

Learning capacity: How professionals learn about mental capacity on post qualifying education programmes

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Abstract: The focus of this paper is the way in which learning on a post graduate professional academic training module is developed and articulated via processes of shadowing and the production of two assignments (a written case study and a reflective piece). The context is learning about key aspects of Mental Capacity legislation and the data for the study came from work submitted by fifty students on four successive iterations of a ‘best interests assessor’ (BIA) training course in England. We sought evidence of the use of key elements including specific sections of the Mental Capacity Act 2005 (MCA) as well as case law; professional values; practice guidance; and classroom education. Moreover we were interested in the ways in which a brief shadowing of a practicing BIA helped to make sense of these disparate elements in practice. Practice guidance from expert bodies such as SCIE and NICE, the formal legal test of capacity, and certain relevant pieces of case law were not referred to as much as expected, but most candidates showed the ability to deftly navigate the tensions and challenges which arise when trying to meld case law, statute law, codes of practice, and classroom learning and ensure that this is used to safeguard the rights of vulnerable adults.

Keywords: Mental Capacity Act 2005; MCA; professional learning; Best Interest Assessor; BIA; vulnerable adults; practice learning

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Introduction

This paper addresses aspects of how health and care professionals learn on a specialist post qualifying course, and how they demonstrate that learning. We first explain the context and content of a short course which relates to Mental Capacity and Deprivation of liberty legislation in England and Wales, before analysing a sample of work submitted by students as part of their formal assessment for that course. The main approach taken was to audit the submitted work and look for evidence of the use of the following elements: specific sections of the MCA as well as case law; professional values; practice guidance; classroom education; and shadowing a qualified BIA in practice.

The Mental Capacity Act (2005)

In recent years many countries have enacted legislation and have adopted international conventions/protocols which require professionals to routinely assess the decision making capacity of service users, and to do so using formal legal frameworks (Alzheimer Europe, 2016). The exact nature of these frameworks vary between countries but within individual jurisdictions there is often a tension between law that aims to enable a person to make their own decision and statute that grants a nominated person the right to make a decision on behalf of another. For example, supported decision making is a key element of the United Nations Convention on the Rights of Persons with Disabilities (United Nations, 2007). This requires that individuals maintain rights to autonomous decision making, regardless of any impairment, and should be given as much support as necessary to make their own decisions. On the other hand substituted decision making, in which a surrogate decision maker steps in and makes a decision on behalf of a person who has been shown to lack the requisite decision making ability, is prioritised in many legal frameworks, including within our own MCA.

Campbell et al. (2018) suggest that the separation between supported and substituted decision making is blurred, complex and not binary. This can be seen in the Mental Capacity Act (2005) (MCA) for England and Wales which has elements of both supported decision making and of substituted decision making. Martin (2011) has argued that the MCA

furnishes a good example of an antinomial law; that is, one which offers two different arguments, each of which are sound in themselves, but which lead to contradictory conclusions. In the case of the MCA he shows that there are in fact a number of antinomies. The concepts of 'capacity' and of 'best interests', for example, map onto different value structures and conceptions of the person, where a person is given the right to make unwise decisions (MCA, Section 1) but equally, if found to lack capacity for set decisions, can have decisions made on their behalf in their best interests (MCA, Section 1) Even within the concept of 'best interests' there are frequently antinomies, when a person's 'wishes and feelings' (which are required to be given significant weight in any assessment) may conflict with what health and care professionals may determine is best for the well being of the person in the long term.

The MCA was implemented in 2007, and since then has required a formal assessment of the mental capacity of an individual in relation to specific decisions, when there is any evidence that capacity may be lacking. The fact that 2 million people in England Wales are estimated to lack the capacity to make some decisions for themselves highlights the importance of capacity assessments in contemporary care settings (Care Quality Commission, 2016). Each of these individuals will at some point need decisions or often a whole series of decisions to be made about interventions in relation to health and care, ranging from decisions about choice of food and daily activities to life changing decisions about surgery or where to live. The MCA was designed to provide a statutory framework for the promotion of autonomous decision making and for upholding the rights of those who may lack decision making capacity. The act has created a range of new roles which existing health and care professionals have had to adopt, including assessing decision making capacity, conducting 'best interests' meetings and arriving at best interests decision for those who lack requisite decision making capacity.

Where individuals are found to lack decision making capacity, others are empowered by the act to make decisions on the individuals behalf, always using the principle of 'best interests'. A checklist is offered in section 4 of the MCA detailing how 'best interests' should be determined but as noted above, the different elements within that checklist may lead to different decisions and cannot always be reconciled.

Campbell et al. (2018, p.143) note that 'where new ... capacity laws have been introduced there is surprisingly little research on the knowledge and perspectives of those involved in professional decision making'. Given that

there are competing imperatives within the legal frameworks, it is perhaps not surprising that where research has been conducted it has been found that those at the front line of delivery of care find it difficult to interpret and consistently implement the elements that are mandated by the legal frameworks.

For example studies such as those by Manthorpe et al (2009, 2012) found that confidence about knowledge of the MCA, and the use of the MCA in practice, varies widely among both health care professionals and those working as volunteers with older people with dementia.

The above discussion highlights some of the complexity and challenges which might be involved in developing the knowledge and skills to assess mental capacity, and to determine what is truly in the 'best interests' of an individual. It should also be clear from this that judgements about mental capacity and 'best interests' will need to be considered by all care professionals in their different roles, depending on the decision to be made. For example, where the decision relates to a health intervention then it may be that a nurse is required to make the assessment and judgement; where it relates to a proposed move to a care home or other new accommodation then it is likely that a social worker will be the person responsible.

Deprivation of Liberty Safeguards

There is one specialist area of practice which has arguably a greater degree of complexity and contention, and yet is one which is particularly important since it relates to a fundamental freedom, namely the right to liberty. The Deprivation of Liberty Safeguards (DOLS) were introduced in England and Wales in 2009 to provide safeguards for those who and are deprived of liberty within hospitals or care homes and lack capacity to consent to residence there (Department of Health, 2008). Many commentators have noted the complexity and bureaucratic burden which the DOLS brought to practice (Hargreaves, 2009; House of Lords, 2014). These regulations also introduced a new professional role, that of the Best Interests Assessor (BIA). The BIA conducts key assessments that determine whether a person has capacity to consent to residence in a care setting for the purposes of receiving care and treatment, and whether the circumstances of that residence amount to a deprivation of liberty. This role involves hugely important decisions which determine whether a person should be granted the autonomy to make their own decisions.

Hubbard (2018, p.90) suggests that 'the BIA's sole purpose is to illuminate decision-making and ensure possible alternatives have not been sidelined'. The Law Commission pointed out that 'the role and expertise of the best interest assessor is a highly-regarded aspect of the DOLS' (2015, p.75). The role is open to social workers, nurses, occupational therapists and psychologists with two years post qualifying experience.

It is important to note that, in response to a range of critiques, and mounting evidence of problems, the DOLS have been formally superseded by new Liberty Protection Safeguards (Mental Capacity Amendment Act, 2019). However, much of the Mental Capacity Act remains unchanged and within these new safeguards, assessments of mental capacity remain pivotal.

A common recommendation which is made by those who have investigated knowledge and use of the MCA is for more training (House of Lords, 2014). However, whilst more in depth training on the detail may be helpful, Marshal and Sprung (2016) and Willner et al (2013) both found that the delivery of MCA training to staff was not in itself a precursor to increased levels of knowledge and confidence. These studies suggest that the depth, quality and nature of the training are important to consider in terms of barriers to implementation of the MCA.

If we provide further refreshment of surface knowledge of the MCA without critical scrutiny of the antinomial elements within it, of the ways in which resource limitations and other legal and practice frameworks may provide competing imperatives, the difficulties of application in real cases, and the realities of human decision making, then it is arguable we are unlikely to see the greater consistency in application of the act which many commentators call for. The authors would argue that quality training around the MCA should involve these wider elements. However good the training course, the limits of training transfer should be acknowledged. It is known that the transference of knowledge and learning gained on training courses in practice remains disappointingly limited. Leimbach (2010) suggests that only 10–40 per cent of knowledge is transferred immediately, and only 15 per cent of that transferred lasts more than one year after a training event. There are though a number of things which can enable and enhance such transfer. In relation to the specific training referred to here using practice based case studies and analysing the specific decisions required by professionals in those cases are examples of elements which can aid learning transfer. These help individuals retain and make sense of new knowledge in relation to the realities of their own role and practice, and also help in honing their decision making skills.

Decision making and professional practice

In recent years a growing body of work has developed, informed by psychology and the social sciences on the reality and complexity of human decision making (Kahnemann and Tversky, 2012). This has led to initiatives such as the Good Judgement Project in North America (Ungar et al., 2012). This work is helping practitioners to move towards more informed and appropriate decision making, and the lessons from this work are being applied across the health and care professions. In social work, there are initiatives such as the Decisions, Assessment and Risk Special Interest Group (DARSIG) of the European Social Work Research Association, set up to support the development of research on decision making, assessment and risk in social work and to promote the use of research on these topics to inform practice, management and teaching in the profession (ESWRA, no date). There is a separate literature which has built up over several decades on Nursing decision making and clinical judgement (see for example a review by Nibbelink and Brewer, 2018). We introduced some of this material into a training curriculum for BIAs.

Most qualifying professional training incorporates some discussion of decision making and there are a number of popular social work and nursing texts which introduce theory and evidence in relation to this (O'Sullivan, 2010; Standing, 2020). The ways in which social workers and other professionals actually approach decision making has been subject to increasing scrutiny, but the focus of much research has been in relation to work with children and families (Whittaker, 2014; Taylor and Whittaker, 2018).

To date, less attention has been paid to work with adults and the only studies of decision making in practice by BIAs are an early study by Cairns et al. (2011) who looked at the decisions of several different professionals involved in the DOLS process and a more focussed study by Carpenter et al. (2014) involving a survey of 93 BIAs.

These studies produced contrasting results. Cairns et al (2011) found that the agreement among the professionals studied in relation to 'deprivation of liberty' was no greater than chance. Carpenter et al. (2014), using vignettes and factorial analysis found that BIAs were generally confident in their decision making. They did not compare the decisions of individual professionals with each other, so it is hard to know whether confidence was warranted in that regard. However, they did find a good level of agreement with regard to factors that were important in determining deprivation of liberty.

Only one study has examined the other important decision which needs to be made by a BIA, which is whether a person has the capacity to consent to residence for the purpose of care and treatment. In an earlier study, we used a vignette methodology to assess the weight given to various factors by professionals who were required to assess mental capacity in the context of Deprivation of Liberty Safeguards (DOLS) (Rogers and Bright, 2019).

The application of knowledge and theory to practice is rarely straightforward and debates about the nature, breadth and depth of knowledge required by professionals have been lengthy and sometimes heated (Howe, 2013). A number of models have been developed and utilised to assist students in reflecting on knowledge, and articulating on how it is applied to practice. The three stage theory model (Collingwood, 2005) and the Practice Pyramid (Gordon and McKay, 2017) are examples which have been adopted in Social Work training, though largely in qualifying programmes. There is literature providing guidance on integrating reflection, theory and practice on placements (Mathews et al., 2013) but less in relation to shadowing and placements on specialist post qualifying programmes. Placement experience on qualifying programmes is characterised by highly structured supervision and observations of practice, and the role of practice educators is crucial to this process (Nicholas and Kerr, 2015). Again, a body of literature and a set of models have been developing which assist stakeholders in understanding the needs and experiences of those involved in these processes (Stone, 2018). This is much less the case in relation to post qualifying programmes.

The foregoing discussion suggests that there remain gaps in understanding how professionals learn about decision making, how they apply this knowledge in practice when assessing capacity and best interests, and how their post qualifying learning in these areas may best be facilitated.

Methods

In the present study, we audited the work submitted by 50 students on a post graduate 'Best Interests Assessor' course. We used work submitted by four consecutive cohorts of students in 2018 and 2019. 43 of the cohort were female and the mean age was 38.

Our cohorts typically consist of qualified social workers and nurses

with the requisite experience. In this sample, 40 were social workers, 8 nurses and 2 occupational therapists. The training is designed to provide the knowledge and skills required to carry out this specialist role. Key elements of the role include an assessment of capacity and, where capacity is shown to be lacking, determining whether there is any deprivation of a persons liberty and whether any such deprivation can be authorised using the principle of 'best interests'. The role of the BIA is clearly set out in regulations and a code of practice (MOJ, 2007), and their specific tasks and requisite legal knowledge are fairly easy to make explicit and pass on via training.

Elements and skills which are perhaps less easy to articulate and develop relate to how practitioners should deal with questions of risk and decision making when cases are complex or borderline and where legal guidance is not sufficient to provide a clear steer for practice.

We require students to shadow at least one assessment conducted by a practising BIA and to write a case study based on this experience, and then to submit some critical reflections on the DOLs regulations as a whole.

We were interested in determining which elements of their existing knowledge skills and values were given prominence by students, and which elements of the specialist BIA training, and why. We also wanted to explore whether students felt their learning was enhanced by the shadowing experience and whether they reflected on this or not.

Students gave written permission for their work to be used as part of an audit, and possible publications; as well as for the usual purposes of academic assessment. This exercise was an audit and not research. Documents which were analysed were those submitted in the normal way as part of a programme of academic study. The assessments of capacity took place as part of a validated learning activity and none of the material which appears allows identification of any service user or professional.

Both authors independently scrutinised the transcripts of two separate pieces of work from 50 separate students. These were: a case study based on their experience of shadowing a practising BIA for the duration of the assessment of an individual following a referral via the DOLS system; and a set of critical reflections on the safeguards as a whole, with reference to their own practice experience. Whilst the shadowing required them to observe a qualified BIA making the actual decision, the student was required to comment on the process, including any decisions that they might have approached differently, and with reasons.

We assessed the transcripts for evidence of use of the following factors

in the decision making and reflections of students: MCA principles; MCA sections 2 and 3 (diagnostic and functional tests of capacity); MCA section 4 (best interests checklist); elements of case law; professional values; practice guidance; classroom education; and in particular how shadowing facilitated the integration and application of learning to practice.

Results

The following section gives an overview of the results, with selected quotes used to illustrate the ways in which students articulated the different elements identified above as important.

Table 1

The statutory principles of the Mental Capacity Act (2005)

1. 'A person must be assumed to have capacity unless it is established that he lacks capacity.'
 2. 'A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.'
 3. 'A person is not to be treated as unable to make a decision merely because he makes an unwise decision.'
 4. 'An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.'
 5. 'Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.'
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Section 1 of the MCA sets out the statutory principles for those using this legislation right at the beginning, prioritising how the law should be applied through a lens of an empowering and non-discriminatory value base. Principles 1, 2 and 3 are based on the premise of enabling and maximising a person's capacity to make specific decisions, whereas principles 4 and 5 move into the realm of best interests decision on behalf of the person, thus illustrating in stark form the antinomies of autonomy and paternalism highlighted in our introduction. Nearly all our BIA students are familiar with these principles and our audit of their academic work demonstrates this in an area where there is consistency in terms of

retention and application of their knowledge base of the MCA (2005). It might be possible to speculate that such knowledge pre-dates the specialist BIA training, as the statutory principles are often a core component of the online learning resources (mandatory and CPD related) that are available to practitioners through their work bases. Where there are disparities is between those students who analyse how they witnessed such principles being applied (or not) in their shadowing experience and those who just list them in their academic assignments. Even the small number of students (3 out of 50) who do not explicitly reference the principles, have demonstrated some implied knowledge (often around principle 2) when discussing at what time of day an assessment took place or how a person being assessed was made to feel comfortable. Those students who applied the principles in critical detail (4 out of 50) were more likely to challenge the decisions of the assessors they were shadowing, for example one student raises the issue of the need for an interpreter when a person is reverting back to speaking mainly in their native language as a result of their dementia.

MCA Sections 2 and 3

In contrast our audit showed less consistency in student work around the application of Sections 2 and 3 of the MCA which set out the required two stage test of mental capacity. This includes a 'diagnostic' test, which requires that the decision maker identifies the impairment that is thought to lead to incapacity; and also a 'functional' test which requires an assessment of the ability of a person to:

1. understand the information relevant to the decision;
2. retain that information; use or weigh the information as part of the process of making the decision; and
3. communicate the decision by any means (MCA, 2005).

These assessments have pivotal importance since their outcome leads to either independent and autonomous decision making by the individual or, if capacity is deemed to be lacking, the loss of autonomy as others step in and make decisions on their behalf.

Forty of the 50 students did explicitly discuss this process, but 5 displayed errors in their understanding and 6 did not make reference to

the relevant sections of the legal framework, perhaps suggesting some students are less confident in citing actual legislation. Our experience over the 10 years of teaching the BIA programme has been that there can be professional differences in this area. Nurses are sometimes less familiar than social workers are with using legislation in detail and this may reflect differences in qualifying training requirements.

In some cases, sound understanding and practice in relation to conducting assessments was demonstrated, but the consequences in relation to the DOLS requirements were not always understood, with potentially important consequences for service users. In one case a candidate reported that the DOLS assessment process was stopped as it was found that the individual concerned did in fact have capacity to make the decision about care and residence. This is correct and it is not uncommon to find that individuals in care settings do in fact have the requisite decision making capacity when it is properly assessed (Edge National BIA Survey 2016) This candidate went on to state that

Whilst S did not meet the assessment criteria for a DOLS to be authorised this does not mean that he is free to leave the care home. The Code of Practice 2.10 advises preventing a person from leaving a care home because of identified risks is likely 'to be seen as a proportionate restriction or restraint to prevent the person from coming to harm. Restricting S from leaving the care home of his own volition in itself would be unlikely to constitute a deprivation of liberty.

This analysis misses the point that these things only apply in a situation in which a person is judged to lack capacity and you then have to make a best interests call. When a person is judged to have capacity it is their own decision to make. If S is objecting and wants to move then he is at liberty to move.

MCA Section 4 'Best Interests'

It was good to see a number of candidates pay particular attention to the principle enshrined in the MCA of ensuring that when making best interests decisions 'regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedoms' (MCA, S1 (6)).

For example, one candidate observed that

'It is therefore important when completing best interest decision to reflect upon conditions that could be put in place such as access to the community and activities that could have a positive impact and lessen some of the restrictions on that person.'

Crucially, as expected, we found fairly consistent references both to the benefit/burden approach of weighing up different options for reaching a decision about what is in the person's best interests and to the participation and voice of the person in the decision made. Such facets of the decision making process are supported by the ADASS guidance (2015) on completing the form 3 (BIA report) as well as by case law, where rulings on best interests are increasingly giving weight to the person's wishes and feelings. (*Wye Valley NHS Trust v Mr B* 2015).

Case law

Case law provides specific judgements which follow from a piece of legislation being tested and debated in a court of law. As such, it can provide a useful source of guidance for practitioners, since case law focuses on the implementation of statute in particular cases, rather than the general principles. The teaching content of the BIA programme does contain a variety of case law judgements and a session on understanding the relevance and status of judgements delivered by different Courts to assist students in interpreting such judgements and which takes priority. As such we would expect to see some reference to this specialist area of knowledge in students' academic work.

Perhaps the most important 'case' considered in legal judgements was that relating to 'Bournewood'. This was the case which led to the need for the DOLS regulations, after it was found that an individual was unlawfully deprived of liberty whilst under de facto detention in a psychiatric hospital without the formal use of the Mental Health Act. The second particularly important case is the so called Cheshire West case (*P v Cheshire West and Chester Council*, 2014) which introduced a welcome clarity in relation to what constitutes a deprivation of liberty. This is now known as the 'acid test' for deprivation. We require all candidates to reference both pieces of law in their work and this is almost without exception adhered to.

Several pieces of guidance note that the case law in relation to the so called 'causative nexus' is important. The 'causative nexus' originates from the PC

v City of York (2011) case and highlights the necessity of demonstrating a causal link between the 'impairment' identified in the 'diagnostic' stage of the two stage capacity assessment and the person's inability to make the decision in the 'functional' part. A person's vulnerability or factors such as duress are not sufficient alone to justify incapacity in relation to specific decisions. Of the 50 students, 31 did demonstrate knowledge of this judgement, but 4 of these misunderstood how to apply it, and 5 offered an implied understanding without citing or naming the judgement. Interpretation and application of legal judgements in specialist areas of professional practice (BIA and AMHP) has become high on the agenda in CPD forums in the last 10 years, but it could be argued that some students find legal language and judgements intimidating, especially when given Latin names and this may hinder learning. Equally case law offers students an unique opportunity to explore and understand specific challenging areas in application of primary legislation.

One such area is that of how much information a person is expected to understand, retain and weigh in relation in the set decision in an assessment in order to demonstrate capacity. While the legal requirements dictate that it is the assessor who has to prove a person's incapacity, in reality capacity assessments often hinge on a professional's interpretation of how well an individual performs in relation to these aspects of the 'functional test' and in effect the person is required to 'prove' these abilities with reference to the information the assessor deems to be relevant. The CC v KK (2012) case is frequently cited in this instance, where the Judge observed that the 'bar should not be set too high' and that a person 'need only understand the salient details' relevant to the case. Subsequent to this ruling, however, there have been judgements that spell out what a person needs to understand in great detail and containing extensive lists of information around the decision to move into 24 hour placements. (See LBX v K, L, M. [2013] EWHC 3230). Only 7 out of the 50 students discussed this area of case law, but those that did were able to offer some in depth critical analysis of the challenges here.

Other elements of case law were referenced by students particularly to make points about best interests. Several quoted Lord Justice Munby, 'what good is it making someone safer if it merely makes them miserable?' (Cited in; Local Authority X v MM 2007 paragraph 120) when considering how to balance considerations of the risks to the person which persist if a person lives independently against the risks to well being if a person is moved against their wishes into a care setting. Others referred to seminal cases

such as London Borough of Hillingdon v Neary and Essex County Council v RF as demonstrating that “*best interests*’ choices often fail to give major weight to – let alone prioritise – the individual’s wishes and feelings prior to arrangements being completed to deprive the individual of their liberty’.

Professional values

Different BIA training courses will of course emphasise different elements and aspects of the complex role. We believe that professional values should be given more prominence and that reflecting on values may provide a useful tool alongside those which are given more emphasis in most training, particularly the legal and procedural elements of the MCA. In a previous study of decision making in relation to Deprivation of Liberty Safeguards we found that reference to professional values was not much in evidence in the judgements made by practitioners (Rogers and Bright, 2019). The ethical nature of capacity assessments and best interests decisions has also been highlighted by other commentators in terms of the need for the practitioner to recognise both their own values and those of the person they are assessing. (Kong, C, and Keene, A. 2019) Given the emphasis afforded to this in our teaching, we would expect to see this aspect given particular emphasis in our students assignments.

We noted that only 14 out of the 50 did not make some explicit reference to values, and detailed reflections were evident in many of the submissions.

The course and the shadowing experience showed me the importance of supported decision making, and this fits with my social work values. But this also poses challenges for BIA’s – this can be more difficult when there is also the need to be independent and have no prior knowledge of person and also in finding the time and space and the right environment to conduct assessments.

Some reflected on the point that whilst case law can illuminate the way to proceed in many situations it does not always provide the answers

there is a disconnect between the values we espouse as care professionals and the pragmatic needs, as seen by the courts, to make processes less cumbersome and easier to manage.

Practice guidance

BIAs now have a wide range of resources to guide their practice. These include academic textbooks (Hubbard, 2018; Rogers and Bright, 2014), and online resources such as those produced by the Social Care Institute for Excellence (SCIE, undated) and NICE (2017, and updated August 2020). For guidance on the application of the law to practice we have also found that specific guidance produced by the Association of Directors of Adults Social Services (ADASS, 2015) and the Law Society (2015) are particularly useful. Since the outset of DOLS the major piece of guidance for BIAs has been the DOLS code of practice (MOJ, 2007). We require students to reference this throughout their work. Most students did make repeated references to this document to support their points, although only four referred to the additional sets of guidance from the expert bodies referred to above.

Classroom education

References to the discussions, case studies and signposted readings which followed from the classroom sessions were explicit in 40% of the submissions. We were pleased to note in depth reading and reflection on the part of many of the students and perceptive analyses of how the BIA role and the new AMCP role might be approached and developed in future.

For example, in considering the difficulties surrounding assessment, one candidate suggested that

There is an opportunity for using alternative techniques and methods which may lead to a more person centred assessment. The optimal way to assess behavioural changes... may well lie in combining different assessment techniques, such as questionnaires, semi structured interviews and in vivo observations, in order to evaluate various attributes or problematic functioning.

Shadowing

Scourfield (2018) has noted the discrepancy between the amount of shadowing that goes on in professional education in social work (and other professions), and the attention it has received as an object of study.

In their reflections a number of candidates reported on the value that the shadowing element had added to their learning, and how it allowed elements of knowledge, skills, theory and values to cohere in their minds.

during the course, the emphasis was mostly concerned with the legislative and procedural aspects of practice, however when I shadowed the BIA I was conscious of the importance of incorporating the skills of social work: empathy, communication skills, unconditional positive regard and relevant theoretical considerations such as Attachment theory and Loss, Activity and Disengagement theory.

Students were able to observe how BIAs enact the principles of the MCA in practice

I felt this was an in-depth piece of work, which I felt privileged to be part off. For me, it reflected a true account of how the principles of the Mental Capacity Act 2005 should operate, keeping the person at the centre, whilst being compassionate and respectful, ensuring the individual was involved as much as practicably possible in any decision making.

Shadowing allows students to witness both good and sometimes poor practice, and this can enable learning, where they document how they challenged such issues and how this has impacted BIA practice in their areas.

Those students who did not comment on the shadowing process (18 out of 50) were more likely to give to a very procedural account of the assessment process, evidencing the basic knowledge and competencies required for the BIA role, without reflecting on the learning process itself. This maybe a result of the way the assignments are structured with students being asked to critically reflect on the DOLS regulations as a whole in a separate assignment to the case study account of their shadowing experience. The authors are aware that other BIA programmes often combine these two elements in longer piece of assessed work and have debated the merits and disadvantages of this approach over the years.

Discussion

Having a large sample of student work to draw on and using a framework of key elements to audit has allowed for a clear picture to emerge of the degree to which expected elements of learning are reflected in student work and how individuals meld knowledge, skills, values and shadowing experience in their accounts of their journeys of learning to understand and implement DOLS regulations and the MCA 2005 more generally.

We found that, with some variation, the identified elements of learning were in evidence in the submissions of most students. The perception of students was that the BIA training course prepared them well for the role, and this was also supported by a separate course evaluation. Many also noted that the shadowing element was a crucial part of their learning.

The expected elements which were least in evidence were references to practice guidance other than the DOLS code of practice, and to case law beyond the key cases which relate to the 'acid test' for deprivation of liberty and to the 'causative nexus'.

We expected to see more references to up to date practice guidance. It may be that we over emphasised the role of the DOLS code of practice and that candidates assumed that references to this document would be sufficient in their accounts. Similarly with case law, it may be that candidates assumed that including references to two the seminal Cheshire West case which gave the 'acid test' for deprivation of liberty would tick the case law box, and further examples were not required within the constraints of assignment word counts.

It is also of note that the learning had benefits for professional practice as a whole and not only in preparing the individual for the specialist BIA role as the following examples show.

In the past I have had a difficult client who has been protesting their placement, the DoLS assessor has said that they have had capacity at the time of the visit and could not go ahead with the DoLS, yet as I know the person well she has fluctuating capacity and cannot be cared for at home and it is in her best interest and from a safety point of view to remain in the placement. Working closely with the BIA's allowed me to better understand the situation and come to a satisfactory conclusion.

Within my own role as an Adult Social Worker working in a Care Management Team I have reflected how different my Capacity Assessments are now in comparison to before my Best Interest Assessors training, I feel my assessments are much more

focussed and decision specific, I am also more conscious of the 'practicable steps' element of the assessment.

These comments suggest successful learning transfer. As noted earlier, the amount of learning which does transfer to practice remains stubbornly lower than educators might hope for. However, a lot of work has gone into elucidating what might facilitate and increase the application of knowledge gained in the classroom to practice situations. Cree and McAulay (2002) have shown how the design of the learning task and the set up of the learning environment are crucial elements which can enhance learning transfer in social work training, though they also note that there are a number of elements which relate to the individual learner that we cannot control.

We believe that the design of the training course, and in particular the shadowing requirements, assist in maximising learning transfer. It would be useful in the future to design a study to measure the actual extent of this transfer.

The scope and length of the training course referred to here is limited, and this is true for many post qualifying short courses. The responsibility for continued learning then passes to the individual learner and their employer. Specific recommendations which arise from this audit for practice and continual professional development include ensuring that professionals refer to national guidance produced by SCIE and NICE in relation to the conduct of capacity assessments, and the need to emphasise the importance of case law and to understand specific cases that relate to current practice.

For us as educators, the conducting of a detailed audit which moves beyond the usual course evaluation, has enabled us to develop a more nuanced understanding of which elements work well within our programme, and which need development or adaptation.

Limitations

The study has a number of limitations. Whilst our sample contained members of three different professions and from a diversity of workplaces (in terms of organisations and geography) they had all received the same training at one institution. We are aware that the curriculum and the way

in which it is delivered varies across different BIA courses, and a similar study with graduates of a different programme may produce very different results.

The new Liberty Protection Safeguards which will replace DOLS in 2022 have some very different requirements, and the role of BIA will morph into a different one: the Approved Mental Capacity Professional (AMCP). That said, despite some procedural differences the role of the new AMCP will remain one which is aimed at upholding the rights of vulnerable adults who are deprived of liberty for their own care and protection. The knowledge skills and values required will remain broadly similar as will the challenges of preparing individuals for the role.

We used a pre-determined framework and looked for evidence of a limited number of specific elements in our samples. This may have closed off some evidence and using a different approach such as thematic analysis may have allowed for additional information which was important to candidates and to the process, to come to the fore.

Conclusion

This study has illustrated some key aspects of how professionals learn to make decisions in relation to mental capacity and best interests as required by the current Mental Capacity legislation and DOLS regulations in England and Wales. Students on a best interests assessor training course demonstrated the ability to articulate how a number of existing and new elements of knowledge and skill were integrated with professional values to produce a generally coherent approach to practice. With few exceptions candidates showed the ability to deftly navigate the tensions and challenges which arise when trying to meld case law, statute law, codes of practice, and classroom learning and ensure that all of it is used to uphold the rights of vulnerable adults. As we move to new regulations and a new training course for the new role of Approved Mental Capacity Professionals (AMCP) we suggest that it will be important to foreground within the training three elements in particular. 1. Use of up to date case law. 2. National guidance from NICE and SCIE on the conduct of capacity assessments, and 3. A structured shadowing process which enables trainees to observe and reflect on the way that a qualified practitioner carries out their role.

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