Emerald Working with Older People

Understanding of the Mental Capacity Act in work with older adults exploring the 'unintended consequences' for service users' emotional wellbeing.

Journal:	*Working with Older People*
Manuscript ID	WWOP-04-2016-0010
Manuscript Type:	Critique
Keywords:	emotional wellbeing, mental health, Mental Capacity Act, safeguarding, older people, rights

Understanding of the Mental Capacity Act in work with older adults exploring the 'unintended consequences' for service users' emotional wellbeing.

Purpose

This paper aims to explore the consequences for older people's mental wellbeing of understandings relating to the Mental Capacity Act 2005 (MCA).

The MCA seeks to maximize people's abilities to make decisions and provides a framework for decisions to be made in a person's best interests should they lack the mental capacity to do so themselves (Graham and Cowley, 2015). Practice varies widely amongst health and social care practitioners and little is known about the nature of interventions under the MCA or the outcomes for service users' lives and health, especially their mental health and emotional well-being.

Approach

By reflecting upon existing evidence this position paper offers a narrative of how practice in applying the principles of the MCA may impact upon the mental wellbeing of older people. Drawing upon court of protection judgments and existing research the author analyses the way the MCA is understood and applied and how institutional mechanisms might hinder good practice.

Findings

There are tensions between policy imperatives and examples of practice linked to the MCA, the spirit of the MCA and tenets of good practice. Despite efforts on promoting choice, control and rights there is growing paradoxical evidence that the MCA is used as a safeguarding tool with the consequences that it constrains older people's rights and that it may encourage risk averse practice. The consequences of this for older people are considerable and include lack of choice, autonomy and self-determination. This discussion suggests that anxiety in relation to the application of the MCA stills exists in practice and that maximizing older people's capacity and supporting decision making is central in promoting mental health and well-being.

Practical implications

This position paper will identify how the MCA might be interpreted in action through consideration of existing evidence. This paper may lead to future research on how understandings of the MCA are constructed and what values underpin its application from conception to outcomes in relation to understandings of risk, risk aversion, decision making and the potential and need for emancipatory practice. Essentially, the paper will discuss how the MCA actually seeks to enhance the mental health and emotional wellbeing of older adults by offering a rather radical approach to understanding people's wishes and feelings, but how attitudes may lead to misunderstandings and negative outcomes for the individual.

Originality/value

In a climate of serious case reviews identifying concerns and abuses in care it is imperative that understanding of the MCA inform good practice. However, what constitutes good practice requires unraveling and the agendas, requirements and attitudes of interventions need considering from an epistemological perspective as well as to project how the outcomes of decision making impact upon the mental health of alder adults. This paper will discursively add value to the narrative around how the MCA is applied in practice and how chosen practice often constructs the mental wellbeing of older adults.

Introduction

Mental capacity has various meanings depending upon the environment in which it is considered. From a legislative perspective, mental capacity is defined as the ability to make a decision (Graham and Cowley, 2015). Therefore the MCA has intrinsic value in assisting carers and health and social care professionals to understand what mental capacity is but also what might encompass someone lacking mental capacity to make any given decision at any given time. The tension that exists in making connections between mental capacity, the MCA and wellbeing in older people requires a level of analysis that transcends what are quite often basic understandings of mental capacity and how it is considered in relation to best interests decision making.

It is suggested that mental capacity is a construct and only exists within the subjective determination of either the individual or another person. For example, a practitioner may

determine that an individual lacks capacity based upon a number of variables, most notable being an assessment of capacity and consultation with others. It is suggested that the person's objective capacity pails into insignificance based upon the professional's assessment which will ultimately result in the actual determinant of capacity. Of course, correlation may exist but this is dependant on the professional's knowledge of the MCA and skills and values around person centred care. What must be remembered is that the MCA states that a person is to be assumed to have capacity unless it is established that he lacks it. This tells us something of great importance, which is that law states a person has mental capacity and another person can establish that it is lacking through a process of assessment.

Discussion

The MCA is increasingly being 'used' as a piece of safeguarding legislation, inasmuch that people are often assessed in relation to health and social care outcomes when elements of risk to the person are deemed to be present. This is often in direct conflict with the first three principles of the Act that clearly refer to capacity, maximising capacity and choice around making decisions which others might deem to be unwise.

Skewed interpretations and application of legislation do not lend themselves to much needed discussions around mental health and wellbeing. The ability to make a decision is a central tenet to wellbeing in older adults. Emmett, *et al* (2013) in their research in relation to assessing capacity of dementia patients to make decisions about hospital discharge, observed "where assessors did not agree with patients' decisions, they were prone to interpret the decision as lacking capacity" (p.77). Such an observation clearly infers risk averse practice where it is suggested that where potential for significant risk is present then professionals may err on the side of caution resulting in, at best, people whose capacity is questioned being over-assessed and, at worst, determining a 'lack of capacity attitude' actually prevailing within practice.

In the case of *Heart of England NHS Foundation trust v JB* Mr Justice Peter Jackson concluded that "we should not ask more of people whose capacity is questioned than those whose capacity is undoubted". The court noted that in various of the written statements about JB's capacity, expressions had been used which suggested that the requirement to presume capacity, and the burden of proof of incapacity being on the person disputing capacity, had not been properly applied ([2014] EWHC 342 (COP)). Considering citizenship and how this embraces autonomy, self-determination, rights and choice being central to understanding the

spirit of the Mental Capacity Act and good practice in relation to the Act will demonstrate this by people's autonomy being enhanced at every opportunity. It is suggested that good practice in relation to the MCA with older people is not evidenced through how many capacity assessments are held on file or how many best interests decisions are implemented, but rather through seeing people making decisions with confidence and their emotional wellbeing being enhanced at every opportunity.

Anecdotal evidence, despite criticisms of it lacking methodological weight, offers an insight into the discourse that surrounds links between mental capacity as a construct, legislation that essentially oversees best practice and how both of these factors impact upon the wellbeing of older adults. Court of Protection judgments clearly indicate in several cases where outcomes of mental capacity assessments have had a detrimental impact upon an older person's wellbeing, albeit that the decision may have 'safeguarded' the individual's physical health and soothed concerns in relation to risk. A more notable case in relation to this issue is that of CC v KK and STEC EWHC 2136 (COP).

KK was an 83 year old woman with a diagnosis of Parkinson's disease and vascular dementia. KK was a widow when she moved into a rented bungalow in her 70s. Due to physical health concerns KK was admitted to hospital following a fall at home. KK was assessed as lacking capacity and a best interest decision was made for KK to move into a residential care home. A short time later KK was assessed as having capacity following some improvement and returned home. Over a period of months her physical health deteriorated and she was later assessed as lacking capacity and was admitted to a nursing home where a deprivation of liberty authorisation was put in place, which was challenged by KK herself who wanted to be at home, and it was this that led to the case being heard in the Court of Protection (Graham and Cowley, 2015).

In this case, Mr Justice Baker referred to the danger of professionals conflating capacity assessments and best interests decisions and "conclude that the person under review should attach greater weight to the physical security and comfort of a residential home and less importance to the emotional security and comfort that person derives from being in their own home". His honour criticised the local authority in question and reminded them of their duty to follow the Code of Practice and the principles of the MCA. Therefore, what we clearly see here is a legal judgment which essentially triangulates mental capacity, the MCA and

wellbeing and presents an outcome which, quite simply, reminds health and social care practitioners of the basics of legislation.

The conflict that is experienced here is that the application of the basics of legislation might actually not be basic at all. Evidence of this has certainly be observed on MCA training courses where practitioners from all fields discussed their observations and own stories of how the MCA is understood and applied by themselves and colleagues. Hollingsworth (1994) demonstrates how collaborative conversations can go beyond informative chats to become a place for research and in which transformative processes occur (Feldman, 1999). Once the MCA is discussed beyond the realms of legislation and professionals feel confidant to enter into the discourse that surrounds capacity as a construct then a narrative can be formed based upon knowledge of older people's identity, their own stories and narratives and how they wish to live their lives.

What is ultimately being suggested here is that professional understandings of mental capacity must be firmly located with the person, their experiences and any associated risks and concerns, but in addition to this how the professional understands their own ability to critically comprehend the meaning behind the individual's experiences is a key issue in transforming mental capacity from an objective phenomena to essentially a subjective one which is fluid and the formation and determination of which has a direct impact upon people's wellbeing in later life. Mc Dowell and Newell (1996) suggest that health is broadly defined focusing on well-being and functioning along with illness and disease (Waite and Das, 2010). Health is conceptualised in a social and cultural context using the resources of the individual, family and social environment (Waite and Das, 2010) suggesting that the amount of structures and system around the person have a direct influence upon not only how health is considered, but how healthy any individual may be at any given time particularly if they receive large amounts of care, support and supervision. Having said this there is suggested disjuncture between health, mental health and wellbeing particularly when mental capacity is considered and it can be suggested that the consequences of applying the MCA in health and social care settings are not considered as much as they should be when it comes to professional decision making impacting upon wellbeing in later life.

Tanner and Harris (2008, pp190-191) in Carey (2015) highlight further paradoxes when working around risk and protection of older people. For example, tensions persist between the promotion of service users' independence while seeking to protect through further

monitoring and surveillance (p12). Professionals and care-givers are faced with the two threads that essentially emerge from this argument. The first is that safeguarding an older person who lacks the mental capacity to make a specific decision in order to ensure their health and protection may not actually promote that person's wellbeing at all particularly if this involves elements of protection and control. The second theme emerging is that autonomy, self-determination and decision making may not lead to mental wellbeing within the person particularly if the person's scope of decision making is limited because of the care environment in which they live or the care and treatment that person receives. What is being suggested here is that environmental factors within a particular care setting may not facilitate scope for decision-making as there may not be many decisions to make within the course of someone's day, particularly if the care regime which the individual is experiencing is subject to resource difficulties where limited activities and structure takes place.

Cultures of care within care homes and hospitals, for example, may often have the individual's health and safety as a central tenet to the service which is provided and this will undoubtedly appeal to relatives and carers who will wish to feel safe in the knowledge that their loved one is being cared for adequately whilst having their needs met. Reflecting upon bio-psychosocial constructs of identity may enable practitioners to consider the person beyond the physiological and start to identify with the person's emotional and social needs in relation to well-being and positive mental health. Even though there might be a sense to 'do the right thing' for people in our care it is an absolute imperative that the individual is supported to demonstrate individual judgment and have that liberty, through the process of the MCA, to step away from controlling care (Graham and Cowley, 2015). Lack of involvement in decision making increases the dependency of people and reduces their autonomy (Fearns, 2012, in Tew (ed.) 2012) which may ultimately lead to deterioration in health and independence.

Ekelund *et al* (2014) refer to self-determination as being conditional and that the construction of self-determination only exists depending upon whether the individual has been taken into account - as being seen as respected as capable for exercising self-determination. The second factor is whether the individual feels safe and secure in relationships so can trust others to support self-determination, choice and decision making (p95). A sense of safety and security within the older person may unconsciously derive from appreciating that a care provider or any health and social care professional has an holistic understanding of the person and their needs, and views the individual beyond a pathological entity who requires care and support.

Waite and Das (2010) refer to a *conceptual framework* where health is broadly defined as focussing on well-being and functioning along with illness and disease. They state that biophysical, psychocognitive and social capital make up an individual's *health endowment* and that this health endowment is inextricably linked to socially relevant others (partner, kin and friends) with whom they may pool resources, exchange services and provide advice and support (s88). The spirit of the Mental Capacity Act utterly supports the ethos of constructing and understanding a wider discourse into the relationship between capacity, law and well-being and how this specific piece of legislation does not predominantly seek to safeguard people through ensuring capacity is assessed and best interest decisions are made, but foremost seeks to uphold people's rights, choice, autonomy and self-determination.

The Government website *Mental Capacity Act: making decisions* (2015) states that the MCA "covers people in England and Wales who can't make some or all decisions for themselves." (https://www.gov.uk/government/collections/mental-capacity-act-making-decisions). This premise is unhelpful inasmuch that to offer this as an overarching synopsis of the purpose of the MCA misses out an entire demographic of people who have capacity to make decisions for themselves and require the Act to ensure the continual maximising of their capacity and regard to the five statutory principles as set out in section 1 of the Act.

Williams, et al (2012) in the research study, *Making Best Interest Decisions: People and Processes,* looked at professional practices in best interests decision making under the MCA. This research found that 36 of the 385 respondents had indicated that a best interests decision was made for someone who did have capacity (p55). Reflecting upon the reasons for this would be helpful in reaching a conclusion as to why this is considered both acceptable and lawful. Certainly, to support someone to make a decision which the individual believes to be in their best interests is good practice enshrined within the MCA code of practice, but to make a best interest decision for someone who has capacity somewhat throws the principles of the MCA awry within that particular care setting and presents some concern.

It is suggested that one of the greatest areas of concern in relation to discussion and research around the MCA and its application is the lacking evidence of links between the MCA and mental health and well being. A somewhat controversial aspect of the MCA, introduced into the Act in 2009, is the Deprivation of Liberty Safeguards (DoLS). These safeguards were introduced into the MCA due to a 2004 European Court of Human Rights ruling known formerly as HL v UK 45508/99 (2004) ECHR 471 (or, more simply, HL v UK), but this

judgment is mostly referred to as the 'Bournewood Judgment'. This judgment evidenced a legal loophole in UK law whereby many vulnerable adults were being detained unlawfully in hospital and care homes (Graham and Cowley, 2015). Albeit that since its inception the DoLS have offered legal protection for many people it has remained controversial due to the nature of depriving people of their liberty within care homes and hospitals. This concern was exacerbated by the Supreme Court ruling of 2014 that followed the Cheshire West and Chester Council v P ruling (see Graham and Cowley, 2015, p180). The Supreme Court ruling introduced a definition of what constitutes a deprivation of liberty, enshrined within the 'acid test'. The test states that a deprivation of liberty is occurring if:

1. The person lacks capacity to consent to their deprivation of liberty (the regime/care which constitutes the deprivation of liberty); and
2. The person is under continuous supervision and control and not free to leave their placement, and
3. The care regime is imputable to the state. (Graham and Cowley, 2015).

The DoLS have certainly achieved what they set out to do, which was to provide lawful authorisations of deprivations of liberty and that any authorisation will offer a safeguard to the person's rights and protect the care environment by, essentially, legalising the care regime which results in the need for a deprivation of liberty. Probably the biggest criticism of this, however, has been the disconnection with the person's emotional wellbeing. Certainly, the older person's care may well be legislated and conditions attached to ensure specific criteria continues to be met, but the overly bureaucratic processes have often masked good practice. Graham and Cowley (2015) suggest that with regards to best interest decisions many report that there is minimal understanding given to the person's way of communicating or involving them in decision making. Equally, more time needs to be spent taking in the views of family, carers and other relevant people, past and present wishes and least restrictive alternatives (p184). In essence, this suggests that the DoLS and many aspects of the MCA offer robust legal safeguarding processes in terms of legal authorisation to act, support, care and treat a person but the individual to whom they apply is often 'lost' in the mire of legislation in relation to their overall mental health and understanding of how they are located emotionally within that particular care regime.

In July 2015 the Law Commission unveiled its much-anticipated proposals for a framework to replace the Deprivation of Liberty Safeguards (DoLS) after concluding that the current

system was “deeply flawed” (Community Care 2015). The new proposal includes a two-tier system with the first tier being legislated ‘supportive care’ where (regardless of any deprivations of liberty occurring or not) the person will be offered “baseline preventative safeguards” (Community Care, 2015) where advocacy is offered and oversights are put in place to the care being given to the person who lacks capacity to consent to it. The second tier, know as ‘the restrictive care and treatment’ scheme would provide a protective framework to deprive a person of their liberty (Community Care, 2015). It is suggested that the first tier of the suggested framework will, for the first time in mental capacity legislation, afford legal recognition of the person’s wellbeing in relation to the impact of any care regimes and decision making upon them. This is most welcome and may, if it is applied in a person-centred way, offer a connection between mental health, the MCA and emotional well-being.

Conclusion

Literature is somewhat scarce in relation to the connection between mental capacity, legislation and wellbeing, but what is clear is that much research has been done in relation to citizenship, self-determination and autonomy for older people. Court of Protection case judgments have openly criticised how people’s wishes and feelings have been omitted from the application of the MCA and evidence also demonstrates that people who have mental capacity have had decisions made in their best interests. It is time for older people’s emotional well-being to be placed firmly at the centre of the MCA in practice and, perhaps with time, changes to legislation may create a legislated environment where this will occur.

References

Carey, M. (2015). Journey's end? From residual service to newer forms of pathology, risk aversion and abandonment in social work with older people. *Journal of Social Work.* 0(0) 1-18.

Community Care (2015). Law Commission unveils proposals for Deprivation of Liberty Safeguards replacement. http://www.communitycare.co.uk/2015/07/07/law-commission-unveils-proposals-deprivation-liberty-safeguards-replacement/. Accessed 7th July 2015.

Ekelund, C., Martensson, L., and Eklund, K. (2014). Self-determination among frail older persons – a desirable goal older person's conceptions of self-determination. *Quality in Ageing and Older Adults 15 (2), 90-101.*

Emmett, C., Poole, M., Bond, J. and Hughes, J. (2013). Homeward bound or bound for a home? Assessing the capacity of dementia patients to make decisions about hospital discharge: Comparing practice with legal standards. *International Journal of Law and Psychiatry 36, 73-82.*

Fearns, P. (2012). Finding a Way Forward. A Black Perspective on Social Approaches to Mental Health. In Tew, J. (2012). *Social Approaches in Mental Health.* London: Jessica Kingsley Publishers.

Feldman, A. (1999). Conversation As Methodology in Collaborative Action Research. http://people.umass.edu/~afeldman/ActionResearchPapers/Feldman1999.PDF Accessed 12th June 2015.

Gov.UK (2015). Mental Capacity Act: making decisions. https://www.gov.uk/government/collections/mental-capacity-act-making-decisions. Accessed 7th July 2015.

Graham, M. and Cowley, J. (2015). A Practical Guide to the Mental Capacity Act. London: Jessica Kingsley Publishers.

The High Court of Justice The Court of Protection. Heart of England NHS Foundation Trust v JB. [2014] EWHC 342 (COP). Peter Jackson J. www.bailii.org/ew/cases/EWHC/COP/2012/2136.html, accessed 26th June 2015.

Waite, L. and Das, A. (2010). Families, Social Life and Wellbeing at Older Ages. *Demography*, Volume 47 – Supplement. S87-S109.

Williams, V., Boyle, G., Jepson, M., Swift, P., Williamson, T., and Heslop, P. (2012). Making Best Interests Decisions: People and Processes. Mental Health Foundation. http://www.mentalhealth.org.uk/content/assets/PDF/publications/BIDS_report_24-02-12_FINAL1.pdf?view=Standard. Accessed: 26th June 2015.