

Assessments of mental capacity: upholding the rights of the vulnerable or the misleading comfort of pseudo objectivity?

Purpose

The purpose of this paper is to present findings from a research project which investigated the approaches of different groups of assessors to the mental capacity assessments which are required to be conducted as part of Deprivation of Liberty Safeguards (DOLS)

Design/Methodology/Approach

Four case study vignettes were given to participants. Three groups involved in the DOLS assessment process were interviewed by telephone about the factors that may influence their capacity assessments.

Findings

Most assessors did not refer to the required two stage test of capacity or the 'causative nexus' which requires that assessors must make clear that it is the identified 'diagnostic' element which is leading to the inability to meet the 'functional' requirements of the capacity test.

The normative element of capacity assessments is acknowledged by a number of assessors who suggest that judging a person's ability to 'weigh' information, in particular, is a subjective and value based exercise, which is given pseudo objectivity by the language of the MCA. A number of elements of good practice were also identified.

Research limitations.

In this exploratory study, participant numbers were small (n= 21), and we relied on self-

report rather than actual observations of practice or audit of completed assessments

Practical Implications

The findings are of relevance to all of those working in health and social care who undertake assessments of mental capacity, and will be helpful to all of those tasked with designing and delivering training in relation to the Mental Capacity Act 2005 (MCA). They also have relevance to policy makers in the UK who are involved with reforms to DOLS regulations, and to those in other countries which have legislation similar to the MCA.

Originality/Value

Much existing literature exhorts further training around the MCA. We suggest that an equally important task is for practitioners to understand and be explicit about the normative elements of the process, and the place of ethics and values alongside the more cognitive and procedural aspects of capacity assessments.

Introduction.

The Mental Capacity Act 2005 (MCA) is a significant piece of legislation in England and Wales. One aim of the developers of this act was to bring about a paradigm change, in terms of viewing all citizens, including those with a range of impairments, as bearers of a set of rights. This shift has led to an environment in which law, policy and practice guidance in health and social care fields privilege autonomy, and aim to put the individual at the heart of decision making (House of Lords, 2013). A number of other countries have enacted similar legislation. For example, a survey of 32 European countries found that most had legal and policy frameworks which protect individual rights to some degree for those whose decision making is impaired because of dementia (Alzheimer Europe, 2016).

The fact that 2 million people in England Wales are estimated to lack the capacity to make some decisions for themselves highlights the importance of capacity assessments in contemporary care settings (Care Quality Commission,2016). Each of these individuals will at some point need decisions or often a whole series of decisions to be made about interventions in relation to health and care.

A key distinction, in the framework of the MCA, is between those patients or service users who are deemed to have the capacity to make decisions for themselves, and those who are not, and who are then subject to decisions being made for them on a 'best interests' basis. Health and social care professionals in the UK now routinely make assessments of mental capacity in relation to a whole range of decisions about care and treatment.

Capacity assessments must be specific to a particular decision but there may be multiple decisions to be made, and therefore multiple assessments required. These range from those relating to day to day routines of living such as food and clothing choices, to significant decisions about surgery or moving out of a family home into a care home.

The required assessment of capacity is set out in a two stage test within sections 2 and 3 of the MCA. This includes a diagnostic test, which requires that the decision maker identifies the impairment that is thought to lead to incapacity; and a so called 'functional' test which requires an assessment of the ability of a person to: understand the information relevant to the decision; retain that information; use or weigh the information as part of the process of making the decision; and communicate the decision by any means (MCA, 2005)

These assessments have pivotal importance since their outcome leads to either independent and autonomous decision making by the individual or, if capacity is deemed to be lacking, the loss of autonomy as others step in and make decisions on their behalf. Such proxy decision making should be done in the 'best interests' of the person and other elements of the MCA require support for the person to be provided, and their involvement as far as possible, even where they are deemed to lack the capacity to make a particular decision independently (MCA 2005). None the less, a judgement that I lack capacity clearly places significant limitations on my autonomy.

The architecture and aims of the MCA have been widely welcomed and praised in a range of reports, including in a wide ranging review by the House of Lords (House of Lords 2014). The Deprivation of Liberty Safeguards (DOLS) were added to the MCA in 2007. They apply only to hospitals and registered care homes and are aimed at ensuring that those who lack the mental capacity to make the specific decision about residence in the care setting, are not unlawfully deprived of liberty. These regulations have been less welcomed than the main MCA in some regards, because of their complexity and the perception that they have added unnecessary bureaucratic burdens on both care providers and commissioners of care (Hargreaves, 2009; Rogers *et al.*, 2014). However, whilst they have been subject to significant criticism (House of Lords, 2014) and are currently being reformed (Mental Capacity Amendment Bill, 2018), it is clear that these safeguards have brought welcome scrutiny to care settings and have demonstrably led to improved rights and improved care in many instances (Edge Training, 2016). Assessments of mental capacity are central to the safeguarding process which DOLS are designed to provide.

In relation to the DOLS safeguards, 200,000 referrals are now made every year from care homes and hospitals to local authorities, for assessments of capacity to make the crucial decision about consenting to residence in a hospital or care home (CQC 2017). Following a landmark case heard in the Supreme Court in 2014, which clarified the way in which deprivation of liberty should be considered, there was a fourteen fold increase in referrals between 2014 and 2017 (CQC, 2017). This situation has created a huge cost burden for adult social care services who are charged with commissioning the necessary assessments (including the capacity assessment) for a DOLS authorisation. This has been estimated at as much as £1 billion per year (Law Commission Impact Assessment, 2015).

Given the importance of the process, the research literature regarding capacity assessments is relatively sparse. As a precursor to this study, a focussed review of the literature was conducted. Existing reviews on the MCA as a whole are few. Jenkins (2012) conducted a review for a large UK mental health charity, the Mental Health Foundation. She noted seven studies which specifically addressed capacity assessments and concluded from these that there remained a lack of training and a lack of understanding and also a perceived lack of involvement in the assessment process by service users. More recently Hinsliff- Smith (2015) conducted a systematic review of the literature but this was limited to applications in relation to frail and older people. Key findings from that review of 38 relevant studies included: the lack of knowledge of the act on the part of lay and informal carers, and the limited effectiveness of current approaches to education and training about the act. Marshall and Sprung (2016) conducted a further review but limited their studies to those relevant to nursing practice. Their findings, based on 32 studies echoed those of a detailed enquiry published by the House of Lords (2014): that risk averse and paternalistic practice continues and that there is a need for both significant further training and widespread embedding of the values and procedures of the MCA into

practice. The authors noted studies which highlighted how professionals were using the outcome of individual's decisions to guide assessments of capacity, rather than the ability of the individual to retain weigh and use information relevant to the decision.

Guidance for assessors

Some useful guidance exists for practitioners, which gives step by step pointers in relation to assessments of mental capacity (National Institute for Health and Care Excellence, 2018). For DOLS procedures, there is a clear and bounded issue at the heart of the capacity assessment, namely: can the person provide valid and capacitous consent to residence in the care setting for the purpose of care and treatment.

In term of how assessors should approach capacity assessments, there is some specific guidance for those involved in the DOLS process (Ruck Keene *et al.*, 2014). The assessor must focus on the actual regime that will be in place. The question is not an abstract one, and the person must have been given the information relevant to the specific care regime that is proposed (or is already in place). Relevant information will include that the person is in a hospital or care home to receive care and or treatment and will also include the main elements of that care and treatment, including any measures put in place to supervise and control the person, and to restrict their movements; and what would happen should the person try to leave the care setting.

In the English (and Welsh) setting, in *A PCT v LDV & Ors* [2013] EHH272 (Fam)– a case concerning deprivation of liberty in a psychiatric hospital – the judge held that 'The relevant question to ask is that set out in the "mental capacity requirement" in paragraph 15 of Schedule A1, i.e. "whether or not he should be accommodated in the relevant hospital or care home for the purpose of being given relevant care or treatment,' and that 'The information relevant to that question goes beyond simply the information relating to the

placement to include information about the care and treatment and, broadly, the nature of the restrictions that will amount to an objective deprivation of their liberty'.

Little evidence was found in our brief literature review about the extent to which the guidance referred to above is followed and how helpful it might be to practitioners, hence the need for this study.

Methodology

The aim was to investigate the way that those involved in DOLS assessments approach the required assessment of capacity to consent to residence in the care setting. The scale and cost of the DOLS assessment process was noted earlier. The lack of consistency in assessments has been noted in national reports as a persistent and sizeable problem (House of Lords, 2014; CQC, 2016). Our methodology was designed to allow us to explore this issue in some depth.

Our objectives were to understand which factors influence the decision of a practitioner about whether an individual has capacity or not; how often individuals are judged to have capacity or not; and to explore and understand differences between professional groups in their approach to capacity assessments.

To achieve this, we recruited individuals from three groups of people who regularly conduct and scrutinise capacity assessments for DOLS authorisations.

1. best interests assessors (BIAs). They are usually qualified social workers, but may also be nurses or occupational therapists
2. mental health assessors (MHAs). They are medical professionals and usually psychiatrists

3. DOLS signatories (DS). They are employed in local authorities to scrutinise and check the quality of assessments and may have a range of different professional backgrounds.

One of primary aims was to understand the role of a variety of key predictors of clinician behaviour in relation to their approach to capacity assessments. Case study vignettes were chosen as the most suitable method for this study, because, As Evans *et al.* (2015) have suggested, 'as a hybrid of traditional experimental and survey methods, vignette studies can offer aspects of both the high internal validity of experiments and high external validity of survey research in order to disentangle multiple predictors of clinician behaviour'. Four vignettes were developed, in consultation with a core group of three best interests assessors, who were not participants in the research study, to concisely represent some typical complex situations that can be associated with DOLS authorisations. These included scenarios involving:

1. An adult male with brain injuries following a road traffic accident.
2. A 94 year old female with suspected dementia.
3. A 28 year old female with a diagnosis of personality disorder who uses alcohol to excess and frequently self-harms.
4. A 21 year old male with a learning disability and autism.

The information given in the vignette in relation to the latter case was as follows:

S is a 21 year old male with a learning disability and autism. S has limited verbal communication and communicates with a mixture of basic signs and by means of a PECS book. S has lived in the current placement for the last two months following the breakdown

of his previous placement as a result of 'challenging behaviours' towards staff. S's mother lives some 200 miles away and there have been safeguarding allegations made against her in the past, when she insisted that S could be transported home by herself without a staff escort. S's mother wants S to live at home again and S has indicated that this would be his preference too. S needs support with all aspects of daily living including personal hygiene, meal preparation and medication and has been assessed as lacking capacity to consent to his care and treatment arrangements by his social worker and by the managing authority. Care staff have to use physical interventions to manage S's challenging behaviours.

Recruitment took place via a range of networks, including local authority and health trust contacts and relevant training providers. Using regional and national networks enabled us to recruit from all parts of England. In total we interviewed 16 people including 11 BIAs (Best Interest Assessors) 3 MHAs (Mental Health Assessors) and 2 DOLS Signatories, all of whom were currently active in these roles and who gave their written consent to take part.

Following expressions of interest individuals were sent detailed participant information sheets and consent forms. After participants had given their consent to take part vignettes were emailed to them 30 minutes before an agreed time for a recorded telephone interview. For each vignette, participants were asked to judge whether or not the person featured in the vignette had capacity or not. Questions were then asked to explore factors that might influence their approach to capacity assessments and some of the specific questions and information that they would put to the person (P) being assessed.

Participants were asked to score, on a scale of 1 to 10 how much each of the following factors would influence their judgement.

- (a) Case law
- (b) Risk of harm to person if not in 24 hour care
- (c) Current presentation of person
- (d) Information from others about person's impairments and how they impact on them
- (e) Previous capacity assessments
- (f) The person's ability to communicate with you
- (g) Professional values and codes of conduct
- (h) Fear of litigation
- (i) Other- please specify

Recorded interviews were transcribed using a professional transcription service. The data was then analysed using a thematic analysis approach. Thematic analysis is a qualitative research method that can be widely used across a range of epistemologies and research questions. It is a method for identifying, analysing, organising, describing, and reporting themes found within a data set which can produce trustworthy and insightful findings (Braun & Clarke, 2006; Nowell *et al.*, 2017).

Ethics

Because we intended to interview staff based in both NHS bodies and Local Authorities, relevant permissions for the research were sought and obtained from both

Local Authorities (individually and jointly through ADASS) (ADASS reference: RG18-03; and the NHS- Health Regulatory Authority (HRA) (Project Number IRAS 238255).

Findings

In the following section extracts from transcripts are used which refer to participants from the three groups by an abbreviation and numerical code (e.g. BIA 8). The person who is being assessed is typically referred to in case law as P and this convention is followed in the next section.

One objective was to understand differences between the three groups in their approaches and the factors that might influence them. Small numbers in two of the groups limited the available data. Findings need to be treated with caution and future studies with much larger numbers in each category of assessor would help to verify and elaborate on any between group differences. The findings here suggest a greater focus by MHAs on diagnostic criteria and the identification of the impairment in stage one of the two stage test for capacity in section two of the MCA.

A further objective was to explore whether or not, in these brief cases, individuals would be judged to have capacity or not. Most participants were understandably reluctant to surmise on whether the people in each vignette might have capacity or not, given both the limited information and the lack of ability to meet the person and undertake the actual capacity assessment: 'I haven't seen the person; haven't been in the room with them; haven't looked at the body language; haven't read the notes' (BIA 2). Despite this only one participant abstained from answering consistently. Others began to answer this with some qualifications such as 'depending on further details' (BIA 1) or 'If I am able to compile the evidence' (MHA 1). A number of participants did offer some explanations for their decisions including principle one of the MCA (presumption of capacity) and/or how they interpreted the information available. Three participants (MHA 1, DS2 and BIA 11) mentioned the difficulties surrounding 'fluctuating capacity' in relation to vignettes 1 and

4. There is no clear consensus from any of the participants around the capacity of the person in each vignette, but interestingly there is a tendency to opt for a lack of capacity, apart from vignette 4 where a majority thought the person was likely to have capacity. A possible inference from such data might be that assessors are used to coming across people, who do indeed lack capacity in relation to their care and treatment arrangements and therefore are likely to see this in the information given.

Beyond these differences, five key themes were identified in the thematic analysis: risk; the subjectivity of assessments; the challenges posed by capacity assessments; the quality of previous capacity assessments; and the level of compliance with existing guidance on capacity assessments.

The first theme relates to risk. Figure 1 illustrates the scores for key factors that participants were asked about. A key similarity between the three groups was the low score given to 'Fear of Litigation' with the majority of respondents stating that they were fairly confident that this would not be an issue, provided they could justify their decisions: 'I always think can I justify my decision to a judge?' (BIA 8) 'If you have done a good job as a mental health assessor, then risk of litigation is low' (MHA 2). Some participants considered vignettes 3 and 4 to carry more potential risks to them as assessors than vignettes 1 and 2 .

Factor	Case law	Risk of harm if not 24 hour care	Current presentation	Info from others	Previous capacity assessment	Ability to communicate with you	Professional values and codes	Fear of litigation
Average score across all participants	7.5	7	7.5	7.5	5	8	7.5	3.5

Figure 1. Average scores of the importance accorded to selected factors in influencing assessments of capacity (on a scale of 1-10).

One of the DOLS signatories gave higher than average scores for this factor, which may be unsurprising given the legal responsibility for scrutinising and signing off the assessments necessary for a DOLS authorisation.

It is interesting here to compare the scores for fear of litigation compared to the scores for 'Risk of harm to person if not in 24 hour care', which generally has been scored higher by all participants. These are two very different factors, but both potentially relate to the 'risk-averse' practice identified by the House of Lords (2014) and also highlighted by some respondents in this report. Respondents commented on the practice of others '...working with care homes that don't have a great understanding of the MCA and are often very risk averse' (BIA 4) and

'I've done mental health assessments with other doctors who are really scared about the consequences of their decisions. So they make safe decisions that are not particularly welcome to the person being assessed' (MHA 2).

Such statements suggest that practitioners are alert to 'risk-averse' practice in relation to capacity assessments for DOLS and the impact that this might have on a vulnerable adult who will be denied the right to make their own decision about care arrangements, if the risks of not being in 24 hour care are perceived as too great. Whilst not commenting on

their own practice in this regard, the scores suggested that respondents also use risk of harm as a significant consideration in making their own judgements. Only one participant (BIA 4), scored the 'risk of harm' factor at zero, recognising that this is not strictly a consideration required by the two stage test for capacity in sections 2 and 3 of the MCA (2005): 'The level of risk isn't relevant: it's about his appreciation of the risk. Zero, really, because it's not relevant'.

Whether or not a person is assessed as having the ability to weigh and appreciate information about potential risks of harm may well be the point in a capacity assessment where subjective judgements are difficult to avoid, or where if a person disagrees with the way a health and social care worker sees the risks, there is a likelihood of a lack of capacity being identified:

'people have just referred them for DOLS because they are not making the decisions that maybe people would want them to make' (BIA 5).

The evidence threshold required by the MCA is that of the 'balance of probability'. As one participant noted:

'people sometimes use the phrase 'on balance of probability' as a way of saying 'it's risky, so I will go with the safest decision' (BIA 8).

A second theme relates to the subjectivity of assessments. Two of the Mental Health

assessors acknowledged that, as psychiatrists, they wished to be 'objective' and 'scientific', but that complex capacity assessments and emotional influences in human decision making did not really allow this:

'so the assessor is being asked about whether the subject's ability to use and weigh is sufficient to meet the task in the MCA. This is a bit of a subjective judgement' (MHA 1).

He went on to note that it may be straightforward in certain cases of dementia or psychosis, but that

'many personality disorders have the result that the person just decides something on an emotional basis, not on a cognitive basis at all, and their decisions can vary widely from one day to another'.

The assessor then has to make a subjective judgement about the pattern of those decisions and what it means. A danger here is this morphs into judgements about the best interests of the person rather than the kind of judgement about capacity that the two stage test requires.

The MCA explicitly protects the right of all who have mental capacity to make unwise decisions. We do not always and do not have to act in our own best interests. The best interests consideration only enters in when we are asked to make decisions on behalf of others who lack capacity. A problem in practice is that the two become conflated and

practitioners make judgements about best interests when trying to judge capacity, instead of reserving that judgement until such a time as lack of capacity has clearly been shown. (Taylor, 2016).

The third theme relates to the challenges involved in undertaking capacity assessments. Complexity and time pressure were the main challenges identified in this regard. Work load and financial pressures made it difficult for assessors to spend the time required to deal with the complexity of the individual situations. MHAs were generally clear they can only visit P once, and then rely on others for information, whereas BIAs were more likely to say they will do necessary research independently before visiting P, and then may visit P on another occasion if it is likely that P will be more lucid or able to take part. This though is difficult for BIAs who are typically faced with a huge backlog of cases and pressure to work through that backlog more quickly. The second and third themes are linked in the sense that the complexity which exists for an assessor partly relates to the subjective nature of the judgement and the range of factors, including the emotional state of P and the values and emotions of the assessor which need to be considered. There were comments about the difference between how MCA defines decision making as purely a cognitive process which can be understood in a straightforward way, and the reality.

'The problem with capacity assessments is that they sound like they are objective but they are completely subjective and vulnerable to the biases of the assessor' (MHA2).

In that reality, the assessment process may be one in which complex and difficult

subjective judgements have to be made about the ability of the person to weigh information, and manage risk, and there are norms against which that ability is judged. A procedural guide such as that provided by the MCA and Code of Practice, may be a necessary but insufficient aid to practice in such a scenario. What may also be of help is some method of normative evaluation. Professional codes of ethics and values may be useful in this regard, and this is something that was asked about. There were some differences among the three groups with respect to the weight that they accorded to such guidance, with BIA's giving an importance of 8 out of 10, compared to 3 out of 10 for mental health assessors.

A fourth theme which emerged relates to the quality of capacity assessments already undertaken by care homes, other DOLS assessors, and/or by those professional staff involved in a person's admission to 24 hour care. As figure 1 shows, previous capacity assessments were one of the factors that would least influence the capacity assessments undertaken by participants. A number commented very clearly on what they perceived as the shortcomings of other assessments:

'there is often no consideration given to what the person would wish', 'the person is often not informed what is going on', 'there is no prior warning – often assessors will just turn up' (BIA 1) 'the wishes of the individual are sometimes not as central to the process as they should be' (BIA 2). One BIA commented on extensive experience of being an authoriser:

'I was reading hundreds of assessments, and they vary enormously in quality, and in quantity of relevant information' (BIA 2).

Other assessments were either too brief, or conversely too long - 'you end up with these massive assessments and losing the core message' (BIA 5). It may be that it is easier to spot poor practice elsewhere than to demonstrate exemplary practice. From this study it is clear that there are significant number of mental capacity assessments conducted which do not follow good practice standards.

This last point links to the final theme – the level of compliance with existing guidance. Elements of legal guidance on the question of DOLS related capacity were summarised earlier. On more than one occasion, judges have stated that the relevant information to provide to the person in order to assess their capacity includes information about the care and treatment and, broadly, the nature of the restrictions that will amount to an objective deprivation of their liberty. One aim of the study was to explore the extent to which this guidance was followed. Most of the participants referred to providing specific information about the care setting, and about the care and treatment in question. References to the restrictions that might amount to deprivation of liberty were less common. One participant talked generally about giving information 'just around the care and support the person gets and the restrictions', but otherwise few talked about the nature of the restrictions which might cumulatively amount to a deprivation of liberty. The other very clear element highlighted in legal guidance is what was referred to in *PC and NC v City of York* (2013) as the 'causative nexus'. This requires that assessors must make clear that it is the identified 'diagnostic' element which is leading to or causing the inability to meet the 'functional' requirements of the capacity test. In terms of that two stage capacity, few interviewees referred to the diagnostic element of the test and none referred explicitly to the causative nexus.

Good Practice

The themes highlighted above point to a number of difficulties and challenges in relation to the required assessment process. Based on responses to vignettes characterising common situations encountered in mental capacity assessments for DOLS, a number of elements of good practice can be identified. Whilst not part of the procedural guidance of the MCA, many respondents stressed the importance of relationship building in order to be able to make the person more comfortable in the assessment and to make it more likely that the required information could effectively be gathered. There was also frequently a recognition of the need to have full information regarding alternative options for residence, care and treatment before assessing, as recommended in case law. One element which was noted consistently in the responses was in relation to identifying 'practicable steps'. The question was: 'What 'practicable steps' would you take or expect to have seen taken in order to support the person make their own decision?' Nearly all respondents gave sound ideas here in line with the principles of the MCA. A number of comments pointed to the importance of providing time, space, support, and the right environment for the assessment, as well as the need for repeat visits if necessary.

'For all the case studies, if there was an opportunity to enable that person to make a decision, if I thought another visit, or continued visits, would help I would consider that. I wouldn't just end the assessment and say they lacked capacity' (BIA 9).

Specifically in relation to the vignette described earlier, most respondents referred in detail

to the kind of practicable steps that might be taken in relation to communication with S.

'I would ask to have somebody who could sign', 'I would want to have his mother present because it looks like he has a bond with her' (BIA 7), 'I would expect to go armed with, or find at the care home some kind of flash cards or similar from which he can choose to express whatever he is trying to say' (BIA 2), 'I would expect support from a speech and language therapist' (BIA 4).

Finally, and something which can be seen as gaining increasing traction within the developing case law, an emphasis was evident on establishing the wishes and feelings of the person being assessed in order to support autonomy as far as possible.

Conclusion

Assessments relating to DOLS have become a growing element in adult social care practice. Although the capacity assessments in this sphere remain a specialist areas of practice for BIAs, those assessments are in one sense paradigmatic of the kinds of capacity assessments undertaken by Social Workers more generally. They are decisions about the capacity to consent to a change of accommodation and they are complex, often contested, and involve one big decision which may subsume a range of other decisions

Brown (2011) pointed to the limitations of the approach of the MCA which is predicated on the idea of individuals making rational decisions in their own best interests. She eloquently highlights the central role of emotion in decision making by service users. She warns that when assessing decision making capacity, we need to guard against overlooking emotional factors as a 'consequence of relying on a mythical model of decision-making

that stresses the “rational” as if it can ever be untouched by emotional considerations or interpersonal dynamics'.

We would go further and suggest that it is not only the non-rational elements of the service user's decision making that need to be considered, but also the non-rational elements of the practitioner's decision making. We noted a number of comments which pointed to the messy and complex nature of assessing capacity. Practitioners may be swayed by emotional elements of decision making as much as a service user is, though this may not always be acknowledged. The evidence amassed by the House of Lords (2014) report showed that risk averse practice, driven by fear of litigation (i.e. an emotional response) or other adverse consequences to the practitioner, appears to be a bigger driver of practice than the procedural guidance offered in the MCA Code of Practice. Our participants gave relatively low weighting to fear of litigation as a conscious factor in influencing their capacity assessments but high scores when considering the risk of harm to a person if they were not in the proposed 24 hour care. A capacity assessment requires that a practitioner judges the ability of P to weigh up and assess risks but it seems that practitioners often substitute their own weighing up and assessment of risk. In a practice culture which is fearful and averse to risk (Carey, 2016) this tends to lead to findings of incapacity when the desire of a person for the independence and autonomy which the MCA promises is deemed too risky by the state. Assessment of risk is an important element of practice across health and social care. However, assessment of the risk to a person if they do not follow a particular course of action should not govern assessments of capacity. Practitioners should be careful not to conflate assessments of capacity with best interests assessments.

The Lords report noted a number of problems with the implementation of the MCA2005. Their prescription, like that of others who have examined failings in terms of the implementation of the legislation, was for further training and better understanding of the principles and details of the act. We suggest that further training, with a focus on legal detail and procedure will be insufficient. Perhaps if a bigger role for emotion and values was admitted into the guidance there would be less of a disconnect between that guidance and the realities of practice. We concur with Brown (2011) that the model of decision making which frames it solely as a rational activity is a mythical one. The role of emotions and non-conscious factors in decision making has now been very well established across many fields of human activity (Kahnemann, 2012; Loewenstein and Lerner, 2003). For BIA's and all practitioners faced with undertaking assessments of mental capacity, attention to professional codes of ethics and values, critical reflection on practice, and an awareness of emotional drivers of behaviour would provide useful complements to legal and procedural knowledge. Fook and Gardner (2007) made explicit reference to the emotional aspects of critical reflection and suggested that this can have a therapeutic aspect to it while also directly feeding into ongoing practice and decision making. It has been demonstrated that supervision is an important vehicle for such reflection and the development of the emotional awareness (Hawkins and Shohet, 2000). Ingram (2013) argues for the essential role of supervision to professional practice and for a 'supervisory relationship which seeks to place the emotional elements of practice at the core of practice rather than leaving them potentially marginalised' (p17).

These are important messages for those working within the framework of the MCA, but also apply to those working in care roles in any setting and jurisdiction.

The Mental Capacity Amendment Bill (2018) is introducing proposed changes to authorising deprivation of liberty (House of lords 2018). One of the commitments in the bill

is a requirement that the necessary medical and capacity assessments must be completed by those with appropriate experience and knowledge. It is to be hoped that this also means professionals who are following appropriate codes of ethics, receiving regular supervision and critically reflecting on the emotional and value based elements of practice.

Limitations

The findings reported here are from a university funded pilot project which paid for the costs of transcriptions of the recorded telephone interviews. Individuals self-selected and the only exclusion criteria applied by the researchers was that participants needed to be currently active in one of the three main roles described. This may have excluded some potentially interesting material from respondents in management/safeguarding roles. We also did not involve any IMCAs (Independent Mental Capacity Advocates) as they ostensibly do not have a direct role in capacity assessments, but who again may have had valuable views to offer. Another potential limitation is reliance on what people tell a researcher as opposed to seeing their actual practice. The findings and conclusions reflect only the views expressed by the professional groups involved, and most participants (11 out of 15) were from just one of those groups – best interests assessors. The views of others involved in the process (for example care home managers) may provide a very different perspective. Brief case study vignettes have limitations and some participants were reluctant to make judgements about capacity based on the limited information provided in a brief vignette. It is suggested that future research on this subject also includes audit and analysis of completed capacity assessments, in order to better understand records of real world decision making.

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