Submission No. 55

The Australian Psychological Society Ltd

Submission

To The

Victorian Law Reform Commission's Guardianship and Administration Act Review

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The **Victorian Section of the College of Clinical Neuropsychologists (CCN) of the Australian Psychological Society (APS)** welcomes the opportunity to provide input into the Victorian Law Reform Commission's review of the Guardianship and Administration Act (GAA).

The main contributors to this submission were:

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- **David L Stokes** (APS Senior Manager Professional Practice and Clinical Neuropsychologist).

Contributions to the submission were also made by other CCN members working in fields such as aged care and mental health.

As a representative group of Clinical Neuropsychologists we intend to focus our submission on the following specific questions from the terms of reference of the Guardianship Information Paper:

- **Q6**. Should it be necessary for a person to have a "disability" before a guardian or administrator is appointed, or is it preferable to rely on concepts such as lack of "capacity" or "vulnerability"?
- **Q7**. What are the best ways of assessing whether a person's decision-making capacity is impaired?
- **Q11**. Is there a continuing need for substitute decision-making laws?
- **Q15**. Is there a need for new laws that formally recognise supported decision-making? How should any supported decision-making laws operate?

We will begin by outlining the training and role of clinical neuropsychologists. We will then focus on the questions outlined above.

TRAINING AND ROLE OF CLINICAL NEUROPSYCHOLOGISTS

Clinical neuropsychologists are specialist psychologists who are qualified at masters or doctoral level, necessitating 6 to 8 years of full-time tertiary study. Clinical neuropsychologists specialise in the assessment, diagnosis and treatment of psychological disorders associated with conditions affecting the brain. These include neurological, medical

and psychiatric conditions across the lifespan. Clinical neuropsychologists' skills are underpinned by knowledge of brain structure, function and dysfunction, and the effects of multiple factors on cognitive, behavioural and emotional functioning.

Neuropsychological training involves extensive education about the relationship between psychometric test performance and the areas of the brain that subserve those skills addressed by the tests. In addition, their knowledge of the neuropathology, neurological and developmental conditions that can be associated with various testing profiles and characteristic performances is extensive. These skills serve to alert neuropsychologists to likely issues, disabilities and limitations that certain conditions may impose on the individual person being assessed.

Clinical neuropsychologists provide assessments and treatment recommendations for people experiencing difficulties with memory, learning, attention, language, reading, problem solving, decision-making or other aspects of behaviour and thinking abilities. Referral questions may relate to issues such as diagnosis/differential diagnosis of dementia and likely impact of cognitive impairments on a person's ability to manage independent living and/or financial legal matters, to re-enter the workforce, to continue to drive a motor vehicle or to benefit from rehabilitation. Neuropsychological assessments involve the gathering of information relevant to the referral question, a clinical interview and a range of individually administered tests that are interpreted in the context of the person's background, for example, their age, cultural background and level of education. Neuropsychological assessments provide a detailed profile of the person's strengths and weaknesses and are recognised as a sensitive tool for the diagnosis of cognitive impairment, particularly in cases where changes are subtle and not evident on cognitive screening assessments or neuro-imaging. Based on the person's detailed profile, clinical neuropsychologists are able to provide recommendations for working with the person towards relevant goals, for example, rehabilitation goals or appropriate support for decision-making or independent living.

Most neuropsychologists who work in acute hospitals, rehabilitation facilities, aged care, psychiatry, memory clinics, private practice and community settings will at times be asked to assess a person's capacity to make lifestyle, financial or legal decisions. This is primarily limited to times when the person's capacity is considered unclear by other health care or legal professionals, or when there is a particularly conflictual situation requiring an objective expert opinion. Referrals often occur in contexts where healthcare staff have concerns about potential exploitation of vulnerable people, or there are potential risks to a person's health and safety. Neuropsychological assessments are a scarce resource and therefore only used when less specialised methods are considered inadequate.

The Australian Psychological Society has recently published Guidelines for Preparation of Neuropsychological Reports for the Guardianship List of the Victorian Civil and Administrative Tribunal (2009). These guidelines were prepared with input from the Office of the Public Advocate and Guardianship List (see attachment). Other publications in the area of capacity by Australian clinical neuropsychologists include the following:

Bennett, H. P., & Hallen, P. (2005). Guardianship and financial management legislation: What doctors in aged care need to know. *Internal Medical Journal, 35,* 482-487.

Crowe, S. (2005). The parallel universe: Does neuropsychological assessment tell us anything about the real world? *Inpsych, 27(3),* 10-13.

Crowe, S. F., Mahony, K., & Jackson, M. (2004). Predicting competency in automated machine use in an acquired brain injury population using neuropsychological measures. *Archives of Clinical Neuropsychology, 19,* 673-691.

Crowe, S. F., Mahony, K., O'Brien, A., & Jackson, M. (2003). An evaluation of the usage patterns and competence in dealing with automated delivery of services in an acquired brain injury sample. *Neuropsychological Rehabilitation, 13,* 497-515.

Hoskin, K. M., Jackson, M., & Crowe, S. F. (2005). Can neuropsychologist assessment predict capacity to manage personal finances? A comparison between brain impaired individuals with and without administrators. *Psychiatry, Psychology and Law, 25,* 531-540.

Hoskin, K. M., Jackson, M., & Crowe, S. F. (2005). Money management after acquired brain dysfunction: The validity of neuropsychological assessment. *Rehabilitation Psychology, 50,* 355-365.

Mullaly, E., Kinsella, G., Berberovic, N., Cohen, Y., Dedda, K., Froud, B. Leach, K., & Neath, J. (2007). Assessment of capacity: Exploration of common practices among neuropsychologists. *Australian Psychologist, 42,* 178-186.

Sullivan, K. (2004). Neuropsychological assessment of mental capacity. *Neuropsychology Review, 14*, 131-142.

Sullivan, K. (2005). Measuring mental capacity: Models, methods and tests. In B. Collier, C. Coyne, & K. Sullivan (Eds), *Mental Capacity: Powers of Attorney and Advance Health Directives.* Sydney, NSW: The Federation Press.

Todd, J. A.., & Lipton, J. D. (2004). Financial management of the elderly: Legal issues and the role of neuropsychological assessment. *Psychiatry, Psychology and Law, 3,* 25-38.

All psychologists, including clinical neuropsychologists, are registered with the Psychologists Registration Board of Victoria (from 1 July 2010, the Psychology Board of Australia). Psychologists follow strict guidelines for professional conduct that cover client privacy and confidentiality. Ethical codes have been developed to safeguard the welfare of recipients of psychological services and the integrity of the psychological profession.

SPECIFIC QUESTIONS FROM TERMS OF REFERENCE:

Q6. Should it be necessary for a person to have a "disability" before a guardian or administrator is appointed, or is it preferable to rely on concepts such as lack of "capacity" or "vulnerability"?

Neuropsychologists believe that guardianship and administration laws have been, and should continue to be, based on the presumption that all adults have capacity (and the ability to manage their financial affairs), unless proven otherwise. Neuropsychologists believe that establishing whether a person has a 'disability,' as broadly outlined in Victoria's GAA, remains a valid criterion for determining the need for a substitute decision-maker. In particular, neuropsychologists are concerned that opinion regarding a person's underlying capacity to make decisions should not be based solely on the apparent wisdom or outcome of the decisions that the person makes (a situation known as the "outcome approach" to capacity). In the absence of establishing whether a disability is present, the GAA could be applied to individuals who make poorly considered decisions, but who do not possess a cognitive impairment that impacts on their ability to make decisions. Neuropsychologists therefore support the retention of establishing whether a person has a disability underlying poor decision-making, as defined in the current GAA (e.g., dementia, brain injury, mental disorder), as a necessary 'threshold requirement'.

Neuropsychologists, along with other specialists, assist in the process of establishing whether a person has a diagnosable condition as outlined under the current GAA. Importantly, however, a diagnosis of disability alone does not mean that a person has impaired decision-making capacity. The existing GAA requires demonstration of a causal link between the person's cognitive disability and impairment in their decision-making capacity. Neuropsychological assessment also provides information regarding this causal link, that is, information about the person's underlying capacity to make decisions. Due to their cognitive disability, individuals may not be able to fully comprehend and weigh up the risks, benefits

and potential consequences of a particular decision. If a person lacks the capacity to fully engage in the process, they may make decisions with dire consequences for their independence and health (e.g., loss of accommodation, inadequate nutrition, medical complications). Neuropsychologists therefore believe that establishing a causal link between cognitive disability and impaired decision-making capacity is a key safeguard for individuals with a disability and that this key safeguard should be retained.

In the process of conducting a neuropsychological assessment to establish whether or not 'disability' and 'incapacity' are present, neuropsychologists identify not only cognitive weaknesses but also a person's cognitive strengths and capabilities. Thus, through the process of assessment, neuropsychologists can also recommend how to work with a person with a cognitive disability to maximise their potential to engage in decision-making and pursue least restrictive options in which the person can be maximally engaged (refer to question 15).

Q7. What are the best ways of assessing whether a person's capacity is impaired?

There are three potential approaches to the assessment of capacity that have been described in the literature. The 'diagnostic approach' is based on the idea that individuals with particular diagnoses or disabilities lack capacity on the basis of their diagnosis or disability alone. The 'outcome approach' is based on the idea that individuals can be classified as lacking capacity based on the wisdom or outcome of the decisions that they make. The current GAA is based on the third approach, the 'functional approach.' This approach involves assessing whether the person's abilities are sufficient for the demands of the particular situation at hand.

Neuropsychological assessment of decision-making capacity utilises the functional approach. The following section outlines the processes and components involved in a neuropsychological assessment of capacity.

Collection of background information: Within the demands of the functional approach there are several steps involved in gathering data about a person's decision-making capacity. Neuropsychologists take a detailed history from the person to gain an understanding of medical status, educational and occupational background, family relationships, cultural and lifestyle factors and personal beliefs and values. This information is supplemented by documentation available in medical or case notes as well as information obtained by interviewing family, carers and other professionals.

Structured interview: The neuropsychologist obtains information regarding the lifestyle, legal or financial decisions that the person is facing and then conducts an interview with the person about the decision under consideration. By using structured interview questions, the neuropsychologist assesses the person's understanding and reasoning abilities and their capacity to look ahead to evaluate the likely consequences of their decision. The person needs to demonstrate an understanding of the existence of alternative choices open to them, and show that they are aware of the risks associated with their own choice.

Some people may need to be informed of the existence of alternative choices or what may be some of the possible risks associated with each choice. Assessment of the person's decision-making capacity should be based on whether they are able to understand, evaluate, select, and reflect on the consequences of their choice in the context of the range of options available, after being given every opportunity to learn the relevant information.

Formal cognitive assessment: Neuropsychologists will also assess cognition using objective measures as a way of providing additional information about cognitive abilities

important for decision making, for example, comprehension, memory, problem-solving and reasoning. This assessment throws light on the cognitive processes observed during the interview and provides the neuropsychologist with a firmer foundation on which to base their opinion. Neuropsychological assessments can assist not only in determining capacity but also in finding ways to enhance decision-making capacity or to compensate for specific problems (refer to question 15).

Neuropsychologists can use nonverbal and culture-free tests for assessing memory and problem solving. They can also make allowance for both limited and high levels of education through choice of appropriate assessment tasks and appropriate normative data for interpreting performance on tasks. Thus, objective cognitive assessment can not only provide relevant information about decision-making capacity for individuals who are unable to perform well on the interview component of the assessment for reasons of language or culture but it can also detect cognitive impairment in well educated individuals who present well in conversation and interview.

Guardianship and administration orders are usually set for specific time frames and prescribe periods for review. In cases where there is recovery and improvement over time (e.g., some types of acquired brain injury), or where the person gains skills through rehabilitation (e.g., money management skills, daily living skills), neuropsychologists can provide objective information regarding change and recovery by reviewing the person at a later date. This information can assist with reviewing a guardianship order and determining when less restrictive options may be feasible, given improvements in a person's cognitive capacity or their ability to implement practical strategies to manage with less protective measures.

In summary, neuropsychologists adopt a functional approach based on gathering information, conducting structured interviews and objective assessment of a person's cognitive abilities. We believe that some individuals with a brain injury require this more formalised and comprehensive approach to establishing whether they have the capacity to make reasonable and informed decisions.

When is a neuropsychological assessment indicated? Potential 'signposts' for those individuals who require neuropsychological involvement when determining capacity may include the following:

- where a person's diagnosis is unclear or where their diagnosis cannot be established by other means
- in situations where the consequences of the decision to be made are likely to have direct negative consequences on the person's health and welfare - for example in cases where the person may be at risk of self harm or abuse
- when advice and practical strategies are required to engage and support a person in making decisions, either in a 'supported' or 'substitute' decision-making context
- when a person presents well in conversation or interview but informant reports indicate that cognitive function is not consistent with presentation, for example, the person is not adequately recalling conversations or information or they are agreeing to undertake actions that are not subsequently carried through.

Neuropsychological assessment can identify subtle cognitive difficulties that directly affect a person's capacity to make decisions. In particular, brain impairment affecting the frontal regions of the brain can directly impair a person's capacity to make decisions. The frontal lobe of the brain mediates a range of cognitive functions, including reasoning, judgment, problem solving, and insight. Neuropsychological opinion is frequently sought for individuals with brain pathology affecting frontal lobe function, such as alcohol-related brain impairment, dementia, traumatic brain injury or multiple sclerosis. In such cases, qualitative and objective

information obtained during assessment often reveals evidence of poor reasoning and problem solving plus poor insight into difficulties and the potential consequences of actions, as highlighted in Case Example 1 below.

Individuals with these conditions may appear to be capable of making decisions based on interview or basic cognitive screening assessments such as the Mini Mental State Examination (MMSE). They can often articulate 'how' to do a task or action on interview, but in real life they may not be able to initiate or carry through actions because of their brain impairment. For example, they may be able to describe in detail how they pay their bills, but in actual practice, they may not be paying their bills because they lack the requisite cognitive sub-skills such as planning, organisation, and initiation as well as insight. In these situations, the expertise of a neuropsychologist in diagnosing and managing brain impairments affecting frontal functions may be required.

The following three case examples illustrate how neuropsychological opinion can assist in evaluating a person's capacity and determining the ways in which a guardian or administrator can best assist the person. Case example 1 describes a physically well and previously high-functioning older man for whom formal testing confirmed moderate executive (frontal lobe) difficulties and a dementing condition that clearly affected his ability to make lifestyle and financial decisions. Case example 2 is a man with significant frontal lobe dysfunction following an assault, where neuropsychological opinion assisted in both identifying the need for a guardian and highlighting the ways in which the guardian could best communicate with him. Case 3 is a woman with a degenerative neurological condition and very complex psychosocial circumstances who lives in a nursing home. Despite some cognitive impairment she was deemed competent on multiple occasions to make decisions about her accommodation, and it was recommended by the neuropsychologist that the focus be shifted to solving practical issues relating to potential accommodation options. However, illustrating that decision-making capacity is specific to decisions about a specific issue at a specific time, her former home subsequently became the subject of legal dispute and neuropsychological opinion at that time was that she did not have capacity to instruct a solicitor in relation to this dispute.

CASE EXAMPLE 1

Kevin is a physically very well, retired, 72-year-old man. He was a tertiary-trained aeronautical engineer and production manager for a large manufacturing company. He divorced about 10 years ago and has subsequently lived alone.

Referral was made to a geriatrician due to family concerns about poor financial decisions that led to the loss of Kevin's house and life savings. Following a 5-year history of losing $300,000-$400,000 on recurrent internet scams, he had $5 left in the bank and his only income was the aged care pension. After eviction from private rental accommodation 18 months ago for failing to pay rent, he slept in the back room of a friend's business premises until his daughter obtained Ministry of Housing accommodation. He was not reliably eating meals provided by his supportive children and progressively lost 20 kg over six months. His family also reported that he was somewhat more argumentative and rigid in his beliefs and preferences. The geriatrician found no impairment, with a Mini Mental State Examination (MMSE) score of 27/30 and no relevant physical illness. There was no anxiety, depression, bipolar or psychotic signs. CT brain scan was normal.

Kevin was then referred to a Cognitive, Dementia and Memory Service (CDAMS) clinic for neuropsychological assessment. Intellectual assessment results, while within the 'average' range, were clearly below expectation for someone with his educational and work history. Memory appeared reasonably well preserved. However, a clear pattern of moderate executive dysfunction (i.e., difficulty with problem-solving, reasoning, planning and

organisational skills, generation of ideas, and self-monitoring) was evident across all tasks sensitive to executive loss. Consistent with executive dysfunction on formal testing, during interview Kevin showed no insight into his current situation and his family's concern about his welfare. Explaining the risks associated with his situation did not lead to any understanding of how his psychosocial wellbeing was being threatened. He was unable to demonstrate any comprehension that, if he were to retain control of his financial/legal affairs and lifestyle choices, he would continue to be at risk of more adverse outcomes.

Application was made for guardianship and administration. At the VCAT hearing, the neuropsychologist reported a diagnostic opinion of probable dementia of the frontal lobe type and an opinion that, due to moderate executive dysfunction and profound lack of insight, Kevin was cognitively not able to manage his lifestyle and financial decisions. Guardianship and administration orders were made with appointment of the family members. At a follow-up meeting with Kevin, his family, the geriatrician and the neuropsychologist, Kevin showed no development in his understanding of anything that had transpired.

CASE EXAMPLE 2

John is a 36-year-old man who sustained a traumatic brain injury in an assault. He has a history of schizophrenia and substance abuse. He is an inpatient in a sub-acute rehabilitation unit. Prior to his assault he was living with his mother, who has decided that John cannot live with her when he leaves hospital.

John participated in a neuropsychological assessment as part of his rehabilitation program. On interview he stated that he was managing well and that he would not need any help or supports on discharge from hospital. He described in detail how he would manage daily activities, including shopping, cooking and bill paying. Formal cognitive testing showed that John had significant deficits in memory and executive functions -his day-to-day memory was unreliable and he had problems with planning, organising, reasoning and problem-solving skills. The basis for his cognitive difficulties appeared to be multi-factorial given his history of schizophrenia, substance abuse and traumatic brain injury.

John subsequently asked to be discharged from hospital - he was vague about his plans and rejected referrals for support services such as meals-on-wheels or RDNS as he did not think he needed them. Given the uncertainty regarding his discharge destination and accommodation options, John spent a period of time in the rehabilitation unit's independent living flat with the support of his occupational therapist. The occupational therapist and neuropsychologist worked together to develop memory and organisational prompts to assist John to manage routine daily tasks.

Following several months of practice in the independent living unit, John was assessed as unsafe to live on his own without supports. He caused a small kitchen fire on one occasion and he could not monitor his food intake-he regularly consumed his week's allotment of food within a few days. He struggled with everyday financial transactions without help from others. He could not remember to take his medication even with external cues due to his daily disorientation. He continued to ask to be discharged from hospital even though he did not have anywhere to live.

Based on the objective information obtained via the neuropsychological and occupational therapy assessments and interventions, an application through the VCAT Guardianship list was made for an administrator and a guardian, which was subsequently granted. Without the support of a substitute decision maker, John would have self-discharged from hospital

without the necessary supports to ensure that he had adequate accommodation, regular medication and adequate nutrition. The neuropsychologist was able to provide advice to John's guardian regarding how to communicate and support John in light of his significant memory and frontal dysfunction, which included using simple written information, and structuring his options so he was not overwhelmed with too much information.

CASE EXAMPLE 3

Jean is a 72-year-old woman with a 43-year history of multiple sclerosis (MS) that is now in secondary progressive phase. She has a high level of physical care needs. Jean entered a nursing home 8 years ago following rapid MS decline and states that this move occurred against her will. She maintains a focused long-term goal of returning to community living and has enlisted a disability advocate to support her. She divorced 5 years ago, and her ex-husband died in 2008 in another nursing home. She has been estranged from their children since entering the nursing home. Enduring Power of Attorney (Financial) is held by an accountant.

In 2007, Jean was referred by the Office of the Public Advocate for neuropsychological assessment regarding her capacity to make decisions about accommodation. Two previous guardianship applications were dismissed/withdrawn following neuropsychological opinion that she was competent to make accommodation-related decisions. At interview in 2007, she demonstrated clear understanding of her condition and care needs. She also demonstrated understanding of her complex financial situation, which included a Family Court agreement regarding tenancy and rental proceeds from the family home that she half owns. Formal testing again indicated that she was cognitively competent to make informed decisions regarding accommodation. Due to concern about the protracted nature of the accommodation issue, including multiple neuropsychological assessments indicating retained capacity, the neuropsychologist detailed a list of practical questions requiring clarification regarding accommodation (e.g., where Jean would live, wait time for a care package, funding for hours needed to "top-up" the package). VCAT did not appoint a guardian, and Jean's disability advocate continued to work with her to facilitate return to community living. However, progress stalled due to lack of funding for "top-up" hours although a package was to be considered if such funding were available.

In 2009, Jean was referred by her enduring attorney for urgent neuropsychological opinion, regarding her capacity to instruct a solicitor in relation to contesting apportionment of the family home in settlement of her ex-husband's estate. Concern was expressed about her fragile emotional state and lack of insight regarding future lifestyle choices. Nursing home staff reported increased social isolation and occasional physical aggression. At interview Jean reported physical deterioration, and during assessment she also acknowledged decline in thinking abilities since the last assessment. She consistently expressed her view that she was entitled to 100% of the family home, although her ex-husband's 50% had been left to their children. She also presented her will in which she specified that no part of her estate would be bequeathed to her children. She clearly explained that if she owned the house, she planned to move back in because it had been modified for her care needs and she would be able to fund "top-up" hours. She appeared reasonably well informed about the property value and legal costs involved in the case, and her enduring attorney reported no unrealistic requests for funds. Performance on assessment tasks indicated decline in aspects of higher-level cognition, particularly ability to reason in an abstract way, so that thinking was 'concrete' and with extreme difficulty considering alternative points of view. Neuropsychological opinion was that, due to interaction between changes in higher-level cognition and her emotional distress related to chronic family conflict, Jean did not have adequate capacity to provide instructions in the impending litigation. It was recommended

that application be made to VCAT for consideration of an Administration Order limited to providing a substitute decision-maker for the legal proceedings. It was stressed that there was no incapacity in management of routine financial operations.

Q11. Is there a continuing need for substitute decision-making laws?

Neuropsychologists believe that there is a need for substitute decision-making laws for those individuals with a cognitive disability that impacts on their capacity to make competent decisions. We support the current legal framework of the Victorian GAA, which stipulates that application for guardianship is to be considered as a measure of last resort, where there are no other options available and all other less restrictive alternatives have been explored. People with a disability have the right to take risks and make bad decisions. However, those with a cognitive disability (resulting from dementia, acquired brain injury, etc.) directly affecting their capacity to make decisions have a right to be protected from making bad decisions that could have potentially life-threatening consequences or significantly restrict their quality of life and well-being.

The current Victorian GAA stipulates conditions under which guardianship should operate in practice: that the guardian encourage the person as much as possible to participate in the process, and that the guardian engages the person and their social supports to gain an understanding of the person's views, values and past history. Neuropsychologists support the continuation of these guidelines in any new legislative framework to ensure that the person's rights are protected in a 'substitute decision-making' context.

Q15. Is there a need for new laws that formally recognise supported decision-making? How should any supported decision-making laws operate?

While it is not within the professional expertise of the College of Clinical Neuropsychologists to offer comments regarding how new laws could incorporate supported decision-making, we would like to comment on the implementation of supported decision-making in any future changes to the legislation. We believe that supported decision-making should be based on a thorough understanding of how the person can be engaged and supported to make decisions. For many people with a disability, this process does not require the involvement of a neuropsychologist or other specialists. However, for those individuals with a cognitive disability that directly impacts on their decision-making skills, specialist expertise can identify the most effective strategies to support the person to make competent and informed decisions.

Information obtained through neuropsychological assessment can be used to determine how to support a person with a cognitive disability to make decisions. Neuropsychological opinion is often sought to identify a person's cognitive difficulties, strengths and capabilities. Through the process of assessment, neuropsychologists can determine how to work with a person with a cognitive disability to maximise their potential to engage in decision-making. For example, for someone with a memory disorder who requires information and advice to make a fully informed decision, a neuropsychologist may suggest a strategy of providing the person with clearly written information that is consistently reinforced over time.

Some individuals with a cognitive disability may have difficulties responding to certain types of questions, such as 'open-ended' questions where they have to generate ideas or options. Others may respond in the affirmative to questions put to them, without fully comprehending the possible consequences of their response. Thus, some individuals with a disability may be vulnerable to the potentially negative or harmful influence of others. In these situations, we believe neuropsychologists have a key role to play to ensure that the person with a

cognitive disability is not disadvantaged due to inadequate or inappropriate support mechanisms for decision-making.

Should the new law incorporate the construct of supported decision-making, it would be useful to identify when specialised assessment may be indicated to assist with the development of a plan for supported decision-making. In situations where family, service providers and others working closely with the person require advice about the person's capacity to engage in supported decision-making, neuropsychological and other specialist advice may be indicated to provide recommendations and guidance. This would safeguard those individuals with more significant or complex cognitive difficulties, where the process of engaging them in decision-making may not be clear cut or transparent given the nature of their cognitive disability.

FUTURE DIRECTIONS

The Victorian Section of the APS College of Clinical Neuropsychologists thanks the Victorian Law Reform Commission for the opportunity to comment on the review of Victoria's Guardianship and Administration Act, and we look forward to responding to any proposed draft amendments or guidelines put forward through the course of the review. We would appreciate the opportunity to be involved in any future forums and consultation processes involving proposed changes to the Guardianship and Administration Act.

Psychologists uphold the principles of promoting and protecting the rights of persons with a disability. Neuropsychologists, along with others, assist people with a cognitive disability to participate in the process of making decisions. We feel that it is vital that any changes made to the Act do not disadvantage those individuals with impaired capacity by removing the protective aspects of human rights while attempting to promote the rights of the person to self-determination and autonomy.