THE IMPACT OF THE MENTAL CAPACITY ACT 2005 ON SOCIAL WORKERS' DECISION MAKING

A REPORT FOR SCIE

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BACKGROUND

This research was commissioned by the Social Care Institute for Excellence to support the implementation of the Mental Capacity Act 2005. The Mental Capacity Act provides a statutory framework to empower and protect vulnerable people who are not able to make their own decisions. It makes clear who can take decisions, in which situations, and how they should go about this. It also enables people to plan ahead for a time when they may lose capacity. The Act was fully implemented on 1st October 2007, and a Code of Practice issued by the Lord Chancellor in April 2007 explains in detail how the Act is to be implemented. Information booklets aimed at the public, family carers and health and social care staff have been widely distributed, and training materials were published in May 2007.

As a "small study" into the immediate impact of the Act, this piece of work focused on one area – the county of Norfolk – and one group of staff; social workers working with older people with dementia. Access was negotiated with senior managers in Norfolk Adult Care Services. Ethics approval was given in accordance with the Research Governance Protocol for Social Care. Approval for the study was also given by the Research Ethics Committee of the School of Social Work and Psychosocial Sciences at the University of East Anglia. The Alzheimer's Society in the East of England provided a reference group for the research involving project workers and carers of people with dementia. The research question was the impact of the Mental Capacity Act on assessments of capacity and best interests decision-making and their integration into record keeping and care planning.

METHODOLOGY

A random sample of social workers working with older people with dementia was sought by asking for volunteers from fieldwork teams for interview. Volunteers came from five community teams, clustered in three geographical areas. No volunteers came from hospital teams, though two social workers in the sample were co-located in a hospital mental health team. Fourteen interviews were arranged; thirteen were with qualified social workers, one was with an experienced social work assistant. The length of time qualified ranged from 15 years to two months. Twelve were women, and two were men; one was also an Approved Social Worker.

Interviewees were provided with an information sheet about the research, and signed a consent form. Semi-structured interviews were carried out within which the interviewees were asked to describe a case with which they were currently working which involved an assessment of mental capacity. Their recording of that case, both on file and electronically was then looked at. They were also asked to describe a similar case that they had worked on prior to the coming into force of the Act. Assessments of capacity and best interests decision making were explored, as was the impact of the Act and any policy changes and training received, on their practice. Interviews were recorded and transcribed, and analysed thematically. Field notes were made of recording practices. Emerging findings were explored with the Alzheimer's Society reference group, supplemented by two carers who were available for individual discussions.

THE LEGAL CONTEXT

The Mental Capacity Act is based on five statutory principles:

1. A person must be assumed to have capacity unless it is established that they lack capacity;
2. A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success;
3. A person is not to be treated as unable to make a decision merely because he makes an unwise decision;
4. An act done, or decision made, for or on behalf of a person who lacks capacity must be done, or made in his best interests;
5. Regard must be had to whether the purpose for which the decision is needed can be as effectively achieved in a way that is less restrictive of a person's rights and freedom of action.

The 'lack of capacity' under the Act must be attributable to 'an impairment of or a disturbance in the functioning of, the mind or brain'. This may be permanent or temporary, but cannot be established merely by reference to the person's age or medical diagnosis. A person is unable under the Act to make a decision for himself if he is unable:

(a) to understand the information relevant to the decision;
(b) to retain that information;
(c) to use or weigh that information as part of the process of making the decision; or
(d) to communicate his decision.

If a person is unable to make a decision for himself, the decision-maker must nevertheless, so far as reasonably practicable, 'permit and encourage' the person to participate in decisions relating to him. In determining what is in a person's best interests, it is necessary to consider, so far as is reasonably ascertainable, the person's past and present wishes and feelings, and beliefs and values. The decision-maker must similarly take into account the views of anyone engaged in caring for the person or interested in his welfare. If these steps are followed, there is no liability on the part of the decision-maker..Although the Act contains a best interest checklist 'Best Interests' is an objective test, not defined in the legislation; it is not a test of 'substituted judgement'.

Independent Mental Capacity Advocates (IMCAs) provide a statutory advocacy service in a limited number of situations where people are assessed as lacking capacity. The role of Mental Capacity Advocates is set down in regulations. IMCAs must be involved where there are important decisions to be made about change of long-term accommodation, and serious medical treatment in situations where there are no family or friends with whom it would be appropriate to consult about such decisions. In addition, IMCAs may be instructed in adult protection cases, and in accommodation care reviews. An IMCA is not a decision-maker, but a supporter who can make representations to the decision-maker, particularly about the individual's wishes and feelings, beliefs and values.

PREPARATION FOR THE COMING INTO FORCE OF THE MENTAL CAPACITY ACT

Following some preliminary work in developing generic training for all staff, and some specific training for those in mental health, Norfolk Adult Services appointed their Access team manager as Mental Capacity Act lead, and made a new appointment of a Project Manager in August 2007. A project plan and a training plan was produced to make training and information available across the county, and across all sectors of health and social care. In addition to brief awareness raising sessions provided by the project manager, an independent trainer was commissioned to deliver a number of 'generic' multi-disciplinary workshops for District Nurses, Consultants and Care Workers, as well as intensive briefing sessions for NHS staff. Awareness raising sessions were also held by the IMCA team.

A review of training sessions for team managers showed that they were not comfortable in their knowledge of the Act, or in cascading training down to their staff. This finding led to the appointment of two trainers within the local authority residential sector, with capacity to extend their training to the independent sector. An Open Day is planned for those interested in training as Best Interests Assessors with a view to commissioning twelve training places for September 2008. The County is also looking at delivering more refined training on assessments and supported decision-making. The plan is to train Locality Champions who will be invited to an Action Learning Set for case-study based learning for dissemination to teams. The project team have also taken responsibility for dissemination of information about the Mental Capacity Act by mailing 650 organisations across the County; this will include free access to an e-learning package, also available through public libraries, and a flow chart of MCA processes.

In anticipation of the Act, some social services documents were re-written to incorporate awareness of the Act and a website giving basic information and links was constructed. No new policies apart from that of the Instruction of IMCAs were however developed; this is being done currently, making reference to policies produced by other local authorities. The Project Manager was aware of gaps in the Care First on-line documentation which does not contain prompts for mental capacity. However, guidance is planned to instruct assessors to record capacity within the Fair Access to Care Services categories of Autonomy and Health and Safety, using information from the FACE documentation which can be amended to include material relevant to capacity. The Project Board has agreed that the planned Mental Capacity Act mail-out will include the FACE assessment form and guidance, and also licence applications for partners to be able to use FACE. Norfolk are also reviewing the pre-admission form for residential care, and the care planning form. These also will be mailed out as templates for other organisations. A working group is currently looking at procedures for the appointment of Deputies by the Court of Protection, where there are no family or friends willing to act. Research and Development Services representatives are also developing a protocol for research consultees. Persuading s12 approved doctors within the Mental Health Trusts to undertake further training for the Mental Capacity Act is seen as a challenge to produce sufficient cover for the County. Where to locate expertise on the Mental Capacity Act within the local authority structures is a significant issue. Conceptually, the Mental Capacity Act may sit well within the agenda for Safeguarding Adults, which is clearly multi-disciplinary.

Because the Act has no statutory forms, agencies have had to decide whether and how to create their own forms. Although the issue of capacity is essentially a legal issue, in Norfolk there does not seem to have been a formal process for consultation with the County solicitor's department on policy or implementation issues, and they are not involved in training. In some ways the County was a latecomer to tackling the practice issues generated by the Mental Capacity Act, and the interviews undertaken for this research accordingly reflected some confusion among participants about the proper application of the Act and how to record decisions made under it.

Training for the implementation of the Mental Capacity Act was welcomed by those interviewed. Though the training sessions that had been provided were experienced as helpful, it was difficult for most participants to retain the information given. This was particularly true for those who had attended an intensive half day session they were the group most likely to want follow-up training in the application of the Act. This is to be offered through a structured programme.

> "My training was before the Act came in and started, so it was difficult to fully understand the implications of what was going to happen and why. It has become easier having worked with it and using it.
>
> (Social Worker, A)

THE REFERENCE GROUP

The Alzheimer’s Group in the East of England convened a reference group to represent the views of service users and carers to the project. The group comprised the Regional Organiser for the Alzheimer’s Society, an outreach worker for the Society and a family carer (who had also previously owned a private care home). In addition, two carers who were unable to attend the meeting were contacted by telephone. The group commented on the themes that were emerging from early interviews with social workers, and raised the following issues for consideration:

- The position of people with fluctuating capacity. The group were concerned that a person might be assessed to have capacity on the basis of a single visit at a time when they were functioning well, though when assessed over a period time, a lack of capacity would have become apparent.
- The importance of involving, rather than just ‘consulting’ families at every stage of the assessment, and supporting them through change.
- The difficult position of spouses who could not recognise the amount of care that their wife / husband needed, and who sought inappropriately to discharge them from residential care. There were similar issues with children / stepchildren who could not agree amongst themselves where a parent’s best interests lay. Families could also project their own preferences onto the older person, e.g. not sharing a room, where the person with dementia enjoyed the sharing.
- The Deprivation of Liberty provisions had not yet been covered in training, but were seen as potentially useful for an authoritative decision on the type of care that was in the person’s best interests.
- Solicitors were seen as not properly engaged with the Mental Capacity Act when giving advice. In particular they were reluctant to advise on the new Lasting Powers of Attorney to enable people put their affairs in order whilst they still had capacity. Such was the concern about inappropriate advice, that a local MP had been involved in writing to the Law Society to make members aware of briefing papers on the Mental Capacity Act and Powers of Attorney.
- Self funders were seen as particularly in need of protection both under the Mental Capacity Act and under the Human Rights Act. An estimate was given that two thirds of people in residential care with dementia were self-funding. Self-funders were seen to be more at risk of inappropriate placement in residential care, because they did not have professional involvement. Protecting proactively the human rights of people with dementia needed legal support in circumstances where families had been observed to say “My mum’s got dementia, so she has no rights.”
- “Best Interests” Case Conferences as a forum for decision-making were seen as a helpful suggestion, with the caveat that they needed to be well chaired.
- Although the majority of Alzheimer’s funding came from social care, most of their work was with health care services and professionals. Funding was unstable, and perceived as inadequate to deal with a larger number of people with dementia and their carers. Funding from service reorganisation was not seen as being channelled back into communities. Outreach workers from the Society saw people individually and in groups but with only 51 hours of time a

week available for the whole of North Norfolk (given as an example), the service was under pressure. The message then was “if legislation (such as the Mental Capacity Act) is driving the independence agenda, then that has to be supported (with appropriate resources)”.

- Access to diagnosis, and continuing support thereafter from health care professionals was seen as critical. It is the Alzheimer’s Society’s position that formal diagnosis of dementia does matter. The group agreed that it matters for a number of reasons: it is a gateway to services; it leads to financial benefits within the social security system; psychologically it is important for the person with dementia and for carers, who may be relieved when a diagnosis is given..
- A diagnosis of dementia was seen as important to the implementation of the Mental Capacity Act, where general memory loss, or confusion was seen as ‘not strong enough’, because these were symptoms which could be attributable to other causes. Carers in the community were particularly concerned that diagnosis should be followed up with support services and regular monitoring, which were currently seen as inadequate.
- Assessments under the Mental Capacity Act were seen as risk assessments, where the social worker exercised professional judgement on the basis of risks discussed with the individual, in the light of their history and present circumstances. There was an awareness that social workers could face adverse publicity if things went wrong.
- How assessments were recorded, and whether records from statutory agencies should be shared with the voluntary sector was a topic for debate. The Alzheimer’s Society has no access to statutory records, and their independence from the statutory sector was seen to be a strength in their confidential work with clients. However, detailed record keeping by professionals was seen as necessary under the Mental Capacity Act to show how they had reached a decision. It could also highlight changes in a person’s behaviour, for example, the onset of aggression that could be useful for others to know about. Experience of shared record-keeping in other contexts was seen as helpful in enabling fluctuations in capacity to be noted, presentation in different contexts to be recorded, and formal assessments to be amended accordingly. There was support for both voluntary sector and family carers having access to information about the Mental Capacity Act, and training. Most branches of the Alzheimer’s Society run ‘Positive Caring’ courses for new carers, but there was seen to be a need for further training for people who had been caring for longer.
- The Alzheimer's Society encourages advocacy, but in the Eastern Region only Peterborough and Ipswich are funded to provide an advocacy service. There was no direct experience within the Reference Group of people having used the IMCA service, and not a lot was known about how the service operated. It was felt that the government position that successful tenders to run the IMCA service had to cover all specialisms, may have impeded take-up. Specialist organisations (for people with dementia / people with learning difficulties) might have raised the profile of the service.
- Discussion of communication skills and tools for use with people with dementia produced a range of suggestions of approaches which had been successfully used in practice. These included the use of written communications, pictures, photographs and ‘talking mats’. The use of ‘life

books' to aid reminiscence was seen as a great success in communicating preferences, wishes and feelings.

- Carers supported by the Alzheimer's Society spoke very positively about the service that was provided. The informative and supportive nature of the group work undertaken with carers was particularly valued. 'Knowing the system' was seen to be critical in accessing statutory services, and there were concerns about difficulties in re-referral and a lack of follow up. Carers felt that 'seeing the situation' at home was important to understand the needs of the person with dementia and their carers. For their part, Outreach Workers valued the facility (not available everywhere) to contact a psychiatrist directly to receive early-stage referrals and to feed back concerns. G.P.s were seen as a weak link; lacking in knowledge about dementia, and hard to engage in order to secure referrals to secondary services, where no direct approach was available.

FINDINGS FROM THE RESEARCH

Findings from the research are presented thematically, including case examples and direct quotations from interviewees.

An Appendix gives more detail about the interviewees, the cases selected by them, and the impact of the Mental Capacity Act on practice and recording.

THE SIGNIFICANCE OF DIAGNOSIS

Not all of the people described in the case studies had a formal diagnosis of dementia, or any other mental disorder, though most did. The Mental Capacity Act requires the lack of capacity to be attributable to ‘an impairment of, or a disturbance in the functioning of the mind or brain’, but because capacity is decision specific a global diagnosis of ‘dementia’ does not mean that the individual therefore lacks the capacity to make any particular decision. Decision makers understood this and in all cases approached their assessment of capacity independently of a medical diagnosis. Having a formal diagnosis of dementia was however sometimes a gateway to particular types of service provision, and the involvement of mental health professionals through the process of assessment and diagnosis was in most cases seen as ‘validating’ the social worker’s opinion.

In some of these cases, the diagnosis was very vague, for example: ‘he had severe memory problems’; ‘when she was admitted to residential care four years ago, records said she appeared to be in the early stages of dementia’

> “That seems to happen quite a lot, you often have letters from GPs that have dementia on them , but when you ask have they been properly assessed. Oh, no, no”
>
> (Social Worker A).

The referral process to obtain a mental health assessment could be complex and time consuming. Securing a referral to secondary services for an assessment by an old age psychiatrist involved going through the GP, who could be reluctant to make a referral: ‘he’s just old’. Problems of liaison between primary care and district general hospital non-psychiatric services meant in two cases that opportunities to assess the patient’s mental state during emergency admission to hospital for physical conditions was lost. Co-location of social workers within a mental health team had the advantage that advice from mental health professionals was more readily available.

Assessment by a consultant psychiatrist did not always lead to a formal diagnosis, but it could be sufficient to identify a ‘cognitive deficit’ which the social worker could use as the basis for their assessment of capacity. Pursuing secondary services to provide this option could be time-consuming and could create delay in decision-making. On the other hand, an awareness that capacity could fluctuate over time meant that re-referrals had to be made as situations evolved, and a “once and for all” diagnosis was not sufficient. In some cases, the social worker’s assumption that the person must be suffering from mental disorder was not confirmed by the psychiatric assessment. When this happened in the context of a referral for an assessment under the Mental Health Act 1983 it meant that the person did not meet the criteria for detention It also raised doubts as to whether the Mental Capacity Act would apply, when the person’s behaviour was seen as an eccentric choice of lifestyle. Hoarding of rubbish and living in insanitary conditions were more likely to be seen in this way as eccentricities than as symptoms of mental disorder, in the cases discussed.

Less experienced social workers were more likely to want to involve mental health services in making their assessment of mental capacity: ‘anything to do with mental health, they are the experts’. This did not mean however that any of the workers interviewed sought to avoid what they saw as their professional responsibility to make decisions. There was a clear awareness that what was sought was corroboration (and collaboration) from mental health services rather than a ‘referral on’ to pass responsibility. This confidence in one’s own ability to assess capacity was a significant impact of the coming in of the Act.

> “Having the faith that I can actually assess whether someone is mentally capable of making decisions, whereas before we would always rely on the GP or psychiatrist telling us whether or not the person had capacity’’
> (Social Worker A).

- Not all people being assessed under the Mental Capacity Act will have a formal diagnosis of mental disorder.
- There was an awareness that capacity could fluctuate over time and that reassessment was needed as situations evolved.
- Mental health services are used also to corroborate social worker’s assessments of incapacity.

THE INTERFACE BETWEEN THE MENTAL CAPACITY ACT AND OTHER LEGAL PROVISIONS

The relationship between the operation of the Mental Capacity Act and the Mental Health Act 1983 and Section 47 of the National Assistance Act 1947 was an issue in some of the cases. Compulsory admission under the Mental Health Act was seen to be an appropriate course to pursue where there was a belief that the person was suffering from mental disorder and there was a perceived need to move them quickly (though this was usually for care rather than for treatment). When sectioning was not possible, the Mental Capacity Act (or capacity arguments using the Common Law, pre-Act) was called in aid as a fallback position. This is what happened in one (pre-Act) case where the Consultant Psychiatrist and ASW determined that the woman was not suffering from mental disorder; she was later admitted to residential care through the joint endeavours of the social worker and G.P. In another case, a woman had been admitted to residential care using the Mental Capacity Act, but following an incident at the residential home, a Consultant Psychiatrist had been called in to assess her mental state. He concluded that though she was attempting to evacuate the home being deluded that it was on fire, she was not thereby a risk to herself and others. The placement continued, as remaining in that setting was in her best interests.

Conversely, in another case, a man who had been admitted to residential care using the Mental Capacity Act and who had been compliant with the admission attempted to leave by smashing windows in the home. A psychiatric assessment led to him being sectioned under the Mental Health Act and admitted to hospital. Mental health professionals' understanding of the Mental Capacity Act was called into question by an interviewee who was also an ASW. She reported that the proper operation of the Mental Capacity Act and its relationship to the Mental Health Act was a frequent topic for discussion at ASW meetings. There had been instances where psychiatrists had tried to encourage ASWs to use the Mental Capacity Act to avoid sectioning non-compliant patients, seeing it as an easier route into hospital, or as an alternative admission to residential care. Such issues are likely to be more frequent when the Deprivation of Liberty provisions under the Mental Capacity Act come into force in April 2009 to allow patients lacking capacity to consent, to be admitted to psychiatric care for treatment without sectioning. A colleague of one of the interviewees, who was an Approved Social Worker had also suggested using guardianship as an alternative legal route to making a placement in residential care, when there was doubt about capacity.

In cases involving older people living in insanitary conditions and not receiving proper care, a possible overlap between the provisions of the Mental Capacity Act and those of compulsory removal from home under s.47 National Assistance Act 1948 was discussed with environmental health officers. Section 47 applies to those who are not suffering from mental disorder under the Mental Health Act, but allows for a judicial process to compel an admission to general hospital care or (more usually) residential care. Section 47 is in practice rarely used, and is seen as (arguably) contrary to Human Rights Act provisions respecting privacy and family life. The issue arose in multi-disciplinary contexts, but there seemed to be no appetite from any of the agencies involved to pursue this course of action.

The proper scope of the Mental Capacity Act and its differentiation from or overlap with other legal provisions thus provided a focus of debate within social work teams and between those teams and other professional groups. When people needed to be moved in a crisis (as often they did), there was the problem of what legal authority existed to physically relocate them to another place, when clearly they were not managing at home. Referring to an earlier case, one social worker raised the problem of the authority to take away and transport:

> "we could see things weren't right but because of the lack of any law there was nothing we could do … if the Mental Capacity Act had been in force we would have been able to say 'right. Is she capable of managing at home, do we think she's got the understanding to be able to look after and feed herself?' But the problem is, even after you've made that decision and they haven't, there really isn't anything you can do about it still unless you look at the Mental Health Act".
>
> (Social Worker B)

- The Mental Capacity Act may operate as a "fall back" position if compulsory intervention under the Mental Health Act is not possible.
- Social Workers are questioning whether mental health professionals share their understanding of the proper application of the Mental Capacity Act.
- The relationship between the operation of the Mental Capacity Act and s.47 National Assistance Act 1948 and Environmental Health legislation is in need of clarification.

INTERPROFESSIONAL WORKING

Inter-professional working, with housing, environmental health and the police, as well as with colleagues in health was a strong feature of all of the cases described, both before and after the implementation of the Act. What the implementation of the Act did bring to light, were differences in perceptions, based often on different value bases. Most of the social workers interviewed felt that the Mental Capacity Act had enhanced their status as decision-makers in their own right, and that its structured approach to problem solving had increased their confidence in developing defensible arguments. This had given them authority when working with other professionals, and had empowered them to challenge others' perceptions and assumptions.

Joint working with health professionals was a common feature of most cases both before and after the Act. Usually this meant working with Community Psychiatric Nurses (CPNs). Mostly these relationships were positive, with sharing of information and joint visiting. Discussions with CPNs were perceived as helpful in checking our social workers' own assessments that a person did or did not have capacity in relation to the matter in question, and this was most apparent when the issue was entry to residential care. The social worker naturally took the 'lead' in maintain residents with complex needs in that environment, particularly during an assessment period. However, there were some difficulties, perhaps best described as 'organisational', rather than professional, when nursing support had been abruptly withdrawn following assessment, or as a consequence of a move to a new area. Whether or not the client had the capacity to sign the standard consent form enabling information to be shared with other agencies was an issue in some cases.

> "She told me she was happy for me to speak to her GP and everything, bur I didn't feel I should be asking her to sign something if there was a query over her capacity".
>
> (Social Worker B)

Working with GPs was more sporadic, though some GPs would attend review meetings, or proactively involve other services. One GP for example arranged an ambulance during a patient's 'lucid interval' to transport her to residential care, and was involved in long-term planning for the patient. Other GPs were slow to refer to secondary services, or condensed complex situations into brief diagnostic letters which unhelpfully 'crystallised' situations. So, for example, in one case, a GP's letter to a solicitor that the client 'had dementia and so was not capable of making a Power of Attorney' closed down discussion of whether the client was able to choose whether her neighbour or a family member was the most appropriate person to help her deal with her financial affairs. Some social workers had little confidence that GPs acknowledged the existence of the Mental Capacity Act:

> "I do think that social workers seem to be the only ones who have any knowledge of the Act – GPs seem to have no concept of it"
>
> (Social Worker B)

Consultant psychiatrists were presented as authoritative figures who could ‘clinch’ an argument through a timely diagnosis. Except for the co-located social workers in the hospital setting, there did not seem to be a continuing dialogue between social workers and mental health services at this level – more was delegated to CPNs. Certainly carers would have liked more continuing involvement and monitoring by the consultants; there was some feeling of abandonment once a diagnosis had been made.

The police were seen, on the whole, as useful allies who understood the complexities of situations. The ‘professional’ knowledge of one family member who was a police officer proved helpful in giving an older person support through a difficult transition period when anxieties about self-neglect were high. The fact that he had seen similar situations as a serving officer assuaged the anxieties both of other family members and of the professionals directly involved. Though the police, in other cases, had had to deal with complaints from neighbours about living conditions, or repeated telephone calls from anxious older people with dementia, they were ultimately respected for their willingness to see situations in ‘welfare’ terms rather than as ‘legal’ problems.

Housing providers and environmental health officers by comparison were presented as more legalistic in their approach. Housing providers were able to use the threat of eviction to make impossible the ‘less restrictive’ alternative of a return home with support for tenants who had presented as a nuisance. Pressure from resident wardens or neighbours was particularly potent in such cases. The social work role was one of advocate for the older person, and very convincingly so in some cases. It was in such cases that the Mental Capacity Act was seen as having made a critical difference to the way in which arguments needed to be framed, and to the outcomes that could be achieved. One particularly difficult case concerned an older couple living in a rural location in a tumbledown property which was the focus of numerous complaints to the local council from well-connected local residents. Environmental health were inevitably involved, but the social worker was able to use the Mental Capacity Act to ‘pace’ the process of assessment and to use the legal test of capacity to argue for the rights of the couple to retain their chosen lifestyle. So, the most convincing argument that the social worker could muster was the challenge to ‘commonsensical’ assumptions that the couple would not choose to live this way if they had capacity:

> “the test is not, ‘is this how I would choose to live’? the test is does he have capacity to make this decision, and he does’.
>
> (Social Worker I)

- Inter-professional working is a strong feature of Mental Capacity Act cases.
- Differences in perception are attributable to different value bases.
- The Mental Capacity Act challenges ‘commonsensical’ assumptions that people would not choose to live in insanitary or unsafe circumstances.

SOCIAL WORKERS' APPROACHES TO ASSESSING MENTAL CAPACITY AND BEST INTERESTS DECISION MAKING

Social Workers' approaches to assessing mental capacity, and best interests decision making can be conceptualised as a sub-set of approaches to the assessment and management of risk. The Mental Capacity Act provides, in section 3, a 'checklist' for assessing the inability to make decisions which places individuals in the category of 'people who lack capacity' in Section 2. Section 3 states that a person is unable to make a decision for himself if he is unable a) to understand the information relevant to the decision b) to retain that information c) to use or weigh that information as part of the process of making the decision, or d) to communicate his decision (whether by talking, using sign language or any other means). Though social workers, in their discussion of cases, may not explicitly have followed this description of the decision-making process in making their assessments, they did show an understanding of the importance of these issues and gave examples of their application in practice.

It was common for three or four visits to be made to repeat information, to compare responses given at different times and in different circumstances, and to involve other professionals and/or family members in validating the conclusions that the social worker was beginning to make.

> "So, following, my visit I thought she actually probably needed further investigation, further visits really because I thought she probably had the capacity to make the decision, but she was easily swayed".
>
> (Social Worker B)

There was general acceptance of the presumption that the person had capacity, but also an awareness that capacity could fluctuate; hence the final conclusion 'capacity or not' tended to be an aggregate of different assessments over a period of time. A distinction was drawn between capacity in relation to the significant decision that had to be made, for example concerning finances or where the person lived, and the (different) capacity to make day-to-day decisions. Most assessments of capacity were on single issues; overwhelmingly, admission to residential care but sometimes combined with financial issues. Admission to residential care is a good test of the integrity of the Mental Capacity Act in establishing 'due process' for assessing capacity in support of a functional model. When the Mental Capacity Act was being developed, alternatives to the 'functional' (cognitive) test of capacity were discussed; a 'status' model which would have relied on a diagnosis of dementia or learning difficulties to establish incapacity, or an 'outcomes' model which looked at the quality of the decision made as an indicator of capacity.

Though the existence (or otherwise) of a diagnosis of dementia was not determinative of capacity in the cases discussed, 'medical opinion' was an important factor in some decisions. 'Medical opinion' was the trump card in one case, where the GP's statement that a woman did not have capacity 'because of her dementia' was used to override the Social Worker's negotiated solution to a complex financial situation, that the woman should enter into a Power of Attorney. In another case, where the arguments for and against capacity were very finely balanced, intervention by a

Consultant Psychiatrist produced what was seen as an authoritative determination that the woman lacked capacity to return home from residential care.

The potency of an ‘outcomes’ model in dealing with the consequences of risky decision making was apparent in some cases, even if not explicitly acknowledged. Discussion focused around the interpretation of s.3 (1) (b) of the Act: ‘a person is unable to make a decision for himself if he is unable … to use or weigh that information as part of the process of making the decision’. Section 3 (4) further explains that ‘the information relevant to a decision includes information about the reasonably foreseeable consequences of – a) deciding one way or another, or b) failing to make the decision’. Quite properly, in such cases, the social worker shared information with the client about the reasonably foreseeable consequences in terms of clear risks to health in remaining in insanitary conditions, or in living alone when the risks of falling were high and the consequences of a bad fall were likely to be severe. The older person’s failure to see the consequences in the same terms as the social worker then became the focus of a discussion about whether such a failure meant that the person lacked capacity, or whether they had indeed appreciated the risk and had chosen to accept it. In other cases, service users were unrealistic about the capacity of friends or relatives to continue to provide care, and discounted the social worker’s perception of ‘carer breakdown’ as a reasonably foreseeable consequence of refusing domiciliary support services. So, a client who wanted to go back to living alone, was assessed in these terms:

> “I think she has the capacity to make that decision, however, I don’t think she’s realistic about what her care needs are and what she can do; her daughter does an awful lot for her.
>
> (Social Worker G.)

Concerns could arise, however, with regard to the amount of information that needed to be given and understood in order for a person to make an effective choice. When the consequences of inaction were grave, a higher degree of competence was thought to be required when capacity to make life or death decisions was called into question. Professional conflicts arose in one such case where the risks of severe infection from living in insanitary conditions were considered:

> “I think he (the doctor) felt she had the right to make that choice. I felt it wasn’t necessarily a fully informed choice because you know, that is a very unpleasant death”.
>
> (Social Worker J)

The social worker’s own experience of similar cases was thus brought into the decision-making process in ‘actuarial’ terms, predictive of generalised outcomes against which individual outcomes had to be measured. One recently qualified social worker perceptively analysed such situations in terms of professional ‘risks’ of criticism from families and the community in standing back whilst people made decisions that the professionals knew that they were uncomfortable with. She described her position as one of “nervous power” and tempered her support for the Act with the perception that she, unlike some of her colleagues, had not yet had a case where the client had chosen to make a decision which she felt disregarded obvious risks.

Encouraging people to participate in decision-making, and to communicate decisions in ways other than involvement in case discussions, was not particularly evidenced. Apart from one social worker who had considered involving a speech therapist, no spontaneous examples were given of using assessment 'tools' as an alternative to verbal communication. Observation, as a means of assessment was a source of evidence brought in by managers of care homes. There were also instances of the Mini Mental State Examination being used. For people assessed as lacking capacity, a 'best interests' decision had to be made. Though service users were involved in care home reviews, the extent of the service user's participation in constructing and monitoring the care plan was not explicit. One exception to this was a case in which the social worker intervened to advocate for the service user where the carer (a neighbour) was over zealous in imposing solutions to domestic problems like leaving pans unattended or kettles to boil dry. Assistive technology and day care support had been negotiated with the service user so that she could understand the options and choose what support she liked in terms of prompts and domiciliary help. Much of the work here had been undertaken with the carer to explain how dementia did not involve a global lack of capacity, and to involve the person with dementia in decision making rather than 'taking over'.

- It is common for several visits to be made when assessing capacity.
- Social workers apply functional, rather than status test of incapacity, but are influenced by outcomes models.
- Encouraging people to participate in decision-making was not well evidenced.

CONSULTING FAMILIES

Social Workers with older people are well used to working with families, and seeing the older person as part of a wider network. They are also used to working with family carers and have statutory responsibilities to undertake carers' assessments, together with a power to provide services directly to carers. Family carers are bound by the principles of the Mental Capacity Act in the same way as professionals to assume capacity, to make best interests decisions and to act in ways which are less restrictive of the person's rights and freedom of action. The decision-maker in determining what is in a person's best interests must take into account 'if it is practicable and appropriate to consult them', the views of 'anyone engaged in caring for the person or interested in his welfare'. Some resistance was noted on the part of some family members to seeing the person with dementia as able still to be involved in decision making, and members of the reference group confirmed that this was not an unusual experience. Nevertheless, without exception the social workers interviewed were able to focus on the person with dementia as 'their client' in determining what was in that person's best interests.

The importance of focussing on the client's best interests was well illustrated by an example from a case involving adult protection concerns. A family member's ability to care properly for a very disabled relative had been referred under Adult Protection Procedures, and the Social Worker had been asked to assess whether staying at home was in his best interests. Although the man could not speak, the Social Worker observed his behaviour, spoke to family members and devised a checklist based upon the principles of the Mental Capacity Act as an aid to determining what was in his best interests. This was a good example of a very structured use of the Act to provide a decision-tree from evidence that could later be presented in a case conference format. Furthermore, an exploration, using the Act, of the gentleman's previous character and 'typical' family routines showed that the rather rigid regime that his family adhered to had been usual in that particular household in previous times. The team manager of the social worker involved in this case had devised a format for 'Best Interests' meetings between families and professionals which he himself chaired. Such meetings operated formally to record how the Act was being interpreted and to seek to find a solution that was acceptable to all parties. These explicitly 'Best Interests' meetings were an innovation in that particular team, and were not found elsewhere. The Reference Group endorsed such meetings as 'good practice in ensuring good communication with families'. Formal meetings with families that were described as having taken place in other teams were usually prompted by the social worker seeking further consultation, or took place as part of the scheduled review process for residential placements.

In two cases, similar differences in perception occurred between the social worker and family members about the weight to be given to the older person's previous wishes and feelings. This arose in the context of whether or not it was in the older person's best interests to move permanently into residential care. In both cases the family member was relying on previous negative comments about 'being with other older people', or on the acceptability of residential care as a place to live. The family members' perception was that they were communicating and supporting the older person's wishes, as they would an 'advance decision' with respect to medical treatment. The Social Worker's view was that family members were acting on out of date information which did not fit present circumstances when needs were very different.

Delays in obtaining a social work assessment or in receiving community care services were raised by family carers within the reference group as part of the consultation on good practice. A further difficulty was not being able to keep contact with one social worker throughout the 'journey', leading to complexities in re-referral and a lack of continuity. Monitoring and anticipating changes as they occurred therefore become more difficult. This meant that it was harder to seek preventative services; as a consequence carers were nearer breakdown when services eventually became available. For the social worker this could mean that what was supposed to be a simple request for respite care became an unplanned admission to long term care, and attempts to investigate the capacity and best interests of the older person in this situation had to be done quickly when all concerned were under pressure.

- Family carers want easy access to social work assessments and services, and a continuing relationship which enables change to be monitored and responded to without delay.
- In cases of conflict, social workers are able to focus on the needs of the older person as 'their client', but are concerned that some families may interpret a diagnosis of dementia as a loss of rights.
- Explicit 'Best Interests' meetings with families are seen as helpful in formalising consultation, and making decisions.

INVOLVING INDEPENDENT MENTAL CAPACITY ADVOCATES

The Independent Mental Capacity Advocate (IMCA) service appeared to have quickly established itself as knowledgeable, authoritative and useful. IMCA involvement in training events had raised their profile in teams and had given social workers a sound awareness of their role. In some instances, social workers had approached the IMCA service for advice in a complex case and this had been experienced as helpful and supportive. Though the IMCA had refused to be drawn in to the case, explaining the statutory limitations on their role, this had obviously been well communicated and there was a general respect for such boundaries. IMCAs were seen as knowledgeable in legal matters, and were in some instances described as a preferred point of contact above the County's own legal department. None of the interviewees had consistently involved the County's solicitors directly in their casework, though in one case a private firm of solicitors had been experienced as helpful. Given the complexity of the law, and the lack of clarity in the interpretation of some of the terms within the Act prior to the development of case law, there may well be an opportunity here for some more focused source of legal advice to be developed.

> "I know I have found him (IMCA worker) very, very helpful and I have passed on to the team if they need any advice or information, call him and he will talk through whether or not he needs to be involved. Also very helpful around points of law and the guidance as it took a while for practice guidance to be available."
>
> (Social Worker A)

As many of these cases involved admission to residential care, which was likely to become long term, statutory involvement of IMCAs is triggered if the person is 'unbefriended'. IMCAs may also be instructed to represent residents in care reviews if the local authority or NHS body are satisfied that it would be of particular benefit to the person to be represented. These criteria were generally understood by the case accountable social worker, but in only a minority of cases did the circumstances of the case appear to call for an IMCA to be instructed. The IMCA report produced in one case and shown to the researcher was well structured around the statutory criteria, and showed evidence of appropriate consultation with interested parties and with the service user. The recommendation supported the social worker's assessment that it was in the best interests of the service user to be placed in long term care. In this particular case, the social worker had acted quickly to engage the IMCA service as soon as it became apparent that this crisis placement was likely to become permanent. Other cases involved emergency or short term placements that were likely to become long-term situations. Given that the IMCA service must be involved when the County Council is proposing to place a person in a care home for more than eight weeks, or the person is likely to stay in a care home for longer than eight weeks, it is important to ensure that social workers correctly anticipate the need to contact the IMCA service as soon as they realise that this situation is likely to arise. This type of rapid response is even more critical when the proposed placement is in long term hospital accommodation, or is a move to different hospital accommodation, because in such cases the relevant placement period is only 28 days.

There was some confusion amongst social workers about the appointment of IMCAs when older people do have friends or relatives but such friends and relatives are in dispute with the social worker or each other about the making of a placement, or they are considered not to be acting in the best interests of the service user. The issue may then be whether the interpretation of the phrase ‘there are no friends and relatives whom it is appropriate to consult’ would exclude relatives who are not acting in the best interests of the older person. A similar interpretation has been used to exclude nearest relatives from consultation under the Mental Health Act 1983, but unlike under the Mental Health Act there is no statutory provision to displace a nearest relative. Ultimately, under the Mental Capacity Act disputes could be referred to the Court of Protection for resolution. Alternatively, if the person were suffering from mental disorder, the guardianship provisions of the Mental Health Act could be used to provide authority to determine where the person should live. In some cases which were presented, there were adult protection concerns, namely that the person would not be well cared for by the relative who was seeking to discharge them from residential care. Clarity in formulating these cases as adult protection is needed to enable IMCAs to receive instructions where there are also family and friends who can be consulted. The reference group was aware of a number of instances where family had sought to discharge a person with dementia from residential care against that person’s best interests.

- The IMCA service is seen as helpful and well informed on legal issues.
- If there is some confusion about the circumstances in which the IMCA service should / must be involved, this needs to be resolved at an early stage.
- The ‘displacement’ of family or friends is a particularly contentious issue where conflicts of interest are perceived between them and the incapacitated client.

THE IMPACT OF THE AVAILABILITY OF APPROPRIATE SERVICES

The availability of good quality support services, and the willingness to collaborate of individuals within those services, was a significant factor both in enabling considered decisions to be made, and in finding ‘best interests’ solutions which were less restrictive. All of the social work teams had access to particular resources which enabled them to make better decisions than they would have been able to make alone. There was much praise for particular residential homes, admission to which served as a period of assessment. Skilled managers were able to monitor fluctuating levels of capacity and to advise on the older person’s awareness of risks. A community hospital placement similarly enabled a social worker to assess capacity and to perform a holding function whilst longer term solutions were discussed. Established good working relationships between Social Workers and CPNs facilitated collaborative working in which Social Workers did not feel that they were surrendering their professional role in assessments of capacity.

Conversely, the absence of 24 hour community support services meant that retaining the most frail older people in their own homes was not a viable preference. Almost all of these cases resulted in admission to residential care, but there was no overt discussion of whether residential care, as opposed to a complex and possibly intrusive package of care at home, was in itself a less restrictive alternative. In this, the Mental Capacity Act produces a less clear outcome than the Mental Health Act in which (compulsory) admission to hospital is seen as the outcome to be avoided. Perhaps for the frailest older people, residential care is a positive outcome, though the process by which that decision is reached and the exact timing of it is something which the Mental Capacity Act can regulate.

For some older people, the limits of maintenance at home had already been reached, and it should not be forgotten that in some cases home care had provided support in difficult circumstances for many years. For some individuals, narrower definitions of home carer permitted tasks, and more stringent health and safety requirements meant that domiciliary support was no longer available at a level to be effective. However, for those with more modest needs, creative solutions were found by using direct payments to pay friends to provide social support, and to provide day services to relieve pressure on neighbours to monitor well-being. There did not appear to be an urban/rural divide in the availability or use of resources. The tolerance of communities of “eccentric” behaviour was explained in terms of social class, rather than location, though there was a strong ‘rural’ character in some cases relating to social isolation, neglect of property.

Issues for further discussion in the provision of resources include the degree of capacity necessary to consent to and to manage complex direct payments arrangements, and the capacity needed to choose services within individualised budgets. Examples of such services were not given within this sample.

- The availability of good quality provider services facilitated assessments and ‘best interests’ solutions.

- Conversely, limits on the provision of community support services made admission to residential care almost inevitable in many cases.
- Capacity to consent to and manage complex direct payments and individualised budgets was not examined in this research but needs to be considered in care planning.

RECORDING

Norfolk uses the Care First electronic system for recording community care assessments which incorporates Version 5 of the FACE Single Assessment Process Overview Assessment. Norfolk has adapted the FACE Recording and Measurement Systems Guidance and Prompts for local use. Operational Instruction 582 'Norfolk Social Services – eligibility Framework and Criteria for Accessing Adult Social Care' requires staff to record the eligibility for service decision to include:

- The statements of risk to independence that apply, and
- The needs that give rise to those identified risks to independence, which if addressed will ameliorate, contain or reduce those risks, and
- The reasons/evidence to support this conclusion.

Eligibility operates according to four bands reflective of those in Fair Access to Care Services: Critical, Substantial, Moderate or Low. The highest banding that applies to each statement of risk to independence determines the overall level of need/risks. Risks falling within all eligible bands, not just the highest, have to be addressed. Levels of need and eligibility decisions are grouped into four categories:

- Autonomy and Freedom to Make Choices
- Health and Safety
- The Ability to Manage Personal and Other Daily Routines
- Involvement in Family and Wider Community Life.

Where and how social workers should use Care First and the FACE Assessment to record mental capacity issues was reported to be a matter for debate, and practice varied. There is at present no separate 'box' or prompt for recording mental capacity. However, this facility – for including a separate 'box' for mental capacity – does exist on a new revision of FACE which is currently being introduced. Some of the interviewees were aware that this new form was being developed, though none had seen it. Some said that colleagues in residential settings had seen it, as had a Community Mental Health Nurse with whom they worked closely.

Guidance

Case sampling as a quality assurance mechanism has recently been carried out by the Performance, Planning and Information Team for the Department. The report from this is not yet publicly available, but does comment on difficulties in documenting issues under the Mental Capacity Act. New summary standards and guidance for the completion of written assessments has recently (May 2008) been produced. Though this is a general 'good practice' guide, aspects of it emphasise issues of personal preferences, communication and choice within available options that are particularly relevant to person-centred working within the Mental Capacity Act. The Standards and Guidance document is set out as a series of standards; each of the standards is set out below, together with relevant descriptors which may be linked to the decision-making process under the Mental Capacity Act:

Standard One Service Users and their carers are treated with respect and dignity.	Cultural, spiritual and person preferences should be covered and commented upon. Evidence of communication issues should be covered and commented upon. Language used is familiar to the service user.
Standard Two The assessment was needs led, person centred and outcome focused	There is evidence that supports placing the current situation in historical and personal context. Evidence which supports that needs have been clearly identified and the potential for recovery, maintenance or improvement has been explored.
Standard Three The assessment evidences the service users independence, well being, health and inclusion.	Evidence of independence and strengths are reflected. Evidence of how the service user approaches change and their desire to optimise their life and lifestyle.
Standard Four The assessment evidences appropriate multi-disciplinary involvement across Health and Social Care.	Written evidence of multi-disciplinary involvement in complex situations, and where the assessment process is over a series of interviews and contacts.
Standard Five The assessment clearly records areas of risk and analysis for the management of risk.	There is evidence of risks being identified. Evidence that the risk analysis is empowering. Evidence of options to support, care, empower and protect should be expected.
Standard Six The assessment confirmed the eligibility for services and gave indications of the type and range of services to be explored.	Inclusion of the reason/evidence to support the decision.

Standard Seven The Service User was offered written information in an appropriate format and in keeping with their wishes.	There is a need to respect the service users wishes and the extent to which they wish to be involved in receiving written assessment information. In some situations it may be appropriate to involve service user's family/carer in signing and retaining copies of the assessment.
Standard Eight The carer was given an opportunity to discuss and determine their support needs.	There is written evidence that an assessment has/has not been requested.

In Norfolk, there is only one piece of policy guidance that has been specifically produced for the implementation of the Mental Capacity Act; this is the Joint Guidance on the Instruction of Independent Mental Capacity Advocates (May 2007). The Guidance is joint between Norfolk County Council Adult Social Services and Local Primary Care Trusts and Hospital Trusts, including the Mental Health Partnership NHS Trust. The Guidance repeats the five statutory principles of the Mental Capacity Act, descries the IMCA service (locally provided by Rethink), sets out the circumstances in which an IMCA can and cannot be instructed and sets out their role, and gives contact details for referral. The guidance also states that Rethink provides a consultation service which can be used prior to referral, and interviewees who had used this service had found it helpful. Anecdotally, interviewees speculated on the extent to which health colleagues were aware of the proper role of the IMCA service, as contained in the guidance. Examples were given of hospital staff thinking that an IMCA needed to be instructed where a person without capacity received treatment for a broken leg (not 'serious' medical treatment under the Act), or where any admission to residential care was anticipated (even if for short term care of less than 28 days).

In one part of the County, Team Managers had devised a flow diagram for the Assessment and Care Management System, giving detailed guidance on completing the Care First recording domains. The process is described from referral through to closure and review. Correct completion of all domains included in the FACE assessment is necessary in order to be able to commission services. The process is a complex one, and time consuming. Recording of the assessment and care plan for one service user could take most of one working day. There are no specific prompts within the flow diagram for the Mental Capacity Act.

Most social workers recorded Mental Capacity assessments in the FACE documentation under the domain of "Psychological Well Being" using the categories of 'mental health problem', or 'memory'. The 'Brief description of person's presenting problems, difficulties or concerns, relevant person history' provided an opportunity to give a narrative account of the issue (e.g. ability to manage finances) which was the focus of the referral, a brief history of the case, and the steps which the social worker had taken in order to assess capacity. The implications of the lack of capacity were further explored under the domain of 'Risks', and eligibility for services under FACS was attributed to Autonomy or Health and Safety.

Separately from the assessment documentation, Care First enables "Observations" to be listed as a running record of contacts with the clients and with other professionals. The 'Observations' could be used to develop an argument to a conclusion; for example 'Mrs H was assessed as not capable of managing her finances or making a decision on where she live'. The care plan is written separately, and although mostly directing the social worker's attention to activities of daily living, other capacity-related needs can be identified here and linked to a care plan. So, in Mrs H's case, a need for support with financial management led to the specification in the care plan of a referral for appointeeship, and involvement of the Court of Protection. Not all relevant events could easily be included in electronic systems; minutes of Case Conferences, for example, had to be scanned in, and letters from GPs and reports from IMCAs were typically kept in a separate paper file. Though it is important that the proposed amendment to the Care First system alerts practitioners to identify issues of capacity, it is equally important that assessment, care planning and 'observations' are structured to support the sort of decision-making about capacity, best interests and less restrictive alternatives that the Mental Capacity Act requires professionals to make and to evidence.

Knowing how to record effectively and appropriately was a concern for the social workers interviewed.

> "We discuss mental capacity in team meetings all the time, because of our concerns, because we haven't got the paperwork".
>
> (Social Worker G)

Those who said that their practice had not fundamentally changed since the coming into force of the Act, nevertheless said that they were more careful in their recording, wanting comprehensively to cover all of the legal categories contained in the Act.

> "Because of all the legalities and all those sorts of things … you've got to make sure that everything you decide is thoroughly backed up with evidence and everything documented of why you made the decisions".
>
> (Social Worker, B)

There was some regret that the ability to write 'narratives' of cases which earlier recording systems had allowed, was no longer available. Recording of cases prior to the Act tended to include more personal detail, and written 'contact sheets' more fully documented the twists and turns of cases than the 'Observations' on Care First appeared to allow. All interviewees were positively anticipating opportunities explicitly to record capacity as a separate category within the assessment, with prompts to direct them to do so.

- Recording is needs led, person centred and outcomes focused, reflecting imperatives within the Mental Capacity Act.
- There is however only one specific policy (on IMCAs) which is specific to the implementation of the Act.
- The significance of recording defensible decisions is recognised, and prompts for recording mental capacity are anticipated.

THE IMPACT ON SOCIAL WORK ROLES

Discussion of the Mental Capacity Act was perceived as a key topic within teams; though inevitably some members of the same team were more enthusiastic about the issue than others, all of the interviewees appeared to find the topic intellectually interesting. Some teams had proactively organised their own training events and case study groups around the Mental Capacity Act All teams had copies of the Code of Practice available in the office; some teams were merely aware of its existence, whilst others reported that they used it very much as a working tool. Though care management approaches to assessment, planning and review shaped the social work task, such structures were not perceived as a constraint upon the proper management of cases of incapacity. Adequate time appeared to be given for extended assessments and monitoring to take place, with cases commonly being kept open for a number of months. Even though some respondents said that they had had to resist some pressure from team managers to close the case, in all instances they had succeeded without too much difficulty in doing this. It was reported however that team managers' practice in supervision varied: some prioritised discussion of capacity issues; others did not raise it as a topic for discussion unless prompted by the worker. There was no apparent correlation between the style of the manager and that of individuals within the team. There was however a lot of sharing within teams and mutual support.

The Mental Capacity Act potentially enables social workers to take on a range of different roles according to the way in which they interpret the legislation. These roles may variously be:

- Legal representatives
- Protectors
- Advocates

Each of these roles is linked to a particular value base. Examples of each of them were evident in the interviews with practitioners, and individual practitioners could move in and out of different roles.

'Legal representatives' worked with the legislation, applying it in a positivist way as a set of rules prescribing action. They welcomed structure in decision-making and sought to replicate this in their recording. One social worker had produced her own written guide to the Act based on a training session that he had attended; he would then apply these principles as a checklist to the case in hand. Another practitioner had immersed himself in a close reading of the Act and associated documents, and in legal textbooks. 'Legal representatives' were very aware of the formal, statutory nature of their role and embraced opportunities to discuss legal issues with colleagues, to share materials and to debate with other professionals, including lawyers. The value base of the 'legal representatives' was one of respect for individual rights and procedural justice. The checklist (below) for assessing mental capacity was produced by one social worker to inform decision-making in an adult protection case, and follows closely the structure and language of the Mental Capacity Act.

Checklist for assessing mental capacity

Mr C was referred following an adult protection strategy meeting, In assessing whether it was safe for Mr C to remain at home, Mr C's social worker sought to involve him in that decision. Drawing upon existing skills in structured decision-making and report writing as an ASW, Mr C's social worker devised the following check list:

- Could Mr C decide where he would prefer his care to be provided, and by whom?
- Is there an impairment of his decision-making ability
- Is the impairment or disturbance sufficient to cause the person to be unable to make that particular decision?
- Does the person have a general understanding of what decision they need to make and why they need to make it?
- Does he understand the likely consequences of making the decision, or of deciding one way or another?
- Are they able to understand, retain and weigh up the information relevant to the decision?
- Can they communicate their decision? Would the services of a professional be helpful?

Protectors were less likely to present the discussion of their casework as driven by the imperatives of the Act, though they were able to use concepts such as 'best interests' and 'less restrictive' to explain their decision-making. 'Protectors' saw decisions under the Mental Capacity Act as a sub-set of risk assessments, applying familiar strategies to balance positive against negative outcomes and to devise protection plans which sought to minimise risks. Protectors were more likely to interpret the requirements of the Act in the context of a wider 'duty of care' towards the client, and were also more likely to interpret incapacity as an inability to foresee and to take precautions against obvious risks.

> "I said to her (the daughter), I know it's what you want, but I need to know that he can contribute to that decision and I need him to tell me that he understands the risks his putting himself under".
>
> (Social Worker F)

Where the client had capacity (or others felt that the client had capacity) to choose the risky option, there was still felt to be scope for persuasion to encourage them to accept a less problematic outcome. Protectors worked hard not only with individuals but also with support networks and service providers to develop 'systems' which would continue to monitor well-being over the longer term.

Advocates were explicitly person-centred in their approach, and did not necessarily experience social systems as benign. They saw that other agencies could sidestep the Mental Capacity Act by creating stereotypes of older people with dementia as a threat to their neighbours and their community. Advocates based their arguments on human rights principles of respect for family life and privacy, and fiercely defended unjustified encroachment on these rights. Advocates were keenly aware that ‘best interests’ decision making could be jeopardised by the personal interests of other decision makers. They were the most comfortable with ‘risky’ outcome, and, like Social Worker I, saw themselves as “advocates, working in peoples’ best interests”.

Dealing with complex situations involving conflict and loss was clearly going to have an emotional impact on workers. They acknowledged that such cases could be perplexing and worrying.

> “I found it very stressful and worrying that there was no avenue I could go down that was both appropriate and legal to protect this lady”.
>
> (Social Worker J)

But there was a very positive finding from this small-scale research; the existence of a legislative framework for decision-making was perceived as both enabling and empowering. It enabled decision-making to be structured, providing reference points in what were often chaotic situations. It also gave formal status to social workers in discussions with other professionals and with families. Some interviewees went so far as to say that they had felt ‘privileged’ to work with such challenging cases (even when things did not go straightforwardly). Though aware of the potential for criticism if older people were left in what others could perceive to be unsatisfactory situations, there was a core confidence that such decisions were defensible. The impact of the Act was perceived positively. Those who said that their practice had not fundamentally changed, did acknowledge that they recorded decisions more satisfactorily, and more appropriately, even taking into account the limitations of formal recording mechanisms, discussed elsewhere.

The Mental Capacity Act has brought home to social workers the power inherent in their role. This was mentioned explicitly by a number of interviewees, as they reflected on present experience compared to the (lesser) impact of past cases. Field Social Workers were also cast as the ‘voice of authority’ by others in the system as evidenced by the two referrals from private care homes to give an opinion on whether two long-standing residents had the mental capacity to continue with existing arrangements for handling their financial affairs. One of the interviewees who chose such a case also stated that since the coming into force of the Act there had been more requests for social workers to carry out ‘complex’ reviews. (Simple reviews of residents in long term care are carried out annually by unqualified staff). This process of flagging up issues for complex review may be the channel by which request for Deprivation of Liberty assessments are made, in future.

- The Mental Capacity Act has enabled social workers to undertake roles of Legal Representatives, Protector and Advocate for people with dementia.
- The existence of a legislative framework for decision-making is perceived as enabling and empowering.
- Social workers are perceived as authorative in their role under the Act.

REFLECTION AND REFLEXIVITY

All of the interviewees were able to reflect upon the way in which the Mental Capacity Act had made them more keenly aware of their own decision-making styles and of their own value base. Some were anticipating future challenges under the Act: two issues in particular were referred to; the introduction of Deprivation of Liberty safeguards and the formalities surrounding this, and the piloting of individualised budgets which raised new issues of capacity to consent to and manage new forms of service delivery.

Responding to such challenges requires practitioners to move from reflection to reflexivity. The essence of reflexivity is the recognition that knowledge and theory use is constantly being constructed in part through practitioner experiences, but also through the practice context and formal theoretical base. The reflexive practitioner is aware of their own thinking, whether that comes from 'technical' sources such as the law, from agency sources or from personal stereotypes, strengths or anxieties. Bringing together cognitive approaches and affective approaches (feelings) enables the experience of casework to be assimilated into everyday practice in a way which acknowledges 'learning from doing'. Sharing this process with clients moves reflection into reflexivity; applying the learning from reflection to make a difference to the next encounter. Assessments under the Mental Capacity Act are particularly appropriate vehicles for reflexivity. Judging the ability of an isolated and bewildered older person to make rational decisions is not a technical task that can be approached in a vacuum. It needs to take into account the social and personal context in which the question is being asked. If people's capacity to make decisions is being judged upon their ability to foresee and appreciate risks then we have a professional responsibility to share with them our accumulated knowledge about the existence of those risks, the likelihood that they will occur and the consequences of not taking precautions against such risks. For balance, it also needs to include the risk of precipitately entering residential care and giving up one's home and savings. We need to lay out in front of people, all the factors to be taken into account in making a decision. Indeed the Act states that we must lay before people the relevant information. S.3(4). We also need to be prepared to discuss how previous life experiences may have narrowed down their opinions at this point. If it is decided that the person lacks capacity, the next decision: what is in their best interests, is not ours alone, but ours to share with that person, participating as fully as possible in that decision.

> "I would have decided on the principle of where she would be safely and appropriately cared for, looking at all the issues – not just the needs that she had … but also the fact that she'd got to the point where she said I'm frightened of dying. She would need that spiritual support in the widest sense as well; it wouldn't just be a case of making sure she was clean and tidy – there was more to it than that, and giving that respect and consideration to her bereavement at not going home because that was where the ashes of her husband was – that was such a paramount thing for her".
>
> (Social Worker J)

- The Mental Capacity Act has made interviewees aware of their own decision-making styles and value base.
- Reflective and reflexivity were apparent in professional practice.
- Deprivation of Liberty safeguards, and the introduction of individualised budgets were predicted to be future challenges for decision-making.

CONCLUSION AND SUMMARY

Social Workers in Norfolk, working with people with dementia were asked to describe their casework and recording and to reflect upon the impact that the coming into force of the Mental Capacity Act 2005 had upon their practice.
The cases chosen by the participants in this research all related in some way to residential care, and most concerned capacity to make the decision to enter or remain in residential care.. They concerned very vulnerable older people, their families and other professional supporters. The Act had had a significant impact in the way in which decision-making was structured. To the extent that the recording format allowed this, the way in which assessments and interventions were recorded had been influenced by the language and the principles of the Act.

Fundamental questions of rights versus risks and professional responsibility were generated by the decisions of the Act. Not all cases were amenable to a clear-cut solution and relationships with family members and other professionals, the availability of resources and the impact of training all played a part in fashioning outcomes. Professionally, the social workers involved appeared to have developed greater professional confidence in their assessment and decision-making skills within the structure provided by the Mental Capacity Act. Mental capacity had become a topic that was discussed with other agencies, and integrated into the care management process.

Key findings from the research are summarised below:

- Not all people being assessed under the Mental Capacity Act will have a formal diagnosis of mental disorder.
- There was an awareness that capacity could fluctuate over time and that reassessment was needed as situations evolved.
- Mental health services are used also to corroborate social worker’s assessments of incapacity.
- The Mental Capacity Act may operate as a “fall back” position if compulsory intervention under the Mental Health Act is not possible.
- Social Workers are questioning whether mental health professionals share their understanding of the proper application of the Mental Capacity Act.
- The relationship between the operation of the Mental Capacity Act and s.47 National Assistance Act 1948 and Environmental Health legislation is in need of clarification.
- Inter-professional working is a strong feature of Mental Capacity Act cases.
- Differences in perception are attributable to different value bases.
- The Mental Capacity Act challenges ‘commonsensical’ assumptions that people would not choose to live in insanitary or unsafe circumstances.
- It is common for several visits to be made when assessing capacity.

- Social workers apply functional, rather than status test of incapacity, but are influenced by outcomes models.
- Encouraging people to participate in decision-making was not well evidenced.

- Family carers want easy access to social work assessments and services, and a continuing relationship which enables change to be monitored and responded to without delay.
- In cases of conflict, social workers are able to focus on the needs of the older person as ‘their client’, but are concerned that some families may interpret a diagnosis of dementia as a loss of rights.
- Explicit ‘Best Interests’ meetings with families are seen as helpful in formalising consultation, and making decisions.
- The ICMA service is seen as helpful and well informed on legal issues.
- If there is some confusion about the circumstances in which the IMCA service should / must be involved, this needs to be resolved at an early stage.
- The ‘displacement’ of family or friends is a particularly contentious issue where conflicts of interest are perceived between them and the incapacitated client.
- The availability of good quality provider services facilitated assessments and ‘best interests’ solutions.
- Conversely, limits on the provision of community support services made admission to residential care almost inevitable in many cases.
- Capacity to consent to and manage complex direct payments and individualised budgets was not examined in this research but needs to be considered in care planning.
- Recording is needs led, person centred and outcomes focused, reflecting imperatives within the Mental Capacity Act.
- There is however only one specific policy (on IMCAs) which is specific to the implementation of the Act.
- The significance of recording defensible decisions is recognised, and prompts for recording mental capacity are anticipated.
- The Mental Capacity Act has enabled social workers to undertake roles of Legal Representatives, Protector and Advocate for people with dementia.
- The existence of a legislative framework for decision-making is perceived as enabling and empowering.
- Social workers are perceived as authorative in their role under the Act.
- The Mental Capacity Act has made interviewees aware of their own decision-making styles and value base.
- Reflective and reflexivity were apparent in professional practice.
- Deprivation of Liberty safeguards, and the introduction of individualised budgets were predicted to be future challenges for decision-making.

APPENDIX – THE IMPACT OF THE MENTAL CAPACITY ACT

PRACTITIONER	**CASE I** (pre Act)	**CASE 2** (post Act)	**IMPACT of ACT**
A 8 years qualified Practice Consultant / Assistant Team Manager, working in a community team for physically disabled / older people.	Service user in residential care – dispute about who should manage her financial affairs . Whether she had the capacity to manage her financial affairs or to be the donor of a Power of Attorney. ● Family solicitor said she didn't have capacity to make financial decisions. ● Her previous competence in managing money and working in finance did not appear to be influential.	Referral from care home following review – whether service user had capacity to delegate management of her financial affairs. Mental capacity issue meant a 'complex' review by a qualified practitioner was requested	● Greater confidence in assessing capacity and in challenging other professionals. Less reliant on medical opinion. ● Recording of capacity decisions is more focused and more detailed. ● Mental capacity a topic on the agenda for the team.

PRACTITIONER	**CASE I** (pre Act)	**CASE 2** (post Act)	**IMPACT of ACT**
B 2 years Qualified Social Worker	Older person living in insanitary conditions, but unrealistic about the risk to her health, and the ability of family and carers to provide sufficient support. ● no explicit discussions of capacity at that time. ● no legal option if psychiatrist and Approved Social Worker say the risk does not warrant compulsory admission to hospital. ● case management characterised as ‘tact and diplomacy’	Referral from care home – daughter wishing to move mother to a different care home. Not known if mother had capacity to consent. Client in need of support to make a decision about which she appeared ambivalent and distressed.	• Organisationally, the Act has drawn attention to the issue of whether the client had capacity to sign the standard Freedom of Information Act form allowing information to be shared with other agencies. • Rights have replaced persuasion. • Had always assumed capacity, but assessment was more a ‘gut feeling’: the Act makes it clear what you are looking for . ‘Is she coping’ is replaced by ‘does she have the understanding’? • The emphasis in the Code on the social worker as decision-maker conflicts with the introduction of panel decisions on resources. • IMCA service provides a useful advisory function where there are dilemmas concerning residential care.

PRACTITIONER	**CASE I** (pre Act)	**CASE 2** (post Act)	**IMPACT of ACT**
C 3 years qualified and Approved Social Worker	Assessment of adequacy of care provided for person with dementia at home. ● reliance on consultant's assessment of capacity ● difficult to challenge family member ● assessment not explicitly based on best interests.	Assessment of best interests in context of an adult protection case. A specific brief to assess capacity and to give an opinion on whether care at home continued to be in the person's best interests	• Act provides an authoritative framework for decision-making. Enabled the creation of a capacity / best interests checklist, and authority for intervention on the basis of a 'duty of care'. • Team manager instituted formal 'Best Interests' meetings for consultation with family, in anticipation of Act. • Difference of interpretation apparent between mental health consultants and ASWs about the use of the Act for detention, and also some confusion amongst hospital staff about the IMCA role. • Facilitates challenges to carers' presumption that dementia equals incapacity.

PRACTITIONER	**CASE I** (pre Act)	**CASE 2** (post Act)	**IMPACT of ACT**
D 3 years qualified. Social Worker with older people.	Man being maintained at home by wife as carer. Previous compulsory interventions under Mental Health Act. • Psychiatric assessment of lack of capacity was global. • Social worker perceived his ability to communicate his wishes during lucid interviews, but did not explicitly relate this to best interests decision-making.	Couple both with long-standing mental health problems. Process of assessing the separate needs of each of them within a best interests framework. Outcome was her admission to residential care as it was unsafe for her to remain with him, given the deteriorating mental health of both of them, and the limits of community resources.	• Beyond the initial diagnosis by a psychiatrist, the social worker is able to make decisions about care. • Clear now that capacity is decision-specific. • Requires explicit use of best interests decision-making, and attention to the views of the incapacitated person. • Enables best interests decisions to be made which are not the least restrictive, but requires the decision–making process to be documented to show how and why options are rejected.

PRACTITIONER	**CASE I** (pre Act)	**CASE 2** (post Act)	**IMPACT of ACT**
E Recently qualified Social Worker, Community Team	Adult protection referral concerning person with dementia not receiving appropriate care at home. Client unable to communicate • All discussion channelled through carer. • Other people not allowed to do intimate care. • Strategy discussion held, but no further action taken.	Man in residential care for respite; partner not able to care for him. Ambivalence created by his previous views that he would not want to be in a home with older people. Family relationships made case more complex than referral suggested.	• Clarity that the person has capacity until proved otherwise. • 5 principles "in my head", but format for recording does not facilitate mental capacity decisions. • Mental Capacity Act has given social worker confidence to challenge decisions on behalf of client when welfare jeopardised. • Mental Capacity Act informs and formalises safeguarding adults decisions. Greater awareness of legal responsibilities • Access team need more awareness of Act when assessing whether the individual has consented to the referral.

PRACTITIONER	**CASE I** (pre Act)	**CASE 2** (post Act)	**IMPACT of ACT**
F Qualified 16 years. Practice Consultant	Family discharged very vulnerable lady from residential care. Fear she would not receive good enough care. • No legal authority to prevent discharge. • Criminal law inadequate to protect people in these circumstances.	Man with substantial package of care now in short term care. No formal diagnosis – client mistrusts doctors. Social worker “needs to hear it from him” that he understands the risks of going home.	• Gives clarity and guidance “a more professional approach”. • A protection for the social worker when there are conflicts with family. • Safeguarding Adult procedures and the criminal offence in s.44 Mental Capacity Act enable sanctions to be applied when incapacitated adults are neglected. • IMCA service ensures ‘best interest’ are supported in adult protection cases. • Administrative procedures are needed that prioritise the Act over performance indicators. • Other professionals do not necessarily see the Act as high profile for them.

PRACTITIONER	**CASE I** (pre Act)	**CASE 2** (post Act)	**IMPACT of ACT**
G 4 years qualified, Social Worker, Community Team	Client requiring assistance to take medication, because of short term memory loss. Assistance provided by social services care staff now refused, because of charges levied. Now referred to mental health services, hoping for reassessment as a 'health' problem and free-of-charge intervention. • Capacity to refuse to pay charges may render care plan unworkable. • Boundary between health and social care is controversial where support is needed because of incapacity.	No diagnosis of dementia. Conflict with family with whom she is living. Now saying she would like to return to her own home, against advice. Mental health services being involved for assessment.	• Difference clear between an 'unwise' decision and one which the person does not have the capacity to make. • Practitioners need recording systems which support their understanding and analysis of good practice. • Sufficient training, managerial support and collaboration with mental health services are required to support practitioners in the application of the Act. • The Act may generate more disputes about the boundary between health and social care.

PRACTITIONER	**CASE I** (pre Act)	**CASE 2** (post Act)	**IMPACT of ACT**
H 7 years qualified Social Worker. A range of previous experience. Currently working in Community Team.	Previous experience of capacity assessments in other authorities was more collegial because of shared paperwork and a structured format for decision-making. • Other authorities have anticipated the requirements of the Act for new assessment forms and collaborative working.	Person threatened with eviction, delusional and paranoid. Psychiatrist had made global assessment of capacity. Later admitted to residential care – not sectionable because not a threat to herself or others, but delusional state impaired capacity. Is being managed in care home, but referred to IMCA service as unbefriended.	• Exposes the need for better, informed collaboration with other agencies, especially health, but also housing, and environmental health. • Requires policies and computer systems that are adapted to the requirements of the Act. • IMCA service experienced as positive and professional, but there is a more general issue of who is available to advocate for unbefriended people at each stage of a protracted process from community to residential care. • Professionally challenging when the role is confrontational, rather than ‘working alongside’.

PRACTITIONER	**CASE I** (pre Act)	**CASE 2** (post Act)	**IMPACT of ACT**
I 6 years qualified, Practice Consultant: Continuing Care Assessor.	*Same case discussed pre and post Act.* Case initially dealt with as Adult Protection because of self neglect. Couple removed from tumbledown property to care home, but returned home within 24 hours. Physically fit, no metal health problems. • Human rights issue – respect for privacy and family life. • Pressure from community experienced as oppressive. • S.47 National Assistance Act 1948 (compulsory removal from home) discussed. • Court proceedings brought by environmental health authorised compulsory cleaning of premises.	*Same case discussed pre and post Act.* Case managed according to the principles of the Mental Capacity Act. Social worker's role one of advocate for non-intervention.	• Human rights arguments can crystallise around the Mental Capacity Act in individual cases. The Mental Capacity Act clarifies the person-centred focus of the test of capacity, and supports opposition to normative assumptions about choice. • Operation of the Act exposed conflicts between the value bases and priorities of different agencies. • The interface between the Mental Capacity Act and public health legislation will raise difficult issues for courts.

PRACTITIONER	**CASE I** (pre Act)	**CASE 2** (post Act)	**IMPACT of ACT**
J Assistant Practitioner, working with older people.	Client with alcohol problem evicted from property and re-located elsewhere. GP and District Nurse pressed for him to be given services which he refused. • Choice of lifestyle not an indicator of incapacity. • Other agencies not understanding that services could not be imposed. • Social worker's long-term relationships with client informative for assessment of capacity.	Patient discharged from hospital following a fall. Hospital felt that she would not be safe at home: not clear that staff had discussed capacity with her, or that the patient had played a significant role in the discussion. Family's ability to support the patient was in doubt. Careline alarm and memory prompts enabled safe return home, following re-assessment by social worker in the community.	• Different agencies / locations continue to have different understandings of the centrality of the Act. In the current case, the hospital's priority was a 'safe' discharge rather than an assessment of capacity. • Importance of assessing patient's strengths independently of family concerns, and devising a risk management plan in consultation with the patient. Facility to record this needed. • Awareness capacity is decision-specific and time specific. The emotional impact of family conflict may distort the perception of capacity and this has to be compensated for in the assessment process.

PRACTITIONER	**CASE I** (pre Act)	**CASE 2** (post Act)	**IMPACT of ACT**
K 8 years qualified, Social Worker with older people.	Services unable to support physically disabled woman in own home, where there were real risks of infection from insanitary conditions. A mental health assessment said she was not suffering from mental disorder and had capacity. Following an emergency admission to residential care she was persuade to remain by an authorative family member. • Social worker had seen a significant deterioration over several years, but had no legal mandate to intervene. • The experience of a number of bereavements appeared to be a significant factor in the deterioration that was observed.	Bereavement was also a significant factor in this case affecting the client's mood and functioning, but there was no formal diagnosis of mental disorder. Risks of neglecting self care and medication were addressed by home care and support from pharmacist. Some concerns in this case that family were exaggerating risks in order to ensure her admission to residential care.	• If the facts of case 1 were to arise following the implementation of the Act, the client would remain at home in very risky circumstances with no support services. • Professionals need assurance not only that no liability will follow in such circumstances, but that communities will also understand the absence of a legal mandate to intervene. • Further analysis needs to take place of the impact of psycho-social factors on a formal assessment of capacity.

PRACTITIONER	**CASE I** (pre Act)	**CASE 2** (post Act)	**IMPACT of ACT**
L Qualified 1 year, Social Worker, working mainly with physically disabled people.	Increased home services for client who was unable to manage her medication. Diagnosis of Alzheimer's was on file. Also modestly increased support from friends secured through a direct payment. • No formal assessment of capacity in this case. • No liaison with previous CPN support, or memory clinic. • What test of capacity should be applied to receive or increase direct payments.	Husband becoming aggressive to wife – diagnosed with Alzheimer's. Short term care arranged for him became permanent. Very clear this was his decision, and not his wife's, and that he had capacity to make this decision.	• Social worker devised own check list (based on training under the Act) and applied it to the facts of the case. Has increased confidence. • Capacity issues now prominent in recording; some concern it may not be appropriate to send all of this to carers. • Act has reinforced good practice in linking with other involved professionals, and finding out more about the client's history. • Capacity to consent to and manage a complex package of direct payments, or an individualised budget is in need of clarification. There are also particular concerns about direct payments recipients employing unsuitable personal assistants.

PRACTITIONER	**CASE I** (pre Act)	**CASE 2** (post Act)	**IMPACT of ACT**
M Qualified 8 months, Social Worker with Older People.	Client with dementia supported by friend who found it difficult to enable the person she was helping still to make decisions and stay in control. • The importance of encouraging supporters to see beyond the diagnosis, to the issue of capacity to continue to make specific decisions. • The helpfulness of Alzheimer's Society literature which explains how dementia affects people differently and is not global in its impact.	Family pressing for admission to residential care of man with a diagnosis of vascular dementia. Admission took place and permanence was confirmed at review when staff said he had settled well and challenging behaviour had diminished.	• More confidence in challenging family's assumption that seeking the opinion of the person with dementia "had no point". • Act has encouraged more careful recording of meetings, but also of behavioural observations. • Well informed colleagues provide a network of support. • Concerns remain over cases where risks are high, but the client has capacity.

PRACTITIONER	**CASE I** (pre Act)	**CASE 2** (post Act)	**IMPACT of ACT**
N 5 years qualified, Social Worker working in a community team with older people and physically disabled people.	Younger disabled person with short-term memory loss, following stroke. Lack of understanding in taking her medication prompted referral, but issues of debt, social isolation also emerged. • Casework was informed by an awareness that a recovery period could lead to regaining capacity. • Psycho-social interventions increased confidence, money management skills, and better structures within which she could make her own decision.	Older person in isolated location with no mains electricity or water, and concerns from Environmental Health. Currently receiving treatment for physical disorder. Whether she has the capacity to return home. Consultant psychiatrist has diagnosed paranoia and a cognitive deficit. An IMCA referral is being considered in anticipation of a move to residential care.	• In case 2, the Act has raised the ethical question "is this about her living conditions, or how she 'chooses' to live?" and dilemmas in taking away choice. • If this person had not been admitted to hospital (following a call-out to paramedics), what authority would there have been to "take and convey" her to residential care if she was not competent? What also is the relationship between the Mental Capacity Act and guardianship? • In both cases, the importance of social work time and skills as a 'resource' in assessment, and in pursuing less restrictive alternatives. • Practitioner interest in the Act has led to networking with local solicitors.

			• Greater awareness of the potential for challenge has led to better minuting of meetings and recording.