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Capacity assessment and estate planning - the therapeutic importance of the individual

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ABSTRACT

Demand for legal capacity assessments is increasing, especially assessments of financial capacity for estate planning purposes such as wills and enduring powers of attorney. This article proposes that such assessments will be improved by taking greater account of the client experience, including individual and relational factors and processes, and considering the practice framework.

A literature review was undertaken with a two-fold aim: firstly, to understand the fundamentally important perspective (inclusive of these experiences) of the evaluee; and, secondly, to identify potential improvements in the capacity assessment process with a view to informing best practice. No studies were identified that directly addressed the individual perspective in capacity assessments. Case studies and commentaries that indirectly discuss the individual perspective were therefore analysed to identify any potential issues and recommendations. This analysis showed that individual factors, such as the evaluee's functional and disease status, and relational factors, such as trust, should be considered by examiners. This review demonstrates that there is a significant gap in the literature examining the individual's perspective and experiences in capacity assessments, as well as, any impact this may have on the assessment process and outcomes. Further research into this vital perspective is needed so that the experiences of those undergoing assessments can help inform best practice and ensure that optimal processes are adopted when assessing the capacity necessary to make legally recognised decisions. This article examines the importance of the participant perspective and experiences in capacity assessments through the novel lens of therapeutic jurisprudence. It includes practice suggestions and provides the direction for this future research.

1. Introduction

People are living longer, yet it is often without the capacity necessary to make their own, legally recognised decisions. The growth in the aging population, and incidences of mentally disabling conditions, such as dementia, is creating an increasing need for legal capacity assessments (Grant, 2017; Kim, 2007; Moye, Armesto, & Karel, 2005; Stasi, 2012). Such assessments can occur for a range of reasons and in varying circumstances. Estate planning presents one such situation. This term covers a wide range of legal decisions and transactions, such as executing wills and enduring documents, with each decision/transaction having its own standard of capacity (Hamliton & Cockburn, 2008; Moye et al., 2005; Purser & Rosenfeld, 2016; Stewart, Bartlett, & Rowan, 2005).

According to the World Health Organization, active aging should preserve the autonomy, independence and participation of adults (World Health Organization, 2002a). Even if specific capacities have failed, or are failing, the care and advice provided by health and legal professionals should accord with these principles. Much has been written about capacity assessment, including procedural guidelines (for useful examples of guidelines see, for example, American Bar Association Commission on Law and Aging & American Psychological Association, 2008; American Bar Association Commission of Law and Aging, American Psychological Association, and National College of Probate Judges (2006); American Bar Association Commission on Law and Aging & American Psychological Association, 2005; British Medical Association & the Law Society, 2015). Surprisingly, however, there appears to be scant literature on how to effectively engage people in the assessment of their own capacity and few of the practical guidelines make specific reference to this need. There seems to be even less empirical research on how, or even if, this occurs in practice and whether it affects the outcome, despite the suggestion that effectively engaging individuals in the assessment process has the potential to positively

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heighten both their experience and the assessment outcome (Marson, 2016; Peisah, 2005; Purser & Rosenfeld, 2014). Thus, it appears that the views of the people who are being assessed are generally being ignored or, at the very least, are not being taken into account in developing best practice.

There are several reasons why examining the lived experiences of people who have undergone capacity assessments is vital to inform the process of satisfactorily assessing capacity. This includes to enable effective engagement, which is fundamental for two main reasons. First, respect for individual autonomy and personal sovereignty requires that, if unable to make decisions for themselves, people should be given the opportunity to participate in decision-making processes which affect their person for as long as possible. This is further evidenced by the paradigmatic shift from substitute towards supported decision-making evidenced by the *Convention on the Rights of Persons with Disabilities* (United Nations, 2006). Second, individuals should be given the opportunity to engage in the assessment process. This is because participation in and engagement with the process can heighten an individual's capacity in order to meet the required legal standard given the particular decision being made. That is, once an individual is educated about and understands the assessment process, it stands to reason that he/she is ideally less likely to be confused by and/or fear the assessment, resulting in a better outcome.

Changes in health-system design also highlight the critical importance of understanding the perspectives of people who have experienced capacity assessments. It is increasingly common to call for integration of the 'consumer (or individual) perspective' because it: can yield novel information, including process improvements; helps to build trust in the process; and, addresses a growing public expectation for consultation (Brenner, 2003; Carlin, Silberfeld, Deber, & Lowy, 1996; Daveson et al., 2013; Facey et al., 2010). The 'consumer perspective' is different from 'consumer satisfaction' about the process because it is not merely reactive to nor solicited only at the end of a process (Facey et al., 2010). Rather, it is information that can be used in the effective development and design of best practice methodologies to help maximise the potentiality of a positive assessment experience and/or outcome. Given growing questions about the adequacy of current assessment practices and professional liability concerns (Purser, 2015), an approach that includes various stakeholder input, particularly that of participants, is crucial to developing authentic best practice (Purser, 2015).

This article aims to report findings from a literature review to identify what is known of individual perspectives and experiences in capacity determinations in the estate planning context. Prior to discussing this, however, a brief examination of legal and medical capacity, testamentary and financial capacity, and how capacity is assessed in this context will be undertaken. Some of the most relevant mentally disabling conditions will also be discussed, as will the perceptions of 'older' people and how these may impact the process. This is necessary given the aging population and rates of mentally disabling conditions in that cohort. The notions of autonomy, participation and trust are key in capacity assessment best practice. They are also foundational tenets of therapeutic jurisprudence. Therefore, therapeutic jurisprudence will then be applied as a novel lens through which to examine the potential significance of understanding participant experiences in best practice design. As will be suggested, the engagement of individuals in the assessment process is fundamental. To this end, some best practice suggestions will then be made for legal and health practitioners. First, however, a definitional note on what is meant by 'estate planning' in this article.

2. Defining estate planning

The areas of law informing, either directly or indirectly, the capacity necessary to make legally recognised decisions in the estate planning context are complex and multidimensional. This is further complicated by the varied processes adopted to actually assess capacity – within and between both jurisdictions and disciplines, and the definitional dilemmas that exist in this area. With this in mind, estate planning is defined here as legal planning for the future, including for death and incapacity. It focuses on wealth retention, growth, protection and transmission. Estate planning most commonly utilises wills, enduring powers of attorney (EPAs) and advance health directives (AHDs). Although, many varied legal structures can and are utilised in estate planning such as trusts (commonly although not exclusively discretionary in nature), self-managed superannuation funds, corporate structuring, as well as contractual and property transactions. It is acknowledged that naming conventions vary internationally and in some jurisdictions there is a separation of estate planning as purely focusing on testamentary instruments, with EPAs and AHDs falling within a category of 'advance planning'. We have adopted a definition of estate planning here including both inter vivos and testamentary documents.

3. Legal or medical capacity

Capacity is an incredibly complex construct, and is both time and decision specific. A distinction between capacity as a medical construct and competency as a legal notion was previously favoured. It is now acknowledged, however, that such an attempted theoretical distinction is unlikely to gain traction, especially amongst legal and health professionals in practice (Purser & Rosenfeld, 2014; Sousa, Simoes, Firmino, & Peisah, 2014). Therefore, in the interests of definitional clarity the terms legal competency/capacity and/or medical/clinical competency or capacity will be used where appropriate in this paper.

Legal capacity is concerned with an individual's ability to undertake and complete a specific task and/or to make a particular decision which is recognised at law (Gibbons v Wright, 1954; Moye, Butz, Marson, & Wood, 2007; Fitten & Waite, 1990). Accordingly, the standard of legal capacity required varies depending upon the particular decision in question, for example executing a will or an EPA. This also includes consideration of the complexity of the decision being made; for instance, the capacity required to execute a straightforward will differs to that necessary to execute one containing a discretionary trust which disposes of a number of different assets to different beneficiaries (Szozda v Szozda, 2010). The standard can also vary depending upon the legal jurisdiction in which the requisite capacity is being assessed (Berg, Appelbaum, & Grisso, 1996; Gibbons v Wright, 1954; O'Neill & Peisah, 2011).

To be capable at law an individual needs to be able to understand the nature and consequences of the specific decision and/or transaction in the particular circumstances, after it has been explained to him or her, and to be able to communicate the decision once made. See, for example, Hoff v Atherton (2005) per Peter Gibson LJ and Gibbons v Wright (1954) per Dixon CJ, Kitto and Taylor JJ. This definition has been applied in, for example, Re Beaney deceased (1978) and In the estate of Park deceased [1954] p 89. Thus, there are two main aspects to legal capacity generally. First, consideration must be given to the individual who has presented for the assessment (the evaluee), including the effect of any specific mentally disabling conditions upon that individual. This then has to be evaluated in light of the second factor, which is the character and difficulty of the particular decision at the specific time it is being made after the relevant information has been explained to the individual (Frost, Lawson, & Jacoby, 2015; Masterman-Lister v Brutton, 2003).

Capacity is not global (Darzins, Molloy, & Strang, 2000). That is, the capacity to make one decision does not indicate capacity, or the lack thereof, to be able to make any other decision. To this end, it is important not to predetermine legal capacity (or clinical capacity) based upon previous decisions. For example, as the standards and legal tests differ, a person who is determined to be unable to make a legally binding decision about accepting, refusing or withdrawing medical treatment may be assessed as being capable to make a will or certain

financial decisions (Grisso, 2003, p. 9). However, in certain extreme situations, such as an individual being in a coma, global assumptions are valid. Capacity assessments can occur either contemporaneously or retrospectively (O'Neill & Peisah, 2011).

Accordingly, legal capacity is, and has to be, an extremely adaptable construct. However, the necessary flexibility has resulted in definitional perplexity over what can, and should, constitute capacity, and what standard is required to be deemed to have the requisite legal capacity in any given circumstance. This is compounded by the intersection between different disciplines, particularly the legal and health professions, who are becoming increasingly involved in assessing capacity (see for example Purser & Rosenfeld, 2014). Absent clear definitions setting a strong foundation, implementing best practice processes may continue to prove elusive.

4. Capacity in estate planning

Most common in the estate planning toolkit are wills and enduring documents highlighting, in particular, testamentary and financial capacity.

4.1. Testamentary capacity

To have testamentary capacity, a testator must be able to understand the nature and extent of her or his property, any potential beneficiaries who have a moral claim upon her or his estate, the effect of making a testamentary disposition, and have no 'disorder of the mind' which has affected the dispositions in the will (Banks v Goodfellow, 1870). Little research exists mapping the requirements for testamentary capacity against specific mentally disabling conditions, particularly dementia, and how this can affect the examinee's experience of the assessment process (Lonie & Purser, 2017).

4.2. Financial capacity

Financial capacity is a person's capability to administer her or his own property, including finances, in keeping with that individual's own interests, morals, beliefs, and general approach to life (Marson, 2013). It underpins many estate planning mechanisms, such as wills, enduring powers of attorney, trusts, superannuation, corporate structuring and property transactions. Although a will requires testamentary capacity, it also needs financial capacity as understanding the nature and extent of the estate assets is a requirement to establish testamentary capacity.

Eight domains of financial capacity have been identified including monetary skills, financial knowledge, cash transactions, managing a cheque book and bank statement, exercising financial judgment, paying bills, and knowing the extent of personal assets and the content of one's estate (Marson & Zebley, 2001). Decisions can range from simple, such as the counting of one's money in his or her wallet, to complex financial decisions, such as investing in multimillion dollar property development deals. It utilises a multitude of cerebral networks, information, understanding, reasoning and judiciousness (Marson, 2016) requiring higher cognitive functioning (Marson, 2013). An individual's education and socio-economic level as well as her or his financial experience can all further effect an individual during the assessment process (Marson, 2013). Financial capacity is, therefore, fundamental to a setting in which individuals are living longer but often without the capacity necessary to make legally recognised financial decisions (Hebert & Marson, 2007; Pinsker, Pachana, Wilson, Tilse, & Byrne, 2010; Webber, Reeve, Kershaw, & Charlton, 2002). This is particularly relevant, for example, to the execution of EPAs.

From an individual's perspective, the loss of the capability to undertake simple arithmetic and the associated effects upon the management of finances is an early marker of diminishing financial capacity (Marson, 2013). It can have a severe impact on the individual – not only from the viewpoint of losing the ability to manage her or his own affairs but also when confronted with the knowledge that this is happening. Further, questions may arise as to potential repercussions of this loss of capacity upon individual autonomy.

In an attempt to achieve a balance between autonomy and protection, schemes exist internationally which enable a substitute decision-maker to make financial decisions (EPAs) for an individual upon the loss of the requisite legal capacity. For example, there is a lasting power of attorney in England, and Scotland has a continuing power of attorney (CPA). Substitute decision-making mechanisms also exist in Canada, the United States of America and Ireland (Purser, Cockburn, Cross, & Jacmon, 2018). Terminology, authorising and monitoring provisions including legislation, guiding principles, and enforcement can differ between domestic and international jurisdictions. So too do the tests for establishing capacity. For example, in Queensland, Australia the capacity necessary to validly execute an EPA is set out in s 41 of the *Powers of Attorney Act 1998* (Qld), whereas in New South Wales, Australia the test is contained in the common law (In re K, 1988; Ranclaud v Cabban, 1988).

The specifics of the jurisdictional requirements, and differences, for EPAs are beyond the purview of this paper except to note that the capacity to execute each document can vary. For example, generally, the capacity to make a will differs from that required to make an enduring power of attorney or advance health directive, which differs from the capacity required to enter into a property transaction, contractual arrangement, or even give instructions to a solicitor (Frost et al., 2015). Depending on the complexity of the will being made, the test for testamentary capacity is generally lower than that required in relation to enduring powers of attorney. This is because people are often more familiar with the concept of a will and the effect of the document (see, for example, Banks v Goodfellow, 1870; In re K, 1988; Ranclaud v Cabban, 1988; Purser & Rosenfeld, 2014).

It is also important to note that the capacity necessary to enter into both the initial transaction but also to make decisions going forward may be in question. Further, consideration needs to be given to an individual's capacity at the outset to even give instructions, let alone make subsequent decisions. There may be significant consequences for not only the individuals, but also their families and carers, legal and health professionals, as well as other relevant stakeholders, including professional liability concerns, if an incorrect determination as to an individual's capacity is made.

4.3. Capacity to make health decisions

Estate planning can also include preparing for a loss of capacity to make health decisions (AHDs). This is particularly relevant when considering the rates at which populations are aging, the average lifespan, but also the increasing incidents of mentally disabling conditions. That is, although people are living longer, it may not necessarily be with the capacity required to make legally recognised decisions. Similarly to EPAs, schemes exist internationally facilitating AHDs. This can include the appointment of a substitute decision-maker for health matters but also an indication of the principal's wishes with respect to those matters. Given the time and context specific nature of capacity, the standard required again differs from the capacity required to make both a will and financial decisions. For example, the test for capacity to make an advance health directive in Queensland, Australia, is set out in the *Powers of Attorney Act 1998* (Qld) s 42. As stated above, the jurisdictional particulars for AHDs are beyond the scope of this paper except to note the varying standards of capacity required to execute each document, again highlighting the importance of the assessment process.

5. Assessing capacity

The assessment of capacity highlights the intersection of law and health as satisfactory capacity assessments necessarily need to examine issues of clinical capacity within the relevant legal framework.

Ultimately, it is for a court to determine whether an individual has the requisite capacity necessary to be able to make a specific legally-recognised decision. In practice, however, it is often legal and health practitioners who are assessing capacity or making recommendations about it for a court to consider. It has been suggested that these assessments are being undertaken on an ad hoc basis, often with little to no reference to best practice (Purser & Rosenfeld, 2014). Several guidelines exist internationally that could help remedy this situation, for example, those prepared by the American Psychological Association and the American Bar Association in the United States of America as well as those developed by the Law Society and the British Medical Association in the United Kingdom (American Bar Association Commission of Law and Aging, American Psychological Association, & National College of Probate Judges, 2006; American Bar Association Commission on Law and Aging & American Psychological Association, 2005; American Bar Association Commission on Law and Aging & American Psychological Association, 2008; British Medical Association & the Law Society, 2015). Nevertheless, it is unclear whether and how these guidelines are used in practice, including ongoing debate as to who should conduct the assessments, or when assessments should take place.

With respect to who should perform these assessments, debate exists over whether capacity assessments should be conducted by a legal and/or health practitioner and at what point consultation between them is needed. Further, upon seeking an opinion from a health professional, should it be, for example, an 'expert' or a general practitioner, and in what context should each type of evidence should be sought (Purser, 2017). That is, there is no set assessment paradigm, or indeed assessor 'profile' in any given circumstance. Assessments are instead often conducted by individuals from different disciplines with differing skills and experience who may or may not make reference to one or more of the many sets of guidelines depending upon the jurisdiction in which the assessment takes place. There would seem to be merit in adopting a multi-disciplinary approach, if not for all then for some clients, as this could facilitate the delicate balance between individual autonomy and protection of the vulnerable.

It is clear that the client's knowledge and judgment are key factors for consideration in assessing capacity (Earnst et al., 2001; Pinsker et al., 2010). A further factor that can impact the assessment includes the nature and stage of an individual's mentally disabling condition. Additionally, whether the patient has support available; and how the assessment is performed, including whether it provides educational opportunities for the individual to inform him or herself about the process, could have a bearing on the outcome. It has also been proposed that these assessments should (but rarely do) take into consideration the impact that social, cultural and familial influences, as well as individual values and morals, can have on an assessment (Pinsker et al., 2010), as well as relational factors for the person, such as their opportunity to interact with others and the trust established for the process (O'Connor, 2010).

A person's level of education may also have an effect on capacity (Dunn, Nowrangi, Palmer, Jeste, & Saks, 2006). This is particularly important to recognise if the assessor(s) relies on the Mini-Mental State Examination (MMSE) as being determinative of cognitive ability in specific legal situations (Shulman, Cohen, Kirsh, Hull, & Champine, 2007). Although a detailed discussion of the advantages and disadvantages of the MMSE is outside the scope of this paper, it is important to note that reliance on the MMSE as being determinative of capacity can be problematic. This is because it is an abstracted screening test: it does not measure subtle cognitive dysfunction nor does it provide a careful assessment of the higher order cognitive skills that may be particularly relevant to planning, such as executive dysfunction. Further, it is possible for highly educated people to pass the MMSE despite experiencing decline, and potentially to a degree that may be functionally evident (Lonie & Purser, 2017).

It is vital to recognise and comprehend the significance of individual experiences of capacity assessments in developing best practice design. This is because factors such as the density of the information, as well as the manner in which it is conveyed can have a direct effect on capacity and are likely to have an effect on the outcome. It is the *explanation* and *understanding* of the information that is examined when determining if a person has capacity and this can be far more difficult than merely *telling* someone something and determining if they can repeat it back (Frost et al., 2015). The effective execution of the process also requires consideration of relational elements (O'Connor, 2010), including the power dynamics of the relationship. Understanding all of the elements that can influence the assessment process, and seeking to adopt a client-centred approach, could therefore improve the process. This is because the heightened understanding may spur better assessment practices; for example, by influencing the procedural aspects such as assessment duration and selection of tools or addressing relational factors, which, in turn, could improve the validity of the outcomes.

6. Mentally disabling conditions

Essential in satisfactorily assessing capacity is an understanding of the nature and stage of the mentally disabling condition. However, problems can occur because of the difficulty in identifying the effects of a particular mentally disabling condition within the relevant legal framework. It is therefore important to understand not only the type of cognitive impairment, but also the stage and effect in light of the specific decision to be made, and if/how this impacts individual experiences of assessments.

Mentally disabling conditions can be classified generally as developmental or intellectual disability, acquired brain injury, alcohol and drug-related diseases, mental illness, and cognitive illnesses such as dementia (Carney & Keyzer, 2007, p. 255). The indicators of a mentally disabling condition can include acute or manic depression, withdrawal, reduced motivation, confusion, anxiety, inability to make decisions or pay attention, poor short or long term memory retention, or delirium (O'Neill & Peisah, 2011, p. 3). Untreated depression in particular can have negative consequences on cognitive and functional abilities which can result in a potentially inaccurate assessment of capacity if the assessor(s) is not aware of its existence and effect (Okonkwo et al., 2008, p. 656). Importantly, however, a particular diagnosis does not automatically result in the loss of capacity, especially given that capacity is time and decision specific, and may be increased with an appropriate treatment plan (Darzins et al., 2000, p. 4). The effects of medications and any comorbidities also have to be considered in any assessment process (Frost et al., 2015, p. 8).

Dementia is one of the most common presentations in which the question of capacity may arise. However, consideration must be given to its type and stage, and the functional impact of the disease (Peisah & Brodaty, 1994, p. 382; Liptzin, Peisah, Shulman, & Finkel, 2010, p. 950). This is because the term 'dementia' may be used as shorthand for disparate neurological disorders, the most well-known being Alzheimer's disease (Kawas, 2003, p. 1056). While capacity may exist in the early to mid-stages of disease when cognitive functions are just beginning to decline, people with advanced dementia will not experience lucid intervals – a legal term through which capacity can be determined to exist to make a specific legally recognised decision or document, for example, a will (Timbury v Coffee, 1941).

Indeed if any mentally disabling condition is present, this may affect the assessment process *and* the person's experience of that process. If, as we posit above, one of the best ways to promote a positive outcome for a capacity assessment is to take an educative approach, the practitioner must have a general understanding of how these conditions could affect capacity and the assessment, and if they are relevant for the particular individual. This is especially pertinent given the paradigm shift towards supported decision-making.

7. The older individual, capacity assessment and estate planning

It should also be noted that age alone is not an indicator of a lack of capacity. To presume that a certain age equates with a loss of capacity is to perpetrate ageism and infringes upon an older person's basic human rights. Definitional certainty determining at what age a person becomes 'older' remains elusive. Proposed definitions for what constitutes 'older' range from fifty-five years and over, up to sixty-five years and over (Australian Institute of Health and Welfare, 2017; United Nations, 2015; World Health Organization, 2004). Significantly, it should also be noted that the definition of 'older' for indigenous peoples can commence anywhere from fifty years of age and up (Australian Law Reform Commission, 2017, p. 34). We define 'older' as anyone sixty-five years of age and over for the purposes of this article.

Diminished and lost capacity are not exclusively the domain of 'older' people. However, it must be recognised that as the population ages worldwide, associated issues with cognition mean that capacity is increasingly becoming a concern, especially for those in the 'old, old' category – defined to be approximately eighty-five years of age and over (Australian Law Reform Commission, 2016, p. 22). This is because the risk of conditions which affect cognition, such as the dementias, increases with age and are often expressed with regard to specific age cohorts. That is, in the 'old, old' age bracket, some cognitive loss is inevitable, it is the rate at which the loss occurs that differs.

When discussing capacity and older people, the problem of elder abuse cannot be ignored. This is because as people age they can become increasingly dependent on other individuals to meet their daily functional needs. This increasing dependency can open up opportunities for exploitation, including via the withholding of care or support, or by financial exchanges. To this end, the World Health Organization defines elder abuse as: 'a single, or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person' (World Health Organization, 2002b). It can be financial, physical, psychological or emotional, sexual, social, and/or chemical (Australian Law Reform Commission, 2017, para. 2.45). Issues of elder abuse arise, both overtly and covertly, in the estate planning context and, consequently, considering what constitutes 'elder abuse' becomes a constituent part in the planning process (Australian Law Reform Commission, 2016, p. 17). This is especially the case as awareness of elder abuse grows and people are becoming more cognizant of the roles that diminished or lost capacity and/or vulnerability can play in the perpetration of abuse against individuals, especially as they age. Definitional issues have resulted in a limited evidence base with respect to elder abuse. This affects not only the ability to effectively assess the prevalence of abuse, but also the ways in which the law can better engage with individuals who are developing (estate) plans for aging (Australian Law Reform Commission, 2017, pp. 4, 37 & 93).

It is through estate planning mechanisms, particularly enduring documents, that people may, ideally, be able to act to prevent abuse. Enduring documents can, however, also provide vehicles for abuse and thus satisfactorily assessing capacity is fundamental to helping address abuse in this context. Key to this is understanding the experiences of all age cohorts of the assessment process, but in also recognising the specific needs of certain groups, such as older people, and effectively engaging with them. This might include encouraging early planning when issues of dependency are less likely to impact on the assessment process or outcome, or if this cannot be avoided, for professionals to consider if vested interests may be affecting the process or their recommendation.

8. Participant experiences and therapeutic jurisprudence – a novel lens

Adopting a novel lens or framework through which to evaluate individual perceptions of capacity assessments may help facilitate best practice to achieve accurate and transparent assessment processes. Therapeutic jurisprudence offers such a lens. Briefly, the doctrine analyses the therapeutic or anti-therapeutic effect(s) of the intersection of society, and the people comprising that society, with 'the law'. 'The law' here includes substantive and evidential rules, legal doctrines, procedures, as well as legal 'actors' such as lawyers and members of the judiciary (Finkelman & Grisso, 1996, p. 588). A concrete definition for the term 'therapeutic jurisprudence' or even 'therapeutic' in this context is, however, elusive and is one of the major criticisms of the doctrine (Winick, 1997; Freckelton, 2007, p. 576). However, as noted by Wexler (1995, p. 221), given the role of therapeutic jurisprudence as a 'mere lens' through which to better perceive and understand the law and its impact, a clearly demarcated definition could hinder exploration of new ideas arising from its novel application. The ambiguous nature of the doctrine is actually part of its appeal – as it is ultimately concerned with whether the law and legal actors have either therapeutic or anti-therapeutic outcomes, and determining how to transform roles, rules and procedures to maximise the therapeutic consequences (Wexler, 1995, p. 231; Winick, 1997, p. 185; Slobogin, 1995, 194). Thus, therapeutic jurisprudence promotes the idea of individuals participating in legal processes because it is through exercising the ability to participate that individuals will be far more likely to receive a positive benefit. Consequently, being able to understand the experiences and perceptions of individuals who have participated in capacity assessments should ensure a positive effect for those individuals, but also facilitate procedural improvements for people undergoing assessments in the future.

Whilst therapeutic jurisprudence was initially mental health law centric in the American context, it has been extrapolated to new areas, in different jurisdictions, including the estate planning context (Winick, 1997, p. 184; Champine, 2003, p. 177). In fact, testamentary and enduring documents can actually serve to help empower people to plan for a future in which they might not possess the ability to make their own, legally recognised decisions - demonstrating that the law can have a positive impact (Winick, 1996, pp. 54–55). It is fundamental to therapeutic jurisprudence to explore the effect of law and legal actors on the individuals who come into contact with it, making it an innovative framework in which to critically evaluate the accuracy, transparency and overall adequacy of capacity assessments, especially from the perspective of the person who is being assessed (Winick, 1996, p. 58).

The doctrine's focus on the concepts of participation, dignity and trust further earmark it as an appropriate framework through which to re-examine the assessment of capacity (Kapp, 2003, p. 142). Each of these concepts highlight the importance of understanding the assessment process from the individual's perspective. It is fundamental that the individual be given the opportunity to *genuinely* participate in any assessment as to do otherwise would be anti-therapeutic by infringing upon that person's autonomy and human rights. Actively participating, where possible through, for example, being educated and fully informed about the process in which they are participating, can help increase a person's chances of a favourable outcome as feelings of stress and anxiety may be lessened, which could in turn support therapeutic effects, such as greater openness in the transaction. Respect for the dignity of an individual is one of the foundational tenets of therapeutic jurisprudence and can be seen in, for instance, the movement from substitute to supported decision-making (United Nations, 2006; Perlin, 2013, p. 1173).

Trust is another key element in any best practice assessment, not least because there is a significant amount of faith being placed in both the process and the assessors by the person who is having his or her capacity assessed. The existence of a trust-based relationship can therefore assist in aiding a positive assessment outcome. However, what if the legal and health professionals involved in the assessment in effect betray that trust because they lack the expertise to satisfactorily assess the legal capacity in question? Traditionally, the relationship between individuals and health or legal professionals exemplified a relationship built on trust. This has, however, been eroded in modern society as

people have access to more information and, consequently, begin to both question and demand more from legal and health professionals in a more rights driven approach (Hall, 2002–2003, p. 469).

In the estate planning context, legal professionals are being trusted to prepare estate plans for when an individual has lost capacity and/or upon his or her death. This can often include establishing mechanisms to provide for that individual's family and dependants. If a person's capacity is questioned, he or she is then being asked to also trust that the legal (and health – where consulted) professionals conducting the assessment have the appropriate skill set to do so competently. Consequently, trust is fundamental to the relationship not only between the individual and the relevant professional, but also between the professionals conducting the assessments. This is highlighted by the fact that legal professionals are not trained to assess the impact of, for example, dementia upon testamentary capacity and, vice versa, health professionals are not trained to make a clinical determination with reference to the appropriate legal framework – thus each profession has to rely upon the expertise of the other in making a capacity determination. Therapeutic jurisprudence promotes a transdisciplinary approach which can be developed to maximise the trust the individual needs to feel in both the capacity assessment process and the assessor (s). Thus, the promotion of trust may have therapeutic benefits which should not be discounted, especially as a lack of trust may mean that individuals do not seek either legal or medical assistance (Hall, 2002–2003, p. 478). Adopting a therapeutic jurisprudence lens therefore offers the opportunity to acknowledge and respond to individual perceptions of the assessment process with a view towards developing best practice (Winick, 1998, p. 909), and it raises the potential for anti-therapeutic effects if, for example, trust is eroded, or interprofessional communication is insufficient.

9. Autonomy and therapeutic jurisprudence

Autonomy is one of the pre-eminent principles in therapeutic jurisprudence, being defined as the ability to self-determine and make one's own decisions within the area of personal control or sovereignty (Schopp, 1996, pp. 727–728). Capacity assessments in the estate planning context have the potentiality to confiscate an individual's ability to make her or his own, legally recognised decisions about major life events. This represents the dualism inherent in preserving individual autonomy and the need, where appropriate, to protect the vulnerable. This is especially evident with the growing awareness of the risks of elder abuse when individuals have either diminished or no capacity (Australian Law Reform Commission, 2017). The autonomy and protection dichotomy can be exacerbated by unsatisfactory assessment practices, especially when those methods are oblivious, and therefore unresponsive, to the experiences and perceptions of the individuals being assessed, and the effect this can have on the assessment outcome. For example, not recognising relational factors or client attributes (e.g., language and cultural preferences), and abilities (e.g., sensory or perceptual functioning or cognitive abilities, such as auditory verbal functions) can have a deleterious effect upon the assessment process and final determination. This can, in turn, infringe upon their autonomy and instead promote a (possibly) unnecessary protectionist response. One of the ways in which to promote autonomy, and an individual having a positive interaction with the law and legal actors as well as the health system, is through listening to and acting upon the experiences of those who have undergone capacity assessments.

Autonomy and the labelling of a person as incapable or incompetent, especially if done erroneously, are also closely connected concepts in therapeutic jurisprudence (Winick, 1996, p. 18). This is because labelling an individual as incompetent can remove their ability to make their own, legally recognised decisions and thus be a negative experience diminishing a person's autonomy and personal sovereignty (Winick, 1996, pp. 19–20). These negative effects can be both legal and social, potentially including: societal, legal and familial stigmatisation; loss of credibility, motivation, self-esteem, and the ability to make one's own decisions; and increased vulnerability, placing the person at risk of abuse (Winick, 1996, p. 20; Carney, 1995, 517). The removal of an individual's decision-making ability can result in her or him becoming subject to the power of a third party with the individual, correctly, perceiving decisions to now be beyond his or her control (Winick, 1996, p. 26). Another hazard of incompetency labelling is that by classifying a person as incompetent, it may cause her or him to act in such a manner thus inhibiting her or his capability to exercise autonomous decision-making independent of the label – in effect creating a self-fulfilling prophecy (Winick, 1996, p. 21). It must be noted, however, that such 'labels' can be both necessary and correct in certain circumstances (Winick, 1996, p. 24). For example, the labelling process can protect vulnerable individuals who do lack capacity. Such labels can also be a necessity at law, for example, for an enduring document to come into effect (Schopp, 1996, pp. 727–728; Winick, 1996, pp. 18–19). No matter how well intentioned, an assessment of capacity can be perceived by the individual in question as a personal attack – an affront to their dignity and independence (Winick, 1991, p. 17). Alternatively, such an assessment may sometimes be a relief, either to the person or to family members (Winick, 1991, p. 17). What is clear, is that one of the best ways to know how assessments are perceived is to engage in research about participant experiences and perceptions – research which is currently scarce.

The incorrect application of capacity assessment and labelling processes can threaten an individual's autonomy and right to self-determination as well as undermine trust in, and the validity of, the process. Legal professionals, often unaware of the intricacies of a specific mentally disabling condition, may incorrectly label an individual as lacking capacity. Health professionals may reinforce this with a lack of understanding about how the clinical assessment methods map to the requisite legal framework. What is clear, is that not listening to the individual who has gone through this process is potentially increasing any negative effects that may result from capacity assessments. Further, there is a risk of losing any positive outcomes which can then be harnessed and learned from to improve assessment best practice.

10. Individual perceptions in capacity assessments

As has been discussed, the assessment of capacity for estate planning purposes can have a significant impact not only individuals but also on: their potential beneficiaries, including family members, caregivers, and significant others; *and* the assessor(s) (Grant, 2017). The person may be surprised, upset or angry that a 'trusted' professional or independent advisor has suggested the assessment, which in turn can be challenging for professionals – both in conducting the assessment and also in preserving the relationship with the person (Levitt, 1998; Widera, Steenpass, Marson, & Sudore, 2011). The person may require or seek the practical and emotional support of others, including family members, friends and/or carers, before, during, and after the assessment (on relational frameworks for capacity assessment see, for example, O'Connor, 2010). This can give rise to the issues of, for example, undue influence and suspicious circumstances, which can call into question a document or decision's validity. The heightened emotions raised during an assessment can be further strained if the individual in question does not understand or accept either the need for the assessment or the outcome, thus potentially having a negative, or anti-therapeutic, affect. Therefore, particularly when adopting a therapeutic jurisprudence lens, there is value in ascertaining and understanding the views of those who have undergone the assessment process. Being aware of, learning from and responding to lived experiences can facilitate a more engaged assessment encounter thus not only positively heightening the experience of the person undergoing the assessment, but also potentially the assessment outcome.

To this end, a literature review was undertaken for research that addressed individual perspectives of capacity assessments in estate

planning, focusing particularly on wills, EPAs and AHDs. Relevant studies were determined to be those that referred to or implied issues relevant to this context. To increase the literature base, and to enable a comparative analysis, studies documenting the individual-perspective in related areas such as driving assessments were also considered.

Interestingly, this review of the international literature reveals that there have been no empirical, either quantitative or qualitative, studies undertaken about the individual perspective on capacity assessments for estate planning purposes. However, several case studies were found. These case studies were typically prepared by professionals for professional education about how to perform an assessment, distinct from revealing the individual perspective. Some studies were identified that referred to a 'person-centred' (Lichtenberg et al., 2016; Lichtenberg, Stoltman, Ficker, Iris, & Mast, 2014; Lichtenberg, Teresi, Ocepek-Weilkson, & Eimicke, 2017), 'client-centred' (Mitchell-Cichon, 2002) or 'collaborative' (Jeste et al., 2013; Purser & Rosenfeld, 2014) model for capacity assessment, however, apart from one study (Mitchell-Cichon, 2002) they did not directly address the topic of the individual's perspective.

Other reviews, commentaries, guides and documents were identified that raised potential issues, such as explanations of the process, critiques of measures including the need for instruments or processes that address the consumer's specific cultural, linguistic or other communication needs but, again, there was no evaluation of the impact of any of these measures on the individual's undergoing the assessments to assess their efficacy (Alzheimer's Australia, 2005; Alzheimer's Australia NSW, 2014; Kim, 2007; Moye et al., 2005; Pachet, Allan, & Esrskine, 2012; Sousa et al., 2014). A selection of these studies is shown in Annexure A which highlights the potential consumer issues and practice considerations.

A discussion paper on the prevention of financial abuse of people with dementia was located that included a comment on the assessment of capacity by solicitors which drew on data, including from a small number of consumers (Alzheimer's Australia NSW, 2014); and an analogous report on driving assessments that included the views of older people (Victorian Equal Opportunity and Human Rights Commission, 2012). Both of these documents demonstrate the added value that identifying individual perspectives bring that did not emerge from the other sources. For example, in the first instance, by indicating that consumer complaints can arise (Alzheimer's Australia NSW, 2014), and by extension, that accessible avenues for dealing with them are needed and should be provided to individuals, and; in the second instance, by revealing the potential for, or perceived potential for, age-based and other forms of discrimination in assessment (Victorian Equal Opportunity and Human Rights Commission, 2012), and by extension, the need to identify and manage such risks.

11. Legal and health practitioner responsibilities

Given the increasing incidence of mentally disabling conditions, it is becoming correspondingly difficult for individuals to be able to understand the nature and extent of their assets which can impact their capacity (Kerr v Badran, 2004, para. 49). This is particularly the case given the growing complexity of estate planning mechanisms being utilised as individual wealth across society increases. Accordingly, both legal and health practitioners, especially those who are involved in assessments of capacity, need to have an understanding of the individual, any mentally disabling conditions affecting the individual and how such a condition impacts the individual, as well as if, and how, this then impacts their legal capacity to make a particular decision at the requisite time. Understanding such matters may help to provide a more positive, or therapeutic, assessment approach in which cognitive, environmental and personal factors are optimised to provide the best opportunity for an accurate capacity finding.

In the absence of direct information and literature on individual perspectives of capacity assessments for estate planning purposes, potential issues have been inferred from available literature about the process and ways in which to optimise it for individuals. The identified issues are framed here as practice suggestions for health and legal practitioners as some of the ways in which the objectives of therapeutic jurisprudence may be served. The specific suggestions address both process and outcome. Whether individuals would agree that these are the key issues facing those undergoing capacity assessments cannot be determined absent the much needed empirical research identified here. Consequently, the suggestions proposed here are offered as a starting point for further consideration and development.

Some potential process issues include ensuring culturally sensitive assessment practices, considering the assessment environment, ensuring consumer education about the process, and carefully considering communication with other professionals or significant others. Some outcome considerations include ensuring that the advice is effectively communicated, and taking any additional steps that may be necessary to facilitate implementation (Frolik, 2009; Mitchell-Cichon, 2002). Even before the assessment process can begin, consideration needs to be given to the capacity necessary to be able to give instructions which, as with capacity generally, differs depending on the decision being made and the time at which the decision is being made. Evaluating an individual's ability to be able to give instructions is a part of the assessment process that is easy to overlook. Nevertheless, it is fundamental as to whether that person has the ability to give instructions, let alone to then make a specific decision.

Another practical issue that practitioners need to be increasingly aware of is the connection between diminished capacity and undue influence. These are distinct concepts, although they can be conflated by both legal and health professionals. However, they can exist simultaneously and accordingly, practitioners must be alive to either or both of these issues. Either can complicate the existence of the other and diminished capacity can serve as a heightened risk factor for undue influence (Falk & Hoffman, 2014, pp. 854–855). Loneliness, isolation, as well as emotional and physical dependence can also contribute to an increased vulnerability for individuals (Falk & Hoffman, 2014, p. 855). This is yet another reason for better understanding the individual perspective of the assessment process – it can better serve to correctly identify when there are issues of diminished capacity and/or undue influence, issues that could very likely increase as society ages, wealth increases and rates of elder abuse escalate.

In considering the role of legal and health professionals in the accurate assessment of capacity, it is accepted that best practice guidelines are necessary (Perlin, Champine, Dlugacz, & Connell, 2008). However, health professionals in particular potentially have a vital role to play. Individuals will tend to only go to a legal professional when perceived as unavoidable, or when something negative is occurring, for example the breakdown of a marriage or upon someone's death. Even estate planning will raise an individual's mortality and this in itself can cause discomfort for some people. However, individuals tend to see health professionals more frequently and not always for negative reasons. For instance, they may attend the general practitioner for annual check-ups. Even a sickness requiring antibiotics does not normally invoke the dread (or cost) associated with lawyers. Consequently, health professionals may be better placed to facilitate an understanding of what is happening in an individual's life. The problem often arises when that health professional is then called upon to either, in this context, participate in assessing capacity or to offer an opinion as to the existence of undue influence. From a therapeutic justice perspective, it seems that a lack of a multidisciplinary approach could mean that there is inadequate mapping of the clinical diagnoses to the legal requirements, especially when issues of capacity and undue influence are ultimately for a court to decide.

12. Conclusion

As the population worldwide ages, mentally disabling conditions

increase and a greater transfer of wealth is expected, the demand for capacity assessments in the estate planning context will grow. Consequently, the need to conduct accurate determinations is increasing, not least because of the fundamental connection between capacity and the dualistic notions of autonomy and protection. To accurately and satisfactorily assess when an individual has lost legal decision-making capacity is a challenging question facing a number of stakeholders such as: the legal and health professionals involved in the assessments; their insurers, especially if the legal and health professionals involved in the assessments 'get it wrong' given the increasing attention being paid to capacity assessments; policy makers and governments; financial institutions; and family members as well as carers. Not to mention, the individuals themselves who stand to lose the ability to be able to continue to make their own, legal recognised decisions, thus making them more vulnerable (perhaps increasingly so) to potential abuse and harm. The imperative then is to ensure, as much as possible, 'satisfactory' assessments.

Guidelines offer one, very good, way in which to establish general best practice grounded in a rigorous, consistent and transparent paradigmatic approach. If the ambition is indeed to have best practice guidelines then such a goal comes with the understanding that flexibility to respond to individual circumstances is an inherent element in any best practice design. This is a challenge transcending disciplinary demarcation. In addition to understanding the legal framework and the effect of a mentally disabling condition upon the legal requirements to be able to make a decision recognised at law, assessors must also take into consideration the effect of the specific mentally disabling condition on the *particular individual*.

There is a dearth of research examining capacity assessments from the perspective of the person who is assessed, and how their experience might affect the process and/or outcome. This is surprising - how are assessors able to test the efficacy of assessment methodologies if they are not actively engaging with those upon whom the methodologies are being used? To this end, a review of the literature was conducted to determine what is known of the individual perceptions in capacity assessment in the estate planning context. This review has several limitations. First, it is a non-systematic review and it may not have captured all of the relevant studies. A systematic review was considered premature because of the scarcity of studies in this area. Second, this review reaches conclusions that are largely drawn from professionals' perspective of the process and potential consumer need; therefore it may include errors and biases. It also draws together suggestions from beyond the estate planning literature and some suggestions may only weakly apply in this specific context.

Despite these limitations, it is clear that further consideration is needed of this important issue, which has up until now been neglected. This includes empirical research to guide the further development of best practice guidelines. The wider literature reveals that there are many potential benefits of integrating the individual perspective into estate planning capacity assessments, such as the potential to 'add value' to the service for individuals and practitioners by yielding new and otherwise difficult to obtain information, and building trust in the process from both sides, which in turn, could result in more people accessing better quality and more "therapeutic" services. Some specific issues and strategies have been identified that could be addressed or implemented now by practitioners such as: understanding the individual's physical, emotional and cognitive circumstances, including the existence and impact of any mentally disabling condition; what, if any, effects this has on the individual's capacity given the specific decision to be made; adopting culturally sensitive practices; considering the assessment environment and how to maximise it; ensuring education about the process for the individual who is having his or her capacity assessed; and facilitating effective communication, with the individual but also between assessors. Careful attention also must be given as to who is giving instructions and whether the person in question has the necessary capacity to do so. Given the close connection between diminished or lost capacity and undue influence, awareness also needs to be raised of risk factors which can increase vulnerability and exposure to abuse such as loneliness, isolation, as well as emotional and physical dependence. A multidisciplinary approach has been discussed as optimal, with a focus on the role of legal and health practitioners. These suggestions are intended as a starting point which warrant consideration, if not actual inclusion, in the development of best practice guidelines. Such guidelines should also be informed by, and responsive to, individual perspectives on the capacity assessment process. The assessment itself should be more satisfactory to *all* parties if it results in a process and outcome that is accurate, useful, and relevant (Pachet et al., 2012).

Understanding individual perceptions of assessments can therefore assist in not only determining whether an individual has legal capacity or not but can also aid their understanding of the process as much as possible. Stress, anxiety, fear, a lack of trust, confusion and miscommunication arising from a lack of understanding and education about the assessment process could also have a negative impact on the ultimate assessment outcome. Facilitating an individual's understanding of the process can therefore assist with providing the individual in question the best chance of being found to be capable if warranted, or recognising the need for support. Designing assessments to heighten participant understanding of, and comfort during, the assessment process can help optimise the outcome. Consequently, this will promote the ideal that where an individual comes into contact with the law and legal actors that the individual can place his or her trust in the 'system' and the interaction will not be anti-therapeutic to the extent of negatively impacting the assessment outcome. Consequently, there is an imperative to engage with individuals who are having their capacity assessed to better understand the process, and the issues arising from it, objectively but also subjectively from the perspective of the participants. The strategies offered above provide a way in which to improve upon assessments with a view to, ultimately, positively enhancing the interaction of individuals with the law.

Appendix A. Appendix

A.1. Selected studies (in alphabetical order by first author) highlighting findings and potential practice issues

Authors, date	Study type	Relevance /capacity	Consumer-focus	Issue	Possible consumer implication	Practice consideration
Alzheimer's Australia, 2005	Discussion paper	Indirect Estate planning and other	Consumer	Limiting contestability of decision Full disclosure by consumer	Protection may be higher if formal (not do-it-yourself) process, with full disclosure for appropriate scoping of assessment	Have the process requirements, and any pros and cons been discussed (including for any related processes)? Has full disclosure, including of health conditions, been encouraged/stated?

Alzheimer's Australia, NSW (2014)	Discussion paper, based on mixed method research including with carers and people with dementia	Direct Estate planning and other	Consumer and caregiver	Concern with insufficient rigour /appropriateness of capacity assessment	Assurance that assessing practitioners are adequately trained Confidence in the service Avenues for complaint	Does the assessor have the requisite knowledge/training/skills and how has this been communicated? Action framed to positively affect public/consumer confidence in (and engagement/access) services. Consumers should have, and should have identified for them, potential avenues for redress/ complaint – how has this occurred?
Cho, 2014	Commentary	Estate planning and other	Indirect	Transitioning relationship Framing of assessment Format of assessment	Recognise past connections with consumer and how they influence the present assessment "Work collaboratively" Framing of questions/allowing time for comprehension	If there is a prior relationship, is it affecting current practice/how is the prior relationship being managed? Does the practitioner hold, and have they articulated, a vision of working collaboratively for the assessment? How are consumer-questions framed, and has the practitioner made allowance for extra time for communication or in "complex" cases?
Frolik, 2009	Review	Indirect Estate-planning	Consumer	Format of meetings and communication	Brief, At home if necessary, Large-print font Office set-up[a] conducive to communication	Is the assessment environment (and materials) accessible for consumers and is the location and duration of the assessment appropriate?
Hamliton & Cockburn, 2008	Commentary	Indirect Estate planning and other	Consumer	Format of assessment Professional referral	Involvement of others	If an accompanying person is present, has the practitioner still offered and provided the opportunity for individual instruction? Is the practitioner able to refer to other professionals if the situation demands it, including to practitioners outside of their own profession?
Kim, 2007	Case study and commentary	Indirect Estate planning and other	Consumer	Cultural issues, including ageism Source of information	Language of assessment Self-assessment for unconscious bias	Are language barriers and cultural issues managed?[b]
Levitt, 1998	Review	Indirect Capacity, in general	Consumer	Format of communication Timing and location of assessment Professional referral	Large print, white space, readable (low jargon) At a time and in the environment that is most suited to the consumer Continuity of care	Are the written consumer-products of the assessment suitable and regularly reviewed (e.g., plain language, readability)? Has the scheduling of the assessment included consideration of the consumer's needs (including accessibility)? If the consumer is to be referred, are there potential effects on the consumer of the manner of referral?[c]
Mitchell-Cichon, 2002	Review	Indirect Estate-planning	Consumer	Format of communication Follow through	Basis of communication Implementation	If the assessment involves multiple practitioners *within* a service (e.g., in a clinic/interns), has this been managed?[d] Given that the assessment as part of a larger process has the advice been tailored accordingly?
Pachet et al., 2012	Case study and commentary	Indirect EPOA	Consumer	Communication needs	Communication during assessment	Have sensory and other communication needs been assessed and addressed?
Widera et al., 2011	Case study, with commentary	Indirect Financial capacity	Consumer and significant others	Financial cost Abuse risk (family perspective) and vulnerability (client perspective) Source of information	Cost of assessment Secondary parties may view the client as vulnerable or the consumer may feel vulnerable	Is the cost prohibitive? Have expectations been explored/ tested and clarified? Have secondary parties been informed of the process and their potential involvement, if appropriate?
Williams, 2010	Case study and commentary	Indirect Estate planning and other	Consumer	Defensive practice	Anticipating future dispute can minimise the risk for all parties, including the consumer	Has implementation been safeguarded through documentation of the process and/or by communication with secondary consumers/significant others, where necessary?

[a] Including that the interviewer does not sit in front of window because this can put their faces "in darkness"; but also that the room is accessible for older people who may be unwell or have mobility needs, or that acoustic issues have been managed (minimal background noise). Some references raised multiple issues, but each issue is listed only once in this table.

[b] Potential considerations: Are cultural issues relevant to the consumer's view of the presence of others in the process, or the practitioner's interpretation of that relationship? Has unconscious bias been assessed and addressed? If interpreters are involved, how is the process assured?

[c] Potential considerations: how trust can be maintained, how and with whom future communication will occur, or if there is a burden of further assessment?

[d] Potential considerations: how has the consumer been informed of, and consented to the arrangement, and how has rapport and trust in the handover been established for this circumstance?

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