Health Education Thames Valley

MENTAL CAPACITY ACT

MODULE: CAPACITY ASSESSMENT

TARGET: PSYCHIATRY TRAINEES ST4-6

BACKGROUND:

The Mental Capacity Act 2005 has formalised much of what was already considered good practice. Assessments to determine whether patients have capacity, particularly with respect to their ability to decline treatment for self injury or poisoning, can overlap to a great extent with an assessment for detention under the Mental Health Act. In addition, assessment of capacity in the Emergency Department may be undertaken by several members of the multidisciplinary team who may reach different conclusions. Although the statutory test may appear simple, its interpretation can be difficult, particularly differentiating between 'unwise decisions' and decisions which suggest evidence of a mental disorder. Psychiatrists are often called upon to give advice on mental capacity or undertake these assessments in such situations. A number of recent high profile cases have raised the profile of this issue, particularly in situations where hospital staff, faced with binding advance directives and an apparently capacitous patient, have been required to allow them to die from self poisoning.

This scenario is familiar to many and highlights the issues such a case can present. It offers an opportunity for trainees to consider how they might approach this scenario outside of the situation itself.

RELEVANT AREAS OF THE CURRICULUM

Curriculum	Details
ILO – 1 Assessment	Demonstrate the ability to undertake a thorough assessment including where possible obtaining all relevant information Assess and manage patients with multiple and complex pathologies Identify urgent psychopathology
ILO – 2 Formulation	Demonstrate the ability to construct formulations that include differential diagnosis, liaising with other agencies and specialists and making appropriate referrals
ILO – 3 Management and Treatment	Demonstrate the ability to use information obtained to inform an appropriate management plan taking into account biological, social and psychological domains
ILO 4 Risk	Demonstrate expertise in applying the principles of crisis intervention in emergency situations Make care plans in urgent situations where information may be incomplete
ILO 9 Work effectively with colleagues	Show competence in supervised autonomous working Use effective negotiation skills Manage divergent opinions on patient treatment or intervention
ILO 17 Act in a professional manner at all times	Maintain good professional attitudes and behaviour when responding to situations of ambiguity and uncertainty Support and advise colleagues in dealing with complex professional interactions Recognise own limitations

INFORMATION FOR FACULTY

This is an adaptable scenario which can be used for psychiatry and emergency department trainees. The scenario takes place in the ED and the issues raised concern both disciplines so it can also be used in multidisciplinary training. Any member of the team can undertake the role-play as everyone has a role in assessing capacity. The approach to the scenario will obviously differ in each case.

LEARNING OBJECTIVES

- Greater confidence in undertaking Mental Capacity Act assessments
- An understanding of standards of practice expected
- An understanding of the concepts and issues underlying these situations
- An opportunity to share concerns and explore issues with other trainees

SCENE SETTING

Location:	Emergency Department or training room		
Expected duration of scenario:	10 mins	Expected duration of debriefing:	30 mins

EQUIPMENT AND CONSUMABLES

Trolley/bed
Chair for assessor

PERSONNEL-IN-SCENARIO

Actor playing patient
Doctor or other team member doing assessment

PARTICIPANT BRIEFING

(For Psychiatry trainees: You are the Psychiatry Registrar on call. It is 0130 on Saturday night. You have been called by the ED senior nurse who is very anxious for you to attend as soon as possible.)

A 43 year old man has been brought in by paramedics following on overdose of six boxes of paracetamol and a bottle of whisky. He apparently stockpiled the medication and alcohol specifically and wrote notes to all his relatives saying he was sorry but he couldn't go on any more. He printed an advanced directive off the internet and had his two flatmates sign it as witnesses. It states that he does not want treatment in the event that he attempts to end his life. The advance directive is with him and appears in order. However, after taking his overdose he waited for an hour then rang the ambulance as he 'did not want to die alone'.

There is not much background information available. The patient is not very willing to talk and refuses interventions, just saying that he 'want to die'. He has not provided any contact details for relatives or friends. There are no contact details on the advanced directive and his flatmates are out (he knew they would be out tonight and chose this time specifically). The limited hospital file shows that he has had some contact with mental health services in the past for depression and appears to have been diagnosed with a personality disorder some years ago. It does not appear that he has had any contact with services recently. He is not prescribed any medication at present. There are no medical problems recorded on the file. He lives with two flatmates who are younger than him and are students at the university. He worked at the local car factory until being made redundant last year.

The ED SHO assessed him first and thought he must lack capacity because he was refusing treatment and not talking to him. He refused to have a blood test but his observations were consistent with a high lactic acid. The SHO informed his Consultant who spoke to the patient and felt he probably had capacity but was not happy to make this decision alone and asked for a second opinion from the psychiatry team. When you arrive in the department the doctors are dealing with an emergency so you decide to assess the patient first and speak to them afterwards.

FACULTY BRIEFING

'VOICE OF THE MANIKIN' BRIEFING

No manikin

IN-SCENARIO PERSONNEL BRIEFING – 'PATIENT'

You are Mr Johnson, a 43 year old man who was made redundant last year from his job at the car factory. You worked there for 20 years as a fitter and have never known any other kind of work. You have completely lost your sense of self as a result and this is one of the main factors in your decision to end your life. Your only serious relationship broke down about five years ago. You have no children. You live with two much younger guys who are students at the university and are rarely in the house. They both spend their time socialising or with their girlfriends and you are not included in this. You get on fine with them but you fell they think you are a bit weird because you are much older and alone. You have become increasingly isolated and lonely. Your family are miles away and you don't have much contact with them any more.

You don't think you are depressed. You think this is a rational decision based on the facts of your life. You haven't seen your GP recently. You saw a psychiatrist a few years ago who diagnosed you with depression and you took antidepressants for a few weeks but stopped them due to the side effects. Some time later you saw another psychiatrist when you cut your wrists and they told you that you had a personality disorder but you never understood what that meant.

You planned your suicide carefully. You bought the tablets from three different shops and the vodka specially. You wrote notes to all your relative and posted them. You printed off an advance directive form and made your flatmates sign it, joking with them that it was 'just in case'. You could tell they thought it was a strange thing to do but obviously didn't think you would do it. You waited until Saturday night as you knew they would be out until late on Sunday. You took the tablets and the vodka and then waited over an hour before you called the ambulance. You knew you did not want to die alone and hoped that the ambulance would get there in time so you could hear people's voices around you as you died. You remain adamant that you do not want treatment in the ambulance and with the first staff member who sees you. You retain capacity as you understand the consequences of your actions completely and the potential outcome. However, if subsequent staff members are sufficiently empathetic towards you, you consider that there might be some potential for a better life and agree to be treated.

<u>Example excerpt (psychiatrist as the assessor):</u>

Dr: Hello Mr Johnson, I'm Dr Taylor the psychiatrist on call. I've been asked to come and see you to have a chat about what's brought you in today. The doctors and nurses here are really worried about you.

Mr Johnson (takes oxygen mask off to talk, bit breathless) I don't want to talk about it. Just leave me in peace

Dr: I understand you have taken a big overdose of painkillers. Is that right?

Mr Johnson: nods

Dr: Can you explain why you did that?

Mr Johnson: I just don't want to do it any more. I'm tired. It's better this way.

Dr: The doctors here have recommended that you need treatment for the overdose. Do you know what it is?

Mr Johnson: I forget the name of it. N-something. Counteracts the paracetamol and stops it killing me.

Dr: Do you know what is likely to happen if you don't have the treatment the doctors here are recommending?

Mr Johnson: I know, I know, they told me without the treatment my kidneys and liver will fail and I will die. But that's ok, I want to die.

Dr: So do I understand right that your decision is to refuse the treatment recommended?

Mr Johnson: Yes. I just want to be left to go.

Dr: But why did you call the ambulance if you wanted to kill yourself?

Mr Johnson: I waited until I knew it was too late then called. No-one should have to die alone.

Dr: Is there anything in your life that makes you want to keep on living?

Mr Johnson: Nothing. I got no family to speak of, no real friends. No job. No proper home. What is the point. I'll be happier when I'm gone.

Dr: Are you a religious person?

Mr Johnson: Not especially. I was raised a Christian and I guess I believe in a sort of afterlife.

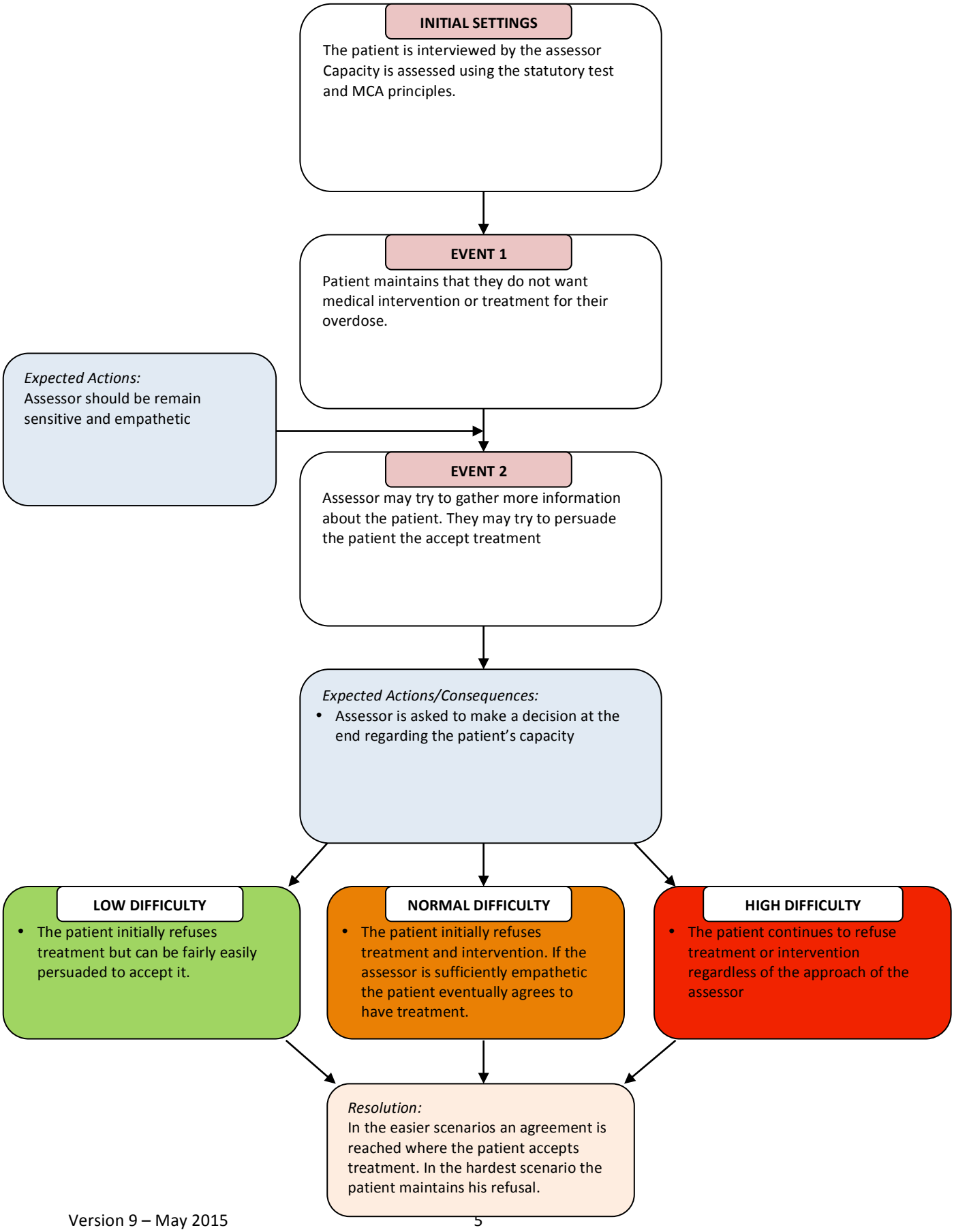
Dr: Do you find that a comfort?

Mr Johnson: I suppose it is. I don't care really. I'm just too tired to care any more…….

Depending on how much time is available, and how talkative the patient is the doctor might go on to explore more about Mr Johnson's psychiatric history, current symptoms of mental illness, features consistent with personality disorder, personal history, medical problems and personal history.

The facilitator will ask the assessor if they think the patient has capacity or not.

CONDUCT OF SCENARIO



DEBRIEFING

POINTS FOR FURTHER DISCUSSION

Points to consider/discuss:

What is the statutory test of capacity?

(An individual must have a disturbance of mind or brain and be incapable of doing one of the following regarding a specific decision: understand and retain the relevant information, weigh up the information and communicate a decision.)

What are the five principles of the Mental Capacity Act 2005?

(Presumption of capacity, right to be supported to make decisions, right to make unwise decisions, best interests and least restrictive option)

On the information available it may be that the patient can be considered to have capacity. In this instance, what action should the hospital staff take?

What about if the old notes arrives and showed a much more extensive history of contact with mental health services including admissions to hospital under the Mental Health Act. Does this make a difference?

What about if he was seen recently and his diagnosis was one of Emotionally Unstable Personality Disorder and recurrent depression? Does a personality disorder amount to a disturbance of mind or brain for the purposes of the Mental Capacity Act?

What if he was also alcohol dependent?

What about if the patient had no history of mental disorder at all?

What about if the patient is under 18?

Who is responsible for assessing capacity? (The person who wishes to make a decision on their behalf.)

What can you do if the person whose capacity is in doubt refuses to be assessed? (Aside from sensitively trying to explain the possible consequences of such as decision, there is nothing else you can do. No-one can be required to undergo a capacity assessment.)

What to do once capacity has been assessed?

Capacity assessments in situations which could lead to the death of a patient should involve as many relevant senior clinicians as possible. These people should wherever possible assess the patient in person rather than offering advice over the phone. If the patient presents to the ED the Lead Consultant should be made aware as soon as possible. Psychiatry services should expect to be consulted about any case where mental disorder is a suspicion (as it will probably be in every case) as should the Trust solicitors. Medical indemnity organisations may offer helpful advice.

Trust Solicitors are likely to offer the following advice:

- If the patient lacks capacity this should be clearly documented in as much detail as possible by senior clinicians. The patient may challenge any treatment he is given later. If the patient lacks capacity he can be treated in his best interests. Treatment can be given using reasonable force (for example, restraint to insert a cannula or take a blood sample.

- If the patient has capacity, a court order would be required in order to give him treatment against his wishes.

- The Mental Health Act can be used to treat symptoms of mental disorder. If there was a strong case that the overdose was a symptom of an underlying mental disorder (including personality disorder) then Section 63 could be invoked if he were detained under the MHA.

- Statutory criteria for detention under the MHA would have to be met. He would have to be assessed by two doctors and an AMHP as having a mental disorder of a nature and/or degree to warrant detention in hospital for treatment. Such treatment would have to be necessary in the interests of his health or safety or for the protection of others.

- If there remains doubt about capacity and a decision must be made about treatment in the night where other help might not be available, it is better to take action to preserve life. Action like this is likely to be viewed sympathetically by a court providing all the decisions and their rationale is fully documented.

- Advance decisions are binding if the person who made them was over 18 and had the necessary capacity at the time. They must be specific. It must be clear that the decision has not been withdrawn when the patient had capacity. The person must not have done anything inconsistent with the decision.

- If the person is subject to the Mental Health Act, any pre-existing advance decisions relating to mental health treatment are not binding (except in the case of ECT.)

DEBRIEFING RESOURCES

Mental Capacity Act 2005 Code of Practice
BMA MCA Toolkit Card 9 Advance Decisions Refusing Treatment

PSYCHIATRY SCENARIO 5 - HANDOUT

INFORMATION FOR PARTICIPANTS

Assessment of mental capacity is a skill which all doctors and health care professionals should be able to demonstrate. For more complex decisions, particularly where life is threatened, several members of the multidisciplinary team may be called upon to assess capacity and reach a decision together. Differentiating between 'unwise decisions' and decision which contribute towards evidence of a mental disorder can be difficult.

KEY POINTS

- Greater confidence in undertaking mental capacity assessments
- An appreciation of the statutory test and principles of the Mental Capacity Act 2005
- An understanding of standards of practice expected
- An understanding of the concepts and issues underlying these situations
- An opportunity to share concerns and explore issues with other trainees

RELEVANCE TO THE CURRICULUM

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WORKPLACE-BASED ASSESSMENTS

Curriculum	**Details**
ILO 1,2,3 Assessment, formulation and management	CBD, CP, Mini-PAT, supervisors report

PARTICIPANT REFLECTION

What have you learned from this experience? (Please try and list 3 things)

How will your practice now change?

What other actions will you now take to meet any identified learning needs?

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PARTICIPANT FEEDBACK

Date of training session:.....

Profession and grade:.....

What role(s) did you play in the scenario? (Please tick)

Primary/Initial Participant	
Secondary Participant (e.g. 'Call for Help' responder)	
Other health care professional (e.g. nurse/ODP)	
Other role (please specify):	
Observer	

	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree
I found this scenario useful					
I understand more about the scenario subject					
I have more confidence to deal with this scenario					
The material covered was relevant to me					

Please write down one thing you have learned today, and that you will use in your clinical practice.

How could this scenario be improved for future participants? This is especially important if you have ticked anything in the disagree/strongly disagree box.

FACULTY DEBRIEF – TO BE COMPLETED BY FACULTY TEAM

What went particularly well during this scenario?

What did not go well, or as well as planned?

Why didn't it go well?

How could the scenario be improved for future participants?