



Supporting Capacity for Decision Making in
Everyday Social Work Practice

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Abstract

Social workers have a duty to take 'all practicable steps' (Mental Capacity Act 2005, s.1(3)) to enable individuals to make their own decisions. This support principle is core not only to the Mental Capacity Act 2005 but also the Care Act 2014. The aim of this research was to explore how social workers, employed in statutory adult social care services in England, understand and apply their statutory duties to support decision-making as opposed to making substitute decisions on behalf of people.

Informed by evidence that shows what social workers say they do and the actions they take in practice are not necessarily aligned, this study adopted a qualitative and observational approach of practice in action in the private settings of people's homes. This offers an important contribution as studies of practice in relation to the Mental Capacity Act in such settings are limited.

My findings show that whilst the social work profession positions itself as champions for upholding human rights, challenging discrimination and oppression, and empowering people through their relationships, their competing responsibilities in statutory practice are difficult to balance. When it comes to a choice between upholding a person's right to make their own decisions versus protecting adults at risk from abuse or harm, protection is the dominant focus. This is influenced by social policy, cultural attitudes to the tolerance of risk, and cultures of blame.

Social workers' talk of the actions that they took to support decision making was more comprehensive than that which was observed in practice. This was in not any way considered as a means to deceive; rather a demonstration of how social workers wish to practice and empower people is curtailed by the health and social care system and organisational policies and procedures. In many aspects they are themselves powerless within this system. Practise is seen at the individual level, with social workers holding little belief that they can challenge wider structural and social issues, but small acts of discretionary practise are seen, shining a light on the inherent values of the profession.

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Acronyms and abbreviations

BASW – British Association of Social Workers

CRPD – United Nations Convention on the Rights of Persons with Disabilities

DH – Department of Health

DHSC – Department of Health and Social Care

DWP – Department for Work and Pensions

MCA – Mental Capacity Act 2005

NICE – National Institute for Health and Care Excellence

NHS – National Health Service

SCREC – Social Care Research Ethics Committee

SWE – Social Work England

UK – United Kingdom

Chapter 1: Introduction

This thesis provides a perspective on social workers' interpretation and application of their legal duties to support adults in need of care and support. My interest lies in how social workers understand and go about supporting people to make decisions for themselves. I was interested in exploring how social workers use supported decision making in meeting their Professional Standards mandate, which includes promoting human rights and social justice, placing individuals' views, wishes and feelings central to decision making, and enabling people to have full participation in decisions (Social Work England 2019); and the interplay of meeting statutory and employer obligations within the context of local authority adult social care services.

The Mental Capacity Act 2005 (MCA) is a legal framework for people who have difficulty with decision making due to 'an impairment of, or a disturbance in the functioning of, the mind or brain' (MCA, s.2(1)); or who wish to make arrangements for a time in the future when this may occur. One of the core principles of the MCA is that people must be provided with 'all practicable steps' (MCA, s.1(3)), referred to as the *support principle*, to help the person make decisions for themselves. The right to make 'unwise decisions' (MCA, s.1(4)) is also made explicit. Where 'all practicable steps' have been taken without success, the MCA provides a legal framework to make substitute decision for people in their 'best interests' (MCA, s.1(5)).

Social workers employed in adult social care carry multiple roles and powers which do not easily marry together. The role of statutory social work, stipulated through legislation, includes promoting wellbeing; preventing and reducing people's need for support; meeting the social care needs of those who need extra support, including carers; and the protection of adults at risk, referred to as safeguarding (Care Act 2014). Services are targeted, with eligibility determined through a needs assessment and subsequent care and support planning. Gatekeeping of resources is an inescapable function, and the power of the professional significant. In limited circumstances, social workers may take actions without the person's consent, including as part of adult safeguarding (Care Act 2014, s.42), or as part of making substitute decisions under the MCA. With regards to UK legislation, it should be noted that there is policy divergence across the devolved areas of England,

Scotland, Wales and Northern Ireland. The MCA is applicable to both England and Wales; the Care Act 2014 only to England. The focus of this study is England.

Through my statutory social work career, the criticisms towards an overly bureaucratic system grew from practitioners and academics (Munro 2011; Jones 2014; Trevithick 2014). It has been argued that this bureaucracy and managerialism has resulted in 'zombie social workers' (Forrester 2016) who are limited to the what and when, whilst overlooking the why and how of practice.

When working as a Principal Social Worker, I had the role of leading on practice. Social workers consistently voiced their frustrations that they spent too much time completing administrative functions to feed the system, to the detriment of spending direct time with people to understand and support them through life's challenges.

The seeds of this study arose from my contact as a team manager, with a young woman who was being illegally deprived of her liberty by professionals, due to concerns about her vulnerability. The 'protection imperative' (CC v KK and STCC [2012] EWHC 2136) took precedent over the person's expressed wishes, her emotional needs and opportunities to develop relationships and life skills equal to peers of a similar age. Following one social worker's questioning and challenging of the status quo, the Mental Capacity Act 2005 was used to uphold this young woman's rights under Article 8 of the European Convention of Human Rights, as included in domestic law by the Human Rights Act 1998. By utilising 'all practicable steps' (MCA, s.1(3)) to support her decision making and opportunities to develop skills, her capacity to make decisions about relationships and increased independence was clearly evident. The considerable difference this young woman was then able to make to her life and what that meant to her has never left me.

The central focus of this thesis is the statutory duty of the 'support principle' and social workers application of this in their daily practice. In simple terms the 'support principle' means supporting and enabling people to make decision for themselves to avoid, wherever possible, others making decisions on their behalf in their 'best interests' (MCA, s.1(5)). Additional duties under the Care Act 2014 align with this principle. The detail of these duties are outlined in Figure 1 below.

In comparison to other statutes such as the Mental Health Act 1983 (amended 2007), the MCA has relatively few checks and balances, and the 'support principle'

has been found to be neglected in practice (House of Lords 2014). How social workers balance their competing obligations to empower, to promote choice and control, to protect from abuse or neglect, as well as their function of gatekeeping of resources, is therefore pertinent.

In England, the Care Act 2014 builds on the Mental Capacity Act 2005 principles which places people's views, feelings and wishes central to decision making, irrespective of mental capacity. In addition to the requirement to provide relevant information, the Care Act 2014 places a duty on local authorities to involve people, their carers and anyone else of the person's choosing in the assessment process (s9(5)), and in care and support planning (s25(3)). The local authority is required to maximise people's involvement by providing them with the necessary support to enable participation in decisions about their care and support. This includes the involvement of an independent advocate (s67(2)) in the absence of an 'appropriate person' (s67(5)).

The MCA explicitly states that 'A person is not to be regarded as unable to understand the information relevant to a decision if he is able to understand an explanation of it given to him in a way that is appropriate to his circumstances (using simple language, visual aids or any other means)' (s3(2)).

The term 'supported decision making' is used within the Care Act Statutory Guidance referring to the requirement to maximise the involvement of people who may struggle to express their needs (DHSC 2023, s6.11)); and/or have substantial difficulty in navigating the care system, and to routinely provide options in clear accessible formats (DHSC 2023, s10.4)).

The term 'support principle' will be used as a general term throughout this thesis when referring to any of the duties described.

Figure 1: Statutory underpinnings of the 'support principle'.

Chapter 2: Literature review

This chapter offers a brief history of statutory social work, its relationship with human rights and empowerment, and the legal frameworks that dictate and guide supported decision making practice. Empirical research of the 'support principle' in practice is then discussed. This provides evidence of the gaps in knowledge which in turn shapes the research questions of this study.

Within health and social care legislation, policy and guidance in England and Wales, the terms 'supported decision-making' (Care Act 2014; Bogg & Chamberlain 2015); 'all practicable steps' (MCA 2005; Department for Constitutional Affairs 2007); 'supporting decision-making' (NICE 2018); 'support in decision-making' (Finlay 2009); and the 'support principle' (Series 2015), all refer to assisting a person to make and communicate a decision. In contrast, the United Nations Convention on the Rights of Persons with Disabilities (CRPD) 2006 has a much broader definition of the term 'supported decision-making'; its definition and influence on domestic policy and practice will be discussed later in this chapter.

Peer reviewed literature was sourced through Scopus, Assia, CINAHL, PsychINFO. Given the changing of legislation and policy that impacts on social work practice, the primary literature search focused on articles and research published from April 2007, when the MCA was implemented. Search terms used included "mental capacity" and "supported decision making", "supporting decision making", "support principle", "practicable steps", "decision making". In addition Google Scholar and Social Care Online were used. Grey literature on statutory policies, procedures and professional guidance for social workers in England were sourced through the Department of Health and Social Care (DHSC), Social Work England, the British Association of Social Workers (BASW), and the National Institute for Health and Care Excellence (NICE).

Although this study is focused on social work practice, legislation and policy in England, the search for literature went beyond this jurisdiction to gain an understanding of the 'support principle' in other contexts. A broader historical frame on social work was also researched to provide context for how the social work profession has evolved.

2.1 Statutory social work: a brief history

Social work is defined internationally as a profession that promotes social development, change and the empowerment of people, with principles of human rights and social justice at its core (International Federation of Social Workers 2014). Globally, social work is diverse, holding varying meaning to the profession's core purpose. Understanding the context within which social workers are employed needs to be understood as the balance of social change against social maintenance and social control varies across countries.

Within the UK social work emerged with the development of the welfare state, as a discretionary rather than universal provision (Payne 2005). Social workers are employed in various third sector and public body organisations supporting adults, children and families to improve their lives and protect from harm (BASW 2022). Social services departments, established in England and Wales in 1971 under the Local Authority Personal Social Services Act 1970, on the recommendation of the Seebohm Report 1968, became the greatest employer of social workers, and remains so to this day (Skills for Care 2023). Prior to the creation of these generic services, adult welfare had been fragmented, inconsistent, and largely related to older people and mental health (Gray et al. 2013). This was widened to disabled people through the Chronically Sick and Disabled Persons Act 1970; and health related social work was moved from NHS to social service departments in 1974' (Payne 2005).

With the 1970s having been described as the high tide of social work (Langan 1993), practice within social services had a focus on community work and workers held wide discretion in how services were delivered (Payne 2006). Whereas trust had been awarded to professionals to apply their knowledge and skills in direct practice, it is argued that the professional autonomy of social workers was increasingly challenged as the political influence of neoliberal ideology took hold (Spolander et al. 2015). Social policy took an increasingly neoliberal turn following the election of Margaret Thatcher's Conservative government in 1979. Policy was influenced by the high value placed on a free market being best placed to meet the needs of society, as opposed to the state, reducing public expenditure, and despite changes to government this ideology continues to dominate (Spolander et al. 2015).

With increasing criticism about the value of social work, an inquiry into the roles and tasks of social workers was commissioned by government, culminating in the Barclay Report (Barclay 1982). Its recommendations for developing community social work, working in partnership with carers and the wider community to support individuals, was largely ignored by Thatcher's government. Instead, as recommended by Pinker (1984), the statutory role was prioritised. Thus the primary role of statutory social workers was focused on securing arrangements for the discharge of statutory duties rather than delivering the more relational and therapeutic aspects of social work practice. This resulted in a significant focus of practice being on the identification and management of risk, with the aim of protecting people from abuse and significant harm.

Social problems became individualised and radical social work, having been developed in the UK between 1960s and 1980s (Fook 2016), became less visible in the last two decades of the twentieth century (Rogowski 2010). Beck (1999) refers to modern civilisation as a 'risk society', one that is 'increasingly occupied with debating, preventing and managing risks'. Such a weighted focus on risk aversion is in part reflected in the level of audit and monitoring that takes place. Part of mental capacity practice is about risk management. The wider context is that social workers are acutely aware of the potential for high profile negative media coverage if risks or abuse occur and where they are known to services. Because social work is private practice and the associated duties of confidentiality, the profession is limited in how it presents itself to the public and may not always be able to justify their actions or inactions

Though generic practice was the norm, reform of mental health services with the Mental Health Act 1983 introduced specialism with the role of Approved Social Worker, now referred to as Approved Mental Health Professional (AMHP), which saw social workers as 'a defender of legal rights' (Payne 2005, 96). More recently, the Deprivation of Liberty Safeguards that sit alongside the MCA, created the role of Best Interests Assessor which in some ways mirrors the AMHP. This role is often taken up by social workers, can elevate social workers' careers (Hubbard 2018), and is filled with social work values (Hemmington et al. 2021).

Based on the idea that public services should be managed with economic logic (Clarke and Newman 1997), business management structures and systems were introduced to the delivery of social services with the introduction of NHS and Community Care Act 1990. Of significance was the change in functions with a purchaser and provider split. The local authority was responsible for identifying people with eligible needs for care and support based on risks to a person's independence (Department of Health 2003), which was then commissioned through the private market. This meant that in comparison to the more traditional role of relationship-based practice, the social worker role was redefined to a more administrative function (Sheppard 1995; Sullivan 2009), assessing need and arranging provision of services. The increased performance management and the regulation of social work.

Adult social care can be defined as the care and support provided by local authorities, and the mechanisms to achieve that on behalf of government, towards adults who require extra support (Law Commission 2011) to maintain their wellbeing and protect from abuse and neglect (Care Act 2014). This support can extend to people in ill health or with disabilities, older people, autistic people, people with mental health problems, drug and alcohol misuse, and carers.

A significant overhaul of adult social care legislation concluded in the Care Act 2014, the framework of which is outlined in under 2.3. The principle of wellbeing is at the heart of the Act, and grounded in the notion that individuals should have choice and control over their own care, irrespective of their needs. However the local authority role, and by default that of the social workers they employ, remains one that is primarily focused on assessment, support planning, and commissioning of services, not providers of services.

Increasingly social work is being reserved for those with the greatest need, echoing the historical notions of deserving and undeserving citizens. Yet despite the significant changes in policy and managerial practice, ambiguity within legislation and policy, such as 'wellbeing' or 'substantial', within the Care Act 2014, is ever present. This provides the very conditions in contemporary social work practice for street-level bureaucracy that was criticised by Lipsky (1980).

The numbers of people living in England, who may at some point lack capacity in their lives, was estimated at two million people at the time of the MCA's implementation (Ministry of Justice 2007). Undoubtedly this figure will be far greater now and is set to continue to grow. The UK has an ageing population with 11 million people over sixty-five years in 2021, which equates to 18.6% of the population (Office for National Statistics 2023). This is predicted to increase by 32% to 3.5 million people by 2043 (Age UK 2023). There are approximately 1.1 million adults who have a learning disability in the UK (Mencap 2020), people are living longer, and more people are living alone. Whilst dementia is not an inevitable part of ageing, the risk increases with age. The government estimated that there were over 900,000 people living with dementia in the UK in 2022 (DHSC 2022); it is predicted that this number will double by 2040 (Parkin & Baker 2021). These changing demographics mean that the numbers of people whose capacity may be impaired, albeit on a temporary or longer term basis, and who will need support for decision making around care and support, are only set to increase.

2.2 Rights and empowerment

The commitment to the promotion of people's rights and empowerment of individuals are embedded in widely accepted definitions of social work (International Federation of Social Workers 2014; BASW 2021), and professional standards (Social Work England 2020). Standard 3.1 and 4.4. specify social workers are obliged to "embrace and promote the fundamental rights of all people" (ibid), and that support should be provided in line with the duties under the Equality Act 2010.

Regardless of role, social work has a value base that places relationships at its core. There is wide spread literature about working in partnership with those who have need to draw on support, and an emphasis on these being empowering relationships (Ferguson et al., 2020). Yet the reality is few people voluntarily enter into such a relationship. This is particularly so when it comes to social workers employed in local authorities who have a statutory function that includes assessment of need, eligibility determination, the gatekeeping of resources (Care Act 2014), and safeguarding adults at risk (Care Act 2014, s.47).

Whilst having choice and control to make decisions about one's own life, for example where to live and who to have relationships with, are largely viewed as fundamental rights within Western society, 'absolute rights' are limited to right to life, freedom from torture, freedom from slavery and forced labour (European Convention on Human Rights 1953; Human Rights Act 1998). The notion of rights and autonomy are strongly bound to wider philosophical, political and social ideologies about what makes a good society and the individual and collective responsibility of its citizens in achieving this. These are variable across cultures and change over the course of time. Philosophical debates on the concept of autonomy are complex though generally identify dimensions of self-determination and self-governance (Mackenzie & Rogers 2013). The former requires freedom from external influences in order to make practical choices about one's life and determine one's own values and beliefs; the latter is related to internal factors, requiring elements of understanding, often referred to as competence, and will, in order to select and enact decisions in line with one's values and beliefs (Mackenzie & Rogers 2013).

It is argued (Kong and Ruck Keene 2019) that it is problematic for practitioners to assume these conditions are all that need to be known about the concept of autonomy. By adopting the conditions on face value, free of external influence, means those who require support to make decisions may unduly be considered as lacking capacity to make the decision in question. This is in breach of the 'support principle' of the MCA. It is further argued that the act of non-interference could "perpetuate abuse or inequality of groups which require substantive supports to be treated equally in any meaningful sense" (Kong and Ruck Keene 2019, p35).

The existence of a cognitive impairment can bring into question an individual's ability to be autonomous. Whilst theories of autonomy place the ability for critical scrutiny and self-reflection as essential, what is expected in practice is satisfaction of the elements of autonomy, variable to each decision, rather than an ideal of maximal autonomy (Beauchamp 2005). For disabled people in the UK, the right to autonomy is relatively new, having been championed through the disability movement and human rights activists from the 1970s (Duffy 2014), and central to the concepts of self-determination and empowerment.

The disability movement has influenced legislation, policy and social work practice in the UK. Driven by experience of inequality and segregation, as evident by the numbers of people living in large institutions which peaked in the 1970s, it rejected the dominant medical model of disability which focuses on individual blame and looks to prevent or cure (Marks 1997; Shakespeare 2006), and drove the Independent Living Movement. This refers to disabled people having the same freedoms, choices and control equal to others, achieved through provision of practical support as required (Pearson 2013).

In the UK the social model of disability dominated, highlighting the negative impact of structural discrimination to participation that those with a physical disability were subjected to, based on the assumption of tragedy and dependency (Union of Physically Impaired Against Segregation 1976; Oliver et al. 2012; Shakespeare 2013). The traditional definition of the social model has underpinned the ideological and intellectual foundations of the disability movement over the past fifty years (Kett et al. 2009). Though initially focused on the disablement of those with physical impairments, it has over time developed broader inclusion, particularly by individuals with learning disabilities from the 1980s and 1990s (Barnes 2013; Thomas & Milligan 2015), who also reject the individual pathology model.

Within the field of dementia however, the medical model of disability has remained prominent (Gilliard et al. 2005). It is argued that this is attributed in part to the double discrimination of ageism and disablism (Thomas & Milligan 2015), but as more nuanced approaches are developed that include the impact of impairment, the value of a social model perspective has started to be recognised (Davis et al. 2009; Boyle 2014). As Gilliard et al. (2005) argues, a real strength of the social model is that it challenges those who are non-disabled to consider how we as individuals, and collectively, discriminate and exclude.

The social model's influence has endured and been far reaching. Its use of terminology has stuck, with the term 'people with disabilities' rejected as a medical model term; in its place the term 'disabled people', used to highlight that people are disabled by society rather than impairment, continues to be used in the UK today. Notwithstanding its effectiveness in pushing equality and human rights issues up the political agenda, facilitating action including deinstitutionalisation; driver for the

introduction of the Disability Discrimination Act 1995; and the introduction of direct payments in the 1990s, the social model was criticised for its rigid ideology of disability that dismissed the experience of impairment (Morris 1991; Hughes & Paterson 1997). Others such as Shakespeare (2013) have gone further in arguing that the model, applied strongly in the UK, has failed to evolve and hindered longer term progress. Instead he advocates for a more interactional model; arguing that as undeniable that society disables, different experiences from impairment cannot be fully neutralised by support.

With a growing body of biopsychosocial perspectives, Shakespeare is not alone in his thinking. The World Health Organisation promote such a model of disability within its 'International Classification of Functioning: Disability and Health', fusing the medical and social models of disability together, offering 'a coherent view of different perspectives of health: biological, individual and social' (World Health Organisation 2002, p 10). The term disability is then used as an umbrella term for the negative interaction between a person with a health condition and the environmental factors in which they function. Such an approach better fits the 'support principle', and is more aligned to the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) which will be explored in detail later in this chapter.

Running parallel to the disability movement in the UK was feminist care ethics, which emphasised the needs of carers. Whilst this conflicted with the disability movement, which saw the concept of care to be a negative term equating to dependency (Watson et al. 2004), they held common ground in recognising the importance and impact that relationships and wider societal structures have on how people function. This relational aspect is increasingly recognised within contemporary practice and academic debates and examined below.

The personalisation agenda was seen to be a means of empowering disabled people to have 'choice and control' over their own social care support. One strand to this policy was the implementation of Direct Payments Act 1996. Rather than care being commissioned by local authorities, with little choice of when, where or by whom this would be provided, a duty was placed on local authorities to offer cash payments, paid direct to the person, to make their own arrangements to purchase

support for eligible social care needs. The government's commitment to the personalisation agenda was further stated in documents such as the Putting People First (HM Government 2007) which stressed the need for co-production to achieve meaningful reform to public services.

Whilst the concepts of choice and control are promoted in social policy, critics argue that personalisation as the central means to achieve spending cuts has undermined the aspiration of realising empowerment and choice (Ferguson and Lavalette 2014). For those who do self-direct their support through direct payments, the financial envelope is much less than that which the local authority would pay were they to commission the care themselves. Local authority social workers play a part in this through their gatekeeping of resources role (Boxall, Dowson, and Beresford 2009; Carr 2010).

Social work is relational in nature and takes place in the space of the uniqueness, unpredictability and complexity of human lives. In the UK, social work operates across the margins where individual lives and public services meet (Cooper 2011), engaging with people at time of vulnerability, ill-health and crisis, thus working within an environment of rights and risks. An understanding of social divisions (Berger 1966) and analysis of the personal, cultural and structural factors that influence people's lives (Thompson 2001) offers a theory basis for anti-discriminatory practice that looks beyond the individual.

The scope of radical social work in the UK is arguably affected by social workers employment within local government. Social workers are accountable to their employer as well as individuals and families who draw on their support, and their professional regulator. In order to retain their jobs, there are limitations to political action and challenge to structural inequalities and the role of government.

As a profession, social work has shown its ability to flex and adapt in response to changes in political ideology, moving from 'agent of social control' when large institutions were popular, to empowerment and promotion of individual choice and control (Maclean & Harrison 2000: 40). With local authorities holding statutory functions, social workers bear the responsibility of care and protection whilst promoting social inclusion, wellbeing and independence (Rogowski 2010); they act

as a gatekeeper to resources whilst advocating for rights; accountable to the public, their employer and professional regulator.

Notwithstanding these competing roles and the impact of neo-liberalist policies and managerialism, evidence of efforts to practice in a way that is aligned with the social work professions values (Social Work England 2020) can be seen in the Named Social Worker pilot (Innovation Unit 2018). This was established in response to 'No Voice Unheard, No Right Ignored' consultation (Department of Health 2015) in an effort to improve support to people with learning disabilities, mental health and autism. The importance of relationships were core to this approach and explained in more detail under section 2.5 below.

2.3 The legal framework for decision making and support in England

The legal framework of adult social care provision in England is set out within the Care Act 2014. The Act places a duty on local authorities to determine a person's needs for care and support through an assessment and, dependent on eligibility, provide services to meet those needs (Mandelstam 2017), with the primary principle of promoting individual's wellbeing.

In defining wellbeing, the Act lists a range of aspects that can impact, noting that all should be considered of equal importance and apply equally to adults with care and support needs, and carers. They are:

- *personal dignity (including treatment of the individual with respect)*
- *physical and mental health and emotional wellbeing*
- *protection from abuse and neglect*
- *control by the individual over day-to-day life (including over care and support provided and the way it is provided)*
- *participation in work, education, training or recreation*
- *social and economic wellbeing*
- *domestic, family and personal*
- *suitability of living accommodation*
- *the individual's contribution to society*

(DHSC 2023, para.1.5)

In meeting this wellbeing duty, local authorities are required to provide information and advice to its' citizens (s4(1)); to involve all individuals throughout the assessment and care planning process (s9(5); s25(3)). If there is reason to believe that a person has 'substantial difficulty' with understanding, retaining, using and weighing information in relation to their needs assessment and care planning process, then an 'appropriate person' (s67(5)) has to be identified and involved. Where this is not available or appropriate there is a duty to provide independent advocacy (s67(2)), to enable people to navigate and understand the system. This requirement to make reasonable adjustments is further enforced through the Equality Act 2010. The understanding, retaining, using and weighing of information are also key factors in determining mental capacity under the MCA. Where all practicable steps to support decision making have been exhausted and there remain concerns about a person's capacity for decision making about the care needs and support planning, a mental capacity assessment should follow. This could include the following circumstances:

- To consent to or refuse to a care needs assessment / review;
- To consent to or refuse a care and support plan;
- To consent to or refuse care;
- To consent to or refuse residential care;
- To consent to or refuse safeguarding enquiry;
- Capacity to manage finances.

Running through the Care Act 2014 is the principle that individuals are the experts of their own lives; their views and wishes should be central to decision making; they should have control over everyday life decisions. As such a 'person-centred system' (s1.14) is promoted.

The Care Act also introduced for the first time a legal framework for the protection of adults at risk of abuse or neglect. Once again, the importance of taking a person-centred approach is highlighted, this time through six core principles of 'empowerment, prevention, protection, partnership, proportionality, and accountability' (DHSC 2023, s.14.3).

Principles of the Care Act 2014 align with those of the Mental Capacity Act 2005 (MCA) which places significant weight on individuals' views and wishes on decision making. Mental capacity can be defined as the ability to make choices and decisions. In England and Wales, the MCA is the primary legislation that provides a legal framework for third parties to make substitute decisions for individuals, in their 'best interests' (MCA, s.1(5)), in circumstances where they lack capacity due to a cognitive impairment. Applicable to those living in England and Wales aged sixteen plus, the Act offers several examples of both temporary and permanent impairments, which would come under scope. These include:

- 'conditions associated with some forms of mental illness
- dementia
- significant learning disabilities
- the long-term effects of brain damage
- physical or medical conditions that cause confusion, drowsiness or loss of consciousness
- delirium
- concussion following a head injury, and
- the symptoms of alcohol or drug use'

(Department for Constitutional Affairs 2007; 44, para 4.12).

Whilst not without its critics, the MCA has been described as *visionary for its time* (House of Lords Scrutiny Committee 2014). It has five statutory principles, which were designed to protect those who lack may capacity to make specific decisions whilst promoting maximum involvement, regardless of ability. Starting with the assumption of capacity, in line with a common law approach, the onus is on third parties on the balance of probabilities to prove that this is lacking. Principle two specifies that a person should be given 'all practicable support' (s1(3)) to make a decision before any determination that they are incapacitous can be made; with the third principle underpinning people's rights to make what others may deem as

unwise decisions. Only then can third parties proceed with principles four and five which focus on substitute decision-making, in a person's 'best interests' in the least restrictive way.

The 'support principle' of the MCA is framed around promoting and maximising a person's mental capacity to make specific decisions. Where there is reason to believe that a person lacks capacity to make a decision after 'all practicable steps' have been taken, consideration needs to be given as to whether the decision can be delayed.

The MCA Code of Practice (Department for Constitutional Affairs 2007; 44, para 4.10) stresses that it is the responsibility of those who claim that a person lacks capacity to make a specific decision at a particular time to show, 'on the balance of probabilities', that this is the case. This requires capacity assessors to identify the relevant information to the decision, explain what practicable steps to support the person in making their own decision have been taken, why this has failed, and to consider how their impairment affects their ability to decide.

Only once these steps have been taken can substitute decisions based on the best interests of a person, Principle 5, proceed. Whilst the term best interests is not defined, the Code of Practice provides a checklist of factors that should be considered. This includes the views and wishes of the person themselves; consultation with others close to the person; and all relevant circumstances. Thus the 'support principle' runs throughout the Act, irrespective of capacity.

2.4 Contrasting the MCA, Care Act, and CRPD

Article 12 of the United Nations Convention on the Rights of Persons with Disabilities (CRPD) (United Nations 2006) is associated with a view that legal capacity is a universal human right, with mental capacity playing no part in this. This 'new paradigm' opposes substitute decision making, which it defines as making decision(s) on behalf of a person in their 'best interests', instead of supporting them to make decision(s) or, if necessary, others making decision(s) based on the person's 'will and preferences' (United Nations 2014). Instead, the 'new paradigm' demands that states provide whatever support an individual requires to enable them to exercise their legal rights; advocates formal frameworks for support, and choice

over who provides this (ibid; Series 2015; Series & Nilsson 2018; CRPD 2014). The ‘support paradigm’ of the CRPD calls for approaches that are anchored in the ‘will and preferences’ of the person, rather than that which is perceived by others to be in their ‘best interests’ (ibid).

Table 1 contrasts the MCA, and the Care Act 2014 of England, to the CRPD which the UK ratified in 2009 (United Nations 2006). It demonstrates progression within UK law in that the later legislation of the Care Act is grounded in the biopsychosocial model of disability; duty to provide support is broader; the choice of support is explicitly introduced. Nevertheless, whilst substitute decision making remains lawful in England and choice of support is limited, the divergence from the CRPD, which takes a more radical view, remains stark (Series 2015). Even though the ‘support paradigm’ has not been adopted in the UK, it offers a challenging critique of mental capacity substitute decision making laws, and proposes a very different way of understanding support. This reinforces the importance of the ‘support principle’ of the MCA.

	MCA 2005	CARE ACT 2014	UNCRPD 2006 (CRPD Committee 2014)
Type of support	‘Support principle’ (chapter 1, box 1)	‘Support principle’ (chapter 1, box 1)	Support paradigm
View of mental capacity	Mental capacity viewed as individual deficit (MCA, s2(1)).	Mental capacity viewed as individual deficit (based on the MCA, s2(1)).	Legal capacity has no association with mental capacity.
Goal of support	To help a person ‘make a decision’ (MCA, s1(3)), which meets the ‘mental capacity’ standard of decision making.	To promote involvement in assessment and care planning (Care Act, s9(5) and s67), in order to promote individual well-being, and choice and control over their day to day care and support needs.	To facilitate expression or interpret ‘will and preferences’ and use this as basis for exercise of legal capacity by, or on behalf of, the person.
Model of disability	Foregrounded in the medical model of	Grounded in the biopsychosocial model of disability.	Grounded in the social model of disability.

	disability (Clough 2015, p.56), with psychosocial elements through the 'support principle'.		
Duties to provide support	Duty to provide or secure support is placed on the person who assesses capacity; support is time and decision specific as it is an aspect of the assessment framework.	Duty to involve people is placed on the local authority; there is an additional duty to identify an 'appropriate person' to support people who would have 'substantial difficulty' engaging with the assessment and support planning process, usually a family member or friend, with a duty to instruct a Care Act advocate if no appropriate person is available.	Support is holistic; not time or decision specific.
Framework for support	No formal frameworks for support or choice over who provides this. The MCA Code of Practice recommends involving others, for example carers, if that could help the individual in making decisions.	A person's choice of support can be overridden by professionals where they perceived them to be unable to provide adequate support, or have a conflict of interest (DHSC 2023, para's. 7.35 to 7.40).	Advocates formal frameworks for support, and individual choice over who provides this.
Focus of support	Support is anchored in what professionals believe will best promote mental capacity.	Support is anchored around assessing and meeting eligible care and support needs (DHSC 2023, s9(5); s23(3)).	Support is anchored in how the person themselves wants to be supported.
Choice of support	Support through taking 'all	Individual choice, though dependent on	Supporters are chosen by the

	practicable steps' (MCA, s1(3)) is provided by whoever holds responsibility to assess capacity, as well as those they choose to involve to meet this duty.	professionals promoting this right, and agreeing the person's preferred supporter is appropriate.	person themselves.
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Table 1: Contrasting the MCA, Care Act 2014, and UNCRPD.

Despite the requirement to “take all practicable steps” (MCA, s1(3)) to enable people to make their own decisions, there are minimal checks and balances that this takes place within everyday practice. Ruck Keene (2017, p.13) describes the support principle as an ‘orphan principle’, and there is ample evidence to support this assertion (House of Lords Scrutiny Committee 2014; Jayes et al. 2022). Across the devolved nations of the UK, the Mental Capacity (Northern Ireland) Act 2016 has led the way with reforming legislation, described as ‘fusion legislation’ (McCusker et al. 2023, p.3) that addresses mental health and capacity law. The Act is much more directive about practicable support being evidenced and thus closer to the position taken by the CRPD (Davidson et al. 2016; Ruck Keene 2017; McCusker et al. 2023).

2.5 Evidence of the ‘support principle’ in practice

The MCA has the scope to promote equality and human rights by upholding people’s right to make decisions about their lives, as well as protecting those who lack capacity. It is however, its execution that demonstrates society’s belief system concerning the rights and risks of all citizens (McDonald 2010). Whilst the MCA came into force in 2007, full compliance with and implementation of the Act has been repeatedly evidenced as lacking. Seven years after the MCA was implemented, the House of Lords Scrutiny Committee evidenced that many professionals were not meeting the duties of the Act. Their findings identified a prevailing culture of risk aversion in social care and of paternalism in health care (House of Lords 2014). Central to the concerns raised was that the focus of

professional practice is seen to be on protection rather than empowerment; that inadequate time is spent on enabling people to make their own decisions; with the Act too often viewed as a 'framework for making decisions for or on behalf of people rather than encouraging and maximising their participation in the decision-making' (House of Lords 2014: 41, para 79). In short, the 'support principle' was not being honoured or abided by.

Three years on from the Committee's report, the Local Government and Social Care Ombudsman (2017) evidenced similar concerns. This included people being moved against their wishes without having their capacity assessed; decisions being delayed to the detriment of treatment or more appropriate care; and professionals failing to take into account the wishes and preferences of the person when determining 'best interest' decisions.

Two thematic reviews of Serious Case Reviews (SCRs) and Safeguarding Adult Reviews (SARs)¹ having been conducted across the South West's Safeguarding Adult Boards (Preston-Shoot 2017); and SARs conducted across London Safeguarding Adult Boards (Braye & Preston-Shoot 2017), both identify significant practice issues in the application of the MCA in the context of safeguarding adults from abuse and neglect. This included an absence of, or poorly undertaken, capacity assessments; lack of curiosity and inadequate time and persistence in establishing a working relationship; taking things at face value; and inadequate consideration of risk. Concluding that whilst no individual action alone was seen to be a determining factor in the outcome, fundamental flaws in understanding and application of the MCA in practice, alongside organisational factors, resulted in a 'fault line' running through the cases (Braye & Preston-Shoot 2017: 6). The gaps identified in practice align with Principles 1 – 3 of the MCA (s.1(2); s.1(3); s.1(4)), highlighting the importance of the 'support principle' in understanding a person's history, wishes and preferences, their needs and risks, and reviewing of capacity as change occurs.

The MCA Code of Practice (Department for Constitutional Affairs 2007, chapter 3) outlines four practical steps that are key to supporting decision making:

¹ Safeguarding Adult Reviews replaced Serious Case Reviews with the introduction of the Care Act 2014

1. Providing salient information to the decision.
2. Communicating in an appropriate way.
3. Making the person feel at ease.
4. Supporting the person.

Research studies to assess the impact of the MCA in its early implementation (Manthorpe, Rapaport, and Stanley 2008, 2009; Manthorpe et al. 2009b, 2011; Manthorpe and Samsi 2009; Samsi, Manthorpe, and Rapaport 2011; Samsi et al. 2011a; Manthorpe, Samsi, and Rapaport 2012a, 2012b) showed sizeable variation on the understanding of the MCA, and with limited references to the 'support principle'. McDonald's (2010) study which focuses on the impact of MCA practice from social workers differing approaches to risk notes, "few examples of 'practicable steps' other than oral discussion being taken to assist the older person to make a decision" (McDonald 2010: 1234).

Jayes et al. (2020) literature review looking at how professionals within the health and social care system in England and Wales assess capacity found that legal duties are not always met. Whilst professionals described practical considerations of the timing of meetings with people, choosing familiar settings and having someone familiar to them present when discussing decisions, other practicable steps were weak. For example, professionals lacked clarity when discussing concerns and care options available to people. This meant that individuals did not have the salient information to make an informed decision. Capacity assessment was at times based on irrelevant details for example, whether people could recall previous conversations.

Studies have recorded situations where the outcome of an individual's decision was also used as a judgement for capacity (Emmett et al. 2013; Williams et al. 2012; Murrell and McCalla 2016). If they disagreed with the assessor, then were deemed incapacitous.

The social work profession talk positively of the MCA and how its underpinning values uphold human rights (Social Work England 2019; BASW 2021). In Murrell and McCalla's (2016) study, social care professionals, the majority of whom were social workers, reported that they took a range of practicable steps to support

decision making when assessing mental capacity. However, no observation took place to verify this and their findings indicate that the information relevant to decision making was inconsistently identified by the participants. Emmett et al. 2013 and Jayes et al. 2019 have also found that the information health and social care practitioners have deemed relevant to the decision to be inconsistent. Inadequate or incorrect information means that people are unable to make an informed decision.

Practitioners have talked about making reasonable adjustments to individualise assessments depending upon the person's style of communication (Jayes et al. 2020; Scott et al. 2020); have said that they consider when and where they meet with people to discuss decision making (Scott et al. 2020); and who is best to support them (ibid). Yet, observation of social workers assessing mental capacity is rare (Jayes et al. 2020) and as such there is limited verification that what is described actually takes place in day to day practice.

A small number of studies have employed ethnographic methods to better understand how the MCA is applied in practice. Emmett et al.'s (2013) study involved ward-based observations and in-depth interviews with a multi-disciplinary team within a hospital setting, which included social workers, to consider how discharge decisions were made. This took place at an early stage of the MCA's implementation between 2008-2009. They concluded that standards governing the assessment of mental capacity was not applied in practice when assessing capacity to decide place of residence on discharge from hospital; that there was very little evidence of the 'support principle'. It was found that health and social care professionals struggled to identify the information relevant to the decision and communicate this to the person; they struggled in reconciling the notions of autonomy and risk, erring on the side of caution. This was reflected in the determination of capacity being based on outcomes as opposed to functional assessment. The authors note, 'If the person did not agree with the [multi-disciplinary team], he or she was likely to be deemed to lack capacity' (Poole et al. 2014: 7).

Further ethnographic studies within hospital ward settings have found limited evidence of the 'support principle (Kelley et al. 2019; Burrows 2021; Featherstone

and Northcott 2021; Kelley et al. 2021). Burrows' (2021) study was specific to hospital social workers practice, but did not specifically explore the implementation of the MCA.

Case law provides additional evidence of ineffective and poor practice in the application of the MCA, echoing the prevailing culture of risk aversion in social care. Inadequate assessments (Essex CC v RF & PN & JN & CP [2015] EWCOP 1) and an over emphasis of the state's physical protection of vulnerable adults, referred to as the 'protection imperative' (CC v KK and STCC [2012] EWHC 2136), have resulted in unlawful deprivations of liberty.

In each of the cases cited, both people objected to receiving care outside of their home; demonstrated their distress when this occurred; repeatedly asked to return home. The local authorities deemed it necessary for them to be cared for within registered care homes because of the perceived risk to their physical safety. However, the Court of Protection deemed the deprivations unlawful with Lord Justice Munby adding to his conclusions "what good is it making someone safer if it merely makes them miserable?" (Munby 2012).

As noted previously, the Named Social Worker model was piloted with the fundamental belief that trusting relationships are key to supporting people to have a good life. It was recognised that existing systems lacked continuity of support and personal connections are required to build trusting relationships (Innovation Unit 2018). Instead of episodic working, meaning temporary task based work, a named social worker would be assigned to an individual in need of long term support, and have the time to build trusting relationships. Named social workers were encouraged to question existing decisions around a person's mental capacity, supported by a risk-aware permissions framework and peer supervisions (SCIE 2018). The evaluation concluded that not only were people better supported to make informed decisions about their own lives, many had restrictive decisions revoked and decisions about their mental capacity overturned (Innovation Unit 2018).

With supported decision making increasingly championed as a rights based approach, interest has grown across a number of countries, as evidenced in Davidson et al.'s (2018) literature review.

Two studies have explored how social workers, employed in local authorities, interpret their duties to safeguard adults at risk of abuse or neglect. Keeling's (2017) study took place in Wales and entailed observations of an adult safeguarding team followed by interviews with seven of the social workers. The focus of the study was how individuals were supported to make decisions about the safeguarding process, with the majority of data taken from observations of social worker activity within the office. Dixon's (2023) study took place in England. His interest included to what extent the views of individuals in need of social work support contributed to decision making. Observations of social workers within the office, and interviews, were undertaken, but did not extend to practice in action. Again, social workers talked about involving people in decisions. However, the duty to protect people from abuse and/or neglect took precedence.

This study builds on this knowledge by observing social workers' direct practice with people who have need to draw on support, supplemented by interviews and focus groups. It also seeks to build on the few studies that include the perspectives of people who may lack capacity (Jimoh 2021; Wilson 2017), by seeking to elicit the views of individuals social workers support.

2.6 Research gaps and questions

The knowledge gap is in:

- Understanding the enabling factors and barriers to social workers' practice in meeting their statutory duties from the Care Act 2014 and MCA, in providing purposeful support to empower people to make decisions;
- Understanding what support is wanted and deemed effective from people whose capacity may be in question.

This ethnographic study that observes social work interventions and includes the views of people who may lack capacity to make decisions, is viewed as a pertinent piece of contemporary research.

The principle objective of this study is to examine the extent to which social workers understand and apply their statutory duty under Principle 2 of the MCA, to 'take all

practicable steps' (s.1(3)) to maximise a person's capacity to make informed decisions about their own life.

The research questions are:

1. How do social workers understand the duty of 'taking all practicable steps' to help people make decisions for themselves under the Mental Capacity Act 2005 (s1(3)); working together with additional duties to involve the person and support their decision making under the Care Act 2014?
2. What do social workers do to maximise a person's capacity to make specific decisions?
3. How do social workers view third parties' influence on a person's decision making?
4. What are the challenges, tensions and enablers to social workers providing support for decision making?
5. What support is desired and beneficial from the perspective of a person in contact with services and/or the consultee in relation to decision-making?

Chapter 3: Methodology

This chapter sets out my ontological and epistemological positions which underpin this research. I provide an outline of the research design, the steps taken to identify and access the research site, and the methods I drew upon to gather and analyse data. I share the ethical considerations given for the inclusion of individuals who may lack capacity to consent to participate in research, and the decision to withhold the specific focus of this study to social worker participants. Throughout, I reflect on my positionality as researcher and influence on the data observed and its interpretation.

The primary objective of this research is to examine the extent to which social workers understand and apply their statutory duties of the 'support principle' as defined in figure 1 (chapter 1). The research questions are:

1. How do social workers understand the duty of 'taking all practicable steps' to help people make decisions for themselves under the Mental Capacity Act 2005 (s1(3)); working together with additional duties to involve the person and support their decision making under the Care Act 2014?
2. What do social workers do to maximise a person's capacity to make specific decisions?
3. How do social workers view third parties' influence on a person's decision making?
4. What are the challenges, tensions and enablers to social workers providing support for decision making?
5. What support is desired and beneficial from the perspective of a person in contact with services and/or consultee in relation to decision-making?

This study adopts a qualitative and observational approach to understanding the 'support principle' from a social work perspective. This offers an important contribution as studies of MCA practice in action within adult social care are scarce, though there are some notable exceptions. A small number of hospital-based

ethnographies have touched upon implementation of the MCA, for example Emmett et al. (2013); Featherstone and Northcott (2018); Kelley et al. (2019); Kelley et al. (2021); and Burrows (2022). These studies have provided unique perspectives that could not be achieved through alternative methods (see chapter 2.5).

Two further studies observed social work practice with a focus on adult safeguarding teams that sit within local authorities. The first by Keeling (2017) observed an adult safeguarding team followed by interviews with seven of the social workers. The focus of the study was how individuals were supported by social workers to make decisions about the safeguarding process, with the majority of data taken from observations of social worker activity within the office. The second by Dixon (2023) was limited to observations of social workers, and interviews, within the office setting.

It is clear from the empirical research that social work practice that takes place in the privacy of people's homes is rare. In conclusion to a literature review on how professionals assess mental capacity in England and Wales, Jayes et al. (2019) identified this gap in ethnographic methods and recommended future studies adopt such approaches to enhance understanding through observation. This study takes such an approach, adding to the knowledge by observing how social workers employed across adult services of a local authority apply the 'support principle' in their everyday practice, with an intended focus on private settings of people's homes, rather than the more public settings of a hospital ward or the limitations of observing social workers within their office environment.

3.1 Philosophical framing of the research

As described in chapter one, the conception for this research was born from an example of social work practice that was grounded in human rights and relationship-based practice. This was further developed when I was employed as a Principal Social Worker for a large local authority, with lead responsibility for social work practice. My area of interest was the extent that social workers understood their statutory responsibilities under the MCA to take 'all practicable steps' to maximise a person's capacity to make decisions (section 1(3)); and how they achieved this in their daily practice. In my application to enrol on the Professional

Doctorate with Cardiff University, my stated intention was to use the research to inform how my employing local authority could promote a culture of positive risk taking and least restrictive practice. It was to highlight the learning and development needs of practitioners, with an action plan to be produced with the aim of raising practice standards and in turn reduce breaches of people's statutory rights and possible litigation against the council.

In my university application, my intention to take a qualitative approach to explore the behaviour of social workers was noted:

'my experience is that practitioners are able to explain what good practice looks like theoretically but the evidence of practice...is contradictory to this. I want to explore the human reasons for risk aversion/paternalism by holding semi-structured interviews/focus groups with assessing practitioners' (Burden 2015).

As described in chapter two, the majority of MCA research with social workers has relied upon self-reporting methods such as surveys, interviews, or focus groups. This leaves a gap as it is known that what people say they do differs from their actions (House of Lords Select Committee 2014; Jayes et al. 2019). Putting administrative tasks aside, most present day social work practice takes place in the privacy of individuals' homes. This means that the approaches and interventions of social workers largely go unwitnessed and undocumented. The norm of privacy and the sense of intruding on people in their own homes is argued by Twigg (1999) as the primary reason for research rarely taking place within these settings. Yet research that relies solely on social workers' accounts, are limited to the profession's perspective and that which they are able and willing to reveal.

These undocumented interventions, and the fact social work entails working with the unique complexity of human beings, led me to refine my design and select a qualitative approach to observe social workers' practice in action. Taking an interpretivist position enabled me to explore how social workers understand and make sense of their role, whilst providing some 'realism' through my observations of their practice in action. It also offered the opportunity to capture the views of people who draw on support, and their carers, who would undoubtedly hold differing perceptions, understanding and interpretation as to how social workers apply the

'support principle'. With supported decision-making being intrinsically relational, it requires an epistemological paradigm that can embrace the complexity of relationships.

Rather than accepting that phenomena in social research is fixed, the perspective is taken that it is the interplay of relationships between the actors that construct meanings. This will differ from one situation to the next, influenced by the numerous factors in play, fitting with the ontological position of constructionism (Berger and Luckmann 1967). For example, social workers' practical application of the support principle will differ depending on their understanding of the term; their own values; their obligations to protect against harm and to promote autonomy; the needs and context of the person drawing on their support and so on.

I extend this position to include researchers, themselves an actor, who shape social research phenomena driven from their own values and positionality (Gomm & Davies 2000). Hammersley (1992), makes the challenge that whilst ethnography commits to the unveiling of social reality, the naïve realism that the researcher is independent of that being studied is not fully compatible with constructionism. Instead he adopts the position of *subtle realism*. This approach holds greater focus on the researchers own cultural assumptions, fitting with constructionism, yet acknowledges how these can colour that which is observed. I adopt this position, with the view that the world carries on irrespective of it being witnessed, but my understanding through research will never be complete.

Whilst no two lives are identical, and prescriptive interventions by social workers are absent, the position is taken that 'moderatum generalizations' (Payne & Williams 2005) can still be made.

The importance of identifying one's established knowledge, assumptions and values in the role of researcher is key. Some are easily identified; others are more difficult to grasp or indeed go unseen. Undertaking research within one's own profession brings a sense of advance investment, and undoubtedly adds weight to such assumptions. My own practice experience brings developed knowledge to the researcher role and as Coffey (1999) argues, it is not possible for researchers to undo the knowledge they hold. Whilst I can consciously act to be reflexive and to make the familiar strange (Delamont 1981; Delamont et al. 2010), my values and

practice experience as a social worker will undoubtedly influence my interpretation and meaning of the data. As such I have an active role as researcher in the knowledge production of this study (Braun & Clarke 2019), with the conclusions being a reflection of my interpretive analysis of the data.

3.2 Research design

Motivated by concern and an inquisitive mind about the gap between evidence of practice (House of Lords 2014) and the social work rhetoric about values, human rights and promotion of social justice, this cross-sectional study examines how social workers' perceptions and interpretations impact on their application of the MCA and the wider 'support principle' within their daily statutory practice. The method selection was chosen as one able to better understand the social, often private, environments where social work takes place; the interpretation of law, policy and guidance in practice; and how the relational approaches in terms of formal and informal support networks, enables or disables people in relation to decision-making.

To better understand how social workers' interventions support individuals' ability to make informed decisions about their lives, observation of practice was selected as the preferred method. Studies assessing the impact of the MCA to date have largely been based on interview and recall of professionals (see chapter 2.5), thus limited to their construction of reality. Whilst valuable, such an approach is limited to the perspective of one set of actors within the relational intervention that is the 'support principle', as interpreted by the researcher, fitting with a subtle realist paradigm. Whilst professionals self-report that they fully apply the support principle (Murrell & McCalla 2016), observational studies of practice have found limited evidence of this (Emmett et al. 2013; Keeling 2017), suggesting that what people say they do, and their behaviours, are not always consistent. This study offers a differing perspective, taking the position that by observing practice in action enhances understanding of the factors that support and hinder practice. It also offers the opportunity to seek the perspectives of those with need to draw on social work support which provides a fuller picture to what takes place in the largely private spaces of social work practice. Including the voices of individuals who use services are essential to

understanding what interventions enable and empower them to make decisions about their own lives (Loomes 2018). The triangulation of data with pre- and post-observation interviews enables a 'thick description' (Hammersley 1992:12) of the social world within which social work practice takes place. The intention was to maintain an open mind, so data generated theories which fits with an interpretivist theoretical framework (Clough & Nutbrown 2012), with the aim of gaining an insight into how the 'support principle' duty is met by social workers in their daily practice, and how this was received by those they support.

A cross-sectional design was chosen for this study. Whilst not a comparative study, this offered the opportunity to gain a sense of different issues that can arise within the varied teams and workloads of social workers, rather than focusing on any particular grouping of people. Longitudinal studies of capacity and supported decision-making may also have important lessons but was dismissed due to the time restraints of being in employment throughout this doctoral study period and limitations of self-funding.

3.3 Choice of methods

Given the concerns already outlined about the gap between evidence of practice and rhetoric, observation of practice in action was selected as a key method. This was viewed as a way to understand the relationship between how social workers' talk about what they do and how they perform their professional identity through the 'support principle'; against observations of their actual implementation of the 'support principle' in practice. It also facilitated contact with the people drawing on social work support and provided the opportunity to elicit their views as to what support is desired and beneficial for decision making.

The decision to include supplementary pre- and post-observation interviews with social worker participants was chosen as a means to understand context and intended focus of their planned intervention; followed by the opportunity to reflect on the intervention and ask any clarification points. Post-observation interviews with people drawing on social worker support, offered an invaluable perspective and a more inclusive approach to the study.

The later introduction of focus groups into the design, due to an enforced pause related to the Covid-19 pandemic (see 3.10), provided the opportunity to explore central themes identified from the observation and interview data. This enriched data collection in ways I had not foreseen, by providing the opportunity to explore initial themes identified from my observations with a wider group of social workers.

3.4 The research site: access and sampling

This study purposively samples one local authority in England. The local authority was selected because it held adult social care statutory functions and employed adult social workers. It spans both urban and rural areas, and its teams are broadly divided into:

- Short-term teams – with a focus on reablement for up to six weeks; hospital discharge; review of social care needs and packages of care.
- Long-term teams – with a focus on individuals who have eligible social care needs requiring support beyond an initial six-week period; safeguarding people from abuse or neglect. This includes, though not exclusive to, individuals who are autistic, who have a learning and/or physical disability, and dementia.

In observing social work interventions, which are mainly undertaken in people's homes and often in the presence of family or carers, three groups of research participants were identified. The primary participants were the social workers; secondary participants included people who had need to draw on formal supports; followed by any family or informal carers, or other professional supporting them at the time of their contact with the social worker. This third group has been subdivided into three categories in order to clearly identify whether they are acting in an informal or formal role, and the function of support they were providing on the day. They can hold dual participant identities of family member and consultee; or other professional and consultee.

	Participant group	Inclusion criteria
1	Social workers (SW)	Social workers employed in England, who have a statutory function working with adults aged eighteen years and above, assessing need, risk and mental capacity within their daily practice; Consent to be a research participant.
2	People who receive a social work service (P)	People aged eighteen years and above; who are in contact with social workers through the local authority statutory duties; that would come under the scope of the Mental Capacity Act; that is that they have an impairment of, or a disturbance in the functioning of, their mind or brain; who may have difficulty or lack capacity to make specific decisions because of the impairment.
3	Family members or informal carers (F)	Family member or informal carer; Present during social work intervention; Consent to be a research participant.
4	Personal or nominated consultees (C)	Consultee's are specific to research ethics and defined under the Mental Capacity Act (s32). A 'personal consultee' is defined as a person who is: Engaged in caring for a person or is interested in his/her welfare (not professionally or for payment), who has been assessed as lacking capacity to consent to participate in research and; Is prepared to be consulted; Is able and willing to advise on the person's wishes and feelings. A 'nominated consultee' is defined as a person who:

		Knows the potential research participant (in a professional, paid capacity) and is able and willing to advise on the person's wishes or feelings; Is unconnected with the research study.
5	Other professionals (A)	Paid carer or other professional; Present during social work intervention; Consent to be a research participant.

Table 2: Participant group and inclusion criteria.

Potential participants from group 2, and by default groups 3 – 5, were only identified once the individual social worker participants were formally recruited. These were people who the social worker had planned contact with and could include anyone who would meet the criteria of the MCA in that they had, or were believed to have, 'an impairment of, or a disturbance in the functioning of, their mind or brain' (MCA 2(1)) and decision-making was required.

Social Workers (SW)	People who receive a social work service (P)
SW1	P1
	P2
SW2	P3
SW3	P4
	P5
	P6
	P7
SW4	P8
SW5	P9
	P10

Table 3: Planned Observations following Recruitment of Social Workers

3.5 The research site: gatekeepers

Gaining access and opportunities to observe social workers statutory practice was a challenging and time-consuming process. As Berbary (2014) highlights, the process

extends far beyond access to the institution itself, with the need to gain access and consent from multiple stakeholders across various tiers of the organisation, as well as participants. Though I had initially planned to complete this study in my own employing local authority, preliminary studies to the thesis stage of my doctorate led me to reconsider this due to the status that my position of Principal Social Worker held. I recognised the power imbalance and conflict of my role which included quality assurance and, concerned this could influence the data, explored alternative sites, taking advantage of professional national networks developed from my social worker identity. Having used my familiarity to identify a potential research site and primary gatekeeper independent of my employment, I was mindful of the importance in asserting and making transparent my positionality of researcher (Delamont et al. 2010), as opposed to social worker, and taking a reflexive approach throughout to ensure this boundary remained clear. This is a topic that is explored in more depth throughout this chapter.

Whilst formal consent for participation in this study was granted by senior management of the local authority research site, participation of social workers was voluntary, with canvassing and recruitment of social work participants to be led by myself as lead researcher. Despite my insider knowledge of the structure of local authority adult social care services, the layers of gatekeeping resulted in my direct access to social workers being repeatedly frustrated.

It is widely accepted that research that takes place in closed and private settings require greater scrutiny of and conditions to access (Hammersley and Atkinson 1995; Lofland and Lofland 1995), though the layers of approval required exceeded my expectations. Even though formal agreement for this study to take place had been granted through the local authorities' Research Governance Process (Health Research Authority 2017), on 23 April 2019, additional to approval from the Social Care Research Ethics Committee (detailed under 3.9), the senior leadership team demanded a briefing prior to giving their support for data collection to proceed. Disruption to the functioning of teams / services, political positions and reputational risk are factors that can influence gatekeepers' decision-making (Clark 2010). With resources in mind, they sought assurances on the number of observations that would take place. They also sought to understand how the local authority could benefit from the study. There was a real risk that the study would be blocked at this level. This

approval stage added another, informal, layer of gatekeeping and is a demonstration of the power that is held by stakeholders.

Working through these layers added unpredicted delay to the start of data collection, meaning direct contact with teams was delayed until September 2019, six months following ethical approval. Whilst my research design had included briefings to social workers as a means to participant recruitment, in practice the research site viewed this as impractical due to geography and demands on staff workload. Instead, the study was promoted through a presentation to a local authority wide managers' meeting, supported by the Principal Social Worker. This met the requirement from the Social Care Research Ethics Committee that the Principal Social Worker inform managers of the study and the requirements of social workers participation.

It was during this presentation to managers that I gained a clear sense that interest was mixed. One concern raised was the impact on the capacity of individual teams should members be interested in participating. My ability to respond to this, with details set out in my approved ethics application, was well received, although I am not confident this was adequate assurance for all the managers and it would have remained an influencing factor on them promoting engagement. Those who demonstrated most interest in the room were those who I had subsequent communication with, and as a consequence was then able to access social workers direct to promote participation.

Making myself visible to potential social work participants remained a challenge throughout. Having the backing of the Principal Social Worker was key to the feasibility of this study. The added layer of team managers as gatekeepers required establishing connections, garnering support through advocating the value of the study and making myself available to visit individual teams in person, in order to initiate contact with social workers. Changes to key personnel delayed the set up process, with time spent building new relationships. Information for social workers included a flyer in staff newsletters, an audio recording of my pitch to accompany Participant Information Sheets, one-to-one as well as group question and answer sessions. The team managers' influence held great weight. If they were interested and supportive of the study they would promote within their teams; if not they could withhold the information or actively discourage participation.

Modern working practices meant the opportunity to base myself in the office to be visible, encourage interest, and answer any questions about participation, was extremely limited. Agile working practices which enable practitioners' flexibility about the location and timing of work, has meant a reduction in office space (Jeyasingham 2016; Webb 2017; Ravalier & Boichat 2018). Desk availability was on a ratio of 1:2 desk to team members in some offices. Another team had a culture of working from home rather than basing themselves in the office, partly due to geography, resulting in me having limited opportunities for contact when I attended their team meeting or based myself in the office. Nevertheless, sufficient contact was made with social workers to generate interest and take-up, with the first observation taking place on 31 October 2019.

The extent of gatekeeping by social workers themselves is impossible for me to measure. Having no access to social care records, I was dependent on social worker participants' knowledge of those they were working with meeting the inclusion criteria. They may have made judgements on an individual person's ability to consent and engage as a participant, as Boahen (2015) identified in his research. They may have demonstrated bias, consciously or otherwise, and been self-selective of the interventions they were willing to be observed to show themselves and their practice in a good light as discussed by Wilkins and Antonopoulou (2017). Certainly some social workers gave differing reasons why it would be inappropriate for me to observe various interventions, though none were stated to be due to concerns about capacity to consent. Explanations given included sensitivity of a person's situation; inability of those they were supporting to cope with additional people being present. Despite such limitations, this approach was chosen as the most practical in observing practice in action.

It was explained to social workers at recruitment stage that their perception of a person's capacity to consent to participate should not influence their willingness to be observed. Whilst the MCA (s.32) includes circumstances where people who lack capacity to consent to research participation can be included, it does not make any reference to gatekeeping. The 'support principle' applies equally when decision-making is needed about research participation. Yet the responsibility to seek consent to participate lies with the researcher as decision maker. In accordance with the Act, this is time and decision specific and can therefore not be made in advance.

When recruiting participants for focus groups, following a redesign after the Covid-19 pandemic interrupted data collection (detailed under 3.10.), the process was less layered. I liaised directly with the Principal Social Worker and produced a flyer to be disseminated through the authority wide staff newsletter. This swiftly resulted in interest from social workers, with thirty-one booking onto one of six focus groups on offer. Interest in participating in this second stage of data collection was significantly greater than stage one observations. This could arguably be attributed to participants viewing contribution to group discussion less threatening and/or anxiety causing than observations of their practice. Equally it could be seen as a thirst for continuing professional development opportunities which had been unavailable through the peak of the pandemic.

3.6 Researcher or social worker: the challenge of familiarity

The researchers' awareness of their own identity, values and reflexivity, are key to understanding the role that the self plays within research. This is particularly so within observational studies. As an experienced social worker who had practised within local authorities throughout my career, I held considerable knowledge of statutory practice. By adopting a critical reflexive approach throughout the research, familiarity itself is not problematic (Pillow 2003; Delamont et al. 2010).

As already noted my identity of social worker was beneficial in gaining access to key gatekeepers within the research site and securing local approval. However, in turn, I question if this positionality put some social workers off from participating in the study, concerned of my inside knowledge and assessment of their approach to practice. Whilst I endeavoured to present my identity in the field as a researcher, I openly shared my professional background when providing briefings, perceiving that this would offer credibility when recruiting social worker participants.

Whilst my insider knowledge of statutory social work and understanding of language and cultural norms was useful, I had to remain conscious not to assume understanding of acronyms or norms of the teams, so as not to block my researcher sight (Berbary 2014). Choosing a research site outside of my employing authority helped; I was not familiar with local processes which enhanced my curiosity and questioning. Whilst I would have had direct access to social workers and their

managers within my own employing authority, my identity and thinking as a researcher would have been much more challenging. The maintenance of a diary aided a reflexive approach to identifying my emotions, preconceptions and interpretations throughout. This has been particularly insightful in critiquing my objectivity of social work practice, and viewed as particularly important when observing the familiar (Delamont 1981; Clough and Nutbrown 2012).

Some social workers and managers who I held preliminary discussions with about participation were seeking a reciprocal relationship whereby they or team members would participate if I would offer direction or guidance on the MCA. Were I not a registered social worker, I do not believe this would have been asked, but it does indicate a lack of confidence in applying the MCA and/or a desire to learn. This was evident when I was invited to a team meeting to brief potential participants. Lively debate was held about the complexities of balancing risks versus rights for autistic young adults, particularly where the influence of third parties was a concern, how difficult assessing capacity was and concern at the weight of responsibility in reaching a conclusion.

3.7 Data collection methods

Observations

The method of observation was chosen to enable me to achieve the objective of exploring what social workers say they do and how that translates to practice in the field. In qualitative research there are two approaches that this could take, structured or unstructured observation. The former entails the use of formatted rules about what the researcher should look for and record (Bryman 2016). In contrast the latter entails recording as much detail as possible 'with the aim of providing a narrative account of that behaviour' (Bryman 2016, p.270). This is fitting with the interpretivist constructivist paradigm, one which 'acknowledges the importance of context and the co-construction of knowledge between researcher and 'researched'' (Mulhall 2003, p.306). I had a semi-structured observation record prepared so that the focus of any hand written notes made during the observation relating to supported decision making in its broadest sense was captured. This included:

- Others present or consulted

- Methods of communication
- Practical steps
- Views and wishes of the person drawing on support.
- Non-verbal observations

However, importance was placed upon being open so that the data led the learning, fitting with an interpretive approach. The use of audio recordings assisted with this.

Whilst social work practice usually takes place within private spaces, the use of observations in empirical research has been fairly infrequent in the field of social work (Trevithick et al. 2004; Forrester et al. 2008; Ferguson 2010; Westlake 2016). However, direct observation is not unfamiliar to the profession; in acknowledgement that theory knowledge and application in practice are not synonymous, it is used as a means of formal assessment of students within the social work degree and other qualifying programmes (Social Work England 2021, standard 2). It has also been adopted as a tool across social workers first year of post-qualifying practice under the Assessed and Supported Year in Employment programme (Department of Health 2015, para. 12.2). It is therefore noteworthy that observation as a research method to get as close to practice as possible is so infrequent. The majority of observations took place in peoples' homes which provides a unique perspective to this study.

Interviews

Interviews with social workers preceded the planned observations providing the opportunity to explore the purpose of the planned contact and the social worker's intended approach and outcomes. A post-observation interview then provided scope to elicit the social worker's reflection on the intervention. Research questions one and four which focus on social workers' understanding of their legal duties, and the challenges, tensions and enablers to practice, lend themselves to this method.

An interview schedule was used as a guide but not every question needed asking as participants would cover these through the interview process without prompts.

For example, in the post observation interviews questions included:

- How have you used the principles of the MCA?
- Can you talk through the ways in which you have supported the person throughout your recent intervention with them?

Focus groups

Introducing the focus groups, whilst unplanned at the outset, highlighted differences between social work rhetoric and practice in action. Six semi-structured focus groups with social workers were held between 20 April and 7 May 2021, enabling me to explore the use of third parties and social workers concerns about family bias. The absence of third parties during my observed visits is something that I did not fully explore or directly question during stage one data which I am left unsatisfied with. I was overly cautious using questions which could lead participants to identify the specific focus of the study, and anxious about the parameters set by the Social Care Research Ethics Committee, all of which I attribute to my inexperience as a researcher. In effect, having to amend the research design gave me a second chance to explore this.

Data recording

For confidentiality purposes, all participants and identifiers were anonymised. Audio recordings were used for the majority of stage one, and all of stage two data collection, enabling a precise record of discussions. Data capture was less detailed where written notes were used. This included where interviews took place via telephone; where it was viewed as inappropriate by participants; for one observation where I determined it was inappropriate due to not being introduced to the person drawing on support before the social worker's intervention commenced; informal conversations with social worker participants when travelling to and from visits.

Audio recordings and written notes were transcribed and analysed using NVivo. Whilst time consuming, the process of manually transcribing data myself aided familiarity. It also meant that I could record in a way that evidenced pauses and meaning of participants.

If I could go back I would ask participants what pseudonym they would choose to adopt for the purposes of writing up my findings. The use of SW1 or P1 etc. feels very impersonal. After discussing this with my supervisors, the decision was made not to retrospectively change this on ethical grounds (Allen and Wiles 2016). After some deliberation and testing out the use of pronouns I have chosen to refer to

social workers who participated in stage one as 'they' or by their identifying number as part of my efforts to maintain confidentiality of what was a small group.

3.8 Data analysis

Reflexive thematic analysis is an accessible, flexible, interpretive approach to analysis of qualitative data, that enables identification of themes (Braun & Clarke (2022)). Given my philosophical position and positionality with long-term practice experience in local authority employment, I adopted Braun & Clarke's (2012) reflexive approach to thematic analysis of data which, as they argue in contrast to other academics such as Boyatzis (1998), values the researcher's active role in interpreting meaning as a strength (Braun & Clarke 2019). Adopting this approach would enable me to reveal social workers and other actors' accounts and constructed reality, whilst being transparent about the reflexive interpretations that I bring as researcher.

Broad themes were drawn from stage one data consisting of observations and interviews, and used to develop semi-structured questions for the focus groups, which were added to supplement the interviews and observations. This enabled further exploration of themes and drew on a broader range of social worker perspectives and experiences.

There was a time gap of thirteen months between the last of the observations of practice, and the first of the focus groups, referred to as stage two data. Whilst unplanned for in the original design (see 3.11), this enforced pause afforded the opportunity to shape semi-structured questions for the focus groups based on initial analysis of stage one data.

Initially, I used what Ryan and Bernard (2000) refer to as a 'pawing' approach using hard copies of transcripts, as a means to the analysing process. This entailed 'pawing' through the data, highlighting text and underlining phrases that stood out to me. I then identified themes for each sub-set of data: pre-observation, observation, post-observation. I also considered what, if anything, was absent in the observations compared to that which I expected to witness from my knowledge of social work practice. Use of NVivo 12 (Lumivero 2017) software was used sparingly at this stage, with my personal style for focused reading and analysis being the use of hard copies.

This initial approach was undoubtedly influenced by my insider status. I had some ideas about themes aligned to my research questions (what supportive relationships are recognised; evidence of the support principle; communication styles; confidence in applying the five principles of the MCA; how perspectives differ by actors), though I was interested to see how this would develop as analysis progressed. On reflection, I can see that I was looking for what I knew. This early analysis also shows my inexperience in coding. I had written descriptive summaries of the observations and identified codes were broad.

Though beneficial in familiarisation of the data and in developing semi-structured questions for stage two focus groups, I felt unsatisfied with my approach to coding. Having a pause in data collection (see 3.10) afforded me time to step away from the data, then return and review. I revisited literature on thematic analysis and utilised Braun and Clarke’s (2019; 2022) ‘reflective thematic analysis’ approach. Now with a larger data set, having completed stage two data collection, I started anew with original uncoded transcriptions and drew on Braun and Clarke’s 2022 practical guide to steer my approach. With my research questions in mind, I systematically worked through the data set, this time starting with stage two data. This achieved more detailed coding, moving from broad descriptors. Two examples follow:

Initial code	Revised coding
Time	Time is a luxury
	Time has to be negotiated
	Time to assess is supported
	Time of court process lengthy
Fire	Risk concern prompts intervention

Table 4: Revised coding example

This approach enabled me to stay closer to the expressed meaning, rather than my assumptions as an insider, and move away from ‘superficial reading of the data’ (Braun & Clarke 2022: 57). It did however generate a mass of codes which led to me returning to data software. Using NVivo meant that I could better manage this larger data set. Utilising ‘export codebook’ aided the reviewing of codes for duplications and similarities which I then refined. I then printed and cut up the code set, laying it out on

the floor to group into 'central organising concept(s)' (Braun & Clarke 2019), which I will refer to as themes.

Though I had stated in the research design that I planned to take an inductive approach to data analysis as fitting with my interest in meaning and interpretation, I now accept that the process of coding was not as clear cut as this. My insider status, and the process of linking the data back to the research questions, meant that I used a combination of both inductive and deductive approaches. Braun & Clarke (2012) accept this occurs yet argue that a predominant approach is usually present. Through a process of familiarisation, recoding and conscious effort to step back and critically engage with the data, my predominant approach was inductive.

This inductive approach led me to amend one of the research questions from 'How are individuals supported by social workers to make informed decisions where they have previously been assessed as incapacitous?', to 'How do social workers' view third parties' influence on a person's decision making?'. The original research question was very much researcher driven, by my own practice experience; the amendment driven by the data.

3.9 Ethics

The ethics of observing social workers practice in action, in the privacy of people's homes is not unproblematic. Add to that the inclusion of participants who may lack capacity to consent, this study required robust justification. The intent of this research was to identify factors that support and strengthen people's capacity for decision making so that recommendations can be made to further develop the practice of social workers. The phenomenological dimension, exploring people's lived experience of being assessed and the ways in which they are supported was intentional. This study offered the opportunity for individuals who use services to be included in research, regardless of ability, viewing participation as a right for all (Loomes 2018). Few studies include the perspectives of people who may lack capacity (Jimoh 2021; Wilson 2017), something which the research design attempted to bridge. How the MCA is applied in practice holds most significance to those with more severe cognitive impairments, thus understanding their experience is essential. The absence of participants who may have difficulty in understanding the context and consequences of decisions, would result in the research being limited in its findings

and subsequent recommendations for improving social work practice. It would also exacerbate the social exclusion of people who may already be discriminated against due to protected characteristics, for example age or disability (Equality Act 2010).

The MCA Code of Practice (Department for Constitutional Affairs 2007, pp. 202-215) promotes the inclusion of people unable to consent to research participation. Whilst not without its critiques on the limitations of permissible participation and approval process (Heywood et al. 2019), the Code sets out the role of consultees in aiding researchers' decision of inclusion. A commitment was made that wherever practically possible, personal consultees would be identified, should the need arise. This would mean that in some cases, the informal carer participants would have the additional role of consultee. Where a personal consultee could not be identified, a nominated consultee would be approached for their opinion on the views of the person. This fourth group of participants are referred to in Table 2.

As evidenced in a number of studies (Brannen 1993; Hutchinson et al. 1994; Sque 2000) there can be a cathartic effect on participating in research. It is suggested that the proactive exploration of views about social work practice from those who experience social work intervention could have such an effect. Research into the experiences of people who access services and participated in research by Westlake & Forrester (2016) evidence positive benefits, actively embracing the opportunity to comment on services and in being valued in a participant role.

It is a legal requirement of the MCA that all research involving people who lack capacity to consent to participate in England and Wales is reviewed by a statutory Research Ethics Committee authorised by the Secretary of State for Health. Provisional opinion was granted by the Social Care Research Ethics Committee, dependent upon six clarification points. Points one, two, three and five were largely administrative, requiring the development of individual Participant Information Sheets and declaration forms for personal and nominated consultees; Participation Information Sheets for family members who might be asked for information and therefore research participants in their own right, rather than consultees; for an outline topic guide for the post-observation interviews. Point five sought assurances that social work managers of the selected teams were to be made aware of the study by the Principal Social Worker, and the requirements of participating social workers. The

final two points related to health and safety concerns. The development of a lone working protocol, in-line with Cardiff University's Lone Working Policy, detailing how I as researcher would maintain my personal safety during the data collection period addressed point six. It was only point four that required a review to the research design.

The concerns related to the proposal to undertake mobile interviewing methods for pre- and post-observation interviews with social workers on the journey to and from the planned intervention. With car travel to and from visits being the norm within many local authorities, I perceived that the privacy of conversations during this time would meet ethical requirements. Where confidentiality could not be assured, interviews would take place in the social work office. It was the risks around distraction from one driving that the Social Care Research Ethics Committee held concerns about. I revised my design accordingly, stating that social work interviews would take place in a confidential space at their office or on the telephone. On reflection however, I missed the opportunity to evidence to the panel the benefits of having such live discussion post-observation; failed to reference studies where mobile walking and driving interview methods such as Ferguson's 2016 research into child and family social work have been used; failed to argue that their concerns were overly risk averse. In the field, it was only natural for participants to talk about the intervention whilst travelling to and from the visit. This was less formal than a semi-structured, audio-recorded interview and I purposely avoided asking questions to honour my commitment to Social Care Research Ethics Committee, but I did not shut down the conversation when instigated by participants. I did however take key notes which I then picked up on within the formal recorded interview.

With the immediacy of gaining feedback to the observation viewed as important, approaches to achieving this were further developed whilst addressing the provisional opinion points. Whilst a post-observation interview would always be sought, to enable flexing with social worker diaries and to accommodate the choice and convenience of other participants about the date and time of their own interview, I made plans for an audio recorded, semi-structured reflective diary for the social worker to be utilised wherever their post observation interview was delayed in any way. These diaries would then be used to explore the social workers initial reflections in more depth. In practice, this approach was not utilised as all but one post-observation interview with

social workers took place on the day of the observed intervention; the other the day after at the participants request.

3.10 Transparency and disclosure of research questions to participants

Consideration was given to the level of detail to be shared with social workers about the explicit purpose of the study in exploring the nature of social work practice under the MCA. Whilst wanting to be transparent, concern was held that the depth of learning could be weakened by participants adapting their practice with the knowledge of what was being explicitly observed, known as the Hawthorne effect (Chiesa & Hobbs 2008). To balance these competing issues, the evaluative nature of social work practice in relation to the MCA was made explicit at the outset, yet the focus on the support principle was withheld. The original design consisted of briefing sessions with social work participants following data collection and analysis, to share themes identified and it was at this stage that the specific focus of the study would have been shared. With the profession's focus on reflective practice and Continuing Professional Development it was perceived that social worker participants would be accustomed to receiving feedback and use this positively within their own development.

The ethical issues relating to the inclusion and exclusion criteria of participants was also given significant consideration. Firstly, the inclusion of participants whose capacity to make decisions is in question were determined by the nature of the research aims and legal framework of the MCA.

Secondly, the inclusion of those who lack capacity to consent to participate in research was weighed up and on balance, viewed as key to maximising the opportunities for enhancing and therefore improving existing guidance for social workers and therefore improving practice. Greater understanding of the application of the MCA has the potential to benefit individuals who have contact with services, particularly where it is enriched by the views and experiences of the person themselves (Brannen 1993; Sque 2000; Westlake and Forrester 2016).

The understanding of abstract concepts such as writing up observations, analysis and purpose of study, are not necessarily required for consent. It is the consent of process that is key (Dewing 2002; Jepson 2015), for example consent on the day to be observed. This approach moves away from the traditional measurement of cognitive

competence for informed consent, that is non-situational specific and exclusionary (Dewing 2007), to modelling a person-centred approach to research. Detailed recording of actions taken to gain consent is key in terms of external scrutiny, demonstration of adherence to ethics and modelling of the MCA principles.

With social work intervention taking place at times of crisis and ill-health, this observational research was privy to private and sensitive information. Whilst audio recording was deemed necessary to enable effective analysis, the details of individuals' lives will not be detailed in the findings and strict adherence to data protection regulations will be maintained. As an experienced professional, bound by registration and code of conduct, I am attuned to such interventions and need for sensitivity. As an additional measure, in advance of each observation, discussion was held with the social worker participant to direct me to leave the room where my presence was deemed to be causing any distress, though in practice this was not needed.

The participant information sheets and consent forms make explicit my responsibility as researcher in processing, storing and destruction of data; of the limitations of privacy rights in relation to safeguarding concerns. An easy-read information sheet and consent form was developed with the support of members of a local disabled people's organisation. This encouraged me to consider how to simplify my explanation of the study and participants rights.

Consideration had been given to scenarios such as where an individual or carer discloses abuse to the social work participant. I committed to seeking assurance that the social worker reported this following the local authority safeguarding procedures in the event that this occurred. I also planned for abuse being disclosed directly to me, in which case I would report following the procedures of Cardiff University.

3.11 Interruption to data collection

Data collection was due to conclude after six months on 30.04.2020 but was temporarily paused on 19.03.2020 as a direct result of the Covid-19 virus, declared a pandemic on 11.03.2020 (World Health Organization 2020) and associated distancing measures activated. The last observation took place on 27.02.2020.

At this stage, referred to as stage one data collection hereon in, pre-observation interviews had taken place with five social workers, about planned interventions with ten individuals. Seven of the ten planned observations of practice took place; post observation interviews with social workers were recorded for all observations.

Four post-observation interviews took place with people receiving a social work service. Those who participated included people who had a learning disability, autism, stroke and dementia. Only one post-observation interview was held with a family member, who also had the role of personal consultee, because this was the only occasion family were involved during the observation. ‘Other professionals’ (A) were present during two interventions, though neither took part in post observation interviews. A full list of participants included in the study can be seen in Table 5 and Table 6.

Social Workers (SW)	People who receive a social work service (P00)	Family members or informal carers (F00)	Personal or nominated consultees (C00)	Other professionals (A00)
SW1	P1			A1
SW3	P4			
	P5			
	P6	F2	C2	
	P7		C3	
SW4	P8			
SW5	P9			A2

Table 5: Observations during stage one data collection between 31 October 2019 to 27 February 2020.

Social Workers (SW)	People who receive a social work service (P)	Family members or informal carers (F)	Personal or nominated consultees (C)	Other professionals (A)
SW1	P2			
SW2	P3	F1	C1	

SW5	P10			
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Table 6: Pre-observation interviews with social workers, where observation was cancelled on the day.

With no predictable end in sight to the pandemic, the decision was made, in consultation with my supervisors and research site, to amend the study design to enable sufficient data to be collated for this doctoral research. From a methodological perspective, the Coronavirus Act 2020 and associated guidance (DHSC 2020), posed challenges as the working practices had changed in response to the pandemic. The local authority advised that they remained stretched and capacity to support continuation of the study was limited. It was agreed that virtual focus groups with social workers would pose no risk to participants in relation to coronavirus, whilst not being overly draining of their time. The amendment was formally agreed by the Social Care Research Ethics Committee on 1 December 2020 (Appendix A). Focus groups were delayed until 20 April 2021 on the request of the research site due to demand on their resources. They concluded on 7 May 2021.

In total eighteen social worker participants attended focus groups; and one individual interview took place as identified in Table 7. Though invited, none of those involved in stage one observations took part in this stage. A further twelve social workers were booked onto focus groups but withdrew due to work pressures or did not attend on the day.

Focus Group	Social Workers	Notes
Focus Group A	SW6	
	SW7	
	SW8	
Focus Group B	SW9	Individual interview due to non-attendance of others on day
Focus Group C	SW10	
	SW11	
	SW12	
Focus Group D	SW13	
	SW14	

Focus Group E	SW15	
	SW16	
	SW17	
	SW18	
Focus Group F	SW19	
	SW20	
	SW21	
	SW22	
	SW23	

Table 7: Stage 2 participants who attended focus groups between 20 April and 7 May 2021.

The pandemic not only brought unpredicted challenges in concluding the data collection, but also impacted on social workers working practices which may have a bearing on the support principle (Coronavirus Act 2020; DHSC 2020). Having concluded the observational element of practice in stage 1, this aspect will not be explored in detail in this study.

3.12 Limitations

The impact of my own work commitments, alongside professional doctorate studies, had led me to set aside block weeks for research in stage one, with telephone discussion for planning the week prior. Having had little success in recruiting participants, I changed my approach, clearing my diary for a month ahead which was more effective. On reflection sign up would have been easier had I identified designated teams only, with sign-up from managers. Even then, where voluntary, there is no guarantees about this increasing participation.

The intended focus on private settings of people's homes, as set out in the research design, was in reality not so easy to orchestrate. People's lives are unpredictable. In one instance, a pre-arranged home visit ended up being undertaken at the local community hospital due to an unplanned admission over the weekend. It was also influenced by who volunteered to participate and their working environment and remit.

With my direct access to social workers being funnelled through first line managers, my ability to promote research participation was limited. This meant that there was minimal opportunity for me to make a pitch and discuss with social workers; to gain an understanding of the breadth of interest and reasons for any non-participation including selective bias. As such this limited my ability to gain a deeper insight into the subjective reasons social workers chose not to participate. From my perspective, having a full list of social workers to contact direct, as per my initial plan, would have been preferable.

The approach taken to data collection meant that I only observed snapshots of social work practice and only privy to glimpses of peoples' lives, as opposed to frequent and sustained contact.

3.30 Conclusion

Chapter three has provided an explanation of the epistemological, ontological and methodological underpinnings to this study, and reasons for the choice of methods. The position that I take as an insider has been considered as has the need for reflexivity throughout the data collection and analysis process to be able to step back from that which is familiar.

The data analysis and chosen themes have shaped the presentation of the findings of this study. Chapter four considers the professional identity of the local authority social worker, how their competing legal duties impact on their ability to support people to make decisions, and how their responsibilities to their employer shapes their practice. Chapter five then focuses on relationships, a theme that ran through the data, and the influence these have on decision making.

Chapter 4, Data Findings: The Local Authority Social Worker

This chapter focuses on the professional identity, knowledge and performance of local authority social workers in adult social care teams. It starts by considering what social workers perceive stands them apart from other professionals, underpinned by their professional values that have human rights and social justice at the core.

The data showed that in addition to the role of upholding rights, local authority social workers wear many hats. I was interested to explore the tension described by participants of a desired relational and value-based approach to practice, as opposed to procedural task-based practice that is dictated by the wider systemic, bureaucratic and legal context, distilled through their employer, the local authority. The need for social workers to fluidly change between a range of roles and responsibilities, from empowerment to protection, and between activist for social change to agent of the state, is explored. In practice the constructive tension between these varying aspects to the social work role, creates opportunities for discretion, resistance, and change.

I consider, through a systemic lens, how social workers' practice is shaped by their employment within local authorities. The duties to protect (Care Act 2014, section 42), to promote individual choice and control (Care Act 2014), as well as gatekeeping finite public resources through assessing need and applying eligibility criteria (DHSC 2023, section 6) are considered as conflicting responsibilities. Whilst legislation, policy, professional standards (Social Work England 2020), and ethics (BASW 2021), promote relational and collaborative approaches that place the person at the centre of decision making, local authority social work practice takes place within the context of neo-liberal policy and a decade plus of austerity (Cummins 2018), which arguably places responsibility on the individual rather than looking at structural causes of discrimination, oppression and inequality.

Analysis of the data findings in this chapter goes some way in answering the following research questions:

Research question 1: How do social workers understand the duty of 'taking all practicable steps' to help people make decisions for themselves under the

Mental Capacity Act 2005 (s1(3)); working together with additional duties to involve the person and support their decision making under the Care Act 2014?

Research question 2: What do social workers do to maximise a person's capacity to make specific decisions?

Research question 4: What are the challenges, tensions and enablers to social workers providing support for decision making?

4.1 The social worker as holistic professional

Taking a holistic focus and looking at a person in the round when considering the needs and assets of individuals is a fundamental aspect of contemporary social work (BASW 2021). The need to take into account the influence of family and community systems on individual lives are viewed as so important, it is included within the Professional Standards (Social Work England, 2020, 1.4). Social worker participants referred to this holistic approach as that which, in part, distinguished them from other professionals. They described their professional perspective as one that considers the macro, and how this differs from the micro that they attributed to health professionals.

Participants identified differences in approaches to that of other professionals:

'...the constant challenge of the medical model protecting people and doing for, when actually you know somebody's chosen to live this way their whole life...and so we [social workers] need to support them to do that. So it's about keeping them safe versus you know giving them autonomy and independence' (SW21).

"...the nurse only seeing them in their current crisis, never seen in their home...knowing very little about their life" (SW11).

What is inferred here is a difference in models of practice between social workers and health professionals. Participants viewed health professionals as working to the medical model of disability, which views disability as a defect to be treated, or where possible prevented, and focused on the limitations associated with a person's disability (Kett et al., 2009), versus social workers taking a broader,

holistic, perspective. It also indicates the social workers role as having a broader focus than that of medical professionals, which includes seeing people in multiple environments.

Social workers referred to their holistic approach to practice as the 'social model'. Whilst it could be assumed that they mean the social model of disability (Oliver, 2013), they could instead be using this as an umbrella term to capture a range of theories, models and approaches that they draw on within their practice. Statutory and professional guidance for social work with adults draws on a range of approaches (see Figure 1 below), from person-centred and strengths-based (Department of Health 2019), both of which are embedded within the Care Act 2014; the 'social perspective' written into guidance for Approved Mental Health Professionals (DoH 2008, p.4); relationship-based practice (Ruch et al. 2010); systems theory (Payne 2021) and so on. The common thread running through these approaches is the centrality of the person in need of support; recognition of the expertise they hold and what they wish to achieve; how the person's networks, community and wider society impacts on them; how the social worker relationship can facilitate change.

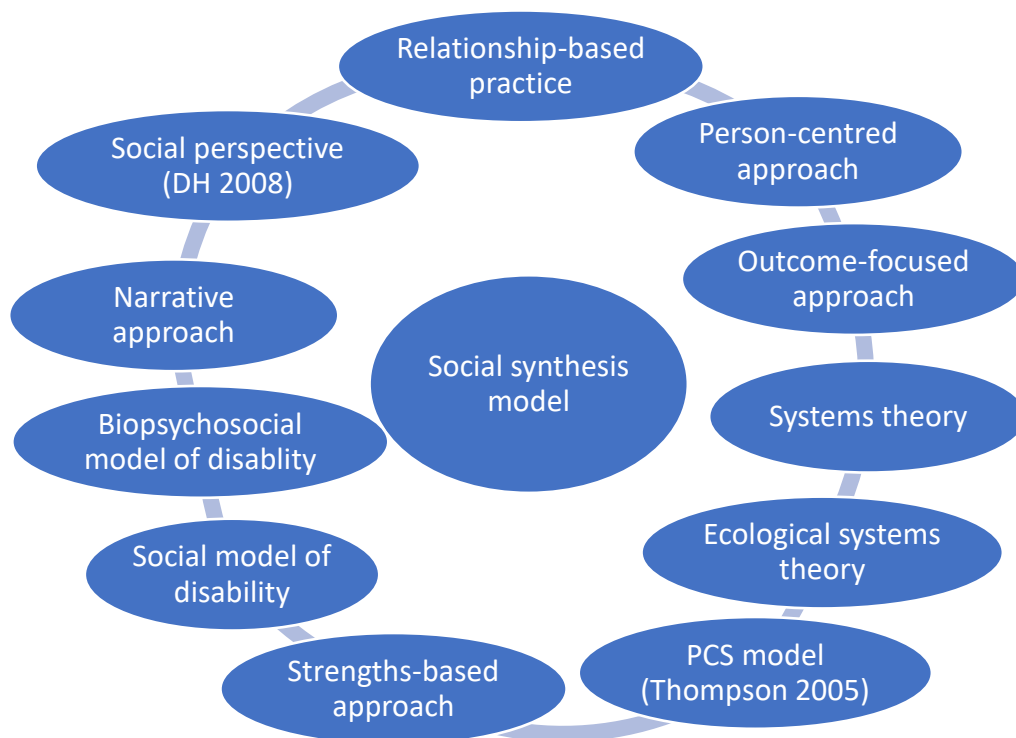


Figure 1: Influences on adult social work practice

I have interpreted participants' use of the phrase 'social model' as a broader term to distinguish social work from other professions, rather than in the manner in which social model of disability theorists such as Oliver (2013) apply it. For brevity, I will name it a *social synthesis model*, one that encapsulates a holistic, relational and systemic approach to practice. Referring to a similar collection of models used in child and family social work, Coulter et al. (2020) stress the importance of theoretical coherence to social work practice, and use the phrase 'contemporary systemic approach' (p. 1221) to refer to a range of models that have relationships and a social constructionist orientation at its heart.

Reference to underpinning models of practice is pertinent, not just because of how this situates social work practice, but because of the nature of multi-disciplinary working and the differing work environments that social workers are based in. Whilst all social worker participants were employed within adult services of the local authority, they were spread across various teams, some of which were co-located with health colleagues in mental health services or hospitals.

Working in health settings brought challenges to the professional identity of participants:

'I think it's quite easy in a hospital from what I've seen is that you can quite easily drift into that medical institution model and be talking about diagnosis stuff and that really isn't social work' (SW23, Focus Group F).

Despite the breadth of roles and working environments, participants' practice was heavily informed by the MCA's embedded values that align with the social synthesis model; it is core identity work for them that spans all aspects of their practice, regardless of setting. This is echoed in Hemmington et al.'s (2021) research on professional identities, which evidenced that the holistic perspective is not only something that social workers self-identify with, but is a discernible identity of the social work profession through the eyes of nurses. This social perspective was equally viewed as important in the Best Interests Assessor role (Ministry of Justice 2008), with the values of social justice, human rights, and supporting decision making being a central tenet to the role.

4.2 The social worker as upholder of rights

Upholding and promoting human rights is a central tenet of the social work profession, consistently listed in professional definitions (International Federation of Social Work, 2014; BASW, 2023). James et al. (2019, p.24), describe how the MCA helped them, as social workers, to rediscover themselves following a loss of identity that came with the care management years under the NHS and Community Care Act 1990; that the empowering ethos of the MCA, underpinned by human rights, provided a framework for 'real' social work. This feeling of being empowered by the MCA to promote and uphold rights was echoed by participants, and clearly core to their professional identity.

Social worker participants described themselves as '*champions for the law*' (SW23), and '*championing people's rights*' (SW20). Other references to the social work role included educating people of their legal rights, amplifying people's voice, of being a facilitator and support to decision making, of being an advocate. This rights agenda, consistent with the professions' value-based definitions set out in the Professional Standards (Social Work England 2020) and Code of Ethics (BASW 2021), was that which was put forward by social work participants as standing them apart from other professionalisms within the health and care sector.

It was recognised that the MCA does not stand alone but is rather interwoven with other primary legislation such as the Care Act 2014:

'You're assessing capacity whether you realise it or not. Every conversation you're having with people and everything you're gathering through the Care Act assessments or care planning it all goes hand in hand, it's so integral to every piece of work that you do really' (SW16 Focus group E).

This statement indicates the inherent complexity of assessing capacity; that the boundary is blurred and ill-defined. Such views are not unique to the participants of this study, but rather reflective of wider research findings (Willner et al. 2010; Ratcliffe and Chapman 2016). As well as being complex, assessing capacity is subjective (Ripley et al. 2008; Ruck Keene 2017), and as such the perspective and values of the assessor undoubtedly shapes the assessment outcomes. This was

acknowledged by participants, with SW9 questioning the appropriateness of 'anyone' being able to assess capacity because of this subjectivity.

The MCA was viewed as legislation that is very much aligned to the social work profession, with the Act's principles allied with social work's Professional Standards (Social Work England 2020) and Code of Ethics (BASW 2021).

"Within our social work training we are building on those morals, values, and looking at things like the mental capacity Codes of Practice. You know they're integral to our training...you could say them to any social worker and they'll be like, yeah we're doing that already...that's what we kind of sign up for isn't it when we go into social work...those values and codes of practice are so important" (SW17).

This alignment with the MCA is an important element of social workers' professional identity. It provides a boundary between them and other professions within the multi-disciplinary teams that they practice within. It is argued that such positioning of professional identity is to be expected within such contexts, with each seeking to define its speciality (Abbot 1988; Lymbery 2006). Yet despite this stated hierarchy, the majority of social work participants shared their lack of confidence in applying the Act in practice. This was unrelated to practice experience or length of career, and often discussed at the same time as describing the weight of responsibility in supporting people.

"I don't think I'm ever that confident if I'm honest...its quite a heavy judgement call you know, we're making big decisions about whether a person can make choices over their lives" (SW9, Focus Group B).

"It's [the MCA] not something I feel very confident with and coming out of children's services which was very prescriptive it's been a real learning curve for me with this and I don't think we're supported enough to know enough in our practice and how we tie [MCA] into it" (SW1).

As other research has shown, a lack of confidence does not equate to incompetence or vice-versa (Willner et al., 2013). Participants explained how applying the MCA in practice is not 'a strictly linear logical approach' (SW13). Focus Group D elaborated that hypotheses about meeting need and managing

risk are made by practitioners and put to those drawing on support, with these hypothetical options heavily informed by knowledge of available resources.

The heavy weight of decision-making not only indicates participants' discomfort with power, but the complexity of assessing capacity, and ensuring that an individual's rights are upheld.

"...what right do I have to sit here and say someone's got capacity or there's you know like unwise decisions? ...it can be daunting if people don't agree or there's conflict" (SW18, Focus Group E).

"I'm standing in a position of power and that's actually quite an uncomfortable place to be on so many levels...I always try and give the power to the person I'm working with and that just goes hand in hand with the capacity assessment. You're trying to give that person every single opportunity to understand what the question is and how to answer that" (SW17, Focus Group E).

"It's a big difference between someone not having capacity [for example] to manage finances and then never having had to do it. So, what can you do to help them learn those skills" (SW8, Focus Group A).

Acting in a person's best interests where incapacity was determined was described with equal difficulty.

"How do you determine the right course of action for this person?...what would this person do if they had capacity? What would they say? (SW6, Focus Group A).

I have reasoned that social workers' lack of confidence in the application of the MCA, in part, stems from a heightened awareness of the MCA, its nuances and the complexities inherent within its application; that they perceive their knowledge underpinned by a rights agenda to be above others.

It is arguable that social workers justifiably view their profession as that most aligned to the principles of the MCA. A commitment to promoting human rights is a thread that runs through social work definitions (IFSW 2014), the Professional Standards (Social Work England 2020). This is taken further within the Code of

Ethics (BASW 2021), stressing the need for social workers to empower people, something that is unique to the profession.

“But the huge challenge we have is the understanding of the Act by other professionals and how other professionals interpret it” (SW21, Focus Group F).

This comment goes some way in demonstrating social work participants' view that their legal literacy, particularly in relation to the MCA, was greater than many other professionals they work in partnership with.

This positioning of social workers' expertise in understanding and application of the law is amplified by the Chief Social Worker for Adults, Lyn Romeo. In the 'Knowledge and Skills Statement for Social Workers in Adult Services', a government published document, she states: 'Social workers have a key leadership role in modelling to other professionals the proper application of the MCA' (Romeo 2015, section 5), inferring that social workers are the experts in this area and application of practice is above the standard of others.

What these two statements omit is recognition that social workers' legal literacy and interpretation of the Act has also been criticised (Preston-Shoot 2012; Braye et al. 2013; House of Lords, 2014; Preston-Shoot, 2017). The House of Lords 2014 report confirmed that the application of the MCA by social care professionals, including social workers, was inadequate, and supported decision making is not well embedded into practice. Complaint investigations completed by the Local Government and Social Care Ombudsman have also evidenced failures in legally compliant MCA practice across social care local authority settings which includes, 'failures to carry out assessments...poor decision making when deciding on someone's best interests; and not appropriately involving families and friends in the process' (Local Government and Social Care Ombudsman 2017, p.1). A sizeable 69% of complaints relating to MCA practice made to this Ombudsman in 2016/17 were upheld following investigation (ibid, p.1).

In conversations and interviews, social workers appeared knowledgeable of the MCA; they regularly cited sections of the Act and nothing was said that was obviously in error, leaving me with the impression that they held sound knowledge

of the law. Whilst the specific focus of this research was not openly shared, social work participants, irrespective of team, described steps they took to support decision making. The importance of working in partnership with people, underpinned by the social synthesis model, suggests the 'support principle' is central to their professional values and practice.

"So, using all practicable steps to support [P8] I've seen her on three occasions...She's been given easy-read copy of the tenancy agreement so she's been able to go over that with [paid carers]...in between visits of seeing her" (SW4).

"I think a lot of the time I spend in supporting people's decisions is to help them understand what the decision is and what your realistic options are because they have priorities of which are different from social care" (Focus Group A, SW6).

"What their hopes and aspirations are as it were for their care journey, and where they want to be. What's possible. So if it's a decision about going back home, you know a description of the house, looking at how things were...so a whole discussion about their life really" (Focus Group B, SW9).

The MCA Code of Practice recommends steps that professionals should take when supporting decision making. This includes individualising communication, providing salient information, and involving others (Department for Constitutional Affairs, 2007, chapter 3). Participants' descriptions of their practice covered these points; in addition they talked about the importance of relationship-based practice, people being enabled to have choice and control, and in social workers taking a positive approach to risk.

As highlighted in the introduction chapter, the seeds of this study came from my own practice experience within the employment of local authorities and the considerable change made to a young woman's life when a social worker questioned and challenged the paternalistic and risk averse practice of other professionals and their misunderstanding and misapplication of the law. I was

interested in the approach taken by the social worker, the ingredients of their working relationships, and the difference made to the young woman's wellbeing as a direct consequence of the support provided and the loosening of imposed restrictions.

Seven years on, the participants in this study also spoke of the need to educate and challenge other health and social care professionals' practice in order to uphold individuals' human rights.

“But the huge challenge we have is the understanding of the Act by other professionals and how other professionals interpret it. Um and the constant challenge of the medical model protecting people and doing for, when actually you know somebody's chosen to live this way their whole life...and so we need to support them to do that” (SW21, Focus Group F).

The opposing underpinnings to practice of the medical model and the social synthesis model, that result in different priorities, were identified by social worker participants as one reason for the need to constantly challenge health professionals in order to uphold people's rights to be informed and make decisions.

‘Yeah we find that it is so impactful on every single case we work on because of the lack of understanding or lack of different interpretation of the Act from a different professional and every case I work on is always with other professionals you know, I don't ever work on my own, it's always with an MDT, always educating. So you can't get to the case and you can't get to working on the case because you first have to get through the barriers of other professionals opinions, which are valid and important, so you've got to acknowledge that and work through what their thinking is before you can even start to come up with a plan. And sometimes as we know and a lot in hospital, the medical teams, especially doctors and consultants make promises to families based on their assessments so, oh absolutely your mother can't make her own decisions, absolutely she needs to go to a care home, then it's unpicking that damage that's been done and then trying to educate the doctor whilst staying professional and then, and then supporting the family to make a you know a decision in their best interests. And it might ultimately be a care

home but it's how you get to that decision, it's not just, oh I think that so this is what's happening, it's the process of assessment' (SW21).

Differences in professional opinions were also seen to extend to the assessment of risk:

'There's a difference between thresholds of mental capacity assessment by by [sic], whether assessed by health than social care. Definitely the focus is different, is very much risk averse [by health professionals]' (SW11).

SW11 described how this is seen within hospital environments:

'...because of the medical model, somebody's unwell, they need treatment, they've come into hospital, the patient is compliant with the medical plan for them, was often mistaken I feel for having capacity' (SW11).

Differing perspectives were not only seen across the multi-disciplinary team. The subjectivity of the assessor when considering capacity, influenced by values, beliefs, training, personal and professional experience, as seen in wider research (Emmett et al., 2013; Jayes et al., 2019; Scott et al., 2020; Williams et al., 2014), was highlighted:

'...we're all very individual in how we approach assessments...I could go in and deem someone not to have capacity, [another social worker] could go in there and think they do have capacity...it can be a fine line' (SW7, Focus Group A).

'...we all have different backgrounds...we do come at things from slightly different angles' (SW17, Focus Group E).

Such statements strengthen the argument that the theoretical underpinnings to social work practice are important when interpreting and applying the Act. Whilst semi-structured questions in focus groups were directed on social workers' own practice, there was a resounding critique of health professionals' legal literacy and practice in relation to the MCA.

"...the criteria for finding mental capacity tends to be very different between health and social care staff. Quite often I was finding that health staff were basing it on compliance. We think they should do that and they need this and

they won't [therefore deemed as lacking capacity]. But then the opposite of that was because somebody didn't object they were finding they had capacity when they often didn't" (SW10, Focus Group C).

This statement implies that health professionals take the powerful position of expert, assuming they know what is best for people. Where individuals disagree with their recommendation, then it is more likely that they would be viewed as lacking capacity to make an informed decision, and substitute decision making would follow. Emmett et al. (2013) evidenced such practices in their ethnographic study of general hospital wards and how decisions about older people's discharge locations were made. In turn, where people went along with health professionals' recommendations about where to live on discharge from hospital, capacity assessments were not always undertaken even where there was evidence of substantial difficulty with decision making (ibid).

The notion that professionals know best fits with the traditional status and power of medical professionals, with doctors being positioned at the top (Clavering and McLaughlin 2007). Such use of power could therefore be seen as a legacy of such social constructs, compounded by society's negative views of older people (Centre for Ageing Better 2023). It was noted in focus group C discussion that doctors and medical professionals are seen as an authority:

'especially in the older generation...as the people that decide for them, and you know they know better, and have to be respected. Even, especially where people are confused, knowing that this is a doctor, or sensing...with the authority, [person drawing on support] would just say "yes yes" to it just because that's their almost like instinct' (SW11).

Underlying this statement is the suggestion that professional hierarchies can also be problematic for interprofessional working; that people will lean towards going along with the recommendations of health professionals even when that is not aligned to their wishes.

Social workers brought the social synthesis model to their understanding of the MCA and the way they practiced, for example challenging other professionals in their application of the law. Formal capacity assessments being initiated where individuals disagree with professionals' view of the best option in any decision is

reflected in wider research spanning the health and social care sector (Cliff and McGraw, 2016; Emmett et al., 2013; Williams et al., 2012). It also indicates professionals' tendency to conflate incapacity with 'unwise decisions' (MCA 2005,s1(4)), which has once again been identified in other research (Emmett et al., 2013; Jayes et al., 2022).

"...this person hasn't got capacity but that was often because although they did I felt, have capacity, they were not agreeing with what the medical model and with with [sic] the how you will get better and what you need to do. Because they didn't actually want to do that and wanted to take risks. Whereas on the flip side of the coin somebody would be seen as having capacity because they went along with medical treatment and the medical plan if the doctor said so, even if they desperately wanted to go home, they would accept going into a placement...because they felt that was part of the doctors or nurses decision about them" (SW10).

"You will often hear the phrase 'they are not agreeing short term placement so they don't have capacity because they can't possibly return home'" (SW11).

'The calls I get from the doctor is she told us she wants to move into a care home. I'm sorry, I just don't believe that, I've had none of that from [P5], I say she does not say that to me. They say you need to put her in a care home. All they see is the diagnosis of dementia, it's very medical led' (SW3).

Social workers clearly viewed themselves as more literate in the MCA than other professionals, and as such take a degree of responsibility to challenge others, but how well do they translate this knowledge into practice?

4.3 The social worker as protector

"It's about keeping them safe versus you know giving them autonomy and independence" (SW21).

Whilst in some discourse social worker participants positioned health professionals as paternalistic, risk averse, and overly protective, social workers also experienced the 'protection imperative' (Oldham MBC v GW and PW [2007] EWHC 136 (Fam)). Comments were made that older people's physical safety is considered a high

priority. *“Um and possibly a much higher priority than their emotional well-being and their wishes”* (SW14). This was attributed to cultural attitudes that the old need looking after, and the pressures on social workers to take protective action.

Wanting to keep people safe is an understandable instinct for those working across the health and social care sector. Care and safety go together. The responsibility of balancing protection with an individual’s right to autonomy is a particular tension for social workers. Safeguarding adults at risk, who as a result of care and support needs are unable to protect themselves, is not just an instinct or moral obligation but introduced as a statutory duty under the Care Act 2014 (section 42), and one in which social workers have a key role. Indeed, statutory guidance states many safeguarding enquiries will require the involvement of a social worker, and they will likely be the most appropriate professional lead in complex safeguarding situations (DHSC, 2023, para. 14.81). Balancing this duty to protect alongside the duty to promote individual wellbeing (Care Act 2014, section 1), whilst also upholding people’s rights for ‘unwise’ decision making (MCA 2005, s1(4)), can be complex.

SW3 had been supporting P4 for a number of years. Initial involvement had been in response to safeguarding concerns around the risk of a house fire due to the amount of belongings in his home that was associated with hoarding. At the outset he was largely independent and did not meet the threshold for care (Care Act 2014, section 13; Care and Support (Eligibility Criteria) Regulations 2015), though the large quantity of belongings in his home impacted his living standards, and the safeguarding duty (Care Act 2014, section 42) meant that SW3 remained involved. Over the past few years, P4 had deteriorated physically and cognitively and had become eligible for care. In a post-observation interview, I asked P4 how the social worker had been supporting him:

“[SW3] just got a bee in [their] bonnet about me and [they’re] trying to get me out into a different way of life, I don’t know um, I’ve often been very happy with the situation I’m in you know. At the moment, I’m in a bit of a mess” (P4).

P4’s comment alludes to a feeling that his lifestyle choices were being judged, that the social worker had a different view of how his life could or should be, whilst acknowledging his current situation was problematic. Separately, SW3 had

explained how they had until now resisted pressure from the GP, housing support and others, to take protective action that went against P4's wishes, in response to concerns about hoarding, something that is seen as socially unacceptable. Instead they had supported P4's wish to live his chosen lifestyle, and taken care to only introduce support at an incremental and proportionate level over a number of years. They stressed the importance of a person's autonomy, citing Judge Munby "What good is it making someone safer if it merely makes them miserable?" (Local Authority X v MM and Anor (No 1) 2007). However, things had now changed. With P4's hospital admission due to smoke inhalation from a house fire, the risks had increased and consequently the situation had to be reviewed.

A number of social worker participants described the great pressure they felt to minimise or prevent harm. This came from what they described as the expectation from third parties, ranging from loved ones of those drawing on support, nurses, doctors etc. as well as from their own employer. The weight of decisions and associated risk was noted as a trigger for formal capacity assessment. It was acknowledged by participants that the dominant focus on risk can result in needless or premature mental capacity assessments which are used to protect professionals and organisations from liability for decision making.

"I've seen [mental capacity assessment] used as a, ah this is just to cover my back. So having that piece of paper and that formal decision to say they do have capacity but now I've got it in writing. But did they...have any reason to be questioning their capacity in the first place?" (SW22).

The culture of blame that is associated with a 'risk society' (Beck, 1992; Giddens, 1990) can result in defensive social work practice. This pressure to predict and manage risk not only comes from the public or other professionals, but from investigative processes such as Safeguarding Adult Reviews (Care Act 2014, section 44)² and inquests; potential litigation for breach of a duty of care, as well as disciplinary proceedings by employer or professional regulator. The reviews retrospectively examine how agencies coordinated their duty to safeguard individuals where serious harm or death has occurred, there is probability that this

² Serious Case Reviews were used between 1998 to 2019 before being replaced by Safeguarding Adult Reviews under the Care Act 2014

could have been prevented, and to learn from the findings to improve practice and prevent similar tragedies in the future. Concern has been expressed that the dominant discourse of failure, focusing on what went wrong, may be damaging to social work practice (Martineau and Manthorpe 2020; Preston-Shoot et al. 2022); that there's an over reliance on individual practice rather than highlighting systemic failings (Jones 2014). Drawing on the research by Preston-Shoot (2019) into the findings of Safeguarding Adult Reviews for individuals who self-neglect, the complexity of balancing autonomy and protection is a dominant theme, as is the complexity of assessing mental capacity.

Where professionals do place emphasis on independence and autonomy, they are open to criticism, as evidenced through Safeguarding Adult Reviews. One found professionals 'misplaced respect' for the choices of a young man with learning disabilities, and supported decision making was lacking (Flynn and Eley, 2015, p.33); another review found that there was a lack of proportionality and failure to assess capacity by adult social care practitioners who were involved in the care of a man found dead in a squalid flat (Kingston and Mortimer, 2018); a third that professionals' focus on independence and choice of Mr X, a man with mental health needs, meant that his ability to manage his environment was overlooked (LGO and PHSO, 2014). Media representation also fuel the blame culture. Leedham's (2022) research on the depiction of social workers by the UK media illustrated that of the negative portrayals, which far outweighed the positives, the perceived failure to act dominated criticism, in comparison to seemingly over-zealous interventions.

Whilst none of the participants used the term 'duty of care' (Kemshall and Pritchard, 1996), the expectation that risk can be identified, measured and managed, a notion that Bartlett (2020) argues is the leading principle of society, means that social workers, as agents of the state, can lack confidence in supporting individuals to take risks due to fear of blame when things go wrong. As such paternalistic practice overrides the principle of empowerment. Whilst not specific to social work, Jingree's (2014) research demonstrates how this duty of care is used by support workers of people with learning disabilities to justify their control of choices and construction of incapacity where decisions are viewed as deviating from the social norm or too risky.

When discussing hospital discharge options for P4, SW3 shared that they had not only had a responsibility to protect P4 as an individual under safeguarding duties (Care Act 2014, section 42), but also a responsibility to consider the safety of the public. The risk of a house fire at his home also posed a threat to the neighbours. This demonstrates the tensions in defending the rights of the individual versus the protection of wider society, how central the concepts of risk and risk management play in the assessment and decision making process, and how supporting decision making has its limits within UK law and policy.

In a Court of Protection hearing, Judge Hedley stressed the importance of principle 3 of the MCA (s.1(4)) to permit people to make unwise decisions:

“The plain fact is that anyone who has sat in the Family jurisdiction for as long as I have, spends the greater part of their life dealing with the consequences of unwise decisions made in personal relationships. The intention of the Act is not to dress an incapacitous person in forensic cotton wool but to allow them as far as possible to make the same mistakes that all other human beings are at liberty to make and not infrequently do” (A NHS Trust v P & Anor [2013] EWHC 50 (COP).

As already discussed, honouring this principle in practice is fraught with difficulty. In the context of hospital discharge Emmett et al. (2013) compared MCA practice by healthcare professionals with legal standards. They found that risk considerations and outcomes that are considered best by professionals, heavily influenced capacity determinations. Whilst P4 had been supported to make decisions about his lifestyle that were deemed as unwise for a significant period of time, the social worker’s threshold to maintain this position appeared to now be met.

4.4 The social worker as bureaucrat

“We spend seventy-five percent of our time in front of a screen frustratingly” (SW3).

A key barrier to supported decision making identified in my observations, interviews and focus groups was a lack of time. The above statement was made

by a social worker participant when asked about that which hinders their practice. Their ability to practice in the manner they wish, that meets not just their legal duties but their Professional Standards (Social Work England 2020) and Code of Ethics (BASW 2021), was in their view hindered by the level of bureaucracy demanded by their employer. As a result, adequate time and space to build relationships and support people with decision-making, as desired by social worker participants, was felt as lacking.

This was not an isolated comment. After observing SW4 in practice, they noted that they were unable to go out in person to meet P8's significant family member to consult about best interests following the conclusion of a capacity assessment, because of the need to '*complete hours of paperwork*' to evidence their work. Instead, they were going to have to '*make do with a quick call*'.

It is not possible to state with confidence the accuracy of SW3's statement as measuring social work activity was outside the scope of study. Having said that, it does align with findings from Baginsky et al. (2010) which found adult social workers' 'overall direct contact with clients accounted for one quarter of working time' (ibid, p 60). Others have highlighted the increased bureaucracy that came with care management under the NHS and Community Care Act 1990 (Lambley, 2010).

'I'm really reluctant to make capacity decisions based on a half hour visit'
(SW3).

The implied inference in this statement is that the complexity of assessing capacity is not recognised. Instead it is the completion of tasks that is valued by the organisation; that social workers' practice is measured by the assessment documentation as opposed to their direct intervention. Social work intervention itself is not measured, instead it is the number of assessments completed, waiting time, number of funded care packages etc. (NHS Digital 2022; Care Quality Commission, 2023). The demand on social workers for throughput of work due to increased demand (NHS Digital 2022) and vacant social work posts (Skills for Care, 2023), left participants having to complete interventions under time constraints that left little scope for supporting decision making. When describing how they support people who draw on services, social worker participants

described a perceived lack of understanding of their role and direct practice skills by managers and/or the system.

'I don't know that it's recognised generally by management, I mean I've got an extremely good manager, but we have a certain number of new referrals to take on each week and I don't know whether it's recognised that these things all take time, as does afterwards considering them, but the pressures are sometimes on one because everybody's got their own thing' (SW10, Focus Group C).

SW10 was not the only participant to be critical of management as a collective, whilst also being more positive about their direct manager, demonstrating a relational aspect that offers some space for negotiation. Whilst frustration of such constraints to practice were shared by participants, there appeared a sense of powerlessness to effect any meaningful systemic change, and an acceptance that managers and the wider organisation dictate how they practice.

In contrast to the values-based definitions of social work (International Federation of Social Workers, 2014; Social Work England, 2019; BASW, 2018), a plethora of documents published and/or endorsed by the government focus on tasks and technical competencies in various capability statements (Department of Health 2015a; DHSC and BASW 2018; DHSC and BASW 2019; BASW 2024). These numerous attempts to define contemporary social work goes some way in demonstrating the multi-level nature of practice, but also fuels the ambiguity.

Relationship-based practice (Dix et al., 2019), evidenced through the Named Social Worker pilot as effective in supporting decision making (SCiE, 2018), was highly valued by participants, yet as already described the bureaucratic system is not designed to afford practitioners time to develop or sustain relationships. The model of episodic working as a form of workload management, being reactive, short term intervention as opposed to having a named social worker who provides continuum support, remains the norm, with the focus on the speed of assessment being completed, and management of risk.

"I don't have any more time" (SW4).

Time was a subject that was raised frequently by social workers throughout. It was viewed as both an enabling and disabling factor in building relationships and supporting people with decisions. When practitioners shared examples of what they perceived as good practice, it included having the benefit of time, of being afforded time. It was something however that they often described as having to negotiate with individual managers, create or find time under the radar of the rules and norms of the organisation's expectations.

This is not a new perception. High levels of administrative tasks (Ravalier et al. 2021), high caseloads (McFadden et al. 2018; Ravalier et al. 2021), and an absence of workload weighting systems in adult services which take into account the complexity of need and time required to support people (Ravalier et al. 2021), have been evidenced and found to impact on social worker wellbeing and ability to build relationships with people.

Restrictions on time to support people was not only perceived as the product of the organisation but attributed to the poor legal literacy and practice of others external to the organisation. This was demonstrated by SW4 who had been assigned the task of supporting P8 to make a decision about a necessary house move and sign a tenancy agreement. P8 has a learning disability and is known to require support with decision-making. Her long-term living arrangement was under a Shared Lives scheme funded by the local authority. Her Shared Lives carer, who she shares a house with, had bought a new property and was relocating. The local authority had been notified less than three weeks prior that the move was taking place and that P8 was moving with them. The actual referral received was a request for the social work team to '*look at [P8 and housemates] capacity around buying all the furniture [for the new house], that's already been bought*' (SW4), as capacity to make such decisions was in question. The enormity of impact on the rights of individuals due to the care provider's ignorance of the MCA was noted by SW4. No alternative options had been given to P8 about the move; no consideration to the fact that a tenancy agreement would have to be signed as this move would sit outside of the Shared Lives scheme; belief that a retrospective capacity assessment could be made about money already spent.

I observed SW4's efforts to explain to P8 the salient points of a tenancy agreement in easy-read format. This was their third visit in ten days specific to this issue, and it was felt by SW4 that were they given more time, there was potential that P8 would be able to understand and sign her own tenancy agreement. Yet SW4 was forced into making a determination about capacity earlier than they were comfortable with. They were out of time. The house move was going ahead the next day regardless. The upshot was that SW4 concluded that P8 lacked capacity to sign the tenancy agreement and a best interests decision was to be made instead³.

The time frame for the house move impacted on SW4's ability to support P8 to make her own decisions and identify at least one alternative option to choose from. They were not only looking at P8's capacity to consent to the move and understanding about change of accommodation, but also three of her housemates.

'I've had about two, two and a half weeks to get all the assessments done, meet all four of them, look at all their capacity, so as you can imagine I've been pretty busy. I've been almost living up there' (SW4).

The late notification of the move meant that what could have been planned support to enable P8 and her housemates to consider the implications of a house move resulted in a reactive intervention. SW4 described the need for multiple capacity assessments. To compound this, SW4 had never assessed a person's capacity to sign a tenancy agreement prior to this and shared their lack of confidence. They had sourced an easy-read tenancy guide independently. How likely it would be that this decision be revisited is questionable.

Other participants noted the challenges of follow up and how rare it is to review capacity decisions in six- or twelve-month periods (Focus Group E).

'One area that maybe gets overlooked is the revisiting of MCAs I think. I think often like you know I've got people who say are in a care home and you've

³ A third party can only sign or end a tenancy agreement on behalf of a person who lacks capacity if they have legal authority under a registered Lasting Power of Attorney, or Enduring Power of Attorney; a Deputy or other person appointed by the Court of Protection. If nobody holds such authority then an application to the Court of Protection to agree the tenancy on the person's behalf can be made.

done the MCA quite often if they haven't got capacity or is deemed they haven't got capacity I think it's quite rare that you then go back like you know six months, twelve months' time and you reassess it again' (SW15, Focus Group E).

Time restrictions for contact with people was particularly problematic for those social workers supporting people with hospital discharge.

'...often at times at point of [hospital] discharge yes they lack capacity, but whether they are all followed up in the community in a timely way, yeah its very questionable' (SW16, Focus Group E).

'Yeah very questionable I would say yeah. So again I've got again a supportive manager who will, who will allow me that kind of flexibility' (SW15, Focus Group E).

Two examples were given to demonstrate the excessive bureaucracy, both relating to the process of providing choice to people, which hinders supported decision making. Firstly, the identifying of options available to meet eligible social care needs, and secondly obtaining funding approval to secure the resource of choice. Social workers' direct involvement in sourcing care for the people they support was curtailed with the introduction of the NHS and Community Care Act 1990 which brought about a purchaser provider split. This led to the creation of brokerage systems, which has been continued under the Care Act 2014. Social workers identify people's needs and support them to plan how their care is met. Where formal support is required, it is the brokers' role to source and purchase this care from providers.

The interface with the brokerage system is integral to identifying accommodation and care options available to people. Think Local Act Personal (2013) explain the term broker as "someone whose job it is to provide you with advice and information about what services are available in your area, so that you can choose to purchase the care and support that best meets your needs..." (ibid). This suggests direct contact between broker and the person drawing on social care which was absent. In fact, it was the role of the social worker to relay information from the brokerage team.

Participants explained that their local brokerage system had been designed to require consent from the person drawing on support, or a best interests decision, in order to initiate the search for care and/or accommodations, so capacity assessments were completed at a premature stage based on abstract concepts:

'...but we have a process...you're assessing their capacity without actually showing them what's out there. Because in order to, you see what I mean, you need to assess their capacity in order to act on their behalf to go through the brokerage system and identify appropriate placements' (SW7, Focus Group A).

Rather than gaining consent, or making a formal best interests decision following a capacity assessment, for brokerage to explore options; and a separate subsequent decision about care arrangements, participants described a process in practice where these two separate decisions are conflated into one.

It was suggested by one participant that such an approach was *'a sort of pre consultation about developing the options'* (SW14, focus Group D), rather than a legally compliant capacity assessment. However, it was acknowledged in the focus group discussion that in practice, systems did not support capacity assessments to follow a strictly linear logical approach and the capacity assessment was unlikely to be repeated once tangible options had been identified.

Thus, a person's capacity to make a decision, for example about where they may live and receive care, would be assessed without any detailed options being provided. This goes against the legal framework of the MCA, statutory guidance (Department for Constitutional Affairs, 2007), and practice guidance informed by caselaw (Ruck Keene et al., 2024), which clearly sets out capacity as being decision specific and can be broken down in various ways:

Capacity to consent to an assessment of need;

Capacity to make decisions about care needs in general;

Capacity to consent to share their information with brokerage and potential providers;

Capacity to make decisions about care and accommodation;

Capacity to make a decision about a specific care home.

The 'support principle' recognises that people can have substantial difficulty being involved in decisions (Care Act 2014), however it is not possible to determine a person's capacity until the salient information is provided and viable options shared.

Rather than enhancing social workers' ability to provide information about available options to support decision making and maximise individuals' choice and control over how their needs are met, the brokerage team were described as the controllers of information. SW7 went on to say:

'So when it comes through brokerage there might be three potential placements, but they will only let you as a social worker, they will only provide you with the cheapest first...and uh you know then you've got to say why you don't think it's good enough...before they then will release that the next one after that' (SW7, Focus Group A).

This piecemeal approach to providing information to people jars against social policy that promotes choice and control over the care people need and receive (DHSC 2021), something which is promoted and a celebrated banner of the local authority. Instead it indicates an organisational culture that adopts a tight definition of best value as that which is cheapest. Statutory guidance permits local authorities to consider costs when deciding what is a suitable option to meet need, but explicitly states 'this does not mean choosing the cheapest option' (DHSC, 2023, 10.27). Publicly accessible policy documents of the local authority research site define best value as '*the most appropriately costed care package to enable a person's eligible needs to be met*' (anonymous, 2018⁴), and applied where the local authority funding is being requested. It goes on to say that preference can be expressed by people about preferred choice of accommodation, but best value takes precedence, unless people have the means to make a top-up payment to cover the difference in cost. The research site is not alone in adopting such positions. Within the context of austerity (Cummins 2018) and increasing pressure on local authority budgets (NHS Digital, 2022), choice and control over care is

⁴ Document reference withheld to maintain confidentiality of research site.

being diminished, replaced by the cheapest option to meet need on the grounds of achieving best value of finite public resources (Bottery and Mallorie 2024).

For SW7 the consequence of this system led approach prevented them from taking 'all practicable steps' (MCA 2005 section 1(3)) to support decision making. It meant that they were prevented from supporting people in a personalised and enabling way, unable to take them out to view different models of living to make informed decisions about how they live their lives, something they viewed as proportionate when making such life changing decisions, as they had done in the 'good old days' (SW7).

This nostalgia of the past is not new. For example, social work educators' perspectives on changes to education and practice examined by Walz et al. (1991) were equally expressing inferior standards within the new generation of practitioners. It has been argued (Brandt et al. 2016) that the one directional perspective of good social work practice being situated in the past, misplaces accountability on new generations of social workers instead of contextualising practice within changing political and societal factors.

Completing mental capacity assessments based on abstract concepts was therefore described as a necessity because of organisational process. For example, a decision to move to a care home is based simply on a discussion about hypothetical generic care, rather than specific available options. This was in direct conflict with participants' articulated legal knowledge about the need to provide concrete options, as reinforced by the courts (CC v KK and STCC [2012] EWHC 2136 (COP)). The significance of such an approach on people who draw on support was recognised by participants:

'... we work with people in the community maybe expecting people to make a decision about something they really know nothing about. They've never been there [care home], they've never seen it, they don't know what it looks like inside, they don't know what the routine is gonna be' (SW14, Focus Group D).

The rules and routines of care homes are variable. As such people require salient information, for example about any restrictions on receiving visitors; what private and shared facilities there are. This was put under the spotlight during the Covid-19 pandemic where some care homes curtailed residents' freedom to go out, to

have visitors, beyond that of the general population (Daly 2020; Tumelty et al. 2022).

SW14's comments capture the conflict and distance between the ideal and reality of practice in a local authority in England. How social worker participants wanted to practice, and the ways the system prevents or controls this became more apparent through discussion within the focus groups.

The importance of exploring options and having a choice was also expressed by people who have need to draw on formal support. P5 summed up the importance of actually viewing accommodation options when she was looking to downsize to a smaller property:

'[SW3] didn't, or I didn't tell [them] what I wanted, and I didn't know what I wanted, and [they] kept showing me all the things I didn't want. But [they] didn't know that because I didn't tell [them] that' (P5).

'Well sometimes we don't know what we want until we [sic]' (researcher).

'Well I didn't you see and [they] took me out to the country and I thought how am I going to get to the supermarket...[they] did realise that and change it' (P5).

It was the process of looking at different accommodation options that assisted P5 to identify what she did and did not want. The freedom to view options in this case was because P5 was self-funding, meaning she was not entitled to help with funding her care as her capital was above the upper threshold (DHSC, 2023, section 8.12). Consequently, the social worker could act independently of the brokerage system to support P5 to make an informed decision. This was not however a similar experience for those financially dependent on the state. When discussing hospital discharge options with P4, a 'step-down bed', a type of intermediate care that provides up to six weeks in a care home whilst needs assessments are completed and longer term options for care and accommodation are explored (DHSC, 2020), was proposed.

'Would you go with that?...I don't want to force you in, you might want to think about it' (SW3).

'Well that would depend on the care home. Where is it?' (P4).

The social worker could not provide such detail. They sought to identify P4's preferred area, and said they would do their best to source care near to his wife, but ultimately it was down to availability.

'They will discharge you from here when you're medically fit. In other words you've got to be safe to go home and medically stable' (SW3).

'I've got to have a home, I've got to have a home they consider fit?' (P4)

'Now because of the fire they may say your home is not fit to go back to because I don't know what the damage is from the fire' (SW3).

'Nor do I' (P4).

'So what I'm going to suggest is that, with your permission, that we find what we call a step-down bed in a care home, just for a couple of weeks for you to try, then we make decisions, not here' (SW3).

Whilst this implies decision making is deferred, it is itself a decision none the less. Whether his home is inhabitable is not known. It does offer P4 a taster of a care home yet I question the likelihood of a return home. My reflection notes taken during and following this observation reads:

'Verbal overload. I struggled to keep up with pace of information being given by social worker even though familiar with the health and social care system and acronyms used. Was every care and accommodation scenario covered because I was observing? What do the terms 'step-down bed' or 'CHC' mean to members of the public? Difference in residential and nursing care? Supported accommodation? Social worker asked, "are you going to remember what we're going to do?" when fully aware of confusion and memory difficulties due to dementia. Nothing written down for them to read again later and no third-party present to support or go back over conversation. The only thing I left being clear on was that this man was going to be moved straight from hospital to an unknown care home of an unknown location for an unknown period of time. I hope that he is well supported to review this decision within a few weeks as promised' (Researcher field notes).

It was left open as to whether SW3 would revisit P4 in hospital before his discharge to a care home, *'I'll come back...or we can maybe get you straight out'* (SW3). It was explained to me that there was substantial pressure to facilitate hospital discharges in a timely manner (DHSC, 2020) so it may be that a call to inform P4 where and when he would be moving would be all that was practicable to achieve. This clearly has an impact on social workers' ability to support decision making as viable options are not provided, and the space and time to explain what facilities would be available, what area the home is situated in, and how contact with loved ones would be facilitated is restricted.

Once care options have been identified a request for funding is sought. Participants described this as an overly bureaucratic process that heavily shapes choices available to individuals, one which demands a bale of documentation to justify their professional recommendation for funded care.

'...one of the first questions a manager will ask is if there's any doubt around somebody's you know assume capacity, they'll be like have you done a capacity assessment? If not why not and certainly things like you know panels, funding panels that other stuff you know you need to be demonstrating that you've assessed somebody's capacity and you know what their wishes and feelings are' (SW15, Focus Group E).

Having capacity assessments as a standard requirement within a bundle of evidence to achieve funding of resources goes against the first principle of the Act of presumption of capacity (MCA 2005 section 1(2)). The onus is not for an individual to prove they are capacitous but for the burden of proof to be on the person questioning this to evidence 'reasonable belief of lack of capacity' (Department for Constitutional Affairs 2007, para 4.44). The Care Act sets out the expectation that local authorities have due regard to the use of 'approval panels', referred to by participants as funding panels, not to be used to amend planning decisions or purely for financial reasons (Department of Health 2014, para 10.85). Nevertheless, panels were described by participants as another gatekeeper to resources and where decisions were resource led and based on cost rather than individualised need. Social workers suggested that they held little power when it came to panels and their professional recommendations were not always

supported. A survey run by Community Care reflects such views, finding 95% of local authorities in England utilised approval panels to make decisions about care provision; 54% of practitioners were of the view their professional judgement and recommendations were not always respected; and where the recommended care provision was refused or deferred, the most common reason was cost (Carter 2018). Such practices indicate that approval panels are being used beyond their intended purpose, and the disempowerment of social workers' professional expertise.

Parity of funding across adult services was highlighted as problematic, and an area where social workers could take action to uphold rights:

'If you look at different client groups um and you look at older people...they don't have options that would be made available to a slightly younger group or different need set um so its almost standardised that you, well this is the option, its either a care home or you can manage at home with a maximum of four visits a day. Um and I think that's where we fall down a bit in championing just those options that we know are available because if we were to challenge that a lot more and say look all these options are available to different client groups maybe there would be some change' (SW23, Focus Group F).

In this local authority, a character limit is imposed to the approval panel submission form, meaning practitioners have to fit relevant information into the box rather than the amount of recorded information being led by professional judgement. This word limit is also replicated in the needs assessments and criticised by participants:

'I spend half my time asking myself what I can leave out because there's too much information, it doesn't fit and so you're sort of cramming things in' (SW6).

As outlined in chapter two, such obstruction to professional social work practice through the introduction of care management has been widely commented on (Spolander and Martin 2015). It reflects the dominance of bureaucracy, narrowing the role of statutory social work to routinised assessment and prescriptive service provision. Placing greater value on procedural aspects of practice that is dictated by managers and policy makers (Smale et al., 2000) can be seen to weaken professional decision making. This leads to 'zombie social work', as coined by

Forrester (2016), whereby the focus of many local authority managers within supervision is on 'the what and the when, with little consideration of the why or how' (ibid, p.12), rather than reflective practice which has been evidenced as aiding social workers' decision making (Cross, Hubbard & Munro 2010).

Maintaining accurate and up to date records is a key requirement of social work (Social Work England 2020; British Association of Social Work 2021) and accepted by participants as relevant. Yet, organisational processes were described as excessively bureaucratic, or dictating of practice and steering practitioners down set paths.

4.5 The social worker as conflicted professional

'Damned if you do, damned if you don't' (SW3).

This statement epitomises the conflicting aspects of the social work role that participants demonstrated and described throughout the observations, interviews, and focus groups.

Whilst the social work profession and individual social workers identify as holistic professionals, the scope for structural change at community or society level (International Federation of Social Work 2014) appears limited. Instead, social workers' influence was, in the main, observed and described at the individual level. This took the form of reducing barriers to individual participation through use of reasonable adjustments, advocating, and supported decision making; through education and challenge to other professionals and family members.

Yet social workers' powerlessness to do any more, to challenge systems and structural disadvantage, was an undercurrent that ran throughout the data collection period. These barriers and lack of power was drawn on to explain and justify the gap between their expression of how they wished to practice, versus that which was actually achievable within practice.

Social work practice takes place within a multi-disciplinary context. In addition to partnership working with individuals, collaboration with other professions is a core standard of Social Work England (2019, 3.6), and central to meeting individual's needs and safeguarding adults at risk. Partnership working is stressed as

particularly important in the context of health and social care integration (DH, 2015, section 9), something which is increasingly on the agenda as noted in chapter two. Capability statements note that social workers should 'challenge partners constructively to effect multi-agency working' (DH, 2015, section 10). In practice, maintaining positive collegial working relationships when needing to frequently challenge health professionals' legal literacy or disagree about mental capacity and/or 'best interests', was noted as difficult to achieve (SW10, Focus Group C).

Legal literacy is another important component within social work, and in ensuring that practice promotes and upholds individuals' rights to make their own decisions. Nevertheless, knowing the theory and translating that into practice are two different skills.

Social work qualifying education programmes, set at degree level or higher since 2003, are required to meet the education and training standards set by Social Work England (2021), which includes ensuring that training is 'in line with research and developments or changes in legislation, government policy and current best practice' (ibid, para. 4.4). As such it is reasonable to expect a baseline of legal literacy across the profession, which by default includes the 'support principle' that sits under the Care Act 2014 and the MCA. As noted previously, I was left with the impression that participants had good knowledge of the law, yet their confidence was lacking, and the complexity and subjectivity of assessment were highlighted.

Participants were largely left unsatisfied from the training made available to them in their qualifying programmes and that by their employers. Whilst accepting that training does not automatically result in knowledge retention or transfer to practice (Jenkins et al. 2020), some practitioners reported not having had any specific MCA training (SW1; SW9; SW12). Neither were all clear as to what training was available to them through their employer, or how to access it (SW6). Training that had been attended was viewed as a useful underpinning of the legal framework (SW15) but there was a clear need expressed to move beyond the overly generic surface level training and broad decisions such as care and accommodation (SW4; SW6; SW9).

Drawing on Jenkins et al. (2020) literature review of health and social care practitioners MCA training, the majority of MCA training provided to social workers is mandatory and accompanied by refreshers every three years. Pike et al. (2010) concluded that whilst e-learning could instil basic knowledge, the lack of opportunity for discussion and peer learning was a negative. This was further supported by Manthorpe and Samsi (2016). In person interactive training that draw on scenarios was seen as a strength in linking knowledge to practice (Gough and Kerlin, 2012; Lee-Foster, 2010; Pike et al., 2010; Willner et al., 2013).

The views of social worker participants within this study reflect such findings. Social worker participants' frustration with having to complete MCA refresher training on a three-yearly basis, as a standard set by their employer, was attributed to the pre-requisite e-learning, viewed as containing overly basic content for the social work role:

"...I don't want to sound arrogant because there's always things that you don't know but it's exhausting to think I've got to go and do all that bloody [e-] learning again now before I can get on this [refresher] course" (SW7, Focus Group A).

Compliance with refresher training was perceived as poor, with some participants sharing that they were overdue by up to five years. This was attributed to the responsibility being put on practitioners to book, limited spaces, location of training, absence of consequences of non-attendance, as well as having to prioritise case work. Participants explained the covid-19 pandemic worsened delays as training was put on hold through its peak, however responses on this topic were similar across stage one, pre-pandemic, data, and stage two, post-pandemic, data.

Social worker participants referred to the difference between theory and application in practice of the MCA, recognising the inherent complexity of capacity and the uniqueness of individuals, meaning that there is no one size fits all approach. In general, participants agreed that learning was optimised through practice experience and partnership working. This is comparative to other research findings (Ratcliff & Chapman 2016; Cliff & McGraw 2016). Opportunities to move beyond the theoretical, to observe others completing capacity

assessments, and for them to be observed and receive feedback, was highlighted as a gap. Practitioners were aware that to be legally literate they need to keep up to date with case law as well as comprehensive knowledge of relevant legislation. A few participants noted that they independently access external information sources such as the 'Mental Capacity Resource Centre' (eq Chambers, 2022), but reading and confidence in interpreting case law independently was low.

"I don't think the vast majority of the practitioners, certainly in our frontline social work team, have the luxury to go over and understand a lot of the case law that comes out" (SW16, Focus Group E).

The requirement to maintain continuing professional development is an individual responsibility under the professional regulator (Social Work England, 2019, standard 4). Yet, participants clearly took the perspective that their employer should facilitate this to some degree. Some participants shared that their manager had agreed protected time for peer group discussion each month that they could log as continuing professional development. This was viewed as supportive, but was an individual manager's decision rather than being reflective of support across the organisation.

Enhanced training to become a Best Interest Assessor, created as part of the Deprivation of Liberty Safeguards as an amendment to the MCA to provide an independent appraisal of the care and treatment of those subject to restrictive care plans (Hubbard 2018), had been accessed by two of the participants without taking up the specific role. Instead, they described the training as enriched knowledge that complemented their social work role. The regular refresher training provided to maintain Best Interests Assessor currency which includes updates on case law was particularly valued and something peers commented that they missed out on.

Critical reflection is something that is required of social workers (Social Work England 2020, section 4.2), used to challenge the self and others, to identify bias, good practice and aid learning. Research participation in itself was viewed as valuable to learning, with lack of confidence in the application of the MCA given by some as the reason for wanting to participate. Having time to reflect was a concern that was raised:

'I feel quite torn sometimes because you can't just take the time to do something, and I'm sure I don't at times give myself enough time to reflect in order to write things up really accurately because you don't always have the time' (SW10, Focus Group C).

Improvements that could be made to training were suggested. These included shadowing opportunities, updates on case law, non-verbal communication training, broadening the focus from overly generalised decisions, and reflective practice opportunities. It should be noted these enhanced learning opportunities are available to those who have trained as Best Interest Assessors, as well as to some extent those in their first year of practice as part of their Assessed & Supported Year in Employment (Skills for Care, 2022).

Whilst the weight of responsibility in making decisions on behalf of others was noted by a number of social worker participants, the fear of getting decisions wrong was dominant. Promoting an individual's right to make autonomous decisions, framed by the social synthesis model, was seen to be important and partnered with the human rights agenda. Nonetheless this at times conflicts with the duty to protect (Care Act 2014, section 42). What is deemed to be a proportionate intervention, an unwise decision, or assessed as an incapacitous decision, is complex to define and subjective to individual perspectives.

Empowerment is defined in the statutory guidance that accompanies the Care Act 2014 as, 'People being supported and encouraged to make their own decisions and informed consent' (DHSC, 2023, para. 14.13). It is a central element of the Care Act, aligns with the 'support principle', and something that participants identified as core to their practice and placed great value on.

Yet the systems within which social work takes place were seen to be a barrier. This ranged from governmental policies of austerity that influenced living standards and availability of resources (Warren 2022), to local government policy on fair charging (Department of Health 2013), commissioning systems including brokerage and funding processes, and demand outweighing capacity which impacts on time and space to practice 'real social work' (SW3). The structural tensions described undoubtedly impact on practitioners' ability to support decision making in line with legal requirements (Care Act 2014; MCA 2005), and good

practice guidance (Department for Constitutional Affairs 2007; Department of Health 2015).

4.6 Summary

Research question 1: How do social workers understand the duty of ‘taking all practicable steps’ to help people make decisions for themselves under the Mental Capacity Act 2005 (s1(3)); working together with additional duties to involve the person and support their decision making under the Care Act 2014?

All participants were aware the purpose of the research was to examine how social workers apply the MCA in their daily practice. Despite withholding the specific focus on supported decision making, social workers demonstrated theoretical knowledge of the core legal frameworks that underpin the ‘support principle’. As well as the MCA, they referenced the Care Act 2014, the Equality Act 2010, and human rights legislation. They consistently took the position that the MCA had an empowering ethos which is strongly aligned to the social work profession, its standards and ethics. Participants widely shared the view that they held greater legal literacy than many of their partners and, with the underpinning of their value base, are the lead experts in the application of the MCA.

Though not specifically named, supported decision making was described as an activity that runs throughout social workers’ interventions, as was consideration of mental capacity. Using the terminology of ‘*practicable steps*’ (SW3; SW4; Focus Groups A, B, D, and F), and ‘*Principle 2* [of the MCA]’ (Focus Group F), participants gave examples as to how they supported decision making in practice. Clarity about what decision needed to be made, the salient information needed to make an informed decision, including choice and control over tangible options, as well as visiting the person on multiple occasions, were frequently mentioned.

Social workers talked about the practicable steps that they view as central elements that enable them to effectively support decision making. This included:

- Knowing a person, their history, lifestyle, hopes and aspirations;

- Individualising communication;
- Time and opportunity to build relationships;
- Partnership working with the person drawing on support, their family, and carers;
- Collaboration with multi-agency partners which for example, enables the gathering of information for a holistic assessment; access to communication support through Speech and Language Therapy;
- Providing salient information about the decision;
- Time, for example consideration of the best time of the day for the person to make decisions; time to build rapport; repeated visits; time to process decisions;
- Education, for example on how to budget money;
- Positive approach to risk, informed by a human rights approach;
- Resources, which included being able to explore tangible options and provide people with a real choice between these.

Such 'practical steps' are in accordance with, though not exhaustive of, the Care and Support Statutory Guidance (DHSC 2023), the MCA Code of Practice (Department for Constitutional Affairs 2007), and NICE (2018) guidelines on supporting decision making. An unexpected finding was the minimal reference to including family to help put the person drawing on support at ease; to facilitate effective communication. In addition, consideration of bringing in an advocate was largely limited to the stage where social worker participants had concluded that a person lacked capacity for specific decision making. There was also minimal reference to delaying a decision.

Of particular interest is that the 'practicable steps' for supported decision making that social worker participants described to me were not fully reflected when I observed them in practice.

Research question 2: What do social workers do to maximise a person's capacity to make specific decisions?

During my observations of practice, I witnessed social workers' interventions with people that ranged from first contact, to established working relationships exceeding three years. Social workers were able to draw on their knowledge of the person, their history and lifestyle where relationships were well established. This was then drawn on to prompt people's memory where they had difficulty, and as such is an example of where relationship-based practice can be beneficial to the person drawing on support. In fledgling relationships, I witnessed social workers utilising third parties to inform and facilitate contact and conversation. These were all paid professionals, other than family members who held legal authority as Lasting Power of Attorney. This is despite the statutory guidance of the Care Act 2014 duty to involve family/other where a person has substantial difficulty (DHSC 2023, para. 10.66), and the MCA Code noting that support from personal relationships can be beneficial for decision making (Department for Constitutional Affairs 2007, 3.15).

Verbal communication was supplemented for two of the seven observations that took place, firstly with the use of an easy-read document, and secondly the use of symbols and a wipe board. Having access to Speech and Language Therapists was seen as beneficial to maximising communication yet difficult to access outside of hospital settings. Social workers found ways to navigate the system to enable them to visit people who had need to draw on support multiple times where they felt it was necessary to support decision making. Information and advice was given to enable informed decision making. Where an individual was financially independent they were supported to view accommodation and support options as part of the decision making process for a house move.

Social workers promoted and advocated for people's rights through education, challenging third parties, and justification for funding requests. This was not however achieved without difficulty or tensions.

Research question 4: What are the challenges, tensions and enablers to social workers providing support for decision making?

Given the discrepancies between practice that is described by social workers, and that which was observed, a summary of the barriers and enablers that can be identified from the data discussed in the chapter are provided.

Barriers

- Communication – social workers were largely reliant on their verbal communication during interventions, with frequent use of professional jargon. No written or other format of information was left with people summarising the salient information, and next steps.
- Salient information for decision making was variable, and a tendency for abstract options to be discussed rather than tangible ones. Whilst this is largely attributed to the design of the social care system, it impedes social workers ability to work in partnership with people and support informed decision making.
- Whilst participants talked about the importance of time for a range of reasons, they experienced organisational pressures to complete interventions swiftly.
- Care and support options are difficult to source which impacts on choice available to individuals.
- Systems restrict social workers' ability to support decision making. The local brokerage system only releases one option at a time; state funding approval process is bureaucratic; funding pot is limited.
- Demand is higher than social work capacity which impacts on time for practice.

Enablers

- Individualised communication was observed on two occasions, described above, which maximised two-way communication. The social workers involved had to break down the key information in order to simplify, and the format enabled non-verbal communication to be understood.
- Involvement of family / trusted relationships, and/or advocacy.
- Time for relationship-building; multiple contacts; to consider decisions; educate; explore options; for reflection.

- Concrete care and support options that people are able to choose between.
Ability to visit, such as accommodation, or meet with prospective carers.
- Non-reliance on state funding enhances choice.
- Legal literacy of professionals and family.

These examples demonstrate the practice I observed does not marry the breadth of 'practicable steps' that social workers told me are regularly utilised to support decision making. It is in no way suggested that there was a deliberate attempt by social workers to use their talk to place a veil over their practice in action. Rather the complexity of applying legislation in everyday practice, the design of the health and social care system, and the limits of available resources, all impact on social workers ability to practice in line with their espoused values. The following chapter builds on the value and hierarchy of relationships in supporting decision making.

Chapter 5, Data Findings: Relationships

Relationships are central to the 'support principle'. Drawing on support when making decisions is common practice for people irrespective of ability. People may seek out information and expertise, and/or talk through options with those they trust. Many factors influence decisions including past experience, the impact on loved ones, the influence of others, options available and finances. The importance and value of relationships in supported decision making is increasingly being discussed and has been highlighted by the United Nations Convention on the Rights of Persons with Disabilities (CRPD) (Martin et al. 2016), as well as disabled people and their organisations (Loomes 2019). Within England and Wales, the legal decision making structure of the MCA's 'support principle' is based upon a functional test of capacity. Where a person is assessed as lacking decision-specific capacity, a best interests decision is made on their behalf. This substitute decision making is increasingly under challenge as it conflicts with a 'new paradigm' of universal legal capacity associated with the CRPD (CRPD Committee 2014; Series 2015).

This chapter will explore the importance of relationships in the context of social work practice and supporting decision making. The legal frameworks of the MCA and Care Act 2014 in relation to supported decision making provides the critical frame for data analysis. The relationships social workers have with people who draw on support are explored, as are wider relationships within care triads, and other third parties, and how these relationships support or influence decision making.

Data analysis in this chapter contributes to answering the following research questions:

Research question 2: What do social workers do to maximise a person's capacity to make specific decisions?

Research question 3: How do social workers view third parties' influence on a person's decision making?

Research question 4: What are the challenges, tensions, and enablers to social workers providing support for decision making?

Research question 5: What support is desired and beneficial from the perspective of a person in contact with services and/or consultee, in relation to decision making?

5.1 Social work and relationships

Relationships are central to social work practice (Dix et al. 2019; Trevithick 2012; Wilson 2008; Munro 2011). Irrespective of the role and length of contact, social work begins and ends with a human encounter (Ruch et al. 2010). Yet the relationship can be complex. Social workers interact with individuals at times of crisis, ill health, loss, distress and in need of support. Rarely is it a truly voluntary relationship and as such, emotions can run strong and interactions be intense.

Trevithick (2003) describes the desired relationship between the social worker and the person drawing on support in Relationship-Based Practice as a 'working alliance' (p. 167). As noted in chapter two, the relationship should not be seen as an end in itself, but that which provides a foundation for understanding, change, and progress (ibid; Coulshed 1991). Hingley-Jones and Ruch (2016) posit how, from a psychosocial and systemic perspective, Relationship-Based Practice entails using the relationship to empathise with and support individuals through struggles, as well as 'mediating contact with other parts of the system' (ibid, p.241). This view aligns with the findings of this study.

Whilst the relationship between the social worker and person who has need to draw on support is important, social work does not take place in a vacuum. There is a need to look beyond this relationship and include family, friends, carers, and other professionals from various disciplines. As Herring (2013, pp.155-156) notes, 'It is simply impossible to make an assessment of any individual's interests outside the context of their relationships'. Consideration also needs to be given to social workers' relationships with managers and the organisational cultures of their employing organisations, as well as legislative and academics, such as Trevithick (2003) and Ruch et al. (2010), argued for a revival of the recognition, value, and placement of relationships at the centre of practice. Disabled people and disabled people's organisations have also influenced a refocus on relationships, seeking a shift in power to collaborative relationships (Beresford, Croft and Adshead 2008; Duffy 2010). The Care Act 2014 reflects and enforces such messages with its

promotion of person-centred and strength-based approaches. The Act's eligibility criteria specifically recognises the importance of personal relationships, and those with the wider community, on the wellbeing of individuals, with 'developing and maintaining family or other personal relationships' (Care and Support (Eligibility Criteria) Regulations 2015, section 2(g)) listed as one of the ten specified outcomes.

The social work profession is aligned with these arguments, identifying the importance of relationships, 'recognising them as an asset' (Social Work England 2020, standard 1.2), and the need for social workers to "draw on and strengthen these...to promote, maintain and enhance the wellbeing of people" (ibid, standard 1.4). This extends to the influence of relationships on people's decision making.

It must be acknowledged of course that not all relationships are an asset. Social workers get to witness the best and worst of human behaviour. They have a statutory duty to protect from abuse and/or neglect (Care Act 2014, section 42), and in some situations have the powers to act against an individual's expressed wishes to achieve this aim. They also provide a gatekeeping function for accessing services. This professional power undoubtedly influences the dynamics of any working relationship with those drawing on support, and will be considered further later in this chapter.

Table 1 (chapter 2.4) shows how the MCA and the Care Act 2014 contrast how support for decision making is viewed against the position taken by the CRPD (United Nations 2006) and offers a critical frame for data analysis. It outlines how the legal duties to provide support under the MCA and Care Act 2014 are time limited, specific to decisions that relate to the assessment and support planning processes to meet eligible needs, and that which professionals believe will best promote mental capacity. Choice of supporter is dependent on professionals promoting this right and agreeing with that choice. How the different relationships influence decision making is the focus of this chapter.

5.2 Relationships of collaboration

With relationships at the core of social work, and duties under the 'support principle' to collaborate with others, I envisaged a range of third parties being present during social worker interventions. During observations of practice, I expected to witness

the involvement of family or, in their absence, independent advocates. By the very nature of the inclusion criteria of this research (Appendix C), it was taken as a given that social workers had judged that the people they were visiting may have 'substantial difficulty' in involvement with the assessment, review, planning or safeguarding process (Department for Constitutional Affairs 2007, para. 7.18). In such situations, the local authority has a duty under the Care Act 2014 to identify an 'appropriate person' to provide support to maximise their involvement, and in the absence of this being available, or the person's choice being deemed inappropriate by professionals, arrange for an independent advocate (Care Act 2014, s.67; Department for Constitutional Affairs 2007 para 7.19). In fact, only half of the ten observations, pre-scheduled by social workers, had arranged to have a third-party present to provide support to the person on their visit. This 'support principle' also extends as a duty under the MCA and is important not just as a legal duty, but from a rights perspective, something which social worker participants very much identified with as outlined in chapter four.

Three of the ten scheduled observations were cancelled on the day, the reasons being recall to prison; ill-health of person; and medical intervention. This demonstrates the unpredictable nature of people's lives and the need for fluidity of social work practice and interventions. Of the seven observations that went ahead, social worker participants were asked in post-observation interviews how they had applied the principles of the MCA. This was in the context of their intervention and specific decision(s) that needed to be made at the time. Having an 'appropriate person' (Care Act, s.67) present to maximise individual involvement was not something that was identified by the social workers as part of their duties other than where family held legal authority of Lasting Power of Attorney. Given that this is a statutory duty and the visits were pre-arranged this was unexpected.

It could be argued that the duty to support P5 went further given that she had already been assessed as lacking capacity to manage her finances beyond everyday spending. In response to this determination, the local authority was applying to the Court of Protection for financial deputyship, to give them authority to manage her finances in her best interests, a process that can take six months to a year (Mieville-Hawkins 2021). The purpose of the social worker's visit was to obtain documentation to support the court application. Whilst there was no arrangement

made for an independent third party to be present on this observed visit, the duties to instruct advocates would only be triggered by an assessment, support planning and reviews (DHSC 2023, para. 7.2) or, in the case of an Independent Mental Capacity Advocate, a decision about accommodation or safeguarding (DHSC 2023, para. 7.4), even though the purpose was related to the 'best interest' (MCA, s.4) decision. These examples demonstrate a gap between the social worker as upholder of legal rights rhetoric, described in chapter four, versus practice in action. The social workers did not consider the involvement of third parties as part of their rights-oriented practice. Yet the action of omission jeopardises the person's involvement in decision making, and explicitly contravenes the Care Act 2014, and where incapacity determined, the MCA.

Of course things are more complicated in real life, and the application of the law is not so clear cut. Capacity is time and decision specific. Consenting to sharing of one's National Insurance details, which was the information requested by the social worker, is a different decision to managing larger finances. Public authority deputies are also permitted to delegate responsibilities to others employed by the wider organisation (Office of the Public Guardian 2023). This includes delegating the requirement to visit the person at least annually to ascertain their views, feelings and wishes, to social workers employed by the public body (ibid, standard 3). SW3 explained that they were doing just that; taking on the delegated task of collating information needed to progress the court application for deputyship.

Family, or other personal relationships, are the first point of call to act as an 'appropriate person' where individuals who have need to draw on support may have difficulty navigating the health and social care system (DHSC 2023, para. 7.4). But of course, not everyone has family available, as was the case for P5, or those who are deemed appropriate by professionals to support them. The duty to provide independent advocacy then comes into play (Care Act 2014, s.67).

A government impact assessment (Department of Health, 2014) on the introduction of the Care Act 2014, estimated that 10% of people requiring an assessment of need under the Act, would require an independent advocate; that this support on average would take seventeen hours (ibid, p55). Yet, in the first six months of the Care Act's implementation, two reports evidenced only 2.1%, or 2%, of those

assessed were provided with support by an independent advocate (McNicoll 2016; Local Government Association 2016). Subsequent research by Newbigging et al. (2017) into the commissioning and use of Care Act advocacy, were unable to provide detail on the numbers of people assessed for advocacy due to local authorities' lack of recording relevant data. They also found it was the perception of many providers that it was local authority staff's lack of knowledge and awareness which was the cause of low referral rates, though this was disputed by employers. Significantly, Newbigging et al. (2021, p.437) found a 'lack of any clear alignment of advocacy with supported decision-making and the rights-based framework of the UNCRPD'. Rather the focus was on commissioning short term, issue-based, statutory advocacy. Given the findings of the observations in this study, it is proposed that the low usage of advocacy is due to a lack of compliance with statutory duties, as opposed to a misestimate of the numbers of people who would be eligible.

It is easy to recognise that a requirement to have an advocate present for every contact, such as the example given above between SW3 and P5, would greatly hinder social work practice, and the system would grind to a halt. However, case law has reinforced the duty for an 'appropriate person' or equivalent to be involved. In the case of *R (SG) v London Borough of Haringey* [2015] EWHC 2579 (Admin), Haringey Council had proceeded with an assessment of need (Care Act 2014, section 9) in the absence of an appropriate third party. This was despite it being clear that the person had 'substantial difficulty' in being fully involved in decision making. Their justification for this omission was attributed to the imbalance of supply versus demand of independent advocates (EWHC 2579, para.56). However, this was not accepted by the Court as a defence and the failure to meet their statutory duty to provide independent advocacy meant the assessment was unlawful. Consequently, they were instructed to repeat all assessment work.

One reason for the absence of an independent third party across observations could be that social workers view themselves as advocates, something which some social worker participants self-identified as a key role. When asked how they saw themselves as supports to people's decision making, social workers talked about being a facilitator as previously evidenced (chapter four).

“I mean we do have other avenues open to us and to use in case work don’t we. People have family members, friends who can fulfil that supporting role. There’s also advocacy and IMCAs and things, but I think it’s it’s [sic] a difficult one as care managers...when you are assessing and care planning, so you do become quite involved in an individual’s circumstances their life at times and part of our professional remit and role is to advocate and support those with whom we work” (SW16, Focus Group E).

The Professional Standards state that social workers:

‘...can act as advocates on behalf of people to support them to say what they wish and/or to access services’ (Social Work England 2020).

It is also noted:

‘A social worker’s role and responsibilities in supporting people to represent their own interests is different when the person lacks capacity, as it then becomes a statutory responsibility’ (ibid).

It is plausible to argue that these statements are confusing. Whilst social workers can advocate for people to support them, it is not the same as being an advocate, which usually has connotations of being someone independent from the assessment and care planning process, and resource allocation decisions, of the local authority. Indeed the need for independence is a requirement stated within statutory guidance (DHSC, 2023, section 6.34). The second statement quoted here suggests that it is only when a person lacks capacity that social workers have a duty to provide support for ‘best interest’ decision making (MCA, s1(5)). Yet this is a clear omission of the ‘support principle’ duty (Figure 1, Chapter 1) to ensure people have support, independent of the local authority, when it is perceived that people may have difficulty in navigating the social care system, expressing themselves, understanding information, making decisions.

It was acknowledged further in the focus group discussion that the boundaries between casework and considerations of capacity can become blurred; that on occasion *“you have to pull yourself back”* (SW16). Beyond this reflection, there was minimal recognition of the conflict the social work role can bring which calls for third parties who are independent on the health and care system.

Advocacy that is independent from institutions and services has been highlighted as important by disabled self-advocates and disabled people's organisations, in order to address power imbalances between the state and people who have need to draw on formal support (Loomes, 2019). Understanding a person's wishes, informing them of their rights, and speaking out for them to authorities were deemed the most valuable aspects of the advocacy role (Loomes 2019). The key here is independence. Unlike a local authority social worker who has a responsibility to protect, with powers to override consent to achieve this, with the gatekeeping of resources and responsibilities to their employer, an advocate's role should be purely to represent the person's wishes. Sadd (2014), who has experience of being a patient in a mental health hospital, describes independent advocacy as 'the seeds of empowerment'. They add that even where professionals endeavour to communicate one's rights, without support of independent advocacy it is ineffective. The benefit of distance that an advocate can provide was, to some degree, recognised by a social worker participant:

'And an advocate sometimes can be that person that's in between, so that you know they might want to talk about something or say something but not to you' (SW12).

However, the term 'in between' suggests that an advocate is not viewed as fully biased to the person they are supporting, but one that has a degree of professional obligation. This aligns with Hardwick's (2014) study in which advocates perceived social workers to be confusing their own role with theirs. In contrast the advocates stated; 'unlike social workers, [advocates] do not work towards 'best interest', but...[are] always acting upon the wishes of the individual' (ibid, p.1711). Thus, an advocate's opinion should not come into play; they are not neutral but involved to enable representation of the person's will and preferences regardless of what that may entail.

Social workers' knowledge of the informal networks that people had during stage one observations, who could potentially act as an 'appropriate person', were seemingly limited. For example, on the periphery P4 appeared to be isolated from all but paid support. The social worker was aware of siblings but informed me that P4 had historically been clear he had little contact and did not consent to sharing of

information with them. During the observed visit, P4 mentioned in conversation that since being in hospital, his son had helped him piece together the details of the house fire, that had led to his admission that weekend, after visiting to view the damage. The social worker was surprised, having been of the understanding that P4 had no contact with him. Yet the timely action of the son, and their apparent ease of accessibility to P4s home, indicates a closer relationship than the social worker perceived.

Multiple reasons could be attributed to this. Relationships change over time; given the long-term working relationship of SW3 and P4, it is possible that this was accepted as fact, that the model of family that had been constructed became fixed, rather than the social worker acknowledging the scope of changes to relationships over time. It could also be attributed to the complexities of blended families, with this being his stepson, and assumptions of who should provide care; or rather that the social worker only had knowledge of that which the person was willing and able to share or had been provided by others. Another consideration is that such information is withheld due to concerns about the negative impact this could have on access to formal support.

Three out of four third parties present during my observations were paid professionals, in the roles of support worker, supported housing manager, and Speech and Language Therapist. There were no advocates in attendance. The two family members who had pre-arranged to be present at the social workers' visits, one of which I observed, held legal authority as Lasting Power of Attorney for finance; the second also held Lasting Power of Attorney for health and welfare. It would be negligent not to question the significance of the minimal involvement of family. Of course assumptions must not be made that all have family, or family who they want involved, yet social workers had disclosed to me their knowledge of family members for others (P1; P4; P7). Thus, it could be argued that social workers apply hierarchical categories to involving others, with professionals, and family members who hold legal authority, at the top. Social workers were clear of the need to involve those with legal authority and how this changed who the decision maker was should incapacity be determined.

5.3 Relationships of trust

As explored in chapter two, relationships of trust are considered a key component for supported decision making. Whilst it is evidenced that relationship based social work practice is effective in supporting decision making (Innovation Unit 2018; FX [2017] EWCOP 36), within the context of statutory social work in England, time to build relationships, and therefore time to establish trust, is variable and often limited. Despite this, social worker participants seemed to assume that people they were supporting would, and should, trust them. I observed working relationships where trust in the social worker appeared to be established; where both parties appeared open and transparent, differing opinions were shared and acknowledged, and recognition that the social worker's words had been followed through with action and thus someone they could rely on. I also observed situations where trust was assumed but not necessarily experienced by the person; where people verbally agreed with the social worker, but their actions suggested otherwise; where professional authority and/or power hung thick in the air.

Observing a conversation between SW3 and P5 goes some way in demonstrating this point. It had previously been determined that P5 lacked capacity to manage her larger finances and the local authority had applied to the Court of Protection to act in the role of financial Deputy (UK Government [No date]a). P5 had no recollection of this decision due to her memory loss associated with dementia. On the observed visit, SW3 took her a letter from the local authority confirming the application to Court, and reiterated their previously expressed concerns that P5 was vulnerable to being financially exploited:

SW3: ... we met [for a Best Interests meeting] because we were talking with you, about how we could help you and support you to make sure the plans you had at the time, and at the time you were thinking about selling the house.

P5: Yes but I can't sell it until I've found somewhere to go.

SW3: Quite. But also when you do, when you make a big decision like that, which involves so much money, if your memory's not great, like you've just said to me, there's a terrible risk that some of that money, something could happen to that money, it goes missing or you know.

P5: It can't go missing. How can it be?

SW3: *It can if you get unscrupulous people involved...If you somehow met up suddenly with someone who found out you had a whole lot of money and got your bank details they could take it from you.*

P5: *Why?*

SW3: *Couldn't they?*

P5: *Oh no.*

SW3: *I know you've always been really careful with your money and I know that. But when I, on the very first time I met you...you showed me your file with all your financial information in it...I could have been bogus, I could have been a thief or something, pretending to be a social worker and you [sic]*

P5: *Oh I knew you weren't...I think they told me you were coming.*

SW3: *Well I would have rung you and said I'm coming.*

The conversation continued, then SW3 then asked for further personal information. The irony was not lost on P5.

SW3: *The [Local Authority's] Court of Protection team's asked me, do you have anywhere, would you, do you think you'd have anywhere your National Insurance number? No one knows. Do you know what your National Insurance number is? It's called your NINO.*

P5: *I expect I do.*

SW3: *Do you know, is it possible that I can have a copy? Everyone has their own National Insurance number.*

P5: *Give you a copy? [then turning to researcher and laughing] Oh no, [SW3's] been telling me to be careful and now [SW3] wants copies.*

The expectations of trust in the social worker here were high. They had already taken details of bank accounts and investments on previous visits 'with her permission' (SW3). Now they were seeking additional personal identifying

information⁵. Yet the social worker's primary concern was that P5 would not be able to protect herself from fraudsters. It is a catch-22 situation: the sharing of personal data (Data Protection Act 2018) upon request could be used to strengthen the concern about risk of exploitation; by not sharing the information, it would hinder any party seeking to make a Deputy application to the Court, which in turn would extend the period of being unprotected.

This expectation of trust in professionals is described by Aves (2021), who has lived experience of mental health services, as 'a one-sided trust; a trust which will never be reciprocated; a trust rarely, if ever, acknowledged in its presence, but immediately called out in its absence'. In Sweden, this unequal relationship is recognised and a framework been put in place to enable people who need support with decision making to develop a trusting relationship with a statutory appointed Personal Ombudsman, which in turn assists them to exercise their legal capacity (Morrissey 2012). Of central importance is the ombudsman's independence from services and family; that this is a long-term relationship which enables trust to be established; that they have the consent of the person and only assist in carrying out the person's expressed wishes (ibid). Such an approach is much more aligned to the CRPD as outlined in table 1 that contrasts the legal frameworks.

Such independent support was not available to P5. Instead, she had a number of paid professionals involved in her decision making about downsizing. She shared that she liked and trusted her estate agent and social worker, who she felt respected her wishes, but distrusted her solicitor whom she felt pushed their own agenda.

'[SW3's] such a nice person and I think that helps a lot' (P5). 'If [they] thought someone wasn't doing right, [they would] soon nip, blow the money, I'm sure [they] would make it right' (P5).

Given the context of the conversation it is plausible that she meant by this statement that SW3 would use their professional power to advocate and challenge others on her behalf, at whatever cost though not necessarily monetary, should

⁵ Information including National Insurance number, income and capital are requested as part of Deputyship for property and affairs applications to the Court of Protection. Interim orders to obtain such details of bank accounts and balances can be applied for should the need arise.

such a situation arise. There was no independent advocacy involved and during the post-observation interview, P5 said she had never given thought to who she had to support her and had no immediate family to draw upon.

People 'ageing without children' (National Care Forum, n.d.) are more reliant on formal support as they age. This gap in the availability of informal care, usually provided by family (DWP 2023), coupled with a lack of advance planning, can greatly impact people's lives. Less is known about the lifestyles people have lived, what their will and preferences are. It leaves people at the mercy of the state in making decisions for them where they lack capacity.

P5 was not the only person supported solely by the social worker during observations of practice, or supported by other professionals rather than an 'appropriate person'. P1, P4 and P8 each had at least one known family member who the involved social worker was aware of. P1 was close to his grandfather; P4 had a step-son; P8 had a sister that she was close to and was involved in her life, which extended to being her benefit appointee. SW5 informed me that she had spoken with P9's sister on the phone but due to distance she was unable to visit, and his loss of verbal communication meant they could not easily converse. He did however have a close relationship with friend who he had lodged with him for a number of years.

The default to social worker as primary support is interesting. It fits with the relational aspect of the role. Yet qualities of familiarity and trust with supporters are highly valued by disabled people (Loomes 2019). None of the social worker participants discussed the power imbalance that their professional authority brought to relationships; how this power could impact on trust.

Of course, not everyone has natural support networks available to them. It was notable that those who expressed positive value in their relationships with social workers were those with limited, if any, informal networks to support that were known to the social worker or shared with me. P4 identified that a big problem for him was his memory loss. He was being told of events that he had no recollection of. The benefit of an established working relationship with his social worker was shared in the post-observation interview:

Researcher: *Does [SW3] help you work those things out, things that you can't remember, or to plan things?*

P4: *Trouble is [SW3] remembers things that I don't.*

SW3's established knowledge of P4's lifestyle meant that they could prompt and fill in gaps where his memory failed him. This in turn enables P4 to express his views and wishes over decisions that needed to be made.

P1 also talked favourably of his relationships with his current social worker. Having had involvement with social care throughout his childhood and into adulthood, he was highly critical of his prior contact with social workers. However, he shared that SW1 was different.

P1: *The new one's [social worker] really good.*

Researcher: *So [SW1]'s different?*

P1: *The new one's different. I was scared of getting [SW1] because of the old one. They've all been nasty. Like when I was a kid they were nasty.*

Researcher: *So what's different about [SW1]? What does [SW1] do that [sic]*

P1: *I don't know. [SW1] seems more like...more like what I imagined a lawyer was like when I was a kid.*

Researcher: *Ok.*

P1: *I thought a lawyer's someone you pay and then they've got your back, legally, anything you need to do with the law or social or the government. You can just go to your lawyer and they'll help you work through it. I found out that's basically what a social worker does.*

Researcher: *So you said 'got your back' and that's what you feel [SW1] does?*

P1: *Yeah.*

I translate this to P1 describing a shift in power. His experiences with previous social workers involved 'power over' him, whereas this had now shifted to a collaborative relationship, to 'power with' (Dumbrill 2006). The social worker was listening to him, sharing their knowledge, and where necessary using their professional power to advocate on his behalf with his consent, in line with their

Professional Standards (Social Work England 2020b) as discussed under 5.3 above). They were someone he trusted, and consequently he was increasingly open to sharing information with them.

The relationship between SW1 and P1 had been established over six months with up to two weekly visits, recently reduced as a consistent support team, commissioned by the local authority, had been formed. SW1 shared that they were afforded the time and opportunity to build relationships and maintain regular contact with people where this could be justified to their manager. Their relationship with P1 had developed quickly as he needed support due to homelessness, court hearings and so on; with SW1 being able to earn trust by actively listening, acting on his wishes, and following through with that which they committed to do. When asked how they used the MCA principles, SW1 described balancing protection and care, with rights to make unwise decisions. The specific decision making in question was about management of finances. P1 had difficulty budgeting, had '*blown the inheritance of the house...an awful lot of money and the majority has gone on drugs*' (SW1), and had multiple debts. Whilst SW1 said they lacked confidence in the application of the MCA, their approach was to influence, negotiate and work in partnership with P1.

'[Been] planting the seed and chipping away at, and ultimately that empowers him. He's made his own decision, and we've been supporting him with his own decision, which for me has to be a better option than taking it away from him and making him feel, 'cause he's very low in self-esteem. When he had his appointment with his psychiatrist, he came out and said to me "you know I'm cleverer than you?" And I said "really?". He said, "He's telling me about Asperger's and how part of my syndrome is I'm really gifted and know a lot...well I thought everyone was cleverer than me and that I had a disability."...That really seemed to change his outlook...he's got loads to offer, it's just like how you sort of encourage him to do it' (SW1).

SW1 described their intervention with P1 as '*being on a journey*'. They were very much aspirational for him, believing that he could learn new skills and have a better future. They were accepting that there were some risks to him continuing to manage his own finances whilst he developed budgeting skills and got his debts in

order, but they trusted this was possible and was part of the learning process. Arguably, this relationship of trust was strengthened by the social worker's acceptance of risk regarding his management of finances. Had they been more risk averse, P1's lived experience of professionals taking control would have been reinforced and the relationship weakened.

For young people such as P1, who may be described as being in the 'emerging adulthood' (Arnett 2000) stage of the life course, which spans late teens to late twenties, this period can be one in which knowledge and judgement is attained (Tanner and Arnett 2016). SW1's trust in the relationship with P1, knowledge of their history and lifestyle, informed their approach. The working rationale was underpinned with evidence of P1's capacity for learning, and effectiveness of incremental support:

'And he's lived for an awful long time where he's had spates where he just doesn't have any money and he lives hand to mouth. That's very much where he's been. And like he said, it's a revelation where you know [A1] got me all this shopping for a tenner' (SW1).

Making unwise decisions is viewed culturally as a 'natural' part of the passage to adulthood (Arnett 2015). SW1, and others, talked about the complexity in supporting this younger cohort of autistic people, and/or those with a diagnosis of Attention Deficit Hyperactivity Disorder. Evidencing the 'causal nexus' (*PC and NC v City of York Council* [2013] EWCA Civ 478) between one's diagnosis and lack of capacity for decision making was complicated. Experimenting with drugs or prioritising personal spending over bills were viewed as the norm for such an age group. With the significant learning at this stage of life acknowledged, social workers appeared to be much more reluctant to reach a decision that individuals lacked capacity than with older age groups. As such, the 'support principle' was much more evident.

An example of this difference in approach in practice between younger and older adults can be seen in the approaches taken in supporting P1 and P5 with managing their finances. Intervention was initiated with P5 to protect her from the risk of being defrauded of money, and as such was a preventative measure. In contrast

intervention with P1 was accepting of the loss of significant amounts of money whilst he developed skills to managing his money.

5.4 Relationships of choice

Trust may be held in professionals as well as family, and/or carers but what is paramount within the support paradigm is that people are able to choose who they wish to support them (Loomes 2019; United Nations 2006).

Social work is relational in its very nature. It includes not only the person drawing on support, but a complex web of relationships that include family, carers and a wide range of professionals from multi-disciplines of primary and secondary health, criminal justice, and the community. Person-led support is embedded within health and social care legislation (Department for Constitutional Affairs 2007; para 1.2), with a commitment to the person's wellbeing, views and wishes being at the core of decisions. Those who seek to / draw on social care services do so in order to have control over their lives and achieve that which matters to them (DHSC 2023, section 1). How people are supported is key to achieving this. Practice guidance reinforces the legal duty of the MCA to support decision making, stating:

'Find out from the person how they want to be supported in decision-making in accordance with principle 2 of the Mental Capacity Act 2005. If they would like someone to support them, find out from the person...who this should be' (NICE 2018, para 1.2.1).

Social worker participants noted that people with need to draw on support would naturally share who they were comfortable to be supported by:

'The person will usually indicate who is good, who they wish to be supported by. They would say, I want my daughter to be here because I don't quite understand that, she she's [sic] good at this, that and that. Or I want an advocate, or I want a solicitor to make that [sic], so they would indicate what is best if they can you know understand. So I would go with that rather than deciding or trying to figure out who's the best person myself' (SW11).

P8 shared with me that her sister, and specific members of her formal support within her home environment, were the people who were important to her, and who

she had discussed the imminent house move with. She said that she did not know the social worker having only met them a couple of weeks prior; that the social worker had not met with her sister, whose support extended to being P8's benefit appointee, but SW4 had telephoned her. The observation that took place was of SW4's third visit to P8 to go through an easy-read tenancy agreement. Whilst P8 had been supported during previous visits by familiar formal carers, this did not meet the 'appropriate person' criteria due to the conflict of being commissioned to provide care and accommodation (Care Act 2014, s67(5)). This additional contact took place in the absence of any third party.

My notes record my feelings whilst observing the interaction: '*this feels like a test...*' (Field note). With the absence of a familiar trusted person, communication was hampered, and I felt that P8 was therefore on an unfair footing. Although an easy-read tenancy document had been provided, SW4 went through the paper three times during this visit. It appeared from my observer view that P8 was drawing on her recollection of the information rather than reading the document.

Once again, this example of social work intervention demonstrates a tendency to draw on paid carers rather than family, even where established relationships are known. P8's voice about who was important to her was not fully listened to or respected. This was not just evident in the social worker's actions but in their talk. In the pre-observation interview the social worker shared:

'[P8]'s got friends and someone she calls a boyfriend that live nearby' (SW4).

The social worker's use of the term 'someone she calls a boyfriend' can be viewed as a negative, socially constructed, stereotype of people with learning disabilities: that they are either sexually innocent or asexual (McCarthy 1999; Esmail et al. 2010). The statement also indicates the social worker's scepticism about the romantic relationship described, and its importance to P8. Given that the planned house move would mean moving some distance from her boyfriend, which would impact on their ability to see one another, I perceived this as significant consideration in making this decision. However, it was not discussed during the contact that I observed.

Loomes (2019, p.4) highlights how there is a 'strong emotional dimension to supported decision making for Disabled people'. One social worker participant

recognised that where individuals may struggle to express their needs, or lack capacity to understand a decision, their emotional attachment to a person will often remain identifiable through conversations:

'Even if they don't have capacity they will talk about this son who did that and he lived there you know. So it will show through the conversation who is the best person I'd say. Might be a friend, might be a neighbour' (SW11).

Preparing for ill-health and frailty when capacitous to make decisions enables people to have choice over who they wish to support them to make decisions, or make them on their behalf if they lack mental capacity for individual decision making in the future. A lasting power of attorney provides a legal framework for such pre-planned decisions surrounding 'property and finances' and/or 'health and welfare' (UK Government [no date]b). Despite this legal framework being available, only two of the ten people discussed with social workers during stage one of the study had put such preparatory arrangements in place. Of course, not everyone has support to draw on.

'I never thought about who I've got to have, who I have to support me' (P5).

P5 was aware of her memory difficulties that were associated with dementia, yet had not put any arrangements in place as a way of future proofing that her will and preferences would be known and honoured. With the holistic nature of practice, social workers are in a good position to discuss such arrangements as part of the 'support principle' whilst people are able to make capacitous decisions. On an initial visit following a referral by a third party, I witnessed SW3 asking P7 whether she had made any '*forward plans*' such as having a will or setting up of a Lasting Power of Attorney so her finances could be managed by a person of her choice should she be incapacitated in the future. SW3 shared that they themselves had made such arrangements and their rationale for doing so, indicating the normality of such preparatory steps as people age.

5.5 Relationships of care triads

Social workers' duty to involve people in any assessment of need or support planning extends to involving any carer(s) (DHSC 2023, para. 6.30). Whilst

recognising that care can be provided by multiple people, this triangle consisting of the person drawing on care, family carer(s) and health and/or social care professional(s) is referred to as a 'care triad' (Adams & Gardiner 2005; Kelley et al. 2021). The dynamics of care triads will vary. As with any relationship, they can be positive or negative, enabling or disabling. The power of coalitions within these triads results in an imbalance of power (Adams & Gardiner 2005). For example, an alliance between professional and carer can leave the person in need of support at a disadvantage, with third parties' agendas and views taking priority, as identified in several cases in Williams et al. (2012) study examining how 'best interest' decisions are made.

During data collection I observed such a dynamic coalition between a social worker and family carer within a care triad. P6 is a retired woman who lives alone in a warden-assisted flat. She has been diagnosed with dementia. Following a fall, the Rapid Response team⁶ had provided support, which could last up to ten days. SW3's role was to review this to determine whether P6 had needs for support to be extended and this was to be their second visit. The summary I received by SW3 in advance was that P6's views were clear. Her greatest wish was to remain in her home; she did not want any equipment or changes being made; was not accepting of the carers that had been visiting twice daily to assist her with care. Her two daughters' views, who between them provided support and held Lasting Power of Attorney for both Property and Affairs, and Personal Welfare, were very different. They were of the view that it was no longer safe for their mother to remain in her home due to increasing memory loss and frailty, and social services or other body should take action to move her to residential care.

On arrival to the flats, SW3 initially met privately with P6's daughter, referred to hereafter as C2, in a communal room. P6 had experienced another fall in the past week and her daughters' concerns were subsequently heightened. Having confirmed that C2 held legal authority under Lasting Power of Attorney, and that P6 was not eligible for state funded care, SW3 proposed the way forward was for them to complete a mental capacity assessment about care and accommodation

⁶ Health and social care joint funded team whose remit is to prevent hospital admission.

decisions. It was explained this would then, if incapacity was determined, enable family to make decisions on behalf of P6 under a legal framework.

“I’ve seen her once and I’ll see her again today and maybe I can see her again...If on those occasions I feel that maybe, I don’t think she can make a decision, I’d call a best interests meeting...and we’d make a decision about what we think needs to happen” (SW3).

“Right” (C2).

“And maybe that gives you some kind of leverage and some kind of authority about what you want to do next, because we’d be saying that we agree that you’re doing this in your mum’s best interest” (SW3).

Though legal limits and the need for incremental steps were covered in the wider conversation, this felt like a significant power imbalance. The reference to ‘we’ making a decision appeared to be exclusionary to P6. The ‘protection imperative’ stood out here: to maintain the physical safety of P6 over her emotional and psychological needs, and over her expressed wishes. C2 shared that P6, in her nineties, had said to her at the end of a long day that week that she just wanted to die. No enquiry followed to explore whether P6 had ever shared how and where she would want to be cared for in later life should she require it, nor what a good death would consist of.

The time spent with P6 that followed was brief. She said that she did not want or need the carers. When SW3 reminded her that she had consented to carers to avoid hospital admission following her first fall, and that concerns were heightened now that she had fallen again, she conceded that they could come once a day but twice was too much. To me this suggested an underlying, unspoken, threat: accept support or there would be consequences. There was no exploration of what it was that P6 did not like about the support or the carers themselves; no alternative options to this provision discussed, other than the option of visiting residential homes in the earlier conversation between SW3 and C2.

It seemed clear to me that P6 was feigning cooperation. Her actions of declining the support of carers when they visited were arguably a truer reflection of her will and preference. Rather than supporting decision making, as an observer this appeared

a significant use of power by the family and social worker. I left questioning how much support would be provided before moving onto substitute decision making. The concerns of family were much louder than P6's voice.

People living with dementia have explained they prefer to be supported with decision making by people familiar to them (Sinclair et al. 2019). Having taken preparatory steps to set up Lasting Power of Attorney, P6 had done just that by choosing her daughter to take on this role. It can be surmised that these chosen supporters would then act in accordance with one's wishes. Indeed this is the assumption that the 'support paradigm' of the CRPD takes. Yet whilst C2 firmly believed that they were acting in their mother's best interests, they were proposing decisions that are contrary to P6's wishes and feelings.

The value placed on family in the UK is reflected in the 'Family Test' first created by government in 2014, updated in 2020, to ensure a family perspective is applied to all policy creation. It states:

'Healthy and strong family relationships are also recognised as an important component of individual, community and national wellbeing...[and] can therefore help government departments to deliver their objectives' (Department for Work & Pensions 2020, p3).

It goes on to state:

'All family members have a role to play in family life...[including] in caring for elderly relatives or disabled family members' (ibid, p16).

The assumption here is that family, and by default chosen supports, will act in accordance with a person's will and preference. Ethnographic research within hospitals by Kelley et al. (2021) identified that members of the care triad often held different understandings of the care needs of people with dementia; that inconsistent communication impacted decision making; that the perspectives of people with dementia were those most likely overlooked. During post-observation interview with C2 she was clear that the input the family desired was for the social worker to be party to the responsibility of (substitute) decision making due to P6's resistance in accepting care, and to assist in navigating the steps to set up care, with the ultimate aim of a move to a residential care home. The thought of their

mother lying on the floor alone for hours after a fall was too much to bear; they wanted to protect their mother and believed they were making the right decision. This reveals how the 'protection imperative' is not simply a professional leaning, but one that runs deep in society.

Concern about risk is clearly a key influencing factor here in decision making, as discussed in the previous chapter. Making decisions that entail risk for oneself is one thing; it is much more difficult to do when doing so on behalf of others.

5.6 Relationships of undue influence

Given the introduction of focus groups, as an amendment to study design prompted by the pandemic, I was able to explore the lower than expected presence of family members and friends during stage one observations. Questions put to focus group participants included, 'to what extent do you view family and friends as supports to people's decision making?'; 'how do you involve family?'; 'would you consider bringing in family to explain difficult concepts?'

When asked how they involve family, and loved ones to enable people to make decisions, the initial response from Focus Group A was that consent should first be sought. It was noted that useful background information could be gained from loved ones but there was a wide rejection of family being present at formal capacity assessments and supporting people to make decisions. The following extract demonstrates this:

"I mean I wouldn't, I wouldn't normally do a capacity assessment with a parent or a relative sat next to that individual" (SW7, Focus Group A).

"No 'cause they prompt" (SW6).

"I mean I have had like support workers because of communication because I might not be able to communicate effectively with that person and I might need someone who knows them well and is able to do that. I mean it could be a parent but rarely have I done it with parents sat beside them" (SW7).

This was also brought up in a separate interview when asked whether they would bring in family to help explain difficult concepts:

'I would prefer care staff to families. Sometimes, again it depends on the family member and it depends on their bias' (SW9).

Professionals' concern about family members prompting their loved ones during capacity assessments is not new. Mark Neary, whose son Steven was unlawfully detained in 2010 ([2011] EWHC 1377), was not permitted to be present during three capacity assessments during his detention period, nor were his regular support workers, "in case we led Steven, or prejudiced the outcome" (House of Lords 2014, para. 68). This concern about people being led was also raised by social workers in responses to Ariyo et al.'s (2021) survey exploring the experiences of professionals when assessing mental capacity. However it does contravene the 'support principle', whereby those who are potentially best able to communicate with the person being assessed, and therefore maximise decision making, are excluded from the process.

The conversation above also suggests that paid carers are viewed to be more objective than family, something that is further exemplified by SW8 when discussing the planning of a capacity assessment:

"...we had a safeguarding meeting...and the person's sister was there and they were very much, they wouldn't let the person get a word in edgeways, and they said, oh do you want me to be at the meeting on Wednesday, which would have been the capacity assessment. And my thoughts were I think that would actually detract from the person, you know being able to speak and put their sort of, you know views and decisions, things like that across, whereas if perhaps it had been their support worker who'd been there that would actually have maximised their you know communication and things like that" (SW8).

Again, social workers' concern about family members answering for the person in need of support, or correcting them, was also reflected in Ariyo et al.'s (2021) research. In summary, 457 out of 610 professionals, over half of whom were social workers, reported that they were "sometimes'...or 'quite frequently' concerned about undue influence' (ibid, p.10) when assessing capacity.

Another focus group also referred to family bias when I asked to what extent they viewed family or friends as supports to decision-making:

“I don’t think my assumption is ever they [family and friends] are the people who know the way. They know a way, they know the way they want, but not the way” (SW10, Focus Group C).

This statement was preceded with the acknowledgement that family could provide useful information about a person’s history, particularly where their memory is in decline. Nonetheless, the social worker was clear that family tend to have ‘*fairly set views*’ (SW10) about what should happen, that is not necessarily aligned with the person’s own views.

Professionals’ empathy with family members can be understood as being framed with a ‘dash of caution’ (Lashewicz et al. 2014, p.29) because of the duty to protect from abuse and neglect. Indeed, such points were raised by participants with examples of having to intervene to protect individuals from blackmail by family, financial abuse, and controlling and abusive relationships through their careers. Other reasons were also given such as family being ‘*over parental*’ (SW7) and ‘*overly protective*’ (SW8). A recommendation of the Serious Case Review of Winterbourne View Hospital was for social workers, and other professionals independent from provider settings, to find time and space to meet with people on their own so that they have the opportunity to talk freely and disclose any concerns or abuse (Flynn 2012, p.131). This is not limited to safeguarding work and could arguably be another factor in deciding to meet with people alone. The statement below captures the caution that many social workers raised when asked about involvement of family to maximise communication with people:

“[family] want to keep [loved ones] safe, they then make the choices for the [person] and speak for the [person] in that meeting. So I definitely always meet with the person on my own, on their own, before or after with the relative. Because...relatives are not always helpful” (SW21, Focus Group F).

Brown (2015) argues that bias against families runs through the MCA; it provides professionals the ability to side-line families under the banner of protection and empowerment. Whilst acknowledging that families do not always act in their loved ones’ best interests, Brown argues the consequence in not collaborating with those who know people best is a loss to the person’s ‘language and narrative’ (ibid, 2015).

Lashewicz et al. (2014), recommend that by introducing an 'external decision facilitator' to a person's circle of support, the risk of family voice drowning out the person would be minimised.

5.7 Relationships of power

As highlighted in chapter 4.3, and above, the local authority social worker has multiple roles and responsibilities, which carry professional power. The power imbalance within social workers' relationships with people who draw on formal support is flagged by the regulator as something which needs to be considered to ensure they do not negatively influence interventions (Social Work England 2020).

When asked to what extent social workers viewed themselves as supports to decision making, professional power came into discussion:

'I suppose in one way it's hard to say because in one aspect there's a, there's a sort of power element to what we do where we are quite powerful in that we're going in there making quite, you know, big judgement calls about a person's ability to choose the life they want you know, so it's whether you can marry that with supporting the person to make the decision. You can facilitate and trying, as part of the assessment process, you can facilitate and try your best to see if that person is able with your support to make that decision, but it almost feels like there's a conflict between the two sometimes' (SW9).

SW13 shared that they aim to stay as neutral as possible, conscious that their role could change from a provider of information and advice, of assessor, onto decision maker under 'best interests' (MCA, s.1(5)):

to consider their needs and our organisation's needs and do the best I can' (SW13, Focus Group D).

This statement offers an insight into the shifting weight of the obligations of the social worker role; that their ability to support individual's choice can fluctuate depending on the role and legal framework which they employ at any given time. The reference to the '*organisation's needs*' indicates a responsibility to not only work within legal and policy frameworks, but of responsibilities to their employer

which includes limiting time spent with people due to demand, gatekeeping of resources and best value described in chapter 4.

Social workers reflected that the multifaceted nature of their statutory role could lead to a conflict of interest in being the assessor of mental capacity as well as the best interests decision maker:

'There's a kind of pressure on you to...make sure they're safe, and I think that maybe that kind of thing can influence just a pure judgement on do they understand the risks as opposed to are they safe?' (SW14, Focus Group D).

The involvement of third parties in such situations was identified as a protective factor in ensuring the person's voice is heard, as was time for them to process decision making. Having time to reflect as a practitioner was also flagged as important in minimising the conflict between roles and professional power. The social worker continued:

'I wonder if it might be helpful if those two roles were kind of more separated in some ways. But I don't want to say every time, but I could see situations where that might happen where you're really worried or stressed about the person and then you think that's just one more thing. Kind of have, have you got that ability to take a step back and think really what are the actual risks to this person and then put them to that person in a way that they understand. Do they understand those risks? Are they weighing them up...or have you come to a point and thought I think it's too risky now and that's why you're doing the assessment?' (SW14, Focus Group D).

Yet the pull of the 'protection imperative' is strong, even where professionals are passionate about promoting people's rights to live the lifestyle of their choosing. When talking about P4's discharge options from hospital, in advance of the observation, SW3 stated:

'I kind of hope he's going to say to me, look I kind of feel that I've reached the point where I need to be somewhere maybe where I'm more safe, and transitioning him, we could look to a step-down bed so he could just have an experience of what it's like in a residential home...If he doesn't, and he's adamant that he wants to go back home, I suspect I'll have to probably, well I,

it depends how, how able he is to consider the risks and all that comes and goes along with the mental capacity bit but if I think he's not got capacity I'll have to best interest it. I kind of hope he's going to go along with the plan...I suppose the assumption that I'm making is that we could well be moving into best interest decision, so we'd be looking at defining the options formally, as a part of that process. If he says to me though, you know what I'd really like the idea of a trial, a [care] home for a little while, I'll go with that, the hospital thinks that's a good plan' (SW3 pre-observation interview).

Once again, this highlights how easy it is for professionals to slip into conflating capacity with the decision outcome. As summarised in chapter 4.3, the threshold of risk had increased and consequently the social worker had to review their approach to support and protection. The unplanned hospital admission and formal discharge process provided the opportunity for a safer option to be followed and the social worker and hospital team viewed residential care as the preferred option. It was clear that only if P4 disagreed with this plan would a mental capacity assessment be completed.

The importance of supervision and challenge from others as a means to addressing professional power imbalances was discussed in focus group F:

SW23: 'I personally don't feel that I get challenged enough on my [capacity] assessments so I would welcome someone to say, tell me a bit more about this in supervision or another professional. It's, because I'm the one always doing the challenging its assumed I know what I'm talking about but maybe I don't. And I don't think there's time in supervision or management to have learning...it's more about process rather than learning...'

SW20: 'But that's a really important part of supervision isn't it, the reflection because that's the learning isn't it, a really key part of learning isn't it, it's high support high challenge isn't it'.

SW23: '...It's assumed I'm good at my job. But maybe, that's unconscious incompetence, I don't know what I don't know'.

Although it is relatively simple to identify power imbalances in relationships where professionals have statutory powers to protect, or make substitute decisions, more

subtle elements of power within relationships can also be drawn out from the data. When talking about a person choosing between two care options, it was acknowledged in focus groups that social workers' opinions could influence the decision making:

"I'd have to say there might be a slight spin because if there were two care options for example, that we got to the point where you know those were the appropriate options, then I might I might [sic] know both these homes and have a view on which might be better for this particular person" (SW13, Focus Group D).

How choices are framed and communicated matter. Interestingly, social worker participants did not make the link between this more subtle relational power and the undue influence concerns that were raised about family.

5.8 Summary

Research question 2: What do social workers do to maximise a person's capacity to make specific decisions?

Building on the observations summarised in chapter 4.7, it is apparent that social workers' view themselves as having an advocacy role in supporting people to not only make decisions, but to navigate the health and care system. Their multiple roles mean that they are providers of information and advice, assessors, care planners, resource gatekeepers, protectors, and advocates. Marrying these numerous functions can be problematic.

Relationships were central to decision making and identified by social workers as important. Whilst there was evidence of social workers' drawing upon third parties, contact also takes place on a one-to-one basis.

Where social workers had established relationships with people drawing on support, they were able to draw on their knowledge of the person's history, lifestyle and prompt their memory where it failed them. This facilitated discussion and supported decision making, particularly for those who did not have informal support networks readily available to them.

Research question 3: How do social worker's view third parties' influence on a person's decision making?

My interpretation of the data is that social workers apply a hierarchy to the involvement of third parties. At the top are professionals and paid carers, followed by family who can evidence they hold legal authority such as Lasting Power of Attorney, and family, friends and unpaid carers often not involved or deliberately excluded. This is evidenced in the widely expressed concerns about family bias and undue influence; the expressed preference to seek the support of paid carers over family; the absence of 'appropriate persons' during observations, with the exception of those holding legal authority as Lasting Powers of Attorney.

Research question 4: What are the challenges, tensions, and enablers to social worker's providing support for decision making?

The discrepancies in practice that were described against the practice that was observed continued throughout the observations. These points build on those summarised in chapter 4, and for brevity have not been repeated where identified multiple times.

Barriers

- Power imbalances within relationships were seen to dampen the voice of the person drawing on support. This included the power of the social worker, as well as within care triads.
- Absence of established support networks resulted in gaps in knowledge about a person's history, lifestyle and the choices they would likely make.
- Poor legal literacy of professionals and the public meant that people's rights were not always upheld.
- Limited use of advocacy meant that some people did not have independent support.
- Social workers' constructions of family potentially overlooked friends or blended family members who could provide support.
- Risk prompted social work intervention. The physical safety of older adults and people with learning disabilities appeared to be a high priority.
- Family / friends, who are potentially best able to support with communication, were often excluded due to concerns about undue influence.

Enablers

- Relationships of trust are important when supporting decision making.
- Social workers could earn trust through their actions over time.
- People have choice over who provides support with decision making.
- Time to build rapport.
- Knowledge of a person's history, lifestyle, will and preferences.
- Partnership working which demonstrates 'power with' as opposed to 'power over' (Dumbrill 2006)
- Delaying the decision – enabling time to educate, to inform.
- Time to explore options, to process decisions, and for reflection.
- Acceptance of risk as a right of passage to adulthood for young people.

Research question 5: What support is desired and beneficial from the perspective of a person in contact with services and/or consultee, in relation to decision making?

Trust in relationships was important and this extended to being able to trust social workers. Fundamentally, people wanted to be supported by those they had established relationships with; those who knew them and who they trusted; people they could discuss decisions with but did not take over.

From the perspective of the people I spoke with, it is apparent that relationships with social workers hold more meaning to those who have an absence of, or minimal, support in their lives. Trust in social workers was not freely given, but something that has to be proven over time on an individual basis. Consistency in social work support facilitated this as it provided time for familiarity to develop and for the social worker to put their words into actions. Being trusted was also greatly valued, including being trusted to make choices that others may disagree with.

People wanted social workers to listen to them, to honour their wishes and to help them work through any challenges they were facing. This included advocating for them. They wanted social workers to share their knowledge in navigating the complicated health and care system, and assist in them in identifying real options

available to them so that they could make informed decisions. Being supported to view tangible options such as accommodation was noted as essential to being able to make a decision, as was time to think things through.

Chapter 6: Discussion

6.1 Introduction

Through this thesis I have looked into the role social workers play in supporting people with cognitive impairments, as defined by the MCA (s.2(1)), to make their own decisions, referred to as the 'support principle' (Figure 1, chapter 1). In chapter two I drew on existing knowledge and literature to provide a concise history of statutory social work with adults; the disabled peoples' movement's struggle to achieve equal rights; and how this has influenced social work practice, social policy and current legal frameworks of England including the MCA and Care Act 2014.

As explored in chapter two, the discrimination and inequality that disabled people experience in accessing their rights has a long history and is entrenched in society. Social workers have a professional mandate to challenge such discrimination and oppression and advocate for people's rights (Social Work England 2019; 2020) and the MCA is one piece of the legislative framework that underpins this role. My literature review of supported decision making and the implementation of the MCA found evidence of differing interpretations and application of the Act by health and social care professionals, fitting with a social constructionist ontology. It is known that there is poor compliance with the duty to support people to make decisions (House of Lords 2014; Jayes 2022), with professional cultures of paternalism and risk aversion across the health and social care system. At the time of the research design, published studies on MCA practice were either reliant on the recall of professionals, or where ethnographic approaches were used, they did not directly observe mental capacity assessment, only its surrounding context.

It is extremely rare for observational research to take place in the private spaces of people's homes. Instead most of the studies identified observed practice within hospital settings or social work offices (chapter 2.5). No other studies have directly asked people whose capacity is in question about their experiences of capacity assessment. Even with the studies identified in chapter two, there remains a paucity of literature on this important topic. As such this study offers a unique contribution to this field.

The research questions are:

- 1: How do social workers understand the duty of 'taking all practicable steps' to help people make decisions for themselves under the Mental Capacity Act 2005 (s1(3)); working together with additional duties to involve the person and support their decision making under the Care Act 2014?
- 2: What do social workers do to maximise a person's capacity to make specific decisions?
- 3: How do social workers view third parties' influence on a person's decision making?
- 4: What are the challenges, tensions and enablers to social workers providing support for decision making?
- 5: What support is desired and beneficial from the perspective of a person in contact with services and/or consultee, in relation to decision making?

The gap between social workers' talk about empowering people (Scott et al. 2020) and that which was reported by people who draw on support and other evidence (House of Lords 2014), informed my choice of methods. Observation of practice in the private spaces that social work operates was selected as a means to gain greater insight into that which is viewed as an 'invisible trade' (Pithouse 2019). This was supplemented with pre- and post-observation interviews with social workers; and post-observation interviews with those drawing on social work support and/or their consultees to explore what support with decision making is desired and beneficial from their perspective.

I was conscious from the outset about the Hawthorne effect (Chiesa & Hobbs 2008), whereby people change their behaviour when they know they are being observed. Consequently I made the decision to state my broad interest in social workers' application of the MCA within their daily practice, whilst withholding the specific focus on the 'support principle'. I believe this approach went some way in addressing concerns about participants 'performing' (ibid) during my presence. The absence of 'appropriate persons' and/or advocates during observations provides evidence that the subtle concealment of the research focus was effective in minimising participants performing differently due to my presence.

In chapter three, I outlined the ethical considerations that observation of social work practice entails, the laborious process of securing ethical approval through the Social Care Research Ethics Committee, and the complexity of navigating layers of gatekeepers in order to access potential participants and to initiate the data collection period. Whilst the original research design was to solely consist of observations of practice, with supplementary pre- and post-observation interviews, the later introduction of focus groups enabled me to explore themes from stage one data at a deeper level.

The two empirical chapters that precede this have illustrated the practical and stated actions of social workers in supporting people to make decisions within the context of local authority adult social care services. They are broadly split into a) social workers' professional identity, the organisational context they work within, and how this shapes their practice; b) the role relationships play within decision making. In this discussion the themes are pulled together, and the tensions between what social workers say they do, and that which was observed are considered.

6.2 Talking the walk, and walking the talk

Social worker participants within this study strongly articulated a professional identity of holistic professional, one who believed in social justice and equality, and championed peoples' rights. They viewed these professional values to be closely aligned to the MCA, and perceived this legislation as a tool that they could employ to challenge third parties' paternalistic tendencies, and empower individuals with need to draw on support to realise their rights. Combined with the holistic nature of the social work role, the underpinning of human rights were seen as that which stands them apart from other professionals within the health and social care sector, with nurses and doctors specifically named. Indeed the Professional Standards (Social Work England 2019), the international definition of social work (International Federation of Social Workers 2014), and Code of Ethics (BASW 2021) for social work all refer to 'human rights'. The role of social workers to empower people is made explicit in the latter two documents, a term that is not used within professional standards for nurses (Nursing and Midwifery Council 2015, updated 2018) or doctors (General Medical Council 2024). This commitment to empowerment can be

expected to translate in practice through supporting people to make informed decisions, including those that may be deemed unwise by others.

Social workers positioned their legal literacy of the MCA to be above that of other professionals within the health and social care sector whom they regularly work with. They were able to cite relevant sections of the Act to demonstrate this knowledge, including the duty to 'take all practicable steps' (MCA, s.1(3)) to support decision making. Despite them being unaware of the study's specific focus on their statutory duties to support decision making, practical examples in which this duty was met were widely shared. These stated examples reflect good practice guidance set out in the MCA Code of Practice (Department for Constitutional Affairs 2007, pp.22-39); guidance on involving people as set out in the Care and Support Statutory Guidance (DHSC 20023, s6.11); and the NICE (2018) standards on decision making and mental capacity.

Whilst placing their legal literacy above others, social workers expressed a lack of confidence in applying the MCA in practice. From a rights perspective, the weight of responsibility in making a determination about capacity weighed heavily. MCA practice was described as complex and subjective, and there was a consensus that training was too reliant on theory.

The importance of professional values and the theoretical underpinnings that shaped interventions were discussed, with wide-spread unprompted criticism of health professionals. The influences on social work practice, which I have summarised as the 'social synthesis model' (chapter 4.2), was viewed as instrumental in taking a rights-based and risk positive approach. In comparison health professionals were viewed by social workers as being paternalistic and risk averse, with poor legal literacy of the MCA, resulting in social workers having to regularly challenge practice and educate. Social workers attributed this difference in practice perspective to the medical model of disability (Kett et al. 2009) underpinning health professionals' practice, as well as the traditional 'doctor knows best' (Clavering and McLaughlin 2007, p.408) culture. Drawing a clear line between professional identities is not new (Hemmington et al. 2021), and the findings of this study echo such positioning.

Chapter four brought to light how social workers' employment in local authorities shapes their practice. The statutory social work remit is broad and although this small study could not capture the full breadth of their work across adult social care, social work practice with a diverse range of people, ages and needs were observed or discussed in focus groups. In advance of the modernising social care legislation with the introduction of the Care Act 2014, the UK government stated that the role of adult social care in the twenty-first century is about:

'...personalisation empowerment, maximising autonomy and capability. Its function is to enable disabled and older people to make their own choices and decisions; it is about citizens gaining or regaining control over their lives and feeling valued and able to contribute. A modern social care system will help people to build their self-confidence by focusing on what people can achieve, with support, and how to realise their potential and aspirations. We need a social care system that recognises and responds to people as active and involved citizens as opposed to passive recipients of services' (Department of Health 2010).

Echoes of this statement about the function of adult social care were made by social worker participants. They talked about placing people at the centre of decision making, of empowering people to have choice and control over how they lead their lives, and gave examples as to how they do this. This talk is reflective of other studies (Scott et al. 2020).

Relationships were seen to be central to supporting decision making; from the influence of familial, personal, and wider community on individuals; the relationship between social workers and those who have need to draw on support being used as a vehicle for understanding and change; the relationship between the social worker and their manager; to wider partnership working with multi-disciplinary teams.

The realisation of a social care system that 'responds to people as active and involved citizens' (Department of Health 2010) was however described as difficult to achieve. Social workers talked of the barriers that the system presented and how this frustrates their practice. That which was described undoubtedly has an impact on the ability to offer people choice and control over how their care needs are met,

and the mismatch between that which I was told and the practice which was observed support these claims.

Firstly, the operational system of the local authority demanded a pace of work that was not always conducive to building relationships and supporting decision making. In many cases social workers simply did not have the time to build established relationships with people or time to inform and educate. It was certainly not factored into their workloads. With a social care system that is over-due reform (Kings Fund 2018); with lack of investment and reduced resources following years of austerity (Cummins 2018); less social care support being provided to people compared to ten years ago despite more people requesting it (Bottery and Mallorie 2024); and consistently high levels of social worker vacancies (Skills for Care 2023), the pressures on services are plain to see. Yet, whilst core statutory duties remain, the 'support principle' appears to be one that takes too much time and resources to fully implement and too readily skipped over to implement substitute 'best interest' decision making.

The duty to involve third parties (Care Act 2014, s.67(2); s.67(5)), which also aligns with guidance on supported decision making (Department for Constitutional Affairs 2007, c.2; NICE 2018), was identified in social workers' talk, though not always observed to be met in practice. The involvement of family or friends as an 'appropriate person' (Care Act 2014, s.67(5)), or in their absence advocates (Care Act 2014, s.67(2)), was markedly absent during observations. Instead contact was seen to be facilitated through paid carers or other professionals, particularly so where the social worker relationship was in its infancy. For the relationships that were more established, or where formal capacity assessment was taking place, social workers met with people alone. Seemingly, Care Act 2014 duties to ensure that support, which is independent of the local authority, is available to those who may have substantial difficulty in navigating the care system and participating in decisions about their care was not widely recognised, nor part of every day practice.

In effect I observed social workers apply a hierarchy to the use of third parties, with professionals and paid carers at the top; followed by those with legal authority of Lasting Power of Attorney; family, friends and unpaid carers at the bottom. Such a perspective appears to be informed by social workers' practice knowledge, duties,

and experience of intervening in cases of abuse and or neglect (Care Act 2014, s.42). Given the prevalence of organisational abuse, and the fact that 53% of adult safeguarding concerns occurred outside of the person's own home (NHS Digital 2023) this unspoken hierarchy feels somewhat off balance.

Social workers were not only concerned about abuse but about the bias and undue influence of family and other informal relationships, perceiving them to be less objective than paid carers or professionals. The notion that those familiar to a person are able to best communicate with them was recognised as a means to maximising peoples' involvement in decision making. Social workers did not however extend this to family or loved ones being present during a mental capacity assessment due to concerns that they would prompt. This is reflective of other feedback by family members (House of Lords 2014) yet goes against duties for and guidance on supporting decision making. It is also not reflective of a rights-based approach to practice that was put forward as being such a strong part of social workers' professional identity.

Though social workers heavily criticised the paternalistic nature of health professionals such as nurses and doctors, there was minimal acknowledgement that they themselves can also be risk averse and over protective. Mental capacity assessment was usually triggered by risk concerns. As such the greater the risk, the greater social workers' ability to promote and respect a person's autonomy was curtailed. Attaining a balance in promoting and empowering people's autonomy versus the duty to protect adults at risk from abuse, as well as protection to the wider public is fraught with difficulties. The data findings are reflective of this dilemma, with risk and the need to protect ultimately placed above all else.

This protection continuum appeared to be influenced to some degree by a person's age, with social workers appearing to be more aspirational for the generation of young adults, believing that they could learn and change behaviours. Seemingly the acceptance of risk was greater as it was being linked to a natural part of the transition to adulthood. In contrast there appeared to be a culture of greater protection for older generations, with social workers and family leaning to the 'protection imperative', prioritising the physical safety of individuals, and/or taking preventative action to reduce risk. This is arguably reflective of societal attitudes to

older people and the prevalence of ageism. Grenier et al. (2017) explore the precarity of old age, noting how the cumulative effects of disadvantage over the life course increase people's insecurity and reliance on others for support.

Reflection on the role social workers can play in reinforcing discrimination and structural oppression was minimal, though the physical protection of older people was noted as a societal norm. Social workers described the pressure from families, other professionals, the public, and their employer to keep people safe, and the fear of blame in the event of things going wrong and harm occurring was acute.

Participants described circumstances in which the MCA was used primarily as protection for professional and organisational decision making rather than for the protection of individuals' human rights to have choice and control over their lives, including the right to make 'unwise decisions'. There was a clear sense of needing to cover their backs in case risk of harm occurred or their decisions were challenged. The organisational system also fed this risk and blame culture, demanding mental capacity assessments as part of a suite of documents to accompany funding requests, irrespective of whether there was just cause to question capacity.

Though critical of other professionals' personal views influencing capacity decisions, social workers were also seen to link people's apparent compliance or agreement with their recommendations with capacitous decision making. In contrast formal capacity assessments were triggered where people disagreed with professionals about what they saw as the best option for them. Given the criticism that social workers have received for failing to intervene, and/or placing too much weight on right to self-determination as seen in Serious Case Reviews, courts, and the media (see chapters 2.5 and 4.3), it is not surprising that defensive practice is visible.

Social workers' ability to support decision making and empower people was described and seen to be restricted by the health and social care system.

Relationship-based practice was identified as key to empower and effect change, as evidenced through the Named Social Worker pilots (Innovation Unit 2018), but the system directed episodic working practices and fast throughput of tasks. Whilst there was an acceptance of the imbalance of demand versus capacity of services, it

was evident that social workers found space to work around some of the organisational procedures. Drawing on their professional knowledge and expertise to justify their approach, they would for example argue for increased contact with people, or continue working with them after their work was officially closed. This demonstrates how street-level bureaucracy (Lipsky 1980) continues to apply to practice.

There was however a real sense of powerlessness by social workers to effect change beyond their direct work with individuals. One aspect that is key to supporting decision making is being able to provide salient information to people. However this information was controlled by others, and was drip fed to social workers one option at a time. Consequently, they were forced to have conversations with people, and assess capacity, based on abstract options.

Time was seen as an enabling factor by all participants. Time to build relationships and trust; time to inform and educate; time to assess needs and capacity; time to explore tangible options; time to consider decisions; time to revisit decisions. It was however felt to be limited due to organisational pressures.

Practitioners' relationships with their managers were a contributory factor to how social workers practiced and the extent they were able to support decision making. Examples were given where their professional knowledge and expertise was recognised and they were able to negotiate additional time to support people outside of the expectations of the wider organisation. As such, individual managers could be seen as a protective factor for good practice in supporting decision making, acting as a buffer, or 'piggy-in-the-middle' (Jones 2004), from system demands. In the absence of a 'good' manager, social workers described working under the radar, for example discreetly fitting in additional visits or continuing to work with people after their work was officially closed. This practice in the grey areas was a means to being able to practice more in line with their expressed values and in accordance with their Professional Standards (Social Work England 2019) and Code of Ethics (BASW 2021).

6.3 Reflections on, and limitations of, study design

As a lone researcher with insider status as a qualified and experienced social worker, critique could be made that steps to minimise the issue of familiarity by bringing in additional researcher(s) was not made. I have been open about my position and factors that brought me to undertaking this study, and attempted to minimise any personal and professional bias. The use of audio recording, journalling, transcription and academic supervision has assisted me to maintain a level of reflexivity throughout. I left statutory social work practice for a few months during stage one data collection, and then permanently during the writing up stage. This time out of practice was greatly enabling in the reflexive process. I was more readily able to detect and question that which is routine and familiar to the social work profession.

The greatest challenge was gaining access to social workers through the layers of gatekeepers. The research design allowed for two observations of contact between any given social worker and the person they were supporting, though in reality I only observed each pairing once. Any preliminary contact or follow up was unobserved and with no access to social workers' records, I was reliant on participants' recall or stated intentions for interventions which scaffolded that which I observed. The limitations of this approach, in that it only provides a snapshot of social work practise, are acknowledged. Perhaps being overly cautious, I had curtailed my ambition of the research design due to concerns about gaining ethical and access approval. In the field, social workers' interventions will include multiple contacts, consultation with others etc., which in this study went unobserved. Follow-up observations and access to case records would have provided a fuller picture and is recommended for future studies. Within this research, pre- and post-observations interviews with social workers helped to bridge this gap, enabling enquiry as to what actions had gone before and next steps.

Social worker participants volunteered to take part in this study. As such it could be surmised they had a level of confidence about their practice. They also self-selected which interventions I observed and who with, in accordance with the inclusion criteria, and as such added another layer to the gatekeeping. It is reasonable to postulate that this resulted in observations of less complex or contested interventions. Certainly social workers gave a number of reasons why it would be

inappropriate for me to observe their contact with many people they supported. For example, because of the sensitivity of a person's situation, or of people's dislike of strangers. Wilkins and Antonopoulou (2017) note that in their experience with projects that involve observing social work with children and families, it is the social workers who are most resistant rather than the families themselves. To what extent this is transferable to this study is unknown.

This study was measured in its ambition, having no expectation that the full breadth of social work practice, individuals' reasons for support, age, or the variety of decisions that social workers are involved in supporting people with could be captured. It specifically excluded young people aged sixteen and seventeen years old, focusing solely on the definition of adulthood as used in English law which is eighteen years plus (Office for National Statistics 2019). Yet it did happen to demonstrate social workers' role in supported decision making spans from young adulthood through to the later stages of life.

My presence as an observer led to a change in the observed dynamics, whereby some individuals drawing on support attempted to pull me into conversation. It is questionable whether they viewed me as being neutral, an ally, or a colluder, though the behaviour does suggest that I was seen as someone who had some distance from the social worker. I am left reflecting if it is at all possible to be a non-participant observer as a researcher in such intimate and private spaces. This inability to be invisible as an observer has also led me to consider how the presence of a third party, whatever their role, can change the balance of power in such 'working alliances' (Trevithick 2003). Perhaps those drawing on support are able to be more assertive with a third-party present, one who is viewed as having a level of independence from professionals, such as a chosen family or friend as an 'appropriate person', or an advocate; that there is some strength in numbers.

Observational data collection was brought to an abrupt end due to the 'stay at home' order (Cabinet Office 2020) in response to the Covid-19 pandemic. The subsequent pressures on local authorities coupled with the ongoing concerns about public health undoubtedly had an impact on practice; the Principal Social Worker informed me that social workers were undertaking work remotely rather than in person, and pressures on adult social care services were still a significant concern

twelve months on. With it not being feasible to return to observations of practice, an amendment to the research design was made and focus groups introduced. This transpired to be an asset to the study rather than detrimental, allowing the exploration of the reasons for gaps identified between the talk and walk of social work practice. The span of data sources enabled the relationships and influences on social workers' understanding and ability to support decision making from different perspectives.

Whilst the core legislation of the Care Act 2014 and the MCA were applicable throughout this thesis period, and the duties to support decision making has stood firm, the Covid-19 pandemic triggered the introduction of the Coronavirus Act 2020 which gave local authorities the ability to demote some statutory Care Act 2014 duties to powers should the demand of the pandemic on social care provisions warrant it (Baginsky et al. 2020; DHSC 2020). Though the research site did not formally proceed in applying these 'easements' of duties at stages 3 and 4, they did adopt stage 2 which permitted them to prioritise needs and flexibility in their approach to assessment (DHSC 2020). How they implemented this in practice is unknown. McHale and Noszlopy (2021) argue that local authorities could have interpreted the guidance differently as the boundaries between the stages were blurred and decision making was made at a local level.

6.4 Recommendations

Practice

Social workers' professional identity that is underpinned by values of upholding human rights, and empowering people to have choice and control over their lives has been consistent throughout this study. With the MCA viewed by participants as having an empowering ethos, the Act and its duty to support people to make their own decisions is aligned to these professional values. Whilst supported decision making practice can be seen at an individual level, the wider, structural and social conditions that shape people's lives and their impact on decision making also require consideration. Social workers gave examples of challenging paternalistic practice and poor legal literacy. Being able to take a step back and reflect on their own professional power may assist in further challenging oppressive and discriminatory practices at the structural and cultural levels.

It is recommended that MCA training is further developed to include scenarios as a means to link the theoretical legal knowledge to practice. Observation of capacity assessments and feedback would also be beneficial. This could perhaps be undertaken by peers as a reciprocal arrangement, and would contribute to the peer learning that is required by Social Work England (2023) as part of maintaining registration. Case law updates that are reflective of the Continuing Professional Development sessions provided to Best Interests Assessors was identified by participants as a useful learning tool.

Social workers noted that there is minimal scrutiny of their capacity assessments. I suggest that peer supervision could be used to look at mental capacity assessments, with discussion and challenge facilitating reflection and shared learning, including a focus on the practicable steps taken to support decision making.

Some immediate actions that individual social workers, and the employing organisation, could adopt to strengthen rights based practice and compliance with the statutory duties to support decision making are summarised as:

- An 'appropriate person' (Care Act 2014, s.67(5)) to be identified at first contact where an assessment of need (ibid, s.9) is required and it is clear that the person is likely to have difficulty in being involved in the assessment, and care and support planning process (ibid, s.67). In their absence, a referral for an independent advocate to be made (ibid, s.67(2)).
- Brief written summary, or alternative format, of salient information to be left with individual's at the end of social worker contact when information about specific decisions have been discussed.
- Detailed practice guidance to be drafted to provide greater clarity as to when an 'appropriate person' or 'independent advocate' should be present during social workers' interventions.
- Regular peer group supervision to share examples of supported decision making; to be open to peer challenge that 'all practicable steps' (MCA, s.1(3)) are taken before moving on to substitute Best Interests (MCA, s.1(5)) decision making.

- Supervising managers to audit mental capacity assessments for evidence of supported decision making.
- MCA training further developed to include scenarios where social workers would be the decision-maker under the MCA.
- 'Relevant information for different categories of decisions'⁷ (Ruck Keene et al. 2024) guidance to be used to identify the salient information needed for a range of specific decisions, as directed by the courts.
- A central electronic location for tried and tested resources to be shared, for example, the easy-read tenancy agreement that was used by SW4.
- Pertinent case law summaries to be disseminated to all social workers, not just Best Interest Assessors.

Policy

Though Anglo-Welsh capacity laws do not yet reflect the full scope of the 'support paradigm' under the CRPD (CRPD 2014), it is gaining greater prominence and influence elsewhere, such as Canada (Bach and Kerzner 2010; Martin et al. 2016), and Northern Ireland (Davidson et al. 2016; McCusker et al. 2023). It feels to me that there is a mountain to climb to realise supported decision making in practice in England. The basics of taking 'all practicable steps' (MCA, s.1(3)) in determining a person's 'will and preferences' need to be truly realised. At its core are relationships. Circles of support (Pearpoint 1991; Lockman et al. 2022; Wistow et al. 2016) is one means of achieving a more self-directed model of support. Where informal networks are unavailable or inappropriate, or where professional expertise is required, this should include social workers and/or other professionals. Identifying a third party as an 'appropriate person' at initial contact would be a starting point.

Whilst no major changes to the MCA or Care Act 2014 are anticipated in the near future, the Mental Capacity (Amendment) Act 2019 and its Liberty Protection Safeguards is left in suspension. Having been delayed from its original implementation date of 1 October 2020, it has been confirmed that it will now not proceed within this parliament (Whately 2023). If it is to be picked up again, the introduction of the safeguards and a revised Code of Practice is a potential vehicle

⁷ [Mental Capacity Guidance Note - Relevant Information for Different Categories of Decision May 2024 0.pdf \(39essex.com\)](#)

for clarifying and addressing some of the issues raised in this study through the training and competency frameworks that will follow, as could the updated NICE guidelines and the Care and Support Statutory Guidance. For example:

- Greater scrutiny should be placed on how the 'support principle' has been met and exhausted before third parties are permitted to proceed to substitute 'best interest' decision making.
- An 'appropriate person' should be identified at people's initial contact with adult social care where it is known that the individual has a cognitive impairment that would meet the MCA criteria. In the absence of an appropriate person being identified or available, a referral made for Care Act 2014 advocacy.
- Given the power of relationships, choice of support should be promoted so that relationships of trust are available.
- Information relevant to the decision should be provided in additional format(s) to support verbal communication.
- Training plans will need to consider how to translate knowledge to practice in what is a complex and subjective practice. Use of scenarios is suggested by participants, as is case law updates.
- There seems to be a conflict between the guidance in the MCA Code of Practice to involve others, against social workers' concerns about bias and undue influence of family and friends. Clearer guidance for professionals around involving others are therefore recommended.

Irrespective of whether the Mental Capacity (Amendment) Act 2019 is enacted, the findings of this study remain relevant.

The Named Social Worker pilots (Innovation Unit 2018) demonstrate that the quality of and consistency in social workers' relationships with people not only enhances people's capacity for decision making and improves outcomes, but is financially cost effective. It is recommended that this is extended for those with longer term and/or complex support needs; and to fill a gap where informal support networks are low. This would enable time for trust in social worker relationship to develop, something that is highly valued by those drawing on support for decision making.

Research

Given the limited research exploring the interpretation and application of the 'support principle', further studies are recommended in this field. The gap seen in this study between social workers' talk and that which was observed, their walk, highlights the need to move beyond methods that rely on professionals' recall or office-based ethnographic research, and directly observe practice that spans the breadth of decision making support including mental capacity assessment.

The complexities of navigating access for ethnographic research of social work practice in action has been outlined in chapter three. Piecemeal observations of social workers completing aspects of work are fraught with difficulty due to the ad-hoc nature of their working day, and other researchers have echoed such challenges (Dixon 2023; Wilkins and Antonopoulou 2017). Studies that can include practice experienced social workers as researchers is recommended. This will offer inside knowledge in navigating the system, is likely to provide reassurance to gatekeepers, and minimise some of the ethical concerns in observing such sensitive interventions into people's private lives.

Funded research would be beneficial to broaden ethnographic study to span both the office and social work practice in private spaces, and to view any documentation that relates to supported decision making and formal mental capacity assessments for participants. This should include the views of those who have need to draw on support for making decisions about their care.

6.5 Final comments

This study set out to better understand how social workers interpret and apply legislation in the private spaces where much of their practice takes place. All participants demonstrated their commitment to their professional values that promote human rights and social justice, and in improving the lives of those they are employed to support. However, being employed as a statutory social worker in adult social care services brings particular challenges to practice. It is clear that the way in which the health and social care system is designed, the level of bureaucracy, and cultural and societal issues leads to social workers being disempowered from practicing in line with their values, professional standards and

ethics and the way in which they would like to practice. Despite the challenges, social workers can be seen to use their position to advocate, empower, uphold rights, and support decision making at the individual level. This is achieved through negotiation, as well as street-level practice.

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Case Law References

A NHS Trust v P & Anor [2013] EWHC 50 (COP)

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PC and NC v City of York Council [2013] EWCA Civ 478 [2011] EWHC 1377

R (SG) v London Borough of Haringey [2015] EWHC 2579 (Admin)

Appendix A: Social Care Research Ethics Committee Approval



Social Care REC

Ground Floor
Skipton House
80 London
Road
London
SE1 6LH
Telephone:
0207 972 2568
Fax:

18 March 2019

Miss Rebecca Burden
Scarne Farm
Hurdon Road, Launceston
Cornwall
PL159LR

Dear Miss Burden

Study title: The Application of the Mental Capacity Act
2005 in Social Work Practice.
REC reference: 19/IEC08/0003
Protocol number: SPON 1709-18
IRAS project ID: 247399

Thank you for your letter of 08 March 2019, responding to the Committee's request for further information on the above research and submitting revised documentation. The Committee would like to thank you for a very thorough and comprehensive application and response to their provisional opinion letter.

The further information has been considered on behalf of the Committee by the Chair.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to make a request to postpone publication, please contact hra.studyregistration@nhs.net outlining the reasons for your request.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Mental Capacity Act 2005

I confirm that the committee has approved this research project for the purposes of the Mental Capacity Act 2005. The committee is satisfied that the requirements of section 31 of the Act will be met in relation to research carried out as part of this project on, or in relation to, a person who lacks capacity to consent to taking part in the project.

Site Specific Assessment

The Committee decided that the research did not require Site-Specific Assessment at non-NHS sites as it involves no clinical interventions and the Committee was satisfied that the risk to participants is likely to be negligible.

Conditions of the favourable opinion

The REC favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Each NHS organisation must confirm through the signing of agreements and/or other documents that it has given permission for the research to proceed (except where explicitly specified otherwise).

Guidance on applying for HRA and HCRW Approval (England and Wales)/ NHS permission for research is available in the Integrated Research Application System, at www.hra.nhs.uk or at <http://www.rdforum.nhs.uk>.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of management permissions from host organisations

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database within 6 weeks of recruitment of the first participant (for medical device studies, within the timeline determined by the current registration and publication trees).

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to request a deferral for study registration within the required timeframe, they should contact hra.studyregistration@nhs.net. The expectation is that all clinical trials will be registered, however, in exceptional

circumstances non registration may be permissible with prior agreement from the HRA. Guidance on where to register is provided on the HRA website.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Covering letter on headed paper [SCREC application - R Burden]		17 December 2018
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Cardiff University indemnity]		02 July 2018
Letter from sponsor [Cardiff University sponsor letter]		12 December 2018
Other [App B Participant Information Sheet - Members of the Public]	V1.1	12 December 2018
Other [App E Easy Read Consent Form]	V1.1	12 December 2018
Other [Academic supervisor CV - Dr T Slater]		19 November 2018
Other [Academic supervisor CV - Dr L Series]		21 November 2018
Other [Research site 'in principle' agreement]		02 November 2018
Other [App B Participant Information Sheet - Members of the Public]	V1_3	05 March 2019
Other [App C Easy Read Participant Information]	V1_2	06 March 2019
Other [App F Consultee Declaration Form V1_3 (28.02.2019)]	V1_3	28 February 2019
Other [App G Information Sheet - Personal Consultees V1_0 (06.03.2019)]	V0.3	28 February 2019
Other [App H Information Sheet - Nominated Consultees V1_0 (06.03.2019)]	V1_0	06 March 2019
Other [App I Participant Information Sheet (Family Members) V1_0 (06.3.2019)]	V1_0	06 March 2019
Other [App J Outline Interview Schedule & Observation Record V1_0 (05.03.2019)]	V1_0	05 March 2019
Other [App K Lone Working Protocol During Data Collection V0_1 (04.03.2019)]	V0_1	04 March 2019
Other [Response to SCREC provisional opinion - covering letter R Burden]		08 March 2019
Participant consent form [App D Consent Form]	V1_2	28 February 2019
Participant information sheet (PIS) [App A Participant Information Sheet - Members of the Public]	V1_1	05 March 2019
REC Application Form [SC_Form_02012019]		02 January 2019
Referee's report or other scientific critique report [Academic		04 December 2018

supervisors letter]		
Research protocol or project proposal [Research protocol - R Burden]	V1.0	06 December 2018
Summary CV for Chief Investigator (CI) [CV Rebecca Burden]	V1.0	01 December 2018

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document “*After ethical review – guidance for researchers*” gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The HRA website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website:

<http://www.hra.nhs.uk/about-the-hra/governance/qualityassurance/>

HRA Learning

We are pleased to welcome researchers and research staff to our HRA Learning Events and online learning opportunities– see details at: <https://www.hra.nhs.uk/planning-and-improvingresearch/learning/>

19/IEC08/0003	Please quote this number on all correspondence
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With the Committee's best wishes for the success of this project.

Yours sincerely



Pp Ms Susan Harrison Chair

Email: nrescommittee.social-care@nhs.net

Enclosures: "After ethical review – guidance for researchers"

Copy to: *Dr Thomas Slater*

Appendix B: Social Care Research Ethics Committee Approval of
Amendment



Social Care REC

Ground Floor
Skipton House
80 London Road
London
SE1 6LH

01 December 2020

Miss Rebecca Burden
Scarne Farm
Hurdon Road, Launceston
Cornwall
PL159LR

Dear Miss Burden

Study title: The Application of the Mental Capacity Act 2005 in
Social Work Practice.
REC reference: 19/IEC08/0003
Protocol number: SPON 1709-18
Amendment number: SA01
Amendment date: Nov 19 2020
IRAS project ID: 247399

The above amendment was reviewed by the Sub-Committee in
correspondence.

Ethical opinion

The members of the Committee taking part in the review gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

Approved documents

The documents reviewed and approved at the meeting were:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Completed Amendment Tool [Amendment Tool]	V1.2	26 October 2020
Interview schedules or topic guides for participants [Appendix O Focus Group Plan]	V0_1	07 October 2020
Participant consent form [Appendix N Consent Form V0_1 (07.10.2020)]	V0_1	07 October 2020
Participant information sheet (PIS) [App M Participant Information Sheet (Social Workers') V0_2 (11.11.2020)]	V0_2	11 November 2020
Research protocol or project proposal [Research protocol (Stage 2 update) Rebecca Burden]	V1_0	11 November 2020
Validated questionnaire [App P Questionnaire for Social Workers (Stage 2)]	V0_1	01 October 2020

Membership of the Committee

The members of the Committee who took part in the review are listed on the attached sheet.

Working with NHS Care Organisations

Sponsors should ensure that they notify the R&D office for the relevant NHS care organisation of this amendment in line with the terms detailed in the categorisation email issued by the lead nation for the study.

Amendments related to COVID-19

We will update your research summary for the above study on the research summaries section of our website. During this public health emergency, it is

vital that everyone can promptly identify all relevant research related to COVID-19 that is taking place globally. If you have not already done so, please register your study on a public registry as soon as possible and provide the HRA with the registration detail, which will be posted alongside other information relating to your project.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

HRA Learning

We are pleased to welcome researchers and research staff to our HRA Learning Events and online learning opportunities– see details at: <https://www.hra.nhs.uk/planning-andimproving-research/learning/>

IRAS Project ID - 247399:	Please quote this number on all correspondence
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Yours sincerely

Dr Martin Stevens Chair

E-mail: socialcare.rec@hra.nhs.uk

Enclosures: List of names and professions of members who took part in the review

Copy to: Miss Rebecca Burden

Social Care REC

Attendance at Sub-Committee of the REC meeting on 01 December 2020

Committee Members:

<i>Name</i>	<i>Profession</i>	<i>Present</i>	<i>Notes</i>
Ms Laura Bamford	Publisher	Yes	
Dr Martin Stevens	Senior Research Fellow	Yes	

Appendix C: Participant Information Sheet for Social Workers



The application of the Mental Capacity Act 2005 in social work practice

Introduction

My name is Rebecca Burden and I am currently studying for a Professional Doctorate in Social Work at Cardiff University. As a registered social worker and researcher, I am interested in observing interventions and sharing good practice across the social work profession.

You are being invited to participate in a research study which is sponsored by Cardiff University and has ethics approval from the Social Care Research Ethics Committee. This information sheet outlines the purpose of the research project and provides a description of your involvement and rights as a participant should you wish to proceed.

The Purpose of the Study

This research project will observe social workers, employed in adult's services of Devon County Council, who have a statutory role in assessing need, risk and mental capacity, engaging in their daily practice. This research will be looking at how social workers work within the context of the Mental Capacity Act (2005) within their daily practice.

Whilst social workers are the primary participants, this research will entail observing the people they are employed to support, many of whom may have difficulty in decision making. Consequentially the social worker, the person and their carer(s) will be research participants.

What You Will be Asked to do

I would like to observe your direct practice and understand how you apply the Mental Capacity Act (MCA) within your daily duties, with the aim of identifying factors that support social workers in their daily work.

To achieve this, I would like you to agree to be observed on your visits to people you are employed to support.

Observation will be preceded and followed by individual interview. The pre-interview will explore the purpose of the imminent visit/intervention and your intended approach and outcomes. The post-observation interview will provide the opportunity to reflect on the intervention.

Your interviews will be audio taped so that I will have a record of what is said. I will also seek permission from the third-party participants to audio record your visit/intervention. This is to supplement the hand-written notes that I will be taking so that I have an accurate record of what has taken place. Where third parties decline audio recording the observation can still take place.

The audio recordings and written notes will be analysed and evaluated with the aim of sharing good practice across the profession. A summary of the thematic findings will be shared with you in advance of publication.

Please be aware that whilst I have been granted permission by Devon County Council to undertake this research and will be sharing my findings and recommendations, I am an independent researcher and have no ties to the local authority.

Your Rights as a Participant

- Your participation in this research is entirely voluntary; you have the right to withdraw your consent at any stage of the interview or observation, for any reason and without any prejudice.
- All participants will be given an anonymised identification number only known to the lead researcher. This will be completed on the research site. The participation identification list will be stored on an encrypted file, stored at Cardiff University, and will be used for the purposes of identifying and removing participant data where withdrawal of consent occurs. Any personal contact details will be stored with this identification list.
- Your anonymity will be protected throughout the research process. Your real name will not be used at any point of information collection, or in any subsequent

written material; instead, you and any other person and place names involved in your case will be given pseudonyms. Any readily identifiable characteristics will be amended to aid with anonymity.

- Confidentiality will be maintained unless what you say or do means that you or someone else may be harmed. Where this occurs Cardiff Universities safeguarding procedures will be followed.
- Interview transcripts, and notes taken during observations, will only be made available to myself and my doctorate supervisors, Dr Thomas Slater & Dr Lucy Series. All data will be stored securely in accordance with the General Data Protection Regulations 2018 and Data Protection Act 2018. Subsequent analysis of the data will form part of my doctoral research. The results of the study will be written up and published as part of my doctoral research thesis and may also be published in journals or be presented at conferences. No one will be able to identify you in publications or presentations arising from the research.
- Participants retain the right to withdraw consent for their data to be used up until the end of the data collection process which will take six months. After 30 April 2020 the data will have been anonymised and merged into collective findings and it will not be possible to be extracted.
- Personal and anonymised data will be retained for no less than 5 years and for 2 years post-publication, in line with Cardiff University policy. The data will then be destroyed in line with the General Data Protection Regulations 2018. Cardiff University is the Sponsor for the study based in the UK. Cardiff University will be using information from you in order to undertake this study and will act as the Data Controller for this study. This means that the University is responsible for looking after your information and using it properly.
- Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study the data held on the participant identification list will be retained. To safeguard your rights, we will use the minimum personally identifiable information possible.

You can find out more about how we use your information at: <https://www.cardiff.ac.uk/public-information/policies-and-procedures/data-protection> or by contacting the University Data Protection Officer at: inforequest@cardiff.ac.uk

If at any point you have a concern or wish to make a complaint about the way the research has been conducted and you would like to speak with somebody outside of the study team, you can contact: Mel Evans, at the Cardiff University School of Social Sciences Research Ethics Committee by email socsi-ethics@cardiff.ac.uk or telephone 02920 875389

If you are interested in contributing to this research and would like to discuss this further, please contact me direct.

Thank you for your time.

Regards

Rebecca Burden (Professional Doctorate in Social Work Student; Social Worker)

Email: BurdenRE@Cardiff.ac.uk

Telephone: 07596 556261

Address:

Professional Doctorate Programme in Social Work

School of Social Sciences

Cardiff University,

Glamorgan Building

King Edward VII Avenue

Cardiff. CF10 3WT

Supervisor:

Dr Thomas Slater

Email: Slatertb1@cardiff.ac.uk

Telephone: 02920 874155

Address:

School of Social Sciences

Cardiff University,
Glamorgan Building
King Edward VII Avenue
Cardiff. CF10 3WT

The School of Social Sciences Research Office Team

Email: socsi-ethics@cardiff.ac.uk

Telephone: 02920 875389

Appendix D: Participant Information Sheet for Members of the Public



The application of the Mental Capacity Act 2005 in social work practice

Introduction

My name is Rebecca Burden and I am currently studying for a Professional Doctorate in Social Work at Cardiff University. As a registered social worker and researcher, I am interested in observing social workers engaging with members of the public, gathering feedback about your experience and sharing good practice across the social work profession.

You are being invited to participate in a research study which has been approved by the Cardiff University and has ethical approval from the Social Care Research Ethics Committee. This information sheet outlines the purpose of the research project and provides a description of your involvement and rights as a participant should you wish to proceed.

The Purpose of the Study

This research project will observe social workers, employed in adult's services of Devon County Council, who have a statutory role in identifying people's strengths, support needs, risk and mental capacity to make their own decisions about their care and support needs.

Social workers are expected to understand the laws that they use to support people and use them in the correct way. This research will be looking at how social workers work within the context of the Mental Capacity Act (2005) within their daily practice. The Mental Capacity Act is a law that says when people have the 'mental capacity' to make decisions for themselves and when others can make decisions in the person's best interests, for example about assessment or how their care needs should be met.

Whilst social workers are the primary participants, this research will entail observing the people they are employed to support. Consequentially the social worker, the person and their carer(s) will be research participants.

What You Will be Asked to do

I would like to observe social workers in their direct work with people to understand how they apply the Mental Capacity Act (MCA) when working with you or the person you care for. The aim is to identify factors that support social workers to be the best they can in promoting people's independence and rights.

To achieve this, I would like you to agree to me accompanying your social worker when they visit you and observe how they support you. I would like to audio tape the interviews so that I will have a record of what is said. This is to supplement the hand-written notes that I will be taking so that I have an accurate record of what has taken place. If you do not want your conversation to be recorded, or only happy for part of the conversation to be recorded that is fine.

After your social worker has finished, I would like to ask you how you felt about your meeting with them. This could take place immediately following your visit or on another day.

There will be an evaluative nature to this research, with the aim of sharing good practice across the social work profession. I will share a summary of my research with all participants.

Please be aware that whilst I have been granted permission by Devon County Council to undertake this research and will be sharing my findings and recommendations, I am an independent researcher and have no ties to the organisation.

Your Rights as a Participant

- Your participation in this research is entirely voluntary; you have the right to withdraw your consent at any stage of the observation or interview, for any reason and without any prejudice.
- All participants will be given an anonymised identification number only known to the lead researcher. This will be completed on the research site. The participation

identification list will be stored on an encrypted file, stored at Cardiff University, and will be used for the purposes of identifying and removing participant data where withdrawal of consent occurs. Any personal contact details will be stored with this identification list.

- Your anonymity will be protected throughout the research process. Your real name will not be used at any point of information collection, or in any subsequent written material; instead, you and any other person and place names involved in your life will be given pseudonyms. Any readily identifiable characteristics will be amended to aid with anonymity.
- Use of personal addresses, telephone numbers or email, will only be retained where explicit permission is given within consent forms to contact participants after the initial observation visit. The purpose of any secondary contact will be restricted to post-observation interview where this is requested to be at a later date; and/or to provide a summary report of the research findings.
- Personal data includes names, contact details, gender and any medical diagnosis or disability which can individually or collectively identify individuals. Once data is anonymised it is no longer viewed as personal data. Such data will be held separately with the participant identification list.
- Confidentiality will be maintained unless what you say or do means that you or someone else may be harmed. Where this occurs Cardiff Universities safeguarding procedures will be followed.
- Interview transcripts, and notes taken during observations, will only be made available to myself and my doctorate supervisors, Dr Thomas Slater & Dr Lucy Series. All data will be stored securely in accordance with the General Data Protection Regulations 2018 and Data Protection Act 2018. Subsequent analysis of the data will form part of my doctoral research. The results of the study will be written up and published as part of my doctoral research thesis and may also be published in journals, or be presented at conferences. No one will be able to identify you in publications or presentations arising from the research.
- You retain the right to withdraw consent for your information to be used up until the end of the data collection process which will take six months. After 30 April 2020

the data will have been anonymised and merged into collective findings and it will not be possible to be extracted.

- Personal and anonymised data will be retained for no less than 5 years and for 2 years post-publication, in line with Cardiff University policy. The data will then be destroyed in line with the General Data Protection Regulations 2018. Cardiff University is the Sponsor for the study based in the UK. Cardiff University will be using information from you in order to undertake this study and will act as the Data Controller for this study. This means that the University is responsible for looking after your information and using it properly.
- Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, the data held on the participant identification list will be retained. To safeguard your rights, we will use the minimum personally identifiable information possible.

You can find out more about how we use your information at: <https://www.cardiff.ac.uk/public-information/policies-and-procedures/data-protection> or by contacting the University Data Protection Officer at: inforequest@cardiff.ac.uk

If at any point you have a concern or wish to make a complaint about the way the research has been conducted and you would like to speak with somebody outside of the study team, you can contact: Mel Evans, at the Cardiff University School of Social Sciences Research Ethics Committee by email socsi-ethics@cardiff.ac.uk or telephone 02920 875389

I am happy to answer any questions you may have.

Thank you for your time.

Regards

Rebecca Burden (Professional Doctorate in Social Work Student; Social Worker)

Email: BurdenRE@Cardiff.ac.uk

Telephone: 07596 556261

Address:

Professional Doctorate Programme in Social Work

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Supervisor:

Dr Thomas Slater

Email: Slatertb1@cardiff.ac.uk

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Cardiff. CF10 3WT

The School of Social Sciences Research Office Team






Email: socsi-ethics@cardiff.ac.uk

Telephone: 02920 875389

The application of the Mental Capacity Act 2005 in social work practice







Appendix E: Easy Read Participant Information Sheet

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Appendix F: Easy Read Consent Form



The application of the Mental Capacity Act 2005 in social work practice


Do you want to take part in the research?

This is a form to tell me if you want to take part in the research.







It also helps me to know that:





- You understand the research
- You know what taking part in the research means for you
- You can decide if you want to take part in the research

Please circle  or 

		YES	NO
	The information form for this research has been shared with me.	✓	✗
	I know I can ask Rebecca any questions I have about the research.	✓	✗
	I know that I can choose if I want to take part in the research or not.	✓	✗
	I know that I can say 'No'. I do not have to take part in the research if I do not want to.	✓	✗
	I know that I can stop taking part in the research at any time.	✓	✗
	I know that changing my mind will not	✓	✗

	change the support I am getting.		
	I agree to Rebecca recording my meeting with my social worker on a voice recorder.	✓	✗
	I agree to speaking to Rebecca after my social worker meeting.	✓	✗
	I agree to Rebecca recording my interview with her.	✓	✗
	I know that Rebecca will write a report about the research.	✓	✗
	I know that the report will be shared with other people.	✓	✗
	I know that my name will be changed in the report.	✓	✗

	<p>I know that I can stop Rebecca writing about me if I tell her by 30 April 2020</p>		
	<p>I want to take part in the research</p>		

	<p>Name of person:</p>	<p>.....</p>
	<p>Date:</p>	<p>.....</p>
	<p>Signature:</p>	<p>.....</p>
	<p>Name of person taking consent:</p>	<p>.....</p>



Date:

.....



Signature:

.....