

# The role of independent mental capacity advocates

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The Code of Practice<sup>1</sup> for the Mental Capacity Act 2005 states that those working with vulnerable people must be able to demonstrate that they comply with the code. Or, as I am fond of pointing out, they may one day have to explain to the coroner why they did not. The busy doctor or nurse can be forgiven for thinking that the Mental Capacity Act is yet another administrative burden to be grudgingly borne, but it is not. In my opinion, it is the best defence for vulnerable people, and for clinicians, since the Human Rights Act.

In addition to being an older people's nurse, I work part-time as an independent mental capacity advocate. In this role I see a regrettable amount of confusion about how the Mental Capacity Act works. The benefits that it can bring to the busy doctor are also vastly misunderstood. GM's recent article on the Act<sup>2</sup> outlined a case in which I was involved as advocate. My role seems to have been misinterpreted by the author: the impression given was that the advocacy service is optional, and that we provide ongoing support for the patient in decision making. This is not the case. If the advocacy conditions are satisfied—that an individual lacks specific capacity to consent to serious medical treatment, and that they have no one such as close family to represent their interest, then the clinician making the decision is required by

the Act to instruct an independent mental capacity advocate to perform that representative role. This is mandatory, and it is the clinician who initiates the process.

In clinical settings the advocate is involved only for serious medical treatment such as that described in the article, and where time allows. Advocates are not a blue-light service and in an emergency the doctrine of necessity applies as always. For provision of less drastic treatment for people who lack capacity to consent, the Act provides a pathway for clinicians to do so in the patient's best interest,

private audience with the patient. All these rights help to provide us with evidence as to what the patient might have wanted, and to represent that view to the decision-making physician or surgeon. We provide what is effectively the patient's point of view in making the decision to accept treatment. We focus on that issue only, provide our report to the decision maker, and sign off. The decision maker is required to take our report into account, and may then reject its conclusions, but must show good reason to do so.

Reaching a decision has three simple stages: first, a reason to

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and in the process protects them from accusations of assault. The definition of serious medical treatment includes withholding and withdrawing treatment, and do-not-resuscitate orders. The General Medical Council has not yet updated its guidance on these issues.

Unlike traditional advocates, independent mental capacity advocates are statutory, and have certain rights that other advocates do not, including the right to examine clinical records, to require a second opinion, and to have

suspect that a person may lack capacity in this particular instance (ie, has this person a cognitive impairment, and if so, does it prevent them from making this decision at this time?); second, an assessment of mental capacity; third, an assessment of the person's best interest. The subsidiary details of these stages are explained in the code of practice.<sup>1</sup>

In none of the above is consent an issue. The Act provides a route through that dilemma of providing non-emergency treatment to

someone who cannot give consent. The Act provides the answer, through capacity and best-interest assessments, and yet I continue to see consent being sought from third parties: from a spouse, or even from a paid carer.

The Mental Capacity Act simplifies the decision-making process, and is a safeguard not only for the patient, but also for the clinician. Chapter 6 of the code of practice is rhetorically titled **What protection does the Act offer for people providing care or treatment?** The answer is, plenty. If you have followed the three stages outlined above as the Act requires, then you have no more liability for actions in connection with care or treatment than if the patient had given written consent.

I urge clinicians to be very wary of using consent form 4, the Department of Health document used for those who do not have capacity and adapted by most NHS Trusts for their own use. The most recent version by the Department of Health does not comply with the Act, and unless your Trust has recently updated its version with reference to the Mental Capacity Act, it could well lead you into errors of judgement.

#### References

1. McLaren R, Willcoxson P. The Mental Capacity Act in practice. *GM* 2008; **38**: 457–59
2. The Mental Capacity Act Code of Practice. [www.dca.gov.uk/legal-policy/mental-capacity/mca-cp.pdf](http://www.dca.gov.uk/legal-policy/mental-capacity/mca-cp.pdf) (accessed 24 November 2008)

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