

## Central Lancashire Online Knowledge (CLOK)

Title	Outcomes and Well-being Part 1: A comparative longitudinal study of two models of homecare delivery and their impact upon the older person self-reported subjective well-being
Type	Article
URL	<a href="https://clock.uclan.ac.uk/id/eprint/2974/">https://clock.uclan.ac.uk/id/eprint/2974/</a>
DOI	<a href="https://doi.org/10.1108/13663661211215141">https://doi.org/10.1108/13663661211215141</a>
Date	2012
Citation	Gethin-Jones, Stephen (2012) Outcomes and Well-being Part 1: A comparative longitudinal study of two models of homecare delivery and their impact upon the older person self-reported subjective well-being. <i>Working with Older People</i> , 16 (1). pp. 22-30. ISSN 1366-3666
Creators	Gethin-Jones, Stephen

It is advisable to refer to the publisher's version if you intend to cite from the work.  
<https://doi.org/10.1108/13663661211215141>

For information about Research at UCLan please go to <http://www.uclan.ac.uk/research/>

All outputs in CLOK are protected by Intellectual Property Rights law, including Copyright law. Copyright, IPR and Moral Rights for the works on this site are retained by the individual authors and/or other copyright owners. Terms and conditions for use of this material are defined in the <http://clock.uclan.ac.uk/policies/>

# Outcomes and well-being part 1: a comparative longitudinal study of two models of homecare delivery and their impact upon the older person self-reported subjective well-being

Stephen Gethin-Jones

Stephen Gethin-Jones  
is a Senior Lecturer at the  
University of Central  
Lancashire, Preston, UK.

**Abstract**

**Purpose** – *This paper aims to report on a study of outcome-focussed care for older people in one English local authority. The aim of the research is to examine whether altering the delivery of care to an outcome-focused model would improve the individual participant's subjective well-being and save money for the local authority.*

**Design/methodology/approach** – *In order for the aim of the research to be established, a pilot study was devised. This was a longitudinal study over 18 months, using a quantitative design. The sample was of 40 service users aged 65 and over whom all had critical and substantial care needs. Half of the sample of service users was receiving the new form of outcome-focused care and the other half were a comparison group who were receiving care packages according to the traditional form of delivery that could be characterised as a "task-focused" model. The service users were administered the Measure Yourself Concerns and Wellbeing Questionnaire (MYCAW). This questionnaire involves respondents identifying quality of life issues; where they are seeking improvement; and measures change over time in relation to these.*

**Findings** – *The research established that there was a greater improvement in subjective well-being in the group receiving outcome-focussed care, when compared with the comparison group receiving the traditional task-focused model.*

**Practical implications** – *This paper will assist managers in their decision making to implement a more outcome-focused model of home care with older people.*

**Originality/value** – *To use MYCAW in a social care context is an innovative aspect of this study as it has previously been used only in mainstream and complementary medicine. The focus of this paper is to examine the impact of two models of home care delivery for older people, and how these two models impact on the older persons' self-reported well-being.*

**Keywords** *Outcome-focus homecare, Older people, Social care, Home care*

**Paper type** *Research paper*

**Background**

Maintaining the individuals' ability to live independently has been the main thrust of public policy for older people within the UK since the end of the Second World War (Bebbington and Charney, 1990). However, within the UK the thrust of social care policy for homecare

services has been aimed at the promotion of the individuals' physical functional ability. The focus on the physical ability is based on the premise that this would also boost the older adults' quality of life (Kutner *et al.*, 1992; Lawton, 1991). The emphasis on physical functional ability has led to a task-focused approach to the delivery of homecare services to older people. This model divides the activities of daily living (Roper *et al.*, 1980) into time tasked slots of 15 minutes, which enables private and state providers to cost their services and allow the commissioners of these services to purchase services on behalf of the service user through a process of care management (Challis *et al.*, 2002). This model of care has been successful in enabling individuals to be maintained in their own homes and limit the cost to the state of long-term healthcare provision.

However, research conducted by the Social Policy Research Unit (York University) led by Qureshi *et al.* (1998) and Qureshi and Henwood (2000) noted service user and social worker dissatisfaction with the current model of delivery and developed a model of care that was outcome rather than tasked focused. This model has been piloted in the UK urban local authority and compared against the existing task-focused model. The focus of this pilot was to establish if the use of outcome-focused care improved the individuals' subjective wellbeing (SWB) over the existing model. Outcome-focused care is established by an agreement on appropriate outcomes that can be measured by the social worker and the service user, rather than purely agreeing tasked focused approach based on physical care. Therefore, the two parties' allocate time within which these outcomes could be achieved rather than time slotted tasks. This model allowed the individual the flexibility to bank time which could be used to meet their desired outcomes. An example of this is where an 88-year-old lady banked enough time to be taken to her husbands' grave which she had been unable to visit for three years. This model achieved this by the individual and the home-care worker agreeing which tasks could be reduced or curtailed (without detriment to the individual) in order for time to be built up to an agreed maximum of five hours.

Homecare within the UK developed historically around a domestic model of household chores. These chores would involve the provision of cooking and cleaning and would be seen as tasks of care which avoided the undertaking of activities that could be considered to involve any element of emotional care. This left the completion of tasks considered to be of an intimate and emotional nature (caring) to the remit of the family, with an underpinning belief that social support and intimate care would be provided by the female members within these families (Leece, 2003). In situations where families could no longer look after their elderly relatives the expectation was that the voluntary sector would support the individual out of "neighbourliness" or a sense of doing good. Therefore, it was hoped that communities rather than the state would provide support to the family. If these two models of homecare failed then the individual would be placed into some form of residential care provided by the local authority (Means and Smith, 1998). During the post-war period the welfare state continued to take on more of the responsibility for care to reflect the changing structure of the family and the profound social changes in the structure of communities and individuals' increased life expectancy.

## Method

The quantitative data gathering utilised two validated questionnaires: Measure Yourself Medical Outcomes Profile (MYMOP) (Paterson, 1996), Measure Yourself Concerns and Wellbeing (MYCAW) (Paterson *et al.*, 2007). These two instruments had been validated extensively in primary health care and were based on the larger SF-36 health survey (Ware *et al.*, 1994). The designers purpose in developing these two questionnaires was to provide a tool that would enable practitioners to measure changes in self-identified outcomes of patients, and to establish what factors impacted upon their sense of physical and mental wellbeing. In addition to the questions posed in the MYMOP and MYCAW questionnaires some additional questions were added to enable the study to measure the level of social isolation and satisfaction with the paid care provided. The questionnaires were administered face to face by the same researcher.

## Sample

The sample size consisted ( $n = 40$ ) participants. The participants were divided into two cohorts, one cohort being the intervention group: outcome-focused care ( $n = 20$ ) and the other group being a control group: time/task ( $n = 20$ ). All participants were aged over the age of 65 and were assessed as having care needs that were critical and substantial (*Fair Access to Care Services*, Department of Health, 2002). The participants were experiencing severe physical difficulties which impacted upon their ability to self care and ultimately live independently. No service users were accepted onto the study if they were considered to lack mental capacity as defined in the Mental Capacity Act (2005).

## Gender and age distribution

The sample ( $n = 40$ ) was distributed females ( $n = 23$ ) and males ( $n = 17$ ) this distribution would be expected given the mean age of the sample (76.45) as women tend to live longer than their male counterparts in the UK. This division of gender is also supported by the research of Scharf *et al.* (2001) also examining the quality of life in old age with 58 per cent of their sample being female and having a similar mean age of 71.53. This would allow for some confidence in the sample despite its limited size and that these findings might have the potential to be generalised to the wider older population.

## Individuals' self-reported physical and SWB scores

Diener's (2009) concept of SWB is an accepted measure for the measurement of wellbeing in old age. The Berlin Ageing Study (Baltes and Mayer, 1999) has conducted longitudinal studies of wellbeing in old age utilising Diener's concept of SWB. This study focused on the same age group (70-100+) as in this study, with an emphasis on the examination of wellbeing in participants in their third and fourth age. The sample size was large ( $n=517$ ) and looked, as does this paper, at psychological, social and physiological factors impacting upon older persons and their sense of SWB.

The MYCAW questionnaire also utilised Diener's single item question on wellbeing and then added two further questions allowing the participants to self-identify their two main non-medical concerns. The purpose of the MYCAW concern measure was to provide a multi-item scale when considering the individuals' SWB, and to allow a deeper analysis of the factors that were impacting upon the participants' emotional wellbeing. This paper will also examine physical self-identified wellbeing with the MYMOP questionnaire, in order to consider if the changes in the individuals' physical health have either a positive or negative association with how the individuals rate their SWB. Multi-item scales are considered to provide a more accurate measure of wellbeing than single item scales. A number of multi-item assessment tools have been developed to assess older people's SWB, these being the geriatric SWB scales developed by Diener (1984), with Diener arguing that having scales that are particular to a client group is more effective in establishing SWB in particular age ranges. These scales, although considered to be effective in measuring SWB in older people, are quite lengthy and are designed for the general older population. As this particular piece of research was with frail older people, it was felt that these larger scales would be overly intrusive and difficult to complete in the allotted timescale stipulated by the local authorities' ethics committee. However, the fact that Diener's concept of SWB has been applied across national boundaries and to different population groups, which has resulted in similar findings being established, gives some confidence that the use of scales based on Diener's work will provide some face validity to the findings. This also allows for the findings from this research to be compared to other research on older people utilising the same scale.

The MYMOP questionnaire allowed the service user to identify two physical problems that were of the most concern to them. These physical incapacities could be broken down into three main categories. The first category could be seen a physical mechanical problems induced by degenerative bone conditions and the severe pain this induces ( $n = 18$ ). The second category could be seen a physical mobility problems induced by neurological conditions such as strokes and balance or dizziness issues caused by circulatory problems

with these combined conditions ( $n = 12$ ). The final main category revolved around the loss of sight ( $n = 9$ ), with one service users mobility problems being attributed to clinical obese.

The distribution of incapacities appears to be similar across the two groups. This would allow for some confidence that the groups' physical profiles are similar and would provide some confidence in the two groups' representation of the wider social services service user older population.

The MYCAW document asked the participants to identify issues that concerned them. These have been categorized in Tables I and II. The first concern is the primary concern affecting their SWB the most with Concern 2 being the concern of secondary importance.

The MYCAW questionnaire asked the participants to identify these two concerns in addition to their self-rated measurement of wellbeing. The participants could choose anything that concerned them and therefore each response was very individual and subjective. Therefore, in order for any analysis to take place each response was placed within three broad categories. The first category, which had the highest number of respondents ( $n = 20$ ) was the inability to go out, to either visit friends or participate in activities such as church-going or visiting the pub. Not surprisingly, the second category that scored highest was that of loneliness ( $n = 16$ ). The third category was the inability to care for self or others ( $n = 15$ ).

Table III shows that, when Categories 1 and 2 are combined, the responses across the two groups are very similar, with the inability to leave the house scoring the highest number of responses, followed by similar scores for loneliness and inability to care for self or others. We can see that the greatest concerns are the inability to go out, followed by loneliness. Therefore, consideration needs to be given to the type of activity that the different types of intervention provide: for example, the outcome-focused intervention by its ability to conduct tasks outside physical care allows more time for the individual to get out of the house, then this might explain whether it was this aspect of the intervention that had the greatest impact. Again, this was not a question posed in the questionnaire and will be analysed in future research.

When a statistical analysis was conducted (ANOVA) there does appear to be a strong association between the type of intervention the participants received and their SWB score.

**Table I** Outcome-focused interventions: participants' self-identified concerns

Participant ID	Age	Gender	Concern 1	Concern 2
OFRE75	75	Female	Not having family support	Inability to go out
OFAL80	80	Female	Not getting out into the garden	Having someone who understands me
OFAJ65	65	Female	Constantly different staff	No relationship with the staff
OFGJ79	79	Male	Not being able to care for my wife	Not being able to lift my wife and her having to go into a home
OFMB77	77	Female	Loneliness	Not being able to go to church
OFMJ89	89	Female	Not being able to look after myself	Not being able to go out everyday
OFBN92	92	Female	Not being able to go out and meet friends	Not being able to be involved in church activities
OFPC80	80	Male	Being stuck in the house	Not being able to meet friends in the labour club
OFDL74	74	Male	Not being able to read or watch TV	Not going to my local pub
OFAT73	73	Male	People constantly asking me questions	Different people visiting everyday
OFRB66	66	Male	Being dependent on others	Feeling lonely
OFST81	81	Male	Not going out	Becoming so ill I cannot stay in my own home
OFNB69	69	Male	Feeling a burden to my family	Feeling lonely
OFFB78	78	Female	Inability to visit my husband in the care home	Feeling lonely
OFFB70	70	Female	Inability to go into the garden	Not being able to go out and meet up with friends
OFVK88	88	Female	Not being able to hold my grandchild	Not being able to look after my sister
OFAS96	96	Male	Lonely, not being able to go out	Not being able to watch TV
OFEL76	76	Female	Not being able to care for my pets	Loneliness
OFBF77	77	Female	Not being able to cook	Not being able to go out and shop for clothes with my friend
OFFB82	82	Female	Loneliness and becoming totally housebound	Not being able to go to church

**Table II** Time/task participants' self-expressed concerns (MYCAW)

<i>Participant ID</i>	<i>Age</i>	<i>Gender</i>	<i>Concern 1</i>	<i>Concern 2</i>
TTMF70	70	Male	Not having relationship with my wife	No dignity, different people washing and showering me
TTGL97	97	Female	So lonely	No activity in my life
TTIA72	72	Male	Not being able to go to the pub	Forgetting things around the house
TTLT74	74	Male	Not being able to keep on top of the garden	Losing contact with friends as I cannot get out as much
TTDB71	71	Female	Inability to look after my dog	Loneliness
TTRH76	76	Female	Can't go out on my own	Not being able to read any more
TTEH69	69	Female	Very lonely	Not being able to visit friends in their nursing home
TTLO73	73	Female	So lonely	Not being able to get to church
TTHT78	78	Male	Not being able to get to watch the football, so lonely	Walking with a stick makes me feel weak
TTRAM81	81	Female	My lifestyle, unable to meet friends	Feeling low and sad
TTHH69	69	Female	Losing touch with the outside world	Boredom and loneliness
TTBB81	81	Male	Difficulty watching TV or reading	Not being able to visit my daughter and granddaughter
TTLS78	78	Female	Not being able to go out on my own	Difficulty watching TV or reading
TTAS79	79	Male	No major concerns except not being able to go to the pub	Having to be dependent on others, especially care staff who are always changing
TTBB69	70	Female	Not being able to walk any distance	Isolation, being stuck in too much
TTLN72	72	Male	Not being able to wash myself, the lack of dignity with different staff doing it all the time	Isolation, not being able to go out
TTRE73	73	Male	Loss of independence	The stigma of walking with a frame
TTMH66	66	Male	Not being able to drive	Loneliness
TTMW86	86	Female	Not being able to look after my dog	Loneliness, not having any friends and family left
TTRS67	67	Male	Not being able to look after myself	Not being able to care of my grandchildren

**Table III** Self-identified concerns

<i>Categories</i>	<i>Descriptors for Concerns 1 and 2</i>	<i>Outcome-focused</i>	<i>Time/task</i>
Category 1	Inability to go out	10	10
Category 2	Loneliness	7	9
Category 3	Inability to care for self or others	7	8
Category 4	No clear category	5	4

In addition to an improvement in the individuals' SWB score there was a reduction in the level of concern identified by the individuals', with the concern scores also improving in the intervention group more than in the time/task group ( $p$ -value being  $> 0.00$ ). Therefore, there appears to be a global improvement in the participants' overall wellbeing despite a slight decline in their physical health.

Interestingly, when the mean scores are analysed between the two groups as to how the individuals' self-rated physical wellbeing had been over the last week, Measures 1 and 2 demonstrated that the outcome-focused group's condition had deteriorated, whereas the time/task group score actually demonstrated a slight improvement. This finding appears to indicate that the individuals' physical health declining or slightly improving has not had an impact upon their SWB. However, this raises the question as to whether the intervention had contributed to the decline. When this was analysed, there did not appear to be an association, between physical health and the individual's self-reported SWB with the  $p$ -value being  $> 0.11$  which demonstrated there was no association between your physical health and your SWB.

### Benefits and costs of the different interventions

This analysis was conducted in partnership with the local authorities' commissioning finance department. The areas analysed were the actual unit costs of the two interventions, and also



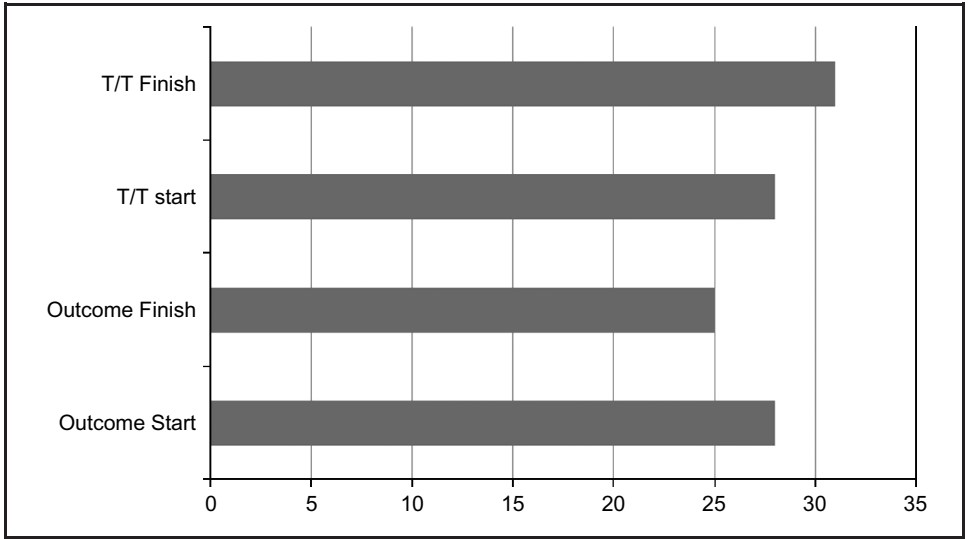
whether the outcome-focused provision led to a reduction in hours required. The assumption made by the local authority was that, based on un-researched anecdotal evidence from other local authorities, the provision of outcome-focused care led to a reduction of hours from service users, as they were more selective over the hours they used and the unnecessary provision of tasks could be eradicated.

The first area considered was the pure financial cost of the two provisions. The finance department tracked the cost of six service users from the outcome-focused group and the time/task group. Service users were selected who had spent at least 18 months receiving their care packages and the number of hours used were measured at the start and finish point of the intervention (Figure 1).

The hours used did support the anecdotal evidence that the number of hours used by the service user did reduce more within the outcome-focus group than with the traditional time/task model. This data were gathered from the time sheets completed by the homecare workers, which identified how long they spent completing tasks with the participants. However, what is masked by these findings is the method of recording. It was noted that the time/task intervention workers recorded each task completed against a 15-minute time allocation, even if the task only took five minutes, whereas the outcome-focused group recorded the time actually spent with the participant, rather than the raw task time. Table IV shows the actual time spent with the participants and the time allocated; the table is again based on the group average.

Table IV clearly shows a difference in the time spent with service users. This makes outcome-focused care significantly more expensive than the time/task model for the service provider.

**Figure 1** Average number of hours used per participant during the intervention period



**Table IV** Duration of paid care visits

Worker	Allotted time with participant in hours	Actual time spent with participant
Of homecare worker 1	4	4
Of homecare worker 2	3	3
Of homecare worker 3	3	3
Of homecare worker 4	4	5
T/T homecare worker 1	3	1.5
T/T homecare worker 2	4	2.5
T/T homecare worker 3	4	2
T/T homecare worker 4	4	2.5

However, this also demonstrates that the actual personnel contact time received by the outcome-focus group was significantly more than their task-focused counterparts. The time/task provider is therefore able to see more service users in a day, and in this particular example the group of time/task homecare workers, by cutting corners on time, would be able to see two more service users in their working day. This in turn allows the agency contracted to lower their unit costs as they are being paid for more hours than they are completing. However, because the care plan stipulates tasks rather than hours to be completed, the agency is not breaching its contract. Therefore, services allocated based on time, as in this case, were 17 percent more expensive, even after the reduction in hours used by the outcome-focused group. This data were calculated by the finance department of the commissioners, and the researcher has not been supplied with the data on how this figure was calculated.

The findings from this analysis show that outcome-focused care participants receive considerably more human contact time with the homecare staff than do the time/task group participants. Because of the limited number of participants involved and because the calculations made to arrive at the cost figures were not supplied, it is impossible to explore this more here and is an area requiring further research.

### Key findings from this paper

This paper has established that the participants have a mean age of 76.45 and are all experiencing severe physical problems induced by either physical disease, neurological impairment, or the loss of one or more of their senses. These incapacities have severely restricted the individuals' independence, so that the participants have a high level of dependency in order to live in the community and interact socially in the wider community. However, interestingly, an important finding was that, despite having family nearby, the majority of participants experienced very low levels of social contact, with their paid carers being the main source of social contact. The participants also demonstrated that the ability to establish a relationship with their carers was very important to them and that this was facilitated by the extra contact time provided by the outcome-focus care model.

The findings from the MYCAW and MYMOP questionnaires were also interesting. The questionnaire demonstrated that, despite individuals within the outcome-focused group indicating a decline in their physical wellbeing (MYMOP), they also demonstrated an improvement in their sense of SWB. More importantly, this data also demonstrated what appears to be an association between the type of intervention and the participants' SWB, inasmuch as those receiving the intervention of outcome-focused care showed the most significant improvement in their self-rated. Finally, the costs of the service analysis revealed that, despite the same amount of time being purchased for participants in both the outcome-focused group and the time/task group, the amount of time actually being delivered to these two groups varied considerably.

### Key themes to be developed

A number of themes have been developed throughout this paper that require further analysis. These themes are:

- Social interaction.
- Loneliness.
- Relationship with paid staff.
- Wellbeing concerns identified by the participants.

These themes were identified as requiring further investigation in future research, to allow for a deeper understanding of the mechanisms that were operating for each participant whether they were receiving the intervention of outcome-focused care or not. This emphasis on the mechanisms would give an understanding of what aspects of the outcome-focused



intervention worked that were not also provided by the traditional time/task model of  
homecare delivery.

Conclusion

This paper has focused mainly on the “does” question. In examining the “does” question, it  
has been established that there is an association between the type of intervention the  
participant receives and their self-rated wellbeing. However, it is not clear why this is the  
case and therefore further qualitatative research, will allow for the context to be studied in  
greater depth to establish why this intervention appears to have an impact upon the  
individuals SWB.

Implications for practice

- Move away from task-focused provision to person-centered services.
- Targeting of outcome-focused care to the most socially isolated.
- Greater focus on the holistic care of the service user rather than pure physical care.

References

Baltes, P.B. and Mayer, K.U. (1999), *The Berlin Aging Study: Aging from 70-100*, Cambridge University Press, New York, NY.

Bebbington, A. and Charnley, H. (1990), “Community care for the elderly: rhetoric and reality”, *British Journal of Social Work*, Vol. 20, pp. 409-32.

Challis, D., Chesterman, J., Lockett, R., Stewart, K. and Chessum, R. (2002), *Care Management in Social and Primary Health Care: The Gateshead Community Care Scheme*, Arena, Aldershot.

Department of Health (2002), *Fair Access to Care Services*, available at: /www.dh.gov.uk/en/consultations/responsestoconsultations/dh\_4017186">http://webarchive.nationalarchives.gov.uk/+ /www.dh.gov.uk/en/Consultations/Responsestoconsultations/DH\_4017186 (accessed 7 April 2011).

Diener, E. (1984), “Subjective well-being”, *Psychological Bulletin*, Vol. 95, pp. 542-75.

Diener, E. (2009), *The Science of Well-being: The Collected Works of Ed Diener*, Springer, London.

Kutner, N.G., Ory, M.G., Baker, D.L., Schechtman, K.B., Hornbrook, M.C. and Mulrow, C.D. (1992), “Measuring the quality of life of the elderly in health promotion clinical trials”, *Public Health Reports*, Vol. 107, pp. 530-9.

Lawton, M.P. (1991), “A multidimensional view of quality of life in frail elders”, in Birren, J.E., Luben, J.E., Rowe, J.C. and Deutchman, D.E. (Eds), *The Concept of the Measurement of Quality of Life in the Frail Elderly*, Academic Press, San Diego, CA, pp. 3-27.

Leece, J. (2003), “The development of domiciliary care: what does the future hold?”, *Practice: Social Work in Action*, Vol. 15 No. 3, pp. 17-30.

Means, R. and Smith, R. (1998), *Community Care: Policy and Practice*, 2nd ed., Macmillan Press, London.

Q1 Mental Capacity Act (2005), HMSO, London.

Paterson, C. (1996), “Measuring outcomes in primary care: a patient generated measure, MYMOP, compared with the SF-36 health survey”, *British Medical Journal*, Vol. 312, pp. 1016-20.

Paterson, C., Thomas, K., Manasse, A., Cook, H. and Pearce, C. (2007), “Measure yourself concerns and wellbeing (MYCaW): an individualised questionnaire for evaluating outcome in cancer support care that includes complementary therapies”, *Complementary Therapies in Medicine*, Vol. 15, pp. 38-41.

Qureshi, H. and Henwood, M. (2000), <i>Older People's Definitions of Quality Services</i> , Joseph Rowntree Foundation, York.	457
	458
Qureshi, H., Patmore, C. and Nicolas, E. (1998), "Overview of outcomes of social care for older people and carers", Report No. 5, Social Policy Research Unit, University of York, York.	459
	460
Roper, N., Logan, W. and Tierney, A. (1980), <i>The Elements of Nursing</i> , Churchill Livingstone, Edinburgh.	461
	462
Scharf, T., Phillipson, T. and Kingston, P. (2001), "SN4695 – survey of quality of life in older age", available at: 4695">www.eds.ac.uk./findingData/sndescription.asp?sn=4695&key=+4695	463
	464
Ware, J., Kosinski, M. and Keller, S. (1994), <i>SF-36 Physical and Mental Health Summary Scales: A User's Manual</i> , The Health Institute, New England Medical Center, Boston, MA, p. 170.	465
	466
	467
	468
	469
	470
	471
	472
	473
	474
	475
	476
	477
	478
	479
	480
	481
	482
	483
	484
	485
	486
	487
	488
	489
	490
	491
	492
	493
	494
	495
	496
	497
	498
	499
	500
	501
	502
	503
	504
	505
	506
	507
	508
	509
	510
	511
To purchase reprints of this article please e-mail: <a href="mailto:reprints@emeraldinsight.com">reprints@emeraldinsight.com</a>	512
Or visit our web site for further details: <a href="http://www.emeraldinsight.com/reprints">www.emeraldinsight.com/reprints</a>	513

Author Queries	514
JOB NUMBER: 145637	515
JOURNAL: WWOP	516
	517
	518
Dear Author	519
Please address all the numbered queries on this page which are clearly identified on the proof for your convenience.	520
Thank you for your cooperation	521
	522
	523
	524
Q1      Please provide author name for reference Mental Capacity Act (2005)	525
	526
	527
	528
	529
	530
	531
	532
	533
	534
	535
	536
	537
	538
	539
	540
	541
	542
	543
	544
	545
	546
	547
	548
	549
	550
	551
	552
	553
	554
	555
	556
	557
	558
	559
	560
	561
	562
	563
	564
	565
	566
	567
	568
	569
	570