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

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| Journal:         | <i>Working with Older People</i>  |
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| Manuscript Type: | Critique  |
| Keywords:        | emotional wellbeing, mental health, Mental Capacity Act, safeguarding, older people, rights |
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3 **Understanding of the Mental Capacity Act in work with older adults exploring the**  
4 **‘unintended consequences’ for service users’ emotional wellbeing.**  
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10 **Purpose**

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13 This paper aims to explore the consequences for older people’s mental wellbeing of  
14 understandings relating to the Mental Capacity Act 2005 (MCA).  
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18 The MCA seeks to maximize people’s abilities to make decisions and provides a framework  
19 for decisions to be made in a person’s best interests should they lack the mental capacity to  
20 do so themselves (Graham and Cowley, 2015). Practice varies widely amongst health and  
21 social care practitioners and little is known about the nature of interventions under the MCA  
22 or the outcomes for service users’ lives and health, especially their mental health and  
23 emotional well-being.  
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30 **Approach**

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

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

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

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21 The MCA is increasingly being 'used' as a piece of safeguarding legislation, inasmuch that  
22 people are often assessed in relation to health and social care outcomes when elements of risk  
23 to the person are deemed to be present. This is often in direct conflict with the first three  
24 principles of the Act that clearly refer to capacity, maximising capacity and choice around  
25 making decisions which others might deem to be unwise.  
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30 Skewed interpretations and application of legislation do not lend themselves to much needed  
31 discussions around mental health and wellbeing. The ability to make a decision is a central  
32 tenet to wellbeing in older adults. Emmett, *et al* (2013) in their research in relation to  
33 assessing capacity of dementia patients to make decisions about hospital discharge, observed  
34 "where assessors did not agree with patients' decisions, they were prone to interpret the  
35 decision as lacking capacity" (p.77). Such an observation clearly infers risk averse practice  
36 where it is suggested that where potential for significant risk is present then professionals  
37 may err on the side of caution resulting in, at best, people whose capacity is questioned being  
38 over-assessed and, at worst, determining a 'lack of capacity attitude' actually prevailing  
39 within practice.  
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48 In the case of *Heart of England NHS Foundation trust v JB* Mr Justice Peter Jackson  
49 concluded that "we should not ask more of people whose capacity is questioned than those  
50 whose capacity is undoubted". The court noted that in various of the written statements about  
51 JB's capacity, expressions had been used which suggested that the requirement to presume  
52 capacity, and the burden of proof of incapacity being on the person disputing capacity, had  
53 not been properly applied ([2014] EWHC 342 (COP)). Considering citizenship and how this  
54 embraces autonomy, self-determination, rights and choice being central to understanding the  
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3 spirit of the Mental Capacity Act and good practice in relation to the Act will demonstrate  
4 this by people's autonomy being enhanced at every opportunity. It is suggested that good  
5 practice in relation to the MCA with older people is not evidenced through how many  
6 capacity assessments are held on file or how many best interests decisions are implemented,  
7 but rather through seeing people making decisions with confidence and their emotional  
8 wellbeing being enhanced at every opportunity.  
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13 Anecdotal evidence, despite criticisms of it lacking methodological weight, offers an insight  
14 into the discourse that surrounds links between mental capacity as a construct, legislation that  
15 essentially oversees best practice and how both of these factors impact upon the wellbeing of  
16 older adults. Court of Protection judgments clearly indicate in several cases where outcomes  
17 of mental capacity assessments have had a detrimental impact upon an older person's  
18 wellbeing, albeit that the decision may have 'safeguarded' the individual's physical health  
19 and soothed concerns in relation to risk. A more notable case in relation to this issue is that of  
20 CC v KK and STEC EWHC 2136 (COP).  
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28 KK was an 83 year old woman with a diagnosis of Parkinson's disease and vascular  
29 dementia. KK was a widow when she moved into a rented bungalow in her 70s. Due to  
30 physical health concerns KK was admitted to hospital following a fall at home. KK was  
31 assessed as lacking capacity and a best interest decision was made for KK to move into a  
32 residential care home. A short time later KK was assessed as having capacity following some  
33 improvement and returned home. Over a period of months her physical health deteriorated  
34 and she was later assessed as lacking capacity and was admitted to a nursing home where a  
35 deprivation of liberty authorisation was put in place, which was challenged by KK herself  
36 who wanted to be at home, and it was this that led to the case being heard in the Court of  
37 Protection (Graham and Cowley, 2015).  
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46 In this case, Mr Justice Baker referred to the danger of professionals conflating capacity  
47 assessments and best interests decisions and "conclude that the person under review should  
48 attach greater weight to the physical security and comfort of a residential home and less  
49 importance to the emotional security and comfort that person derives from being in their own  
50 home". His honour criticised the local authority in question and reminded them of their duty  
51 to follow the Code of Practice and the principles of the MCA. Therefore, what we clearly see  
52 here is a legal judgment which essentially triangulates mental capacity, the MCA and  
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3 wellbeing and presents an outcome which, quite simply, reminds health and social care  
4 practitioners of the basics of legislation.  
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7 The conflict that is experienced here is that the application of the basics of legislation might  
8 actually not be basic at all. Evidence of this has certainly be observed on MCA training  
9 courses where practitioners from all fields discussed their observations and own stories of  
10 how the MCA is understood and applied by themselves and colleagues. Hollingsworth (1994)  
11 demonstrates how collaborative conversations can go beyond informative chats to become a  
12 place for research and in which transformative processes occur (Feldman, 1999). Once the  
13 MCA is discussed beyond the realms of legislation and professionals feel confident to enter  
14 into the discourse that surrounds capacity as a construct then a narrative can be formed based  
15 upon knowledge of older people's identity, their own stories and narratives and how they  
16 wish to live their lives.  
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24 What is ultimately being suggested here is that professional understandings of mental  
25 capacity must be firmly located with the person, their experiences and any associated risks  
26 and concerns, but in addition to this how the professional understands their own ability to  
27 critically comprehend the meaning behind the individual's experiences is a key issue in  
28 transforming mental capacity from an objective phenomena to essentially a subjective one  
29 which is fluid and the formation and determination of which has a direct impact upon  
30 people's wellbeing in later life. Mc Dowell and Newell (1996) suggest that health is broadly  
31 defined focusing on well-being and functioning along with illness and disease (Waite and  
32 Das, 2010). Health is conceptualised in a social and cultural context using the resources of  
33 the individual, family and social environment (Waite and Das, 2010) suggesting that the  
34 amount of structures and system around the person have a direct influence upon not only how  
35 health is considered, but how healthy any individual may be at any given time particularly if  
36 they receive large amounts of care, support and supervision. Having said this there is  
37 suggested disjuncture between health, mental health and wellbeing particularly when mental  
38 capacity is considered and it can be suggested that the consequences of applying the MCA in  
39 health and social care settings are not considered as much as they should be when it comes to  
40 professional decision making impacting upon wellbeing in later life.  
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53 Tanner and Harris (2008, pp190-191) in Carey (2015) highlight further paradoxes when  
54 working around risk and protection of older people. For example, tensions persist between  
55 the promotion of service users' independence while seeking to protect through further  
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3 monitoring and surveillance (p12). Professionals and care-givers are faced with the two  
4 threads that essentially emerge from this argument. The first is that safeguarding an older  
5 person who lacks the mental capacity to make a specific decision in order to ensure their  
6 health and protection may not actually promote that person's wellbeing at all particularly if  
7 this involves elements of protection and control. The second theme emerging is that  
8 autonomy, self-determination and decision making may not lead to mental wellbeing within  
9 the person particularly if the person's scope of decision making is limited because of the care  
10 environment in which they live or the care and treatment that person receives. What is being  
11 suggested here is that environmental factors within a particular care setting may not facilitate  
12 scope for decision-making as there may not be many decisions to make within the course of  
13 someone's day, particularly if the care regime which the individual is experiencing is subject  
14 to resource difficulties where limited activities and structure takes place.

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

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

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3 Waite and Das (2010) refer to a *conceptual framework* where health is broadly defined as  
4 focussing on well-being and functioning along with illness and disease. They state that  
5 biophysical, psychocognitive and social capital make up an individual's *health endowment*  
6 and that this health endowment is inextricably linked to socially relevant others (partner, kin  
7 and friends) with whom they may pool resources, exchange services and provide advice and  
8 support (s88). The spirit of the Mental Capacity Act utterly supports the ethos of constructing  
9 and understanding a wider discourse into the relationship between capacity, law and well-  
10 being and how this specific piece of legislation does not predominantly seek to safeguard  
11 people through ensuring capacity is assessed and best interest decisions are made, but  
12 foremost seeks to uphold people's rights, choice, autonomy and self-determination.  
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20 The Government website *Mental Capacity Act: making decisions* (2015) states that the MCA  
21 "covers people in England and Wales who can't make some or all decisions for themselves."  
22 (<https://www.gov.uk/government/collections/mental-capacity-act-making-decisions>). This  
23 premise is unhelpful inasmuch that to offer this as an overarching synopsis of the purpose of  
24 the MCA misses out an entire demographic of people who have capacity to make decisions  
25 for themselves and require the Act to ensure the continual maximising of their capacity and  
26 regard to the five statutory principles as set out in section 1 of the Act.  
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33 Williams, et al (2012) in the research study, *Making Best Interest Decisions: People and*  
34 *Processes*, looked at professional practices in best interests decision making under the MCA.  
35 This research found that 36 of the 385 respondents had indicated that a best interests decision  
36 was made for someone who did have capacity (p55). Reflecting upon the reasons for this  
37 would be helpful in reaching a conclusion as to why this is considered both acceptable and  
38 lawful. Certainly, to support someone to make a decision which the individual believes to be  
39 in their best interests is good practice enshrined within the MCA code of practice, but to  
40 make a best interest decision for someone who has capacity somewhat throws the principles  
41 of the MCA awry within that particular care setting and presents some concern.  
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49 It is suggested that one of the greatest areas of concern in relation to discussion and research  
50 around the MCA and its application is the lacking evidence of links between the MCA and  
51 mental health and well being. A somewhat controversial aspect of the MCA, introduced into  
52 the Act in 2009, is the Deprivation of Liberty Safeguards (DoLS). These safeguards were  
53 introduced into the MCA due to a 2004 European Court of Human Rights ruling known  
54 formerly as HL v UK 45508/99 (2004) ECHR 471 (or, more simply, HL v UK), but this  
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3 judgment is mostly referred to as the 'Bournewood Judgment'. This judgment evidenced a  
4 legal loophole in UK law whereby many vulnerable adults were being detained unlawfully in  
5 hospital and care homes (Graham and Cowley, 2015). Albeit that since its inception the  
6 DoLS have offered legal protection for many people it has remained controversial due to the  
7 nature of depriving people of their liberty within care homes and hospitals. This concern was  
8 exacerbated by the Supreme Court ruling of 2014 that followed the Cheshire West and  
9 Chester Council v P ruling (see Graham and Cowley, 2015, p180). The Supreme Court ruling  
10 introduced a definition of what constitutes a deprivation of liberty, enshrined within the 'acid  
11 test'. The test states that a deprivation of liberty is occurring if:

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

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

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55 In July 2015 the Law Commission unveiled its much-anticipated proposals for a framework  
56 to replace the Deprivation of Liberty Safeguards (DoLS) after concluding that the current  
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3 system was “deeply flawed” (Community Care 2015). The new proposal includes a two-tier  
4 system with the first tier being legislated ‘supportive care’ where (regardless of any  
5 deprivations of liberty occurring or not) the person will be offered “baseline preventative  
6 safeguards” (Community Care, 2015) where advocacy is offered and oversights are put in  
7 place to the care being given to the person who lacks capacity to consent to it. The second  
8 tier, know as ‘the restrictive care and treatment’ scheme would provide a protective  
9 framework to deprive a person of their liberty (Community Care, 2015). It is suggested that  
10 the first tier of the suggested framework will, for the first time in mental capacity legislation,  
11 afford legal recognition of the person’s wellbeing in relation to the impact of any care  
12 regimes and decision making upon them. This is most welcome and may, if it is applied in a  
13 person-centred way, offer a connection between mental health, the MCA and emotional well-  
14 being.  
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### 24 **Conclusion**

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