Chapter 7

Code of Practice

Chapter 7: Code of Practice

Chapter 7 is in three sections:

A. A description of the English Code of Practice under the Mental Capacity Act.

B. The case for a Code of Practice in New Zealand.

C. Discussion of current guidance and scopes of practice for health practitioners undertaking capacity assessments in New Zealand; a survey undertaken of doctors concerning such assessments; and first steps towards establishing nationally consistent guidance, with the development of a Toolkit for Assessing Capacity.

Introduction

7.1 In New Zealand, there is no nationally accepted Code of Practice or statutory guidance on capacity law and practice for health practitioners, lawyers or others involved with people with impaired capacity. Understanding the law and applying it is an inherently interdisciplinary exercise combining law, healthcare and ethics. It involves health practitioners (doctors, nurses and psychologists) making the capacity assessment and lawyers and judges applying that assessment to the legal tests. Social workers, healthcare providers and families often initiate the legal process and provide valuable information about a person's preferences.

7.2 If there is to be a wider review of the PPPR Act, and its interface with the HDC Code, then it would be premature to draft a complete Code of Practice at present, when the law may change. The revised law should provide simple and concise legislation with an accompanying Code of Practice that would aid its implementation.[837] The MCA Code of Practice has been pivotal in implementing the English legislation. It provides an excellent model from which to develop a New Zealand Code of Practice.

7A: THE MENTAL CAPACITY ACT (MCA) CODE OF PRACTICE

Legal effect

7.3 A central feature of the Mental Capacity Act (MCA) is authorising the issue of more detailed statutory guidance in the form of a Code of Practice that sets standards for the guidance of people using the Act's provisions. The policy intent of the MCA recognised that complex legislation of this sort requires an accompanying Code of Practice for the practical guidance of health professionals, lawyers and a range of people involved with adult incapacity and those affected by its provisions.[838] The MCA Code of Practice (Code of Practice) was formally

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837 See discussion in Chapter IB, Overview of New Zealand Law and Chapter 4 Defining Capacity.

838 Provision for statutory guidance is made in the Act under s 42 of the MCA 2005. House of Lords, House of Commons *Draft Mental Incapacity Bill,* above n 779 at 64 [229].

issued in April 2007 and came into effect on 1 October 2007 as the statutory guidance for the entire MCA 2005 as originally enacted.[839] By comparison, in Singapore where the English MCA was adopted nearly in its entirety, a Code of Practice was drafted, and put in place by the Office of the Public Guardian, at the same the new legislation was passed.[840] Both of these Codes of Practice provide guidance to anyone who is working with or caring for adults who may lack capacity to make particular decisions. They explain the key concepts of capacity and best interests and how the law operates on a day-to-day basis. Examples of best practice are set out for carers and a wide range of professionals involved, reflecting a multi-disciplinary approach to applying the law.

7.4 The English Code of Practice is issued under the statute, which means that certain categories of people have a legal duty to have regard to it when working with or caring for adults who may lack capacity to make decisions for themselves.[841] These people include: an attorney under a lasting power of attorney (LPA), a deputy appointed by the Court of Protection (COP), healthcare professionals, researchers, independent mental capacity advocates (IMCAs) and paid workers acting on behalf of the person who lacks capacity.

7.5 The Act and the Code of Practice are constructed on the assumption that the vast majority of decisions concerning adults who lack capacity are taken informally and collaboratively by individuals or groups of people consulting and working together, rather than by one individual who is given special legal status to make decisions. For most day-to-day actions the "decision-maker" is the carer most directly involved with the person at the time. Where the decision involves the provision of medical treatment, the doctor or other clinician responsible for administering the treatment or carrying out the procedure is the decision-maker, and in some cases the Court of Protection is involved.[842]

7.6 The Code of Practice also aims to provide help and guidance to the wide range of less formal carers, such as close family and friends, who have important relationships with the person lacking capacity and are able to support them. It also emphasises that there are specific decisions that can never be made or actions that can never be carried out under the Act, whether by family members, carers, professionals, attorneys or the Court of Protection, because they are so personal to the individual concerned,[843] or governed by other legislation.[844]

Sanctions for non-compliance

7.7 The Code of Practice is viewed as guidance, rather than instruction.[845] It requires that certain cases to be brought before the court, but no legal liability arises from a breach of the Code

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839 *MCA Code of Practice*, above n 164. A supplement to the Code has since been issued separately to deal with the deprivation of liberty provisions inserted into MCA by the Mental Health Act 2007, which came into effect in April 2009. The Department of Health and the Office of the Public Guardian have also produced complementary materials to the MCA Code of Practice.

840 Mental Capacity Act 2008 (Singapore); Office of the Public Guardian *Code of Practice: Mental Capacity Act (Chapter 177A)* (3rd ed, OPG, Singapore, 2015). The Code of Practice is also much shorter, 100, not 300 pages long, as with the MCA Code of Practice. Interview with Sumytra Menon, lawyer involved with drafting the Singapore MCA Code of Practice, Senior Assistant Director, Centre for Biomedical Ethics, National University of Singapore, 31 March 2015, Singapore.

841 Mental Capacity Act 2005, s 42(4) and (5).

842 *MCA Code of Practice*, above n 163 at 5.8.

843 For example, decisions concerning family relationships such as consenting to marriage or a civil partnership: Mental Capacity Act 2005, s 27.

844 For example, treatment for mental disorder under Part 4 of the Mental Health Act 1983: Mental Capacity Act 2005, s 28, or s 29 – voting rights.

845 *MCA Code of Practice*, above n 164 at 1.

itself. Nevertheless, a failure on the part of a health professional to comply with the Code's guidance would be taken into account in any relevant proceedings in a court or tribunal. It would, for example, be relevant to an assessment of a doctor's fitness to practice before the General Medical Council.[846]

7.8 Compliance with the Code of Practice is relevant to the application of the statutory defences that are available to health professionals under the MCA. Section 5 of the MCA, for instance, provides certain statutory protection to carers and healthcare professionals who provide care and treatment that is necessary and in the best interests of a person who lacks capacity to consent.[847] In the law reform process that produced the MCA, the legal position of informal carers, such as family members, was carefully considered. It was recognised that it was essential that family members and carers comply with their legal responsibilities, and understand the seriousness of their actions and the need to be accountable for them. However, it was considered inappropriate to impose on them a strict requirement to act in accordance with the Code of Practice.[848] Although not under a legal duty, informal carers still have an obligation to act in accordance with the principles of the MCA and the best interests of a person lacking capacity.[849]

Tool for interpretation of the MCA

7.9 Judges frequently use the Code of Practice to interpret and apply the law.[850] In *G v E*,[851] for instance, Mr Justice Baker explained how the Code of Practice applied in a decision not to appoint a sister and a former carer as personal welfare deputies for E, a 20-year-old man who suffered from severe disabilities. While the Code of Practice gives examples where it can be impracticable to insist on decisions being taken by the court rather than by the appointment of a deputy, the scheme of the MCA is to only appoint deputies under s 16(4) in exceptional circumstances, and they were not found in this case.[852]

7.10 The Code of Practice can be used as evidence in a court or a tribunal. In *Aintree University Hospitals NHS Foundation Trust v James,*[853] the first decision of the Supreme Court under the MCA, the Court addressed the question of how doctors and courts should decide when it is in the best interests of a person who lacks capacity to be given, or not given, treatment necessary to sustain life. In a unanimous decision, Lady Hale accepted the statements in the

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846 Brazier and Cave, above n 295.

847 Mental Capacity Act 2005, s 5. The provisions of section 5 are based on the common law doctrine of necessity as set out in *Re F*, above n 125. In addition, s 6 places clear limits on the use of force or restraint by only permitting restraint where this is necessary to protect the person from harm and is a proportionate response to the risk of harm. It is beyond the scope of this report to consider whether statutory protection for carers and health practitioners, as provided for in ss 5 and 6 of the MCA would be appropriate or necessary in New Zealand's medico-legal environment under the no-fault treatment injury provisions of the Accident Compensation Act 2001.

848 Ashton, above n 26 at 85.

849 *MCA Code of Practice*, above n 164 at 2.

850 Interview with Judge Elizabeth Batten, District Judge of the Court of Protection (A Douglass, 16 April 2015, Court of Protection, London).

851 Above n 158.

852 In the Code of Practice examples under MCA, s 16(4) include situations that involve a series of decisions about medical procedures or where the assets of an incapacitated adult are of a magnitude that requires regular management: *MCA Code of Practice*, above n 163 at [8.38] and [8.39]. At [59], Mr. Justice Baker interpreted these paragraphs to mean that, "Common sense suggests that the second of these examples is likely to arise more frequently than the first, that the appointment of deputies is more likely to be more common for property and affairs than for personal welfare".

853 *Aintree,* above n 164.

Code of Practice, regarding withholding treatment that can be futile, or overly burdensome to the patient, or where there is no prospect of recovery, as an accurate statement of the law.[854]

MCA – problems with implementation

7.11 The overall finding by the post-legislative scrutiny report of the House of Lords was that the MCA was a very significant and progressive piece of legislation, with the potential to transform lives.[855] However, the key problem with implementation was that there was no provision in the MCA to monitor compliance with the Code of Practice, or with the Act more generally.[856] This point was made with some force in the House of Lords' report: [857]

> While we recognise that the application of the Act is very wide and a complete picture would be hard to achieve, the absence of any monitoring is indefensible, if the benefits of this legislation are to be delivered.

7.12 In practice, the vast majority of cases before the COP concern property, rather than welfare decisions. The experience of Senior Judge Lush of the COP is that attorneys and deputies show a distinct lack of knowledge of the Code of Practice, which can lead to financial abuse.[858] Most attorneys and deputies are unaware of the existence of the Code of Practice. Very few have a copy of it, or have downloaded it from the internet and, even if they do have a copy, fewer still have read it or applied it in practice. Senior Judge Lush says: [859]

> More than any other feature of the Mental Capacity Act, the Code of Practice has potential to revolutionise the way we treat members of society who are unable to make their decisions. Over time, the standards laid down in the Code should permeate and influence good practice. However, the Code will only be a success if people know about it and read, mark, learn and inwardly digest it and this simply isn't happening.

7.13 In order to address the failure to embed the Act in everyday practice, the House of Lords recommended responsibility for oversight of the Act's implementation should be given to a single independent body. The intention was not to remove ultimate responsibility for the MCA

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854 *Aintree*, above n 164 at [28] and [29] - Lady Hale: "Paragraph 5.31 (of the Code of Practice) gives useful guidance, derived from previous case law, as to when life-sustaining treatment may not be in the patient's best interests. Both the judge and the Court of Appeal accepted them as an accurate statement of the law and so would I. However, they differed as to the meaning of the words in italics. The Code is no statute and should not be construed as one but it is necessary for us to consider which of them was closer to the correct approach."

855 House of Lords Select Committee on the Mental Capacity Act *2005 Mental Capacity Act 2005: post-legislative scrutiny* (TSO, London, 2014), above n 3 at [12] - [20]. The most significant exception to the Act being considered a good piece of legislation was criticism of the poor drafting and implementation of the Deprivation of Liberty Safeguards. See Chapter 1C Problems with implementation of the MCA.

856 While a number of the witnesses to the House of Lords Select Committee emphasised the importance of focusing more on supported decision-making in order to enhance compliance with the CRPD, the House of Lords Report did not review the compatibility of the MCA with the CRPD. However they received evidence of how the use of the Act in practice could be better aligned with the UN Convention: House of Lords, above n 855 at [51]-[53].

857 House of Lords, above n 855 at [35]. A mechanism for the review of the MCA Code of Practice was not regarded as an answer to poor implementation.

858 Under the MCA, professionals may be employed to carry out the role of deputies and some solicitors specialise as professional deputies. The Court may require a deputy to give a bond (security) for the discharge of their functions and submit reports to the Public Guardian.

859 D Lush "Financial Crime Committed Against the Elderly and Infirm: A Review of its Increasing Prevalence and how Effective Practitioners, Public Bodies and the Courts are Tackling it" (paper presented at a joint seminar STEP London Central Branch and ACTAPS, London, 10 December 2014) at 13.

from government ministers, but to locate ownership of the Act in one place, so as to provide a clear form of accountability, and a focus for enhanced activity.[860]

Quality of capacity assessments

7.14 Evidence before the House of Lords' Select Committee gave a bleak picture of the quality of capacity assessments. The implementation of the presumption of capacity[861] – the idea that capacity must be assumed until proven otherwise – was described as "patchy, at best".[862] The reasons given included: a tendency among health and social care staff to make assumptions based on impairment; the failure to conduct assessments when necessary; poor quality of assessments generally; and the failure to take into account the impact of specific conditions on assessment. Disconcertingly, there was evidence of the presumption of capacity being used to support non-intervention by service providers. The Law Society referred to the presumption of capacity principle being applied "perversely", to avoid assessing capacity and to justify lack of provision of services.[863]

7.15 Many of the criticisms raised were about the way in which capacity assessments were being carried out by professionals who were not closely involved with the care of the person affected.[864] A group of lawyers who jointly submitted evidence to the Select Committee found that: [865]

> The best capacity assessments are by people who know P (the person who lacks capacity), and who have experience and training in communicating with people with disabilities, and who see their task as assisting P to make a decision, not testing P's knowledge.

7.16 The English experience to date has demonstrated that even the most up-to-date law that has a clear explanation of its core principles is difficult to embed. It requires participation from the professionals and appointed decision-makers who must implement the law. A consistent theme in the evidence before the House of Lords was the tension between the empowerment that the Act was designed to deliver and the tendency of professionals to use the Act in an overly protective way.[866] Prevailing professional cultures of risk aversion and paternalism have inhibited the aspiration of empowerment for people with impaired capacity from being realised.[867]

7.17 One of the recommendations in the House of Lords' report is that the English Government work with professional regulators and the medical Royal Colleges to ensure that the MCA is given a higher profile. It specifically recommended training for medical students and general practitioners (GPs) to embed and enhance their understanding of the MCA in view of the vital role that GPs play in providing healthcare in the community.[868]

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860 House of Lords, above n 855 at 6, [35], [36], [39]. In the event, the independent body was not established.

861 Mental Capacity Act 2005, s 1(2): "A person must be assumed to have capacity unless it is established that he lacks capacity."

862 House of Lords, above n 855 at [56].

863 House of Lords, above n 855 at [63].

864 The experience of Mark Neary, father to Steven Neary, a young man in his early 20s with autism and a severe learning disability, who was involved with a high profile case, was that the supported process had turned into an adversarial one: House of Lords, above n 854 at [68]. In *Hillingdon v Neary,* above n 461, the COP held that Steven Neary had been unlawfully detained, against his own and his father's wishes by the London Borough of Hillingdon in 2010.

865 House of Lords, above n 855 at [69].

866 See Chapter 4A Unwise decisions and the protection imperative.

867 House of Lords, above n 855 at [15].

7B: DEVELOPMENT OF A CODE OF PRACTICE FOR NEW ZEALAND

Best practice standards

7.18 The New Zealand health and disability sector is very familiar with professional standards, guidelines and Codes of Practice, and with the general use of subordinate or secondary legislation.[869] A significant segment of New Zealand public law has evolved from subordinate legislation and the consideration of its legal effect.[870] Although there can be confusing terminology, many secondary sources of "subordinate legislation", such as "guidelines",[871] are more concerned with establishing best practice standards than definitive rules or regulations.

7.19 Nevertheless, the HDC Code is itself subordinate legislation, as it is a regulation issued under the Health and Disability Commissioner Act 1994.[872] Non-compliance with practice standards in the health and disability sector may result in a provider of services (whether an individual or an institution) being found in breach of Right 4(2) of the HDC Code for failing to provide services that comply with "legal, professional, ethical, and other relevant standards".[873]

7.20 The HDC Code only applies to "providers" of health and disability services and does not cover the wide range of people, including some professionals, who may be involved with people with impaired capacity, such as paid carers, social workers, appointed substitute decision-makers under an EPOA or welfare guardian, and lawyers. Therefore, a Code of Practice based on the English MCA model would need to have much wider application than standards for health practitioners under the current HDC Code.[874]

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868 House of Lords, above n 854 at [18].

869 For example, the Human Assisted Reproductive Technology Act 2004 requires the Advisory Committee to the Minister of Health (ACART) to promulgate advice and guidelines under the framework of that Act and for providers of fertility services to adhere to these, including ethical review by the ethics committee of the assisted reproductive procedures that fall within the guidelines.

870 The Parliament's Regulations Review Committee may draw attention to delegated legislation, including legislative instruments and disallowable instruments to the House under Standing Order 319. See R Carter, J McHerron and R Malone *Subordinate Legislation in New Zealand* (LexisNexis NZ Limited, Wellington, 2013) at 171. "Instrument" as defined under the Legislation Act 2012, s 48 (a) means "any instrument (whether called regulations, rules, an Order in Council, a notice, bylaws, a code, a framework, or by any other name) that has legislative effect and that is authorised by an enactment."

871 For example, the *Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992* (Ministry of Health, Wellington, 2012) provide guidance intended to support the effective and lawful use of the Act and recognise that the Act is not a comprehensive framework for mental health treatment. The introduction to these guidelines states that "no piece of legislation can be framed in such a way that all circumstances that can possibly arise are precisely covered. If there is uncertainty as to the "correct" interpretation, any action should be taken in good faith, be consistent with the spirit and intent of the Act, and reflect best clinical practice."

872 As noted above there is no guidance in the HDC Code about the concept of capacity – referred to as "competence' or how to assess whether the person has capacity for the purpose of giving or refusing informed consent under Right 7 of the HDC Code. Sanctions for a finding by the Commissioner that a health practitioners is in breach of the HDC Code can result in a referral to the Health Practitioners Disciplinary Tribunal or to the Director of Proceedings with potential for a compensation claim in the Human Rights Review Tribunal.

873 For example, a GP's failure to assess the competence of a woman with Huntington's disease was found to be in breach of Right 4(2) of the HDC Code: HDC *Opinion 11 HDC00647 – GP, Dr C* (10 June 2013). See Chapter 1B.

Social workers

7.21 In England, social workers are actively involved with the operation of the MCA, including assessing capacity as well as best interests, for the purpose of meeting the requirements under the Act, including the authorisation of Deprivation of Liberty Safeguards (DoLS) and reporting to the COP.[875] The Code of Practice sets out case studies and gives examples of how to implement the law in situations that can be ethically complex and challenging. Social workers are very familiar with managing a conflict between the person with impaired capacity and their family, or disputes between family members over the care and living arrangements for their relative.

7.22 In some instances, the COP has preferred the opinion of an independent social worker on the issue of a person's capacity over a medical expert on the basis that the social worker had greater knowledge of the person's environment and their potential to achieve capacity for decision-making. In *X v K*[876] a young man, L, with mild mental disability and some learning difficulties, had previously been assessed as lacking capacity regarding his living arrangements and contact with others. When deciding an application by the local authority to place L in his own supported accommodation, Mrs Justice Theis preferred the evidence of an independent social worker over the report of the psychiatrist who had not provided a "compliant" assessment of L's capacity. The psychiatrist had not revisited L or considered the use of drawings or pictures, even though this communication method was used on a daily basis as support for L. The Court found that the psychiatrist's assessment was not in keeping with the provision of support required under Article 12(3) of the CRPD.[877]

7.23 In New Zealand, hospital social workers have traditionally been familiar with the procedural requirements of the PPPR Act and their role is pivotal in assisting families and coordinating applications to the Family Court under that Act. Social workers now practise in diverse environments, from private practice, to statutory roles, and non-governmental and not-for-profit agencies. In response to the need to navigate the complexities of working with families under the PPPR Act, they have developed their own voluntary practice guidance.[878] This requires that when a client's capacity is being questioned, "Social workers will be competent to have conversations about issues of client capacity with others involved in the client's care," and this includes understanding capacity assessments required for activation of an EPOA.[879]

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874 For example, the current HDC Code does not apply to informal carers, lawyers, social workers, appointed substitute decision-makers, e.g. a welfare guardian or an attorney appointed under an EPOA.

875 A "best interests assessment" is often carried out by social workers under s 4 of the MCA. There is a system of accreditation and specific regulations for the role of a "best interests assessor". See Guidance note: Ruck Keene and Butler-Cole, above n 201.

876 *X v K* [2013] EWHC 3230 (Fam).

877 *X v K,* at [51]. The Court specifically referred to [4.16] of the Code of Practice which states: "It is important not to assess someone's understanding before they have been given relevant information about a decision. Every effort must be made to provide information in a way which is most appropriate to help the person understand". The social worker had in fact carried out a best interests assessment (not a capacity assessment). However, this evidence was preferred by the Court to the capacity assessment undertaken by the psychiatrist, resulting in the Court requesting a further capacity assessment to revisit the issue of L's capacity.

878 Australian New Zealand Association of Social Workers (ANZASW) Social Work and Protection of Personal and Property Rights Act Working Group "An ANZASW Practice Note for Social Workers Working with the Protection of Personal and Property Rights Act 1988" (2015). The practice note is to accompany the Code of Ethics of Aotearoa New Zealand Social Work Association. http://anzasw.nz/wp-content/uploads/Practice-Note-for-SW-working-with-PPPR-Act-Sept-2015.pdf.

7.24 The next step would be for greater formal recognition to occur in New Zealand of the role of social workers and all allied healthcare professionals, such as speech therapists and occupational therapists, in working with people with impaired capacity and their families. Based on the experience in England, a Code of Practice could provide valuable guidance to them, including informing them on what the court requires from them in court proceedings.

Guidance for lawyers

7.25 There are guidelines issued by the Family Court for the lawyer appointed to represent a person subject to an application under the PPPR Act, but these guidelines are specific to the representation and that lawyer's reporting to the court.[880]

7.26 There is a lack of guidance for lawyers generally on issues surrounding mental capacity and how to assess or assist clients who lack capacity.[881] Property solicitors, for example, are often faced with questions from a family over their relative's capacity to make an EPOA or a will. In circumstances where a client's capacity is in doubt, it is often desirable, and a matter of good practice, for lawyers to obtain a medical or expert opinion, especially regarding complex or serious decisions. Lawyers need to know what kind of doctor or other health practitioner they should request an opinion from, how to clarify the relevant legal tests, how to provide the relevant information, and how to explain the particular areas of capacity the lawyer wishes the doctor to report on. Individuals may retain capacity to make decisions in some areas of functioning but not in others. They might, for example, be able to understand the issues involved in appointing an enduring attorney to deal with their finances but lack the capacity to make specific financial decisions themselves.[882] A lawyer may need to explain these complexities to the health professionals concerned.

7.27 The statutory framework under the PPPR Act does not codify all the common law tests of capacity recognised in case law, such as the test for capacity to make a will, capacity to marry, capacity to make a gift, capacity to contract, capacity to litigate, and so on. A Code of Practice would recognise that there are both common law and statutory tests of mental capacity, and would explain the different capacity tests that apply when the client may lack capacity to give instructions or make their own legal decisions.

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879 ANZASW, above n 878 at [2.2] – [2.4].

880 Judge PF Boshier, Principal Family Court Judge, *Guidelines for counsel for subject person appointed under the Protection of and property Rights Act 1988*, March 2011, http://www.justice.govt.nz/family-justice/about-us/info-for-providers/documents/guidelines-counsel-for-subject-person-pppra.pdf.
As discussed in Chapter 1B, these guidelines present their own set of challenges for the lawyer appointed to represent the subject person where the person's will and preferences are contrary to the views of others about their welfare and best interests.

881 The Law Society of New South Wales, Australia has published a practical guidance for lawyers which gives guidance to a lawyer's role in a capacity assessment, principles applicable, and techniques available to lawyers. Law Society of New South Wales *A Practical Guide for Solicitors: When a client's capacity is in doubt* (LSNSW, Sydney, 2009). See also legal toolkits available state by state in Australia, e.g. NSW Toolkit: http://capacityaustralia.org.au/wp-content/uploads/2013/10/NSW-Legal-kit-8pp-sept-2013-version-.pdf.

882 Letts, above n 282 at 175.

Compliance with the CRPD

7.28 There are considerable advantages in developing a Code of Practice concurrently with reform of the legislation to bring the law and practice in line with the new human rights framework under the CRPD. A Code of Practice would have greater impact if recognised in revised and well-drafted legislation, and enable better understanding of the law. It would explain the law, provide public education, and establish a framework for professionals involved with people with impaired capacity to make decisions. In doing so, it could reduce the need for State intervention and court proceedings to resolve some issues.

7.29 A Code of Practice would be an "appropriate measure" through which New Zealand could implement supported decision-making in practice and would give effect to New Zealand's commitment to Article 12(3) of the CRPD.[883]

7C: THE FIRST STEP – A TOOLKIT FOR ASSESSING CAPACITY

Who should undertake capacity assessments?

7.30 There is no restriction in New Zealand on the range of professionals who may perform capacity assessments, or the scope of practice required of those who do so[884] (although an EPOA may specify who must conduct the assessment concerning its coming into effect).[885] Only "certificates of mental incapacity" for activating EPOAs (not "de-activating" them when someone regains capacity) have a prescribed form.[886] In the Guidelines to the PPPR Act Regulations,[887] the form for health practitioners completing a certificate of mental incapacity for an EPOA states: "Although there is no prescribed method of assessing incapacity for the purposes of this certificate, it is important that the practitioner records the reasons for his or her opinion in case it is challenged".[888] The certificate must be completed by a "relevant health practitioner whose scope of practice enables him or her to assess a person's mental capacity and is competent to undertake an assessment of that kind."[889]

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883 United Nations Convention on the Rights of Persons with Disabilities, art 12(3).

884 Protection of Personal and Property Rights Act 1988, s 94(4). The PPPR Act allows the court to request a "medical, psychiatric or psychological or other report", Protection of Personal and Property Rights Act 1988, s 76(1)(a).

885 Protection of Personal and Property Rights Act 1988, s 99D(2). The donor may specify in an enduring power of attorney that the assessment of his or her mental capacity for the purposes of this Part be undertaken by a health practitioner with a specified scope of practice, but only if the scope of practice specified includes the assessment of a person's mental capacity.

886 There is no prescribed form for court applications under the PPPR Act. A form that was originally developed by the late Mr Keith Matthews, partner of the law firm, Tripe Matthews and Feist, for the Wellington Family Court, appears on the Ministry of Justice website: http://www.justice.govt.nz/family-justice/other-court-matters/power-to-act/getting-an-order-reviewed/forms-fees-and-cost.

887 Protection of Personal and Property Rights Act (Enduring Powers of Attorney Forms) Regulations 2008.

888 A social worker is not a "health practitioner" for completing the certificate but, nurses, occupational therapists and psychologists (in addition to doctors) are health practitioners under the Health Practitioners Competence Assurance Act 2003.

889 Protection of Personal and Property Rights Act 1988, s 99D. There is currently a proposed amendment to s 99D to replace the requirement that there is a prescribed form of certificate of the donor's mental incapacity to the requirement for "prescribed Information": Statutes Amendment Bill, Part 21 Amendments to the Protection of Personal and Property Rights Act 1988, Clause 78. In its submission on the Bill, the New Zealand Law Society opposed this change as regulations should not be left to define "prescribed information", unless the relevant test for mental incapacity is clearly defined in the PPPR

7.31 The Medical Council of New Zealand has advised that all doctors should be able to assess capacity.[890] The Medical Council lists 36 vocational scopes of practice, none of which include a specific criterion for assessing mental (in)capacity.[891] A "scope of practice" is not, however, intended to describe or prescribe how practice is undertaken but rather the areas of medicine in which a doctor is permitted to practise.[892] The expected "competence" of doctors to undertake capacity assessments is underpinned more by the training required to be a member of the relevant medical Colleges. Nurses could also be expected to undertake capacity assessments, but there is similarly no indication that assessing capacity is within the competencies required of nurses or within their scope of practice.[893]

7.32 Typically, a general practitioner in the primary care setting who has knowledge of the person and the family may be approached to complete a capacity assessment. Where cases are complicated by existing medical or psychiatric conditions, a psychiatrist, geriatrician, or psychogeriatrican may become involved. Increasingly, clinical psychologists undertake capacity assessments, not only in their more traditional spheres of intellectual disability and brain injury, but also in the elder care setting.[894]

7.33 Neuropsychologists can have a more specialised role where a person's incapacity is borderline and requires more in-depth assessment. These assessments are based on how best to identify a person's cognitive strengths and weaknesses for specific tasks, rather than on a "one size fits all" approach.[895] Psychological testing includes assessing executive functioning in intellectual disability and assessing impairment in a person's ability to "weigh up" information as part of the reasoning process.[896] These matters can be very relevant to assessing the extent to which a person's decision-making is unduly influenced by others, via

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Act. The Law Society noted that what constitutes mental incapacity is an area of difficulty under the PPPR Act that is in need of legislative clarification: New Zealand Law Society "Statutes Amendment Bill" (29 January 2016). http://www.lawsociety.org.nz/__data/assets/pdf_file/0008/98207/Statutes-Amendment-Bill,-Part-21-29-1-16.pdf at 4.

890 *Report of the Minister for Senior Citizens on the review of the amendments to the Protection of Personal and Property Rights Act 1988 made by the Protection of Personal and Property Rights Amendment Act 2007 (*Ministry of Social Development, Wellington, 2014), above n 73 at 13; see also Skegg and Paterson, above n 580 at 231.

891 Medical Council of New Zealand https://www.mcnz.org.nz/get-registered/scopes-of-practice/vocational-registration/types-of-vocational-scope/. "Scope of practice" means any health service that forms part of a health profession and that is for the time being described under section 11", Health Practitioners Competence Assurance Act 2003, s 5. Psychiatrists are expected to be able to perform mental capacity evaluations and have the option of completing a Certificate of Advanced Training in Psychiatry of Old Age, which includes a standard on capacity assessments for testamentary capacity and EPOAs. https://www.ranzcp.org/Files/PreFellowship/2012-Fellowship-Program/Psychiatry-of-Old-Age-Certificate/Old-age-Certificate-requirements.aspx.

892 Email communication from David Dunbar, (Registrar, Medical Council of New Zealand) on scope of practice (16 March 2016).

893 The New Zealand Council: http://www.nursingcouncil.org.nz/Nurses/Scopes-of-practice.

894 There has been a submission to the Psychologists Board by neuropsychologists for capacity assessments to be included as a competency within their scope of practice (Email communication from K Cunningham (neuropsychologist), (29 May 2016).

895 KL Cunningham "Neuropsychological Assessment of Medico-Legal Capacity in the New Zealand Context" in JAB Macniven (ed) *Neuropsychological Formulation: a clinical casebook* (Springer, New York, 2016) at 114.

896 Psychologists use a variety of tests, for example, ABAS-II (Adaptive Behaviour Assessment System-Second Edition), whereby adaptive functioning scales can be filled out by the person and a reliable informant (family member and/or health professional). This test gives information of the person's actual daily functioning skills without support or assistance. Cunningham, above n 895 at 94.

emotional or sexual manipulation, for example, and to whether a person has capacity if they decline good support offered to them.

7.34 Members of the different health professions may have different approaches to assessing capacity, depending on the assessment methods to which they adhere.[897] Where possible, it is best to have a health practitioner who knows the person conduct the assessment. In many instances, practice nurses, social workers and occupational therapists may be part of a multi-disciplinary team that contributes to that assessment.

Existing guidance for assessing capacity

7.35 In New Zealand, Young,[898] and more recently Astell,[899] have described approaches to capacity assessment for doctors. However, in contrast to the developments under the MCA and similar laws, no specific guidance has been established in New Zealand that takes into account the provisions of both the PPPR Act and the HDC Code, human rights developments under the CRPD, and the need to recognise tikanga Māori and cultural diversity within clinical practice.

7.36 Traditionally, clinicians[900] have used intuitive or unstructured methods of capacity assessment – sometimes referred to as "clinical judgement". This approach is not accurate enough and will not withstand legal scrutiny, for example when assessing a person's capacity to make a will or gift significant assets. There is often a misconception that tools for assessing cognitive impairment, such as the Mini-Mental State Examinations that produce a scored measure of cognitive function, are sufficient. However, these tools are not specific tests of decision-making capacity.[901] Furthermore, the correlation between decision-making capacity and cognitive ability is not reliable in a legal setting, especially in the earlier stages of dementia.

7.37 A variety of methods of capacity assessment have been published internationally but these mainly relate to other jurisdictions.[902] The MacArthur Competence Assessment Tool for Treatment (MacCAT-T)[903] has provided the basis for a clinical tool now used widely to assess capacity. It is internationally regarded as a "gold standard" of assessment, but requires some familiarity and training to use correctly. It has been used in the United States to assess decision-making capacity in relation to treatment decisions in many different clinical contexts,

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897 K Sullivan "Neuropsychological assessment of mental capacity" (2004) 13 Neuropsych Rev 131.

898 G Young "How to Assess a Patient's Competence" (2004) Feb New Eth J 41. This seminal article was the first New Zealand specific method developed for GPs to assess capacity under the PPPR Act using a mnemonic for remembering the assessment procedure ("Play SOCCUR Excellently").

899 H Astell, J Hyun-Lee and S Sankran "Review of capacity assessments and recommendations for examining capacity" (2013) 126 NZMJ 1383). Drs Astell and colleagues in the Community Geriatrics Department at Middlemore Hospital, Counties and Manukau DHB, identified the need to train specialist nurses and GPs to perform capacity assessments and developed a resource kit for this purpose.

900 The term 'clinician' is used to refer to health practitioners and can include, doctors, nurses and psychologists.

901 M Folstein, SE Folstein and PR McHugh "'Mini-Mental State' – A Practical Method for Grading the Cognitive State of Patients for the Clinician" (1975) 12 J Psychiatr Res 189.

902 Examples internationally: T Grisso and P Appelbaum *Competence Assessment Tool for Treatment (MacCAT-T)* (Professional Resources Press, Sarasota, FL, 1998) (USA); Mental Capacity Act 2005 Code of Practice Chapter 4, A Ruck Keene (ed) *Assessment of mental capacity: a practical guide for doctors and lawyers* (4th ed, British Medical Society and the Law Society, London, 2015) (UK); Attorney General *Capacity Toolkit* (New South Wales, 2008) and Capacity Australia "Mini-legal Kits" www.capacityaustralia.org.au/resources/mini-legal-kits (Australia);
Ontario Ministry of the Attorney General "Guidelines for Conducting Assessments of Capacity" (2005) http://www.attorneygeneral.jus.gov.on.ca (Canada).

903 Grisso and Appelbaum, above n 902, refer to capacity assessments for research participation.

including research.[904] This clinical tool provides a semi-structured interview that enables the assessor to evaluate capacity in terms of four abilities closely resembling the criteria in the MCA test[905] (and the legal tests in the PPPR Act). A semi-structured interview approach is one which provides a framework for questioning, but which allows the clinician to insert details that are relevant to the issue and to the person being assessed. This approach can assist the clinician to ensure that the assessment is systematic and complete but is also sufficiently flexible and specific to the decision and circumstances.

7.38 Major problems faced in the development and implementation of standards for assessing decision-making capacity are inter-rater reliability and the extent to which standards can be objective.[906] Assessment of capacity will incorporate elements of value and rationality and the question is how to apply this in a clinical setting,[907] particularly where the person has a severe psychiatric disorder. A particular difficulty that can arise for the clinician is whether the person's ability to manipulate the information (that is, "foresee the consequences" or "use or weigh" the information) meets the standard of capacity. The assessment should focus on the process used in coming to a decision, not the content of the decision itself. However, assessing how a person weighs up the consequences is particularly subject to normative bias, based on the clinician's own value judgements about how the patient "ought to" use the information.[908] This may extend to cultural bias when assessing Māori, and generally there is a risk of failing to recognise the diverse cultural contexts within which capacity assessments are carried out.[909]

A survey of doctors in New Zealand

7.39 In December 2015, as part of this research project, a survey entitled, "What do you know about assessing capacity, and what would help you do it better?" was sent to all doctors working at both Hutt Valley and Wellington hospitals.[910] Information and a link to the survey were also published in three national newsletters widely read by GPs.[911] The aim of this survey was three-fold: to increase awareness of the role of capacity assessments; to determine what doctors already know about the principles of capacity assessment; and to determine what their educational needs and preferences might be.

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904 P Appelbaum "Assessment of patients' competence to consent to treatment" (2007) 357 New Eng J Med 1834. Note the legal test is slightly different – refer to Chapter 4 on Defining Capacity.

905 G Richardson "Mental Capacity at the Margin: the Interface between Two Acts" (2010) Med Law R 63.

906 See Chapter 4A Defining Capacity.

907 LC Charland "Mental Competence and Value: the Problem of Normativity in the Assessment of Decision-making Capacity" (2001) 8 Psychiat Psychol L 135.

908 Banner, above n 547.

909 See Chapter 2E Supported decision-making in practice and in English case law.

910 The survey was a collaboration by the writer with a number of doctors, led by Dr Greg Young, psychiatrist, Capital & Coast DHB. The collaboration involved Dr Crawford Duncan (psychiatrist), Dr Lorraine Davison (psychiatry registrar), Capital & Coast DHB; Dr Ben Gray, (Academic GP, Wellington School of Medicine, University of Otago); and Professor John McMillan (Director of the Bioethics Centre, University of Otago). A pilot survey was carried out at Hawkes Bay DHB in collaboration with Drs Lucy Fergus, Ian Hosford and Elaine Plesner. The survey received ethical approval from the Otago University Human Research Ethics Committee, (D15/213) and the institutional ethics committees of the Hawkes Bay and Capital & Coast DHBs. Statistical advice for the analysis of the survey was provided by Ellen Hewitt.

911 The Royal College of New Zealand General Practitioners (RCNZGP) circulated the survey on its electronic newsletter, ePulse and it was reported in New Zealand Doctor, "Closer look at GPs tricky job of judging mental capacity", NZ Doctor.co.nz, 16 December 2015 www.nzdoctor.co.nz/.../2015/...2015/.../closer-look-taken-at-gps'-tricky-

7.40 This was a mixed-methods, cross-sectional survey consisting of four parts, using convenience sampling.[912] Part 1 collected demographic information, including the doctor's seniority, specialty, and frequency of experience with patients who may lack capacity. Part 2 asked doctors about the characteristics of a patient lacking capacity who they had encountered in the past year. Part 3 consisted of 13 questions testing the doctor's knowledge about the principles of capacity assessment. Part 4 asked whether the doctor had received any postgraduate training on capacity assessment, whether they felt confident enough to defend their decisions in court, whether they considered assessing capacity to be within their scope of practice, and how they might like to receive educational material in the future. The final question asked doctors to describe what they considered to be the main difficulties they faced when assessing capacity.

7.41 A total of 74 GPs and 153 hospital doctors responded, the majority of whom were medical consultants. In view of the number of doctors invited to participate, the results are of limited generalisability to all New Zealand doctors. However, valuable information was obtained, as the results showed that the doctors responding lacked knowledge regarding capacity assessments. A significant portion of GPs (24.3%) and hospital doctors (30.1%) did not consider capacity assessments to be within their scope of practice. Hospital doctors were sometimes confused as to whose job it was to assess capacity: i.e. whether they should take responsibility for the assessment of their patient or whether to refer them to a specialist, such as a psychiatrist or geriatrician. The median score on the multiple-choice questions in Part 3 was 17/26 for GPs and 18/26 for hospital doctors. Many doctors appeared not to realise that capacity assessment was decision-specific, and many incorrectly believed that a patient's next of kin (without possession of a power of attorney) could give legal consent on that patient's behalf.

7.42 The vast majority of respondents had not had any formal training in capacity assessment. Those doctors who had training scored slightly higher than their peers. Doctors gave various reasons why they had difficulty with assessments, including lack of knowledge and confidence, time pressures, and lack of understanding of the relevant law. GPs also identified having to involve patients' families as an area of difficulty. The reasons given were: resulting pressure from relatives for the GP to do a "grey area" assessment; family having "preconceived ideas"; family not understanding end-of-life care issues; family giving conflicting information to that received from the patient; and conflict between relatives.

7.43 It is clear that most doctors sampled would benefit from structured, formal training in assessing capacity that would impart both clinical and legal knowledge. The survey showed that medical education in this area is particularly urgent, given that most respondents indicated that greater than 20 percent of their patients were aged 65 years or more, and that they had fairly frequently (6 – 12 times per year) been concerned about a patient's capacity, or had to do a capacity assessment. Many respondents were enthusiastic about the prospect of learning how to better assess capacity, choosing various options for receiving educational material, and provided positive feedback to the authors for undertaking this research.

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912 The survey was based on work by Ganzini and colleagues that examined a number of misconceptions and uncertainties about capacity assessment in a group of old-age psychiatrists, physicians and psychologists in the United States: L Ganzini, L Volicer, W Nelson and others "Pitfalls in Assessment of Decision-Making Capacity"(2003) 44 Psychosom 237.

A toolkit for assessing capacity

7.44 The survey clearly identified the need for professional education of doctors on how to assess capacity and on the legal framework. The authors have therefore developed guidance, in the form of a toolkit, using the results of the survey and their combined experience of teaching how to assess capacity to doctors, medical students and other clinicians.[913] This toolkit was circulated widely in draft among doctors (and some lawyers) and was presented at a workshop attended by mainly hospital doctors and social workers.[914] Detailed written feedback was received from over 30 respondents, including GPs and hospital doctors.

7.45 The toolkit is intended to assist doctors and other health practitioners, including psychologists, nurses, occupational therapists (clinicians) and social workers who may be involved in assessing capacity. Guidance or standards for health practitioners need to be clear, appropriate and practically useful to clinicians.[915] A key factor in developing the toolkit has been to ensure it provides the right balance of legal and clinical knowledge for clinicians using it. The toolkit recognises the need for culturally responsive practice when undertaking capacity assessments, especially if the person undergoing the assessment is from a different culture to the clinician. Tikanga Māori has been included by making whakawhanaungatanga, and the process of engagement and establishing connections between people, a platform for supported decision-making.[916] The toolkit is therefore the first step towards providing a consistent and systematic approach to assessing capacity within the New Zealand healthcare setting.

7.46 The toolkit for assessing capacity is annexed to this report.[917]

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913 A Douglass, G Young and J McMillan "A Toolkit for Assessing Capacity" (2016) www.lawfoundation.org.nz; Appendix D.

914 "Elder Law in the Health Sector for Bright Star Training, Capacity assessments of older patients" (Crowne Plaza, Auckland, 24 February 2016). The Royal New Zealand College of General Practitioners (RCNZGPs) circulated the draft toolkit to a special interest group and various doctors were targeted through the network of doctors who supported the project.

915 L Anderson "Writing a new code of ethics for sports physicians: principles and challenges" (2009) 0 Br J Sports Med 1.

916 See Chapter 2D The Cultural Dimension. Advice on tikanga Māori was received from Dr Jo Baxter, Associate Dean of Māori, University of Otago.

917 Douglass, Young and McMillan, above 913, Appendix D.

RECOMMENDATIONS FOR A NEW ZEALAND CODE OF PRACTICE

The recommendations in relation to a Code of Practice for New Zealand are:

1. Revised incapacity legislation should provide for a Code of Practice to be developed by the government agency responsible for the legislation, in consultation with the health and disability, social development and justice sectors, with enabling provisions in the legislation modelled on those of the MCA.

2. There should be a statutory requirement for public consultation and input by the health and disability, social development and justice sectors, in formulating the Code, and in subsequent reviews, as with the HDC Code.[918]

3. The Code of Practice should provide guidance on the interface between the revised legislation and the notion of capacity or "competence" as used in the statement of Rights in the Code of Health and Disability Services Consumers' Rights (the HDC Code).

4. The Code of Practice should explain, and make provision for, supported decision-making as a form of best practice, in keeping with the United Nations Convention on the Rights of Persons with Disabilities (CRPD) and tikanga Māori, as identified in this report.

5. An independent statutory body should be given responsibility for implementation of the new legislation and for monitoring implementation of the Code of Practice.

6. That independent body should promote professional education and involvement of the relevant health practitioner registration authorities, Colleges and allied social work organisations, in this task.

7. The development of the Code of Practice should commence concurrently with a review of the PPPR Act, so it can be in place on commencement of revised legislation.

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[918] Health and Disability Commissioner Act 1994, s 21.