The University of Manchester

Research Summary and Clinical Recommendations

The Mental Capacity Act 2005 and advance decisions: application in the context of self-harm and suicidal behaviour

The Mental Capacity Act 2005 enables adults aged 18 years and over to make advance decisions to refuse treatment when their mental capacity may be reduced in the future. Given the move towards patient autonomy in healthcare and the rise in the use of advance care planning for psychiatric care, advance decisions in the context of suicidal behaviour may present a growing challenge for clinicians.

This document sets out suggested best practice recommendations based on our research. It does not replace clinical judgement.

For further information on the Mental Capacity Act and advance decisions please see:
www.gmc-uk.org/Consent___English_0617.pdf_48903482.pdf
www.legislation.gov.uk/ukpga/2005/9/contents

About the research

This report summarises findings from research examining how advance decisions for self-harm and/or suicidal behaviour should be managed.

Researchers from The University of Manchester led the research, in collaboration with the Universities of Bristol and Oxford.

A series of studies were conducted:

- six focus groups with frontline clinicians (paramedics, liaison psychiatrists and mental health nurses) and community service user groups
- an online survey of frontline clinicians
- a review of existing literature
- a review of existing medical and legal databases.

Background

The Mental Capacity Act 2005 enables people to make advance decisions to refuse treatment ('advance decisions'), as well as advance treatment preferences ('advance statements'), for a time in the future when their mental capacity may be reduced.

Properly made advance decisions are legally binding and are widely used to support "end of life" decisions when there is a chronic or terminal physical illness or disability. However, the use of advance decisions relating to psychiatric care is increasing.

Advance decisions to refuse life-saving treatment following self-harm or suicidal behaviour, although rare, are challenging for emergency service clinicians.

(see examples here **www.bmj.com/content/341/bmj.c4557**).

However, there are currently no recommendations as to how clinicians should manage advance decisions in this particular context.

The team

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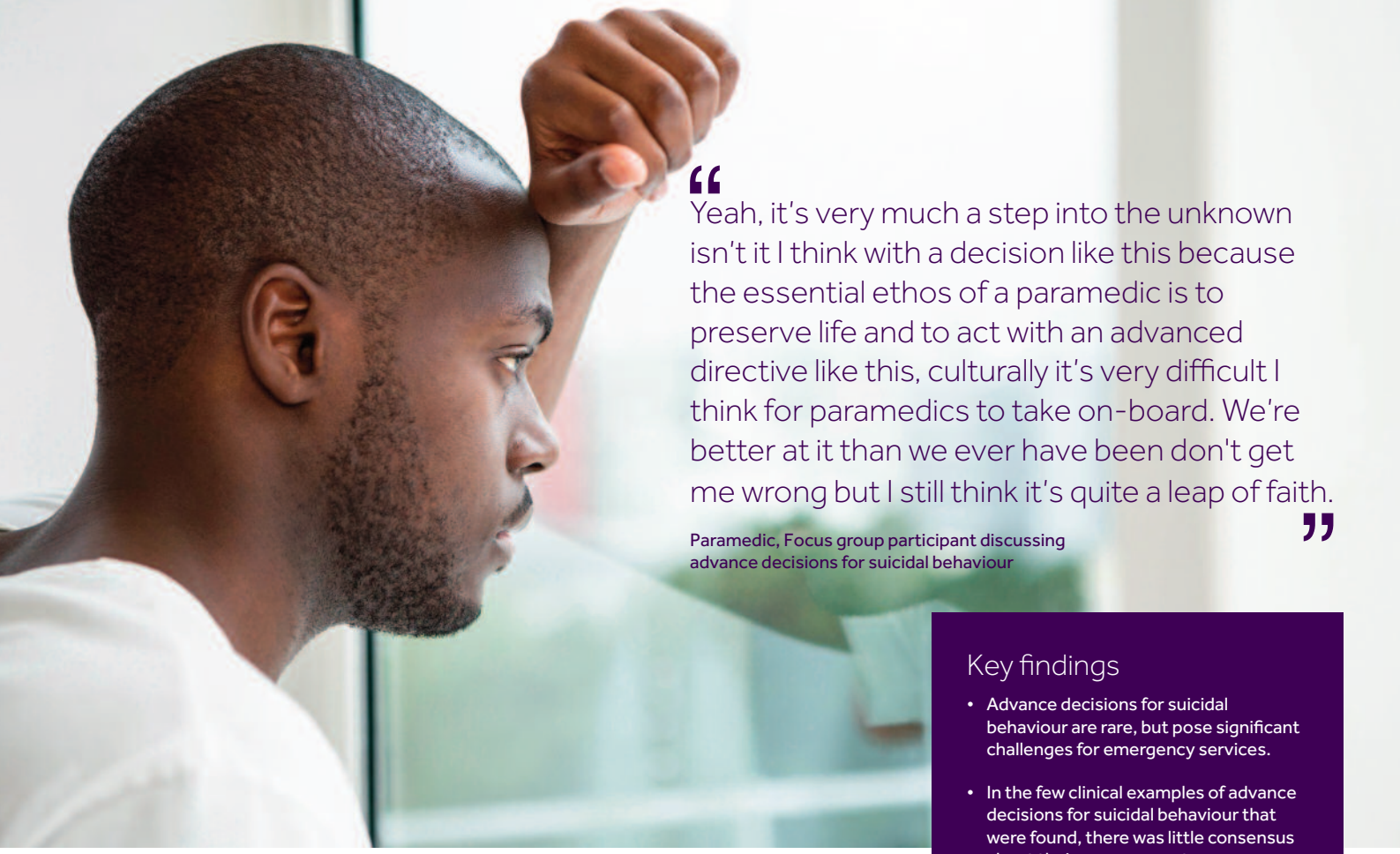


> "Yeah, it's very much a step into the unknown isn't it I think with a decision like this because the essential ethos of a paramedic is to preserve life and to act with an advanced directive like this, culturally it's very difficult I think for paramedics to take on-board. We're better at it than we ever have been don't get me wrong but I still think it's quite a leap of faith."

Paramedic, Focus group participant discussing advance decisions for suicidal behaviour

Key findings

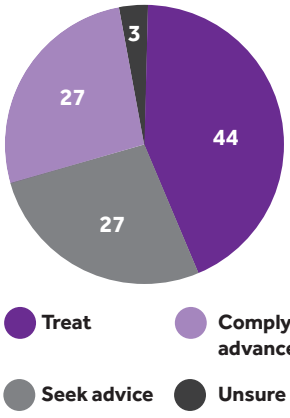
- Advance decisions for suicidal behaviour are rare, but pose significant challenges for emergency services.
- In the few clinical examples of advance decisions for suicidal behaviour that were found, there was little consensus about their management.
- Assessing mental capacity in the emergency services is difficult because mental capacity can fluctuate.
- Clinicians are generally cautious about adhering to advance decisions in this context.
- Validating advance decisions is challenging for emergency services due to time pressures and difficulties accessing relevant services out-of-hours.
- There is uncertainty about whether advance decisions in the context of self-harm and suicidal behaviour are appropriate.

Research Findings

Very few clinical cases with an advance decision in the context of suicidal behaviour were found in medical and legal databases, but treatment refusal following self-harm or suicidal behaviour was frequent.

142 clinicians completed the online survey. Most were familiar with the Mental Capacity Act, but there was little overall consensus about the clinical management of self-harm or suicidal behaviour when a valid advance decision was present:

Clinical management



Some thought the patient's **wishes should be respected** if the advance decision was valid.

Others would treat the patient, with many seeing the **suicide attempt as a symptom of potentially treatable mental illness.**

About a quarter of clinicians wanted to **seek advice** before acting.

A number of key themes were identified in the focus groups and reviews:

The management of advance decisions with self-harm and suicidal behaviour provoked anxiety and was challenging for clinicians, both professionally and personally.

The importance of potentially adhering to the advance decision was emphasised, but there was also uncertainty about how appropriate advance decisions are in the context of fluctuating mental distress and suicidal ideation.

Participants were cautious about advance decisions and sought to corroborate them. This was seen as particularly difficult in emergency services because of out-of-hours presentations and time pressures.

Sharing decision-making, consulting widely and taking time to consider all the evidence were seen as important.

> "And what would make you satisfied ... You've got the document. Were they harassed? Did they have capacity at the time, a few months ago? ... Who signed it? I don't know. Who was it? Was it a relative? How could you ever be satisfied?"

(Emergency Department Clinician, Focus group participant discussing management of advance decisions for suicidal behaviour)

Clinical Recommendations

General principles

- If the patient has a mental disorder of a nature or degree that requires compulsory assessment or treatment in hospital, then the Mental Health Act should be considered.
- While advance decisions for suicidal behaviour can pose significant challenges for emergency services, they are rare.
- Advance decisions only apply when a patient lacks mental capacity. Patients with capacity can make healthcare decisions verbally or by some other means and are not bound by an advance decision.
- Given the complexities involved with self-harm and suicidal behaviour, each case should be considered in its own right.
- Consider whether an application should be made to the Court of Protection to get legal advice on the clinical decision.
- Time should be taken to consider whether the advance decision is valid and applicable to the proposed treatment and treatment should be given until this is determined.
- If the patient lacks capacity and there is doubt about whether the advance decision is valid and applicable, err on the side of caution and treat the patient in their best interests.
- The situation may be challenging professionally and emotionally, so clinicians may require support and supervision.

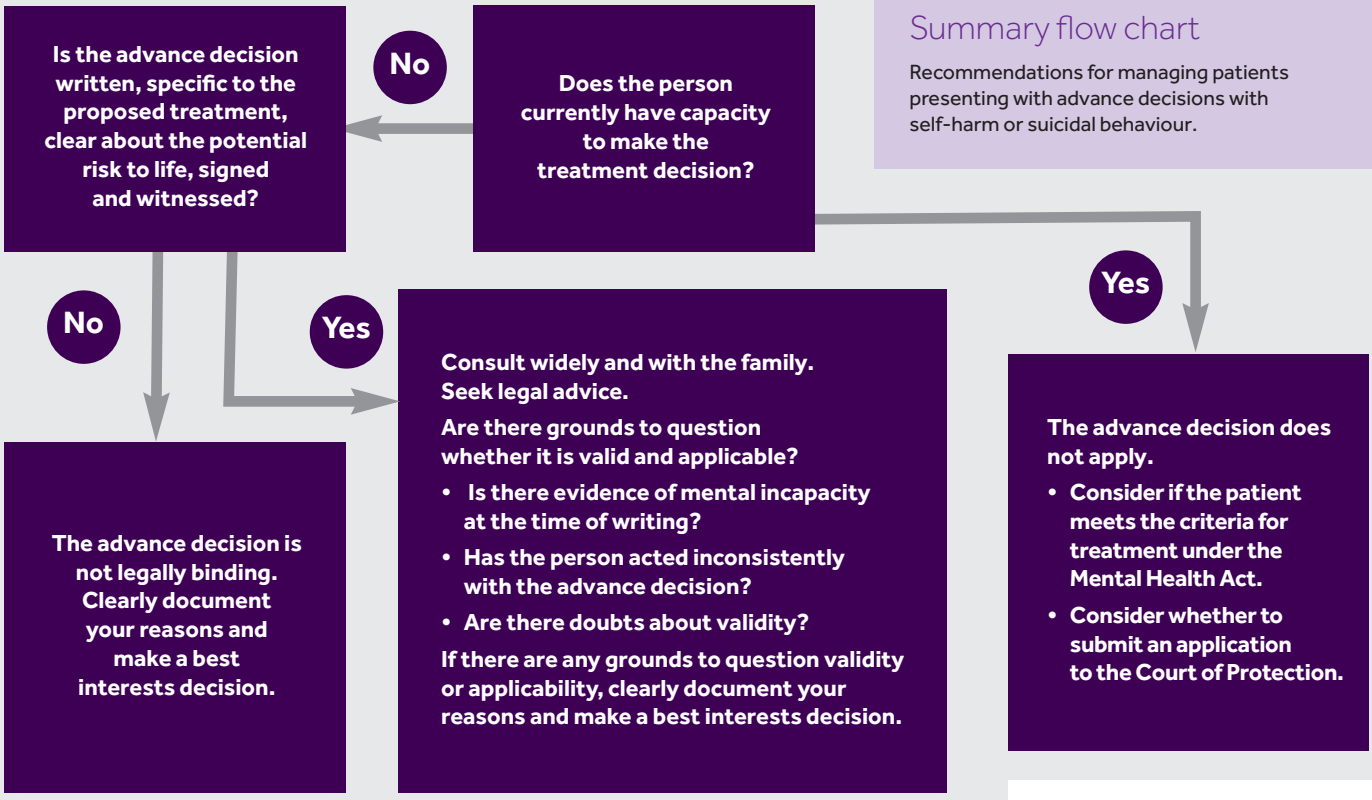
Individual management

Consider the following:

- Professionals should follow general principles of high quality care throughout. Compassion and patient dignity are paramount. Treatment should be given whilst considering the advance decision.
- Where life-sustaining treatment has been refused in advance, check whether the advance decision is in writing, specific to the particular circumstances and proposed treatment and applies even if life is at risk. The document should also be signed and witnessed. Our research has suggested that it may be preferable if a lawyer or medical professional has signed it but this is not a legal requirement.
- Is there evidence that the patient had understood the consequences of their decision, i.e. that they could die if not treated?
- Check that the advance decision reflects the patient's current wishes and circumstances. Our research has shown that this may be challenging in emergency services. Potential sources of information include GP, family lawyer and family. Preferably, corroboration should be sought from more than one source. If the patient presents under circumstances that are not clearly stated in the document, or there is evidence that they have changed their mind, the advance decision will not be valid.
- Consider whether there is evidence of mental incapacity at the time of writing the advance decision. Did they:
  - understand information given to them?
  - retain that information long enough to be able to make the decision?
  - weigh up the information available to make the decision?
  - communicate their decision by some means?
- Attempt to understand the context of the self-harm or suicidal behaviour, for example how the patient arrived at hospital, possible signs of ambivalence, mental health history. Consider discussing with the family, the GP or mental health clinician.
- Consult widely (i.e. with more experienced clinicians, legal and ethical committees, family and, where possible, the patient) before determining how to proceed.
- Professionals need to act in accordance with their professional standards and code of conduct.
- Clinical decision-making should be carefully documented.

Summary flow chart

Recommendations for managing patients presenting with advance decisions with self-harm or suicidal behaviour.



Clinical recommendations
continued

Clinical recommendations

Clinical involvement in the development of an advance decision

When drawing up an advance decision:

- There should be some active involvement from an appropriate healthcare professional who has the ability to assess mental capacity
- The healthcare professional should provide evidence in the document that the person has mental capacity to make the advance decision
- Assessment of capacity should specifically relate to the refusal of treatment in the context of self-harm or suicidal behaviour
- A collaborative discussion should take place, with the healthcare professional supporting the patient to consider all possible treatment options. Ensure the patient understands that in an emergency situation when there is any doubt about the validity of the advance decision document treatment would be given by clinicians
- The advance decision should be included in the patient's medical records so that it is easily accessible. It should be reviewed regularly (depending on the patient's needs) and updated, if necessary, to reflect the patient's current wishes. Consider how the document can be shared with relevant professionals, e.g. emergency services, and whether an advocate could be used in addition to the advance decision document.
- For forthcoming guidance on decision-making and mental capacity, please see **www.nice.org.uk/guidance/indevelopment/gid-ng10009/consultation/html-content-3**

Further information

This research was led by researchers at The University of Manchester and a panel of legal, ethical, psychiatric, emergency medicine and psychological experts, in collaboration with colleagues at the Universities of Bristol and Oxford. To find out more about the research and to read some of the outputs, please visit: **www.bristol.ac.uk/population-health-sciences/projects/suicide-prevention**

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