Once-in-a-Lifetime Toolkit

One chance to get the end of life right.

2021

Disclaimer

Aboriginal and Torres Strait Islander people please be advised that this document refers to the sensitive issue of death and dying (Sorry business and Sad news).

Trigger warning: Please be advised, this document contains sensitive material around end of life topics and may cause emotional distress for some people.

If you or someone you know is struggling with their mental health or is having a negative reaction to the contents of this document please seek professional help and support.

If there is an immediate risk to life please call emergency services on 000.

Alternatively, for mental health assistance or crisis support please contact lifeline on 131 114.

Acknowledgment of Country

In the spirit of reconciliation, the authors acknowledge the Traditional Custodians of the land, sea, their connection to community and their unique ways of viewing the world. As students completing our social work degree we pay our respect to Elders past, present, emerging and those who were unable to reach elder status due to colonial rule. We extend that respect to all Aboriginal and Torres Strait Islander peoples today.

This toolkit has been developed on country of Lutruwita (Tasmania), under the beautiful mountain Kunanyi. In acknowledging the aboriginal history and culture of this land we honour the ceremonies and traditional practices within Sorry Business and Sad news.

Our toolkit strives to be inclusive. As such, we respectfully acknowledge that dying is not a unified experience. We wish to promote all ways of dying, appreciating the diverse range of ceremonies and grieving processes within different regions, communities and cultures.

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Purpose

This toolkit was developed for families and carers to gain the skills and resources to promote choice and control for people with intellectual disability in end of life. This is to empower people with intellectual disability to be actively engaged in making their own end of life decisions and be involved in other death related experiences throughout life.

Family members and carers are typically the best positioned people to have these conversations with people with intellectual disability. As someone who is constantly present, provide care, hold influence, and typically want what's best for their loved ones. Like with all difficult conversations, they should be had with someone they trust and are comfortable with. It is crucial to consider, are you the best person to be having these conversations with the person?

Dying is a natural part of life, and it is not talked about enough. All things relating to end of life should be a normal topic of conversation and not hidden away. Therefore, it should be talked about more often to normalise engaging with all aspects of the end of life process.

Conversations about end of life may be overwhelming because there are many things to consider. Preparing for the end of life before it happens provides everyone with the best opportunity to communicate their wants and desires before they die. Not having these conversations can result in the dying person's wishes not being honoured and families having to make difficult decisions for them.

This happens more often to people with intellectual disabilities as they are generally sheltered from end of life conversations. This can be due to the fear of upsetting someone with an intellectual disability or their perceived inability to cope with these conversations. Therefore, this toolkit has been developed to address these barriers.

Model

This model has been developed to improve the confidence and capability when engaging with end of life. The stages of this model are shown below.

1

Family and carers engaging with death and dying

What: Become comfortable talking about death and dying.
How: Through engaging with resources and getting creative about one's own end of life story.
Why: Before you can help others you need to understand it yourself.

2

Family and carers learning the best practice to carry out safe and effective conversations

What: Understand effective ways to have end of life conversations and communicate clearly.
How: Learning and practicing the communication skills provided within the toolkit.
Why: Understanding how communication can impact the outcome of a conversation is essential to having successful end of life conversations.

3

Family and carers facilitating conversations about end of life

What: Having end of life conversations with people with intellectual disability.
How: Using recommendations and additional resources in the toolkit to provide the best chance of having successful conversations.
Why: To increase involvement, choice and control for people with intellectual disability around end of life.

4

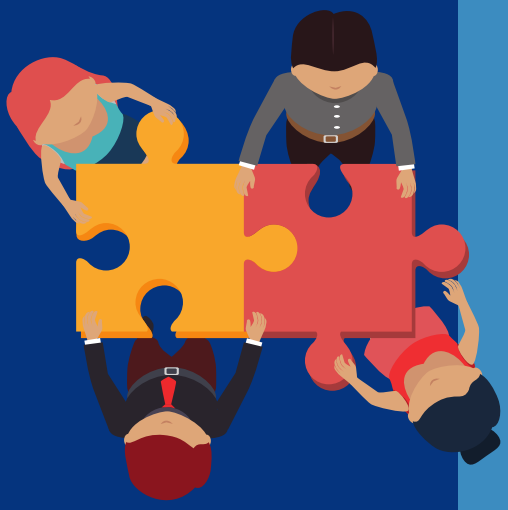
Family and carers being confident and capable in their ability to carry out conversations relating to end of life with people with intellectual disability.

The process may look different for everyone

The Process

BECOMING COMFORTABLE WITH DEATH AND DYING

01



LEARNING COMMUNICATION SKILLS

02

HAVING END OF LIFE CONVERSATIONS

03

Stage 1

01 BECOMING COMFORTABLE WITH DEATH AND DYING

1 Becoming comfortable with death and dying

Throughout life, decisions are made that are right for you based on what you want. This should be the same at end of life. Some people will never become comfortable with death and that's OK. However, as a family member or carer you might be the only person who can advocate for a person with intellectual disability. Before having conversations with others about death, it makes sense to understand your own feelings about end of life before supporting them with theirs.

Life is like a good story. You are the author and make decisions throughout life. Therefore, you should be in charge of how it ends.

- You should be able to write the ending to your own story not have someone else decide the ending to your book.
- The ending should be as amazing as the rest of the chapters beforehand.
- Get creative, there's diversity in death.

It is important to know that you can personalise your end of life. There are many choices you can make when you are well, such as:

- If you became unwell where would you like to spend your time?
- Who you want around you to support you?
- What personal comforts would you like?
- Who would feed your pet if you spent time in hospital?

On the following pages there are online resources to get you thinking about your own end of life preferences. There are additional resources specific to assisting with intellectual disability on page 24.

1 Becoming comfortable with death and dying

'It's recognising that death is a social event with a medical component, not a medical event with a social component.' - Allan Kellehear

Tip:
Click on tips and pictures to find out more

There has been a shift in how people approach end of life. This has started to change the thinking from a medical model to a social and community model.
A social and community model has a stronger focus on the social aspect of end of life. The goal is to bring people together to discuss and support one another through all aspects of end of life.

Death Over Dinner is an initiative to help families and friends address end of life conversations in a relaxed environment. This allows people to express their opinions and gain knowledge of what each other want at end of life. This ensures personal wishes are known and can be carried out when the time comes.

Tip:
Go watch the video and TED Talk provided on their website

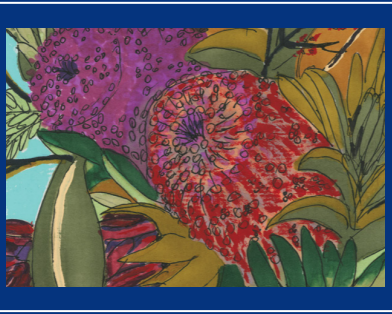
You can find more information on their website: https://deathoverdinner.org/

1 Becoming comfortable with death and dying

Tip:
Click on tips and pictures to find out more

Dying to Talk aims to reach into the community to normalise early conversations about the end of life. Rather than waiting until more time critical or medical focused discussions need to occur.

Dying to Talk Discussion Starter
Dying to talk offers an online discussion starter to help make conversations about end of life easier. The online module will take you through 5 stages these are; reflecting, talking, reviewing, follow up and extra reflection.



What Matters Most Discussion Starter
Helps people work out what would be right for them. If they were really sick or at the end of their life rather than waiting for a crisis to occur.

Aboriginal and Torres Strait Islander Discussion Starter
Dying to Talk have created a discussion starter more inclusive of Aboriginal and Torres Strait Islander people and culture.

Card Game
Dying to Talk provide an online card game to help people get comfortable with conversation around end of life. These Dying To Talk cards can be used to help someone talk about their wishes and preferences for their care at the end of life.

1 Becoming comfortable with death and dying

Tip:
Click on tips and pictures to find out more

The Groundswell Project works with individuals, organisations and communities to improve how people in Australia die, care and grieve.

THE BIG LIST

The Groundswell Project has put together a big list of death literacy, planning & conversation tools which can be accessed on their website https://www.thegroundswellproject.com/the-big-list

They also offer an end of life planning workshop called "Ten Things to Know Before You Go". This can give you the knowledge and confidence you need to plan for the end of life process.

Tip:
Below are two resources:
1. Final Checklist
2. Emotional Will

YOUR Final Checklist

Your Documents

- ❑ Have you written a will? Is it up to date?
- ❑ Have you nominated your power of attorney?
- ❑ Where are your important documents? Who has access to them? Have you recorded your passwords for all your online accounts and social media profiles?
- ❑ Who will be your enduring guardian? This is the person who can speak up for you about medical interventions if you can't.
- ❑ If you have children who will be their legal guardian?
- ❑ Have you told your loved ones what medical interventions you want and do not want and under what circumstances?
- ❑ Have you written your advance care directive?
- ❑ Have you written an Emotional Will?
- ❑ Have you registered your organ and tissue donation wishes and told your family?

Your Send-Off

- ❑ What type of funeral do you want?
- ❑ Do you want to be buried, cremated or something else entirely?
- ❑ Where do you want to be buried or have your ashes scattered or your tree planted?
- ❑ What do you want written on your headstone/plaque memorial?
- ❑ Who do you want to perform the eulogy?
- ❑ Do you want to write your own obituary?
- ❑ Do you want to donate to a charity in lieu of flowers or in lieu of anything else? Or do you want to do both?
- ❑ Have you looked into "Do It Yourself" funerals?

Your Loved Ones

- ❑ Have you discussed your end of life plans with family and friends?
- ❑ Would you prefer to die at home?
- ❑ Is there something comforting that you might want in the room with you as you are dying?
- ❑ What would you like to be said to you in your final days/moments? *(Many people want to be told that their affairs are in order and their dependants will be taken care of)*
- ❑ What do you hope for the people who are around you while you're dying?
- ❑ Who will receive special family items such as photos and treasured heirlooms?
- ❑ Who will take pets and animals under your care?

Everything Else

- ❑ _____
- ❑ _____
- ❑ _____
- ❑ _____
- ❑ _____

Dying To Know day
8th August

Let's change the conversation on Dying to Know Day, August 8th. Host an event, have a conversation with your family, community or workplace. Go to ***thegroundswellproject.com/dying-to-know-day*** *for more information.*

YOUR Emotional Will

What is an 'Emotional Will'?

An emotional will is about your legacy. It is a way to share your thoughts, values, lessons in life, passions, hopes and dreams with your children, friends and future generations. This is your chance to ensure that you don't leave this life with things left unsaid.

Because an emotional will is not a legal document you can be as creative as you'd like to be. You can "leave" memories, thoughts, well wishes, drawings, notebooks, photos, videos, sound recordings, it's really up to you how you do it.

We suggest you take time to complete an Emotional Will. It doesn't need to have a strict format or word limit and it is more likely to be a series of letters left for separate people than one large document. Give yourself time as you will likely revisit it and add things as time goes on.

Firstly you might start by thinking about the important people in your life. Is there a memory or a moment that encapsulates a relationship? is there something this relationship taught you? Are you grateful for an experience you shared? Write a letter directly to that person and place it in a separate envelope.

There are a number of ways to begin:

People

Firstly you might start by thinking about the important people in your life. Is there a memory or a moment that encapsulates a relationship? is there something this relationship taught you? Are you grateful for an experience you shared? Write a letter directly to that person and place it in a separate envelope.

Moments

What are key moments in your life where you have shown great courage, experienced great joy, intense sadness, overcome hardship, completed something you never thought possible or felt great happiness? These pivotal moments are often the signposts of our life, moments when life could have gone one way but it went another. An Emotional Will is an opportunity to share these memories with your loved ones. Often these moments are shared children, nieces and nephews.

Objects

Is there something in your will that you are gifting to a family member? This is another feature of the emotional will - you can share a memory or a story about the object, whether it's an heirloom or important for another reason, usually an object comes with memories and a legacy of its own. Describe this for the person you are gifting it to. Why did you chose this person to give it to? How did the object come to you? To the family? Are there important stories about your family "in" this object?

Memories

Often we have private memories or favourite stories about the people we love. These enduring memories often connect us throughout the years, even to old friends or to family members we only see occasionally. Share a story with an old friend about a cherished time you spent together. What did it mean to you to have them part of your life? You might feel the same about an old mentor or teacher. Write about and share these memories.

Food
The enjoyment and sharing of food is one of life's delights! Why not share your favourite recipe with a loved one. For example: "This is my favourite recipe that helped me through the tough times. It was Grandma's and she taught me how to cook it. I now pass this on to you and ask you to become the guardian of this much-treasured recipe", or "Here is a recipe that I used to make for a lazy Sunday. When you make it, think of me".

Songs/Books
The people who know you probably know what music you liked and books you enjoyed… but perhaps you may still surprise them? Why not put aside a copy of your top 10 books with a personal note written on the inside cover saying why you love this book? Or why not make a playlist of your favourite songs? One for driving? One for doing chores too?

Photos
Go through and label important photos with dates, places and the names of the people pictured. Note any memories or stories you wish to share. We often take for granted that our children or other family members will know the people and places in our photos, but perhaps they don't. Noting down ages is helpful too.

Where to keep your emotional will?

You could leave it with a folder of other important documents - such as your health insurance, funeral plans and digital/online passwords. There are many options now online for keeping documents with free storage, however many people want to keep hard copies. Our advice is to buy a small box or folder to store these important documents. Given the personal nature of the Emotional Will many people choose to give letters to people before they die.

Questions to get you started

- ❑ Who are the people you want to leave messages for in your emotional will?
- ❑ What is a message you'd like to leave for your partner/spouse/best friend/children?
- ❑ Describe a time in your life that you showed great courage
- ❑ Describe a time when you experienced joy
- ❑ Do you have any regrets? How have these shaped your life?
- ❑ What is your most memorable childhood experience?
- ❑ Who were your mentors and how did they help shape you?
- ❑ What were your parents like? How did this relationship shape you?
- ❑ What was your first paid job?
- ❑ What is your first memory?
- ❑ What was school like for you?
- ❑ Did you have a childhood sweetheart? Share a story about this.
- ❑ Describe a time of great sorrow or sadness. What impact did this have you on?
- ❑ What do you remember about your grandparents?
- ❑ Where is your most favourite place? Describe it as vividly as you can.

Dying To Know day
8th August

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1 Becoming comfortable with death and dying

Tip:
Click on tips and pictures to find out more

You n' Taboo

You n' Taboo promotes honest conversation, education and awareness around death. So that people can be well positioned to make informed decisions about death. They are committed to creating a space in the community for conversation and education to challenge negative social beliefs around death.

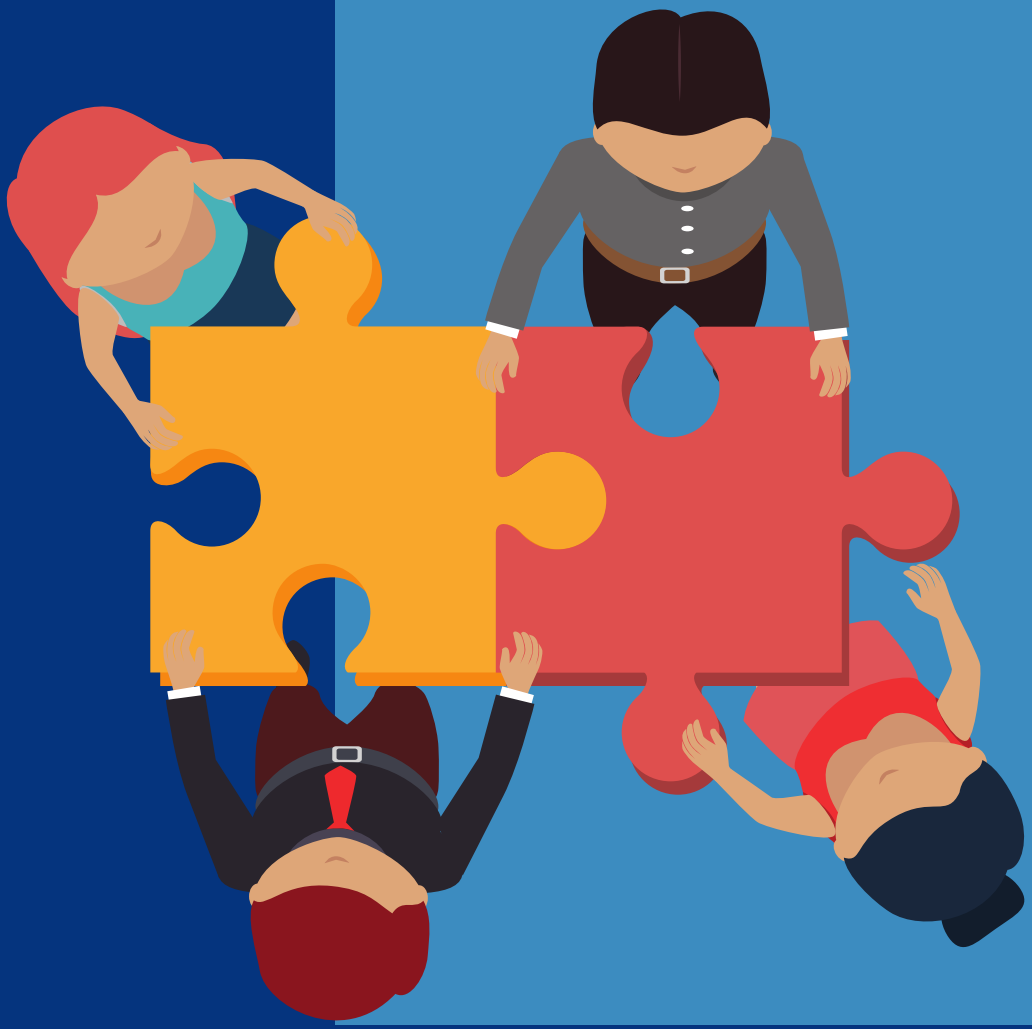
You n' Taboo Talks about how to approach your own end of life:
Podcast: https://player.whooshkaa.com/episode?id=748050

In this article, You n' Taboo challenge the usual ways our dead are dealt with:
Newspaper Article: https://yountaboo.com/death-becomes-her-newspaper-article/

In this news segment, ABC TV takes a look at natural burial which is among a few natural and sustainable choices in death care available in Tasmania:
News Segment: https://yountaboo.com/abc-tv-news-segment/

Tip:
Check out You n' Taboos FAQ page

Stage 2



02 LEARNING COMMUNICATION SKILLS

2 Learning Communication skills

In preparation for talking about end of life, here are some tips for verbal and non-verbal communication.There are also specific communication tips to assist people with intellectual disability.

Verbal

It is important to be aware of how you communicate verbally because what and how you say something can impact how that information is perceived by a person. Being aware of how you communicate verbally can assist in reducing miscommunications.

Non-Verbal

Non-verbal communication can improve a person's ability to relate, engage, and establish meaningful interactions in everyday life. This is particularly important when having sensitive conversations about end of life.

Specific to Intellectual Disability

People with an intellectual disability may require additional communication support or have specific sensory needs which need to be considered. Therefore it is important to have an awareness of these potential needs.

2 Verbal

Use direct & clear language

- People are more likely to pay attention and understand.
- Increases trust and belief.

Check understanding

- Limits the chance of miscommunication.
- Allows individuals to remain focused and have a clear idea of whats being talked about.
- If you are unsure what someone has said ask for clarification.

Don't assume knowledge

- Actively listen and explain clearly.
- Everyone brings a diverse and valuable set of knowledge and lived experience to the conversation.

2 Non-Verbal

These are some things to be aware of when communicating with others. Making sure you are addressing these things when communicating. These things can heavily impact how the conversation goes.

Movement of body
Posture and Gesture.

Eye behaviour
Movement of eyes gazing, looking, eye contact, eye rolling.

Use of physical space
Arrangements of objects and personal space.

Scenes of environment
Cleanliness and smells of the environment, location (inside or outside) and safe and comfortable place

Touching behaviour
Hand shaking, hugging, kissing.

Characteristics of the voice
Volume, tone, rate of speech, pitch, intensity, laughter.

Facial expressions
Eyebrow movement and use of smile.

Use of time
Focus on one thing at a time and be present in the conversation.
Ensure you have enough time to have these conversations.

Reminder: Make sure phones are turned off or on silent so you are not distracted.

Use non-verbal cues to improve the flow of conversation

- Look for cues to know when to speak
- Recognise when you should keep talking
- Signaling when you wish to speak without interrupting abruptly
- Use of silence

2 Communication Specific to Intellectual Disability

This section includes general tips and suggestions to make communication with people with intellectual disabilities more successful.

An intellectual disability can cause limitations in areas of communication and social skills. Therefore, it is important to consider what impact these may have on their ability to communicate their wants and needs. This is especially important when talking about a topic such as as end of life.

These suggestions are not intended to be a one size fits all. Every person with an intellectual disability is different and will need varying levels of support with communication. There are many resources available for you to try depending on your individual needs. It is recommended you try different options and decide which ones work best for you based on your needs.

Important Things to Consider

Capacity - The level of understanding of the person you are having end of life conversations with.

The person's comfort with having an end of life conversation and changes in comfort throughout the conversation.

Take care not to lead the conversation or sway the person's opinion based on your assumptions.

Be aware of the sensory needs that the person may have. Do they need an item to help make them calm and comfortable during end of life conversation?

Are you the right person to have the conversation? Are you a familiar face, trustworthy, and have the willingess and skills to have end of life conversations with them.

2 Communication Specific to Intellectual Disability

There are some important practical skills to use when communicating with people who have an intellectual disability. These skills help to improve how the conversation unfolds by assisting with the clarity of information and ideas exchanged.

Skills include:

- Checking in at various points to see how the person is handling the conversation
- Allowing more time for the person to process what you have said and then respond.
- Active Listening - staying focused and engaged.
- Familiarise yourself with learning aids such as videos and images.

Tip:
Be mindful that all verbal and emotional responses to end of life conversations are valid

2 Communication Specific to Intellectual Disability

When and How conversation suggestions:

When

- It is better to have end of life conversations before being confronted by end of life.
- Try to pick a time when you think this information will be better-received by the person.
- Try to have end of life conversations over time, they should be ongoing they cannot be had all at once.

How

- Take advantage of opportunities that come up in daily life i.e. when someone famous dies in the news.
- Do not use metaphors. Use clear and direct language e.g. do not say passed away, say died.
- Use learning aids such as videos and images to convey the message (TEL).
- Check in with the person to confirm the message is understood. Get them to explain back in their own words.
- Provide strategies for communicating with simpler shorter sentences.
- Advise people involved in the persons care that end of life conversations will be taking place.

Tip:
Start with casual and less confronting conversations to ease into talking about death

2 Communication Specific to Intellectual Disability

"Talking End of Life" (TEL) is a great free resource that teaches people how to have conversations about end of life with people who have an intellectual disability.

Through research, TEL has developed educational modules and videos using disability staff and people with intellectual disability (not actors) who talk about their real life experiences. Listed below are some relevant modules. More can be found on the website: https://www.caresearch.com.au/tel

Tip:
Click on tips and pictures to find out more

Why is this important?

Provides an overview of why it's important to talk to people with an intellectual disability about death.

Dying

Key concepts to think about when talking about dying with a person with intellectual disability.

Talking End of Life
..with people with intellectual disability

Loss, grief and mourning

How to recognise signs of loss and grief and support a person with intellectual disability to mourn.

Death

Key ideas to think about when talking about death with a person with intellectual disability.

Stage 3

03 HAVING END OF LIFE CONVERSATIONS

3

Having end of life conversations

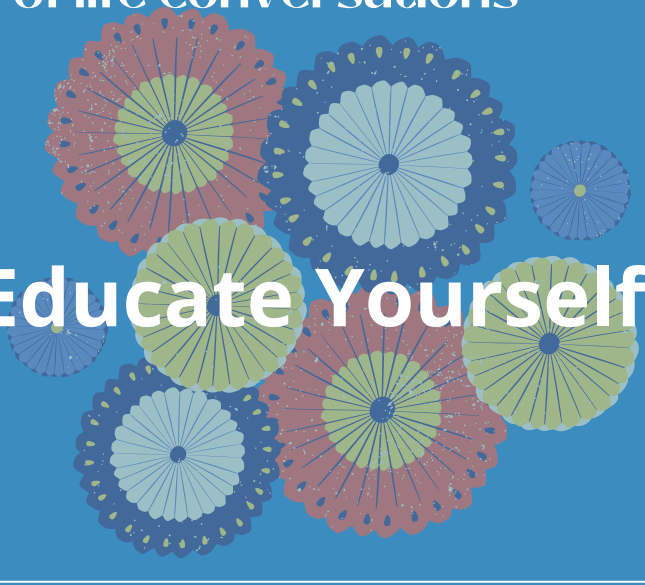
This toolkit is not intended to fix all the barriers people face at the end of life. The aim is to provide families and carers with tools and resources to explore at your own pace. Hopefully these resources provided within the toolkit and on the following pages can increase your confidence to engage with end of life and find any additional resources you need. The following list of end of life resources is not exhaustive. For a broader and more exhaustive end of life service directory check out Kindred Life.

The links to the resources and documents we have provided on the following pages are current as of 09/11/2021. Please ensure you access the most up-to-date versions of the forms and resources directly from the original source.

KINDRED LIFE

Kindred Life are developing a fully comprehensive Service Directory of products and services to help you and others prepare for end of life.

Tip:
Click on tips and pictures to find out more



Educate Yourself

Talking End of Life	Talking End of Life (TEL) is a resource that shows you how to teach people with intellectual disability about the end of life.	https://www.caresearch.com.au/tel/
The Groundswell Project	The Groundswell Project works with individuals, organisations and communities to improve how people in Australia die, care and grieve.	https://www.thegroundswellproject.com/
Dying to Talk	Dying to Talk encourages Australians of all ages and levels of health to talk about dying.	https://dyingtotalk.org.au/
The Books Beyond Words series	Books about dying designed for people with intellectual disability that include only pictures.	https://booksbeyondwords.co.uk/bookshop

Planning End of Life

You n' taboo	You n' taboo offer education, family led home funerals and end of life services. They also offer a free 20 minute consultation to start planning the end of life process.	https://yountaboo.com/
End of Life Bucket List	Death Doula's help people and their families through the process of dying in an open, supportive, and practical way. Tracey Rusden from End of Life Bucket List is Tasmanian based	https://eolbucketlist.com/
Organ Donation	You can register to become an organ and tissue donor when you die by joining the Australian Government Register.	https://donatelife.gov.au/register-donor-today
Super-annuation	To make sure your super and any life insurance you might hold with it goes to the people you'd like it to, you need to keep your super fund up to date by nominating a valid beneficiary.	https://www.amp.com.au/superannuation/super-basics/what-happens-to-my-super-when-i-die

Planning End of Life

The Big Four

These are the four most important legal documents to complete before you find yourself at end of life.

Will	A good will can make sure your wishes are carried out when you die or when you are not able to make your own decisions.	https://moneysmart.gov.au/wills-and-powers-of-attorney
Enduring Power of Attorney	An Enduring Power of Attorney is a legal document that allows appointed individuals to take care of your financial affairs. Even if you lose your decision making capacity.	https://www.legalaid.tas.gov.au/factsheets/enduring-power-of-attorney/
Enduring Guardianship	Enduring Guardianship is a legal document in which you appoint someone to make medical and personal decisions for you.	https://www.advancecareplanning.org.au/create-your-plan/create-your-plan-tas
Advanced Care Directive	This document allows you to decide what health care and treatment you receive if you lose the ability to make decisions yourself.	https://www.advancecareplanning.org.au/create-your-plan/create-your-plan-tas
Advanced Care Plan for persons with insufficient decision-making capacity	This is an advance care plan for a person with insufficient decision-making capacity to complete an advance care directive. This document is **not** a legally binding document and to be used as a guide only.	https://www.advancecareplanning.org.au/create-your-plan/create-your-plan-tas **Tip:** Storing of Advanced Care Plan (Wallet card or My health record (My Gov))

FORM 4

Powers of Attorney Act 2000

GENERAL ENDURING POWER OF ATTORNEY

THIS GENERAL ENDURING POWER OF ATTORNEY is made under the *Powers of Attorney Act 2000.*

Name of donor: .....

Address of donor: .....

1. **I APPOINT**

   Name of attorney(s): .....

   Address of attorney(s): .....

   *Name of attorney: .....

   *Address of attorney: .....

   .....

   to be my attorney(s) *jointly/jointly and severally.

2. **I AUTHORISE** my attorney(s) to do on my behalf anything that I may lawfully do.

3. **I DECLARE** that this general enduring power of attorney will continue to operate and have full force and effect despite any subsequent mental incapacity I may suffer.

Signature of donor: ..... Date: .....

We certify that the donor has signed this general enduring power of attorney in our presence.

I certify that I am not a party to this general enduring power of attorney nor a close relative to a party to it.

Signature of first witness: ..... Date: .....

Name of first witness: .....

Address of first witness: .....

Signature of second witness: ..... Date: .....

Name of second witness: .....

Address of second witness: .....

STATEMENT OF ACCEPTANCE OF GENERAL ENDURING POWER OF ATTORNEY

*I/We the above named attorney(s) under the power created by this general enduring power of attorney on which this acceptance is endorsed (or to which this acceptance is annexed) accept the appointment and acknowledge –

(a) that this general enduring power of attorney is an enduring power of attorney and may be exercised by*me/us despite any subsequent mental incapacity of the donor; and

(b) that*I/we will, by accepting this general enduring power of attorney, be subject to the requirements of the *Powers of Attorney Act 2000.*

Signature of attorney: ..... Date: .....

*Signature of attorney: ..... Date: .....

*Omit if not applicable

LTO USE ONLY

No. .....

FORM 5

Powers of Attorney Act 2000

REGISTRATION APPLICATION

To: The Recorder of Titles;

I apply to register the following instrument:

Type of instrument: .....

Number of pages (excluding this form): .....

Name of donor: .....

Name of attorney(s): .....

.....

.....

.....

Identification number (if applicable): .....NA.....

I certify that the information contained in this registration application is correct to the best of my knowledge.

Signed: ..... Date: .....

Name: .....

Capacity: *(donor, attorney, legal practitioner, other)*: .....

Address: .....

.....

Department of Primary Industries, Parks, Water and Environment

Land Titles Office

GPO Box 541
Hobart
Tasmania 7001

LODGEMENT FORM

134 Macquarie
Street
Hobart
Tasmania 7000

Lodge a SEPARATE FORM with each set of documents carrying out one entire transaction.

To the Recorder of Titles. Please register the undermentioned instruments in the order set out below and return such of them as are returnable to the lodging firm shown in Panel A or as indicated in Panel B.

Insert name of lodging firm (in block letters). If private person, insert name and full postal address (in block letters).

PANEL A

Client Ref:..... Per..... date.....

If one or more of the instruments are to be returned to a person who is not the lodging firm, insert the nature of the instrument and name and address (in block letters) of person to whom instrument is to be sent.

PANEL B

No.	Particulars * (to include title reference/s)	Fees $ c	Particulars of remittance herewith	$ c

Total Fees _____ **TOTAL** _____

*Particulars to include the title reference/s of the Certificate/s affected and to make reference to supporting documents indicating whether they are lodged herewith or already lodged by some other firm, e.g.

'C.T. Vol. .... Fol. .... produced herewith'

'Probate ..... produced by A.B. & Co.'

YOUR GUIDE TO ENDURING POWERS OF ATTORNEY FORMS 3 & 4

Powers of Attorney Act 2000

Land Titles Office
Tasmania

ENDURING POWER OF ATTORNEY

An Enduring Power of Attorney will continue to operate even if you lose mental capacity. For more information on Enduring Powers of Attorney see the "*FACT SHEET"* on Enduring Powers of Attorney.

This is a guide only and should only be used in conjunction with **Form 3** or **Form 4** of the ***Powers of Attorney Act 2000.*** You should only use these forms if you fully understand the requirements of the ***Powers of Attorney Act 2000***. It is recommended that you seek legal advice before completing any Power of Attorney form.

Warning: officers of the Land Titles Office are not empowered to give legal advice, prepare (Powers of Attorney/instruments) for lodgement **or** "pre-check" (Powers of Attorney/instruments) prior to lodgement.

If you plan to complete the Power of Attorney Form yourself, please read these instructions in conjunction with the relevant form.

NAMES:

i) Donor, fill in the **Donor** name and address *(the Donor is the person giving the power of attorney)* - Only one donor per form.
ii) Attorney, fill in the name and address of the person/s who will be your attorney/s.

If you appoint more than one attorney you must decide whether they are to act **jointly** *(your attorneys must agree about a decision together and must sign any relevant documents together)* or jointly and severally meaning jointly together or individually *(either attorney can act independently of the other*). If you want them to act jointly, cross out the words "jointly and severally", and vice versa.

TYPE OF:

if you want to restrict your attorneys' powers you must use **Form 3** Particular Enduring Power of Attorney Form and specify those things you authorise your attorney to do on your behalf. However, most people will grant a General Enduring Power of Attorney **(Form 4)**. It is strongly recommended you seek legal advice before executing a particular Power of Attorney.

SIGNATURE: The normal signature of all parties must be written in the spaces provided.

DATE: You must also enter the date upon which the Power of Attorney is completed in the space provided.

WITNESSES: The document must be signed by the **donor** in the presence of two independent witnesses *(i.e. a person who is not a party to the document nor a close relative to a party to it).*

DATE: You must also enter the date upon which the Power of Attorney is completed in the space provided.

STATEMENT OF ACCEPTANCE BY THE ATTORNEY: The person/s or agency you have nominated as your attorney needs to indicate their willingness to accept the power and the legal obligations which go with that power. The attorney/s must sign and date the **Form of Acceptance** in the space provided.

NOTE: An alteration to a power of attorney is to be made by striking through the word or words intended to be altered so as not to render illegible the original word or words. The alteration is to be initialled by the donor and the attorney. The donors initialling of the alteration is to be witnessed by two people, neither of whom is a party to the Enduring Power of Attorney. **DO NOT** use **white out** or **blot out** the word or words, as this will make the form unregistrable. **DO NOT** write on add to or mark except where provided on this form, this will also make the form unregistrable.

The **original form** only (not a copy) is to be lodged for registration. Together with an application **Form 5** which must also be completed and signed.

For current registration fee on a Power of Attorney see 'Schedule of prescribed fees'. Cheque or money order should be made payable to *The Recorder of Titles*.

Postal address is GPO Box 541 Hobart , Tasmania 7001 *or* in person to Level 1, 134 Macquarie Street, Hobart.

Guardianship and Administration Act 1995
Form1(Section 32)

Instrument Appointing Enduring Guardian(s)

For Tasmania

Section 1: Your details

Write your name, address, occupation and date of birth here.
Occupation examples: Carpenter; Retiree; Home duties

I, (your full name): _____

Of (your address) _____

_____

Occupation: _____

Date of birth: _____

Phone No.: _____

Section 2: Choosing your guardian(s)

Write your guardian's details here.
If you only want to appoint one person as your guardian, complete this section, then go to Section 3. If you want to appoint joint guardians, write the first guardian's details here.

Appoint (guardian's name): _____

Of (guardian's address): _____

_____

Phone No.: _____

Guardian's occupation: _____

to be my guardian.

Optional section:

If you want to appoint **joint guardians**, write the second person's details here. See the info sheet for more information on joint guardians.

I also appoint (joint guardian's name): _____

Of (joint guardian's address): _____

_____

Phone No.: _____

Joint guardian's occupation: _____

to be my guardian.

Section 3: Choose your alternative guardian (Optional)

Optional section:
If you want to appoint an **alternative guardian in case one of your guardians cannot assume the role**, write your alternative guardian's details here. If you do not wish to appoint an alternative guardian, go to Section 4 now.

In the event that my guardian (or one of my joint guardians) becomes incapable or unavailable to exercise this appointment, I appoint

(Alternative guardian's name): _____

Of (alternative guardian's address): _____

_____

Phone No.: _____

Alternative guardian's occupation: _____

By executing this instrument appointing an enduring guardian, I hereby revoke any and all former instruments made by me which appoint any enduring guardians or alternative guardians and such instruments shall cease to have effect upon the registration of this instrument made by me pursuant to Part 5 of the *Guardianship and Administration Act 1995*.

Subject to any conditions specified below in Section 4, I authorise my guardian, in the event that I become unable by reason of a disability to make reasonable judgments in respect of matters relating to my personal circumstances to exercise the powers of a guardian under Section 25 of the *Guardianship and Administration Act 1995*.

Section 4: Conditions upon appointment

I require my guardian to observe the following conditions in exercising, or, in relation to the exercise of, the powers conferred by this instrument:

Optional section: If you want to give specific directions to your guardian, **write your own decisions about your medical care or personal decisions here**. These are called conditions.

If you need more space, add a separate sheet and sign and date it at the bottom of the page.

See the info sheet for examples of conditions and how to write them.

If you do not impose any conditions, a guardian will have **full powers** should you lose capacity.

Section 5: Signatures

You sign here, but before you sign, you must arrange for two witnesses to watch you sign this form.

This is an appointment of an enduring guardian made under Part 5 of the *Guardianship and Administration Act 1995*. I acknowledge that this is a public document and is available for public scrutiny.

Signed: _____

Date: _____

The witnesses cannot be related to you or your guardian(s), or be people whom you have named as guardian(s).

As witnesses we certify that

(a) the person has signed this instrument freely and voluntarily in our presence; and

(b) the person appears to understand the effect of this instrument.

Your first witness signs here, and writes their full name and address.

Signature of witness 1

Signed: _____

Name: _____

Address: _____

_____

Your second witness signs here, and writes their full name and address.

Signature of witness 2

Signed: _____

Name: _____

Address: _____

_____

Your first guardian writes their full name and signs here to say they accept the appointment as your guardian. This should be the person whose name you wrote on the first part of Section 2. They do not need a witness for their signature.

I, (guardian's name): _____

accept appointment as guardian under this instrument and undertake to exercise the powers conferred honestly and in accordance with the provision of the *Guardianship and Administration Act 1995*.

Signed: _____

If you have appointed **two joint guardians** who must act together, your joint guardian writes their full name and signs here. They do not need a witness for their signature**.**

I, (joint guardian's name): _____

accept appointment as guardian under this instrument and undertake to exercise the powers conferred honestly and in accordance with the provision of the *Guardianship and Administration Act 1995*.

Signed: _____

If you have appointed an alternative guardian in case your first guardian cannot assume the role, your alternative guardian signs here. They do not need a witness for their signature.

I, (alternative guardian's name): _____

accept appointment as guardian under this instrument and undertake to exercise the powers conferred honestly and in accordance with the provision of the *Guardianship and Administration Act 1995*.

Signed: _____

How to register this form

Step 1: **Ensure you have signed the form in front of two witnesses who must also sign the document. The proposed guardians must also sign the document.**

Step 2: **Lodge this form at any Service Tasmania Shop with the registration fee or apply for a waiver of the fee on grounds of financial hardship.**

Step 3: **The Board will register the document and send you copies for yourself, your enduring guardian and your family doctor. You may wish to make extra copies for other members of your family, hospitals and your lawyer.**

Note: **This document is not legally binding unless it is registered.**

Tasmanian Government

ADVANCE CARE DIRECTIVE (TASMANIA)

(Tick ☑ as appropriate, format date as DD/MM/YYYY)

FT0215550

Making an Advance Care Directive (ACD) allows you to decide now, or to guide, what health care and treatment you receive, in the future, if you lose the ability to make and communicate such decisions yourself.

You can include in your ACD:

1. **Information about your values or wishes, which can guide a person making a decision about your health care; and**
2. **Specific treatments you refuse and in what circumstances.**

It is recommended that you discuss your future health concerns and treatments with your doctor or a health professional and discuss your wishes with significant people like your family and close friends.

For further guidance see the Advance Care Directive Information Sheet.

You must have the ability to make your own health care and treatment decisions to complete an ACD.

This is the Advance Care Directive for YOU - the person making the directive.

Print Name:	Date of Birth: DD / MM / YYYY
Address:	

Section 1. My Values and Wishes

The values and wishes you express here can guide a person making a decision about your health care. For example, you can include information about the following:

- *What is important to me for my health care*
- *What gives me quality of life and makes my life worth living*
- *What is important to me if I am nearing death*
- *My preferred place of care and place to die*
- *Any reasons for refusing certain treatment (for example, cultural or religious beliefs)*
- *If you are Aboriginal and/or Torres Strait Islander, what else is important to you*

Tasmanian Government

ADVANCE CARE DIRECTIVE (TASMANIA)

FT0215500

Section 2. Medical Treatment I Refuse

List the medical treatment you refuse and under what specific circumstances. It is important that you are clear as this information can be used in the future if you are unable to make and communicate your own decisions.

Medical treatment I refuse:	Under what circumstances:

If there is not enough room to write all your requests and wishes, please attach further pages as necessary. All additional pages need to be signed, dated and witnessed.

Organ and Tissue Donation – *you do not have to complete this section*

I would like to donate my organs and tissue after my death	☐ Yes	☐ No
I am registered on the Australian Organ Donor register	☐ Yes	☐ No
I have discussed my donation wishes with family & friends and they are aware of my decision	☐ Yes	☐ No

Your Signature

I, _____ (*full name of person giving this Advance Care Directive*) do hereby give this Advance Care Directive of my own free will.

Signature:	Date: DD / MM / YYYY

Tasmanian Government

ADVANCE CARE DIRECTIVE (TASMANIA)

FT0215S0

If you are unable to complete or sign this form it may be written by someone else fully directed by you	
Print Name:	
Relationship to you:	
Signature:	Date: DD / MM / YYYY

Witness (Optional)

There is no requirement to have this form witnessed. However, if it is witnessed it may be more likely that it will be recognised and followed by others. It is preferable for witnesses:

- To be over 18
- Unrelated to you
- Not be the person who has assisted you in completing this form
- Not be beneficiaries in your will

I/we certify that the person has signed this directive freely and voluntarily in our presence.

Print Name:	Print Name:
Signature:	Signature:
Address:	Address:
Date: DD / MM / YYYY	Date: DD / MM / YYYY

Interpreter / Translator Statement

If an interpreter / translator is used when this document is completed or witnessed, they must sign as follows:

Print name of interpreter/translator:	
I assisted with interpretation / translation of this document from English to / from _____ , a language I am proficient in.	
Signature of interpreter / translator:	Date: DD / MM / YYYY
NAATI number *(if applicable)*:	

What to do with this form

- Keep the original with you in an easily accessible place in your home
- Give a copy to important people such as your family or friends, General Practitioner, your local hospital and others involved in your health care
- If an ambulance is called show them this form
- Upload to My Health Record through MyGov if available

Abbreviation Key: NAATI National Accreditation Authority for Translators and Interpreters |

Advance Care Planning Australia

BE OPEN | BE READY | BE HEARD

Instruction Guide

Advance care plan for a person with insufficient decision-making capacity

This is an advance care plan for a person with insufficient decision-making capacity to complete an advance care directive[1]. This is **not** a form that is able to give legally-binding consent to, or refusal of treatment. This plan can be used to guide substitute decision-makers and clinicians when making medical treatment decisions on behalf of the person, if the person does not have an advance care directive.

What is advance care planning?

A process of planning for future health care, for a time when the person is no longer able to make their own health care decisions. It relates to a person's future health care and medical treatments. It may include conversations about treatments they would or would not like to receive if they become seriously ill or injured. It includes identifying the person they want to make these decisions and how they want those decisions to be made. It has many benefits for the person (care aligned with preferences), loved ones and treating clinicians.

When should this form be completed?

This form should only be completed if the person no longer has sufficient decision-making capacity to make or communicate their medical treatment decisions. This form is available for use in all Australian states and territories, however the Australian Capital Territory, Queensland, and Victoria have existing recommended forms, see Table 1.

This form is not intended to replace or revoke a legally-binding advance care directive. If the person does have decision-making capacity, they should consider completing an advance care directive. The voluntary completion of an advance care directive, when the person still has decision-making capacity, is preferable over the completion of an advance care plan[1]. The relevant advance care directive form from each state and territory is available at:
www.advancecareplanning.org.au/create-your-plan

Who should complete this form?

This form should be completed by a person's recognised substitute decision-maker(s), assigned to the role by law or appointed by the person to make medical treatment decisions, see Table 2. They should have a close and continuing relationship with the person. It is intended that this form will assist substitute decision-makers and the treating team to make medical treatment decisions that align with the decisions the person would have made in the same circumstances. This information can be used in aged care, community, or hospital settings.

Advance Care Planning Australia

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How to complete this form?

This form allows you to provide information about the values and preferences relating to future medical treatment for a person who has lost the capacity to make their own decisions. The information provided in this form should be guided by the person's past choices and decisions, and any previously expressed values and preferences. When completing this form, you should consider what decisions the person would have made in these circumstances, if they had the decision-making capacity to do so.

When completing this form, the following **guiding principles** should be used:

- When considering the person's values, think about how they like to live their life, what they enjoy doing, and what matters most to them, taking into account things they have said or done in the past.
- Any previously expressed preferences or choices made relating to healthcare, medical treatment, or life prolonging treatments[2], and type or location of care should be regarded.
- Any previously expressed views the person made about acceptable or unacceptable health outcomes should be taken into account.
- Consideration should be given to any observations made in relation to the person including how they make decisions and what their priorities and interests are.

How should this form be used?

Before relying on this form, the person's clinicians should consider their legal obligations relating to consent of medical treatment decisions in the state or territory that they practice in. They should be sure that the person does, at the time that decisions must be made, lack the capacity to make those decisions.

Where possible, the responsible clinicians should ascertain, the most up-to-date advance care directive for preferences for care and/or appointment of a substitute decision-maker. The clinician should also ensure that the person completing this form is the most appropriate substitute decision-maker if no-one has been appointed.

The identities of the person(s) filling out this form on behalf of the person with insufficient decision-making capacity to complete an advance care directive should be assessed carefully. Anyone relying on this form should be confident that the person(s) who completed this form truly represented the person's values and preferences.

How should this form be stored and shared?

Copies of the advance care plan should be shared with the person's substitute decision-maker(s), aged care, community or hospital provider, treating clinicians, General Practitioner and/or stored in My Health Record.

Who to contact for further information?

Advance Care Planning Australia
National Advance Care Planning Support Service: 1300 208 582
Email: acpa@austin.org.au
www.advancecareplanning.org.au

Table 1. Existing Advance Care Plans

State/Territory	Document name
Australian Capital Territory	Advance Care Plan Statement of Choices (No Legal Capacity)
Queensland	Statement of Choices Form B
Victoria	What I understand to be the person's preferences and values

Table 2. Title of legally-binding Advance Care Directives by state and territory

State/Territory	Advance Care Directive - preferences for Care	Advance Care Directive – appointment of a substitute decision-maker
Australian Capital Territory	Health Direction	Enduring Power of Attorney
New South Wales	Advance Care Directive	Appointment of Enduring Guardian
Northern Territory	Advance Personal Plan	Advance Personal Plan
Queensland	Advance Health Directive	Advance Health Directive/ Enduring Power of Attorney
South Australia	Advance Care Directive	Advance Care Directive
Tasmania	Advance Care Directive	Instrument Appointing Enduring Guardian(s)
Victoria	Advance Care Directive	Appointment of a Medical Treatment Decision Maker
Western Australia	Advance Health Directive	Enduring Power of Guardianship

Note: In the absence of a substitute decision-maker appointment by the person, state and territory law assigns this role via a hierarchy, with the exception of Northern Territory.

Reference

1. National framework for advance care planning documents. 2021. Australian Government, Department of Health.
2. Advance Care Planning Australia. Life prolonging treatments. 2021. Available: www.advancecareplanning.org.au/understand-advance-care-planning/life-prolonging-treatments

Disclaimer

This publication is general in nature and people should seek appropriate professional advice about their specific circumstances, including advance care planning legislation and policy in their state or territory.

Advance Care Planning Australia

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If you are a health service or aged care organisation, add your logo within this space.

(For person health record purposes, attach a label here)

UR Number:

Surname:

Given name(s):

Date of birth: (dd/mm/yyyy)

FORM

Advance care plan for a person with insufficient decision-making capacity

This is an advance care plan for a person with insufficient decision-making capacity to complete an advance care directive[1]. This is **not** a form that is able to give legally-binding consent to, or refusal of treatment. This plan can be used to guide substitute decision-makers and clinicians when making medical treatment decisions on behalf of the person, if the person does not have an advance care directive.

Question 1

The person with insufficient decision-making capacity that this document applies to

Full name:

Date of birth: (dd/mm/yyyy)

Address:

Question 2

The person completing this document

Full name:

Relationship to the person:

Address:

Phone number:

I believe that I am this person's legally recognised substitute decision-maker:

☐ Yes ☐ No ☐ Unknown

If yes and appointed, please attach documentation that provides evidence of this (see Table 2 of the Instruction Guide).

If no, the person's legally recognised substitute decision-maker should complete and sign the form.

Advance Care Planning Australia

BE OPEN | BE READY | BE HEARD

Advance care plan for a person with insufficient decision-making capacity

(For person health record purposes, attach a label here)

UR Number:

Surname:

Given name(s):

Date of birth: (dd/mm/yyyy)

Question 3

Additional contributor to this document, if applicable

Full name:

Relationship to the person:

Address:

Phone number:

This person is a legally recognised substitute decision-maker:

☐ Yes ☐ No ☐ Unknown

If yes and appointed, please attach documentation that provides evidence of this, (see Table 2 of the Instruction Guide).

If no, the person's legally recognised substitute decision-maker should be listed above as the person completing this document.

Question 4

Does the person have an advance care directive? (see Table 2 of the Instruction Guide)

☐ Yes (please attach copy to this form) ☐ No ☐ Unknown

If you answered yes, was the person's advance care directive considered when completing this form?

☐ Yes

☐ No Please provide reasons:

Question 5

The person's main health conditions (list all relevant conditions)

Advance Care Planning Australia

BE OPEN | BE READY | BE HEARD

Advance care plan for a person with insufficient decision-making capacity

(For person health record purposes, attach a label here)

UR Number:	
Surname:	
Given name(s):	
Date of birth: (dd/mm/yyyy)	

Question 6

The person's values (as I best understand them)

I believe the things that are <u>most important</u> to this person are:

(Note: consider the guiding principles and the person's desire for independence, social connections, emotional well-being, functional mobility, and participation in activities. An example statement might be 'they would like to be able to have meaningful interactions with family and loved ones such as conversations, eating together, and celebrating special occasions').

I believe the things that would be <u>unacceptable health outcomes</u> to this person are:

(Note: consider the guiding principles and their desired functional requirements, emotional well-being, and willingness to receive medical interventions. An example statement might be 'being fully dependent on care and unable to interact with family and loved ones').

I believe the things that would be <u>acceptable health outcomes</u> for this person are:

(Note: consider the guiding principles and their desired functional requirements, emotional well-being, and willingness to receive medical interventions. An example statement might be 'living with equipment and support for the activities of daily living; being dependent on care if they can interact with family and loved ones').

Advance Care Planning Australia

BE OPEN | BE READY | BE HEARD

Advance care plan for a person with insufficient decision-making capacity

(For person health record purposes, attach a label here)

UR Number:	
Surname:	
Given name(s):	
Date of birth: (dd/mm/yyyy)	

Question 6 continued

I believe the things that this person is hoping to do now and in the future are:

(Note: consider the guiding principles and their desire for independence, social connections, emotional well-being, functional mobility, and participation in activities. An example statement might be 'live in their own home with support of family and paid carers; read novels or the paper daily').

Other values that are important to know about this person

Question 7

The person's treatment preferences (as I best understand them)

If this person became very unwell with either an expected or unexpected deterioration with no hope of an acceptable outcome, the following statement best represents their views: (tick one box only)

(Note: Life prolonging treatment includes but is not limited to Cardiopulmonary Resuscitation (CPR), artificial ventilation, tube feeding, surgery, oral or intravenous antibiotics and/or dialysis.)

- ☐ Living as long as possible is their major goal no matter the outcome **OR**
- ☐ They would want life prolonging treatment that may extend their life, but not if it is likely to result in an unacceptable health outcome **OR**
- ☐ They would not want life prolonging treatment that may extend their life **OR**
- ☐ Not sure

Advance care plan for a person with insufficient decision-making capacity

(For person health record purposes, attach a label here)

UR Number:	
Surname:	
Given name(s):	
Date of birth: (dd/mm/yyyy)	

Question 7 continued

Are there any life prolonging or particular treatments that the person would not want to receive?

I believe if this person is nearing death, they would like the following to be considered.
(Example: place of death, presence of family or loved ones, music, religious, cultural or spiritual support).

Additional notes

Advance Care Planning Australia

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Advance care plan for a person with insufficient decision-making capacity

(For person health record purposes, attach a label here)

UR Number:	
Surname:	
Given name(s):	
Date of birth: (dd/mm/yyyy)	

Question 8

Please tick all to indicate your understanding of the following statements.

- ☐ I am of the reasonable belief that a person for whom this form applies does not have decision-making capacity to make medical treatment decisions.
- ☐ I understand that this document does not provide legally-binding consent to, or refusal of treatment but may be used to guide substitute decision-makers and clinicians to make medical treatment decisions.
- ☐ I understand that if the person does have an advance care directive, the values and preferences expressed in a valid advance care directive will be respected, if their medical treatment decisions are clinically indicated and appropriate.
- ☐ I understand that this person may still receive care for symptoms such as pain and to alleviate suffering regardless of the values or preferences stated in this form and that an advance care directive or advance care plan cannot refuse such measures.
- ☐ I understand that I am documenting this person's values and preferences honestly, to the best of my knowledge and without intent to cause harm.
- ☐ I understand this form should be reviewed if the persons condition changes, can be cancelled or changed whenever needed.

Signing

Legally recognised substitute decision-maker

By signing this form, I confirm this is an accurate record of this person's values and preferences as I understand them at the time of completing this form.

Full name:

Signature:

Date:
(dd/mm/yyyy)

The person's treating doctor or registered health professional

By signing this form, I certify to the best of my knowledge the person completing this form is an appropriate person to represent the values and preferences of the person with insufficient decision-making capacity.

Full name:

Signature:

Date:
(dd/mm/yyyy)

Things to Consider After Death

Notification of a Deceased Person	The Australian Taxation Department needs to be notified about the death of a person.	https://www.ato.gov.au/Individuals/Deceased-estates/Notifying-us-of-a-deceased-person/
Notifying Centrelink	Centrelink needs to be notified about the death of a person.	https://www.servicesaustralia.gov.au/individuals/subjects/death-and-bereavement/who-tell-when-someone-dies
Australian Electoral Commission	The Australian Electoral Commission needs to be notified about the death of a person.	https://formupload.aec.gov.au/Form?FormId=Notificationdeath
Apply for a Death Certificate	In many cases, a funeral director will do it for you. However, If you need to apply for a death certificate it can only be issued after the death is registered.	https://www.justice.tas.gov.au/bdm/applyforcertificate
Legal protections for Aboriginal people	If an Aboriginal person dies without a Will, a person who is not the spouse or blood relative of the Aboriginal person who died may apply to the Court for an order for distribution.	https://www.legislation.tas.gov.au/view/html/inforce/current/act-2010-019

Acknowledgment

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Professor Emeritus Roger Stancliffe, Dr Michele Wiese - Talking End of Life (TEL)
Tracey Rusden - End of Life Bucket List

This Toolkit was developed as part of a professional placement project with 'Oak Possability' by social work students from The University of Tasmania.

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