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LAW REFORM COMMITTEE

Inquiry into powers of attorney

Melbourne — 14 December 2009

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Mr M. Hughes, Acting Chair, Victorian Section College of Clinical Neuropsychologists and Principal Neuropsychologist, The Alfred Hospital

Mr D. Stokes, Senior Manager Professional Practice, Australian Psychological Society and Neuropsychologist

Mr L. Delaney, Chair, "Guidelines for Preparation of Neuropsychological Reports for the Guardianship List of the Victorian Civil and Administrative Tribunal" Working Party and Senior Clinical Neuropsychologist, Alcohol Related Brain Injury Australian Services

Ms E. Mullaly, Member of College of Clinical Neuropsychologists Course Approval Sub Committee and Manager of Psychology Services, Caulfield Hospital.

The CHAIR — We will make a start. Matthew Hughes, David Stokes, Luke Delaney and Elizabeth Mullaly, welcome to the hearing.

Hansard will be recording what we discuss, and you will be sent a copy of the transcript subsequently. You will be aware that our discussion takes place under parliamentary privilege under various acts and that protects you from any action that might be taken against any remarks that you make in this hearing. But that privilege will not be afforded you outside the hearing.

We have received the material from you. Thank you very much for that and thank you for coming today. I will hand it over to you. We are on a fairly tight time line; we have half an hour. I am sorry for that but let us move briskly and I am sure there will quite a lot we get out of it.

Mr HUGHES — Thank you and thank you for the opportunity to come to talk to you. I am Matthew Hughes, Acting Chair, Victorian Section Australian Psychological Society (APS) College of Clinical Neuropsychologists and Principal Neuropsychologist, Alfred Hospital.

Mr STOKES — I am David Stokes. I am a clinical neuropsychologist, but also I am the Senior Manager for Professional Practice with the Australian Psychological Society.

Mr DELANEY — I am Luke Delaney. I am the senior clinical neuropsychologist with an organisation called ARBIAS (Alcohol Related Brain Injury Australian Services) that specialises in alcohol and drug-related brain injury.

Ms MULLALY — I am Liz Mullaly. I am also a neuropsychologist, and I am on the course approval Sub Committee of the College of Clinical Neuropsychologists; I also manage psychology services at Caulfield Hospital where Sally works as a social worker.

Mr HUGHES — I thought I would move through the recent submission we made to you outlining the role neuropsychologists take in the assessment of capacity. Apart from that I can help the Committee in its understanding of how capacity assessments are made and when you might determine that someone does not have the capacity to make a power of attorney.

Neuropsychologists generally endorse the approach of a fairly detailed cognitive assessment, not a formulaic snapshot, X-ray approach to capacity assessments. Typically we are referred people where there may be some doubt as to their capacity — they are on the borderline — and these will be people who have some illness or injury affecting cognitive functions. They could have dementia or suffered a brain injury. I guess it is important to say that we would be aware of those conditions that are transient or may improve with treatment and those conditions that are permanent, so whether we would say it is worthwhile thinking, this is a prospective assessment of someone's capacity rather than it may change in time to come.

A neuropsychological assessment is a fairly lengthy approach and procedure. It is a detailed cognitive assessment looking at thinking skills, assessing people's intelligence, memory function, problem-solving and planning. It is also done in the context of understanding a person's background, so predicting their level of pre-injury or pre-illness function, taking into account cultural issues or English as a second language. We have a look at the whole gestalt of the individual in terms of a decision they might be making or in terms of a capacity assessment for making a power of attorney and analyse all of the factors in their background along with the cognitive assessment data we obtain.

The assessment is done face-to-face in a quiet room. It is not a real world capacity assessment; we do not take someone off to get money out of the bank but we talk to them about how they might do that or how they would make a transaction or make a decision about their lifestyle or medical treatment. I guess it is a fairly detailed approach that we take with making these assessments. We look at all the factors that are involved when someone has to make a decision and also when they are appointing a power of attorney — the pros and cons that are involved in those decisions — and give an opinion regarding someone's capacity.

I will talk a little bit about access to neuropsych assessments. Neuropsychology services are provided in public health and they are also provided privately. It is a limited resource so that is why we assess people who are on the borderline or where there is some doubt about their capacity. We do not do it to uniformly say every person

has capacity; we are looking for that trigger when we are looking at those issues. Neuropsychologists are specifically trained in the assessment of capacity so it is a key part of their education and training now.

I guess I will just come to some recommendations. That will give us ample time for some questions. We feel it would be useful to establish some criteria for establishing an enduring power of attorney. We have some guidelines for what to do if in doubt — if there is a doubt about someone's ability to establish a power of attorney, and what would be a recommendation. If that doubt is in the area of cognition, an area of our expertise, we certainly think people need a detailed assessment of their cognition.

I guess on the surface of analysing someone's decision, they are not judging it to be right or wrong. But in terms of the quality of the decision that they are actually making that decision themselves, at that time it can be quite hard to see that difference — whether it is a poor decision or they are lacking the ability to make a decision. Often a neuropsychology assessment can help to inform that, not always. But in terms of assessing someone's quality function, we can identify these dissociations where people tend to say one thing or act in a different way. In our appendices examples sort of highlight those nuances of human behaviour that we are used to assessing.

I guess we are also just making the point that capacity assessments are sort of complex. Specialised neuropsychological assessments at times would be needed to help determine someone's capacity. It is useful to probably consider a neuropsychologist to be involved in educating legal and health-care professionals, because this is certainly an area of expertise for us. We are often making these kinds of assessments, so we can certainly help streamline and improve the process for others.

Neuropsychology should recognise its own importance in the role of the process. They are the sorts of issues I guess for the role of neuropsychology in assessing capacity and looking at enduring powers of attorney that we want to bring to your attention.

The CHAIR — Would any of the others like to throw in a comment at this point?

Mr STOKES — No, I think we are happy to take it on the basis of questions.

The CHAIR — I do not think any of us have got any professional experience in neurology or any of those areas. So we are going to take it slowly I think. You said it is a complex process that you do in assessing cognitive impairment of some sort. Is that process fairly objectively settled in terms of your field, or is that still contestable in some ways?

Mr STOKES — Can we say that the whole process is based upon the standardised tests which are exhaustively validated across populations and subgroups. So we are first of all working on objective measures which have been both developed in an empirical way and then validated and normed in the empirical way. But as Matthew was saying, in that context you take a standardised test of language, for instance, or expressive language and you nevertheless relate that to the person you are dealing with, because the person brings cultural, experiential and educational differences into that setting which you have to take into consideration on the basis of how you use that standardised test.

But we have a battery, if you like, available to us of standardised tests which we have confidence in which we can apply to any individual in their circumstances and for the purpose for which they have been referred. Does that sort of answer the question?

The CHAIR — It does. So you take an area like culture, a person's background, say. For example, there is an older person whose language reverts or there are changes in the way they are comprehending and the way they are articulating. Have you a standardised tool that enables you in pretty well all cases to get some assessment of where a person is positioned given they have been going through that ageing transition?

Mr STOKES — Sure. You have picked the most complex of all, because you cannot always work in their language and that limits you. So you are often having to use an interpreter, but also to understand the sorts of issues that that person has brought to the situation. That sometimes requires therefore considerable internal adjustment to the understanding and interpretation of a set of results. Liz, that is probably something you know about.

Ms MULLALY — I guess in terms of neuropsychologists, it is not as if we would all sit in a room and if you went to one of us, then another of us and then another you would get exactly the same experiences. There is a clinical aspect to it, and we do draw on all of our training. We have put in six or seven years of university training to sort of bring to bear how to assess this particular person who is in front of you. How would you assess that person's memory, for example, which is a vital aspect in terms of assessing the ability of capacity to appoint an EPA? But because this is the skill we use every time we assess a person — we assess people for many different reasons — it is a transferable skill. I guess we are always trying to sort of find the best approach to assessing that particular person who is in front of us to find out what their abilities are. As Matt said, we combine that assessment, which is standardising tests and measures, with that interview process, which is a very clinical interview but quite a detailed one, and look for that convergence to see whether we are seeing a convergence between the two areas we have looked at.

I guess a lot of other methods involve just the talk, having a chat to the person. Ours has that additional thing that we can see that knowing that this person has a bit of a memory problem, is this seeming to impact a lot on their decision making? Knowing we have picked up some mild problems with their reasoning ability and judgement, is the decision they are having to make so complex that that will impact on it? So it is sort of looking at the both sides of it I guess.

The CHAIR — Right. Just one last one before we move on to the others, you mentioned you also see people who have suffered from a brain injury, for example, through some kind of trauma or something. But you did not mention when you talked about the tools you use to make an assessment. You did not talk about the physical brain at all. Is that included in it, or do you only do it through interview? Do you just do it through interviews?

Mr DELANEY — It is a behavioural assessment in that it is a measure of the person's behaviour, so there is not a MRI scan of the brain involved in it. It is measuring the person's thinking abilities, memory and their behaviour, both on the formal tests and through observation. Through our knowledge of normal brain functioning and of aberrant or abnormal brain functioning we can see patterns of each other.

Ms MULLALY — But neuropsychologists would always seek to have all that information. Any scans, imaging or anything that has been found out about the brain, we bring that to bear. We look at that and interpret things in terms of that. We do not operate independently of the medical profession, radiologists or anything like that. It is very interdisciplinary I guess.

Mr STOKES — What we are saying is that although the concurrence, if you like, or coincidence of the findings are often similar, they are not always similar. The same two brain scans might produce quite different behaviours. You have got to be prepared to make those measures and not rely just on a scan or something of that nature.

As I said, two identical scans can actually emanate as quite different behaviours in people — not a lot, but there will always be some similarities. But you have to be prepared to pick that up and assess it. It is testing the brain as it functions rather than as it looks.

Mr CLARK — In the evidence that the Committee has taken to date, with the questions we have asked on these capacity issues, I think it is fair to say we concentrated on degenerative loss of capacity or injury induced loss of capacity. But it occurs to me there are also potential issues with people who, for example, have a borderline intellectual disability or a developmental disorder like autism or Asperger's syndrome. Do your tests judge capacity in those contexts? If so, is there anything special about how you assess capacity in those contexts?

Ms MULLALY — Yes, I think people certainly see people with cerebral palsy which is another example of those sorts of things. I guess that is the thing about neuropsychological assessment. It is flexible enough that if someone does have communication difficulties or physical disabilities that make it very difficult for them to do the standard tests; we are able to draw on tests that are then useful for that particular person. I guess we still just look at the basic things to do with their memory and their thinking processes.

Of course you have to take into account how much support they are going to get. The whole psychosocial context will come into it as well. It is what Matt was saying about it being a very holistic thing. It can be time consuming, because we do not like to just take a snapshot over 1 hour and then make a judgement on it. I do not think there are any issues. Neuropsychologists work with all of those populations.

Mr STOKES — Regardless of the causation or aetiology of their difficulties, you can still assess their difficulties in one way or another. That is the nature of the tests.

Mr BROOKS — As you have said, you would look at these cases when there is a need for someone who might be borderline, but not in the first instance, I would imagine? We are looking at submissions that suggest that maybe legal practitioners or medical practitioners assess capacity at the time these documents are created. What sort of things would you recommend are considered by those people at the time of creation? Can you give us some advice on what sort of basic things you would want to see covered by one of those practitioners at the time that they are looking at a document, the data, where they have got to tick the boxes and go through a document.

Mr DELANEY — I think to examine whether the person has a known or possible impairment of brain functioning; a condition, whether it be a dementia or a traumatic brain injury or whether they have multiple sclerosis or schizophrenia, it is, 'Does the person have a condition that may affect their brain functioning?'.

Mr BROOKS — How would a lawyer, for example, assess that? Would they ask the person, or would they try to make an assessment?

Mr DELANEY — I think they would only be able to ask the question. They are not going to be able to actually assess that. The medical practitioner was who I was thinking of when I made those comments.

Mr STOKES — I think there can be a set of some screening guidelines we might talk about similar to those that are associated with making a will, for instance, that are already set down in legislation or in guidelines. The same sort of screening device of that nature might well be instituted or provided for non-health practitioners or even some health practitioners as a first screening step. These are the sorts of questions you should ask and if you are getting satisfactory answers then that is fine. If you are not, then you need to think seriously about going for a more expert opinion. That is the way we conceptualise it.

We attached a set of our guidelines for the OPA with the assessment of competence and it incorporates some of that sort of process. We would think that would be a good model to adapt to the EPOA.

The CHAIR — We have only just received this so we have not yet had an opportunity to have a good look at it but could I ask you, in following up on what Colin said, what would your view be of, often in aged care residential, for example — I do not have the technical language for this, but I think they are called mini mentals — and they ask a series of quick questions, are they an appropriate starting point?

Mr STOKES — As long as they accept that it is a screen only, and there are lots of false positives that come out of those sorts of processes and that people who look okay there in actual fact do have difficulties; and that people who do badly on those can sometimes be not too bad. It is a blunt instrument.

The CHAIR — Then how do you know? You have done one, you are in a residential care, we have gone through one of these things, the nurse who is in charge of the area thinks that is fine, but you are saying that it could actually cut either way?

Mr STOKES — You never rely on one particular task, so I would be happy that the mini mental state had been done because it is not a bad starting point, but you would also want to make sure that the set of guideline questions that have been set down, as we do in other settings, had also been administered. It is only when you feel 100 per cent confident that you move on.

The CHAIR — Do you think that should be run past the GP as the normal process?

Mr STOKES — It might well be, but that is another area where we have difficulties because sometimes GPs will miss that process too. That is why I think it has got to be more than just one particular measure, like a mini mental status, so the notion that a mini mental status of 29 out of 30 is okay, is not something we feel comfortable with as saying it is the only measure.

You need to have some other sort of screening processes that should be applied and questions that are of a reasonably constructive nature such as is done with the competency for wills, can be applied in this same process. Something like that would give us more confidence that somebody was actually being thoroughly screened before referral.

Ms MULLALY — I was just going to say: I also think that the person who is assessing the capacity takes into account the complexity of the decision being made and has a higher level of suspicion or concern. If it is a person with a particularly huge estate who you can see is being hovered around by various people who seem to have questionable interest in them, to me, that is the way it works now, that would create the sense of, let us have this capacity looked at very carefully, because you are going to need a higher level of memory, reasoning ability and judgement if you have got a very complex decision to be made.

Given that I do not have anyone who I can really trust, how do I decide who to trust amongst these various people? To me that would require the person to have not just a mini mental status score that is acceptable. That is the circumstance currently where they will often ask for a neuropsychological assessment knowing that later it could be challenged. That is the way the system works, that sort of end-point outcome of whether it will be challenged, as opposed to having it signed off at the beginning of the process.

Mr FOLEY — To return to a lot of the earlier questions; in your recommendations you talk about hospital developments, specific criteria and then in the EPOA whether there might be issues of doubt. You have spoken about the holistic nature of the assessments and the complications between what is normal and apparently functioning, and all sorts of complications that come into this.

The Chair asked a question of how contested this feels at the start. If we are going to establish specific criteria but it is, from a layperson's point of view, such a moving feast, how would we in a piece of broad, enduring legislation, at least for a period of time, go about linking your work to the practical legal administrative outcomes that some of your colleagues have alerted us to earlier?

Would there be a series of guidelines at a general principle level informed by evolving clinical and research practice? What would you see as the linking of your work and the practical work at the coalface where the groups hit the issues there?

Mr STOKES — There are a number of levels, and I just comment, perhaps from a legal point of view, I can imagine that this is like relying on medical evidence, that you will sometimes get varying opinions. But there is an underlying set of criteria about what a person needs to be able to do to be competent that could be made extant if that was going to be helpful in the legal setting such as what skills do they need and what skills can they do without perhaps, but even by specifying what it is that a person needs to have, and therefore would form the basis of an assessment, it might be one way of enunciating that for you.

Although there are going to be variations in opinion; it will be very much on the fine line and for most of it, there would be clearly a memory disorder established, and that is an objective fact. There will be judgement issues concerned, there will be language issues specified, there might be spatial issues identified. All of those sorts of things which are part of a neuropsychologist's assessment, you can specify, if you like, fairly clearly that they exist or they do not exist.

The question of whether they impact, and to what extent, on the competence to make this specific decision might create some differences of opinion, but the underlying assessment or the characterisation of the person would not vary enormously.

The CHAIR — And all that is in the context of what you set up in the beginning, of doubt, within the general framework of doubt, and you are saying there are still areas inside that that are settled, and then there are some marginal ones where finer judgements will be okay?

Mr STOKES — Yes. And it would be more of a question of whether that person can actually write an EPOA or what aspects of their life can they make a decision about, as was suggested by the Alfred, that there are situations which they could buy into, such as their medical treatment but they are not really up to talking about where they live, and those sorts of issues are going to be the areas of doubt.

Ms MULLALY — I think you are asking also, should there be guidelines, because this legislation at the moment is very general, and how much more specific should it be? Or should it be left fairly general but have guidelines that set out what to do and how to look at it, and that would be helpful.

Mr FOLEY — I took it from your recommendations that you were perhaps suggesting guidelines?

Ms MULLALY — Yes, I think we are suggesting the concept of some guidelines so that anyone who is going to get involved in this sort of thing should be familiar with those guidelines or could go to those guidelines when they do and see what would be the useful thing to do.

These ones that we have put together for our own profession are an example of one form. I know the Medical Practitioners Board has a similar sort of thing in some of its publications. These are generated by the professions, but I am not sure whether they would be usefully generated more by the government to expect people to be aware of them.

Mr CLARK — You rightly identified that your profession has a lot of value to add when there is a need to make an assessment of someone's capacity. The issue I am wrestling with is how the layperson can be instructed as to when they need to engage your services, because I do not think it is practical for everybody to undergo a neuropsychological test.

Obviously at the time of making a power of attorney, perhaps a witness or someone has to make that judgement, and then at the time when someone claims to act on a power, because the donor has lost capacity, again there can be questions. Can you suggest any test or guidelines or practical procedures that we can recommend in our report to be adopted in legislation as to how those decisions can be made about whether or not your profession's services need to be engaged?

Mr DELANEY — I think the idea of guidelines is a good way of dealing with this issue, because this is legislation that is going to affect everyone, and there are going to be people of varying levels of knowledge and understanding actually acting under the legislation, whether that be solicitors in isolated locations.

Having guidelines available that step the person through a series of tests which raise issues of doubt. For instance, if in doubt about the person's memory functioning, then perhaps referring to the GP or getting an opinion from a medical practitioner will be the first step. If there is a great deal of doubt then it might be that a neuropsychological assessment may be appropriate. I am thinking of a decision tree or a path that people could go down, which has a written document that backs it up — something in a flowchart style that would help people step through what are the issues that they should turn their minds to, whether they be a solicitor or a medical practitioner signing off on this EPA, to ensure that they have competence, that they have capability. If in doubt — —

Mr CLARK — On to the next step.

Mr DELANEY — Yes.

Mr CLARK — That makes sense.

Ms MULLALY — I know in some other jurisdictions they have the four things, which is understanding, retaining, weighing and communicating. I think they are the four aspects that people can generally understand. Can the person understand what they are doing? Can they retain the vital bits of information? Can they weigh things up and see how it is likely to affect them in the future? Can they communicate what they want?

I do not think that is too detailed to make it so impossible that people will not really do it. I think the layperson could probably get a bit of a grip on that by maybe having those four. I am only saying that because I know that has been used in other legislation. You probably have seen it in other submissions that you got, the suggestion that it be expanded into that sort of arena. As neuropsychologists we would agree that they are the vital elements that need to be in place. That would be part of the guidelines. Whether it becomes the legislation or not is not my area.

The CHAIR — Just finally, you talk in your submission about your professional engagement in training legal people and other professionals involved in this area. What do you have in mind when you say that?

Mr STOKES — I suppose we were suggesting that if, as a result of this, there is a sense that an educational initiative needs to be taken across the health professions and legal professions, then we would be happy to be party to that, both in contributing as well as promulgating it for our own members.

The CHAIR — You do not do any of that at the moment?

Mr STOKES — Yes, indeed we do. Yes, we have workshops constantly as part of our professional development program. Some of those are internal, but we do not do extensive amounts with other professions, which would be useful.

The CHAIR — So you are not at the moment engaged with the legal profession at all?

Mr STOKES — No. That is what I mean.

Ms MULLALY — Not in a formal way. I know I have spoken to the Office of the Public Advocate about neuropsychology, and I have spoken to VCAT members about neuropsychology.

The CHAIR — There is conversation.

Ms MULLALY — But it is not formalised; it has just come about randomly.

The CHAIR — We are out of time. On behalf of the Committee I thank you very much for your attendance today and also for your submission. It has been a very stimulating short conversation. Kerryn and Kerry will probably be in contact to clarify or get some more information from you, and that is appreciated as well. You will get a copy of the transcript.

Witnesses withdrew.