a place of mind
THE UNIVERSITY OF BRITISH COLUMBIA

CAIPS

Capacity Assessment Instrument for People who Misuse Substances

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INSTRUCTIONS

Use this instrument when you are unsure if your client lacks capacity to consent for health care due to substance use. (you do not need to use it during all encounters)

1. Read each of the items to yourself (not out loud)
2. Incorporate each of the items into the casual conversation you have with the client during your nursing encounter
3. Score each item on a scale of 1 – 4 (higher numbers are indicative of higher levels of capacity)
4. Add up all the scores. If the client's score is below 33 he/she likely lacks capacity to consent for health care. **This interpretation should be used in conjunction with other clinical assessments**
5. If your final assessment indicates the client lacks capacity to consent, consider delaying health care or get third party consent with the legal authority to consent on the client's behalf.
6. This instrument is not a legal document but may be used as evidence in a court of law if the clinician is questioned about whether consent was obtained.
7. This instrument only addresses capacity to consent for health care and is not a legal measure related to the clients competency to manage their financial affairs.

Prior to administering the CAIPS instrument it is important to think about some ethical considerations. Please take time now, to consider the following items:

Assumption of Capacity: Capacity to consent for medical care can vary from time point to time point for individuals. In other words, if someone is capable of making a rational decision in the morning, he/she may not have capacity in the afternoon, depending on their mental status or their substance use practices. It is important to enter into an encounter with the assumption that the client has capacity.

Informed: It is important that clients be given sufficient information about the health care intervention being offered. Sufficient is defined as the amount that a reasonable person would require to make an informed decision . In addition the information should be delivered in a manner that the client can understand.

Justice: Clinicians have a moral obligation to provide equal access to health care and resources to clients regardless of the client's status in society.

Autonomy and Avoiding Misuse of Power Differential: All clients have the right to hold views, to make choices, and to act based on their personal beliefs and values.

Reflection: When you are informing the client about a health care intervention, it is important for you to allow the client to ask questions and provide them with time to think about their decision to consent or refuse care. This may mean providing care at a future encounter.

Level of Risk Versus Level of Capacity: Not all clinical encounters involve the same amount of risk. Lower levels of capacity may be acceptable when the level of clinical risk is low and vice versa .

Who Initiated the Clinical Encounter?: Relationship dynamics between a nurse and a client depends on the client's mental preparedness to engage in a medical encounter. Mental preparedness may depend on whether the client approaches the clinician or the clinician approaches the client (e.g., as in street outreach). While assessing capacity to consent, take time to consider whether the health intervention is being requested by the client or being offered by the nurse.

Rate each statement on a scale of 1 – 4 by circling the number beside how strongly you agree or disagree

		Score
1 *Concept: Understanding*	The client is able to repeat back, **in their own words** the main side effects/potential complications of the intervention that is being offered to them.	1. strongly disagree 2. disagree 3. agree 4. strongly agree
2 *Concept: Voluntariness*	The client made their decision about the medical intervention without external pressure or coercion. (i.e. the client is not giving an answer that they feel the clinician wants to hear)	1. strongly disagree 2. disagree 3. agree 4. strongly agree
3 *Concept: Orientation*	The client is oriented to person, place, and time (i.e. do they know who they are, where they are and what year it is?) or, if disorientated, it does not have a direct bearing on the medical intervention being offered.	1. strongly disagree 2. disagree 3. agree 4. strongly agree
4 *Concept: Ability to communicate*	The client can engage in the form of communication that they normally use (e.g., speech, signing writing) excluding a physical difficulty in speaking or use of foreign language not understood by the nurse.	1. strongly disagree 2. disagree 3. agree 4. strongly agree
5 *Concept: Understanding and sustained attention*	The client is able to follow simple verbal or written instructions. (i.e. follow at least one instruction)	1. strongly disagree 2. disagree 3. agree 4. strongly agree
6 *Concept: Distorted reality*	The client is experiencing symptoms of distorted reality (i.e. symptoms hallucinations, delusions, paranoia) and these symptoms have a direct bearing on the intervention proposed.	4. strongly disagree 3. disagree 2. agree 1. strongly agree
7 *Concept: Appreciation*	The client knows that he/she is either at risk of an illness or has an illness and therefore requires clinical care.	1. strongly disagree 2. disagree 3. agree 4. strongly agree
8 *Concept: Reasoning*	The client is able to use the information given to them about the intervention to form a decision about consenting to the intervention or refuse the intervention.	1. strongly disagree 2. disagree 3. agree 4. strongly agree
9 *Concept: Expression of choice*	The client is able to verbally or physically (e.g., nodding yes or holding their arm out for a blood test) indicate a choice.	1. strongly disagree 2. disagree 3. agree 4. strongly agree
10 *Concept: Decision making demands*	While offering care to a client he/she seems to be distracted by friends, other activities, and/or symptoms of withdrawal.	4. strongly disagree 3. disagree 2. agree 1. strongly agree
11 *Concept: Physical indication of substance use*	There are physical indications that the client may have recently used drugs or alcohol (e.g., tweaking, nodding head, slurred speech, gyrating).	4. strongly disagree 3. disagree 2. agree 1. strongly agree

Sum of Scores: _____

Interpretation: Higher scores are indicative of higher levels of capacity. If the client's score is below 33 he/she likely lacks capacity to consent for health care. This interpretation should be used In conjunction with other clinical assessments

GLOSSARY OF TERMS

Presumption of capacity: Until the contrary is demonstrated, **every adult is presumed to be capable** of giving, refusing or revoking consent to health care. An adult's way of communicating with others is not, by itself, grounds for deciding that he or she is incapable of understanding anything referred to in subsection.

Informed: Consent is deemed to be 'informed' if the client is given all the information to be able to make a rational decision in a manner which the client can understand. BC Law states that the health care provider must give the adult enough information a reasonable person would require to understand the proposed health care and to make a decision.

Beneficence: Actions that are intended to benefit others.

Nonmaleficence: Not inflicting harm on others.

Justice: Fair, equitable, and appropriate treatment in light of what is due or owed to persons. all persons should have equal access to health and resources regardless of their status in society.

Opportunities for reflection: Individuals who are asked to consent to health care should be given opportunity to ask questions and be provided with answers. This may take time. Therefore the client should be given ample time to reflect on the information that has been given to them so they can ask questions before providing consent.

Avoidance of misuse of inherent power differentials: Power differentials occur when a relationship, such as a clinician-client relationship, involves on person who is perceived as being in a position of authority.

Level of risk versus level of capacity: The level of capacity required for consent depends on the seriousness or level of risk (long or short term) associated with the medical intervention being offered or requested.

Who Initiated the clinical encounter?: Relationship dynamics between a nurse and a client depends on the client's mental preparedness to engage in a medical encounter. Mental preparedness may depend on whether the client approaches the clinician or the nurse approaches the client (e.g., as in street outreach).

Understanding: Understanding involves the client's ability to process information that is provided to them. It involves the ability to comprehend and recall important facts. However, the ability to recall information is not, in and of itself, indicative of understanding as a person might be able repeat back words that have been spoken to them without actually knowing what the words mean. However, when combined with other aspects of *understanding*, ability to recall may be indicative of capacity.

Voluntariness: The client's decision to accept or refuse medical care should be made without being under the control of another's influence. Information should not be provided with the intent of persuading or manipulating the individual.

Respect for autonomy: Recognition and acknowledgement of the client's right to hold views, to make choices, and to act based on their personal beliefs and values.

Concentration/sustained attention: The client's ability to block out external or internal stimuli (e.g., conversations, hearing internal voices, desire for substances) and focus on the health care being offered to them.

Orientation: The client's ability to know who they are (person), where they are (place), what day or year it is (time).

Verbal abilities: The client's ability to verbalize appropriately by naming items or follow verbal commands. It also involves the client's ability to engage in a conversation.

Conceptual disorganization: An indication that the client is not thinking in an organized way.

Presence of hallucinations, panic, unusual euphoria: This involves the client stating he/she sees things that are not there (hallucinations), or appears to be unusually fearful or unusually happy.

Appreciation of the nature of the situation: The clients ability to apply information to their own health situation

Using the information in reasoning: This involves an assessment of whether the client is able to manipulate information rationally. In other words, is the client able use a logical process when using the information that they were given?

Expression of choice: The client's ability to indicate a choice, either verbally or physically.

Decision-making demands: Situational and/or social factors that contribute to the client's decision or interfere with a client's willingness or capability to make a decision.

Threshold setting: The level of impairment that the nurse uses to differentiate between the client having capacity or not having capacity to consent for health care.

Client's ability to cope: The clinician's assessment of whether the client will be able to adequately respond to an adverse event or positive diagnosis if they were to occur.

Physical indication of substance use: Any physical evidence/indicator, including body movements, posture, manner of speech, and odor of alcohol, marijuana, and other substance that indicate that the client has recently used a substance (i.e. may be under the influence of a substance).

Knowledge of the client's baseline: The clinician's previous experience with the client and the ability to compare the client's present behaviour and mental capacity to previous encounters when substance use wasn't involved.