AWI Training the Trainer Accompanying Guidance Notes

November 2023

Table of Contents

Section One. Introduction/Opening 3
Section Two. Outline of Briefing (Slide 2) 3
Section Three. AWI Principles (Slide 3) 3
Section Four. AWI – Myth Busting (Slide 4) 3
Section Five: Reason for a section 47 certificate (Slide 5) 4
Section Six. Grounds for S47 certificate (Slide 6) 4
Section Seven. Medical treatment (Slide 7) 5
Section 49 Medical treatment 5
Section 50 - Medical Treatment 5
Disagreement on Treatment 6
Section Eight. How the AWI Act Can Help (Slide 8) 6
Section Nine. Power of Attorney (Slide 9) 7
Section Ten. Power of Attorney (Slide 10) 7
Why you might need power of attorney: 8
Section Eleven. Use of 13Za (Slide 11) 8
Section Twelve. Guardianship (Slide 12) 9
Section Thirteen. Timescales for Orders (Slide 13) 10
Section Fourteen. (SDM) Supported Decision Making (Slide 14) 10
Section Fifteen. SDM Stages – Stage 1 (Slide 15) 11
Section Sixteen. SDM Stages – Stage 2 (Slide 16) 11
Section Seventeen. Case example of Ms A1. (Slide 17) 12
Section Eighteen. SDM Stages – Stage 3 (Slide 18) 12
Section Nineteen. Outcome form SDM pilot Project (Slide 19) 12
Last Slide. Thank you and Questions 13
Appendices 14
Appendix 1. Section 47 Certificate of Incapacity, and Flow Chart 14
Appendix 2. SDM Final Report. October 2023 14
Appendix 3. Six-week Report on the Pilot. May 2023 14
Appendix 4. Three-month Report on the Pilot. July 2023 14
Appendix 5. Guidance for Assessing Supported Decision Making. June 2023 14
Appendix 6. SDM Template. July 2023 14

Section One. Introduction/Opening

Section Two. Outline of Briefing (Slide 2)

The purpose of this training is to support health and social care staff gain a better understanding of the following areas of law and practice:

- The principles of AWI legislation - specifically the need to consider the five principles every time you intervene under AWI legislation
- S47 medical certificates and their specific use as it relates to treatment in hospital
- Power of attorney (POA)
- How guardianship works – applications and orders particularly in relation to hospital discharge.
- Supported Decision Making (SDM) and where this can be used.

Section Three. AWI Principles (Slide 3)

It is important to get across that the five principles are the core to anything that happens in AWI legislation. They must always be considered when looking at any intervention using the legislation including part 5 medical treatment, and any decisions made in respect of the persons welfare - where a clear view has been given about the persons lack capacity by a medical practitioner.

Section Four. AWI – Myth Busting (Slide 4)

https://youtu.be/Fe4sZhvUmSI

In the first part of this training, this myth busting video in terms of exploring how AWI is used around hospital discharge, should be played to support the group's introduction to some of the issues around using interventions under AWI and hospital discharge.

The video looks at the myths around hospital discharge and understanding of AWI legislation including:

- No such thing as AWI
- Incapacity is decision specific
- A diagnosis alone doe does not mean that someone lacks capacity to make decisions
- NOK does not automatically have a role under AWI
- AWI does not mention best interests

You might want to pause and consider with group involved with the training the impact of these myths, and if any of them believed any of these. You might wish to go a bit further and look at the differences between the ability to make decisions about treatment and decisions about wanting to return home after a period in hospital.

I would suggest if you did this there are no right or wrong answers but there are a few things to tease out:

- How consistent the person is being about the decision to be made. Do they hold a similar position regardless of who they are talking to?

- The ability of the person in understanding their current circumstances and how they might deal with any limitations when returning home
- Are they willing to accept some support to deal with the issues facing them?

Section Five: Reason for a section 47 certificate (Slide 5)

The Adults with Incapacity (Scotland) Act 2000 safeguards the welfare of adults over the age of 16 who lack capacity in making their own healthcare decisions. It is important for the health professionals to be aware of their responsibilities in relation to proxies such as those appointed under a power of attorney, guardianship or intervention order when making healthcare decisions for adults who are incapable. This will be relevant and important for administering any healthcare treatment such as COVID-19 vaccination.

General principles

The law generally presumes that capable adults are able to make their own decisions regarding the medical care they receive. Under the act, an adult is incapable if they are unable to:

- Make decisions.
- Act on decisions
- Communicate decisions
- Understand decisions
- Retain the memory of decisions

The reasons to grant a section 47 certificate are based on the general understanding provide by the legislation in relation to people s decision making ability. These are straightforward in the main.

You might though want to give an example of “act on decisions.” The ability to act on decisions is seen as central to being capable of making a decision. An example of where a person has lost this ability to reason would be as, often happens, where a person says they are going to leave the hospital but makes no effort whatsoever to do. They are unable to act on a decision they have made and carry out or act on the verbal statement they have made. If you feel it necessary, you may wish to tease this out with people.

The other areas which assess if some is incapable of making a decision are relatively straightforward. It is evident when someone is unable to retain the memory of decisions or where they are confused and cannot make any kind of decision. If you want to you could pause briefly over this slide and ask people for example of where they have worked with someone who has lost one or more of these thought processes.

Section Six. Grounds for S47 certificate (Slide 6)

It is important to set the context in which a S47 certificate is granted so this why we make mention of the five conditions required to deem the person lacks capacity and why a S47 certificate might be granted.

The act allows adults with capacity to appoint a welfare attorney to make decisions for them in case their condition deteriorates, and they lose capacity to make their own healthcare decisions. It also makes provisions for the appointment of a guardian if the patient has already lost, or never had, capacity to make their own healthcare decisions.

Part 5, Section 47 of the Act allows medical practitioners to authorise treatment to be given to safeguard or promote the physical or mental health of an adult who is unable to provide consent themselves. This can be carried out on the completion of a medical certificate of Incapacity. The certificate can only last for a maximum of 1 year (or 3 years if conditions/circumstances prescribed by Scottish ministers apply). The certificate issued by the doctor would need to state:

- The nature of the incapacity
- Form of medical treatment proposed.
- Duration (maximum 1 year, or 3 years if conditions/circumstances prescribed by Scottish ministers apply)
- Consultation with relevant others, nearest relatives, primary carers etc

It is very important to bring all the participants back to the 5 principles and repeat the mantra that they form the basis for deciding if someone lacks capacity or not and not the S47 certificate or a diagnosis by themselves.

An individual may have more than one certificate if they have either complex health needs, or need various treatments to which they are unable to make decisions on, dentist, optical treatment, medication etc. Each treatment should be assessed individually and in each case the principles of the Act applied.

You may wish to speak to staff about making a possible referral to advocacy services when looking to grant a section 47 certificate. It forms a clear part of the person rights and ensures that the treatment they are getting has been checked by an independent person.

Section Seven. Medical treatment (Slide 7)

Section 49 Medical treatment

Where there is an application for intervention or guardianship order the authority to provide medical treatment under a section 47 certificate does not apply where an application has been made to the sheriff for an intervention or guardianship order with powers that cover the medical treatment in question.

Until the application has been determined medical treatment under section 47 cannot be given unless it is authorised by any other enactment or rule of law for the preservation of the life of the adult or the prevention of serious deterioration in his medical condition.

Section 50 - Medical Treatment

where a guardian, attorney or person authorised under an intervention order has been appointed Where a guardian, attorney or person authorised under an intervention order has been appointed and has the appropriate powers to cover the proposed medical treatment then they should be consulted by the person who issued the section 47 certificate wherever this is reasonable and practicable. The authority in relation to the medical treatment in question does not apply unless this consultation has taken place.

Where there is no disagreement following this consultation, the medical practitioner primarily responsible for the treatment of the adult (where the person who issued the certificate was someone other than this practitioner) or any person having an interest in the welfare of the adult can appeal the decision to the Court of Session.

Disagreement on Treatment

If there is a disagreement between the medical practitioner and the proxy decision-maker such as the attorney, guardian, or intervener then the practitioner can consult with the Mental Welfare Commission and ask them for a second opinion as to the medical treatment proposed. The Mental Welfare Commission will provide a 'nominated practitioner', who they consider has professional knowledge or expertise relevant to medical treatment of the kind in question, to provide a further opinion on the medical treatment that is proposed.

The nominated practitioner will have regard to all the circumstances of the case and must consult the proxy, or a person nominated by the proxy, about it. If the nominated practitioner certifies that the medical treatment should be given, then the person who issued the section 47 certificate may do so, or authorise another person to do so, notwithstanding the disagreement with the proxy.

If the nominated practitioner certifies that the medical treatment should not be given, then the medical practitioner primarily responsible for the medical treatment of the adult, or any person with an interest in the personal welfare of the adult may apply to the Court of Session for a determination as to whether the proposed treatment should be given or not.

https://www.gov.scot/publications/adults-incapacity-scotland-act-2000-code-practice-third-edition-practitioners-authorised-carry-out-medical-treatment-research-under-part-5-act/

It not essential for you to share this level of detail with participants as long as they are aware that in these particular circumstances a S47 certificate may not apply. I would also refer participants to the S47 certificate flow chart diagram attached to these notes as appendix 1. It's a helpful guide to exploring the process of deciding on applying a S47 certificate.

Section Eight. How the AWI Act Can Help (Slide 8)

The Act provides the following ways for managing and safeguarding a person's welfare, financial affairs, or both:

Power of attorney – this is a means by which individuals, whilst they have capacity, can grant someone they trust powers to act as their continuing (financial) and/or welfare attorney in case capacity is lost at some future point. One or more persons can be appointed.

Access to Funds scheme – this is a way of accessing the adult's bank or building society account in order to meet his/her living costs. An application can be made to the Public Guardian by an individual or organisation. The person or organisation appointed is called a 'withdrawer'.

Guardianship order (welfare and/or financial) – may be applied for by one or more individuals acting together or local authority and granted by the sheriff. This is appropriate where the person requires someone to make specific decisions on his/her behalf over the long term. Financial guardianship may be appropriate where the person's finances are complex.

Intervention order (welfare and/or financial) – may be applied for by an individual or local authority and granted by the sheriff to carry out a one-off action or to deal with a specific issue on behalf of the adult.

Management of (care home/hospital) residents funds – A certificate of authority may be granted to a care home manager by the supervising body (local authority or health board) where

the resident lacks capacity to manage his/her own funds and there is no other arrangement is in place to manage these funds.

It is important to give participant's a brief overview of what AWI legislation can do and that all of the above are part of a package of measures that can be used to support someone who may be losing capacity.

Section Nine. Power of Attorney (Slide 9)

It is very important to stress with all participant's the significant benefits of supporting POA but the challenges there are in getting people to recognise this. As part of this discussion, you should ask the participants by a show of hands how many of them have a POA in place. It is likely to be a very low number. This supports the view that people struggle to plan into the future but the benefits of doing so are significant for them and their loved ones. One way of doing this is to consider the use of a POA. If for nothing else form a financial point of views most POAs cost in the region of £300 whereas a welfare a guardianship order is lengthy and can cost up to £6000 if legal aid is not granted.

It is also important to mention that a POA has a trigger mechanism before it is enacted or can be used. People will often say that a POA is in use but sometimes it has not been enacted so it is important to ask this and tell people about it when you are doing the training. POAs can be enacted in a variety of ways, and this is usually set up by the person in consultation with a lawyer who has drawn up the POA. It can be done by the lawyer, a loved one or friend. People sometimes ask that a doctor sees them, and they are deemed incapable by a medic before the POA is enacted. A POA is not legally competent unless it has been enacted.

A power of attorney is a legal document which allows you to plan for the future. It is drawn up when you have the capacity to do so.

It gives another person, known as the attorney, the authority to deal with aspects of your affairs. This could relate to financial/property matters and/or personal welfare.

Section Ten. Power of Attorney (Slide 10)

There are two types of Power of Attorney:

- Power of attorney relating to your financial/property affairs is known as a 'continuing power of attorney' and may be given with the intention of taking effect immediately and continuing on you becoming incapable. Or you can decide you only want it to begin if you become incapable
- Welfare power of attorney allows someone you have appointed to make welfare decisions for you, and these powers cannot be exercised until such time as you have lost the capacity to make these decisions

The power of attorney document must be certified by a solicitor or a medical practitioner. They must interview the person granting the power of attorney before they sign the document. This is to make sure they are aware of what they are doing and are not under undue influence.

Powers of attorney – those which are to continue or begin in the event of incapacity – cannot take effect until they have been registered with the Office of the Public Guardian.

You can decide you only want it to begin if you become incapable and can specify how you want your incapacity to be determined.

Why you might need power of attorney:

Without a power of attorney, nobody has an automatic right to make decisions on your behalf if you can no longer do so yourself. Someone might have to go to court for a guardianship or intervention order before they could act on your behalf.

You may wish to pause here and discuss with participants if they ask people routinely if they have a POA in place and what powers are associated it with. POA's need to be enacted. That means people have to agree what the trigger mechanism is for a POA to start working. It is usually but not always when the person loses capacity. Impress upon people the need to ask these questions about a POA and ask families to bring a copy into the ward or unit to be kept on the person's file.

Section Eleven. Use of 13Za (Slide 11)

Section 13ZA of the Social Work (Scotland) Act 1968 was inserted by the Adult Support and Protection (Scotland) Act 2007 to provide an alternative to a guardianship or intervention order where (in terms of section 13ZA (1)) a local authority determines under the 1968 Act that an adult's needs call for the provision of a community care service, and it appears to the local authority that the adult is incapable in relation to decisions about the service. In such situations the local authority may take any steps which they consider would help the adult to benefit from the service, and in terms of subsection (2) that expressly includes moving the adult to residential accommodation provided under the 1968 Act. Previously that outcome was achieved by way of guardianship or intervention orders. Sheriff Baird, in Glasgow, in *Muldoon, Applicant*, 2005 SLT (Sh. Ct.) 52, held that where an adult is compliant with a move into such a care regime, but legally incapable of consenting to or disagreeing with it, then to impose the regime deprives the adult of his or her liberty in breach of Article 5 of the European Convention on Human Rights.

It is useful as a trainer to be aware of the deprivation of liberty issued raised by using 13Za and you might wish to mention this in your briefing. However, it is important to focus on the practical uses of 13Za and outline that it is an option that can be considered when the person is in agreement with the care plan for discharge. The focus should be in sorting out the practical steps for people to process a meeting.

If someone considered 13 ZA may be useful then ensure:

- A meeting is organised with the person and the family present
- There is a medical view about the persons capacity
- An MHO is invented to the meeting.
- An advocacy worker is invited
- A minute is taken that records the outcome of the meeting and the reasons why 13Za was used or not

Section Twelve. Guardianship (Slide 12)

It is not important for participants to know all the details of an application for a guardianship order but to be familiar with how the process works and the impact this can have on their day to today work. With this in mind the presentation explores the following areas:

Two types of orders private and LA applications

Both are made to the sheriff court for a decision to grant the order. There are two types of order that can be applied a local authority application for a guardianship order.
This normally happens when here is no one else in terms of family or friends to support a person in making an application tot eh sheriff court. Then private applications are made by family or friends by employing a solicitor to support them and a solicitor is employed directly by the family to make this application.

- **LA applications require an AWI case conference**

If the decision is made to move forward with an AWI application by the local authority an AWI case conference is required to take place. At this case conference all relevant people should attend including family, friends, the person, advocacy, nursing and medical staff, MHO, and a lawyer from the LA. This is chaired by a local authority manager and focuses on the principles of AWI legislation to decide if welfare and/or financial powers are needed for the person. The manager will outline the powers required at the end of the meeting and send copies of the minutes to all those present.

- **Private applications do not require an AWICC**

A solicitor applied for legal aid for a family which is usually granted and pursues an application for powers to the sheriff court. The solicitor will prepare a writ outlining the powers requested and send it to the local authority along with two medical opinions and an MHO is allocated to carry out a report on the suitability of the family member as guardian within 30 days of the completion of the last medical report.

- **Welfare and Financial orders**

In general, most private applications ask for welfare and financial powers. Most of LA applications apply for welfare only. On occasion where a person has resources and there is no one else to support them the LA will make an application for financial powers. In general, though it is a conflict of interest for Las to apply for these powers and it does not happen often.

- **Interim orders**

If a situation is deemed to be urgent than a request for an interim guardianship order can be made. This is an application that is made to the sheriff court and is completed within 7 days of the request for an order. Because of the urgent nature of these request, they do not happen all that often.

- **Intervention orders**

These are orders that can be used on a one-off basis to support people with a single transaction for instance giving up a tenancy or a specific financial matter liking closing down a bank or post office account. They are useful in supporting people where legal documents need to be signed and the person has lost capacity.

Section Thirteen. Timescales for Orders (Slide 13)

In general, most orders can take up to four months from start to finish to complete. In respect of private applications, the family ned to get through the process of applying for legal aid and having this granted before proceeding with an application. In south Ayrshire we have put a process in place around hospital discharge cases of asking the social worker to check with families if the legal aid process is progressing. The social worker asks at 2, 4 and then at 6 weeks if the process is not progressing then the social worker asks if the family would be happy if the LA took over this process in an attempt to speed it up. If the family wish to continue in applying, then the law affords them this opportunity. If they agree, then the LA can take this on and complete the process somewhat quicker. It stills takes time because applications are at the mercy of the sheriff court. The process for agreeing for the LA to take this process over form family is through an AWICC.

The process for Private and LA applications can be slowed up at various stages and the Scottish Gov ask us to report on hospital delays as a result of the AWI process on a weekly basis. The categories that we are asked to report on are as follows:

Adults with Incapacity Act	9_51X
Awaiting solicitor (private application)	9_51XB
Awaiting completion of medical reports (private application)	9_51XF
Awaiting court date (private application)	9_51XH
Safe guarder appointed/additional reports requested (private application)	9_51XJ
Awaiting case conference (local authority application)	9_51X1
Awaiting solicitor (local authority application)	9_51X3
Awaiting allocation of Mental Health Officer (private application)	9_51XD
Awaiting completion of medical reports (local authority application)	9_51X6

The aim is to eliminate as many of these delays as is humanly possible and give the person a chance of being discharged from hospital as quickly as we can.

Section Fourteen. (SDM) Supported Decision Making (Slide 14)

Supported decision making is not a new concept and is something that professional staff have always done working alongside service users ensuring that it is front and centre of effective practice. It has however formed the spine of the recent Scott reports review of mental health law in Scotland. It is therefore central to the development of any new approaches to supporting services users in health and social work.

It would be helpful to talk a little about the importance of the Scott review in stating that supported decision making is the most effective way in the future of helping people with significant mental. health problems make advanced choices. There are five appendices attached to these notes which would be useful to read and give you an overview of the use of SDM before you do this briefing:

- Appendix 2- Final report SDM pilot.
- Appendix 3 – Six-week report on the pilot
- Appendix 4-three-month report on the pilot
- Appendix 5- Guidance for assessing supported decision-making June 2023
- Appendix 6-SDM template July 2023.

These documents will give you an overview of how the pilot worked, and what the outcomes where. A newly appointed social worker for SDM will be in post from December 2023 and it is important that there is a clear understanding among health staff about how SDM is used and can be used. The findings from the final report found that SDM as currently stands was most effective in working with people at stage 2. The three-stage process to SDM is outlined below:

Section Fifteen. SDM Stages – Stage 1 (Slide 15)

People often begin their service journey by requesting a blue badge as they get frailer or needing some minor adaptions to their home. In addition, they may request support from a home help or direct support service.

Often people will have full capacity at this stage and will not require direct support from statutory services. It is therefore important that social work services are able to gauge their requirements and get the correct information to them about what support they may need if they lose capacity, or it diminishes at a later stage. Information about advanced statements, power of attorney and making provision for their advanced choices should be made available to them. How this information is communicated to them is important and will assist them in making better choices if they have considered these advanced choices before they lose capacity.

The method for including stage one 1 as part of the project will be to widen out the pilot to the case load of the statutory MHO team and not simply relay on the new MHO in hospital discharge. What is meant by this is that those people currently on the SMHO team caseload who have been assessed as having full capacity have an SDM assessment completed by the MHO currently working with them from the team. In this way multiple SDM templates and assessments can be competed in a short period of time with a group of service users already working with us.

Again, some of the challenges with this will be to persuade people to complete the SDM assessment where they have very significant metal health problems, and many people will not want to engage in this process. However, that is the core challenge, and the Scott review principles are designed to work with this service user group. This would be the preference in terms of completing stage 1 assessments where it is required the person has capacity. The MHO in the hospital team will work with those individuals at stage 2 and 3 as outlined below:

Section Sixteen. SDM Stages – Stage 2 (Slide 16)

There is often a mixed picture for people where they may have some physical health issues and are able to continue to do certain things independently and they begin to have some capacity issues but can give a clear view still of their preferences for a whole range of things including medical and personal care. At this stage social workers should be involved to support the person in completing the SDM template which is attached to the updated AWI procedures for South Ayrshire health and social care partnership. This will assist greatly in allowing the persons view to be central to any decisions if later they become very frail and lose capacity.

It is likely that many of the people who present in this way will have had some contact with social work. It is likely that a number will have been referred to the social work hospital discharge team for assessment. It would be preferrable to have a qualified social worker complete this SDM assessment, but it is unlikely that this support will be available in the hospital. Therefore, it would fall to the new MHO to be involved in these assessments. It is envisaged that one SDM assessment every two weeks would be completed because of the limited resource available.

Section Seventeen. Case example of Ms A1. (Slide 17)

The case example of Ms A1 is used to demonstrate the sort of person who would be ideal for referral to the statutory MHO team for an SDM assessment. The essence is to try to capture people who are as near the start of the journey of their cognitive impairment as possible. It would be useful to pause and have a discussion with the group at this stage. The key things to promote are that you do not want people referred for SDM that have reached stage 3 and have completely lost capacity. Ms A1 is a practical example of someone who has started the journey towards a cognitive impairment but has not reached the stage to date where she needs intervention under AWI legislation. It is also important to stress that if someone already has a proxy in place like a POA then referral for an SDM assessment would not work as the POA will come into effect as cognitive decline happens. There are no right or wrong answers here which is why it is important to have a discussion around the case of Ms A1. The aim is for people to leave better informed about what a referral for SDM looks like.

Section Eighteen. SDM Stages – Stage 3 (Slide 18)

At times social work services do not become involved with people until they have lost a significant amount of capacity, and they struggle to make decisions about their current and future needs. This is the stage where AWI legislation is used to support decision making for people and allow them to get the correct help when they need it. SDM is challenging but not impossible at this stage. The hope is that as SDM grows people will have put the right mechanisms in place to support them so that staff are aware of their advance choices. However, if this is not the case it remains useful to complete SDM testing to ensure that any choices that can be made are still being made by the person and that the individual remains the focus of the process of AWI legislation requires to be used.

This would be a central part of the MHO's work as the will be involved in all meetings that consider 13za or an intervention under AWI. The MHO would be involved alongside liaison psychiatry colleagues in assessing the needs of people where there are capacity issues and deciding if with additional support the principles of the Scott review would allow them to move forward without the use of legislation. The MHO will be available to offer this advice at all meetings arranged as part of hospital discharge process and in discussion with her line manager decide which cases may benefit from a full SDM assessment. Several cases will be picked to be assessed in this way.

The pilot has demonstrated that our most effective work can be done at stage 2 of the process, and we can really make a difference with people who are at the early stage of losing capacity. Central to the briefing is the ned to stress with people an understanding of people at stage 2 and being able to refer them to the SDM project. People who are the beginning stages of losing capacity and would benefit from someone assisting them in making choices about their futures around POA or getting a clear set of practical decisions in place if they lose capacity.

Section Nineteen. Outcome form SDM pilot Project (Slide 19)

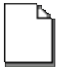
There were a series of outcomes from the pilot project which can be found in the executive summary of the final report. However, I have included the bed days saved as a result of the pilot project to give you an overview of the significance of using SDM with people at stage 2 of the process and the impact this can have.

As can be seen from the graph in slide 19 the average bed days saved using the SDM process were 94 per person. SDM was able to be successfully used with just under half the people referred to the pilot. It is evident that if we can get the training and support right to staff then it will have a significant impact on the hospital discharge process. The training for all hospital staff is key to promoting the use of this service. At present we have seen 20 people in a six-month period that were assessed using SDM which is not enough to say it is a resounding success but rather a positive start to understanding its use in this environment. More extensive work is needed to sustain its use in the hospital environment through developing a clear training and support plan.

Last Slide – Thank you and Questions

Appendices

Appendix 1. Section 47 Certificate of Incapacity, and Flow Chart

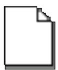


Section 47.
Certificate+of Incapac

Appendix 2. SDM Final Report. October 2023

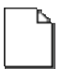
SDM Pilot. Final
Report

Appendix 3. Six-week Report on the Pilot. May 2023



SDM Pilot. Six-week
Review May 2023.pdf

Appendix 4. Three-month Report on the Pilot. July 2023



SDM Pilot
Three-month Review I

Appendix 5. Guidance for Assessing Supported Decision Making. June 2023

Guidance for
assessing SDM

Appendix 6. SDM Template. July 2023

SDM Template