ds_capacity_tool.aspx

Law Society of NSW *Powers of Attorney Act* 2003: A Commentary at https://www.lawsociety.com.au/resources/areasoflaw/ElderLaw/index.htm

To locate a private practitioner see the following websites:

Law Society of NSW
www.lawsociety.com.au

The Guardianship Division of NCAT
http://www.ncat.nsw.gov.au/Pages/guardianship/guardianship.aspx

NSW Trustee & Guardian
http://www.tag.nsw.gov.au/

Alzheimer's Australia
https://fightdementia.org.au/

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http://www.health.nsw.gov.au/policies/

The Guardianship Application Process for Adult Inpatients of NSW Health Facilities

Document Number GL2016_026

Publication date 04-Nov-2016

Functional Sub group Corporate Administration - Governance
Clinical/ Patient Services - Aged Care
Clinical/ Patient Services - Mental Health

Summary This Guideline will assist relevant professionals including medical, allied health, nursing and midwifery staff in NSW Health facilities to understand their roles and responsibilities in regards to preparing and recording applications to the Guardianship Division of NCAT.

Author Branch System Relationships and Frameworks

Branch contact System Relationships and Frameworks 02 9461 7222

Applies to Local Health Districts, Chief Executive Governed Statutory Health Corporations, Specialty Network Governed Statutory Health Corporations, Private Hospitals and Day Procedure Centres, Public Hospitals

Audience Nursing, Medical, Allied Health, LHDs/SHNs, NSW MoH, Primary Health Networks

Distributed to Public Health System, Ministry of Health, Private Hospitals and Day Procedure Centres

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NSW GOVERNMENT Health

GUIDELINE SUMMARY

THE GUARDIANSHIP APPLICATION PROCESS FOR ADULT INPATIENTS OF NSW HEALTH FACILITIES

PURPOSE

This Guideline will assist relevant professionals, including medical, allied health, nursing and midwifery staff in NSW Health facilities to understand their roles and responsibilities when making an application to the Guardianship Division of NCAT.

KEY PRINCIPLES

The Guideline aims to standardise practice across NSW Health facilities to improve the process for adult inpatients waiting for a guardianship hearing by ensuring that NSW Health facilities are aware of:

1. When an application to the Guardianship Division of NCAT is necessary and appropriate
2. Who is responsible for coordinating the application
3. Who to consult for advice when considering making a guardianship/financial management application
4. Making applications and providing reports to the Guardianship Division of NCAT within seven days
5. What assessments and evidence is required when submitting an application to the Guardianship Division of NCAT
6. How to record data for patients waiting for guardianship on the patient flow portal.

USE OF THE GUIDELINE

This document provides guidance to NSW Health inpatient facilities and their relevant staff when considering whether an application to the Guardianship division of NCAT is necessary. This document should be used as a practice guideline rather than a mandatory directive.

REVISION HISTORY

Version	Approved by	Amendment notes
November 2016 (GL2016_026)	Deputy Secretary, System Purchasing and Performance	New Guideline

ATTACHMENTS

1. The Guardianship Application Process for Adult Inpatients of NSW Health Facilities: Guideline

The Guardianship Application Process for Adult Inpatients of NSW Health Facilities

NSW GOVERNMENT Health

Guideline

Issue date: November-2016

GL2016_026

CONTENTS

1 BACKGROUND

1.1 About this document

The Guardianship Division of the New South Wales Civil and Administrative Tribunal (NCAT) hears applications about people who require assistance to make decisions regarding certain aspects of their lives, including where they are living, what medical treatment they will receive and managing their finances. The role of NCAT is to determine whether a person requires a legally appointed substitute decision maker and who that should be.

The Guardianship Division of NCAT deal with the following types of applications which are most relevant to NSW Health:

1. Guardianship
2. Financial management
3. Review of existing power of attorney and/or enduring guardianship orders
4. Consent to medical and dental treatment
5. Approval of a clinical trial.

In NSW Health facilities there are approximately 80 inpatients per month waiting for a guardianship hearing. The impact this has on the health system and patient outcomes is significant. This practice guideline has been developed to standardise practice across NSW Health facilities to improve the process for adult inpatients waiting for a guardianship hearing.

This practice guideline will assist relevant professionals, including medical, allied health, nursing and midwifery staff in NSW Health facilities to understand their roles and responsibilities in respect to determining:

1. When an application to the Guardianship Division of NCAT is necessary and appropriate?
2. Who is responsible for coordinating the application?
3. Who to consult for advice when considering making a guardianship/financial management application?
4. Assessments and what evidence is required when submitting an application to the Guardianship Division of NCAT?
5. How to record data for patients waiting for guardianship on the patient flow portal?

Exclusions

This document does not address guardianship applications for patients who are under 16 years of age. For more information visit the Family and Community Services Website and the *Children and Young Persons (Care and Protection) Act 1998* (NSW).

Whilst this document does not include outpatients who are in the community, it can be used to assist all NSW Health staff to make applications to NCAT.

1.2 Key definitions

Capacity	Capacity refers to a person's ability to make decisions about things that affect their daily lives. For example, where they are going to live, what medical treatment they receive and how they will spend their money. It is always presumed that a person has capacity until proven otherwise. Capacity is decision specific. A person's capacity can vary depending on the decisions to be made, in different circumstances and at different times. Broadly speaking, when a person has capacity to make a particular decision, they are able to do the following: • understand the facts and the choices involved • weigh up the consequences of the choices • understand how the consequences affect them, and • communicate the decision (Capacity Toolkit, NSW Attorney General's Department. 2009). For further information on conducting capacity assessments refer to: 1. Capacity Toolkit 2. Decision-making capacity & dementia. A guide for Health Care Professionals in NSW. Mini-legal kit Series 1.7 3. Capacity and the Law (O'Neill & Peisah, 2011)
Coercive functions (Sometimes known as coercive orders)	Coercive functions authorise a guardian to implement decisions even when the person subject to the guardianship order objects. The coercive function allows the guardian to request assistance from others to enforce the decision, e.g. Police, Ambulance. Only the Guardianship Division of NCAT can approve a coercive function. For example, a coercive accommodation function gives a guardian the authority to enforce the decision that a person must enter residential aged care, even if that person disagrees. The guardian with a coercive function is able to request assistance from police and ambulance to enforce the decision.
Deaf interpreter	A Deaf Interpreter (or 'Relay Interpreter') is recognised by the National Accreditation Authority for Translators and Interpreters as having the necessary skills to provide a unique language or communication bridge for deaf individuals whose communication mode cannot be adequately accessed by a standard Auslan-English interpreter. (adapted from https://www.naati.com.au)

Disability	The *Guardianship Act 1987* Part 1 Section 3 (2) refers to a person with a disability as someone: (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.
Financial Manager	A financial manager is a person with the legal authority to make financial decisions on a person's behalf. The Guardianship division of NCAT (NCAT) can appoint a family member or friend (private person) or the NSW Trustee and Guardian (TAG) as a financial manager. NCAT can appoint a financial manager if it is satisfied that: (a) The person is not capable of managing their affairs and (b) There is a need for another person to manage those affairs and (c) It is in the persons best interests to have a financial manager appointed (d) The person has assets in NSW. An appointment of a financial manager overrides previous powers of attorney or enduring powers of attorney arrangements that were in place (if any).
Guardian	A guardian is a substitute decision-maker appointed by the Guardianship Division of NCAT or the Supreme Court with authority to make personal or lifestyle decisions about the person under guardianship. A guardian is appointed for a specified period of time and is given specific functions (e.g. the power to decide where the person should live, what services they should receive and what medical treatment they should be given). A private guardian that is a family member or friend will be appointed if appropriate. Otherwise, the Guardianship Division of NCAT will appoint the NSW Public Guardian (NSW Civil and Administrative Tribunal, 2015).
Guardianship Act 1987	The *Guardianship Act 1987* is the key legislation in NSW which protects the rights of people with impaired decision making capacity. It sets out the responsibilities and functions of the appointed guardian, the role of the Guardianship Division of NCAT and the principles to be applied when making decisions for people with decision making disabilities.

Guardianship Division of NSW Civil and Administrative Tribunal (NCAT)	The NSW Civil and Administrative Tribunal (NCAT) is the one-stop-shop for specialist tribunal services in NSW. The Guardianship Division of the NSW Civil and Administrative Tribunal exercises a protective jurisdiction under the *Guardianship Act 1987*. Its purpose is to protect and promote the rights and welfare of adults with impaired decision making capacity.
Enduring Guardian	An enduring guardian is appointed by the person (not NCAT) to make lifestyle, health and medical decisions for them when they are no longer capable of doing this for themselves. An enduring guardian can make decisions such as to where the person lives, what services are provided to them at home and what medical treatment they receive. An enduring guardian is appointed whilst the person still has capacity however enduring guardianship only comes into effect if or when capacity to make decisions is lost and will only be effective during the period of incapacity. If the person disagrees with the decisions being made for them by the enduring guardian then an application will need to be made to the Guardianship Division of NCAT.
Power of Attorney	A power of attorney is an individual person or trustee organisation appointed by the person (not NCAT) to manage their assets and financial affairs whilst they are still alive and have capacity. If the person appoints a power of attorney this does not mean that they will lose control over their financial affairs. It simply gives their attorney formal authority to manage their financial affairs according to their instructions. The power of attorney can be revoked at any time provided the person has the capacity to do so. A power of attorney stops operating when a person loses capacity. At this point an enduring power of attorney can take over if they were appointed prior to the person losing capacity.
Enduring Power of Attorney	An enduring power of attorney is an individual person/s or trustee organisation which is appointed by the person (not NCAT) to take control of their financial affairs and make financial and legal decisions on their behalf, for example selling their house or operating their bank account. This is similar to a power of attorney as a person appoints an enduring power of attorney of their choice when they have capacity; however the enduring power of attorney has the authority to make financial decisions on the person's behalf when they no longer have capacity. An enduring power of attorney ceases once a person dies and the executor of the will takes over. If an enduring power of attorney is required but the person no longer has the capacity to understand the implications of appointing such a person, then an application will need to be made to NCAT for appointment of a financial manager.

New South Wales Trustee and Guardian (NSW TAG)	The NSW Trustee and Guardian is an independent statutory authority that protects and administers the financial affairs and property of people who have assets in NSW and are unable to make financial decisions. They also oversee the functions of private managers. NSW TAG may be appointed by the Guardianship Division of NCAT to act as financial manager if there is no other suitable person who can act in the role for the person (About Us - The NSW Trustee and Guardian).
Party to Proceedings	Party to proceedings refers to people who have a right to participate in matters heard before the Guardianship Division of NCAT. These people may include: • The person who is the subject of the application or review • The most recent spouse or de facto spouse with whom the person has a close, continuing relationship. (includes same sex partners) if any • The carer of the person who is the subject of the order or application (excluding support workers) if any • A person appointed under an enduring guardianship or enduring power of attorney if any • The person who made the application for an order or review of an order • Any person that NCAT joins as a party. (NSW Civil and Administrative Tribunal, 2016) Refer to the NCAT Factsheet – Who is party to proceedings in the Guardianship Division for more information
Person Responsible	When a patient lacks capacity and it is not an emergency, all health care practitioners are required under law to consult and seek consent for medical and dental treatment from the patient's 'person responsible'. For patients 16 years and older, the 'person responsible' is determined according to the hierarchy within the Guardianship Act 1987 (NSW): • An appointed guardian (including enduring guardian) with the function of consenting to medical and dental treatment. If there is no-one in this category: • A spouse or de facto spouse (including same sex partner) who has a close and continuing relationship with the person. If there is no-one in this category: • The carer or person who arranges care regularly or did so before the person went into residential care, and who is unpaid (note: the carer's pension does not count as payment). If there is no-one in this category: • A close friend or relative. A person responsible cannot consent to treatment where the patient objects, or where the treatment is "special medical treatment".

Person Responsible (cont.)	Note: terms used such as 'next of kin', 'contact person' or 'family' on patient records does not necessarily correspond with the legally defined 'person responsible' and you should follow the hierarchy above to ensure consent is obtained from the correct person.
Restrictive Practices	A restrictive practice generally involves physically restraining a person or limiting their freedom of movement or access to objects. Restrictive practices usually arise in the context of managing challenging behaviour. Restrictive practices should only be used in the context of a holistic response to the person's needs, and in particular, to the factors that may be causing the behaviour. The restrictive practice aims to control or contribute towards changing the behaviour. NCAT Fact Sheet, Restrictive Practices and Guardianship (August 2016)
Special Medical Treatment	Special treatment means: (a) Any treatment that is intended, or is reasonably likely, to have the effect of rendering permanently infertile the person on whom it is carried out, or (b) Any new treatment that has not yet gained the support of a substantial number of medical practitioners or dentists specialising in the area of practice concerned, or (c) Any other kind of treatment declared by the regulations to be special treatment for the purposes of this Part, (d) But does not include treatment in the course of a clinical trial. (*Guardianship Act 1987* Part 5 Division 1 Section 33)
Substitute Decision Making	Substitute decision-making is a general term for when a person makes decisions on behalf of another person who does not have capacity to make the decision in question for themselves. A substitute decision maker may be able to make certain decisions for a person without being given specific authority to do so under a guardianship or financial management order or through an instrument of enduring power of attorney or enduring guardianship. It is important to remember that if the person is competent, then the substitute decision maker does not have a role.

1.3 Abbreviations

IDT	Interdisciplinary Teams
LHD	Local Health District. Also used throughout this document to include and refer to other public health organisations
NCAT	The Guardianship Division of the NSW Civil and Administrative Tribunal
NSW	New South Wales
NSW TAG	New South Wales Trustee and Guardian
SHN	Specialty Health Network

1.4 Legal and legislative framework

1.4.1 Capacity

In order for NCAT to consider a guardianship application, it must have evidence of diminished capacity. In Australia there are a number of legal tests which determine a person's capacity, depending on the type of decision to be made (NSW Attorney General's Department, 2015).

The Capacity Toolkit expands on this and reports that when a person has capacity to make a particular decision, they are able to do all of the following:

- Understand the facts involved
- Understand the main choices
- Weigh up the consequences of the choices
- Understand how the consequences affect them
- Communicate their decision.

(NSW Attorney General's Department 2009, Capacity Toolkit, p18)

The *Guardianship Act 1987* notes that a person is incapable of giving consent to the carrying out of medical or dental treatment if the person:

- Is incapable of understanding the general nature and effect of the proposed treatment, or
- Is incapable of indicating whether or not he or she consents or does not consent to the treatment being carried out.

1.4.2 Guardianship

All applications to NCAT must be made in accordance with the *Guardianship Act 1987* and its associated principles.

All NSW Health employees must observe the principles of the *Guardianship Act 1987*. The *Guardianship Act 1987* principles state that everyone who works with people with disabilities under the Act has a duty to:

- Give the person's welfare and interests paramount consideration
- Ensure the person's freedom of decision and freedom of action is restricted as little as possible
- Encourage the person to live a normal life in the community
- Take the person's views into consideration
- Recognise the importance of preserving family relationships and cultural and linguistic environments
- Encourage the person to be self-reliant in matters relating to their personal, domestic and financial affairs
- Protect the person from neglect, abuse and exploitation
- Encourage the community to apply and promote these principles.

(Guardianship Act 1987).

2 RESPONSIBILITIES

2.1 Chief Executives of Local Health Districts (LHD) and Specialist Health Networks (SHNs) are responsible for:

- Recognising that as applications will be made to NCAT in the name of the LHD (and not in the name of an individual clinician), there may be potential for legal and financial implications for the LHD in the event that a decision is appealed
- Ensuring that the staff responsible for making applications to NCAT on behalf of the LHD are appropriately supported and resourced
- Supporting the interdisciplinary team in accessing specialists assessments in a timely manner to aid in the guardianship application process as detailed in this practice guideline.

2.2 All NSW Health facility clinicians are responsible for:

- Working in accordance with:
  - the *Guardianship Act 1987* and its associated principles
  - the *Disability Discrimination Act 1992* and its associated principles
  - the *NSW Disability Inclusion Act 2014* and its associated principles
- Identifying patients at risk (see section 5.1)
- Discussing at risk patients with the interdisciplinary team and incorporating all the team members views when making a decision regarding the need for a guardianship application to NCAT
- Referring at risk patients (see section 5.1) to a social worker if possible
- Supporting an at risk patient or a patient with an identified disability to make informed decisions where needed
- Using professional interpreters to communicate with patients and/or carers, in accordance with Policy Directive PD2006_053 : Standard Procedures for Working with Health Care Interpreters
- Undertaking assessments to validate capacity concerns
- Making applications to NCAT on behalf of the organisation or LHD not as an individual clinician
- Preparing and submitting applications (on behalf of the LHD) and reports within 7 (seven) days of the decision being made by the interdisciplinary team that an application to NCAT is required
- Following the procedure set out in Section 5 of this practice guideline
- Being available to participate as a witness to the guardianship hearing either in person or by phone.

2.3 Medical teams are responsible for:

- Submitting applications in relation to consent for medical care and dental treatment to NCAT
- Conducting assessments to assist in determining capacity and risk
- Informing the patient and their carer/family (if appropriate) of the concerns regarding the patient's decision making ability and plan for further assessments

- Referring patients for review to expert clinicians (e.g. geriatrician and/or psychiatrist, rehabilitation, psychologists, clinical neuropsychologist, neurology specialists and allied health) if further assessment is required to determine capacity
- If a patient has an intellectual disability consider consulting with an Intellectual Disability Service
- Documenting in the patient's health care record when they are medically stable (or not suffering from any irreversible cause of infection e.g. delirium, UTI etc.) prior to any formal capacity testing taking place
- Acting on the recommendations of other clinicians and health professionals
- Preparing and submitting a medical report within 7 (seven) days of the decision being made that an application to NCAT is required
- Continuing to coordinate and review management plans to address ongoing risks to the patient during their admission and whilst waiting for a guardianship hearing
- Being available to participate as a witness to the guardianship hearing either in person or by phone.

2.4 Social workers are responsible for:

- Assessing the risk to the patient (see section 5.1) regarding the decision/s in question
- Assessing the need for a substitute decision maker
- Exploring whether there are any appropriate decision making arrangements already in place
- Considering conflict of interest issues that may arise with current substitute decision making arrangements and the capacity of substitute decision makers to fulfil the role
- Conducting or requesting assessments to assist in determining capacity
- Coordinating the guardianship/financial management application and process to appoint an applicant if appropriate
- Where the social worker is making the application on behalf of the LHD:
    - Entering the process of recording patients waiting for guardianship on the Patient Flow Portal as per the Data Capture – Recording Patients Waiting for Guardianship Guideline (see Appendix E)
    - Prompting colleagues to complete and submit all reports to NCAT within 7 (seven) days from the time the decision was made that an application to NCAT was necessary
    - Completing the Social Work Report Template (where required) and submitting this to NCAT within 7 days from the time the decision was made that an application to NCAT was necessary (See Appendix B)
    - Ensuring the patient subject to the guardianship application has been provided with all reports and served with the notice of hearing. The patient should be given the opportunity to ask any questions regarding the reports or discuss any concerns they have
    - Advising NCAT of any special needs that the patient has e.g. interpreter and/or hearing or vision needs, confirming patient's transport arrangements

to the hearing and/or advising NCAT of suitability of alternate venue for the hearing
    - Updating the Nursing Unit Manager (NUM) and Interdisciplinary team on a regular basis regarding the progress of the guardianship application
    - Attend the hearing in person but if this is not possible via video link or teleconference
- Where the social worker has not made an application on behalf of the LHD, they should assist the appointed applicant (e.g. family member) to minimise any delay
- Liaising with the appointed guardian and/or financial manager following the hearing
- Coordinating the relevant information required by the guardian, for example an accommodation proposal for a residential aged care facility needs to include background information and the suitability of available residential aged care facility beds.

2.5 All other allied health professionals are responsible for:

- Making applications (on behalf of the LHD) within 7 (seven) days of the decision being made by the interdisciplinary team that an application to NCAT is required if it has been identified that they are the most suitable clinician to do so
- Conducting assessments to assist in determining function, capacity and risk
- Preparing and submitting a Health Professionals Report (when required) within 7 (seven) days of the decision being made that an application to NCAT is required. For Occupational Therapists an alternate report template has been provided as Appendix C
- Providing recommendations to manage risk to the interdisciplinary team
- Being available to participate as a witness to the guardianship hearing either in person or by phone
- Assisting with discharge planning.

2.6 Nurses and midwives are responsible for:

- Making applications (on behalf of the LHD) within 7 (seven) days of the decision being made by the interdisciplinary team that an application to NCAT is required if it has been identified that they are the most suitable clinician to do so
- Conducting assessments to assist in determining capacity and risk
- Documenting patient's ability to self-care and, manage medication etc. in the patient's health care record
- Preparing and submitting a Health Professionals Report (when required) within 7 (seven) days of the decision being made that an application to NCAT is required
- Alerting the medical team to any concerns or increased risk to the patient immediately, for example: patient absconding, becoming aggressive or other immediate concerns for their safety/welfare
- Assisting with organising transport for the patient to and from a guardianship hearing
- Arranging an appropriate nursing escort for the patient to and during the guardianship hearing if required

- Discharge planning.

2.7 Rural and remote areas

In rural areas where there is no access to social workers or clinical neuropsychologists, it is suggested there is a discussion with the medical team around who is the most suitable person to complete the application and reports to NCAT. It is important that the applicant is someone who can have ongoing contact with the patient and has an interest in the patient's wellbeing, for example, the nursing unit manager.

3 ALTERNATIVES TO GUARDIANSHIP

If the patient lacks capacity and there are appropriate informal arrangements in place that are working or the patient is not disagreeing with the decisions that are currently being made, then there is no need to make an application to NCAT.

NCAT will only hear applications where there are no appropriate decision making arrangements already in place and all other avenues have been exhausted, for example:

- Multiple discussions with the patient have taken place
- Family conferences have been conducted
- All reversible causes of cognitive impairment have been excluded and/or treated in addition to the patient being back to baseline or at their optimum level of function
- A trial of discharge with maximum community services or
- Supported/assisted decision making.

3.1 Supported/Assisted Decision Making

Assisting or supporting someone to make a decision means giving them the tools they need to make the decision for themself. It is about supporting them to make their own decision, and in doing so, safeguarding their autonomy. It does not mean making the decision for them. A person's right to make decisions is fundamental to their independence and dignity.

Capacity principle 6 in the Capacity Toolkit states that before you assess someone as not being capable of making a certain decision themself, you need to do everything you can to support them through the decision-making process. This involves providing them with all the options including pros and cons and ensuring family and carers are involved (where appropriate). The support you will be able to give varies, depending on the following:

- What decision is being made? For example, a significant one-off decision will require different support from day-to-day decisions
- What are the circumstances of the person making the decision? For example: communication techniques and language may change dependant on the type of disability.

It is always important to find the most effective way to communicate with the person.

- How much time does the person have to make the decision? Can the decision be delayed?
- For example: a deaf person may sometimes or always require a Deaf interpreter as well as an Auslan interpreter (see definition p4).

Assisted decision making is a viable alternative if the interdisciplinary team feel that those assisting with the decision making process have the patient's best interest at heart and there is no evidence of undue influence.

For further information on how to support a patient to make their own decision refer to the Capacity Toolkit (Section 6).

4 TYPES OF APPLICATIONS TO NCAT

NCAT deal with the following types of applications which are most relevant to NSW Health:

- Guardianship
- Financial management
- Review of existing power of attorney and/or enduring guardianship orders
- Consent to medical and dental treatment
- Consent to clinical trials.

Before appointing a guardian, NCAT must have evidence of the following:

1. **Disability** – The person has some form of impairment or disability that impacts on their ability to make informed decisions e.g. dementia, brain injury, mental illness or cognitive impairment and
2. **Incapacity** – The person has been formally assessed as lacking capacity to make their own informed decisions in one or more areas of decision making and
3. **Need** – There is a need for a decision to be made or current concerns which would warrant the person having a guardian appointed at this point in time. There are no informal means by which the decision can be made.

4.1 Guardianship

NCAT can appoint a guardian to make personal or lifestyle decisions on behalf of a person aged 16 years and over with decision making impairment. This may include decisions regarding:

- Where the person should live
- What support services the person should use
- What ongoing healthcare and medical treatment the person should receive
- If restrictive practices are appropriate in the management of the person's behaviour.

4.2 Financial Management

NCAT can appoint a financial manager or review an enduring power of attorney on behalf of a person who is 16 years of age or over and has decision making impairment. This may be considered in circumstances such as:

- There is evidence of undue influence
- There are concerns that enduring power of attorney forms or other documents were completed when the patient lacked capacity to make these decisions
- There is evidence of abuse or significant risk of financial exploitation occurring
- A person has significant income and assets that need management and
- There are pending financial contracts to be signed e.g. entering Residential Aged Care Facilities or payments need to be arranged for essential care services.

NCAT will only make a financial management order if:

- The person is not capable of managing their affairs
- There is a need for someone else to manage their affairs for them
- It is in the person's best interests to have a financial management order
- The person has assets in NSW.

(NSW Civil and Administrative Tribunal, 2014)

4.3 Consent to Medical or Dental Treatment

Refer to Section 1.4.1 for information on capacity to consent to medical and dental treatment.

For most medical and dental treatment, the patient's 'person responsible' can give consent, or refuse consent to the carrying out of treatment on behalf of the patient.

However, the 'person responsible' cannot give consent if the patient is objecting to the treatment. An objection includes:

- If the person indicates that he or she does not want the treatment to be carried out or
- If the person has previously indicated in similar circumstances that he or she did not want the treatment and has not subsequently indicated to the contrary and
- The 'person responsible' is aware, or ought reasonably to be aware, that the patient objects to the treatment.

In this situation, or in circumstances where there is no 'person responsible', an application can be made to NCAT for NCAT to provide consent for the treatment. If treatment decisions are ongoing, the medical officer may need to consider making an application to NCAT for the appointment of a guardian with health care and medical and dental consent functions to provide ongoing substitute consent for the patient.

Applications which are primarily for consent to medical or dental treatment should be submitted by the relevant medical teams. It may not be necessary to refer to other disciplines if the matter is urgent and there is clear evidence of incapacity. There is a

separate application form which will need to be completed. This form can be found on the NCAT website. If the matter is urgent please refer to section 5.10.3 and 5.12 of this guideline.

There is no need to obtain consent from the person responsible (or NCAT) where:

1. The treatment is required, as a matter of urgency, to save the person's life, prevent serious injury to health, or alleviate significant pain and distress (the emergency exception) or
2. The proposed treatment is minor treatment, the patient is not objecting, consent cannot be obtained from the person responsible and the treatment is necessary to promote the patient's health and wellbeing.

(NCAT Factsheet - Consent to Medical and Dental Treatment, 2014).
For further information on decision making and consent refer to the NSW Ministry of Health Policy Directive, Consent to Medical treatment – Patient Information PD2005_406.

5 PROCEDURE

Refer to Appendix D. Flow Chart - Making applications for guardianship and financial management orders.

5.1 Is the patient at risk?

Patients who are vulnerable and at risk of poor health and safety are often in circumstances where:

- There are concerns of neglect
- They are living in squalor
- They are homeless
- There are allegations of domestic violence
- Abuse or financial exploitation may have occurred or there is significant risk of this occurring
- Threats to safety have been identified or
- Where conditions of impaired physical function, cognitive impairment, mental health issues and developmental disabilities exist.

A patient who presents in one of these circumstances above along with other key markers may trigger a health professional to question the need to further assess. These other key markers may include:

- Frequent presentations to the Emergency Department with relevant risk factors such as unkempt appearance, cognitive impairment, poor functional status, insufficient social supports or
- Evidence of neglect, assaults, abuse, conflict between carer, family members or 'person responsible'
- Non-compliance with medications and other health-care interventions.

5.2 What referrals/consultations will I require to help identify level of risk?

Where a person has been identified as having relevant risk factors to their health and safety the following should occur:

- Appropriate allied health referrals should be made for completion of allied health assessments for example, clinical neuropsychology, psychology, physiotherapy, occupational therapy, social work, dietitian and speech pathology
- Referrals to clinical nurse consultants (CNC) e.g. CNCs who specialise in dementia and delirium (if appropriate)
- The social worker should conduct a psychosocial assessment, identify risks, and if possible the patient's wishes
- The social worker should where possible liaise with the 'person responsible', family, carers and community members and/or community health personnel to gather evidence regarding any discharge, social or safety concerns, patient's previous wishes and whether there is already a suitable substitute decision maker available
- All assessments should be documented in the patient's healthcare record
- An inter-disciplinary meeting should take place (case conference) to discuss the level of risk identified and appropriate response.

5.3 Does the patient need a capacity assessment?

Always start with the assumption that a person has capacity. Each individual has the right to make their own decisions if they are able to even when you don't necessarily agree with the decision a person makes. Always assess the person's decision making ability and not the decision they make.

A health professional would only consider challenging the presumption of capacity if there were concerns that the patient has a disability that could impact on their decision making ability and there were significant risks with the decisions that the patient was currently making (or were made by others on their behalf).

All options should be provided to the patient in order to support their independent decision making ability (see section 3.1). If there are still concerns regarding the patient's decision making ability the following should occur:

1. The social worker should consult with the interdisciplinary team regarding the risks identified, whether there is a need for a substitute decision maker to be appointed and which specific decisions need to be made for the person
2. A family conference should be considered to explore any other informal arrangements or options that may be available to determine the least restrictive decision
3. The medical team must inform the patient and their carer and family about why they think the patient is at risk and that they suspect the patient is not making a sound decision. The medical team must also inform the patient and their carer and family that they will be conducting further assessments and making a referral for a capacity assessment to be completed (if they are not conducting this themselves). It must be documented in the patient's health care record when they were informed (date/time) and who informed them

4. The patient needs to be informed that the outcome of the assessment may result in an application being submitted to NCAT. This must be done in an appropriate language for the patient to understand and needs to be recorded in the patient's health care record. It is important to book professional interpreters if the patient does not use English as their first language
5. The medical team may need to consult with a geriatrician, clinical neuropsychologist and/or psychiatrist regarding complex cases
6. A capacity assessment needs to be completed and must be documented in the patient's health care record.

A person must be assessed as incapable of making informed decisions in one or more of the areas of accommodation, medical/dental treatment, community services or financial management before an application for guardianship and/or financial management can be made.

5.4 How do I determine capacity?

Comprehensive, interdisciplinary assessments need to be completed to assist in establishing the person's capacity.

Interdisciplinary assessments may include:

- Medical assessments including impact of diagnoses and/or disability and prognosis
- Completed cognitive screening tools e.g. Mini-Mental State Exam (MMSE), Rowland Universal Dementia Assessment Scale (RUDAS), Adenbrook's Cognitive Examination (ACE-R) or the Montreal Cognitive Assessment (MoCA)
- A psychologist or clinical neuropsychologist assessment to determine cognitive impairment or type of dementia.
- Allied health assessments (occupational therapy, physiotherapy, dietitian, social work and speech pathology if appropriate)
- Functional assessments including premorbid status and ongoing care needs.

An interdisciplinary team decision needs to be made regarding who is the most suitable person to conduct the formal capacity assessment. In these discussions it would be useful to consider:

- Whether the decision is complex
- Who has knowledge regarding the type of decision and might be best to explore the pros and cons with the patient
- Whether a referral to a clinical neuropsychologist is required or
- If there is another health professional who has sufficient knowledge regarding the nature of the disability or impairment and the decision to be made and can conduct the assessment.

A valid capacity assessment cannot be completed unless:

1. The patient has been informed first that the assessment is occurring
2. All other options for supported decision making have been exhausted
3. The patient is medically stable as determined by the treating medical team.

Capacity assessments should be conducted in an appropriate environment and at a time which would be optimal for the patient. For instance you may consider conducting a capacity assessment for a patient who suffers from dementia in the morning if you knew they became more agitated in the afternoon. The capacity assessment should only be assessing the specific decision that needs to be made at this time. **Capacity assessments should not generally assess global capacity**.

Capacity assessments should address the following:

- Diagnosis/disability
- The decision making capacity of a person in respect to their physical, cognitive, social, cultural and environmental functional ability and how these impact on the decision that needs to be made e.g. consider the types of questions being asked. Is this appropriate? Can the person hear you? Are they aware that you are conducting a capacity assessment?
- Consider the person's personality, previous wishes and evidence from family/friends and/or carers
- The nature of the decision required e.g. accommodation, medical care, lifestyle or financial
- You must inform the patient that you are conducting a capacity assessment
- In your report summarise the questions asked and the responses given
- Always provide the reasons for your decisions
- Always use an interpreter where necessary including a Deaf Interpreter – see definition p4.

Capacity assessments should demonstrate whether or not the person can:

- Understand the facts and the choices involved
- Weigh up the consequences, and how these might affect them
- Retain the information regarding the decision
- Communicate a stable decision.

All assessments must be documented in the patient's healthcare record.

For more detailed information regarding conducting Capacity Assessments please refer to the NSW Capacity toolkit.

5.5 When do I need to make an application to NCAT?

As discussed in Section 4 you may need to submit an application to NCAT if there is evidence of:

1. Disability
2. Incapacity
3. Need.

Disability alone is not sufficient ground for making an application to NCAT. Neither is disability and incapacity. There must also be a current need for the decision to be made at this time.

In many circumstances where a person has a disability, they will have a suitable 'person responsible' (for medical and dental decisions) or substitute decision maker who can assist them to make appropriate decisions regarding their care. However, if there is a disagreement about what is in the patient's best interest or the person themselves is objecting to a decision, and there was a current need to make the decision it would be appropriate to submit an application to NCAT.

When a patient is objecting to a decision regarding their care and treatment (or discharge arrangements) they are likely to be consistently and strongly refusing or resisting.

It is important to note that in circumstances where a patient is considered to lack capacity and is objecting to either medical treatment, accommodation decisions, or other services, a 'person responsible' or substitute decision maker cannot provide the substitute consent, unless they have been appointed by NCAT and granted a coercive function. A guardianship order is therefore required if no such provisions exist.

If health professionals are not clear as to what constitutes an objection they can contact NCAT for advice on the following telephone number: **02 9556 7600**.

Referral to NCAT is appropriate only when:

- All other substitute decision making options have been exhausted and
- All discharge options have failed or are deemed too unsafe.

An application can be made by a health professional on behalf of the organisation or LHD, Specialist Health Network (SHN) or by a family member, 'person responsible', substitute decision maker, carer or friend. The interdisciplinary team with consultation from the family, 'person responsible' or carer (if available) should determine the most appropriate person to submit the application.

5.6 Submitting the application

Once it is decided who should submit the application, he or she should lodge an application to NCAT within 7 (seven) days from the date a decision was made that an application was needed in order to prevent any procedural delay to the application process. The application form for appointment of a financial manager and/or guardian can be found on the NCAT website.

If it is agreed that the LHD is not the applicant, the LHD should support an appropriate person willing to become the applicant. The applicant is responsible for providing the relevant evidence to support the application. The information required to support the application includes the medical and professional evidence about the person's capacity to make his or her own decisions and information about any risk to the person. The information provided to NCAT is not confidential and may be shared with interested parties. If there are concerns regarding the sharing of information the health professional should seek advice from their supervisor and NCAT.

Where there is a risk to the patient's emotional wellbeing and/or physical condition whilst remaining in hospital this should be highlighted in the application to expedite the guardianship hearing.

Data is to be entered on the Patient Flow Portal as Waiting for What Guardianship 1 – Application to be submitted as per the Data Capture – Recording Patients Waiting for Guardianship Guideline (see Appendix E).

5.7 What reports are required by NCAT?

All health professionals involved with the assessment process should submit a written report. This report is to be completed within seven (7) days of the decision for an application so as to prevent any unnecessary delays with the hearing.

The information required to support the application includes the medical and professional evidence about the person's capacity to make his/her decision in regards to the decision in question.

A minimum of two professional reports are required for each application. The following types of reports could be submitted:

- **Medical and/or Neuropsychology Report** - An example to follow for a medical report is in Appendix A. Alternatively you can use the health professional's report template on the NCAT website. Additional supporting documentation may also be required
  Please note that a Neuropsychology report can be used where available but is not mandatory
- **Social Work Report** - Social Workers are recommended by NCAT to use the Social Work Report Template (Appendix B). Please note, NCAT identified this report has the information they require to support an application. In essence this report brings together the all the information in a holistic way and therefore an additional/separate psychosocial assessment is not required
- **Occupational Therapist –** an example of an Occupational Therapy assessment can be found in Appendix C. The Occupational Therapy report provides vital information regarding a patient's functional ability. It is important that this report shows clear evidence of how the patient's functional ability is at risk due to the patient's cognitive impairment, disability or mental illness and ability to make informed decisions (if appropriate)
- **Other Allied Health Professionals, Nursing and Midwifery reports.** Other allied health professionals e.g. physiotherapist, speech pathology, dietitians, nurses and midwives can use the health professional's report template on the NCAT website which is suitable for all health professionals' reports.

Reports must be evidence based, relevant to the type of application being submitted and should include:

- Your assessment of the patient and findings
- Summary of your interventions and prognosis
- Summary of all the options trialled and failed, to assist with decision making and managing risk for the patient

- Evidence of incapacity
- Recommendations and reasons for your recommendation
- Whether you support/don't support the application to NCAT.

It is recommended that reports are reviewed by a senior clinician (such as your supervisor) prior to being sent to NCAT.

Reports will form part of the proceedings and should be informative, factual and avoid adversarial language.

Applications and reports should be emailed to NCAT at gd@ncat.nsw.gov.au or can be faxed on 02 9556 7777.

Data is to be entered on the Patient Flow Portal as Waiting for What Guardianship 2 – Reports to be submitted as per the Data Capture – Recording Patients Waiting for Guardianship Guideline (see Appendix E, page 41).

5.8 Waiting for a hearing date

Once an application has been submitted to NCAT, the person managing the application on behalf of the LHD will receive a letter with a reference number. You will need to use this reference number for all future communication with NCAT regarding the patient's application.

The matter will be allocated to an NCAT case worker who will prepare the application for hearing and provide a summary report. The case worker will contact all those who have been identified as having a legitimate interest in the application to seek their views and organise the hearing date and venue. These people may include spouses, children, other family/friends, carers or support workers depending on their level of involvement and contact with the patient. The NCAT case worker will contact the person the application is about to try to seek their views. The applicant may need to assist in facilitating this conversation.

The person managing the application on behalf of the LHD must continue to liaise with NCAT, the health team, family, carer and the patient as to the progress of the application, update on any changes and ensure a coordinated discharge plan is in place well in advance of the hearing. If there are any changes NCAT must be notified.

The interdisciplinary team should also continue to investigate if the patient can be safely discharged from hospital to a suitable place prior to the hearing e.g. a non-acute facility or respite at an aged care facility. This must be considered the least restrictive option and can only occur if the patient does not object.

If appropriate a patient can proceed to have an ACAT assessment completed whilst they are waiting for the guardianship hearing. This assessment determines eligibility for Commonwealth funded aged care services. Transfer to a residential aged care facility can only occur if ACAT has approved the patient for the level of care required and the patient does not object.

For guidelines on the required consent for an ACAT assessment, please refer to the Aged Care Assessment Programme Guidelines.

It must be noted that if the patient is continuing to object to being transferred to an alternative facility then they cannot be moved against their will without appropriate functions approved by NCAT. The patient in this circumstance will need to wait for the NCAT hearing to proceed before any discharge decisions can be made.

However, it is important that whilst the application to NCAT is pending that discharge planning continues. This will minimise any delays once a decision has been made by NCAT (if the application is successful and relevant) and ensures that options for discharge are ready to present to the appointed guardian.

Data is to be entered on the Patient Flow Portal as Waiting for What Guardianship 3 – Hearing date as per the Data Capture – Recording Patients Waiting for Guardianship Guideline (see Appendix E).

5.8.1 What to do if the person managing the application on behalf of the LHD cannot continue with their role

If the person submitting and managing an application on behalf of the LHD cannot continue in this role they must ensure that they handover their responsibilities to another suitable staff member.

There may be no need to complete a 'request to transfer applicant details form', as the applicant will remain the LHD, it is just the name of the contact person for the applicant/LHD that is changing. If required, the form can be obtained by contacting NCAT on tel: **02 9556 7600.**

5.9 Preparing for the hearing

A risk assessment needs to be carried out in advance of the hearing by the person submitting and managing an application on behalf of the LHD to determine safety issues for patient's and applicant's attendance at the hearing. Important factors to consider include: whether the patient would be medically compromised if they were to leave the ward area or attend the hearing in person; any concerns regarding transporting the patient to the hearing or access for the patient to use the amenities (see Appendix F. Guardianship Risk Assessment Resource).

Where it is not appropriate for the patient/applicant to attend the hearing in person, the applicant should contact the NCAT case worker and make alternative arrangements for a hearing venue such as on the hospital grounds or via teleconference/video link.

It is important to remember that the information you provide to NCAT is not confidential. If there are genuine concerns that the release of certain information will place yourself or the patient at risk you must discuss this with the NCAT caseworker. NCAT can in exceptional circumstances make non publication or suppression orders.

A Notice of Hearing and copy of the NCAT hearing report, application, and health professional's reports and other relevant documentation will be sent to the person submitting and managing an application on behalf of the LHD. A Notice of Hearing and copy of the application will also be sent to the patient who is subject to the hearing. It is the responsibility of the person submitting and managing an application on behalf of the LHD to serve the papers to the patient and explain the process. A Notice of Hearing and copy of the application will also be sent to all other interested parties to the application.

It is also important that the health professionals who provided a report to NCAT are available to be contacted via telephone by the NCAT panel during the hearing if necessary.

5.10 The hearing

5.10.1 **Guardianship and financial management hearings**

One of the key responsibilities of the person submitting and managing an application on behalf of the LHD is to attend and participate in the hearing. It is also a responsibility of the applicant to organise for the patient who is subject to the hearing to attend and participate (if determined to be safe to do so as per section 5.9).

NCAT guardianship hearings are conducted by a panel of Tribunal members. The panel will usually be made up of:

1. Senior Member – Legal
2. Senior Member – Professional
3. General Member – Community.

The Tribunal panel will consider the relevant written evidence that has been provided. The panel will ask the person submitting and managing an application on behalf of the LHD to verbally report on the reasons for the application and any further information that needs to be provided. The panel may also take evidence from those attending the hearing, most importantly from the person the application is about. Parties and witnesses may attend the hearing or give evidence over the telephone or by videoconference, if necessary (NCAT Factsheet – What to expect at the Hearing - Guardianship Division, 2016).

After considering the evidence, and if the Tribunal panel is satisfied that the person does not have the capacity to make informed decisions, the panel decides if a guardian and/or financial manager is required and who should be appointed.

5.10.2 **Consent to medical and dental treatment hearings**

Applications for consent to medical or dental treatment may be heard by a panel consisting of less than three Tribunal members. NCAT may consent to medical/dental treatment if the treatment is minor or major and there is no 'person responsible' or the patient is objecting to the proposed treatment. NCAT considers the written evidence that has been provided and takes evidence from the parties and witnesses.

The Tribunal may also consent to special medical treatment. For example this may include terminations, administration of androgen-reducing medications for behavioural control or use of medication affecting the central nervous system where dosage, duration or combination is outside accepted norms. A panel consisting of three Tribunal members must hear an application for special medical treatment. A 'person responsible' or guardian cannot consent to special medical treatment. If a patient does not have capacity to make these decisions an application must be lodged with NCAT.

The application process and evidence required in support of applications for consent to special medical treatment are different from those for minor or major medical treatment. See NCAT Special Medical Treatment Guidelines (NCAT Guardianship Division, April 2016).

5.10.3 **Emergency hearings**

Emergency hearings are normally requested when there is a high risk to the patient's immediate health or welfare.

When the need arises for an emergency hearing there are generally two types:

- An emergency hearing for a person who is already awaiting a guardianship hearing, for which you are awaiting a date, and/or a date has been set, but the situation becomes more urgent e.g. person has absconded
- An emergency hearing for a person who has previously not been identified as needing either guardianship and/or financial management.

Emergency hearings are not held during normal business hours and occur after 5.15pm or before 9am Monday to Fridays, and/or at any time over weekends or public holidays.

The process involves contacting the NSW Civil and Administrative Tribunal (NCAT) as soon as the need is identified:

- **During working hours 9am to 4pm** on 9556 7600. An urgent written application needs to be submitted (if not already done so), to NCAT which identifies than an after-hours hearing is needed. A hearing is usually scheduled for that evening.
- **Outside usual working hours**: The main NSW Civil and Administrative Tribunal (NCAT) number of **9556 7600** has a paging service, you need to document the number then call that service, and leave a message and a member of the after-hours NSW Civil and Administrative Tribunal (NCAT) will contact you. They then determine from the information given if an emergency hearing is needed and/or organise the hearing.

If an emergency NCAT hearing occurs, these are usually phone hearings and only short term orders of 1-6 months will be granted.

Depending on the severity of the issues identified, an emergency hearing can take somewhere between hours to days to organise.

5.11 After the hearing

In most cases the Tribunal Panel will make a decision at the end of the hearing. The decision will be effective immediately. A written order and reason for the decision will be sent to all parties (NCAT Factsheet – After the hearing - Guardianship Division, 2015). In some rare circumstances the hearing may also be adjourned (this occurs where a hearing is partially heard and is re-listed to be continued on a later date).

If a private guardian or private financial manager is appointed then they are authorised to make decisions for the patient according to the functions they have been given in the order from the day of the hearing. A copy of the report and decisions will be sent to them at a later date.

If a Public Guardian or NSW Trustee and Guardian (TAG) has been appointed, then a copy of the hearing report and decisions will be sent to them. This may take up to 28 days. The Public Guardian can only make decisions for the patient according to the functions they have been given in the order. If the NSW Trustee and Guardian are appointed as the financial manager, they will begin to take over the management of the patient's finances once they have received the written orders from the Guardianship Division of NCAT.

The person submitting and managing an application on behalf of the LHD is to inform the relevant health care team immediately of the outcome of the NCAT hearing and if a guardian has been appointed. He/she should then work closely with the guardian to expedite a satisfactory discharge arrangement and/or furnish the guardian with any background information to assist him/her with decision making so as to prevent any unnecessary delay.

The outcome of the NCAT hearing, who is appointed as the guardian and/or financial manager and what functions they have been given should be clearly documented in the patient's healthcare record.

Upon receipt of the written order and decisions, a copy must be placed in the patients' healthcare record.

Data is to be entered on the Patient Flow Portal as Waiting for What Guardianship 4 - Public Guardian to be appointed and/or Guardianship 5 - NSW TAG financial manager to be appointed as per the Data Capture – Recording Patients Waiting for Guardianship Guideline, if relevant (see Appendix E).

5.12 Emergency Situations - what should I do?

Often an urgent and difficult situation arises when the patient (although sometimes family or friends) does not believe that he or she needs to remain in hospital whilst the treating medical and allied health team do.

When this occurs the following courses of action could be considered:

1. Re-direct the person and try to encourage the patient to remain in hospital

2. Consider whether a consult with the mental health team is appropriate
3. Lodge an application for an emergency NCAT hearing.

5.13 Withdrawing an application

In some circumstances, an applicant may wish to withdraw their application before it goes to a hearing. Applications can only be withdrawn with the permission of the Tribunal.

The Tribunal must be satisfied that there is no longer a need for an order to be made for the person who is the subject of the application.

The applicant must complete a Request to withdraw a Guardianship Division application form and provide evidence about how the issues that prompted the application have been resolved.

(NSW Civil and Administrative Tribunal, 2015)

6 APPENDICES

6.1 Appendix A. Medical Report Outline for a Guardianship Application

Guardianship Division of NCAT
PO Box K1026,
Haymarket
NSW 1240

Click here to enter a date.

To Whom It May Concern:

Re: Insert patient's full name, DOB and address

Introduction

My name is Insert name and I am a Insert current position and title at Insert facility.

Insert professional qualifications and experience.

Relationship with the patient

Include:

- Duration of doctor-patient relationship.
- Under what circumstances that you have known the patient e.g. Inpatient, outpatient, community etc.

Medical and social history

Include:

- Known medical background and treatments required.
- Diagnosis that had affected their ability to make executive decisions, such as dementia, brain injury, alcohol related brain damage etc.
- Personal history if known.
- Social circumstances e.g. live alone, with a carer (brief description, refer to social work report).
- Support network or the lack of support e.g. spouse, children, friends, and relatives.
- Examples of such executive function impairment preferably if available e.g. ability to manage ADLs, administrating (or compliance with) medications, meal preparations, bill payments etc. (brief description, refer to occupational therapy, registered nursing reports).
- Evidence of hazardous or harmful behaviour eg; fire, speeding fines, car accidents, overdosing or under dosing causing adverse medical outcomes, aggression/abuse, over/under spending, unpaid bills, risk of being exploited financially etc. (Can consult with general practitioner).
- Assessments or supporting statements from other specialties e.g. allied health, clinical neuropsychologist, and their conclusions.

Physical and cognitive assessment

Include:

- General appearance, mental state assessment and cognitive screen such as MMSE and/or RUDAS, and/or other assessment batteries used. Include details of specific areas of deficit e.g. memory, planning, problem solving.
- Examples in impairments of executive function, especially frontal lobe functions e.g. abstracting, programming, disinhibiting (loss of inhibition due to brain impairment).

Capacity assessment

Include:

- Time specific and task specific ability to identify or recognise alternative options, and their pros and cons before making decisions, especially in regards to accommodation and medical needs.
- This can also be done by summarizing and/or including reports from clinical neuropsychologist and occupational therapist etc.

If financial manager is required provide:

- Evidence of patient's inability to manage his or her own finances eg; unsure of their own asset/cash, bank statements, unsure of the bills they need to pay, unreasonable spending etc.
- This can be done by summarizing the social worker's and psychologist's assessments and reports.

Other medical signs

Include information on other aspects:

- Which affect the persons function e.g. cardio respiratory failure, functional impairment, exercise tolerance, tissue or organ damage etc.
- This could also include a summary of nursing Assessment and Reports regarding health management issues i.e. diabetes, COPD/Asthma, continence management and wound care etc.

Previous management plans

Include what plans have been previously attempted to assist in decision making and minimising risk, for example:

- Home with services
- Medications
- Respite
- Carer distress
- Recurrent hospital admissions.

Conclusion

I believe that Insert patient's name Choose an item capacity to make executive decisions on issues such as:

☐ Accommodation
☐ Medical treatments
☐ Services received
☐ Financial management
☐ Other (please specify) - Choose an item.

Therefore I support a guardian and/or financial manager Choose an item be appointed to make decisions regarding

☐ Accommodation
☐ Medical treatments
☐ Services received
☐ Financial management
☐ Other (please specify) - Choose an item.

Yours sincerely

Insert Name
Insert position
Insert facility details
Insert address
Insert email address
Insert phone number.

6.2 Appendix B. Social Work Report Template

Insert Social Worker's name
Insert Social Worker's contact details

The Guardianship Division of NCAT
PO Box K1026
Haymarket
NSW 1240
Email: gd@ncat.nsw.gov.au

SOCIAL WORK REPORT

Name of Patient	
Date of Birth **Home Address** **Current place of residence**	

GENERAL	**Use for reports for both Guardianship and Financial Management applications**
Your name *Are you the applicant? If not, do you support the application?* *Qualifications* *Current position and period in this position* *Experience/Professional background* *Extent of contact with the client.*	
Client's social history: *Background prior to this contact (cite all sources of information)*	

Current circumstances, including: *Family and other informal support* *Living Arrangements* *Other support, both formal and informal* *Other factors relevant to the application.*	
Other relevant matters: *For example: hearing, vision, or speech impairment which may affect how a person communicates their decision. Any other factors such as bereavement which effects current decision-making but may improve with time or treatment.*	
Physical Diagnoses and their likely impact	*Refer to medical report if available*
Medications and their impact on decision making ability, *(if any*).	*Refer to medical or nursing reports if available*
Documented mental health issues and their likely impact, *(if any).*	*Refer to medical or nursing reports if available*
Documented drug and alcohol issues, *(if any*).	*Refer to medical or other reports if available*
Cognitive and Emotional Functioning *Alertness/Level of*	*Refer to other reports if available e.g. neuropsychology, occupational therapy, medical, psychology*

Consciousness *Memory and Cognitive Functioning* *Emotional Functioning* *Fluctuation*	
GUARDIANSHIP ORDER	**If the application is for a Guardianship Order please give the following information:**
Nature and extent of person's decision-making disability • *Ability to make decisions* • *Ability to Plan* • *Ability to understand implications of decisions*	
Functional Status	*Refer to OT or neuropsychology report if available*
Informal supports *What informal supports are/have been used that has previously negated the need for a formal decision-maker?*	
Current Decision Making Arrangements *How are decisions usually made by/for the client?* *Can this be maintained?*	
Why is an Order the only solution?	

What decisions need to be made now? • *Accommodation issues* • *Health care issues* • *Issues around consent to medical and dental care* • *Provision of appropriate services* • *other,(e.g. access)*	
Risk of Harm and Level of Supervision Needed • Nature of risk • Severity of the risk • Social factors involved	
Describe any conflict, objection, or evidence of abuse, exploitation or neglect *(cite sources of this information)*	
Values and preferences • goals and quality of life • person's understanding and expressed view of this application • family/carer's understanding of this application and wishes	
Degree of urgency	
(If supporting the application for Guardianship) If a guardian is appointed who should that be*? Give reasons*	

FINANCIAL MANAGEMENT	**If the application is for a Financial Management Order please give the following details:**
Client's source/s of income	
Known assets (approximation)	
Client's financial obligations: dependents, debts, bills, financial commitments, etc.	
Formal assessment of financial decision-making ability	*Refer to OT or neuropsychology report if available*
Nature and extent of person's incapacity to: • understand financial matters • appreciate or recognise financial risk or exploitation • plan/budget/save money/live within his or her current means	
What financial decisions need to be made and when?	
Risk of financial harm: • nature of risk • immediacy of risk	
Action needed to protect the client from risk	
Has the client appointed an enduring power of attorney? *(If yes, give details)*	
What informal supports are/have been used that have negated the need for an Order to date?	
Can these be maintained?	
Is an Order the only solution?	

Is there any conflict, objection, or evidence of abuse/exploitation? *(Cite sources of this information)*	
Values and preferences • goals and quality of life • what does the person think about financial management? • person's understanding and expressed view of this application • family/carer's understanding of this application and wishes	
(If supporting the application for Financial Management) If a Financial Manager is appointed who should that be? *Give reasons*	

Concluding comments and recommendations:

On the basis of this report, and following discussions with member of the multi-disciplinary team and other stakeholders, I Choose an item this application.

I would be pleased to discuss any element of this Social Work Report with the Guardianship Division of NCAT. My contact details are provided above.

Yours sincerely

Name
Position

Click here to enter a date.

6.3 Appendix C. Occupational Therapy Report Template

Guardianship Division of NCAT
PO Box K1026,
Haymarket
NSW 1240

Click here to enter a date.

Occupational therapy report for Choose an item

Re:
Name - Click here to enter text

Address - Click here to enter text

Date of birth - Click here to enter text

The multi-disciplinary team involved with Insert patient's name have agreed that Choose an item would be beneficial for Choose an item. This report summarises why the Occupational Therapist involved Choose an item the application.

Introduction

My name is Click here to enter text and I am a Insert qualifications/role at Insert facility. Insert patient's name is a Insert patient's age year old Choose an item who was admitted to Choose an item on Click here to enter a date following Enter reason for admission.

Insert patient's name became involved with the occupational therapy service at insert facility name. on Click here to enter a date.

Add details regarding OT involvement, how often seen etc

Assessments

(Delete after reading: include both functional and paper based assessments & dates completed.
Click here to enter text.

Background

Current Diagnoses / Medical History
Click here to enter text.

Social Situation

Click here to enter text.

Mobility and Transfers (Delete after reading - Sit to stand transfers, bed transfers, mobility [indoors vs outdoors/community], aides used, assistance or supervision requirements, steps, etc.)

Pre-admission Function:
Click here to enter text.

Current Function:
Click here to enter text.

Self-care (Delete after reading – Showering/bathing, toileting/continence [day and night], aides used, assistance or supervision requirements, medication management, etc.)

Pre-admission Function:
Click here to enter text.

Current Function:
Click here to enter text.

Productivity (Delete after reading – Financial management, meal preparation, cleaning / laundry, groceries, yard maintenance, etc.)

Pre-admission Function:
Click here to enter text.

Current Function:
Click here to enter text.

Cognition (Delete after reading – SMMSE, MoCA, ACE-III, Cognistat, RUDAS, Functional cognition [e.g. meal preparation assessment result], etc.)

Pre-admission Function:
Click here to enter text.

Current Function:
Include outcome of current cognitive assessments completed.

Other (Delete after reading – Transport/driving, community access, etc.)

Pre-admission Function
Click here to enter text.

Current Function
Click here to enter text.

Home Environment
Click here to enter text.

Does the person's disability affect their ability to make informed decisions about the following? (Delete after reading: only complete the relevant sections below. If not relevant to the decision needing to be made then delete the inappropriate section.

☐Accommodation, care and services: ☐Yes ☐No
If yes, in what ways?
Click here to enter text.

☐Health and medical care: ☐Yes ☐No
If yes, in what ways?
Click here to enter text.

☐Financial affairs: ☐Yes ☐No
If yes, in what ways?
Click here to enter text.

☐Other: ☐Yes ☐No
If yes, in what ways?
Click here to enter text.

Recommendations:
Summarise concerns and clinical reasoning for these here.

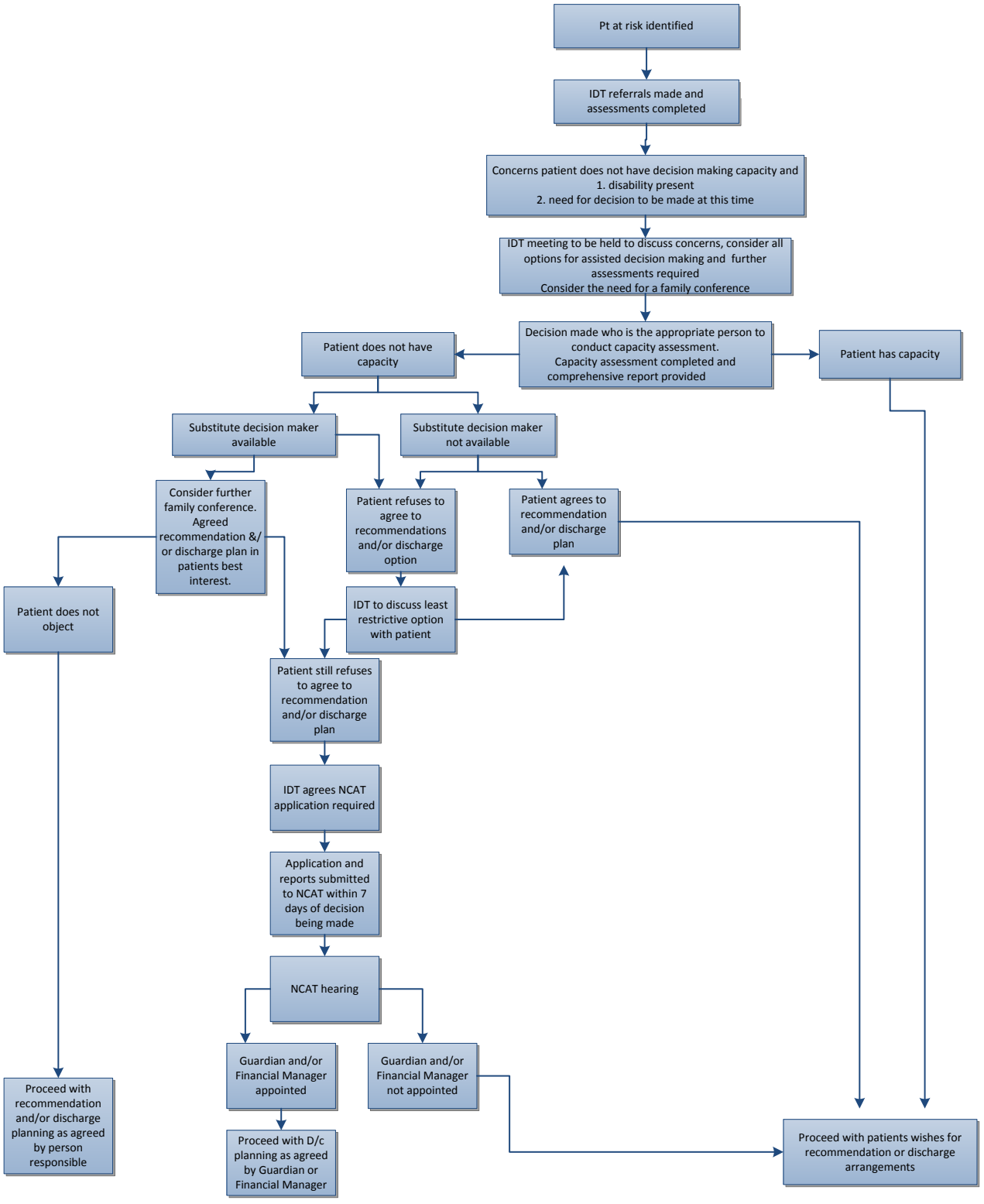
Based on this, I support guardianship for the following:
☐ Accommodation
☐ Medical treatments
☐ Services received
☐ Other (please specify) - Click here to enter text.

In addition, I support:
☐ Financial management

Please feel welcome to contact me on Insert contact details if you would like to discuss this report further.

Insert Name
Occupational therapist
Insert facility details
Insert address
Insert email address.

6.4 Appendix D. Flowchart – Making applications for guardianship and financial management orders



6.5 Appendix E. Patient Flow Portal – Data Capture - Recording Patients Waiting for Guardianship Guideline

Background

The NSW Ministry of Health Whole of Health Program has initiated a project in collaboration with LHDs/Specialty Health Networks to build capacity within facilities and to minimise the impact on patients who are waiting for a guardianship hearing. The project aims to improve processes within facilities and reduce the wait time for guardianship hearings so that patients who do not need to be in hospital will be in the most suitable care setting.

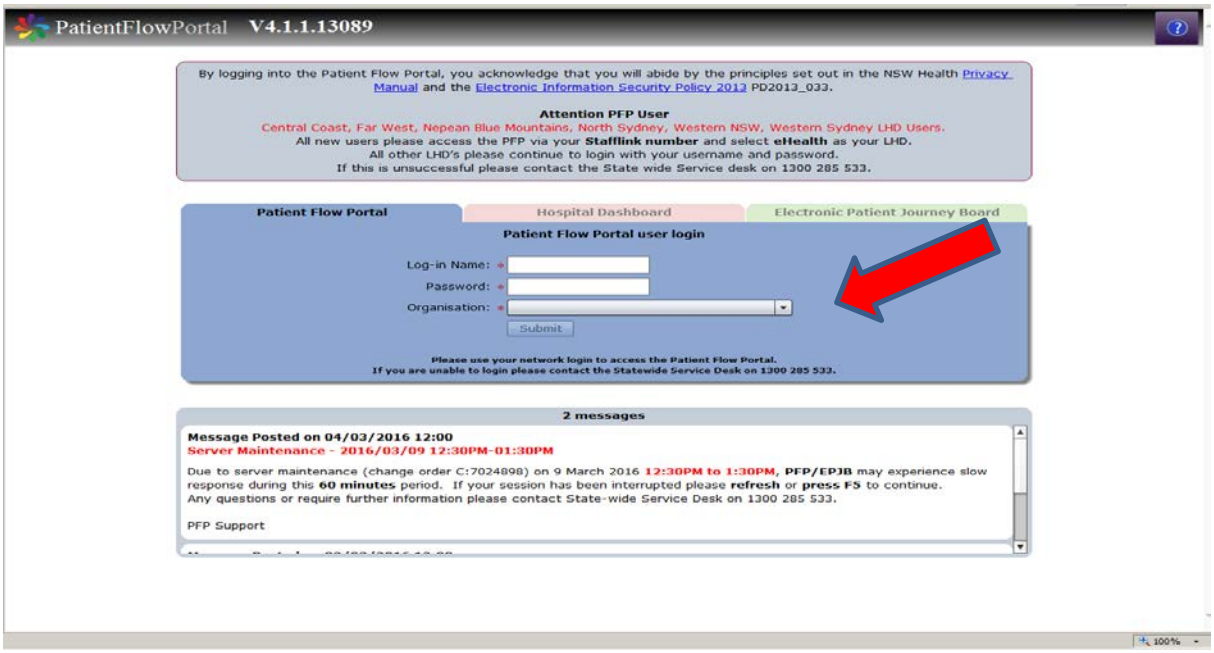
The objectives of the project are to:

- Minimise unnecessary lengths of stay for patients who are waiting for a guardianship hearing.
- Work with LHDs to capture accurate data.
- Develop an education package for NSW Health staff to assist in making application to NCAT on behalf of patients.
- Develop a state-wide NSW Health practice guideline for making a guardianship application for patients who are inpatients of an acute health facility.
- Develop relationships with NCAT to review guardianship applications from NSW Health inpatient facilities within 21 days.

Waiting for What – Recording Patients Waiting for Guardianship

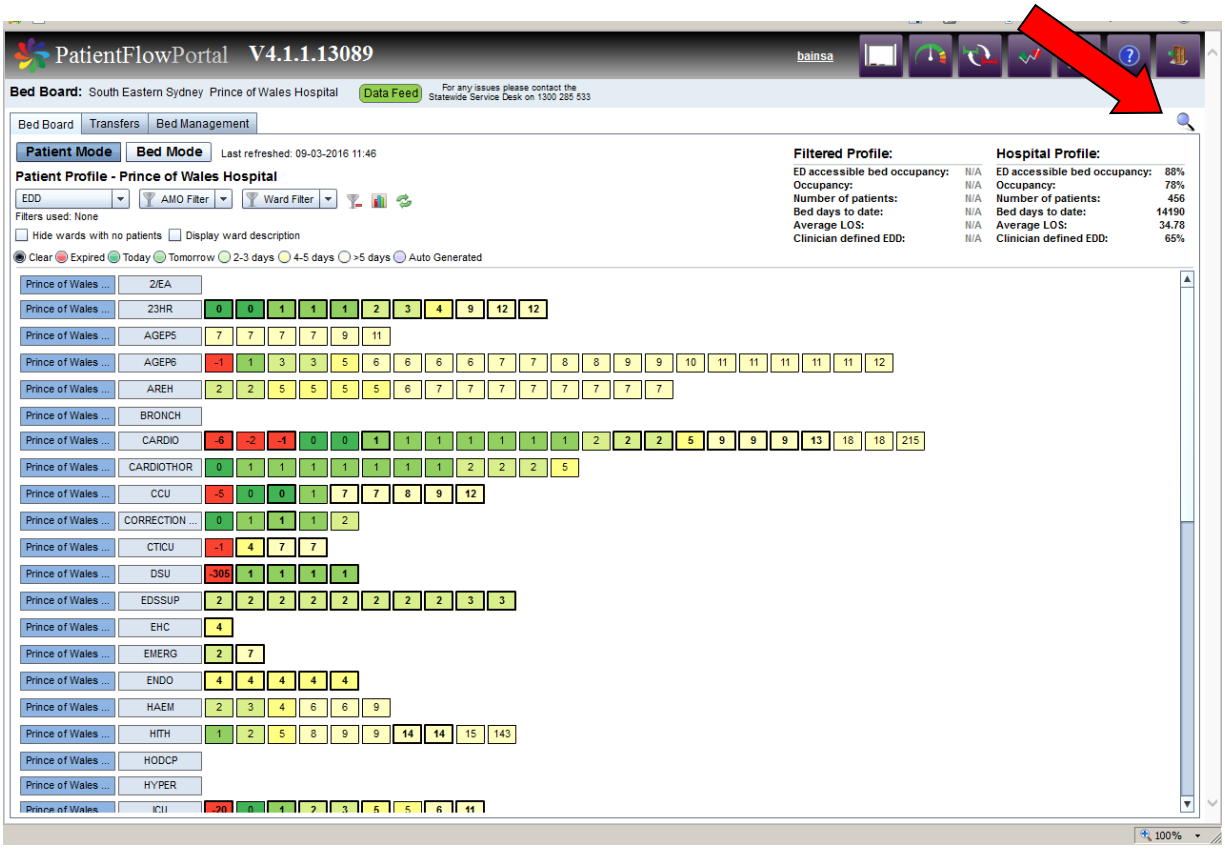
One of the objectives of the project is to capture accurate data across the state which reflects the number of patients waiting for guardianship, the length of time it takes for guardianship matters to be resolved and areas to improve in order to minimise length of stay for these patients.
The Patient Flow Portal is a NSW state-wide database that is currently in place in every hospital across the state and can be used to capture data for patients waiting for guardianship.
This Guideline will show you how to record this data in a consistent way.
Please ensure that you have access to the Patient Flow Portal (PFP). If you do not have PFP access please click on this link. http://www.health.nsw.gov.au/pfs/Pages/bedboard.aspx#bookmark2. Alternatively contact your Patient Flow Manager or line manager.
In order to log onto the Patient Flow Portal click on the following link: http://pfp.healthtech.nswhealth.net/pfp/ or access this through your LHD intranet.

Log in using your Staff link ID and password.
In organisation select your relevant LHD that you work for.

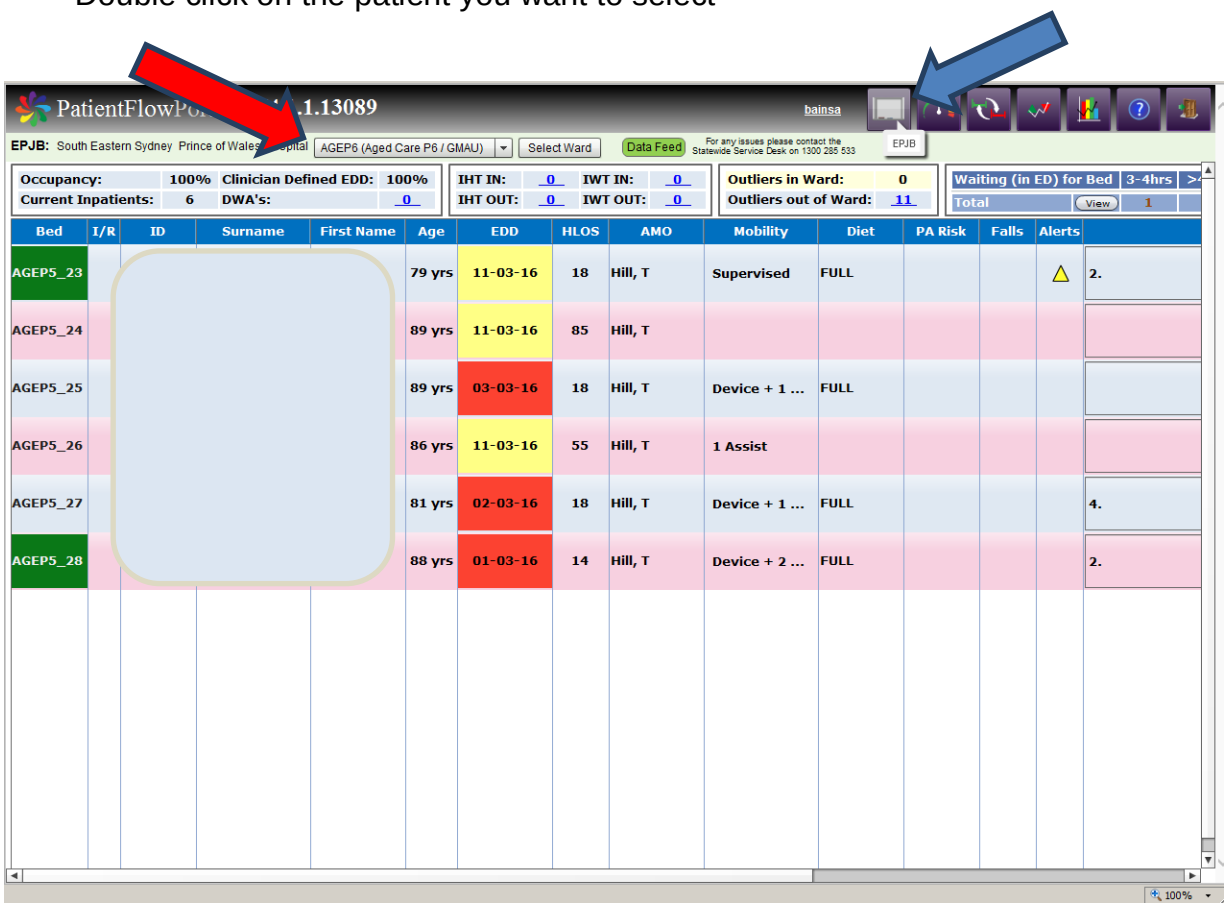


You can search a patient 1 of 2 ways.

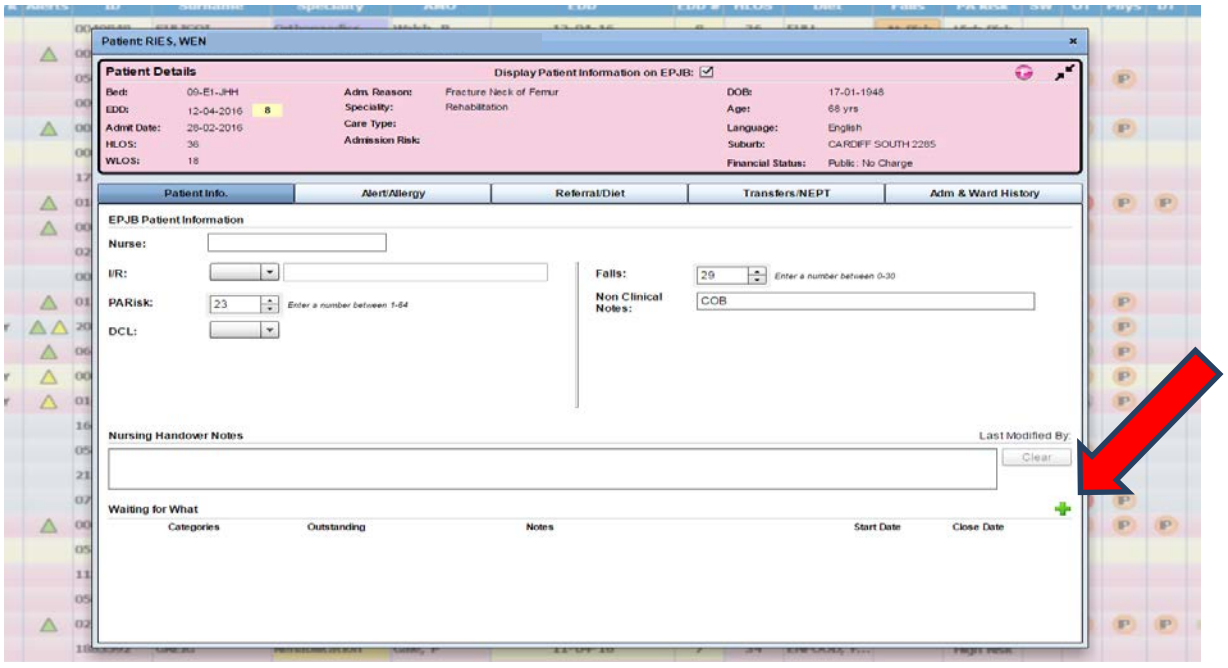
1. **Patient Flow Portal Bed Board** - Click on the magnifying glass on the top right hand side of the Bed Board screen when you log in. (see arrow) and then search by name or MRN or…



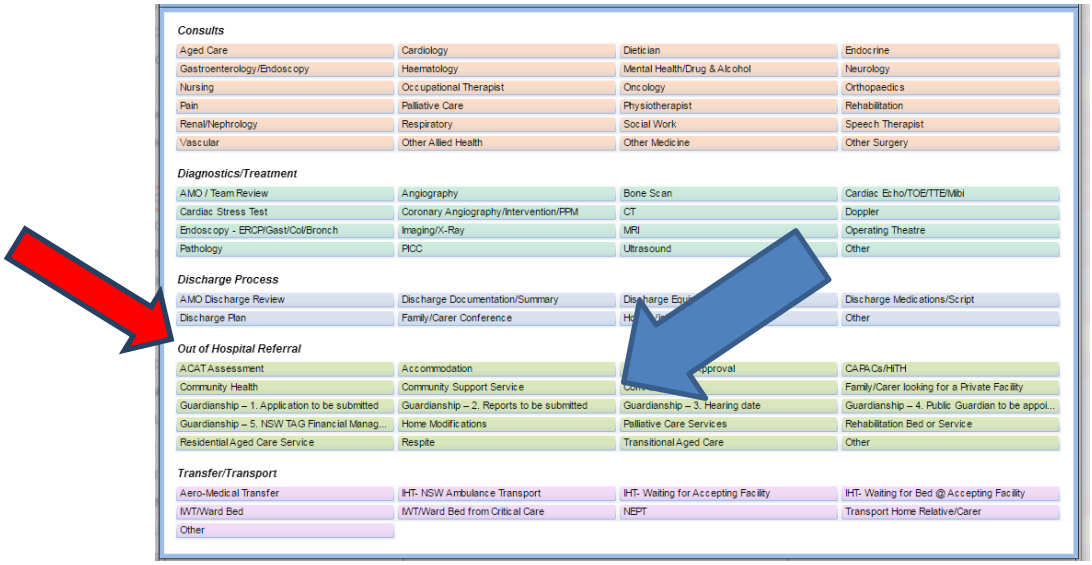
2. **Patient Flow Portal Electronic Patient Journey Board (EPJB).**
   Click on the Patient Journey Board (blue arrow)
   Then select the appropriate ward (red arrow)
   Double click on the patient you want to select



Click on the waiting for what ‘add’ icon



Then go to Out of Hospital Referral section and click on the appropriate Guardianship delay reason.

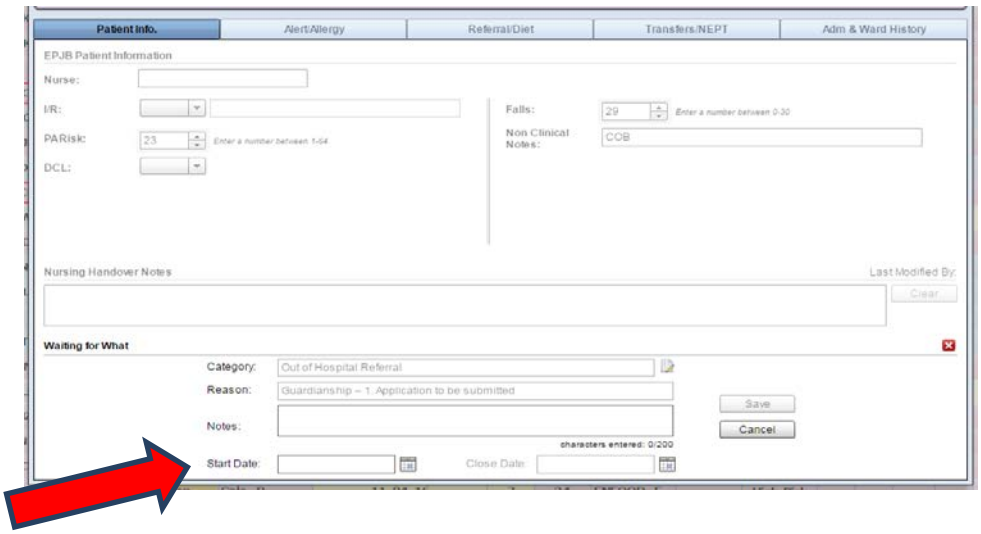


There are five different delays to the guardianship process that can be recorded. This means that you will need to insert a waiting for what delay episode for each. The different areas are identified below.

Waiting for What Guardianship Process

You will need to insert a **start date** and add **notes**
You have 200 characters to insert relevant comments in the notes section. Underneath the title you have space to record further information regarding possible reasons for length of stay.

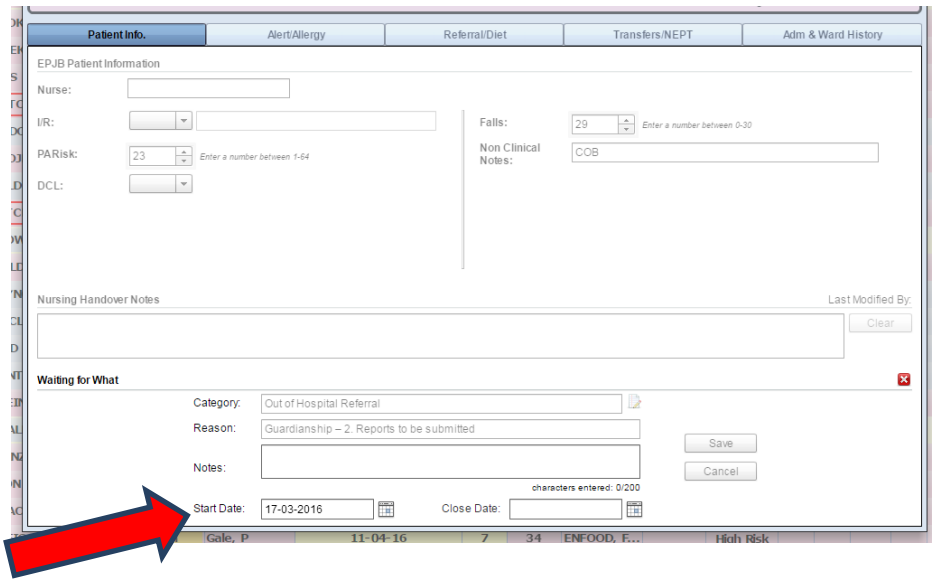
1. **Application to be submitted**
   Start date = the date the multidisciplinary team decision was made that a guardianship application was needed to be submitted to NCAT.



Click Save.

2. Reports to be submitted

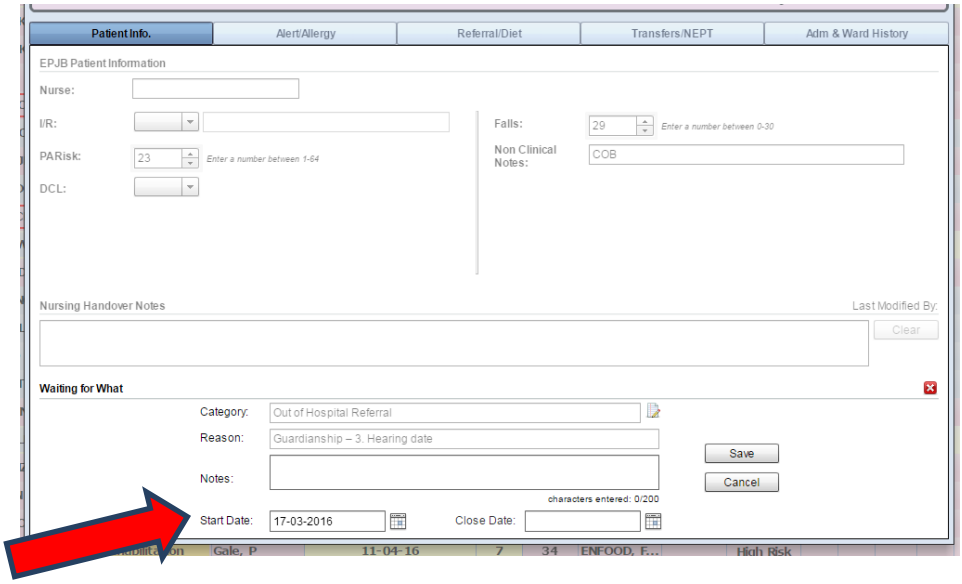
Only fill this section out if you have sent your application forms to NCAT before you have submitted all the reports.
Start date = date application submitted
In notes please indicate what reports you are waiting for.
If there are multiple reports, include the date they were sent and any reason for delay.



Click Save.

3. Hearing date

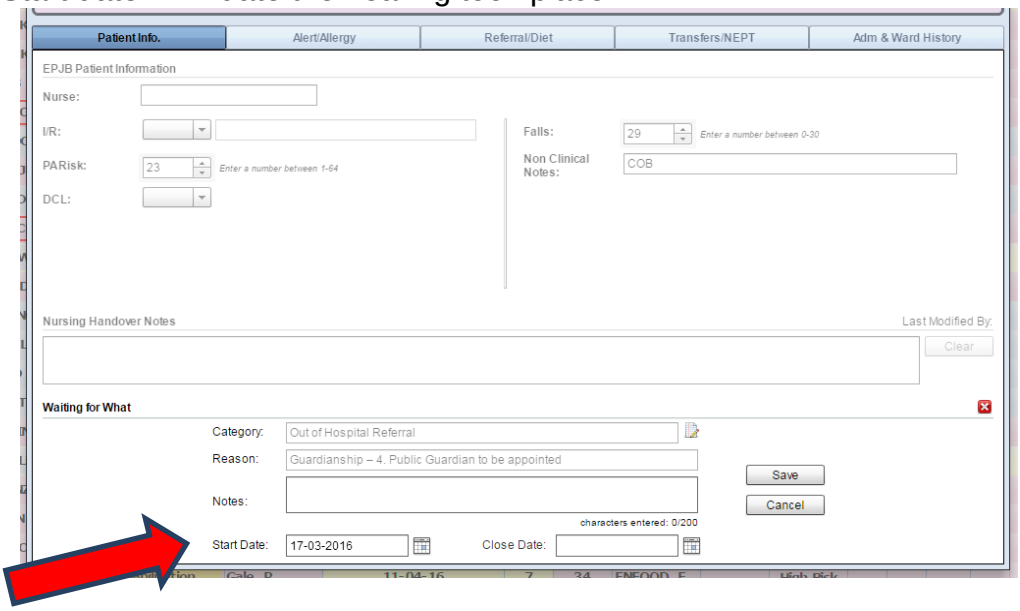
Start date = date the application was submitted to NCAT if you submitted both the application and the reports together or
= date the final reports were submitted to NCAT



Click Save.

4. Public guardian to be appointed

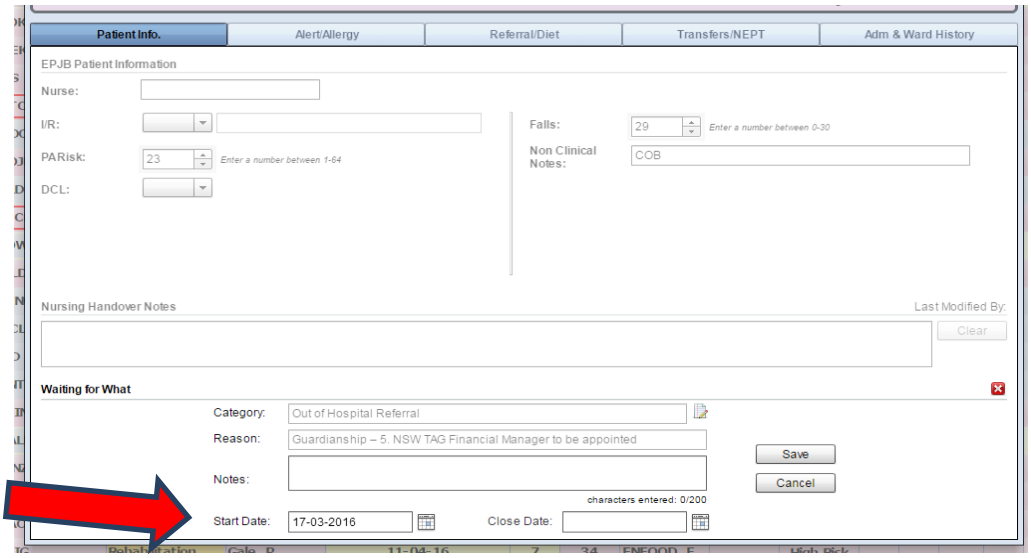
Start date = date the hearing took place



Click Save.

5. NSW TAG financial manager to be appointed

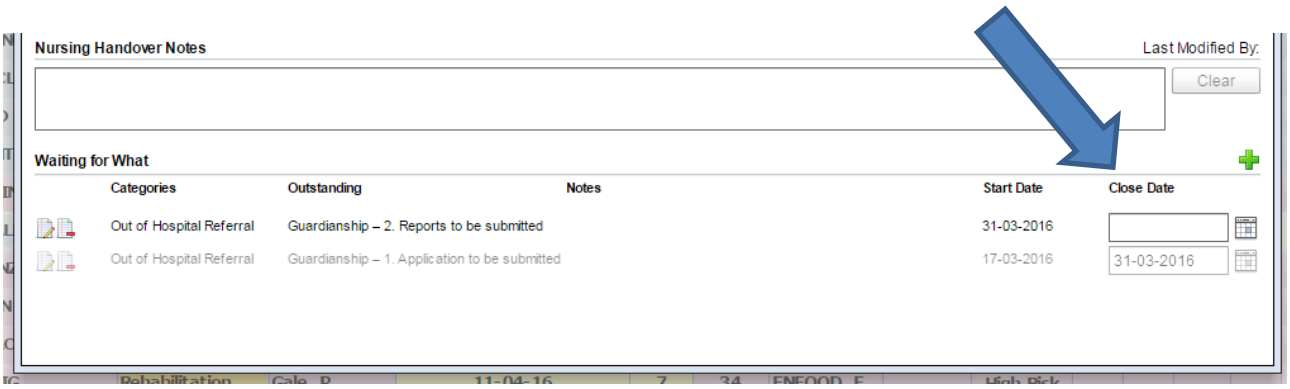
Start date = date the hearing took place



Click Save.

Closing the episode on Waiting for What

Once you know the close date you will need to log back into the patient profile on the patient flow portal. Click on the notes page icon to get back into the waiting for what episode that is relevant.



The close dates for each heading are as follows:

1. **Application to be submitted**
   Close date = the date the application was sent to NCAT.

2. **Reports to be submitted**
   Close date = date all relevant reports have been submitted to NCAT

3. **Hearing date**
   Close date = date the hearing took place

4. **Public guardian to be appointed**
   Close date = once a public guardian has been appointment and they have agreed a discharge plan.

5. **NSW TAG financial manager to be appointed**
   Close date = once a NSW Trustee and Guardian (TAG) financial manager has been appointment and they have agreed a discharge plan.

If the patient was appointed a private guardian or financial manager then you can cease recording at stage 3. There would be no reason to record stage 4.
This will then cease the waiting for what guardianship data. Patients are then no longer waiting for the guardianship process. Their discharge is likely pending because of other factors e.g. waiting for residential care.

There are other appropriate 'waiting for what' categories that can be used to record these reasons for extended length of stay.

Points to remember

1. This is a real time data base.
2. You cannot go back and insert information once the patient has discharged or the episode is closed.
3. You will need to update your patients waiting for guardianship regularly.

6.6 Appendix F: Guardianship Risk Assessment Resource

This table has been created to assist staff to manage possible hazards/risks that may occur during the guardianship process. It should be used in conjunction with local risk assessment or safe working practice protocols/procedures.

Guardianship Phase	Hazard/Risk	Possible Control Measures
Trigger phase	• Patient is unable to consent or there are concerns regarding their decision making ability • Dispute between carer/family members or between the carer/family and health professional • A patient with a disability objects to a proposal for his/her care • A patient with a disability suffers from neglect, exploitation or abuse and there is no one to protect their interests • A person who is the patient's enduring power of attorney or enduring guardian allegedly is not acting in the person's best interest • Inappropriate or inadequate supports for communication and/or decision making.	• Consider what is needed to assist the patient to make the decision themselves • Consultation with interdisciplinary team regarding need for substitute decision maker • Consider the need for a family conference • Consultation with ward staff, interdisciplinary team regarding care plan • Viewing medical record alerts for aggression or risk factors • Reviewing current and old inpatient medical records • Consulting community staff, organisations and service providers • Corroborative histories and disclosures from family, friends, carers and general practitioner • Consultation with person, family and/or carers (in line with privacy obligations) as to need for augmentative communication, visual aids, interpreter provision etc
Assessment phase	Identification of risk for In-hospital Assessments • A risk of patient aggression is identified on ward	• Health professional to identify appropriate environment to conduct assessment through consultation with senior clinicians and management • Health professional to identify safety measures to be taken during interview with patient • Refer to Safe Working Practice Policy (if available) for aggression minimisation • Health professional is to consult directly with Management to determine appropriateness of assessment • Security to be called or on standby as required • Health professional should not isolate themselves with the patient or carer/family members and remain in a public place or semi-public place

Guardianship Phase	Hazard/Risk	Possible Control Measures
Assessment phase (cont.)		• Inform team and other staff of the interview times and details • Health professional to consider whether to take a second staff member to attend this meeting • Health professional should take care not to disclose irrelevant personal details and be mindful to protect their privacy and identity outside of their employment
	• Potential disagreement between professionals regarding a patient's decision making ability	• Health professionals should attempt to resolve any conflict regarding need for guardianship directly with the other professional • Workplace grievance procedures to be followed • Escalation of any unresolved conflict to health professional's line manager/supervisor
	Identification of risk for Home visit Assessments • Evidence of aggression is identified • Threats of fire arms or other weapons • Evidence of pets in the home or potential risk • Hoarding, structurally unsafe premises, or squalid living environment	• Health professional is to consult directly with management to determine appropriateness of visit • Refer to local home visiting policy if available • Health professional to gain a full functional history of the patient prior to admission in order to determine if patient is safe to take on home visit • Consider if patient's functional/cognitive status is suitable to go on home visit from hospital • Identify occupants and other residents of the home prior to decision of home visit to assess safety and wellbeing of staff • Health professional to assess the inherent risks of home visit considering environmental and structural condition of residence • Staff should complete home visit risk assessment form for exploratory evidence, including risk of weapons when doing a home visit
Application Phase	• Potential conflict about who will be 'the applicant'	• The individual health professional reserves the right to decide whether or not he or she will be the person submitting and managing an application on behalf of the LHD in any proceeding • Decision to be made as to who will be the applicant and act in the best interest and welfare of the patient
	• Potential conflict from the person and their family/carers regarding the guardianship application	• Effective communication is required with all stakeholders regarding the guardianship application and process, and all documentation needs to be current • Consider the need for a family conference
	• The patient is attempting to leave the hospital prior to the hearing date	• Attempt to redirect the person and encourage them to remain in hospital • Consider the need for an emergency NCAT hearing • Consult with the mental health team

Guardianship Phase	Hazard/Risk	Possible Control Measures
Application Phase (cont.)	• Potential disagreement between professionals regarding the need for a guardianship application	• Health professionals should attempt to resolve any conflict regarding need for guardianship directly with the other professional • Workplace grievance procedures to be followed • Escalation of any unresolved conflict to health professional's line manager/supervisor
	• Delays in guardianship application process, leading to increased length of stay for person of interest in application	• Application to be submitted to NCAT within 7 working days of decision for guardianship being made by the interdisciplinary team • Applicant with the support from social work to identify what orders will be requested from NCAT and what further assessments and or evidence may be necessary and important to include in the application
	• Not identifying all key stakeholders	• Identifying all stakeholders, advising them of the guardianship application and seeking their input as appropriate
Serving application	• NCAT requires the applicant to serve copy of notice of hearing to the person subject to the guardianship application prior to the hearing date. • Adverse response from person being served the application	• The applicant should consider the possible response from the person when they are notified of the application being made to NCAT • The application should deliver the hearing paperwork to the person subject to guardianship in a public or semi-public place whilst ensuring privacy is maintained • The applicant can consider whether to take a second staff member to attend this meeting • The interdisciplinary team should be advised of the application being served to minimise the risk to other staff and patients
Hearing Phase	• Location of NCAT offices (in the CBD) • Transporting patient to the hearing is inappropriate due to mobility, function, continence or cognition	• Person subject to the hearing should always be given every opportunity to attend the hearing • Consider other suitable options for holding a remote hearing e.g. teleconference video conference or alternate hearing venue • If held off site, safe working practices to be considered • If patient is unable to attend NCAT, the hearing should be held on hospital grounds if possible to reduce risk of harm to staff/others, manual handling injuries, and infection control • Applicant to source a suitable location that maximises safety of all participants and where necessary to have security on standby or in attendance at the hearing
	• Adverse response from patient during the hearing	• Co-ordination of all relevant management, staff and stakeholders to manage potential risk of hearing

Guardianship Phase	Hazard/Risk	Possible Control Measures
Post Hearing Phase	• Person subject to the guardianship process or their family/carer do not understand or support the outcome of the hearing	• Applicant to discuss outcome of the hearing with the patient at conclusion of the hearing to attempt to ensure that they understand
	• Extended length of stay for patient post hearing and decisions • Delay in Public Guardian or NSW TAG process	• Applicant to notify the interdisciplinary team regarding the outcome of the hearing same day or next working day and record in medical records • Social worker (if involved) to liaise with appointed guardian or financial manager to agree discharge plans and timeframe • Social worker (if involved) to liaise with Public Guardian or NSW TAG if appointed • Social worker (if involved) to escalate any delays in guardian/financial manager's decision making to interdisciplinary team and supervisor

7 AVAILABLE RESOURCES

The Capacity Toolkit	Provides information about capacity, capacity assessment and the various legal tests of capacity in NSW	www.justice.nsw.gov.au
Guardianship Division of NCAT	Guardianship Division of NCAT is a Tribunal whose panel can make orders and put formal arrangements in place for people who have a decision making disability	www.ncat.nsw.gov.au/guardianship
NSW Office of Public Guardian	The Public Guardian is a legally appointed substitute decision maker if there is no one else suitable. They assist people under guardianship orders to make informed decisions regarding certain aspects of their lives	1800 451 510, www.publicguardian.justice.nsw.gov.au
NSW Trustee and Guardian (TAG)	NSW Trustee and Guardian's role is to act as an independent and impartial executor, administrator, attorney and trustee for the people of NSW. It also provides direct financial management services and authorisation and direction to private financial managers	1300 320 320 www.tag.nsw.gov.au
Private Guardian Support Unit	A free and confidential service to assist legally appointed guardians in their role. This includes enduring guardians or guardians appointed by NCAT or the Supreme Court	1800 451 510 ww.publicguardian.justice.nsw.gov.au
Health Professionals Report	Standardised template for writing NCAT reports	www.ncat.nsw.gov.au/Pages/guardianship/gd_forms.aspx
Aged Care Assessment Programme Guidelines	These guidelines provide an operation guide for the Aged Care Assessment Programme and assessment by the Aged Care Assessment Teams.	https://agedcare.health.gov.au/programs-services/guidelines/aged-care-assessment-and-approval-guidelines
Mental Health Advocacy Service	A specialist service of the Legal Aid Commission which provides free legal advice and representation at Mental Health Act hearings at psychiatric hospitals and hearings at NCAT	97454277 www.legalaid.nsw.gov.au
Multicultural Disability Advocacy Association of NSW	Provides an advocacy service for people with disabilities who come from a culturally and linguistically diverse background	1800 629 072 or 9891 6400 www.mdaa.org.au
The NSW Multicultural Health Communication Service	Funded by the NSW Department of Health to provide information and services to help health professionals communicate with non-English speaking communities throughout NSW	www.mhcs.health.nsw.gov.au
Aboriginal Health Liaison Officer (AHLO)	Positioned within in hospitals the AHLO plays a key role in supporting and the journey of the Indigenous patient through	Contact local hospital

	the hospital and health systems	
Centre for Aboriginal Health (CAH)	Part of the Population and Public Health Department at the NSW Ministry of Health. The CAH addresses health and service delivery disparities between Aboriginal and non-Aboriginal people	www.health.nsw.gov.au/aboriginal/Pages/centre-for-aboriginal-health
Transcultural Mental Health Centre (TMHC)	TMHC works in partnership with the community and mental health services to improve the mental health status of people from a Culturally and Linguistically Diverse background	1800 648 911 or 9840 3800 www.dhi.health.nsw.gov.au
Intellectual Disability Services	Intellectual Disability Services. There are a number of Health-funded services which can assist clinicians and patients	http://www.health.nsw.gov.au/disability/Pages/services-and-initiatives-for-people-with-disability.aspx
Deaf Society.	The Deaf Society can provide support to Deaf people with cognitive disability, and can advise on the need for Deaf interpreters	http://deafsocietynsw.org.au/
NSW Council for Intellectual Disability	An information and advocacy service for people with intellectual disability	http://www.nswcid.org.au/
Alzheimer's Australia	Provides and education, information and advocacy for people living with Dementia, their families and professionals.	https://nsw.fightdementia.org.au/

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9 ACKNOWLEDGEMENTS

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NCAT
NSW Civil & Administrative Tribunal

Restrictive practices and guardianship

This following information explains how NCAT's Guardianship Division makes guardianship orders with a restrictive practices function.

Role of NCAT's Guardianship Division

The NSW Civil and Administrative Tribunal (NCAT) can make a guardianship order for a person with a disability who is incapable of making personal and lifestyle decisions for themselves.

NCAT can appoint a guardian to make decisions in specific areas, for example accommodation and health care. These decision making areas are called the functions of the guardian. One function that NCAT may appoint a guardian with is 'restrictive practices'.

Restrictive practices

The *Guardianship Act 1987* does not define restrictive practices. A restrictive practice generally involves physically restraining a person or limiting their freedom of movement or access to objects. Restrictive practices usually arise in the context of managing challenging behaviour.

Using medication to chemically restrain a person is also a restrictive practice. However, this is generally not covered by a restrictive practices function as consent for the medication should be obtained under the medical consent provisions in the *Guardianship Act 1987*.

Restrictive practices should only be used in the context of a holistic response to the person's needs, and in particular, to the factors that may be causing the behaviour. The restrictive practice aims to control or contribute towards changing the behaviour.

Why is a practice unlawful without the consent of a guardian?

Many restrictive practices are what the law calls assault, false imprisonment or detinue.

Assault is the application of force to a person, for example a hit, holding someone down or dragging them. Also, doing something that makes a person fear they are going to be assaulted, for example raising a fist.

False imprisonment is confining a person to a particular space, for example locking a person in a house or room or using a tray table to keep the person in a chair. However, stopping a person going into a particular space, for example locking the kitchen, is unlikely to amount to false imprisonment.

Detinue is withholding a person's possessions, for example refusing to hand over a knife belonging to the person. However, refusing to hand over a knife belonging to an accommodation service does not amount to detinue.

Legal defences

Assault, false imprisonment and detinue are unlawful unless a legal defence exists:

Informed consent - by the person with a full understanding and comprehension of the situation.

Consent by a guardian - with a restrictive practices function.

Self-defence - Where you believed on reasonable grounds that it was necessary self-defence to do what you did. For example, holding the arms of a person who is about to hit you or someone else, but not if there is a clear opportunity to get away.

Necessity - Where you believed on reasonable grounds that it was necessary to do what you did to avoid death or serious harm. For example, grabbing someone who is about to walk in front of a car; taking a lighter from someone who is about to start a fire in their bedroom.

"Duty of care" is not a defence but action taken for this purpose may be covered by self-defence or necessity.

Applying to NCAT

When should I apply for a guardian in relation to a restrictive practice?

There are situations where NCAT has generally seen a need for a guardian because of the doubtful lawfulness of a practice that is being **used to manage challenging behaviour**:

- Physical restraint, for example holding a person down when they are aggressive.
- Mechanical restraints, for example a tray table or lap belt to stop a person taking other people's food or splints to stop self-injurious behaviour.
- Confining a person to a specific place like a room or courtyard, for example in response to aggression.
- Locking premises to keep a person out of trouble with the law.
- Preventing a person from accessing their own possessions, for example to stop the person self-harming with a knife.
- Using aversives, for example putting pepper on a person's hand to stop them biting themselves.

You should also consider an application in other situations where you think a guardian may be needed to protect the person. The restrictive practice might be aimed at managing behaviour, avoiding accidental injury to the person or another purpose. You might think a guardian is needed because of one of the following factors:

- The practice may be unlawful without the consent of a guardian.
- There is disagreement about the use of the practice, between the person and others or between family and service providers.
- The practice is experimental or risky or of doubtful benefit to the person.

The focus of an application must be the best interest of the person.

The application should be focused on planned or regularly used restrictive practices, not one off responses to crises.

How to apply for guardianship with a restrictive practices function

The application form sets out the information and reports that should be included with the application for a guardian.

If you are seeking a restrictive practices function, you should make that clear in the application and provide:

- A summary of the person's history, current circumstances and skills.
- A summary of data on challenging behaviour.
- An assessment of the person's lifestyle and skills and the causes/functions of the behaviour.
- A medical report outlining the person's health and that an assessment has ruled out medical causes of the behaviour.
- The behaviour plan and any related plan including both positive elements and restrictive practices. Positive approaches include improving the person's environment, skills development/maintenance and preventative measures to reduce the likelihood of challenging behaviour.
- Details of alternative approaches that have been tried to address the situation.
- Details of medications used in relation to the behaviour, including a report from the prescribing doctor who should usually be a relevant specialist.
- Information on when and how the behaviour plan will be reviewed.
- Information on other relevant circumstances listed below in "Granting a guardian a restrictive practices function."

In urgent situations, NCAT may consider making a short order where not all of the information is available, with an expectation that full information will be provided at a review hearing.

Tribunal hearing

Granting a guardian a restrictive practices function

NCAT considers all of the circumstances including whether the practice would be unlawful in the absence of the consent of a guardian. If the practice is unlawful, that alone may result in a restrictive practices function.

Other relevant circumstances may include:

1. The views of the person and others, including how the person reacts to the restriction.
2. The context:
    a. Does the person have a fulfilling lifestyle?
    b. Has a skilled professional assessed the behaviour and developed positive behaviour strategies?
    c. Do the strategies address the causes of the behaviour?
    d. Will the strategies be implemented and monitored?
3. The restriction:
    a. What is the nature and degree of the restriction?

b. What is the purpose of the restriction? For example, is it for behaviour change or to keep the person safe or healthy?
c. Is the restriction addressing a clear risk to the person?
d. Is the practice being used partly for the benefit of others?
e. Is it only used as a last resort?
f. Have other non-restrictive approaches been tried?
g. Does the practice involve risks for the person?
h. Is there a danger that the restriction will be abused?
i. When restricted, does the person have a comfortable and fulfilling environment?
j. Will the use of the practice be reduced?
k. Does it conform to current accepted standards of practice?

4. Does the person have a strong independent advocate, such as a family member?

5. Are there other monitoring and review mechanisms?

6. Is a guardian needed anyway in relation to other issues?

NCAT determines each application on its merits and concludes whether a practice is restrictive and decides whether a guardian needs to be appointed to consent to it. NCAT will not necessarily appoint a guardian because an agency's policy says that a guardian is needed in relation to certain practices.

Witnesses who should participate at the hearing

- The person and any family or other advocate.
- The professional who has assessed the behaviour and developed the behaviour strategies.
- A service worker who has day to day contact with the person, for example a key support worker.
- A service manager.
- Others as relevant.

Orders about restrictive practices

The guardian's role is to give or withhold consent to the restrictive practice. The guardian can only consent if this is in the best interests of the person.

NCAT usually includes a condition saying that the guardian may only consent to a restrictive practice if positive approaches are also being used to address the person's behaviour and needs.

Consent to medical treatment

Psychotropic medication is sometimes used to address challenging behaviour. This may be to treat a diagnosed mental illness or it may be chemical restraint. In either case, consent is required under Part 5 of the *Guardianship Act 1987* and the medication is only permissible if it is needed in the person's interests.

If the person is unable to consent to the medication, consent is usually needed from a 'person responsible'.

Who is a 'person responsible'

A person responsible is the first person identified in the list below:

1. A guardian (including an enduring guardian) who has the function of medical and dental consent.
2. The spouse or de facto spouse.
3. An unpaid carer.
4. A relative or friend.

For more information read the Guardianship Division's 'Person responsible' fact sheet.

When is NCAT's consent required?

In some situations, the consent of NCAT is required rather than a person responsible:

- Where there is no person responsible.
- Where the patient is objecting.
- Any medical treatment involving an aversive stimulus.
- Androgen reducing medication for the purpose of behavioural control.
- Psychotropic medication in dosages, combinations or durations outside accepted modes of treatment.

Please see the fact sheet on medical and dental consent for more information about the types of treatment and who may provide consent.

Where medication is being used to address challenging behaviour, it should usually be accompanied by positive approaches to the behaviour. This is important if the medication is being used as chemical restraint. A person responsible or NCAT will need evidence of positive approaches before giving consent.

NCAT
NSW Civil &
Administrative Tribunal

Resources

Tribunal decisions

Do a database search for 'restrictive practice' in NCAT Guardianship Division decisions available on the NSW Caselaw website **www.caselaw.nsw.gov.au**

Australian Psychological Society

Evidence-based guidelines to reduce the need for restrictive practices in the disability sector is available on Australian Psychology Society website **www.psychology.org.au**

Ageing, Disability and Home Care (ADHC)

Behaviour Support Policy and Practice Manual is available for download from the ADHC website **www.adhc.nsw.gov.au**.

Department of Health Ageing and Aged Care

Decision-making Tool: Supporting a Restrain Free Environment in Residential Aged Care handbook is available for download from the Department's website **www.agedcare.health.gov.au**

NSW Health

Working with People with Challenging Behaviours in Residential Aged Care Facilities guideline is available for download from the NSW Health website **www.health.nsw.gov.au**

NSW Public Guardian

Now You're the Guardian is a guide for people appointed as guardian available on the Public Guardian website **www.publicguardian.justice.nsw.gov.au**.

Contact NCAT

1300 006 228 | www.ncat.nsw.gov.au

Interpreter Service (TIS) 13 14 50
National Relay Service for TTY users 13 36 77

For more information and assistance visit the NCAT website or contact NCAT's Guardianship Division on (02) 9556 7600 or 1300 006 228.