

## **MCA Application: Social care settings**

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### **Introduction**

Following the *Mental Capacity Act* (MCA) becoming law in 2005, and prior to its coming into force in 2007, there was a sustained effort to train support staff in the many social care settings where this new law was applicable. This training drive was necessary because, prior to the MCA, mental capacity law had evolved in the courts through consideration of a small number of cases that concerned serious medical treatments. These included the withdrawal of artificial nutrition and hydration (*Airedale NHS Trust v Bland* (1993)), blood transfusion (*Re T* [1993]), tissue donation (*Re Y* [1997]), and the provision of experimental medication for terminal illness (*Simms v Simms and another* (2003)). In line with the Law Commission's recommendations, the MCA extended the application of the law to 'all acts in connection with care or treatment' (MCA, s. 5), meaning that, overnight, social care settings and informal family care environments immediately fell within the scope of the legislation.

The government's intention was that the new legislation, with its principles set out in Section 1, would be a radical and enabling law whose focus would be on involvement, inclusion and choice. The emphasis of the MCA's provisions is to do things *with* rather than *for* people who may have difficulties making decisions for themselves – an orientation towards person-centred care that aligned closely with the historical and philosophical trajectory of social care services. Yet, its primary purpose as legislation consists in its new regulatory requirements that determine when, and under what circumstances, care staff who need to provide support to an adult are permitted to make that decision on behalf of the adult concerned, when it would normally have been a decision for the adult to take for him/herself.

In getting to grips with this implicit tension within the MCA it is useful to consider the MCA from two standpoints: the first concerns the philosophy of care that underpins the legislation, and the second is more specifically on the legal powers that it authorises – powers which can be particularly significant when the person being supported is acting in a manner that is potentially putting him/herself at risk. Specific issues dealt with by the MCA in social care settings concern adults' capacity to make decisions; uncertainty about how to conceptualise best interests, the freedom to act to shape everyday life in a supported environment, and issues around the broader responsibilities that support staff have in planning their work and care interventions. In this chapter we aim to show that the application of the MCA in these settings is particularly demanding given the general challenges faced by the social care sector, the heterogeneity of those being supported, and the range of decisions that need to be made on a day-to-day basis – from the relatively minor to the potentially very serious.

## **Background: The changing landscape of social care services**

The focus of social care policy has, over many years, moved away from hospital-based or institutional care to a much greater emphasis on home-based interventions that respect individual choice, and that broaden the availability of support options according to need. The social care landscape is now characterised by services that offer a few hours a week of home-based care, to supported living, to long-term residential care, typically in suburban home-like environments. Unlike in-patient healthcare, social care support is provided through a marketplace of services in which private and third sector organisations bid for contracts, and the quality of care subsequently provided is monitored, in England and Wales, through periodic Care Quality Commission (CQC) inspections. This market system and the division between purchasers (commissioners) and providers of services, it was argued, would be best able to respond to changing needs and deliver high quality support. However, there are increasing concerns that this system is dysfunctional and under-funded by local authorities. With increasing pressure on resources, the viability of individual social care providers and the system as a whole is at risk. Importantly, these changing circumstances are also relevant to the application of the MCA, and the propagation of its empowering principles.

In addition to the complex and changing service models that exists, it is also important to appreciate the heterogeneity and increasing complexity of need of those in receipt of these services. It is particularly those adults with disorders that have impacted on the functioning of the central nervous system, and/or have resulted in significant mental health needs, that come within the remit of social care services. This is because it is these adults who require care or support in numerous aspects of their personal and social lives, or because of more specific health needs. Examples include people with intellectual (learning) disabilities, enduring mental illness, an acquired brain injury, or dementia. For some, the impairment or disability in question will have been life-long. For others, they may have developed a progressive disorder of the brain later in life. Some will experience life-long impairments that impact on their capacity to make all decisions, whilst others will have cognitive impairments or mental states that fluctuate over time. Changing demographics will also have a major impact on need, given the likely rise in age-related cognitive illnesses. Between 2012 and 2032, the population of 65-84 year olds and over 85s, in the UK, is expected to increase by 39 and 106 per cent respectively (King's Fund, 2012). Alongside improved survival rates of people with complex disabilities of childhood origin, and higher expectations placed on the quality of services provided, these trends are all likely to add to the complexity and pressure on the services concerned.

## **The MCA in social care practice: everyday decisions that need to be made**

The MCA sits in the background of this complex and changing care landscape, providing the overarching legal framework to permit everyday care and treatment decisions to be made on behalf of others. In hospital settings the decisions in question will in general be focused around the need for investigations and

treatment. In contrast, in social care the decisions may be more nebulous and are likely to be concerned with a mixture of routine issues, including day-to-day decisions about what to eat, what to wear and what to do during the day. However, there will also be decisions that need to be made that are of great significance, and the outcomes of which have the potential for both benefit and harm to the person concerned. Examples of such potentially problematic decisions include moving between social care settings and the basic freedoms that the person will be able to enjoy in a different residential environment. Decisions around personal relationships and friendships can also be very challenging, particularly when there are concerns about exploitation and abuse, or when the person is engaging in behaviours that stand in stark contrast with the values or preferences they exhibited earlier in life. Those providing social care support also may be faced with what to do when there are concerns about a person's health and the person him/herself is refusing to do anything about it.

In all situations, those providing support should have a good relationship with the care recipient, and be appropriately supported themselves by senior colleagues to make decisions and take action in ways that addresses any legal, ethical or practical concerns that go beyond mere questions of mental capacity. During the course of providing support it may, for example, become apparent that, rather than a question of cognitive understanding, the problem for the person is knowing how to deal interpersonally with 'friends' who are acting in an abusive manner, or are his/her only 'friends' in what is for him/her a lonely existence. Or, perhaps, the problem may be fear about going to the GP or the hospital following negative experiences of past health interventions. These are examples where the issue is not fundamentally about whether or not someone has the capacity to make a decision. Rather, it is the challenges in supporting a service user to negotiate relationships, or to manage anxiety, that staff need to attend to.

Care must also be taken to ensure that regulatory powers around mental capacity and substitute decision-making do not function to turn the value of empowerment on its head, seeing a judgement of capacity as foreclosing the possibility of providing further care and support interventions to the person. There have been recent examples where a person in receipt of care has died for reasons that could have been prevented, but where it appears that nothing was done as the person was considered to have the capacity to make the relevant decision. Examples include a person with ID, Richard Handley, who died as no action was taken to address his chronic constipation and a person with ID and severe epilepsy, Connor Sparrowhawk, who drowned in a bath whilst unattended having had a seizure. Lying in the background of the MCA are ongoing ethical issues concerning how best to balance respect for choice against the risk of harm, and these issues will be relevant to address, regardless of whether the person is judged, legally, to have the capacity to make a decision for him/herself.

In cases like these, the issue of the person's capacity to make the relevant decision is certainly relevant. However, appropriate care also hinges on the quality of support provided in the round: the relationship that staff have with the person concerned, and staff members' willingness to better understand the person's apparent refusal, to negotiate appropriate harms and benefits in the social care

environment, and then to act accordingly. In many circumstances, there will be systematic issues that will need to be addressed in social care in order to resolve these issues and to apply the MCA in ways that adhere to the overarching spirit of the legislation. The quality and expertise of support staff and particularly senior support staff, the availability or not of other expertise, and the practicalities of lawful interventions in circumstances where those receiving care may have funding for only limited support, all need to be recognised as significant in this context.

### **Assessment of decision-making capacity in social care settings**

The MCA is clear that the assessment of mental capacity, and an orientation towards care and support more generally, should start from presuming that the person is capable of autonomous decision-making. If there is doubt as to the person's capacity, in relation to a specific decision, this is to be determined by a two-stage test. The first stage is to determine whether or not that the person has 'an impairment or disability of the brain or mind', and this diagnostic threshold will almost always apply in social care. The second stage requires a determination that, because of this impairment or disability and having provided the person with time and the necessary information in the most easy-to-digest format, the person is unable to understand, retain, or use and weigh up the information, and/or to communicate a choice.

We draw on three examples of people living in the community where there was uncertainty about capacity and where their behaviour had the potential to put them and/or others at risk. These examples are:

- **Miss A** has a severe ID. She receives intensive support in all day-to-day activities in a residential care home. She has been seen to be engaging in sexual touching with a male resident.
- **Mr B** had a severe traumatic brain injury as a teenager. Now 25, he is spending the money received from his insurance company in ways that his support workers consider are reckless.
- **Mrs C** has dementia. She is still living in her own house but behaving in ways that are beginning to put her increasingly at risk of harm. Her family are considering supporting her to re-locate to a residential care home but are concerned that this is not something that she would want.

First, social care staff need to be aware what information needs to be known and understood in order to be judged to have the capacity to make a specific decision. Generally, this involves determining whether the person understands specific facts about the decision to be made – the so-called “salient facts” (LBJ v RYJ & VJ [2010]) – rather than the broader context or the wider implications associated with making the decision in a particular way. Thus, Mr B and Mrs C will be judged to understand the information, and use it and weigh it in making a decision, if they can give a coherent, reasoned account of the decision, and can reasonably foresee the consequences of it. Even if care staff do not agree with how Mr B and Mrs C are using or weighing up the information in making a decision with potentially negative consequences, this is irrelevant to the question of whether they can, in

fact, use or weigh the information in the decision-making process. Also, Mr and Mrs C do not need to be able to grasp and consider all potential risks associated with the decision. Nor do they need to take a considered view on the relationship between the decision and the harm that might result, in light of their personal values or preferences. A common feature of social care settings is the interface between i) individual vulnerabilities, ii) environmental circumstances, iii) the demands of a particular decision-making task, iv) a potential changing or fluctuating impairment in function, and v) the porous boundary between what might be a capacitous (but foolhardy decision) versus an incapacitous decision. Those providing support will have to make difficult judgments about the person's capacity in such circumstances.

Decisions concerning sexual relationships, and the capacity to make these decisions, fall outside the scope of the MCA's framework. However, these decisions do arise frequently in social care contexts, and case law has adopted a slightly different stance to the one codified within the MCA. If the person is unable to i) describe the nature of the act, ii) understand the possible consequence of the act including the risk of sexually transmitted diseases, iii) recognise that the persons concerned had a choice and had the right to refuse, and, iv) where relationships are heterosexual, understand the possibility of pregnancy, then he/she should be considered to lack the capacity to consent (*IM v LM & Others* [2014]). This lack of knowledge and understanding may, of course, be due to a lack of education rather than just the person's cognitive impairment. If that was a possibility, it would be expected that the person might be supported to gain the necessary information. This position also does not mean that responsibility of support staff stops ends at this point, with continued input and support necessary if the person is identified as being at risk from entering into an abuse and exploitative regardless of the fact that a determination of capacity has been made.

In social care settings, the notion of a culture change in terms of respect for autonomy is most relevant and has implications for applying the MCA's capacity assessment provisions. Those providing support need to act in a forward-thinking manner that facilitates and involves the person concerned in the day-to-day decisions that they may have to make. This will include the routine support that is offered on a day-to-day basis, but also requires social care staff to be proactive, and to think and plan ahead using more formal tools. With Mrs C, for example, it might well be possible to assist her to make the significant decision about where she receives care, if this is addressed in the early stages of her dementia. This would require advance and personalised care planning, and ensuring that others (including family members) are aware of the relevant supports that need to be put in place to maximise that person's ability to participate in the decision and to exercise a choice. This can be particularly challenging if resources are limited, if support staff who are frequently changing, or if there are disagreements among family members and others as to what should be done. If the decision about a care placement that Mrs C needs to make is unexpected, then the skills required from those who know her well will concern how to use the correct resources available to present her with the relevant information in a way that can optimise her understanding and communication abilities.

Finally, there are also differences in what is expected, depending on the nature, complexity, seriousness and urgency of the decision in question. The threshold below which someone might be judged on the balance of probabilities to lack capacity should be lower where the outcome was life-determining. In Miss A's situation, for example, support workers will be required to make continuous capacity assessments for each and every decision that they make on behalf of Miss A. These decisions will include what time Miss A gets out of bed, what she eats for breakfast, and how she spends her day. Whilst staff should constantly be judging Miss A's decision-making abilities and encouraging her participation in these daily activities, this process will need to be an informal and continuous judgement rather than an explicit and separate process. If not, there is a clear risk that the requirements of providing high quality care and support to Miss A will be under threat. In contrast, if evidence of her mutual sexual touching with another resident triggers a capacity assessment, this serious question of bodily integrity and sexual freedoms will need to be considered carefully, and possibly with additional specialist input from psychiatrists or other suitably experienced professionals.

### **Determining 'best interests' in social care settings**

The MCA also proscribes which approaches to substitute decision-making are lawful for those who lack mental capacity. Of overarching importance in the social care context is the codification of the 'best interests' principle to guide how a decision ought to be made on behalf of an adult who is judged to lack capacity. One immediate difficulty facing all health and other care professionals is that the MCA's approach to best interests aims to shape the process of how to deliberate about the different factors that are relevant to a person's best interests, rather than precisely determining what best interests actually consists in, from a universal legal standpoint (Dunn *et al.*, 2007). There are of course good reasons for this; respect for the person means attending to his/her individual preferences and values in ways that capture a truly person-centred approach to making a judgement about what would be best for him/her. In practice, however, this can rise to ethical dilemmas for those who need to apply the law. We consider two types of challenges that can arise.

#### Balancing past and present wishes, feelings, beliefs and values

It is common for mental incapacity to occur as a result of impairment that arises late in life, and after the person has lived a life in which they have developed preferences and values. The ethical principle of respect for precedent autonomy underpins the MCA's framework for substitute decision-making, codifying a role for advance decisions to refuse treatment and for consideration to be given to the person's previous values and preferences.

Difficulties can arise, however, when there appears to be direct conflict between these values and evidence about the person's in-the-moment preferences. This can be the case in care of people with dementia, such as Mrs C. If we imagine that Mrs C lacks the capacity to make a decision and it is uncertain whether it would be in her best interests to move to a care home on the grounds that she had always expressed the view to her children that she never wanted to live in a nursing home, but it was uncertain whether she would actually maintain that view when she

moved to the home. If a trial stay at the care home was arranged and Mrs C appeared to really enjoy her new home environment, the challenge in determining her best interests would require her previous values and preferences to be weighed against her current (positive) experiences.

In relation to more day-to-day decisions, a person with dementia who had been a life-long committed vegetarian on moral grounds might find herself distressed when denied the bacon that all other residents are having for breakfast. The relative weights to be given to previous values and current experiences is likely to depend on i) the strength of the previous values, ii) what would need to be done to respect these values, iii) the impact of respecting previous values on current well-being, and the strength of the person's current wishes and desires (Hope *et al.*, 2010).

#### The best interests of those with life-long, profound intellectual impairments

The focus on determining best interests by reference to a person's past and present wishes, beliefs, feelings and values under the MCA also gives rise to a small but significant group of adults who have life-long and profound disabilities. Those with profound and multiple intellectual disabilities (PMID) are likely to lack, and have lacked, the capacity to make even mundane, everyday decisions for their entire life, and who do not offer a clear or interpretable sensory response from any external stimulus. Thus, they have no previous values or wishes on which to base a substitute decision, and it might be challenging or even impossible to ascertain any current experience-driven preferences from them. How should the best interests of these adults be conceptualised?

In practice, there is evidence that support workers in residential care settings draw upon their own life experiences and understanding of a meaningful life in making substitute decisions on behalf of adults with PMID (Dunn *et al.*, 2010). Some have argued for substantive ethical principles such as respect for human dignity to shape decisions in this context (Cantor, 2005), whilst others prefer an approach that recognises, and responds to, the lived realities of people with PMID. This means recognising that people with PMID live alongside other individuals, in families or in communities of residents and caregivers, who do have a range of commitments to comprehensive sets of values, and that drawing on these values, in this context, is a justifiable strategy to adopt (Lim *et al.*, 2016).

#### **Managing the deprivation of a person's liberty**

The final component of the MCA's application in social care that we consider is the additional requirements associated with the MCA's Deprivation of Liberty Safeguards (DOLS), introduced in 2007 as part of the legislative process of amending the Mental Health Act 1983. The highly procedural and time- and resource-consuming nature of DOLS has led to questions being raised about their appropriateness. Indeed, the Law Commission has recently recommended their wholesale replacement (Law Commission, 2017), as part of making some more general suggestions for improvement to the MCA, and the government has committed to overhauling and replacing the current DOLS framework with new

Liberty Protection Safeguards (LPS), endorsing the Law Commission's recommendations (Department of Health and Social Care, 2018).

The current DOLS review process is undertaken by people specially appointed by the local authority who are required to determine whether, amongst other things, a deprivation of liberty would be in the best interests of the person concerned. DOLS applications and approvals are predominantly made in social care settings; in 2015-16, over three quarters of all applications came from registered care homes, in both the local authority and private sectors. The key issue for those working in social care is the need to recognise when a deprivation of liberty might be taking place, in order to seek the appropriate authorisations. Following the 2014 Supreme Court judgement in *Cheshire West*, a deprivation of liberty is recognised as having taken place when a person lacks the capacity to consent to care arrangements that involve him/her being subject to continuous supervision or control (for a "non-negligible period of time"), and where s/he lacks the freedom to leave that continuously supervised or controlling environment. Importantly, whether a deprivation of liberty has occurred is not relative to the person's degree of impairment or support needs, what a 'normal' life could otherwise be like for that person, or whether s/he is happy and comfortable in the liberty-depriving care setting. This broad and non-relativist account of deprivation of liberty led many care homes to recognise that situations in which they thought were merely placing certain restrictions on residents' lives actually qualified as deprivations of liberty, with a 1000% increase in the number of DOLS applications submitted in England in the year following the *Cheshire West* judgement (Health and Social Care Information Centre, 2015).

For those devising care plans in social care, considering a person's ability to exercise their freedoms within the care environment needs to be placed front and centre of the care planning process. Arrangements that are in the best interests of a person lacking capacity and that only place restrictions on his/her liberty rather than depriving him/her of his/her liberty are always to be preferred – and these restrictions should be the least necessary to act in that person's best interests. Care home staff will need to be imaginative in how they meet a person lacking capacity's care needs when s/he is behaving in such a way that requires freedom restricting interventions to be used in the day-to-day delivery of care. After all, care home arrangements can easily slip into DOLS-eligible territory if liberty-restricting steps are imposed for non-negligible lengths of time. This might include steps being taken to impose a curfew on a person's movements outside the care home, the use of keypad locks on care home doors to prevent a person from leaving the home without supervision, and instigating a high-degree of observation or control in the home environment itself.

One common issue that can arise in care homes is that a person-centred care decision that triggers a DOLS application for one care home resident might, because of its impact on the entire community of residents, require DOLS applications to be submitted for all residents. Take the example of a keypad lock on the care home door. If this is introduced to prevent a care home resident who lacks capacity from leaving the home without supervision in her best interests, it will likely constitute a deprivation of liberty – particularly if she is only permitted



to leave the home on infrequent supervised breaks. However, this lock will have knock-on effects on other residents' freedoms too, which may well not be in these residents' best interests because the lock has not been introduced as a response to their individual needs. Care planning around individual deprivations of liberty must, therefore, take a broad look at any communal 'ripple effects' on the liberty of other residents living in the same environment.

Social care service providers also need to be aware that DOLS applications can only be made from care homes. Other social care services, such as supported living services, shared lives schemes, extra care housing, and all forms of domiciliary care fall outside the MCA's DOLS regime. Care arrangements that deprive a person lacking capacity of his/her liberty in his/her best interests in these supported living settings can only be approved by the Court of Protection. It is less likely that deprivations of liberty will arise in such services because care interventions are likely to be less intensive, and the freedom to move around and leave the home environment are widely seen as a defining feature of these care arrangements. However, those working in these supported living services cannot afford to be complacent. Best interests interventions by staff in supported living settings that function to i) restrict the person's ability to access the community, ii) leave the home, iii) impose physical restraints on the person, or that iv) require very rigid daily regimes to be put in place might constitute the deprivation of liberty. If so, approval from the Court of Protection will be required. The intention is for the new LPS to apply in all care settings in which the Article 5 right to liberty is engaged (including in domestic settings where the state has positive obligations to meet a person lacking capacity's care needs).

## **Conclusion**

The MCA has always been a snug fit with a social care sector that has long embraced an empowering, person-centred approach to planning and delivering care and support. This partly explains why the MCA has been well-received in social care, even if its provisions are not always fully understood or if the lawful basis of substitute decision-making is not explicitly recognised (Manthorpe and Samsi, 2014).

Yet, the close alignment between the ethos of the MCA and social care practice must not function to render invisible certain specific challenges that arise when applying the law in this context. As we have shown in this chapter, such challenges are numerous, and require careful thought in order to be resolved in a legally and ethically sound manner.

First, the assessment of capacity involves specific legal criteria, but it is one that must be situated within interpersonal care relationships and system-level care planning and delivery decisions that must address broader questions of how the needs of social care service users can be best met. Second, the best interests principle needs careful interpretation if it is going to be able to handle wide-ranging decisions from the utterly mundane to the life-changingly important, particularly for adults with dementia and those with learning disabilities whose past and present values, wishes, beliefs and feelings will differ in ethically

significant ways. Finally, decisions made on behalf of an individual adult lacking capacity, particularly when these decisions concern the deprivation of his/her liberty, can never be deliberated about entirely in isolation from those of other adults who share the communal living environment, and whose own interests and freedoms could negatively be affected by any substitute decisions made. Social care staff need support, resources, and experience if they are going to be able to handle the correct application of the MCA in their daily working lives.

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