

THE MENTAL CAPACITY ACT 1: ADVANCE DECISIONS

AUTHOR Teresa Lynch, MSc, DipNEd, RCNT, RNT, RGN, is support and information specialist nurse at The Prostate Cancer Charity.

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This is the first of a two-part unit on the Mental Capacity Act 2005. Part 1 outlines the act's key principles and implications. Healthcare professionals' responsibilities are examined in relation to advance decisions.

KEY PRINCIPLES

The emergence of life-support technology, which assists patient survival, means that some patients who before would have died can now survive brain damage.

Medical advances in the 1960s prompted the creation of advance directives in the US. These encourage people to plan ahead for a time when they may lose capacity and choose ahead of time to forgo treatment.

The Mental Capacity Act 2005 (Department for Constitutional Affairs, 2005) took effect in England and Wales from October 2007. It promises people input into their future care, even after severe brain damage (Lo and Steinbrook, 2004). The act provides a statutory framework to empower and protect vulnerable people who are not able to make their own decisions or have no living will (advance decisions). It makes it clear who can take decisions, in which situations and how this should be done.

The act applies to those aged 16 and over, with potentially 1.2 million people directly affected. It includes those with dementia, learning disabilities, brain injury, mental health problems and autism.

There needs to be the option to assess capacity at home, in hospital, care homes, GP surgeries and voluntary services. This will have implications for many clinical and professional staff groups, as well as care home staff, housing workers, relatives and carers.

The Mental Capacity Act (MCA) 2005 is

LEARNING OBJECTIVES

1. Know the Mental Capacity Act's five main principles.
2. Understand the concept of advance decisions and professional responsibilities.

based on five key principles:

- A presumption of capacity – section 2(1) states: 'For the purposes of this act, a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of the mind or brain' (DCA, 2005). It must be assumed and accepted that every adult has the capacity and the right to make her or his own decisions unless proved otherwise;
- Support for individual decision-making – no one can conclude that people cannot make their own decisions or do not need all appropriate support in making their own decisions. All steps must be taken to help an individual's decision-making process before lack of success in this attempt has become evident;
- The individual must retain the right to make what might be seen as eccentric or unwise decisions – professionals who disagree with a patient or team decision should let their viewpoint be known immediately to their line manager or deputy who will need to take responsibility for the patient's subsequent management;
- Best interests – anything done for or on behalf of people without capacity must be in their best interests. Professionals will need to satisfy themselves, in line with their duty of care, that patients (if possible) and/or relatives are fully aware of the implications of the planned treatment or its omission in relation to their best clinical interests;
- Least restrictive intervention – anything

done for or on behalf of people without capacity should be the least restrictive, in line with their basic rights and freedoms.

Implementing the act has resulted in the following:

- New lasting powers of attorney – this means a patient-appointed person responsible for personal welfare and property, who may override medical decisions;
- Court-appointed deputies who can become the exclusive responsible person to make decisions about non life-sustaining treatment, place of care and handing on care to another professional, in cases of dispute;
- A new criminal offence of failing to protect someone who lacks capacity;
- A new independent mental capacity advocate (IMCA) service to help people who may lack capacity.

MENTAL CAPACITY ADVOCATES

The IMCA service is a key provision in the act (Department of Health, 2005). Adults who lack capacity and have no family or friends to speak on their behalf are particularly vulnerable.

Adults faced with a decision about serious medical treatment will be entitled to an IMCA caseworker's services. The service is the first statutory provision of advocacy, launched in April 2007 in England and in October 2007 in Wales. Practitioners have a continued responsibility to advocate patients' best clinical interests when communicating with independent mental capacity advocates, in accordance with the NMC's (2008) code of conduct.

ADVANCE DECISIONS

In an advance decision or living will, under the MCA, a patient may request that life-preserving treatment be withdrawn if they become too ill to communicate or feed themselves.

Assisted food and fluid is now considered as 'treatment' under the act, as part of withdrawing and withholding life-prolonging



medical treatment. Death for those who have asked for it can mean the removal of tubes providing assisted nutrition and hydration, so patients die from dehydration and starvation.

Nursing staff caring for patients with a documented advance decision or who express the desire to document wishes for future treatment should be aware of the act's associated code of practice (DCA, 2007) and their own organisation's guidance.

NHS trusts may provide an agreed advance decision template for patients without their own forms. Assistance and ample time should be given to patients who may wish, in the first instance, to discuss and then complete an advance decision form. It is important that patients are fully informed of the possible implications of their choices. No pressure should be applied to those who have not made up their minds about advance decision-making.

To avoid uncertainty over validity of an advance decision, it should always be put in writing including the patient's name, date of birth, address and GP details and be prominent in their nursing and medical notes. Verbally expressed wishes only can lead to confusion.

Advance decision documentation:

- Should include a statement that patients wish the advance decision to apply if they

lack capacity to make a decision at a particular time;

- Must specify precisely, including the circumstances, what kind of treatment is to be refused;
- Should include a documented declaration by the relevant health professional, stating that an assessment of patients' mental capacity has been carried out and that they have capacity to make decisions;
- Must be signed and dated by patients and their signature should be witnessed.

Anyone who has made an advance decision is advised to regularly review and update it as necessary (DCA, 2007).

Practitioners can provide treatment if in doubt over the existence, validity or applicability of an advance decision. They should, however, check the appropriateness and need for review of long-standing advance decision documentation.

THE ACT'S CODE OF PRACTICE

Throughout the act's code of practice (DCA, 2007), a person's capacity (or lack of capacity) refers specifically to their capacity to make a particular decision at the time it needs to be made.

The former Lord Chancellor Falconer (2007), in his foreword to the code of practice, stated the Mental Capacity Act 'will 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'.

RESEARCH

The act includes the provision for non-consensual and non-therapeutic research on mentally incapacitated patients.

The MCA code of practice stated it is important that research involving people who lack capacity can be carried out, and that it is conducted properly. It pointed out that without such research, it would not be possible to improve knowledge of what causes a person to lack or lose capacity.

However, the appropriate authorising organisation can only approve a research project for the act's purposes if there are reasonable grounds for believing the following:

- The risks to patients taking part will be negligible;

KEY REFERENCES

Department for Constitutional Affairs (2005) *The Mental Capacity Act*. London: The Stationery Office. www.opsi.gov.uk

Department of Health (2005) *Independent Mental Capacity Advocates*. London: DH. www.dh.gov.uk

Falconer, C. (2007) *Foreword to the Mental Capacity Act Code of Practice*. London: The Stationery Office.

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- That anything done to or in relation to patients will not interfere with their freedom of action or privacy in a significant way or be unduly invasive or restrictive (DCA, 2005).

The act applies to all research that is 'intrusive', which means research that would be unlawful if it involved a person who had capacity but had not consented to take part (DCA, 2007).

CONCLUSION

Practitioners must consider various issues in relation to patients' mental capacity and advance decisions.

Depression is an important factor to consider in patients planning or having completed advance decision documentation. Apart from the fact we cannot know how patients actually feel or whether they might recover, one issue is that we all can change our minds. Depressed patients may be vulnerable and reliant on others who may be unwilling to offer a chance for any treatment to aid their survival.

Professional guidance for patients wishing to complete or review an advance decision is essential, in line with patient advocacy. This allows patients, with or without relatives, to be as informed as possible when making significant decisions about their future treatment and implications for future care. ■

- Part 2 of this unit, to be published in next week's issue, discusses the Mental Capacity Act's ethical implications.

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