
Assessing Capacity to Consent

asking the right questions in the right way

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What's the fuss about?

*Department of Health guidelines and the new mental capacity legislation require **valid consent**. This means having full knowledge of what's going to happen.*

Capacity to consent is no longer a once-and-for-all judgement

Capacity is contextual, not based on diagnosis or condition

Clinicians must make every effort to communicate in ways clients can understand – including non-verbal methods

So you give people the information then ask if they've understood – right?

*The Act says that people must be able to **receive and retain** the necessary information then **weigh it up** in order to make a decision.*

*Finally, they must **communicate that decision** at the time it is required.*

For many people, this is not always straightforward...

Because...

- *People forget what they've been told*
- *Most interview techniques are incompatible with memory*
- *Vulnerable adults resort to acquiescence when they don't know or they feel intimidated*
- *Many choose the second of any two options*
- *Interviews can be 'contaminated' by the views or knowledge of the interviewer*

Consent with vulnerable people is a dynamic not a static process

- **Information may have to be given many times using several different modalities**
- **In long term therapy, consent may be measured in different ways, including verbal communication, behavioural compliance, active contribution to the process**
- **It may have to be checked repeatedly**
- **Just turning up may not indicate positive consent**

Interviewing to assess capacity

- Uses a technique, the cognitive interview, developed as police interview methodology for child victims of abuse and researched with categories of vulnerable adults
- Addresses the witness element of the capacity/consent process
- Memory compatible
- Avoids leading questions
- Avoids acquiescence
- Empowering
- Minimises interviewer contamination

Principal components

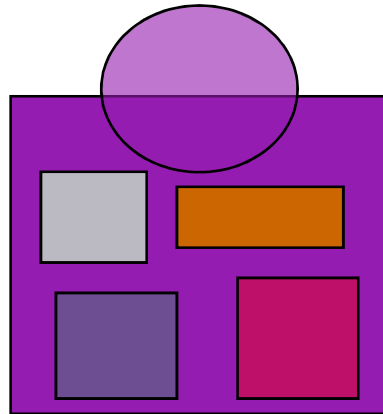
- *Free, uninterrupted report*
- *Non-leading, open questions*
- *Facts not feelings*
- *No interventions or interpretations*
- *Minimal reinforcement of content to reduce the risk of validating inaccurate recall*
- *Written 'as you go' recording*

This is not a clinical interview

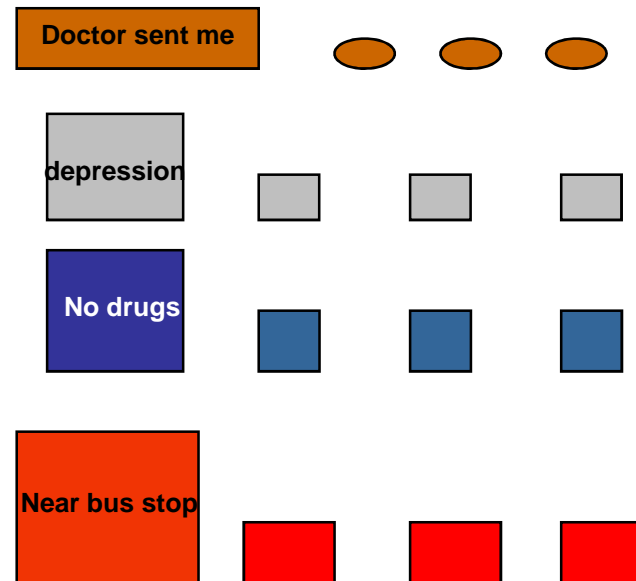
	Topic
I've been having problems with...	Context
Tell me a bit about that...	Who referred for therapy?
Well, we met at school really..	Why?
Ah, so your parents didn't ...	What options offered?
Well that was because of my mother's sister..	Why this therapy?
So in 1968, that wasn't quite..	How long? What pros and cons?
Well then I ran away so we didn't get together until..	What expected outcomes?
So how did it feel to meet up again after...	What problems or risks?
	Are any elements necessary to valid consent missing?
	Recall of all necessary elements

A capacity interview

Free report



Specific questions



Structured interview to examine missing elements

The Interviewer has to know:

Details of the proposed procedure

Details of the context

Details of choices

Details of risks

The Interview Process

Format - Cognitive Interview plus Structured Interview

Set context

Free report

Open questions

Specific Questions

The use of booklets that illustrate the procedure is invaluable

Avoids acquiescence and contamination

Information to Elicit

Does the person know what is proposed?

Do they know why?

Do they know about any other choices?

Do they know they can refuse?

Do they know the risks of agreeing or declining?

Do they know about any pain or discomfort?

What about any short or medium term loss of function?

Can they tell you about an anaesthetic and its risks?

Any post-procedure medication or treatments?

How long in hospital?

What difference will the procedure make to their life?

Outcomes – what are we looking for?

- *Some knowledge of the purpose of the procedure*
- *An idea of the risks of going ahead – including anaesthetic risks, pain, permanent or temporary disability, distress, re-emergence of painful memories*
- *What might happen if they don't go ahead*
- *That they can refuse*

Is this a measure of capacity?

Yes

And no...

If capacity isn't once-and-for-all, it isn't all-or-nothing either...

- *Some people are not able to focus on the information they are given*
- *Some people cannot retain the necessary information*
- *Some have not been given all the information or it was too complicated for them*
- *Some have not been told about risks*
- *Some seem to block out the negatives, especially when they are keen to go ahead*
- *Most know something about what is going to happen and some know everything*

Our advice to clinicians

- *View procedures in terms of **urgent, essential, or desirable** and balance expected gains against limitations in capacity to consent.*
- *Where people can not focus on the information – proceed **‘in the person’s best interests’** with full specialist support and care plans in place.*
- *Where people have partial information – offer the missing information then proceed according to ‘best interests’ protocols if necessary.*

Essentials

- *Clinicians responsible for procedures need to give detailed but **clear information** to clients and essential others*
- *It should be **simple** but not simplistic – the average reading age for the UK is 10 years!*
- *It must be **full** without being over-inclusive*
- ***Multi-modal is good – pictures, diagrams, a tape to take home***
- *Specialist workers, families and carers need to ask for information and be clear about what is going to happen*
- *Moving towards capacity to consent takes time and effort*
- *Interviewers need to be trained to ensure rigorous adherence to procedure but they don't need to come from any particular profession*
- *They need to be independent of the information-giving process*
- *It's possible to train 'mediators' at very short notice to assist with clients who have communication difficulties*
- *The process seems ethical and accountable and suitable for planned procedures. The questioning technique is suitable for some emergencies.*

Some Key Points

- *Knowledgeable refusal does not constitute lack of capacity*
- *Nor does an unconventional but fully informed decision*
- *Ill-informed consent is not valid, this includes signatures*
- *Knowledgeable oral consent is valid without a signature*
- *Knowledgeable non-verbal consent is also valid*
- *Consent cannot be obtained on behalf of any adult from any other adult*
- *Skilled information-giving and interviewing will minimise potential abuse of the 'best interests' protocols*
- *It will also maximise people's understanding of what is going to happen to them and why*

Best interests

- There is no evidence yet that clinicians have addressed fully this part of the consent procedure. Most are just beginning to appreciate the need to give information and to seek an opinion about capacity.
- The new framework for understanding capacity was enacted in 2007.
- Assessing capacity and managing best interests is likely to be cumbersome and time consuming at the beginning.
- This should not be a reason for moving to quick fixes. Instead, we all have to become more competent and efficient.

Open and Closed Questions

- n Closed questions can lead to acquiescence
- n Open questions encourage free report and increase the amount of information reported

Closed

è Did you go to the café today?

è Yes

è Did you enjoy it?

è Yes

è Were you at the bus stop when the man hit Polly?

è Yes

è Is that the man who hit Polly?

è Yes

Open

- è Where did you go today?
- è *We went to the garden centre and the swimming pool*
- è What was that like?
- è *Swimming was good but the garden centre was boring*

- è What happened today at the bus stop?
- è *This bloke came running up and bumped into Polly*
- è What can you tell me about this man?
- è *I can't remember but he was big and he had a red jacket*
- è *Can you see this man here?*
- è *No, they're all too thin*

Leading and Misleading Questions

- n Leading questions offer correct information that may not be known to the interviewee
 - è Was it a yellow sweater?
 - è So then he went into Boots didn't he?

- n Misleading questions offer incorrect information, often because the interviewer is guessing

Upgrading Responses

- n This is where an imprecise term is replaced by the interviewer with a 'better' word that may be completely wrong
- n Use the client's own words, this is why recording the interview in writing as you go is important
- n Try not to educate or correct during the interview, this adds new information which is not in memory and so can't be used as evidence of understanding
- n Where people use language that might be construed as offensive, try to go with it just so long as it appears not to be intended as such

n **A story about plant pots:**

- è So what happened next?
- è *Well Jim brought these pot things in on a tray...*
- è What, coffee pots, mugs do you mean?
- è *Well he brought them in and dropped them*
- è So the coffee went all over the floor?
- è *I suppose so*

n **A false confession:**

- è So you were on your own on Thursday afternoon, what happened next?
- è *I went to get the bus from town*
- è From the bus station?
- è *Maybe. I don't think so.*
- è You can get lots of buses from there?
- è Yes
- è So you were on your own at the bus station when this girl was robbed
- è *Well...*
- è There was no-one else there so who could have done it?
- è *Well, I suppose...*

This example shows acquiescence and pinning out.

Beware Alternatives and Comparisons

- n Did she have brown hair or blond?
- n Was it wet or dry outside?

People often choose the second alternative when they are unsure

- n Was he taller or shorter than me?
- n Was the car bigger or smaller than ours?

People have trouble with comparisons, especially abstract ones – happier, calmer, lighter, darker and so on. They tend to choose the second or the last option.

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The Cognitive Interview Structure

- n Context reinstatement
- n Report everything
- n Change order
- n Change perspective
 - è Witness compatible questioning
 - è Transfer of control
 - è Establishment of rapport

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Efficacy

- n Enhanced recall of up to 63%
- n Reduction in the rate of questioning
- n Increased open questions
- n Increased information obtained
- n Increased information per open question

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People with Learning Disabilities

- n Susceptible to suggestion
- n Acquiescence
- n Global memory difficulties
- n Dependency on external cues
- n Communication difficulties



Contaminated and inaccurate reports

- n CI enhances accurate recall by up to 32%

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Handy openers

- n Where.....?
- n What.....?
- n When.....?
- n Why.....?
- n How.....?
- n Tell me about.....
- n You said that.....what was that about/how does that work?

And if you find yourself in the middle of a leading question, just stop and leave the leading element unsaid:-

- n So was that the time when.....?
- n Did you tell him about.....?
- n Was it the one in the.....?

Evidence

- n The cognitive interview as a tool for gathering best evidence from vulnerable witnesses is well researched.
- n Its use as an assessment tool to address capacity is unresearched.
- n Most studies have used methodologies that reflect a population reference in an attempt to develop norms and cut off points.
- n This tool recognises the individuality of the circumstances for each client and so takes an ipsative approach – measuring the person against themselves and their own particular requirements for consent.
- n This approach allows for qualitative judgments about the weight of items recalled.
- n It also allows for clinical judgment about the ability of the person to balance the information and make a decision.