CONSENT

1. INTRODUCTION

PiC recognises and abides by the legal principle by which a patient / resident is informed about the nature, purpose and likely effects of any treatment proposed before being asked to consent to accepting it.

This policy should be read in conjunction with:

- PiC Operational Policy – *Mental Capacity Act*
- PiC Operational Policy – *Policy for Working within the Mental Health Act 1983 (amended 2007)*
- Mental Capacity Act 2005
- Mental Capacity Act 2005 – Code of Practice
- The Mental Health Act 1983 (amended 2015) Code of Practice
- The Mental Health (Care and Treatment) (Scotland) Act 2003
- The Mental Health (Care and Treatment) (Scotland) Act 2003 Code of Practice Volume 1
- The Mental Health (Care and Treatment) (Scotland) Act 2003 Code of Practice Volume 2
- Adults with Incapacity (Scotland) Act 2000

Please note that the law on Mental Capacity differs for Scotland.

This policy should be implemented within the context of the PiC Values:

- Valuing people – respecting our staff, patients, their families and communities
- Caring safely – for ourselves, our patients, our customers and communities
- Working together with everyone
- Uncompromising integrity, respect and honesty
- Taking quality to the highest level

2. CAPACITY TO CONSENT

The principle of the Mental Capacity Act is that it should be assumed that an adult (aged 16 or over) has full legal capacity to make decisions unless it can be shown that they lack capacity to make a decision for themselves at the time the decision needs to be made. This is known as the presumption of capacity. The Act also states that people must be given all appropriate help and support to enable them to make their own decisions or to maximise their participation in any decision-making process.

Section 2 of the Mental Capacity Act sets out the diagnostic test for capacity which has the following two elements:

1. Capacity is issue specific in relation to a particular issue at a particular time. A lack of capacity in one issue does not automatically mean a lack of capacity in relation to another.

2. Incapacity must derive from an impairment or disturbance of the person's mind or brain. This can include mental illness, learning disability, personality disorder, brain damage, dementia and toxic conditions. This list is not exhaustive. Incapacity may derive from both organic and non-organic causes.

Where a patient / resident has borderline capacity for a decision, careful consideration should be given to what might assist that particular patient / resident.

Where a patient / resident has fluctuating capacity it will be important for that patient / resident to undergo regular capacity reviews.

3. CAPACITY TEST

Section 3 of the Mental Capacity Act sets out a single clear test for assessing whether a person lacks capacity to take a particular decision at a particular time. This test also applies to the capacity to consent to treatment.

A person is unable to make a decision if s/he is unable:

(a) To understand the information relevant to the decision,
(b) To retain that information,
(c) To use or weigh that information as part of the process of making the decision and having considered it, arrive at a choice as to the course they wish to pursue, including information about the reasonably foreseeable consequences of making a decision one way or another or failing to make a decision or
(d) To communicate the decision (by means of talking, writing, sign language or other means)

If a person fails to satisfy any one or more of the criteria (a) to (d) above, the law regards them as not having capacity.

4. POLICY PRINCIPLES

A person who lacks capacity to consent to treatment, even if they cooperate or actively seek it, cannot be treated as consenting.

It is the duty of everyone seeking consent to use reasonable care and skill, not only in giving information prior to seeking consent, but also in meeting the continuing obligation to provide the patient / resident with sufficient information about the proposed treatment and alternatives to it.

The information must be relevant to:

- The particular patient / resident
- The particular treatment and
- Clinical knowledge and practice

In every case, sufficient information must be given to the patient / resident to ensure that they are able to understand in broad terms the nature, likely effects and all significant possible adverse outcomes of that treatment, including the likelihood of its success and any alternatives to it. A record should be kept of information provided to patients / residents.

Patients / residents should be invited to ask questions and professionals should answer fully, frankly and truthfully unless there is a compelling reason, in the patient / resident's interests, for not disclosing certain information. A professional who chooses not to disclose information must be prepared to justify their decision. A professional who chooses not to answer a patient / resident's question should make this clear to them so that they know where they stand.

PiC also requires that any decision not to disclose certain information to a patient / resident is covered in the individual's clinical risk assessment.

Patients should be told that their consent to treatment can be withdrawn at any time. Where patients withdraw their consent (or are considering withdrawing it), they should be given a clear explanation of the likely consequences of not receiving the treatment and (where relevant) the circumstances in which the treatment may be given without their consent under the Mental Health Act. A record should be kept of the information provided to patients and the reasons given for the withdrawal of their consent.

Where a patient / resident does not have capacity to consent, clinicians should check if they are required to consult with any other person on the matter in question or matters of that kind e.g. where the patient / resident has named a person to be consulted on their behalf, any donee of a lasting power of attorney granted by them or any deputy appointed by the court.

5. BEST INTERESTS

The Mental Capacity Act introduces a 'best interests checklist'.

A person's best interests must be the basis for all decisions made and actions carried out on their behalf in situations where a person lacks capacity to make a specific decision. Any act done or decision made for and on behalf of an incapacitated person will have complied with the law if s/he reasonably believes what they are doing is in the patient / resident's best interests. The only exceptions to this are around research and advance decisions to refuse treatment where other safeguards apply.

What amounts to 'best interests' will depend on individual circumstances. Section 4 of the Act sets out a checklist of steps to follow.

Best Interests Checklist

Any person making a decision or undertaking an act on behalf of an incapacitated patient / resident must consider the following points:

- Is the individual likely to have capacity at some time in the future to the matter in question, such as the treatment decision?
- If so, when is that likely to be? It is not always possible to predict this.
- The patient / resident for whom the decision is to be made should be encouraged to participate as fully as possible in any decision or act done for him/her.
- Nothing done must be motivated to bring about that patient / resident's death.
- Consideration must be given, as far as reasonably possible to the individuals past and present wishes, feelings, beliefs and values and any other factors they would be likely to take account if they had capacity. Clinicians should make enquiries of relatives carers and friends where appropriate.
- Any written statements made while the patient / resident had capacity.
- As far as is appropriate and practicable, clinicians must consult the following:
    - Anyone named by the incapacitated person as someone to be consulted
    - Anyone engaged in caring for the incapacitated person or interested in their welfare
    - Any donee of a Lasting Power of Attorney relevant to the matter in question
    - Any deputy appointed by the court

Refer to the Mental Capacity Act Code of Practice for additional information.

6. MENTAL HEALTH ACT

6.1 Definitions

The Mental Health Act 1983 (amended 2015) Code of Practice describes the basic principles of consent as being; *"Consent is the voluntary and continuing permission of the patient to be given a particular treatment, based on a sufficient knowledge of the purpose, nature, likely effects and the risks of that treatment, including the likelihood of its success any alternatives to it. Permission given under any unfair or undue pressure is not consent*

In the Mental Health Act, "medical treatment" also includes nursing, psychological intervention and specialist mental health habilitation, rehabilitation and care.

The Act defines medical treatment for mental disorder as medical treatment which is for the purpose of alleviating or preventing a worsening of a mental disorder or one or more of its symptoms or manifestations.

This includes treatment of physical health problems only to the extent that such treatment is part of, or ancillary to, treatment for mental disorder (e.g. treating wounds / injuries self-inflicted as a result of mental disorder). Otherwise, the Act does not regulate medical treatment for physical health problems.

6.2 Detained Patients

The Mental Health Act permits medical treatment for mental disorder to be given without consent with the requirements for Second Opinion Appointed Doctor (SOAD) certified as set out below. The patient's consent should be sought before treatment is given, wherever practicable, although care should be taken to ensure that the consent is valid.

Valid consent requires that the patient:

- Has capacity for the specific issue
- Is given the information that they need to make the decision and
- Is not put under any duress or inappropriate pressure

The clinician should review the issue of capacity to consent where a treatment regime is particularly complex or there are risks of significant side effects that need to be balanced by a patient. The clinician's assessment of the patient's capacity to consent and the patient's consent or refusal should be recorded in their notes.

If a patient withdraws or loses the capacity to consent the treatment should be reviewed. The clinician in charge of the treatment must consider whether to proceed in the absence of consent, to provide alternative treatment instead or to give no further treatment.

Part 4 and 4A of the Act deals mainly with the treatment of people who have been detained in hospital, including those on community treatment orders (CTO's) who have been recalled to hospital.

Some patients detained in hospital are not covered by these rules. These are:

- Section 4 – Patients detained on the basis of an emergency application unless or until the second medical recommendation is received
- Section 5(2) or 5(4) – Patients held in hospital under the holding powers
- Section 35 – Patients remanded to hospital for a report on their mental condition
- Section 135 or 136 – Patients detained in hospital as a place of safety
- section 37(4) or 45A(5) – Patients temporarily detained in hospital as a place of safety under, pending admission to the hospital named in their hospital order or hospital direction
- Restricted patients who have been conditionally discharged (unless or until they are recalled to hospital).

There are no special rules about treatment for these patients – they are in the same position as patients who are not subject to the Act at all, and they have exactly the same rights to consent to and refuse treatment.

Unless sections 57, 58 or 58A apply, section 63 of the Act means that detained patients may be given medical treatment for any kind for mental disorder, if they:

- Consent to it; or
- Have not consented to it, but the treatment is given by or under the direction of the approved clinician in charge of the treatment in question.

6.3 Advance Decisions & Consent to Treatment

If a patient has made an Advanced Decision refusing medical treatment for mental disorder under the Mental Capacity Act this is rendered ineffectual. Please note the following however:

Nottinghamshire Healthcare NHS Trust v RC [2014] EWCOP 1317

The patient was detained under the Mental Health Act. He was a Jehovah's Witness and had made an advance decision to refuse blood transfusions. He was self- harming in hospital. The Doctor had to consider whether to give the patient a blood transfusion. The Doctor could have given this treatment without the patient's consent under section 63. However she felt in a difficult ethical position doing so, given the patient's advance decision. The Court held that the Doctor was right not to give the treatment under section 63. It was held that the patient's advanced decision was valid and applicable and therefore treatment should not be given under section 63.

Clinicians should never ignore the existence of an advance statement as it should be treated as an expression of the patient's wishes as under the "best interest checklist".

6.4 Treatments to Which Special Rules and Procedures Apply

Sections 57, 58 and 58A of the Act set out types of medical treatment for mental disorder to which special rules and procedures apply, including, in many cases, the need for a certificate from a Second Opinion Appointed Doctor (SOAD) approving the treatment.

Situation	**Exceptions to the normal rules in the MCA**
Section 57	Neurosurgery for mental disorder Surgical implantation of hormones to reduce male sex drive *The Mental Capacity Act may not be used to give anyone treatment to which section 57 applies*.
Section 58A	ECT and medication administered as part of ECT *The Mental Capacity Act may not be used to give detained patients ECT or any other treatment to which section 58A applies*.
Section 58 – Treatment for detained patients	Medication (after an initial three-month period) – except medication administered as part of electro-convulsive therapy (ECT) *The Mental Capacity Act may not be used to give detained patients any other medical treatment for mental disorder. Treatment must be given in accordance with Part 4 of the Mental Health Act instead*.
Treatment for Community Treatment patients who have not been recalled to hospital (Part 4A patients)	*The Mental Capacity Act may not generally be used to give these patients any medical treatment for mental disorder, but attorneys, deputies and the Court of Protection may consent to such treatment on behalf of these patients*.

7. CONSENT AND THE HUMAN RIGHTS ACT

Clinicians authorising or administering treatment without consent under the Mental Health Act are performing a function of a public nature and are therefore subject to the provisions of the Human Rights Act 1998. It is unlawful for them to act in a way which is incompatible with a patient's rights as set out in the European Convention on Human Rights ("the Convention").

In particular, the following should be noted:

- Compulsory administration of treatment which would otherwise require consent could be held as being incompatible with Article 8 of the Convention (respect for family and private life). However, it may be justified where it is in accordance with law (e.g. Mental Health Act) and where it is proportionate to a legitimate aim (in this case, the reduction of the risk posed by a person's mental disorder and the improvement of their health) as it would satisfy the best interests test if:
    - It is in accordance with responsible and competent professional opinion
    - A less invasive form of treatment likely to achieve the same beneficial results is not available or not appropriate
    - It is necessary that the treatment be given with regard to (a) resistance to treatment (b) the degree to which treatment is likely alleviate or prevent a deterioration (c) the risks presented to himself or others (d) consequences of the treatment not being given (e) any possible adverse effects.

Article 8 does not require treatment to be a therapeutic necessity or that it is guaranteed to work. The section 58 Mental Health Act test is a distinct test where it applies.

- Compulsory treatment is capable of being inhuman treatment contrary to Article 3 of the Convention, if its effect on the person concerned reaches a sufficient level of severity. But the European Court of Human Rights has said that a measure which is '*convincingly shown'* to be of therapeutic necessity from the point of view of established principles of medicine cannot in principle be regarded as inhuman and degrading.

Scrupulous adherence to the requirements of the legislation and good clinical practice should ensure that there is no such incompatibility. But if clinicians have concerns about a potential breach of a person's human rights they should seek senior clinical and, if necessary, legal advice.