Assessing capacity in the general hospital: case discussions

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Introduction

• Different jurisdictions
• MCA & MHA
• Case examples to illustrate use
  – Refusal of treatment
  – DoLS
  – Overdose
Why can assessing capacity be a problem?

• Law – black & white
• Medicine – shades of grey
• Dealing with people and human behaviour is often complex and uncertain
• Capacity issues often arise when treatment is refused
Case 1: Refusal of treatment
Case 1: Refusal of treatment

- 68 year old man
- GI bleed
- Cancer of the colon
- Declining potentially curative surgery
- Does he have the capacity to refuse treatment?
Capacity to consent to or refuse medical treatment

• For consent or refusal to be valid, a patient must:
  – Be provided with enough information
  - Act voluntarily
  - Have capacity to take that decision
Mental Capacity Act

- A legal framework for decision making on behalf of adults who lack capacity to make decisions for themselves
  - Financial
  - Personal welfare
  - Healthcare
Five “statutory principles” that guide assessment and decision making

1. Adults are assumed to have capacity unless shown otherwise
2. All practical steps must be taken to help an individual make a decision
3. A person is not to be treated as unable to make a decision merely because they make an unwise decision
Five “statutory principles” that guide assessment and decision making

4. An act done or decision made on behalf of a patient who lacks capacity must be done in their “best interests”

5. … and in the least restrictive way
Assessing capacity

An adult can only be considered unable to make a particular decision if:
1) They have “an impairment of, or disturbance in, the functioning of the mind or brain” (permanent or temporary)
Assessing capacity

2) They are unable to undertake any of the following steps:
   - Understand the information relevant to the decision
   - Retain the information
   - Use or weigh the information as part of the process of making the decision
   - Communicate the decision
Understand the information

- Risks and benefits of the treatment
- The implications of not having it
- Alternatives
- Level appropriate to the individual
Retain the information

• Deficits often apparent during the assessment
• Cognitive testing may help
• Can the patient recall or paraphrase the discussion?
Weigh up the information

- Can the patient:
  - Appreciate the wider consequences of the decision?
  - Apply the information to their own situation?
  - Weigh up the risks and benefits of options?
Capacity is not “all or nothing”

- Decision specific
- May vary with the complexity of the decision
- May fluctuate
- The more serious the decision, the greater the degree of capacity required
Case 1: Refusal of treatment

- Personal and family history of post-operative complications
- No evidence of psychiatric disorder that might interfere with capacity
- Able to understand & retain information
- Weighing up influenced by previous experience of surgery
Capacity assessment is not a test of reasonableness

- Statutory principle: A person is not to be treated as unable to make a decision merely because they make an unwise decision
- People are entitled to make their own decisions based upon their own value systems
- Even if this is considered to be irrational by the assessor
- Explore reasons, and provide information where necessary
Case 1: Refusal of treatment

- Judged to have capacity to decline surgery
Patients with capacity who refuse treatment

Advice to hospital colleagues:
• Don’t take it personally!
• Remain involved and offer alternative treatment, e.g. symptom relief
• Give patient opportunity to reconsider
• Psychiatry not routinely required in capacity assessment
When might a psychiatric opinion be required?

- Complex & uncertain cases, especially when a second opinion would be helpful
- When psychiatric disorder may be affecting decision-making ability
- Treatment decisions rest with the treating doctor
Case 2: Refusal of treatment
Case 2: Refusal of treatment

- 46 year old man
- Known to have chronic schizophrenia
- Admission following GI bleed
- Refusing OGD
- Does he have the capacity to refuse treatment?
Capacity & mental disorder

- Capacity *may* be affected by chronic disorders...
  - e.g. dementia, depression, psychosis
- ...and transient mental states
  - e.g. intoxication, panic, shock, fatigue
- Psychiatric disorder does not automatically make someone incapable of making health-care decisions
Assessing capacity

An adult can only be considered unable to make a particular decision if:

1) They have “an impairment of, or disturbance in, the functioning of the mind or brain”

2) They are unable to undertake any of the following steps:
   - Understand the information relevant to the decision
   - Retain the information
   - Use or weigh up the information as part of the process of making the decision
   - Communicate the decision
Case 2: Refusal of treatment

- Psychotic thinking significantly impaired ability to understand and weigh up information
- Judged *not* to have capacity to consent to or refuse OGD
- What happens if someone lacks capacity to make a treatment decision?
Can capacity be improved?

- Involve family & carers
- Minimise anxiety
- Repetition
- Improve communication
- Fluctuating capacity
- Improve mental state
- But if this is not successful, or in urgent situations…
What about the Mental Health Act?

• Primarily regulates the treatment of mental, but not unrelated physical health problems
• Mental Health Act have the same rights as others regarding decisions about physical health-care
What about the Mental Health Act?

• The MHA allows medical treatment for mental disorder to alleviate or prevent a worsening of:
  – the mental disorder
  – or one of its manifestations

• Examples
  – Parenteral feeding in anorexia nervosa
  – Consequences of self harm
Case 2: Refusal of treatment

- Chronic schizophrenia
- GI bleed
- Refusing OGD
- Lacks capacity to consent to or refuse treatment
- Could he be treated under the MHA?
Case 2: Refusal of treatment

- Chronic schizophrenia
- GI bleed
- Refusing OGD
- Lacks capacity to consent to or refuse treatment
- Could he be treated under the MHA?
- No – so what happens next?
What happens next?

• Has the patient made provision for future loss of capacity?
• If not...
• Statutory principles:
  – An act done or decision made on behalf of a patient who lacks capacity must be done in their “best interests”
  – … and in the least restrictive way
Provision for future incapacity

• Lasting Power of Attorney
• Advance Decision to refuse treatment
• Informal statements about future wishes are not legally binding, but should be considered in an assessment of “best interests”
What are “best interests”? 

- Not strictly defined
- Broader than just medical considerations
- Depends upon the individual and their circumstances:
  - Physical
  - Psychological
  - Social
  - Spiritual
Assessing “best interests”

- Are they likely to regain capacity? Can the decision wait?
- Optimise the patient’s participation
- Consider past and present wishes, values & beliefs
- Involve those close to the patient
Independent Mental Capacity Advocates (IMCAs)

- Patient lacks capacity
- No family, friends, carers
- Duty to appoint IMCA
- Informs “best interest” decisions
- Local authority employees
Refusal of medical treatment

- **Capacity**
  - Yes
    - Respect patient’s decision
  - No
    - Provision for future incapacity?
      - No
        - Best interests
Case 2: Refusal of treatment

- Judged not to have capacity to consent to or refuse OGD
- No provision for future incapacity
- Judged that OGD was in patient’s “best interests”
- OGD under GA
Court of Protection

- Patient lacks capacity
- Difficult or contentious decisions
- Application made to Court of Protection
- Court Appointed Deputy for ongoing decisions
Case 3: Deprivation of Liberty Safeguards (DoLS)
Deprivation of Liberty Safeguards (DoLS)

- Supplementary to the MCA, April 2009
- Apply to people who lack capacity in a hospital or care home
- To provide legal protection for people who are “deprived of their liberty”, but do not require treatment under the Mental Health Act
Deprivation of Liberty Safeguards (DoLS)

- Arose following “Bournewood Case” & ruling of European Court of Human Rights
- Patient with severe learning disability and lacking capacity to consent to aspects of care and treatment
- Admitted to hospital in best interests
- Liberty greatly restricted
- No legal framework for patient or family to challenge decisions
Deprivation of Liberty Safeguards (DoLS)

- Designed to bridge gap between:
- A) Detention under MHA, with its legal safeguards
- B) Restraint or restriction of liberty in best interests under MCA
- i.e. those who do not require A, but require greater restriction of liberty than permitted by B
Deprivation of Liberty Safeguards (DoLS)

- Request for assessment made by the Trust (managing authority) to the PCT (supervisory body)
- Initial assessment made
- Usually by 2 people (most likely to be a doctor and SW) who have undergone specific training
- System of regular review
Case 3: DoLS

- Mr H a 56 year old man
- Fall and head injury
- Significant cognitive impairment
  - disoriented, thought in an office (with beds!)
  - poor STM
- Occasionally trying to leave the ward
- Or not wishing to leave when required
Case 3: Question

- Do DoLS apply in this case?
Deprivation of Liberty Safeguards (DoLS)

• When does restraint or restriction of liberty in a patient’s best interests become “deprivation of liberty” that requires DoLS?
• DoLS Code of Practice provides guidance on interpreting the law

Restriction? Deprivation?
Deprivation of Liberty Safeguards (DoLS)

The following would not by themselves constitute deprivation of liberty:

- “Benign force” to take a confused patient to hospital
- Feeding, dressing or providing medical treatment
- Bringing back a patient who has wandered off the ward
- Use of physical restraint or medication in an emergency to respond to disturbed behaviour
- Dissuading a confused patient from leaving a ward, even if this happens on more than one occasion
Deprivation of Liberty Safeguards (DoLS)

• Overall the threshold for use of DoLS is relatively high
• Depends on nature, degree, frequency and consequences of measures
• Use in a general hospital is likely to be very infrequent
• Most likely to apply to a small number of patients with chronic cognitive impairment in long-term care
Case 3: DoLS

- 56 year old man
- Head injury
- Significant cognitive impairment
- Occasionally trying to leave ward
- Is he “deprived of his liberty”?
- No, judged that restriction was not severe or frequent enough
Case 4: Overdose
Case 4: Overdose

- 26 year old man in A&E
- Overdose of 70 paracetamol tablets
- Refuses assessment, investigation and treatment
- Wishes to leave
Case 4: Overdose

- Of what use could the Mental Health Act be in this case?
- Is the patient likely to have capacity to refuse treatment?
Of what use could the Mental Health Act be in this case?

- Patient may require assessment &/or treatment under the MHA for a mental disorder
Of what use could the Mental Health Act be in this case?

- The MHA allows medical treatment for mental disorder to alleviate or prevent a worsening of
  - the mental disorder
  - or one of its manifestations
- Includes consequences of self harm
- However, may be too time consuming to complete the MHA assessment...
Refusal of medical treatment

- **Capacity**
  - Yes
    - Respect patient’s decision
  - No
    - Provision for future incapacity?
      - No
      - Best interests
What difficulties might there be in assessing this patient’s capacity?

• Assessment of uncooperative patients:
  – Presumption of capacity?
    vs.
  – Patient without capacity denied essential treatment?
Is the patient likely to have capacity to refuse treatment?

• Capacity may be affected by chronic disorders…
  – e.g. dementia, depression, psychosis
• …and transient mental states
  – e.g. intoxication, panic, shock, fatigue
• Take into account
  – Urgency of proposed treatment
  – Evidence for a mental disorder likely to effect capacity
What happens in practice?

- Patients often accept treatment after careful explanation and persuasion.
- Many are relieved to hand over responsibility to health professionals.
- A 2\textsuperscript{nd} opinion &/or senior opinion should be sought.
To consider…

• Would I prefer to have a living patient sue me for assault & battery for saving a life they said they did not want in a highly emotional state…

• … or have the grieving relatives of a dead patient sue me for negligence?
Conclusions - Record keeping

- Capacity issues may be contentious
- Keep clear, precise and legible records
- Document your assessment of capacity
Conclusions

• Use legal principles to guide complex assessments
• Dealing with people & human behaviour is complex and uncertain
• Discuss &/or seek a second opinion where necessary
• Record assessment & conclusions
• Further information: Codes of Practice
At this point someone will usually ask a question about a particularly tricky case...
Refusal of medical treatment

- Capacity:
  - Yes
    - Respect patient’s decision
  - No
    - Provision for future incapacity?
      - Yes
      - Best interests
Children & adolescents

- Under 16 years
  - MCA does not generally apply
  - Legislation mainly Common law and Children Act
  - May have capacity to consent ("Gillick competence")
  - Otherwise those with parental responsibility
  - Refusal may, in certain circumstances, be overridden by those with parental responsibility or a family court
  - In such cases, the welfare of the child is paramount
Children & adolescents

• 16 & 17 years
  – MCA extends adult rights to this age group such that refusal cannot be overridden
  – However, cannot make a Lasting Power of Attorney or an advance decision to refuse treatment
  – If lack capacity and disagreements about care, case may be heard in either family court or Court of Protection.
Advance Decisions to Refuse Treatment

- Provision for adults with capacity to refuse treatment in advice should they no longer have capacity
- Must specify treatment to be refused
- Cannot insist on clinically unnecessary treatment
- Specific requirements for refusal of life-sustaining treatment
Restraint

- Patients with mental disorder can be restrained or detained under the following legal powers:
  - MHA, e.g. Section 5(2)
  - MCA
  - Common law
Restraint in the ED

Does the patient with mental disorder lack capacity to consent to or refuse care?

Yes

MCA
Necessary
Proportionate
Best interests

No

Common law
Necessary
Proportionate