THE C-WORDS

CAPACITY, CONSENT, COMPULSION AND COVERTNESS

IN CONFUSION

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DECISION MAKING CAPACITY

REASONED MODEL EMBODIED IN MCA

- Understand
- Retain
- Use/weigh
- Communicate

- Though in terms of best interests decision making allows for wishes, feelings, beliefs, values

DECISION MAKING

- What information is there to be used?
- What information is actually used?
- How is it used?
- What is the validity/accuracy of the outcome?

- Background beliefs and assumptions

Everyone complains
about his memory
and no one complains
about his judgement

La Rochefoucauld

TRAUMATIC BRAIN INJURY AND CAPACITY TO MANAGE FINANCIAL AFFAIRS

- What is the relationship between frontal lobe syndrome and capacity?
- Very high
- High
- Moderate
- Low
- Nil

	Lacks capacity	Has capacity
Frontal lobe syndrome	160	40
No frontal lobe syndrome	80	20

DECISION MAKING -FINANCE

- Beliefs about consequences of purchase – so need concepts of proportion of resource, timescale, income to renew resource
- Know what purchasing / renting
- Aware of different perspectives and different calls on money
- Understand social expectations and whether to ignore

- ie process can be difficult

BUT IS DECISION MAKING DIFFICULT?

- Young (high school) children do not generally complain of indecisiveness
- Adults do, especially when stressed and even more so with MH problems
- As frontal lobe function improves people get more indecisive
- Most adults agree they act on spur of moment and almost half agree to a statement that they act rashly

HEURISTICS AND BIASES – LIFE'S SHORT CUTS

- Do no harm heuristic
- Outrage heuristic
- Illusory correlation
- Optimistic bias
- Discounted utility
- Emotional persistence
- Fast and frugal heuristic

and almost 500 others

PEOPLE (INCLUDING HEALTH AND SOCIAL CARE PROFESSIONALS):

- Have odd notions of probability and likelihood
- Use the information they first come across
- Assume best outcome likely
- Have inflated view of own correctness
- Make statements that do not reflect a reasoned process
- Take limited account of risk to others
- Express stereotyped repetitions of beliefs

FOR THOSE WHO LACK CAPACITY

- Use of reasoned process goes down
- Use of heuristics goes up
- Influence of biases increases

SOURCES OF EVIDENCE

- Interview
- Standardised tests
- Non-standardized tests
- Informants
- Actual behaviour

SO IN ASSESSING CAPACITY

- Remember it is a test of your ability to analyze and if required promote capacity not of the person assessed to demonstrate it – be aware of why you have over-ridden the presumption of capacity
- Look for evidence of poor use of information
- Draw on different sources of evidence – are implications consistent?
- Realize you are compiling evidence from which to draw (or allow others to draw) conclusion that not absolute
- Try to recognize own biases and heuristics
- Note what efforts have been made to promote capacity
- Be aware of influences (and if disinterested advice required)

COMMON PITFALLS ASSESSING CAPACITY OF A PERSON WITH DEMENTIA I

- Failing to assess capacity, taking apparent lack of objection as capacitous agreement
- Failing to assess capacity, progressing to best interests, ignoring possibility of a capacitous (perhaps unwise) decision
- Failure to clarify salient, relevant information required for a ‘broad understanding’
- Over-reliance on single short interview to give definitive opinion

COMMON PITFALLS ASSESSING CAPACITY OF A PERSON WITH DEMENTIA II

- Overstatement of deficits eg ‘no awareness’ or ‘no understanding’ when person can have some relevant discussion undermining assessor credibility
- Documentation of clear deficits in one or more criteria of legal test – then concluding has capacity as preference expressed
- Failure to describe how nature and/or degree of mental impairment leads to lack of capacity (causal nexus)

THE INCREASINGLY COMPLEX CONCEPT OF CONSENT

WHAT INFORMATION SHOULD BE PROVIDED IN CONSENT TO INVESTIGATION AND TREATMENT?

- Previously based around Bolam decision on treatment case, doctor not negligent if 'acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in this particular art'. Sidaway judgment (1985) included reference to what a reasonable person would wish to know.
- Modified to include Court's authority to ensure the justification 'must withstand a logical analysis of risks and benefits' (Bolitho judgment 1997)

GMC GUIDANCE

- In deciding how much information to share with your patients you should take account of their wishes. The information you share should be in proportion to the nature of their condition, the complexity of the proposed investigation or treatment, and the seriousness of any potential side effects, complications or other risks.

AFTER MONTGOMERY V LANARKSHIRE 2015

Did the doctor take reasonable care to ensure that the patient was aware of material risks involved in the treatment (would a reasonable person in the patient's position be likely to attach significance to the risk or the doctor should reasonably be aware that the particular patient would be likely to attach significance to it) and of any reasonable alternative (including no treatment) ?

Therefore clearly no longer a solely medical matter

DEVELOPMENT REFLECTED:

- General shift in doctor-patient relationships with patients no longer ‘passive recipients ‘ of care
- That factors other than clinical judgment (cost containment, service efficiency) influence options and should be a way to challenge such decisions
- Advice now given in context of widely available, if of variable reliability, information from the internet

ALSO INCLUDED:

- Risk is not only about percentages but how the nature of the risk interacts with the specific patient's characteristics
- Doctor is advisory in seeking consent with duty of comprehensibility (in dementia less information may be more effective in promoting capacity)
- The 'therapeutic exemption' to avoid distressing patient and causing adverse health consequences 'should not be abused'

CAPACITY TO CONSENT TO SEXUAL ACTIVITY IN DEMENTIA

- Capacity to consent to sex can become impaired
- Although threshold low (and some information relevant to others may not be relevant eg potential for pregnancy) cognitive changes may lead to it no longer being met
- Impact on long term relationships and capacity to initiate new ones (eg in care home) both potentially major
- Important to consider individual circumstances and have supportive framework in place to facilitate appropriate relationships / activities – acknowledge potential difficulties re 'appropriate' but don't file under 'too difficult'

COMPULSION

MENTAL HEALTH ACT

- Authorises compulsory interventions on basis of treatment of mental disorder in defined circumstances
- Safeguards in place through requirements for multi-professional input, formal procedures, certification of professionals, second opinion appointed doctors, mental health review tribunals

MENTAL CAPACITY ACT

- Authorises compulsion for those with lack of relevant capacity in their 'best interests'
- Code of Practice describes how law should be applied but main safeguarding through organisational policies / CQC inspection.
- Law applies to all making decisions on behalf of person lacking capacity – including family/friends.

MCA DOLS

- Residence for purpose of receiving care, authorises Deprivation of Liberty (+/- conditions) in best interests
- Safeguarded by right to request review and also Section 21 A appeal to Court of Protection
- Imminent replacement by Mental Capacity (Amendment) Act introducing 'Liberty Protection Safeguards' for protection from harm.

INTERACTION OF DIFFERENT ACTS

- The different principles on which the Act are based can lead to uncertainty over which legislation applicable in some circumstances
- Individual care plans will often have elements underpinned by more than one Act (MCA, MCA DoLS, MHA) as well as common law consent
- The same intervention in different settings (or the same setting at different times) may have different legal authorisation required

MENTAL HEALTH UNITS (USE OF FORCE) ACT 2018

- Relates not to authorisation of but to the oversight and management (including recording) of the appropriate use of force in relation to people in mental health units
- Covers physical, mechanical and chemical restraint
- Refers to interventions that are 'intended to prevent, restrict or subdue movement of any part of the patient's body' when 'non-negligible' in degree (so exempting some interventions eg MCA supported restraining to wash /dress person with dementia)
- Although enacted in response to death of Seni Lewis (following restraint in hospital by police) it applies to all staff working in mental health units

COVERTNESS

AG V BMBC & ANOR [2016] EWCOP 37

- *covert medication …. is an interference with the right to respect for private life under Article 8 of the ECHR and such treatment must be administered in accordance with a law that guarantees proper safeguards against arbitrariness. Treatment without consent is also potentially a restriction contributing to the objective factors creating a DOL within the meaning of Article 5 of the Convention. Medication without consent and covert medication are aspects of continuous supervision and control that are relevant to the existence of a DOL. It must therefore attract the application of Section 1(6) of the Act and a consideration of the principle of less restriction and how that is to be achieved.*

SO UNLESS COVERED BY MHA

- If person has capacity and refuses administration of medication request prescriber review
- If person lacks capacity (to consent to specific medication) and refuses then before covert administration can be used several steps required

REQUIREMENTS FOR COVERT ADMINISTRATION (OUTSIDE MHA)

- Prescriber review of capacity to consent and strength of indication / available alternatives – covert as last resort option
- Best interests formally agreed (unless emergency) with patient perspective included eg through family and with check that neither Health and Welfare attorney nor relevant advance decision are in place
- Plan for administration to involve pharmacist
- Recording and review system established

RESOURCES I

- Codes of Practice to MHA, MCA, MCA DoIS all available on line
- A number of law firms provide commentaries on important medico-legal developments eg https://www.39essex.com/ which has option to sign up to email newsletter
- A more discussion-based approach on background influences and policy in this area of law can be found at https://www.mentalcapacitylawandpolicy.org.uk/
- A key resource book that looks at the areas in which doctors are asked to assess capacity is: Assessment of Mental Capacity – A Practical Guide for Doctors and Lawyers 4th Edition published by BMA and the Law Society

RESOURCES II

- Specific guidance on topics: Social Care Institute for Excellence has guidance on covert medication in care homes and expression of sexuality in dementia. Care Quality Commission publishes guidance on relationships and sexuality in adult social care services
- The Supreme Court decision on Montgomery v Lanarkshire which provides an explanation of how the legal position has developed can be found via searching on http://www.bailii.org/uk/