

# A TOOLKIT FOR ASSESSING CAPACITY



A Douglass, G Young and J McMillan\*

## CHECKLIST FOR ASSESSING CAPACITY

This toolkit is a clinical, legal and practical guide for health practitioners (clinicians) when assessing an adult's capacity to make decisions. The checklist is a summary of the toolkit. It is intended to assist clinicians who do capacity assessments infrequently. Each bullet point is hyperlinked to the [main](#) Toolkit or to external websites and resources to provide more information. There is more information on the [legal framework](#) at the end of the toolkit.

## KEY PRACTICE POINTS

- A person is [presumed to have](#) the capacity to make a decision unless there are good reasons to doubt this presumption.
- In general, capacity is assessed with respect to a [specific decision at a specific time](#).
- Assessment is of a person's [ability to make a decision](#), not the decision they make. A person is entitled in law to make unwise or imprudent decisions, provided they have the capacity to make the decision.
- [Supported decision-making](#) involves doing everything possible to maximise the opportunity for a person to make a decision for themselves
- Capacity assessment procedures need to consider [tikanga Māori](#) and cultural diversity.

## Legal Test for Capacity

A person lacks capacity if they are unable to:

- [understand](#) the nature and purpose of a particular decision and appreciate its significance for them;
- [retain](#) relevant, essential information for the time required to make the decision;
- [use or weigh](#) the relevant information as part of the reasoning process of making the decision and to consider the consequences of the possible options, (and the option of not making the decision); or
- [communicate](#) their decision, either verbally, in writing, or by some other means.

---

<sup>2</sup> This toolkit may be cited as: A Douglass, G Young and J McMillan *A Toolkit for Assessing Capacity* in A Douglass "Mental Capacity: updating New Zealand's Law and Practice" (Report for the New Zealand Law Foundation, July 2016) [www.lawfoundation.org.nz](http://www.lawfoundation.org.nz) | [www.alisondouglass.co.nz](http://www.alisondouglass.co.nz)

## CARRYING OUT A CAPACITY ASSESSMENT

### Stage One: Preparing for the Assessment

- **Triggers:** why is this person's capacity being questioned now?
- **Decision:** what is the capacity decision to be assessed?
- **Legal test:** what is the legal test against which capacity is to be assessed, under the PPPR Act or other laws? (for example, "wholly" or "partly" lacking capacity)
- **Gathering Information:** do you have all the relevant information about the decision, including the circumstances and details of the choices available?
- **Medical history:** does the person have a [medical condition](#) that impairs their capacity and does this need treatment before the assessment can be done?
- **Support measures:** what can be done to [assist](#) the person to make the decision?
- **Cultural considerations:** is [cultural support](#) needed?
- **Where and when:** what is the best time and place for the assessment?

### Stage Two: The Assessment Interview

- **Engagement:** have you explained who you are and the [purpose of the assessment](#)?
- **General health and cognition:** what is the person's mental state? Is there a [medical condition](#) that is currently active and is impairing the person's cognitive function? If so, can you measure its severity using a cognitive screening test?
- **Legal test:** have you asked [questions](#) to determine whether the person is able to understand, retain, use or weigh the information or, communicate the decisions by any means?

### Stage Three: After the Interview

- **Decide:** do you have enough information to [decide](#) if the person has capacity or not: is a second interview necessary?
- **Communicate:** have you told the person, and where appropriate their family, the outcome of the assessment?
- **Document:** have you [recorded](#) your reasons in the person's clinical records that the person has or lacks capacity for a particular decision? Is a medical certificate or report required?

# A TOOLKIT FOR ASSESSING CAPACITY

## A INTRODUCTION

[Top](#)

### Purpose

1. The purpose of this toolkit is to guide health practitioners, including doctors, psychologists, nurses, occupational therapists (clinicians)<sup>1</sup> and social workers when assessing an adult's capacity to make a decision(s).<sup>2</sup>
2. The toolkit provides a consistent and systematic approach to assessing capacity within the New Zealand healthcare setting. It covers: key practice points, how to carry out a capacity assessment, and an overview of the relevant law.
3. The [UN Convention on the Rights of Persons with Disabilities](#) has shifted the focus towards supported decision-making for people with impaired capacity: not only is it important that good judgements are made about whether or not a person has decision-making capacity but it is equally important to provide ways in which a person can be supported so as to make their own decisions.
4. This toolkit aims to recognise supported decision-making within New Zealand's diverse cultural contexts and that [tikanga Māori](#) is central to capacity assessment of Māori.
5. A list of [useful resources](#) is provided at the end of the toolkit.

### Guidance, not legal advice

6. This toolkit does not take the place of legal advice. Where a formal assessment has been requested, the referrer should clarify: the legal test, the particular questions to be answered, and that the clinician has been given all the necessary information to be able to complete the assessment.
7. People with impaired decision-making capacity may be vulnerable to abuse, coercion and undue influence from others, which may compromise their decisions being made freely and voluntarily. If there is suspicion of undue influence, then consider whether other professionals, or social agencies need to be involved and who can support the person in obtaining that advice. For example, whether the person should obtain independent advice from a lawyer or accountant, or support from Age Concern.
8. Assessing a person's decision-making capacity may not be straightforward. Where the decision involves significant risk, or where there is conflict about the decision, it can be difficult to separate incapacity from differing personal values or unwise decisions. In these

---

<sup>1</sup> For ease of reference, health practitioners who assess capacity are referred to as "clinicians". The word "person" rather than patient or consumer, is used in recognition that the person (an adult) being assessed may not actually be undergoing health treatment, and in law is referred to as the "subject person".

<sup>2</sup> This guidance is for the assessment of adults – in law, 18 years and older. However, the functional method of assessment used in this Toolkit may also be used for assessing the decision-making capacity of children and young persons provided the correct legal tests are identified.

situations it is a good idea to seek the advice of senior colleagues. It is also common for clinicians to seek legal advice and, where possible, advice from a clinical ethics advisory group.

### Defining capacity

9. Decision-making capacity (or simply, “capacity”) refers to a person’s ability to make decisions. Examples range from simple decisions about what to have for breakfast, to whether to go to the doctor when feeling ill, to far-reaching decisions about serious medical treatment or financial matters.
10. In New Zealand legislation, both “capacity” and “competence” are used interchangeably. In a clinical context, “competence” tends to refer to the process of decision-making, and capacity to the legal term that is used.<sup>3</sup> In this toolkit, the term “capacity” is used throughout.
11. Deciding whether a person has the capacity to make a particular decision has legal implications and in some cases may need to be determined at a court hearing. A capacity assessment is part of the evidence that informs the legal decision. There are legal tests which are applied to determine whether a person has capacity to make specific decisions or whether someone else or the court, a substitute decision-maker, should make decisions for them.

### Legal test for capacity

12. The purpose of assessing capacity is to determine by clinical interview whether the person is unable to make a legally effective decision. A functional test is used. A person lacks capacity if they are unable to:
  - **understand** the nature and purpose of a particular decision and appreciate its significance for them;
  - **retain** relevant, essential information for the time required to make the decision;
  - **use or weigh** the relevant information as part of the reasoning process of making the decision and to consider the consequences of the possible options, (including the option of not making the decision); or
  - **communicate** their decision, either verbally, in writing or by some other means.

## B KEY PRACTICE POINTS

[Top](#)

### Presumption of capacity

13. The starting point when assessing capacity is always to [presume that a person has capacity](#) to make the decision. However, the assessment will be taking place because a reason exists to question the presumption of capacity. The capacity assessment is an examination of the person’s decision-making process.

---

<sup>3</sup> “Capacity” and “mental capacity” are generally the terms used in Europe and the United Kingdom, and “competence” in the United States.

14. Clinicians need to be alert to triggers that question the person's capacity for the present decision and the reasons why they are being asked to assess a person's capacity.

### **Capacity is decision and time specific**

15. A person's capacity should be assessed in relation to a particular task or decision. Capacity cannot generally be inferred from one task or decision to another.
16. The person's incapacity may be temporary, or fluctuating. If possible, an assessment of capacity should be done when the person's condition has improved. For example, if the person has a delirium, it is better to wait until this has resolved, or at least improved as far as can be realistically expected.

### **Assessment of a person's decision-making ability, not the decision they make**

17. Assessing capacity involves examining the mental processes a person goes through in order to arrive at a decision: it is not an assessment of the decision made. A person cannot be assessed as lacking capacity simply because they make a decision that is considered [unwise or imprudent](#). However, an uncharacteristically imprudent decision may constitute a "red flag" to trigger an assessment of the person's capacity.

### **Supported decision-making**

18. [Supported decision-making](#) involves doing everything possible to maximise the opportunity for a person to make a decision for themselves. A capacity assessment can give guidance about the extent and nature of the support the person requires.
19. Supported decision-making is in keeping with established [legal principles](#), including:
- using the least restrictive intervention;
  - maximising a person's capacity to the greatest extent possible; and
  - people being entitled to make unwise or imprudent decisions.

### **Substitute decision-making as a last resort**

20. If all efforts made to support a person through the decision-making process are unsuccessful, and the person does not meet the legal test for capacity, then a substitute decision-maker can make the decision for the person. Where a substitute decision-maker is involved, a capacity assessment can provide useful information about the person's views, values and beliefs, which remain central to them being supported in the decision-making process, as well as the nature of the difficulty they may have with decision making.

### **Tikanga Māori and cultural diversity**

21. There is a need to recognise [cultural diversity](#), and in particular the rights of Māori as tangata whenua, in all aspects of clinical practice in New Zealand. This remains true when assessing capacity; culture, language, and religion are integral factors in how a person makes decisions and in what decisions they make.

22. Having respect for the needs, values, and beliefs of Māori is crucial when assessing capacity with [Māori](#). *Whanaungatanga* provides a platform for capacity assessment and supported decision-making and is fundamental to culturally responsive practice. [Whakawhanaungatanga](#) refers to the process of establishing what connections, either through family or other social relationships, exist between people. For Maori in particular, formal relationships such as that between the parties in a capacity assessment will be greatly enhanced if efforts are made to establish connections and relatedness at the outset, and if the assessment is conducted in a manner that is mindful of those connections. This is one way in which the mana and dignity of the person being assessed can be supported.
23. An example would be where a Māori elder has a stated preference to stay living in their home when the whānau believe the support of hospital care is needed. In such instances there may be tension between recognising the collective view of whānau and ensuring that the elder's mana is accorded respect. Both aspects, and their interdependent nature, need to be understood.
24. In practice, carrying out capacity assessments requires clinicians to be [culturally competent](#), especially if the person is from a different culture than the clinician. This involves knowing when and how to enlist the support or assistance from whānau and others to support the person through the assessment process.

### Form of assessment

25. There are broadly two contexts in which clinicians assess capacity:
- **Informal assessments:** These may often occur in the context of assessing a person's capacity to give or refuse consent to medical treatment. They are narrowly focused on the knowledge of the relevant information, available options, and consequences, and on the reasoning and communication abilities of the person giving consent. These capacity assessments are often conducted "intuitively" or informally by clinicians, without using structured assessment methods, recourse to courts or formal legal processes. The assessment by the clinician should still be documented in the person's medical record.
  - **Formal assessments:** These are assessments that are required to provide an opinion (often with a medical certificate) under the adult guardianship law (PPPR Act) or for other legal proceedings, or for some other legal purpose. This type of assessment is intrinsically more formal. These capacity assessments are used to support, for example, the activation of an Enduring Power of Attorney (EPOA) or an application to the Family Court to appoint a welfare guardian, or they may take the form of advice to a lawyer or other professional on whether to accept a person's capacity to make a certain decision, such as the making of a will.
26. Other more immediately practical decisions, such as the decision to move into supported accommodation, may also require a formal assessment of capacity. An important aspect of the assessment of capacity where a decision with long term consequences is to be made, is the likely cause of the incapacity and the probability of the person regaining their capacity to make decisions.

27. In many contexts, an intuitive assessment, which is the type of assessment most commonly used in medical practice, is not accurate enough and will not withstand legal scrutiny, for example when assessing a person's capacity to make a will or to gift significant assets.

### Who should carry out the assessment?

28. If the assessment is about a medical decision, the [clinician who is providing the treatment](#) should assess the person's capacity to consent to that treatment, though they may consult others for assistance.
29. Where the decision is about other matters such as personal welfare, living arrangements or property matters, it is usually best for a clinician who is well-known to the person, for example, the family GP, to do the assessment. Where this is not the case, particular attention will need to be given to the process of engagement, and, in the case of Māori, whakawhanaungatanga.
30. In cases of doubt, or in relation to complex major decisions, it may be advisable to collaborate with other health practitioners with experience in relation to the needs of the person, such as a nurse, occupational therapist, psychologist, or speech and language therapist.
31. Final responsibility for obtaining effective [consent for treatment](#) rests with the person intending to carry out the proposed medical procedure, not with other health practitioners advising about capacity.

## C CARRYING OUT A CAPACITY ASSESSMENT

[Top](#)

32. It is useful to think of the process of assessing capacity as consisting of three stages:
- **Preparing for the assessment:** What is the decision to be made, why is the person's capacity in doubt, is there a reversible cause for the incapacity, or is the incapacity due to a permanent or progressive condition? Usually there will need to be some contact with family members or other professionals involved in the person's affairs at this stage to clarify these issues, especially where the person being assessed suffers from dementia and the assessment is more heavily reliant on collateral information. It may also be useful to involve a supportive family member or friend to assist the person in getting to the assessment. This stage of the process is particularly important if there is any question of undue influence or financial abuse, as it will be vital to obtain a history from a range of people to ensure the reliability of the information.
  - **The assessment interview:** Attention needs to be paid to engaging the person. There needs to be a brief review of the person's health, mental state and cognition, and the clinician needs to assess the four abilities central to the functional test to capacity.
  - **Actions following the interview:** These can include a second assessment interview to assess the consistency of the person's decision-making, referral for review of a medical condition, feedback to the person and family, recording the assessment and/or or completion of a report or legal certificate.

## Stage One: Preparing for the Assessment

[Top](#)

### Triggers: why is this person's capacity being questioned now?

33. The starting point is that a person is presumed to have capacity. Concern or doubt about the person's capacity usually occurs when the person has a medical or psychiatric condition affecting their mental state, and in the context of that condition the person is required to make a decision that has serious consequences or high risk. The combination of the mental condition and the significant decision can be thought of as a trigger for the assessment. The clinician will need to have a clear understanding of the trigger, which should be documented. In some situations the trigger for the assessment may be simply an unusual feature of a proposed decision, and the mental condition may only be discovered at the assessment. For example, assessment might be considered if a person makes a decision that deviates markedly from their known disposition, without justification.
- The condition affecting the person's mental state is most frequently cognitive decline or dementia, but may also be psychiatric illness such as severe depression, psychotic illness, profound grief or stress, or severe physical illness associated with pain, insomnia or emotional distress.
  - A number of factors about the decision may cause the person's capacity to be questioned. These include significant risk or long-lasting consequences associated with the decision, the decision the person is proposing to make is contrary to reasonable advice, without justification (for example, refusal of standard medical treatment for a serious but treatable condition), or the person is unable to make a decision at all despite being provided with all the relevant information and the appropriate support, where it is imperative that a decision needs to be made (for example, about residential care).
  - A person is unable to communicate a decision (for example, a person affected by a stroke).
  - A family member, carer, lawyer or service provider has expressed concern about a person's decision-making ability. This may occur before a diagnosis of dementia has been made or it may be part of future planning, for example, encouraging a person to appoint an attorney for an EPOA.
34. People have the right to make unwise or imprudent decisions, as long as they retain capacity to make the decision at the time they are making it. Nonetheless, an unwise decision may trigger a more detailed assessment, particularly if the decision is out of character or has significant consequences. The assessment should only proceed on that basis that something can be done - an intervention in the person's best interests – If the person lacks capacity in respect of the specific decision.

### Identifying the decision

35. Clarify what the decision is that the person needs to make, why it needs to be made now, what information would be needed for anyone making a similar decision, what are the alternative options available, and what are the reasonably likely consequences of those options or of not making a decision at all. Where, for example, the decision concerns a legal matter, the clinician can reasonably expect written instructions from the lawyer identifying the decision, the relevant information and the applicable legal test. If it concerns moving



into residential care, the notes of the multidisciplinary team that assessed the person as needing to move, giving the reasons for the move being recommended, should be available to the clinician assessing capacity.

36. For the appointment of a welfare guardian or property manager, it is important to identify the kinds of decisions or aspects of them that will be relevant to a person's current circumstances and those decisions that will need to be made in the foreseeable future. For example, a person may be capable of consenting to routine treatment medical or dental treatment but would not be able to weigh up more complex decisions and the risks and benefits about whether to consent to elective surgery or chemotherapy.

### **Medical conditions that impair capacity**

37. Consider whether there are any medical conditions that could be impairing the person's capacity and if so, what treatment is being given and how effective it is. This step includes reviewing medical notes and contacting the person's usual doctor if required. Medical conditions that could impair capacity include:

- dementia and degenerative and other neurological diseases;
- acquired brain injury, including traumatic injury and stroke;
- delirium;
- any physical condition that is causing severe discomfort or distress;
- severe mental illness, either persistent, such as schizophrenia, or acute such as acute depression or mania;
- alcohol and substance addiction; and
- learning disability, including intellectual disability and autistic spectrum disorder.

38. Consider referring the person for further assessment if there is a realistic possibility that the person's capacity is impaired by a condition that is outside the clinician's scope or expertise. The purpose of this referral will be for the condition to be diagnosed and treated, and not for the capacity assessment itself to be passed on to another health practitioner, although a second opinion about the person's capacity may be helpful.

### **Support measures and communication**

39. The clinician has a role in ensuring that the person to be assessed has already been given the best chance of making a decision, for example, by the existing health care team or service and/ or with assistance of the person's family. All reasonable attempts that have been made to support the person make a decision should be documented, including what these attempts have entailed. Examples of what may be done include:

- Treating a medical condition which may be affecting the person's capacity (for example, delirium);

- Using a different form of communication (for example, providing written material) or by providing information in a more accessible form (for example, drawings); and
  - Ensuring that discussions with the person about the decision have been conducted in an appropriate environment (for example, respecting a person's privacy and minimising distractions on a busy hospital ward or visiting the person in their own home).
40. Where necessary, arrange to have the assistance of a professional interpreter with appropriate accreditation and experience in health interpreting. If English is the person's second language, it is common for a person whose capacity is deteriorating to lose their ability to communicate in a second language early in the process. Using a family member or friend is not acceptable. Even with an interpreter available, a fully bilingual clinician, if available, may be a preferable option for undertaking the assessment.

### **Involvement of family/whānau and support**

41. It is a matter of judgment as to whether an immediate family member should be present for the assessment interview. If the person is accompanied by a family member or friend, it will be necessary to consider conducting at least part of the interview privately with the person, especially if there are reasonable grounds for suspecting undue influence or coercion. In this case it may be necessary to consider having another professional person, such as a trusted carer, a health and disability advocate, or a [cultural support person](#) present.
42. Where the person being assessed is Māori, consider the relevant cultural competencies and tikanga Māori. For all persons being assessed, thought needs to be given to the process of engagement as capacity assessment, which is motivated essentially by doubts about the person's capacity, may be experienced by some as demeaning or humiliating.

### **Where and when**

43. Consider the time and place for the interview; ensure that enough time is available for the interview to be conducted at an easy pace and that the place chosen for the interview is comfortable and private. It is important to avoid interviewing later in the day for older persons when they may be suffering from fatigue or "sundowning".
44. Hearing, visual and communication aids, where used, should be brought to the interview.

### **Gathering information**

45. It is vital that all relevant information to the decision is accurate and complete. For example, the outcome of a needs assessment is relevant for the person to decide between living in supported residential care and living at home. Family or other professionals involved, such as the person's lawyer, should be consulted as appropriate.
46. It may be helpful, or even essential, to obtain background history from an informant, a friend or family member, particularly where the person has dementia and there is likely to be a progressive decline in the person's capacity. The purpose of contacting informants is to use the information objectively and to check the extent to whether the proposed decision is out of character or inconsistent with the person's previous decisions and life patterns. This

information may include the history of cognitive decline, problems with previous decisions of a similar nature and may involve getting a range of views from other informants if need be.

47. Once all the relevant information has been gathered, the clinician assesses capacity by interviewing the person.

## Stage Two: the Assessment Interview

[Top](#)

### The interview process

48. The assessment interview follows the usual process of a clinical interview, however, because of the legal implications of the assessment, the interview needs to be more structured than a routine clinical interview. Particular care may be required when a formal assessment is carried out by the person's own clinician and takes place within the context of a continuing therapeutic relationship. If the clinician is unfamiliar with the person, extra care may be needed to engage with them and attention should be paid to ensuring that the person has the appropriate personal and cultural support. The success of the assessment is very dependent on the cooperation of the person being assessed.
49. Explain to the person that the purpose of the assessment is to ensure that they are fully informed about the decision, and whether they are in a position to either make the decision independently or make the decision with further support.

### General health and cognition

50. Consider what assessment needs to be done of the person's general health and cognitive state. If the assessing clinician is the patient's regular GP, it may only be necessary to check that the patient's level of cognition is "as good as it usually is in the present circumstances", and to exclude such conditions as delirium aggravating the cognitive impairment of a known dementia. Where the person does not already have a diagnosis of dementia, for example, a more detailed assessment would be needed.
51. Cognitive functioning may be assessed with a recognised test such as the Montreal Cognitive Assessment (MOCA) or Mini Mental State Examination (MMSE), which provide a measure of the severity of cognitive impairment. It is important for the clinician to be aware that brief tests of cognitive function do not provide a measure of capacity. Their value is in the providing some rigour to the assessment of cognition and to allow a comparison of the person's cognition at the time of the capacity assessment to their own, and the population baseline. Specific tests of frontal lobe function correlate better with measures of capacity because they assess problem solving, judgment and mental flexibility, which are all frontal lobe tasks.

### Consider the four elements of the legal test: understand, retain, use or weigh, and communicate

52. **Understand:** *does the person know what the decision is, why it is important for them (ie appreciate its significance) and why it needs to be made now, the alternative options available and the option to make no decision at all?*

- It is useful to explain all of the information relevant to the decision to the person at the beginning of the assessment interview, unless it is apparent it has been clearly explained to them recently.
- The level of understanding required must not be set too high. It is not necessary that the person has the ability to understand every element of what is being explained to them.
- The person must be given all the necessary information and options so that their capacity to weigh up those options can be fairly assessed: they should not start with a “blank canvas”.

53. **Retain:** *is the person able to retain enough information for a sufficient amount of time for them to go through the decision-making process?*

- The length of time for which the person should be able to retain the information depends to some extent on the decision being made. In the case of a treatment decision, it may only be necessary to retain information about the possible complications and alternative options for long enough to make the decision or give consent. In that case the test would be asking the person to repeat the information back to the assessing clinician when the assessment is being done. On the other hand, it would be expected that if the decision was to change a will, the relevant information would be retained for longer.

54. **Use or weigh:** *is the person able to state the benefits and risks (consequences) of each option using relevant information and explain why they prefer one of the options?*

- This element includes the idea that the person is thinking about or “weighing” the options. The person’s thinking process is either logical, or at least based on the information available, and is actually engaging in the decision-making process itself. The person has the ability to “foresee the consequences” of decisions (similar to the PPPR Act test), including the option of not making a decision.
- Using and weighing information is the most difficult element to evaluate when assessing capacity for a number of reasons. It is an assessment of a thinking process that the person may not easily demonstrate to the clinician.
- The standard of “weighing up” or “using information” can be difficult if the person is weighing the important medical facts against their personal convictions, beliefs or values. The assessment of an apparently bizarre idea or irrational decision, for example to refuse treatment, needs to be considered in the context of the person’s related beliefs and values taken as a whole. It may or may not turn out to be coherent in that light. It may be, for example, that in deciding to refuse lifesaving treatment, the person attaches no value to living in a particular condition (severe disability) and therefore does not give positive weight to the option of treatment. The test is of the person’s ability to weigh up the options: the weight to be attached to that information in the decision-making process is a matter for *that* person.
- The standard of weighing up is usually a basic one; the information is considered in the decision-making process, and the person shows some flexibility to change their

decision if additional information, even if hypothetical, is offered. For example, “if this decision could result in you suffering serious medical consequences or death, would you consider doing something different?” A person might not be considered able to use or weigh the information if they are unable to accept that they suffer from the condition that is requiring treatment. However, if the person refuses the advice of professionals, despite serious consequences, they may still be regarded as retaining capacity as long as they acknowledge these serious consequences.

- It is also important to consider whether a person’s ability to use or weigh information is freely and voluntarily made where there is suspicion of susceptibility to undue influence or coercion from others.

55. **Communicate:** *can the person communicate a decision or choice?*

- The inability to communicate is a stand-alone ground for establishing a person lacks capacity. Where a person cannot communicate a decision in any way, by talking, using sign language or any other means, they are unable to make a decision for themselves.
- Any residual ability to communicate is enough so long as the person can make themselves understood.
- An assessor should help facilitate communication, for example, by providing all necessary tools and aids, and enlisting the support of any carers or family who may assist with communication.

### Stage Three: After the Interview

[Top](#)

#### Consider the findings of the capacity assessment process and decide how to proceed

56. It may be possible to form an opinion about the person’s capacity during the assessment interview, and decide that no further assessment is required. As a rule, this opinion should be explained to the person, either at the interview or at a suitable occasion after the interview. Capacity assessments for decisions that carry greater risk, are for the longer-term, or that may be contested in court, for example, testamentary capacity, may often require more than a single interview, particularly where the person’s condition may change.
57. Inconsistency in decision-making may suggest that the person lacks capacity. For example, a person with fluctuating cognition due to delirium may make contradictory decisions. Another type of inconsistency is the person who makes a will that is radically different from a number of previous wills and that contradicts their previously stated intentions. Information from other members of the multidisciplinary team or from the person’s family may be another way of checking inconsistency with previous decisions or expressed wishes and out of character decisions.
58. Based on the findings of the whole assessment, the clinician will then need to decide whether the person has capacity to make the decision that they now need to make. Even though the person may have some ability to make the decision, a binary yes/no assessment of their capacity to make the current decision may be required. For example, regarding the

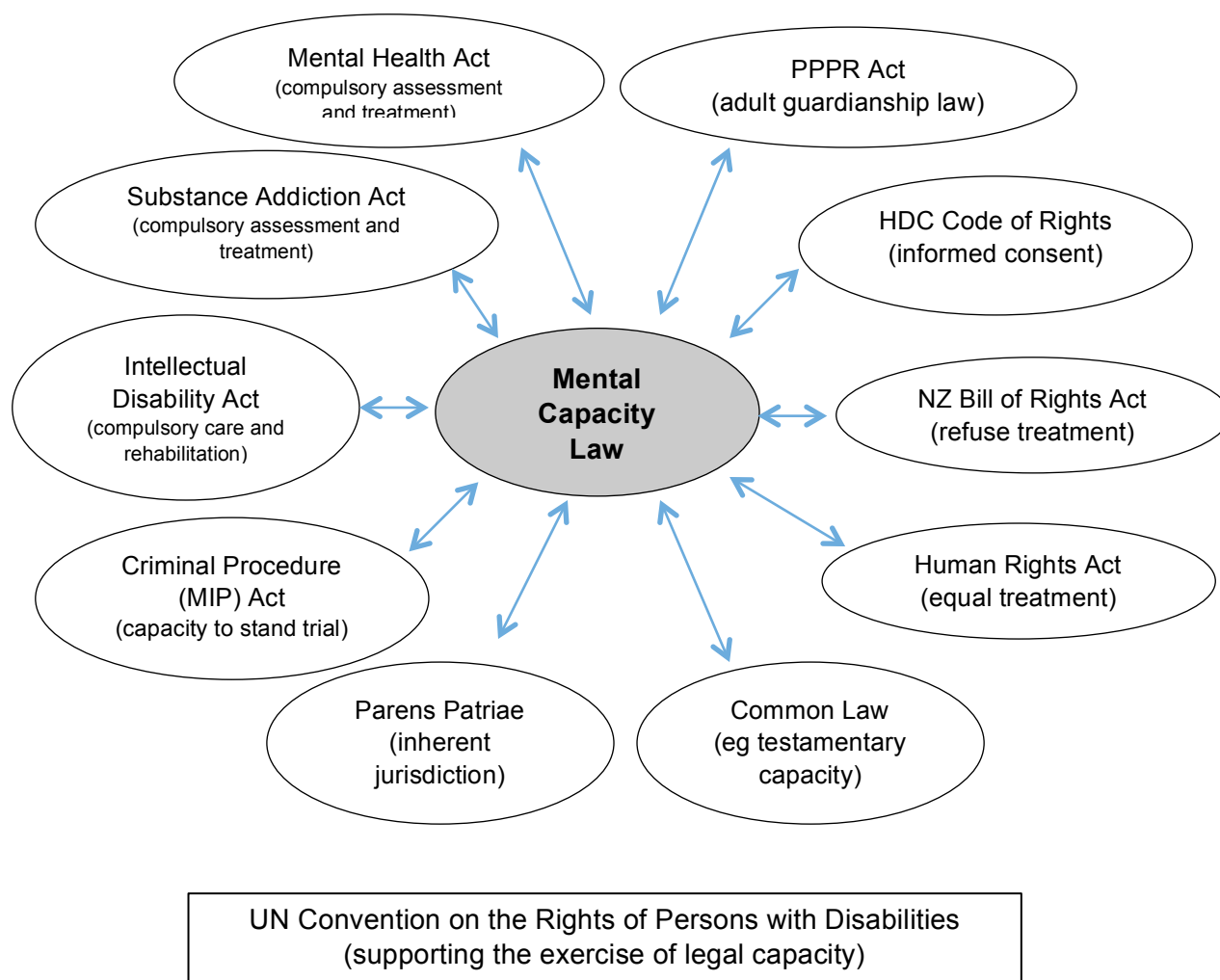
activation of an enduring power of attorney or an application for the Family Court to make a personal care order, the clinician may be required to decide whether the person lacks capacity to make a significant decision (or range of decisions) or not.

### Recording your assessment

59. Document the findings of the assessment. Any report or opinion for a formal assessment should be prefaced with an outline of the clinician's expertise, experience, and contact and professional relationship with the person (for example, acting as their GP for 20 years), and the circumstances of assessment (for example, carried out in the person's home for one hour). Informal assessments should be recorded in the person's clinical records.
60. The report of the assessment requires the clinician to be clear about the capacity decision that is being assessed, the information that is relevant to the decision, and an explanation whether the person was unable to satisfy the legal test and why. The person will be considered to lack capacity if they are unable to satisfy any one of the elements of the test of: understand, retain, use or weigh, or communicate a decision. The clinician should give detailed, specific examples (actual quotes) of where the person has not shown the requisite abilities.
61. Where an intervention will be longer-lasting, for example an order to move into supported residential care, the clinician will need to describe the medical condition or disability that is causing the incapacity and whether any treatment is available that could restore the person's capacity.
62. Where the person has capacity for the specific decision, but serious concerns have been expressed by family members or others, or where the decision carries significant risk, it is equally important to document the findings of the assessment, showing that the condition that is causing the impairment has been assessed and that despite the condition, the person has the ability to understand, retain, reason, and communicate adequately for the decision.
63. The prescribed information required for a certificate of mental incapacity for activating EPOAs (there is no longer a prescribed form) and the medical report form for court proceedings under the Protection of Personal and Property Rights Act 1988 (PPPR Act) are in the [resources](#) at the end of the toolkit.

## D THE LEGAL FRAMEWORK

[Top](#)



### Mental capacity law in New Zealand

64. There is a wide range of legislation and common law (case law) in New Zealand that is relevant to people with impaired capacity for decision-making. This section explains the main New Zealand law and legal tests relevant to capacity assessments.
65. The [Protection of Personal and Property Rights Act 1988 \(PPPR Act\)](#) is the adult guardianship law that applies to people who lack capacity and are 18 or older. It authorises the appointment of substitute decision-makers by the Family Court (welfare guardians and property managers) or “one-off” orders for care and treatment decisions (personal orders), and provides the mechanisms for making and activating enduring powers of attorney (EPOAs), when a person lacks capacity for decision-making.
66. The [Code of Health and Disability Services Consumers’ Rights \(HDC Code\)](#) concerns consent to health care treatment and procedures. Under the HDC Code, consent to health care procedures is necessary as required under Rights 5, 6 and 7, including the right to make an informed choice and give or refuse consent.

67. Under the PPPR Act and the HDC Code, a substitute decision-maker can include:
- an attorney appointed by the person for property or care and welfare decisions under an enduring power of attorney (EPOA);
  - a welfare guardian or property manager appointed by the Court;
  - the Court making a specific personal order about the person's care and treatment or approving the person's will made by the person or the person's property manager;
  - the clinician that is providing care and treatment to the person can make a decision in the person's best interests where there is no substitute decision-maker, provided reasonable steps are taken to ascertain the views of the person and others as set out in Right 7(4) of the HDC Code.

### Identifying the relevant legal test

68. To assess capacity, it is necessary to identify the decision required to be made and the relevant legal test. As with many countries, New Zealand follows a functional, not a status approach to capacity.
69. The test of capacity used in this toolkit is based on a review of the functional approach in the PPPR Act and case law, which broadly reflects the functional test and the same concepts in the Mental Capacity Act 2005 (England and Wales) (MCA test). The four elements of the MCA test are the inability to: *understand, retain, use or weigh relevant information, or to communicate the decision*, and provides simple and logical steps to assessing capacity.
70. There are several tests for capacity in other legislation, for example, capacity to stand trial in the Criminal Procedure (Mentally Impaired Persons) Act 2003. There are tests that have been developed in court cases (known as common law). These cover the capacity to: make a will; make a gift; to enter a contract; litigate (take part in legal cases); and to enter a marriage.

### PPPR Act: capacity thresholds

71. In general terms, a person lacks capacity if they cannot understand the nature and foresee the consequences of decisions, or are unable to communicate them. The clinician is required to assess what degree of impairment the person has in relation to the applicable legal test. The four elements in the core functional test are used to assess the person's ability to: understand, retain, use and weigh or reason – similar to “foresee the consequences” - and communicate a decision.
72. The PPPR Act has five different tests for capacity depending on the kind of decision-maker to be appointed or the decision to be made. For example, the threshold for appointing a welfare guardian requires that the person “wholly” lack capacity whereas the court may make a personal or property order if the person “partly” lacks capacity.



73. There are two different thresholds for when the Court makes an order (and a [report form](#) to complete):

### Court orders

- [“partly”](#) lacks the capacity: personal order, ss 6 and 10 (for example, medical treatment or living arrangements), order to administer property (low level assets and income); and [“wholly or partly”](#) lacks the capacity: property manager, s 25 (2)(b).
- [“wholly”](#) lacks the capacity in respect of particular aspect(s) of a person's care and welfare: welfare guardian, ss 6 and 12.

### Activating EPOAs

74. An enduring power of attorney (EPOA) is a legal document where the donor gives someone else (the attorney) the power to act for the donor if they become “mentally incapable” and lose the ability to make significant decisions for themselves. There are two different thresholds for activating an EPOA:

- [“not wholly competent”](#): property EPOA , s 94(1)
- [“lacks the capacity”](#): care and welfare EPOA, s 94(2)

When activating an EPOA, there are no longer prescribed certificates to complete however any certificate or opinion of mental incapacity must include the [prescribed information](#) shown in the Regulations.

### Making EPOAs

75. Following changes to the PPPR Act and Regulations in 2017, there are new standard explanations and prescribed forms for the making and cancelling (revocation) of an EPOA. The threshold test is: [“understand the nature of the instrument, potential risks and consequences”](#), s 94A(7)(ab) and (b).

A certified witness (usually a lawyer or legal executive) must certify that they believe on reasonable grounds that the donor:

- understands the nature of the EPOA; **and**
- the potential risk and consequences of the EPOA, **and**
- is not acting under undue pressure or duress, [s 94A\(7\)\(ab\)](#).

And further:

- that the witness has no reason to suspect that the donor was or may have been mentally incapable at the time of signing the EPOA; [s 94A\(7\)\(b\)](#), **and**
- the witness is independent of the attorney and the witness is satisfied that no more than negligible risk of a conflict of interest arises [s 94A\(7\)\(c\)](#).

## HDC Code: capacity to consent to treatment

76. Capacity is an essential component to validating consent, or refusal to consent, but there is no specific legal test for capacity set out in the HDC Code itself. The person must be able to:<sup>4</sup>
- understand the *nature, purpose and effects* of the proposed treatment;
  - *weigh up the options, the risks and benefits*, including the likelihood of success and any alternative forms of treatment;
  - appreciate the possible *consequences of receiving, or not receiving, the proposed treatment*; and
  - *communicate* their decision.
77. Even where there is an appointed welfare guardian or attorney, every effort should be made to help the person participate as much as possible in the decision to be made. Right 7(3) of the HDC Code provides that:

Where a consumer has diminished competence, that consumer retains the right to make informed choices and give informed consent, to the extent appropriate to his or her level of competence.

### Right 7(4) of the HDC Code

78. Where a person lacks capacity for consent and there is no authorised decision-maker, [Right 7\(4\)](#) sets out the legal position for providing services to them.
79. Right 7(4) provides that if a person is not competent to make a particular personal care and welfare or treatment decision, and they do not have a an EPOA or welfare guardian (or the EPOA or welfare guardian is not available), services can be provided or treatment given if it is in the best interests of the person. Clinicians are required to follow the steps in Right 7(4) in reaching a decision, including taking into account the views of the person, or where these are not possible to ascertain, the views of other suitable people interested in the welfare of the person.
80. The use of Right 7(4) is most appropriate where decisions need to be made in the short-term and should not be relied upon for ongoing decision-making regarding longer-term care and treatment. In these circumstances, those involved with these decisions should consider making an application to the Court for orders under the PPPR Act.

### Capacity to make a will

81. The essential elements of capacity for making a will (testamentary capacity) is the common law test set out in the English decision of *Banks v Goodfellow*, and applied in the New Zealand Court of Appeal.<sup>5</sup> This requires that the person understands:

<sup>4</sup> *Re C (Adult: Refusal of Medical Treatment)* [1994] 1 WLR 290; [1994] 1 All ER 819; *Re MB (Medical Treatment)* [1997] 2 FLR 426; *Heart of England NHS Foundation Trust v JB* [2014] EWHC 342 (COP) 26.

<sup>5</sup> *Banks v Goodfellow* (1870) LR QB 549; applied in *Woodward v Smith* [2009] NZCA 215.

- the nature and effect of making a will;
  - the extent of the property which the person has for disposal; and
  - the moral claims of potential beneficiaries when making the will.
82. The will-maker must have the requisite mental capacity at the time they execute the will. Susceptibility of the will-maker to undue influence or the extent to which they have suffered from a serious mental illness, immediately before and subsequent to, making a will, may be relevant to legal grounds in challenging whether the will is valid.
83. A capacity assessment may be required for a person subject to a property order under the PPPR Act. There is a presumption of capacity to make a will even if the person is subject to a property order. The person or their property manager may make a will only with the permission of the Court: PPPR Act, ss 54 and 55.

#### **Refusal to undergo a capacity assessment**

84. Apathy or lack of cooperation to undergo a capacity assessment should not lead to the conclusion that a person lacks capacity. In circumstances where a person refuses to undergo a capacity assessment, it may be possible to persuade them to agree to an assessment if the consequences of refusal are carefully explained for example, the implications of a medical procedure. However, in the face of an outright refusal, (and in the absence of a Court order), no one can be forced to undergo a capacity assessment. Refusal to cooperate with an assessment together with other available information may be relevant in a legal decision about the person's capacity.
85. Where there are serious concerns about the person's mental health, the Mental Health (Compulsory Assessment and Treatment) Act 1992 may be used but only for the purpose of assessment or treatment of the mental disorder itself.

## E USEFUL RESOURCES

[Top](#)

### Legal resources

- PPPR Act: <http://www.legislation.govt.nz/act/public/1988/0004/latest/DLM126576.html>
- Ministry of Justice website for the PPPR Act forms in relation to EPOAs and court proceedings: <https://www.justice.govt.nz/about/form-finder/?Keywords=pppr>
- EPOAs standard explanation:
  - personal care and welfare <http://superseniors.msd.govt.nz/documents/epa-documents/standard-explanation-epa-personal-care-and-welfare.pdf>
  - property <http://superseniors.msd.govt.nz/documents/epa-documents/standard-explanation-epa-property.pdf>
- EPOAs certificates of mental incapacity – prescribed information: <http://www.legislation.govt.nz/regulation/public/2008/0310/latest/whole.html>
- Health and Disability Commission fact sheet: Consent for consumers who are not competent: <https://www.hdc.org.nz/resources-publications/search-resources/fact-sheets/consent-for-consumers-who-are-not-competent-fact-sheet-1/>
- UN Convention on the Rights of Persons with Disabilities – Office for Disability Issues: <https://www.odi.govt.nz/united-nations-convention-on-the-rights-of-persons-with-disabilities/>

### Education videos

- E Plesner, L Fergus and G Young, Training Video on Capacity Assessment, University of Otago, Wellington <https://vimeo.com/uow/capacityassessment>
- E-learning courses for GPs, Goodfellow Unit, Auckland University: <https://www.goodfellowunit.org/courses/assessing-decision-making-capacity-clinical-basics>

### Cultural competence

- Health Quality and Safety Commission in conjunction with eCALD (Culturally And Linguistically Diverse) groups: <https://www.ecald.com/courses/cald-cultural-competency-courses-for-working-with-patients/cald-1-culture-and-cultural-competency/>
- Free foundation course in Cultural Competency (Māori) Mauriora Health Education Research: <http://mauriora.co.nz/cultural-competency-maori/>

## International guides to capacity assessment

### England and Wales

- 39 Essex Street: “Mental Capacity Act: A brief guide to carrying out capacity assessments” (2019) <https://www.39essex.com/mental-capacity-guidance-note-brief-guide-carrying-capacity-assessments/>
- Mental Capacity Act 2005 *Code of Practice* (TSO, London, 2007, update 2019) - Chapter 4 “How does the Act define a person’s capacity to make a decision and how should capacity be assessed” [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/497253/Mental-capacity-act-code-of-practice.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/497253/Mental-capacity-act-code-of-practice.pdf)

### Australia

- Capacity Australia: “Capacity Mini-legal Kits” for use by health care professionals in assessing decision-making capacity: <https://capacityaustralia.org.au/resources/mini-legal-kits/>
- NSW Capacity Toolkit: [http://www.justice.nsw.gov.au/diversityservices/Documents/capacity\\_toolkit0609.pdf](http://www.justice.nsw.gov.au/diversityservices/Documents/capacity_toolkit0609.pdf)

## AUTHORS

Alison Douglass, Barrister, 2014 recipient of the New Zealand Law Foundation International Research Fellowship, Honorary Senior Lecturer, Bioethics Centre, University of Otago

Dr Greg Young, Consultant Psychiatrist, Capital & Coast Health DHB, FRANZCP, Affiliate of the Bioethics Centre, University of Otago

Professor John McMillan, Bioethics Centre, University of Otago

## ACKNOWLEDGEMENTS

The development of this toolkit follows on from a survey about the educational needs of doctors in carrying out capacity assessments. We especially wish to acknowledge advice and input on tikanga Māori from Associate Professor Jo Baxter, Associate Dean of Māori, University of Otago. Thank you to our many medical, legal and bioethics colleagues who provided helpful feedback and comments on the survey and an earlier draft of the toolkit. Special thanks to: Crawford Duncan, Ben Gray, Lorraine Davison, Sue Walthert, Iris Reuvecamp, and John Dawson; the helpful resources provided by Alex Ruck Keene, barrister, 39 Essex Street Chambers, George Szmukler and Gareth Owen psychiatrists, Kings College London; and, Carmelle Peisah, psychiatrist, Australia.

The authors would like to acknowledge the generous support of the New Zealand Law Foundation.