

POLICY REGARDING DECISION-MAKING, CONSENT AND CAPACITY WITHIN DRH FACILITIES

1.0 INTRODUCTION

DRH seeks to maintain and to demonstrably improve our service users' quality of life. A climate that supports and encourages decision-making is an essential element of a positive service and a major aspect of a good quality of life.

DRH recognise that people with a disability should be presumed to be capable of making their own decisions in the absence of evidence to the contrary, and should be supported to make their own decisions.

Seeking the consent of our service users to major, as well as everyday decisions, is part of a respectful relationship with people with disabilities and should be seen as a *process* and not a *one-off* event.

We recognise that many of our service users may be limited in their capacity to make certain autonomous decisions. As a specialist provider DRH seeks to optimise the capacity of all our service users to make decisions by providing appropriate help and support. In the event that a service user's capacity to decide is severely impaired we will ensure that decisions based on their best interests are made on their behalf.

DRH recognise that an individual's capacity to make fully autonomous or assisted decisions is strongly influenced by the environment within which that decision has to be made. Decision-making can be promoted by a comprehensive analysis of the available opportunities for choice and by clear and agreed team strategies for communicating opportunities for choice. Choices should be respected. For example, a decision **not** to participate in a particular activity may represent a very positive choice for an individual service user.

It is the responsibility of staff to ensure that possible consequences of specific choices are clearly explained to service users in a way they will understand. However, staff should avoid imposing their own preferences on to service users.

DRH recognises that choices have consequences and that these consequences may present a risk to the service user or to others. We have a duty of care to our service users and must be aware of the risks, which may be associated with particular choices. However, a good quality of life always involves risk-taking and service users should be free to take reasonable risks.

When decisions are made on behalf of service users we will always seek to involve those closest to the service user and to ensure that decisions reflect that service users best interests.

2.0 LEGAL FRAMEWORK

The Mental Capacity Act 2005 provides a statutory framework to empower and protect vulnerable people who may not be able to make their own decisions. It makes clear who can take decisions in which situations and how they should go about this. It also enables people to plan for a time when they may lose capacity

Guidance on the Act will be provided in a Statutory Code of Practice. A draft code of Practice has been published.

The Act is underpinned by a set of **five key principles**:

- **A presumption of capacity** – every adult has the right to make his or her own decisions and must be assumed to have capacity unless it is proved otherwise
- **The right for individuals to be supported to make their own decisions** – people must be given all appropriate help before anyone concludes that they cannot make their own decisions
- **That individuals must retain the right to make what might be seen as eccentric or unwise decisions**
- **Best interests** – anything done for or on behalf of people without capacity must be in their best interests; and the
- **Least restrictive intervention** – anything done for or on behalf of people without capacity should be the least restrictive of their basic rights and freedoms.

The Act deals with assessment of the person's capacity and the actions by carers of those who lack capacity:

- **Assessing lack of capacity** – any test for capacity should be "decision - specific". No one should be labelled incapable as a result of a particular medical condition; diagnosis or by reference to a person's age, appearance or behaviour
- **Best interests** – everything that is done for or on behalf of a person who lacks capacity must be done in their best interests.
- **Acts in connection with care or treatment**- where a person is providing care or treatment for someone who lacks capacity

"Consent" is defined as the voluntary and continuing permission of the service user to receive a particular treatment, based on an adequate knowledge of the purpose, nature, likely effects and risks of that treatment including the likelihood of its success and any alternatives to it. Permission given under any unfair or undue pressure is not "consent". (1983 Mental Health Act, Code of Conduct, Page 67)

The European Court of Human Rights has ruled (HL v.UK 2004) unlawful the current situation in the UK where many people with a learning disability are deprived of their liberty because they do not have the capacity to articulate their wishes. The UK government has not yet identified an appropriate legal remedy to address the ECHR decision. DRH have many service users for whom the ECHR decision applies. We have a responsibility for ensuring that all

service users are assisted to make autonomous decisions wherever possible and to ensure that any decisions taken on behalf of service users are in their best interest.

3.0 NATIONAL CARE STANDARDS

National Care Standards requires Care Homes and Independent Mental Health Hospitals to comply with the following standards relating to Decision-making:

- ❑ Staff in homes should respect service users' rights to make their own decisions and should only act to limit that right through a full assessment process, involving the service user, and as recorded in the individual service users plan.
- ❑ Staff in homes should provide service users with the information, assistance and support they need to make decisions about their own lives.
- ❑ Staff should help service users, if they wish, to find and participate in local advocacy/self advocacy groups and/or to find peer support from someone who shares the person's disability, heritage or aspirations.
- ❑ Staff should be able to demonstrate how individual choices have been encouraged and made and to record instances when decisions have been made by others, and why.
- ❑ Service users should be encouraged and enabled to manage their own finances and should be provided with support and tuition as required. The reasons for, and the manner of such support should be documented and regularly reviewed.
- ❑ Any limitations on facilities, choice or human rights put in place in order to prevent self-harm, self-neglect or abuse, or harm to others, should be made only in the service users' best interests and should be consistent with the purpose of the service, and the home's duties and responsibilities under law.
- ❑ Service users should be consulted on changes and participate in all aspects of life in a home
- ❑ Service users should be allowed to, and should be supported in, taking risks as part of a normal independent lifestyle.

3.0 The National Service Framework for Mental Health has ten "guiding values and principles". These include an assurance that people with mental health problems can expect that services will *"offer choices which promote independence"*

The learning disability White Paper, **"Valuing People"** sets out 4 main objectives:

- Rights
- Independence
- Choice
- Inclusion.

The contracts that DRH have with our purchasers, both health and social care agencies require us to ensure that these principles, values and objectives are reflected in the services we provide to our service users and clients.

4.0 CAPACITY & CONSENT

For a persons consent to be valid, the person must be:

- Able to comprehend and retain information material to the *specific* decision
- Use and weigh information when making the decision
- Acting voluntarily and without pressure or duress from anyone
- Provided with enough information to enable them to make a decision
- To communicate a decision by what ever means

(Mental Capacity Act 2005)

A person's capacity should always be determined in the context of a specific decision. It should never be assumed that because a service user is incapable of making certain kinds of decisions they cannot make some decisions about their own life.

A service user's capacity to consent should be assessed and the outcome of that assessment should be recorded. Life and support plans should reflect the extent and limitations on the service user's capacity to make decisions. Individual plans should also identify the measures that need to be taken to develop and support the service user's decision making abilities.

A service users *capacity* to make a decision should not be confused with a carers assessment of the *reasonableness* of the service users decision. A service user is entitled to make a decision, which is based on their own value system even if others perceive it as irrational. An irrational decision has been defined as "one which is so outrageous in it's defiance of logic or of accepted moral standards that no sensible person who had applied his or her mind to the question could have arrived at it."

A competent person does, for example, have the right to refuse a life-saving procedure, although every effort would be made to encourage them to accept.

Consent may be expressed in writing, verbally and non-verbally. Normally consent to personal care is indicated by the service user's speech and behaviour. For example, active co-operation with assistance to dress or bathe can be taken as an indication of the service user's consent.

A person with capacity is entitled to withdraw consent at any time.

5.0 INCAPACITY –BEST INTEREST

When decisions have to be taken on someone else's behalf, the decision must always be in their best interests. The following factors should be taken into account:

- The past and present wishes and feelings of the service user.

- ❑ The need to permit and encourage the service user to participate as fully as possible in any decision affecting them.
- ❑ The views of others whom it is appropriate consult about the service user's wishes and feelings – and what would be in their best interests.
- ❑ Whether the desired outcome from a specific decision can be achieved in a manner less restrictive of the service user's freedom of action.
- ❑ The need to be satisfied that the wishes of the service user were not the result of undue influence.

6.0 CONSULTING WITH OTHERS

Significant decisions affecting the life of a service user, whose capacity is impaired, should only be taken following appropriate consultation. Consultation should take place with close family, friends, members of the immediate care team, day care team, care managers and independent advocates. Members of the care team have a valid contribution to make to any decision but this may well need to be balanced with the opinion of an external advocate. Similarly, it should not be assumed that a family member is necessarily best placed to represent the interests, wishes and feelings of their relative. Staff must take note of any declared wish of the service user that a particular family member should not be involved in such decisions.

Following appropriate consultation, a final decision needs to be taken by that person (or agency) that is best placed to do so. For example, a decision to transfer a service user to another Home or service may ultimately be taken by the service user's care manager. Following discussion on the relative merits of a medical intervention, the decision to proceed rests with the medical practitioner who will carry out the intervention – after they have consulted with people who are close to the service user.

A medical practitioner cannot be required to carry out a procedure that they do not believe to be clinically appropriate. Equally, a medical decision to proceed with a certain intervention may be disputed by those close to the service user – including staff – and a second medical opinion should be sought.

Consulting widely may help to clarify whether the service user has the capacity to make a particular decision and also to determine the service users' "best interests".

The Mental Capacity Act 2005 creates the first national statutory advocacy service. Advocacy and representation via Independent Mental Capacity Advocacy service will be provided only to people who lack mental capacity for whom "serious medical treatment" or a change of long-term accommodation is proposed, and who do not have a representative (such as a carer or concerned relative) of any kind. The service will not replace existing independent services.

7.0 ADVANCE DIRECTIVES – MENTAL HEALTH

An advance directive (also known as a "living will" or "advance refusal") is a way of making a persons views known if s/he should become mentally incapable of giving

consent to treatment or making informed choices about treatment in the future. Care professionals cannot ignore an advance directive unless:

- a) the advance directive does not apply to the particular situation which arises.
- b) the advance directive lacks sufficient clarity about the person's wishes.
- c) The Mental Health Act allows professionals to override the person's wishes

An advance directive cannot compel a health professional to give a particular type of treatment but it can detail the kinds of treatment or other interventions that the person does **not** consent to.

A valid advance directive can be made by any DRH service user who is mentally competent to understand the nature of a directive and the future effect it may have. Advance directives are particularly appropriate for service users at D.R.H.'s two Independent Mental Health Hospitals – Elsadene and Fairfield House – who's mental capacity may fluctuate with the onset of a period of mental ill-health.

All service users who wish to, and who are capable of making an advance directive should be supported by the Home Manager and support team. Copies of the DRH Guidance on Psychiatric Treatment Advance Directive should be made available to service users who may wish to record an advance directive.

8.0 SERVICE USERS DETAINED UNDER THE PROVISIONS THE 1983 MENTAL HEALTH ACT

The general provisions of this policy apply to all DRH service users – including those who may be detained under the 1983 Mental Health Act at our two Independent Mental Health Hospitals (Elsadene and Fairfield). However, under certain circumstances a person may be given treatment without their consent under the provisions of Part IV of the Act.

REFERENCES:

Mental Capacity Act 2005

Mental Health Act Code of Practice 1999

National service framework for mental health: modern standards and service models 1999

Valuing People - A New Strategy for Learning Disability for the 21st Century 2001

SG/June 06