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Health and social care practitioners’ experiences of assessing mental capacity in a community learning disability team

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Accessible summary

- The Mental Capacity Act says when and how to assess someone’s ability to make a decision and how best to support them to do this.
- Eight workers in community learning disability teams were interviewed about their experiences of assessing people’s ability to make decisions.
- The workers said that there were a number of areas that they felt were important and which helped them to do good assessments. They also said there were some things that they found difficult.
- We suggest some changes that could be made to help workers when assessing people’s ability to make decisions.
- It is important to help people make decisions for themselves where they can and to help them when they cannot.

Key words

Mental Capacity Act, Assessment, Thematic Network Analysis, learning disabilities

Summary

The study explored experiences of health and social care practitioners within community learning disability teams in undertaking mental capacity assessments with people with learning disabilities. Semi-structured interviews were conducted with eight practitioners. The information gained was analysed using thematic network analysis. Twelve basic themes emerged which fit into five organising themes labelled as: ‘systemic barriers to assessment’; ‘capacity assessing as a process’; ‘person specific challenges’; ‘protective practices’ and ‘protection of a fundamental human right’. A global theme, ‘freedom of action versus restrictions on action’, was identified. The themes highlighted that there were a range of organisational, systemic, and person specific factors that impacted on the perceived quality of and assessors’ confidence in their assessments of mental capacity. Furthermore these factors appeared to create a range of tensions for assessors increasing the

likelihood of cognitive dissonance. Practice implications surround maintaining knowledge, ensuring adequate skills in the practical application of knowledge, and reducing organisational barriers.

Introduction

The Mental Capacity Act (MCA) (2005) came into force towards the end of 2007 and its implementation was supported by the publication of the Mental Capacity Act Code of Practice (Department of Constitutional Affairs 2007). Although the MCA largely codified existing good practice and common law, it nevertheless re-invigorated services to adhere to a range of statutory requirements designed to support individuals whose mental capacity had been brought into question.

The MCA has established some guiding statutory principles in relation to the assessment of mental capacity. Principally, it sets a legal presumption of capacity, and when an assessment of capacity is required a functional test must be employed. This requires an assessor to establish whether the person understands the information relevant to the decision, is able to retain the information, can use or weigh that information, and is able to communicate his or her decision. Furthermore, the person must not be treated as unable to make a decision unless all practicable steps have been taken to enable them to make the decision (Department for Constitutional Affairs 2007).

Whilst the MCA is undoubtedly an impressive piece of legislation that deserves serious ethical attention (Hope et al 2009), its application in practice deserves some scrutiny. The present study arose from the lead author’s experience of undertaking and supporting others to complete mental capacity assessments and reviewing completed reports within three community learning disability teams (CLDTs) providing specialist health and social care support to adults with learning disabilities. This experience identified that there was a great deal of variability in the quality of capacity work being undertaken. Some of this variation seemed to be explained by gaps in knowledge and misunderstanding on the part of professionals; however, systemic factors relating to the service in which practitioners worked also appeared to be playing a part. It seemed that many professionals were feeling ‘pressure’ from this area of work; on the one hand believing strongly in the principles of the legislation and being aware of the additional scrutiny on their professional practice, whilst struggling with knowing how to translate theory into practice. In essence, this latter concern reflected the belief that the MCA had told practitioners *what* to assess for, but they were unsure *how* to do this to the standard or level that would be considered a sufficiently robust or competent assessment of capacity. The latter point of *how* to assess is of course one for practitioners to concern themselves with, rather than legislators.

The research literature has identified two areas of concern which support these observations. Firstly, there continue to be evident gaps in knowledge regarding the requirements of the Mental Capacity Act. Secondly, there remains concern about how to operationalise and practically apply the generic points laid down in statute to specific cases. For example, Alonzi et al (2009) in a study of community healthcare professionals identified their most frequently reported concern (78.4% of participants) as being their ability to apply the statutory requirements in practice. Limitations on the application of the MCA in practice were also highlighted by Brown et al (2013). Their study, using a retrospective cohort study of psychiatric inpatients between 2007 and 2010 indicated that whilst there had been a significant increase in the number of mental capacity assessments undertaken, only 14.7% of them explicitly used the MCA criteria. Similar issues relating to a lack of knowledge regarding how capacity should be assessed in practice have also been highlighted in the field of old age psychiatry (Shah et al 2010).

It appears that whilst many organisations have developed comprehensive training around the MCA, this has not necessarily led to a high quality application of these statutory requirements in the practice of assessment. A recent study by Willner et al (2010) found significant gaps in knowledge of mental capacity issues amongst health and social care professionals within a community learning disability team, despite comprehensive training around mental capacity. A subsequent study identified that even with formal training events, some significant limitations with the NHS practitioners’ understanding of capacity assessments remained, with evidence that many still performed poorly in relation to the conduct of the mental capacity assessment (Willner et al 2013). The findings indicated that the main practical effect was to sensitize practitioners to the need to think about mental capacity, with little improvement shown in their practical ability to deal with mental capacity assessments. Willner at el (2013) therefore advocated for a more practically focussed training model whereby practitioners work alongside more experienced colleagues to conduct mental capacity assessments.

Assessors often have to take into account a significant range of complex factors when looking at decision making capacity, and this complexity in practice may not be fully reflected in statutory provision and guidance, or in training. Banner (2012) comments that determining decision making ability is one of the most conceptually and ethically challenging areas of clinical practice and that uncertainty in practitioners' judgement arises because the descriptive criteria for capacity overlook the intrinsic normativity of the judgement. Valios (2008) further reflects the complexity of mental capacity assessing with a non exhaustive list of factors that should be considered as part of the assessment process, including reasoning, memory, attention and concentration, information processing, verbal comprehension, cultural influences and social context. A further area of importance to take into account, and one that is often is ignored, is the potential for the assessor's influence over the person to be abused (Ramasubramanian et al 2011). In one of the few qualitative studies in this area, Samsi et al (2011) explored the experiences of Admiral nurses using the MCA. They identified three themes entitled 'knowledge acquisition and confidence with implementation', 'practice experiences', and 'practice expectations'. Their findings were largely positive with a recognition that the MCA had empowered both the Admiral nurses in their clinical practice and carers. However, participants often reported not feeling confident about their understanding of the MCA, mainly due to their lack of experience in applying it in practice.

Aim

The current study had two aims. Firstly to explore the experiences and in particular the principal challenges and barriers in undertaking mental capacity assessments amongst health and social care practitioners. The second aim was to identify ways that practitioners and services could address these issues to improve the quality of assessments being completed and to help practitioners feel more confident in working in this area.

Method

Eight participants were interviewed by [Author 1] all of whom worked within integrated health and social care CLDTs: three qualified community learning disability nurses, one physiotherapist, one occupational therapist, one speech and language therapist and two qualified social workers. All of the participants had worked within the CLDTs for at least seven years and had experience of undertaking mental capacity assessments. Given that this was an integrated service where health and social care practitioners worked closely together and attended the same training on the Mental Capacity Act, it was felt appropriate to include both groups of practitioners in this study.

Approval for the research was given by the local NHS research ethics committee (reference 09/H1011/79). Senior practitioners and managers were asked to cascade information relating to the study within the teams in order to identify participants.

A semi-structured interview schedule was used to guide the interviews. The schedule focussed on participants' experiences of undertaking capacity assessments, the impact of the MCA and suggestions for future developments for capacity work. The interview schedule included open ended questions to allow people to describe their experiences with some follow up questions and prompts.

The interviews were recorded and transcribed verbatim and thematic network analysis was carried out. Thematic network analysis is a way of organising the data by looking for the themes that are salient in a text and structuring them within a network that specifies lower order and higher order themes (Attride-Stirling 2001). Basic themes are the lowest order themes (and greatest in number) and represent a simple premise in the data. An organising theme is a middle order theme that organises basic themes into clusters of similar issues. Global themes are super-ordinate themes that make sense of all the lower and middle order themes.

Familiarisation of the data was undertaken as the first step followed by the collation and coding of data. Themes were identified independently by the first and second authors and then reviewed jointly to determine whether all potential themes had been identified and to structure and organise the themes. The first and second author met several times during the analysis to further discuss and refine the content and structure of themes.

Results

Twelve basic themes emerged from the data which fit into five organising themes as shown in figure1. The organising themes were felt to accurately summarise the principal assumptions of the basic themes as stipulated by Attride-Stirling (2001). The organising themes were labelled as follows: ‘systemic barriers to assessment’; ‘capacity assessing as a challenging process’; ‘person specific challenges’; ‘protective practices’; and ‘protection of a fundamental human right’. The global theme was labelled: ‘freedom to act versus restrictions on action’.

Fig I: Thematic network

Systemic barriers to assessment

The first organisational theme recognises that assessors do not work within a vacuum; rather they work within systems which have their own particular characteristics, agendas and pressures. The nature of these systems impact upon how mental capacity assessments are undertaken and upon practitioners’ confidence in relation to their assessments.

The existence of work-related pressures caused by the volume of work (capacity and non capacity related work) and limited time to adequately plan and complete capacity assessments was one of the most dominant basic themes:

> *Time and volume of work is the number one [pressure]. It is kind of extraordinary really how that’s shifted particularly over the last 12 months and its not relenting, you can see it’s not going to, you know it’s really huge.*

This pressure led to a degree of professional role conflict amongst practitioners, particularly between social care and health care practitioners, with regard to which practitioner is best placed to complete assessments:

> *People are under an increasing amount of pressure in this work and people will see it as additional work rather than perhaps part and parcel of the work we have to do. I think people are quite nervous about work and I think by default when people are a bit anxious and they are under a lot of pressure in their own work they sometimes think well surely someone else is better placed for this.*

Broader service agendas were also reported by many of the participants as creating a context that was not wholly conducive to facilitating practitioners' decision making capacity:

> *I know what my organisation would prefer the outcome to be and I had to be careful about not letting that influence how I was discussing information and giving information.*

In particular there was a service level pressure to ensure that risks of harm to individuals were limited as far as possible, thereby potentially conflicting with the practice of positive risk taking and allowing capacitous individuals to make unwise decisions.

Capacity assessing as a challenging process

This organising theme concerned certain key 'process' factors that need to be present to ensure a competent and robust assessment of capacity. There was a strong recognition amongst participants that careful planning is required before meeting with the client face to face, but this could at times prove challenging:

> *Knowing what the decision is, planning…..So thinking about their level of understanding perhaps, what their life experience is, planning what sort of questions you might be asking…In many ways the actual assessment*

> *is the easy bit when you're actually face to face with the person, the difficult bit is gathering the information.*

In addition, it was recognised that assessing clients about their decision making capabilities, often with regard to fundamental aspects of their lives, was often quite distressing for clients and emotionally challenging for the assessor:

> *You have to go a bit circuitously around things and you do feel a bit cruel because you really are demonstrating to them that they don't know...In the end you come round to proving that they don't actually know their own mind.*

Participants were therefore aware of the need to gather information whilst limiting anxiety and a particularly strong theme was the notion that the assessment was most appropriately undertaken with an informal and conversational style:

> *Well we always approach it as we're going to have a discussion… we never talk about it as an assessment, it's always about a conversation.*

Of central importance to this theme was the importance of ensuring the involvement of carers in the process of capacity assessment. A key challenge identified by participants was the difficulty that support workers and family members can have in accepting a process that may allow, on the basis of capacitious decision making, courses of action that they do not necessarily agree with. Many carers hold a very general view of capacity, which does not always recognise the fact that capacity can vary depending on specific decisions and contexts. The process of capacity assessment can then become a source of anxiety for family members which can lead to tension with practitioners involved in the person's care:

> *You can have people who have family who will make a blanket statement that their child, even though they are an adult, does not understand or have capacity, and they still are the person who should make decisions….You have to be very tactful, very careful, about not offending but still unfortunately, because of the Mental Capacity Act,*

> *although they are still the parents and they are still very important, and you have to emphasise that, but that is the law and is what we have to do.*

However, participants also spoke of how the MCA has helped to facilitate carer involvement:

> *I think that it has in some ways, if you do it right, forced us to communicate better with family members, to explain why we are doing things and to get them involved. So I think it has actually improved our, from a personal point of view, I think it has improved relationships.*

The presence of a strong legal framework in the form of the MCA was seen as helping professionals to bring families 'on-board' with the process and to help families recognise that this is a duty rather than the subjective position from a particular practitioner.

Person specific challenges

Practitioners also reported that there were specific challenges related to the range and complexity of the skills and characteristics of people being assessed and the complexity of the decisions being made.

It was often difficult for practitioners to reach a conclusion on mental capacity for Individuals whose decision making ability was described as 'borderline'.
The term 'borderline' was commonly used to describe individuals who were regarded as 'higher functioning' and who were able to demonstrate a surface level ability to hold a conversation but whose reasoning skills hard for the assessor to determine:

> *The ones where capacity is borderline, they are the ones who I think my confidence has dipped a bit to be honest… it is very difficult when people have borderline capacity, whether they have or not [capacity] is very subjective.*

In determining what factors shifted an assessment from 'simple' to 'complex', it was recognised that other cognitive abilities such as a person's level of acquiescence and suggestibility played a significant role, particularly if there was concern that undue influence was being exerted by carers.

The issue of complexity went beyond discussions of cognitive ability and environmental influence to the nature of the decisions being made. Whilst practitioners often discussed assessing for typical or re-occurring decisions such as accommodation, there were other less typical but challenging capacity issues such as relationships, marriage, and understanding specific legal processes:

> *The most complicated ones [capacity assessment] for me are around people having relationships and marriage.*
>
> *The police caution and bail conditions are always difficult….. [the police caution] is very complex to understand and to break down.*

Protective practices

Participants adopted or highlighted strategies that helped them feel more confident about the outcomes of assessments. A strong theme was the importance of joint working and less formal support was viewed as essential to working practice. Participants frequently sought out other colleagues to discuss cases with and to 'sound out' thoughts or ideas:

> *I think with more complex decision making, you feel there is a greater responsibility... I have knowledge of that by getting advice, and other workers viewing over the work that I have done and the decisions that I have reached.*
>
> *I have gone to nursing colleagues and also psychology and I have found it useful because I think it clarifies your own thought process.*

In addition, some participants wanted to have more explicit guidance on how to assess for specific re-occurring decision making areas. They felt this would aid their confidence, particularly with respect to judging where the threshold for capacity lies:

> *I think …. for recurrent decisions that we are making around accommodation and finances, for there to be a format to ensure that's consistent across services: we are all using the same thing, so therefore it will be able to be used in a court of law, that type of thing.*
>
> *At what point are they capable of understanding and weighing up all the information, or is a simple kind of acceptance, this is what people do, this is my home, my money is sorted out by them, enough? So that is where I struggle I think.*

Protection of a fundamental human right

It was generally accepted that whilst the issue of capacity and the promotion of people's rights to make decisions had existed prior to the MCA, the codification into statute of these long held principles has provided a more intense focus for services and practitioners on both the rights of individuals.

It was felt that there had been a shift towards facilitating decision making capability and inclusion in decision making process for major life choices. The question of a person's autonomy to make decisions had also become more firmly rooted in a person's day to day life, as opposed to only being considered for serious and rare events:

> *If you looked at people's decision making ten years ago you would never have thought that you'd be looking at people who wanted to make a decision about who they wanted to live with and whether they wanted to get married or have a relationship or whether they should have a family, now it's like bread and butter stuff.*
>
> *To me it's [the MCA] promoted people's rights and equality within a service that historically has been oppressive and discriminatory.*

Global theme

The global theme is meant to be a conclusion or final tenet, representing a macro theme that reflects a further interpretation of the text. (Attride-Stirling, 2001). The global theme identified from the data from this study was labelled: ‘freedom to act versus restrictions on action’.

Discussion

A number of previous studies have examined the knowledge of learning disability practitioners around the MCA and the success of training programs in furthering knowledge (Willner et al 2010, 2013). However, there have been few, if any, studies that have used a qualitative methodology to explore the experiences of practitioners within CLDTs in their undertaking of mental capacity assessments. Whilst the study reported here is small-scale, it is hoped that the findings will help to address this gap.

Overall, the study indicates that the introduction of the MCA has been a positive step and that the generic provisions and guidance laid down in the MCA lay the basic building blocks for the assessment of mental capacity. However, there are numerous other factors that can impact on the quality and outcome of these assessments. The current study supports previous studies (e.g. Willner et al 2013 and Samsi et al 2011) that indicate that the confidence of practitoners in undertaking assessments goes far beyond simply knowing the content of the MCA. It is evident that mental capacity assessments produce a range of challenges that can be difficult for even experienced health and social care practitioners to navigate.

The issue of complexity was largely recognised as residing in three principal areas. Firstly the characteristics and other psychosocial factors (internal and external) associated with people who were being assessed were regarded as a challenge, particularly in cases of ‘borderline’ ability. These complexities have been recognised in previous research (Brown et al 2013), particularly with the weighing up component of the MCA (Willner et al 2010). Secondly, complexity was also recognised in the current study in relation to some of the decisions which were less typical or which were intrinsically challenging (e.g. capacity regarding relationships). Finally, there were a range of organisational issues that made it difficult for practitioners to practically undertake a ‘gold standard’ assessment. Resource limitations such as time have been documented elsewhere in the literature (Ramasubramanian et al 2011; Kiani et al 2006). However, the more substantive issue of organisations creating a culture that inadvertently makes it harder for practitioners to assess capacity in a wholly objective manner is less well documented. The current study also identified some organisational issues with role boundaries and conflict between practitioners, supporting previous research findings (Samsi et al 2011). Specifically, the debate about who is best placed to complete assessments may occur both across different health professional groups and across co-located social care and health practitioners. Despite this, practitioners also reported a range of supportive practices between colleagues which were felt to be a protective factor in maintaining their confidence in their assessments of capacity.

The analysis revealed a broader global theme referred to as: ‘freedom to act versus restrictions on action’. The data as a whole appeared to show a broad commonality reflecting an inherent series of tensions, that while not the sole preserve of this type of work, was certainly a very dominant characteristic. These tensions were reflected at both an individual and organisational level. The tensions lay between allowing the client to make and act upon their own decisions (fostering independence), and at the same time acting as a paternalistic ally by wanting to restrict decision making capability, and therefore potentially limiting a person’s ability to act, in order to protect them from harm. These tensions may reside as part of the practitioner’s own beliefs or values, but may also be affected by reputational fears at an organisational level. Furthermore, it was clear that organisational tensions were created by services repeatedly reminding practitioners of their responsibilities under the MCA, whilst creating practical challenges on time and resources that made these responsibilities difficult to adequately fulfil in practice.

Banner (2012) has previously argued that in cases where capacity is hard to determine, capacity assessing effectively becomes a normative judgement and that striking the balance between autonomy and protection is difficult. We suggest that the contradictory position of promoting positive risk taking alongside risk averse cultures may create cognitive dissonance within practitioners. Cognitive dissonance refers to the experienced discomfort when two or more conflicting cognitions (beliefs, attitudes, values) are held. When this occurs, it can create a feeling of disequilibrium and negative emotional state (Festinger 1957). Importantly, this issue of cognitive dissonance, particularly with the ‘borderline’ cases may create a pressure to move unconsciously towards an ‘outcome’ approach to assessment of mental capacity whilst maintaining an illusion of a purely functional assessment. Individuals with ability to make a particular decision may therefore be found to lack capacity in order that risk to the individual and to the services reputation is limited through imposed restrictions made on the basis of ‘best interests’. Despite the fact that the MCA Code of Practice (Department for Constitutional Affairs 2007) explicitly requires a functional approach to be adopted and that current ethical thinking is moving away from paternalistic practice (Jacob et al 2013) the power of beneficence may continue to influence practitioners.

Implications for practice

The findings indicate that service development is needed at three levels: maintaining knowledge, ensuring adequate skills in practical application of this knowledge, and reducing organisational barriers.

Services must ensure the ongoing development of practitioners' knowledge and confidence in undertaking capacity assessments beyond formal ‘one off’ teaching. This could include developing formal peer support groups in the area of mental capacity work and ensuring that there is significant awareness of the need to keep up to date with changing case law supported by a process for disseminating this information in an accessible way. Services also need to ensure that there is adequate training on the practicalities of mental capacity assessing. The MCA does not tell practitioners ‘how’ to assess capacity and therefore training on this should include the relevant cognitive and psychosocial factors, approaches to communication, interviewing skills specific to this type of work and the importance of case law.

In addition to the giving of knowledge, services should focus on the ongoing development of its practical application and ongoing learning within a practical context. Ways of doing this could include the development of mentoring or shadowing opportunities between experienced and less experienced practitioners, including cross speciality provision. Monitoring the quality of capacity assessments, for example by auditing completed assessments, would be helpful and a number of tools already exist for this purpose (e.g. British Psychological Society 2010). The results of the current study would also point to the development of a mental capacity assessment templates or guidance documents for common decision making areas (e.g residency, tenancy agreements).

Perhaps most importantly, fundamental changes need to be made at a systemic or organisational level in order to create a working environment whereby cognitive dissonance amongst workers is limited. This is a complex challenge to any service, but one that is not insurmountable. At a most basic level services need to accept that assessments of this nature involve a degree of time resource and that short cuts which impact on the statutory requirements to maximise and review capacity must be avoided. At a more complex and less obvious level services need to ensure that there are processes in place that allow practitioners to feel reasonably comfortable in tolerating risk. Structured pathways for assessing, managing, and sharing risk, alongside processes for complex case coordination are essential to fostering confidence to reach conclusions on capacity that may have risk implications. Whilst the issue of capacity and risk should not be conflated, it is important to recognise that practitioners are open to biases and weightings in their own judgements, as are the people they support. For capacity assessments in people with borderline decision making ability, there will be an inherent normativity in each practitioner's judgement of capacity (Banner 2012). Explicitly stating this to practitioners and normalising this may make the process of undertaking mental capacity assessments a little less anxiety provoking.

Conclusions

Whilst the current study identifies a range of challenges and complexities it also highlights that the MCA has produced many benefits for practitioners and supports the overall positive attitude towards this piece of legislation found in previous studies (e.g. Samsi et al 2010). In particular the MCA was felt to support positive working with families by providing legal clarity and a clear statutory recognition for people's fundamental right to self determination. This was a small-scale study producing a snap-shot of experiences of mental capacity assessing within one service. It would be interesting to explore whether similar issues exist in other community learning disability services, or indeed services working with other client groups and whether introducing service developments can improve the experience of capacity assessing for practitioners. It could also be useful to explore the perspectives of people with learning disabilities, paid and family carers on the process of mental capacity assessments.

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Fig I Thematic network