16th Annual Conference of the
National HIV Nurses Association (NHIVNA)

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North Manchester General Hospital

26-27 June 2014- City Hall, Cardiff

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Manchester City Council

Manchester Mental Health and Social Care Trust NHS

Mental Health: Assessing Capacity & Managing Risk

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Assessing and Managing Risk

“ The governing principle behind good approaches to choice and risk is that people have the right to live their lives to the full as long as that does not stop others from doing the same. Fear of supporting people to take reasonable risks in their daily lives can prevent them from doing the things that most people take for granted. What needs to be considered is the **consequence** of an action and the **likelihood** of any benefit or harm from it”

Department of Health, *Independence, choice and risk: a guide to best practice in supported decision making*, DH, London, May 2007.

Risk Assessment

- Risk assessment is concerned with carefully weighing up the likelihood (risk) of a particular event (benefit/harm) occurring.
- Risk assessment has been described as an inexact science, as it is based on judgement rather than accurate prediction. (S C A)
- This process requires linking historical information to current circumstances to anticipate possible future change (Morgan, 2000).
- Gut reactions & hunches are important but must be backed up by other methods of assessment.
- Consider the positive resources such as coping strategies because these might help in the management

Risk Assessment Model

- **Two models** of risk assessment have been identified (Davis, 1996):
- The **risk-taking model** (risk is normal and positive and assessment focuses on mental wellbeing, rights, abilities, choice and participation).
- The **risk minimisation model** (which targets those most at risk and assessment focuses on physical health, danger, control and incapacity).

Davis, A (1996) **'Risk Work and Mental Health',** in H. Kemshall and J. Pritchard (eds) Good Practice in Risk Assessment and Risk Management, London: Jessica Kingsley.

Risk Formulation

Risk formulation is the process of *analysing and evaluating* the risk assessment information and evidence base to inform the risk management plan. It involves developing an understanding of the risk profile of the individual service user and the level of risk presented, including:

- **NATURE** What the potential risks are (What are the risks? Who are the risks to?)
- **LIKELIHOOD** How likely is it to happen?
- **CONSEQUENCE** If it happens how serious could it be?
- **IMIMINENCE** When is the risk likely to be present?
- **MAINTAINING TRIGGERS** What might (or does) trigger the event/risk
- **FREQUENCY** How often is the risk present?
- What indicators might there be of the risk?

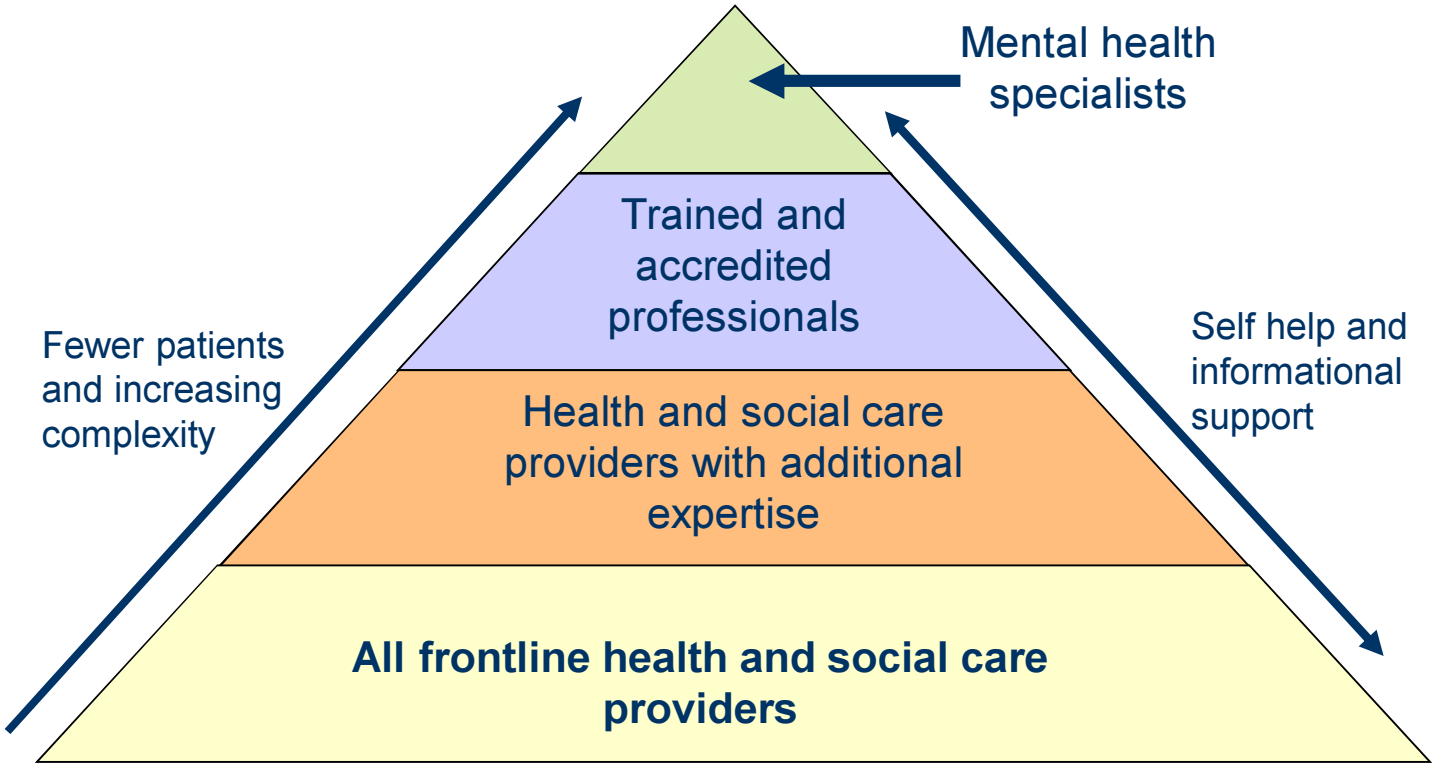
Risk Formulation

- Presenting problems
  - List problems, risks and needs
- Predisposing factors
  - Early factors that made the person vulnerable
- Precipitating factors
  - Events close in time to the development of the problem(s)
- Perpetuating factors
  - What keeps the problem(s) going?
- Protective factors
  - What contributes to resilience or absence of problem
- Underpinning mechanism
  - Psychological processes and how these produce the presenting problems
- Obstacles to treatment
  - What might stop the person engaging in treatment?

Risk Formulation

Where?	Location of incident or event
When?	When this happened
Who?	Patient and their relationships to others present or involved
What?	Detail (antecedents, behaviours, consequences)
Why?	Motivation (internal and external) (incl. Disinhibitors, e.g, alcohol, drugs)

Stepped Care Model for Psychological Support in HIV Services



Standards for Psychological Support for Adults living with HIV (2011)

The Stepped Care Model

Level 1	Assessment	Interventions
Information and Support	Understanding psychological needs **<u>Understanding risk of harm to self and others</u>** Recognising overt psychological distress	- Effective provision of relevant information - Supported self help - Signposting and referral to appropriate providers - Response to overt distress - Supportive communication and general psychological support -Signposting self-management strategies e.g. books, computerised resources etc -Peer support

The Stepped Care Model

Level 2	Assessment	Interventions
Enhanced Support	Screening for psychological distress Screening for cognitive difficulties Assessment of risk of self harm to self and others	-Discussions aimed at acceptance & adaptation to living with HIV -Signposting & referral to more appropriate services & peer support -Education sessions on psychological and psychiatric problems – coping skills -Brief interventions aimed at behavioural change e.g. sexual risk, substance misuse

The Stepped Care Model

Level 3	Assessment	Interventions
Counselling and Psychological Therapies	Assessment and formulation of psychological problems Identification of psychiatric problems Screening for cognitive impairment Risk Assessment	-Counselling and psychological interventions – specific theoretical frameworks for specific problems: •Moderate or severe anxiety •Substance misuse •Moderate or severe depression •Psychosexual/relationship issues •Sexual trauma/PTSD -Interventions for cognitive impairment - Psychological interventions based on explicit theoretical frameworks (coping/resilience)

The Stepped Care Model

Level 4	Assessment	Interventions
Specialist psychological and mental health intervention	Psychiatric diagnosis Neuropsychological assessment/assessment of cognitive impairment Assessment & formulation of complex problems Risk assessment	-Specialist psychological and psychiatric interventions for severe and complex psychological problems, cognitive impairment, PTSD or co-morbid psychiatric problems, such as: •Psychosis •Severe depression •Mania •Eating disorders •Personality disorder •Cognitive impairment •Complex adolescent & family issues -Cognitive rehabilitation

Case Example:
A person who is recently diagnosed with HIV presents with problems adhering to medications, together with low mood, hopelessness and some suicidal thoughts.

Some questions you may want to ask regarding risk—

- When did you start having suicidal thoughts?
- How often do you feel suicidal? How strong are those thoughts?
- Are there any particular times when the suicidal thoughts are worst?
- What has stopped you from carrying out those thoughts (any protective factors)?
- Do you have any suicidal plan?
- Do you live alone? Do you get any support from family and friends?

Questions to ask

- Is there a history of suicide in your family?
- Have you self harmed or attempted suicide in the past?
- Have you made any suicidal attempt yet? If yes, how did you do it? Did you leave a note? Avoid discovery? How long ago was it? How do you feel now about the suicidal attempt? Did you have any alcohol or illicit substances before you attempted suicide?
- How can we help you to keep you safe? Can I refer you to mental health services?
- Stockpile of medications?

Actions to Manage Risk

- Provide the client with information about their treatment and diagnosis. Continue to engage with clients to further assess the situation.
- With their permission, discuss their presentation with their support network including services involved.
- Refer the client to HIV in-house mental health workers like the clinical psychologist or counsellor.
- Contact client's GP who has access to local mental health services.
- Knowing what local mental health services (both voluntary and statutory) are available can be very useful.
- Seek direct advice from local mental health team including Mental Health Home Treatment/ Assessment Team; and Community Mental Health Team.

Actions to Manage Risk

- If risk to self or others is very high---
  - Refer the clients to A&E where they can be assessed by the mental health liaison team.
  - Contact emergency services like the Police (report concerns for welfare) and ambulance.
  - Discuss with on call psychiatrist via local hospital switch board.
  - Contact statutory mental health services (community mental health team, mental health home treatment team/ assessment team) and request a Mental Health Act assessment. This however, should be the last resort.

Capacity

Background

- Capacity vs. competence?
- Lack of clear guidelines – vulnerable citizens open to abuse
- European Convention on Human Rights
- Human Rights Act (1998)
- Mental Capacity Act (MCA; 2005) – legal framework - covers England and Wales

Consent

- Informed consent:

  'The voluntary and continuing permission of the patient to receive a particular treatment, based on 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' (MCA code of practice)

- Informed consent requires:
  - Adequate information (including details of alternatives)
  - Absence of coercion
  - **CAPACITY**

Mental Capacity Act 2005

- **What does 'lacking capacity' mean?**

  "A person lacks capacity in relation to a matter if at the material time he/she is unable to make a decision for him/herself in relation to the matter because of an impairment of, or a disturbance in the functioning of the mind or brain"

- **Core purpose of Mental Capacity Act (MCA)**

  "…to empower people to make decisions for themselves wherever possible, and protect people who lack capacity by providing a flexible framework that places individuals at the very heart of the decision making process" (foreword to MCA – Lord Faulkner)

- **Covers all areas related to healthcare, personal welfare and financial matters**

- **MCA 2005 Code of Practice**

What MCA DOES NOT Cover

- The Act **does not** permit a decision to be made on someone else's behalf on any of the following matters:
  - Consenting to a marriage or civil partnership
  - Consenting to have sexual relations
  - Consenting to a decree of divorce on the basis of two years of separation
  - Consenting to the dissolution of a civil partnership
  - Consenting to a child being placed for adoption or the making of an adoption order
  - Discharging parental responsibility for a child in matters not relating to the child's property or
  - Giving consent under the Human Fertilisation and Embryology Act 1990

Mental Capacity Act 2005

- **Five Statutory Principles**

1) A person **must be assumed to have capacity** unless it is established that they lack capacity.
2) A person is not to be treated as unable to make a decision unless **all practicable steps** to help him/her to do so have been taken without success.
3) A person is not to be treated as unable to make a decision merely because he makes an **unwise decision**.
4) An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his **best interests**.
5) Before the act is done/decision made, regard must be given to whether the purpose for which it is needed can be as effectively achieved in a way that is **least restrictive** of the person's rights and freedom of action.

Assessing Mental Capacity

- **Who can assess for capacity?**
  - The **decision maker** – the body with responsibility for deciding whether someone lacks capacity – can be any professional, a lay person or an MDT.
  - The decision maker may be **uncertain** their decision is the right one, yet the code states that your decision is sound so long as you have **followed the code and can produce your findings**.
  - Assessing capacity is **decision specific** - cannot label anybody as generally 'incapable' as a result of a particular condition, or based on judgements concerning age, appearance, behaviour etc

Assessing Mental Capacity

- There are two parts to assessment: The first part involves establishing whether:

    1) The person has a possible impairment of the brain or mind.
    2) There is indication that due to this impairment that they may be unable to make a specific decision.

- **If no impairment is found then there are no legal grounds for further assessment**.

- **Remember** within the five key principles a person is assumed to have capacity unless proven otherwise, they are also able to make a decision potentially considered 'unwise' by others. It is the assessors responsibility, therefore, to provide evidence of a person's incapacity to make the specific decision in question.

Assessing Mental Capacity

- **Possible reasons for impairment of brain or mind:**
  - Significant learning disabilities
  - Someone who has experienced brain damage
  - Dementia
  - Physical or medical conditions that cause confusion, drowsiness or loss of consciousness
  - Delirium
  - The symptoms of alcohol/drug abuse
  - HIV Associated neurocognitive disorder/dementia (HAND/HAD)

4 Steps of Capacity Assessment

Step 1:

'Is the person able to understand the decision to be made'

Things to consider:

- If capacity is fluctuating/temporary should assessment be delayed?
- What information is relevant for the person to know in order to understand the decision?
- Is the information being presented in a form that is both understandable and appropriate to the person? Be creative!

4 Steps of Capacity Assessment

Step 2:

'Is the person able to retain that information in their mind'

Things to consider:

- Memory problems – although MCA clearly states that information only needs to be retained for long enough to make an effective decision
- Memory aids may be helpful – e.g. visual information/cues

-

4 Steps of Capacity Assessment

Step 3:

'Is the person able to use or weigh up information as part of the decision making process'

Things to consider:

- What does weighing up mean? The British Psychological Society suggests – demonstration of 'reasoning processes' e.g. appreciate wider consequences of decision on self and others, and assessment of risks and benefits of different options

- other factors that may influence the reasoning process to ensure that any decision made is the persons own

4 Steps of Capacity Assessment

Step 4:

'Is the person able to communicate their decision'

Things to consider:

- Communication - may vary greatly from speaking through to signing to other non verbal means such as pointing .
- Does process require repeating to ensure consistency?
- Asking the person to explain their choice (where able) and what they have considered in order to make it, is also useful.

Lack of Capacity?

- **Best interests paramount**

- **Things to do:**
  - Check for lasting/enduring power of attorney
  - Look for relevant documentation
  - IMCA?
  - Call best interests meeting, with relevant family, partners and professionals etc - invite IMCA if involved
  - Ensure significant others views are heard
  - Involve person in question as much as possible

Lack of Capacity? Contd….

- **IMCA** – (Independent Mental Capacity Assessor) are independent advocates who represent individuals when a serious or significant decision/s need to be made and where the person has no one else to speak for them.

- They are able to access all relevant files, interview the person in private as well as interview any other relevant others.

- The are **NOT** the decision maker but they are able to challenge decisions. Their aim is to bring to the attention of the decision maker all factors they consider relevant to the decision.

Other Important Terms/Bodies

- **New court of Protection**

  Replaces the old court of the same name that only dealt with decisions about the property and finances of people lacking capacity to manage their own affairs. The new court also deals with serious decisions affecting healthcare and personal welfare; previously these were only dealt with by the high court.

Other Important Terms/Bodies

- The Court of Protection has the powers of the high court and aims to build expertise in all issues relating to capacity. It is also able to set presidents for others on the basis of cases brought before it. Thus It has the power to:
    - Decide whether a person has capacity to make a particular decision for themselves
    - Make declarations, decisions or orders on financial and welfare matters affecting the person who lacks capacity to make such decisions
    - Appoint deputies to make decisions for a person lacking capacity
    - Decide whether an LPA or EPA is valid
    - Remove deputies who have failed to carry out their duties
    - Their decision is final

Other Important Terms/Bodies

- **Lasting Power of Attorney (LPA)**

  LPA is a person who is appointed by you to make decisions on your behalf. Attorneys can make decisions for you when you no longer wish to or when you lack the mental capacity to do so. They can make decisions in the areas of: **health, welfare, property, finance.** LPA replaced Enduring Power of Attorney (EPA) – only dealt with property and finance.

Other Important Terms/Bodies

- **Court Appointed Deputies** (CAD)

  A CAD is a person appointed by the Court of Protection to manage the affairs of someone who has lost capacity where they have not planned ahead by making an LPA There are two types of a Deputy, one for Property and Affairs and one for Health and Welfare. A CAD is not, however, able to refuse consent to life sustaining treatment. Public guardians monitor deputies

Other Important Terms/Bodies

Advance directive (or living will)

- An advance directive/decision allows a person to state what medical treatment/s they would be willing to accept or refuse should they lose capacity to consent to such a procedure in future.
- A person cannot ask for their life to be ended but they are able to refuse treatments/procedures that may artificially prolong their life should they become seriously unwell.
- Once completed an advance directive is legally binding.

Other Important Terms/Bodies

What is an advance statement?

- An advance statement is a statement that refers to a persons wishes about any other aspect of their care or treatment. Examples may include, whether a person would prefer to be buried or cremated, whether they would prefer to be bathed or showered if unwell, or any particular dietary requirements.
- An advance statement is not legally binding but every effort should be made to take a person's wishes into account, where relevant and where possible.

Other Important Terms/Bodies

DOLS (Deprivation of Liberty Safeguards)

Aim to provide legal protection for those vulnerable people who are deprived of their liberty. DOLS covers patients in hospitals and people in care homes whether placed there under public or private arrangements. They do not cover people under the Mental Health Act (MHA) as this has its own safeguards in place concerning deprivation of liberty.

Other Important Terms/Bodies

The DOLS process:

Hospital/care home identifies a person who lacks capacity and is currently being/risks being deprived of their liberty (not under MHA)

Application to the 'supervisory body' for authorisation of DOL; supervisory body will be will vary depending on which organisation is applying.

The 'supervisory body' requests certain information, makes assessment and subsequent decision. If no grounds for DOL, decision will be fed back and the person allowed to go - legally the organisation cannot hold them.

Once the decision is made, the person or someone acting on their behalf, can request a review by the 'supervisory body' at any time, or by the court of protection.

When authorisation runs out the care home or hospital will have to reapply.

Thank you for listening

Questions?

References

http://www.legislation.gov.uk/ukpga/2005/9/contents

- **For the full copy of the MCA**

http://www.direct.gov.uk/prod_consum_dg/groups/dg_digitalassets/@dg/@en/@disabled/documents/digitalasset/dg_186484.pdf

- **For a copy of the MCA code of practice**

http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085476

- **For the addendum to the code of practice that discusses DOL's**

http://www.bps.org.uk/sites/default/files/documents/standards_for_psychological_support_for_adults_living_with_hiv_nov.2011.web__0.pdf

- **For the Standards of Psychological Support for Adults Living with HIV**