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What do NHS staff learn from training on the Mental Capacity Act (2005)?

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Purpose. Many studies have reported that professionals have a limited understanding of mental capacity issues. Implementation (in England and Wales) of the Mental Capacity Act (MCA) (2005) presents a challenge to services. The aim of this study was to evaluate the extent to which National Health Service (NHS) staff benefited from attending MCA training courses.

Methods. Participants were assessed before and after MCA training using a structured interview, which included three scenarios describing mental capacity dilemmas, four vignettes addressing the role of the Independent Mental Capacity Advocate (IMCA), and 16 true–false items.

Results. Interview performance improved post-training, but this could be largely ascribed to an increased awareness of mental capacity issues, with minimal improvements in the knowledge that would be needed to undertake the assessments. Nine areas were identified where there remained significant gaps in participants' knowledge post-training. Participants with experience of dealing with mental capacity issues performed better than those without.

Conclusions. The results suggest that methods other than formal training events may be needed to prepare health staff to implement new legislation.

Most societies recognize that some individuals lack the mental capacity to make certain decisions, and in many jurisdictions, including the United States, a body of case law has been developed to create a legal framework to determine when individuals lack capacity and how those situations should be managed. In the UK, the situation regarding

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mental capacity has been formalized through two Acts of Parliament, the Adults with Incapacity (Scotland) Act (2000) and the Mental Capacity Act (MCA), 2005, which applies in England and Wales. The MCA was implemented, with publication of a Code of Practice, in 2007.

The MCA enshrines several principles about capacity over which a consensus has developed in western societies (Berghmans, Dickenson, & Ter Meulen, 2004; Murphy & Clare, 2003): it creates a legal presumption in favour of capacity; capacity is defined in functional terms (the ability to understand, retain, and evaluate the relevant information, and communicate the decision), rejecting alternative approaches based on diagnosis or outcome (Grisso & Appelbaum, 1998); and it is acknowledged that capacity can fluctuate over time and is decision specific. Proxy decisions on behalf of persons who lack capacity must be made in their best interests, after consulting (where practicable and appropriate) 'anyone engaged in caring for the person or interested in his welfare', though responsibility for the decision rests with the decision maker. Where people lack capacity and have no family or friend to represent them, an Independent Mental Capacity Advocate (IMCA) must be involved in decisions concerning serious medical treatment or change of long-term accommodation (including residence in hospital). Some topics fall outside the MCA, including decisions about personal relationships.

Widespread confusion has been reported about the meaning of mental capacity, the criteria for assessment, and the purpose of assessment (Myron, Gillespie, Swift, & Williamson, 2008). Consequently, implementation of the MCA presents a challenge to services (Hardy & Joyce, 2009; Johnston & Liddle, 2007). Many studies have reported a generally poor state of knowledge regarding consent to treatment, and other mental capacity issues, among doctors and other National Health Service (NHS) staff (Evans, Warner, & Jackson, 2007; Fisher-Jeffes, Barton, & Finlay, 2007; Guvver, Hindle, Harrison, Jain, & Brinsden, 2010; Jackson & Warner, 2002; McCullough, 2009; Richards & Dale, 2009; Sawhney, Mukhopadhyay, & Karki, 2009; Schofield, 2008; Willner, Jenkins, Rees, John, & Griffiths, 2011), though two recent studies of specialist staff were more encouraging (Shah, Banner, Heginbotham, & Fulford, 2010; Wilson, Seymour, & Perkins, 2010). While some mental capacity issues may need a specialist assessment, any health care worker could be faced with a patient whose capacity is uncertain, so it is essential that mental capacity issues are understood generally, not simply in specialist services. The importance of training on the MCA has been highlighted (Alonzi, Sheard, & Bateman, 2009; Myron *et al.*, 2008). However, the effectiveness of MCA training is unknown.

This study reports an evaluation of MCA training. It was based in a single NHS Trust, but the training followed a standard model that is widely used across the NHS. While the specific outcomes concern legislation that is specific to England and Wales, the study has some more general implications for the way that training on legal issues is delivered in other jurisdictions.

Methods

Setting

This setting for this study was an acute NHS Trust containing 13 Directorates, covering all of the major medical specialities. They included a Directorate of Learning Disability Services that provides specialist health care to people with intellectual disabilities, mainly in community settings, and a Mental Health Directorate that provides support to individuals with mental health problems, including dementia in older adults.

Participants

The participants were 86 professionals who enrolled in MCA training in late 2009 and early 2010, and included nurses ($n = 37$), occupational therapists ($n = 12$), physiotherapists ($n = 9$), clinical support staff ($n = 6$), psychologists ($n = 4$), doctors ($n = 3$), speech and language therapists ($n = 2$), social workers ($n = 2$), clerical staff ($n = 4$), and other occupations ($n = 7$). Only six participants were non-practitioners. A total of 67% were from the Learning Disability Services ($n = 15$), Mental Health ($n = 24$), and Intermediate Care and Re-ablement ($n = 19$) Directorates, with 33% ($n = 28$) from the other 10 Directorates in the Trust.

Training

Training was delivered by two university lecturers, who have dual nursing and legal backgrounds. The stated aim of training was 'to inform and make practitioners aware of the law with the objective of transferring this theory into practice'. Basic training consisted of a 3-hr session in a largely lecture format that introduced the key principles and concepts of the MCA. Advanced training, a 3-hr workshop based on clinical scenarios, introduced the processes and documentation of the MCA, the Code of Practice, assessing capacity, determining best interests, advance decisions, and lasting powers of attorney. These were the standard training packages used within the Trust, which were not modified in any way for the purpose of this study.

Procedure

Everyone on the enrolment lists, for a total of eight training sessions, was invited by e-mail to participate in the study. If there was no response, a second e-mail was sent a week later, followed by an attempt to make contact by phone. Early in the study, respondents were randomized to participate in either pre-training and post-training interviews, or only one post-training interview. Later, everyone was asked to participate twice.

Forty-nine pre- and post-training and 22 post-training interviews were conducted, at locations convenient to the participant. A further 15 participants were interviewed pre-training, but became unavailable for the post-training interview. Overall, 40% of participants who attended the relevant training sessions were interviewed (basic training: $n = 44$; advanced training: $n = 42$). Interviews were conducted on average 16 days (range 3–31) before the training session and 19 days (range 5–42) after the training session.

Interview

After some demographic questions, participants were first asked to rate (0–100%) how well informed and confident they felt about dealing with mental capacity issues.

The first three substantive sections of the interview were as previously described (Willner, Jenkins, *et al.*, 2011). Briefly, participants were presented in turn with three vignettes, describing financial, health, and relationship issues relating to people with learning disabilities (the UK term for 'mental retardation'), with questions about each scenario designed to simulate an actual assessment. Prompts for further information, and feedback on incorrect responses, were provided at certain points so as to enable the simulated assessment process to proceed. Eight questions were asked about each of the financial and health scenarios, moving from (1) recognition of a need to assess mental capacity, through (2) identification of the decision needed and (3) judgments about

whether capacity can be assessed from the information provided, to (4) recognition that a best-interests decision is needed (after the interviewer advised that the person had been assessed as lacking capacity to make this decision), and (5) identification of the decision maker, who should be consulted, and what information should be considered. The relationship scenario tested participants' awareness that personal relationships fall outside the scope of the MCA, and also included questions about risk assessment and management. For each question, a range of likely answers had been anticipated, which were coded live; other responses were recorded verbatim and coded later, with discussion among the research team where necessary.

The fourth section of the interview was a set of 16 true/false statements addressing the principles of the MCA. (This was also used to provide feedback after the post-training interview.)

Next, participants were presented with four brief vignettes (items A, C, E, H from Martins, Willner, Brown, & Jenkins, 2010) and asked to choose from a list of options: who is the most important person (other than the care manager) to consult, to do what, and why. Two of the vignettes described situations that require the statutory involvement of an IMCA; the other two vignettes described an adult protection case and a case requiring support from a general advocate.

Finally, participants were asked about their prior experience and training, and re-rated how well informed and confident they felt. Feedback was provided using the true/false question set.

Scoring (maximum = 50)

Sections 1–3: Up to 10 points could be earned for each of the financial and health scenarios, and 6 points for the relationship scenario, which were scored as described by Willner, Jenkins, *et al.* (2011), with two very minor modifications:

(1) questions 3 and 4 on the relationship scenario had maximum scores of 1.5 rather than 2 points, so that the question 'Is the MCA relevant to this scenario?' (1 point) could be included in the scoring;
(2) because there was some uncertainty about the extent of consistency between different raters, question 2 on the financial scenario ('What is the decision that needs to be made?') was scored using a more relaxed criterion ('Should he use his money to buy the car?') than in the earlier study.

Section 4: Up to 16 points could be gained on the true/false questions.

Section 5: Each advocacy scenario was awarded one point for a correct identification of the person to contact, with a further 0.5 points for correctly identifying why, and to do what (maximum = 8).

Statistical analysis

Data were analysed mainly by analysis of variance. Three initial between-subjects analyses examined the effect of participants' Directorate and prior experience on pre-training scores, and the effects of a pre-training interview on post-training scores. Next, total interview scores were subjected to two-way ANOVA with the within-subjects factor of time (before/after training) and the between-subjects factor cohort (basic/advanced); the same design was used for a multiple ANOVA of the various components of the

interview. A similar mixed design was used to analyse the effect of Directorate on interview scores pre- and post-training. A two-way within-subjects ANOVA was used to analyse participants' self-ratings of how well informed and confident they felt before and after each interview.

Other factors affecting pre-training performance were analysed using *t*-tests or Pearson product-moment correlations. Changes in individual questionnaire items following training were analysed using Wilcoxon, McNemar, or *t*-tests, as appropriate. One-tailed tests were used where there were clear directional hypotheses (e.g., that performance would be better in people who had previous experience of MCA training). Results are reported as mean ($\pm$ standard error).

Results

What do participants bring to MCA training?

An initial analysis of data from all pre-training interviews ($N = 64$), asked whether performance was enhanced by working in environments where issues of mental capacity are likely to be frequently encountered. Relative to the other 11 Directorates in the Trust (mean interview score: 24.14 $\pm$ 0.58), interview scores were significantly [$F(2,63) = 7.38$, $p < .001$] higher in staff working in Learning Disabilities (28.27 $\pm$ 0.97) and to a lesser extent, Mental Health (25.77 $\pm$ 0.72). When these directorate differences were taken into account, interview scores were marginally higher [analysis of covariance: $F(1,61) = 3.09$, $p = .084$] in participants who reported having experience of dealing with mental capacity issues ($n = 43$) relative to those who did not ($n = 21$). Over 90% of the participants who had encountered mental capacity problems reported that they had addressed them in consultation with other professionals.

Among all participants who were interviewed prior to training, interview scores were not significantly higher in those who reported having had previous training on the MCA than in those who did not [$t(62) = 0.98$, NS].

Do participants benefit from MCA training?

Post-training interview scores were almost identical in participants who had also been interviewed prior to training (27.74 $\pm$ 0.58) and those who had not (27.45 $\pm$ 0.87). This means that there was no practice effect for participants who were interviewed before and again after training. All subsequent analysis of training effects is therefore based on before–after comparisons within this group ($N = 49$).

Figure 1A shows that training improved performance overall [$F(1,47) = 33.00$, $p < .001$] and in four of the five components of the interview: the financial scenario [$F(1,47) = 4.22$, $p < .05$], the health scenario [$F(1,47) = 3.33$, $p = .075$], the advocacy scenarios [$F(1,47) = 9.28$, $p < .005$], and the true/false questions [$F(1,47) = 10.26$, $p < .002$]; there was no significant improvement on the relationship scenario [$F(1,47) = 0.89$, NS]. However, in none of these analyses (or in any of the analyses subsequently reported) was there any significant difference between the Basic and Advanced training cohorts [max $F(1,47)$ for main effects and interactions = 2.02, NS].

Figure 2A confirms the superior performance of participants from the Learning Disabilities and Mental Health Directorates, relative to other clinical areas [$F(2,46) = 6.78$, $p < .005$], and also shows that all participants benefited to a similar extent from training [interaction: $F(2,46) = 0.68$, NS]. A similar effect was seen when only the

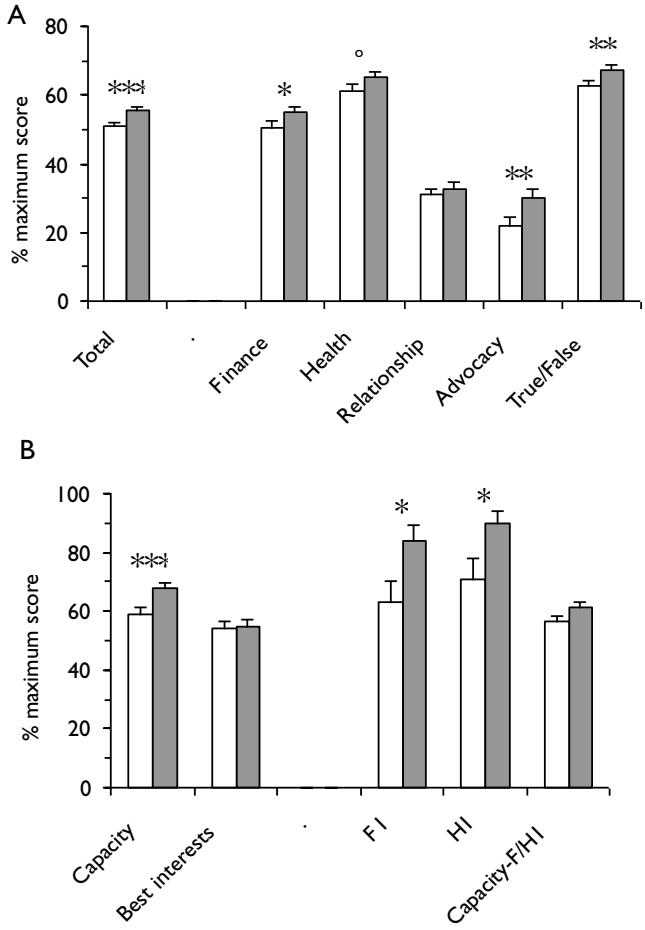

Figure 1. Interview performance before (open bars) and after (filled bars) MCA training, shown as the mean (+SEM) proportion of the maximum attainable score. (A) Total scores (left-most bars) and (right) scores for the five sections of the interview. (B) (left) a breakdown of the capacity and best interests, averaged across the financial and health scenarios; (right) performance on the first question (F1, H1) for each of the scenarios ('What is the first thing the multidisciplinary team would need to consider next?'), and averaged across the other six questions relating to capacity assessment (Capacity-F/H1). $^{***}p < .001$, $^{**}p < .01$, $^{*}p < .05$, $^{o}p < .1$.

true/false section of the questionnaire was analysed (Figure 2B): the overall effect of Directorate was only marginally significant [$F(2,46) = 2.58$, $p = .086$], but there was a significant difference between Learning Disability and 'other' participants in a restricted analysis of these two groups (excluding Mental Health) [$F(1,35) = 4.26$, $p < .05$]. Figure 2B also includes a comparison of performance between the 'other' group of established NHS staff, versus a group of newly appointed staff ($n = 106$) who completed the identical 16-item questionnaire before and after a 10-min presentation on the MCA as part of their Trust induction training (Willner, Bridle, Dymond, & Lewis, 2011). The established staff performed better [$F(1,134) = 6.08$, $p < .02$], and the two groups benefited from their training experience to a similar extent [interaction: $F(1,134) = 3.0$, NS].

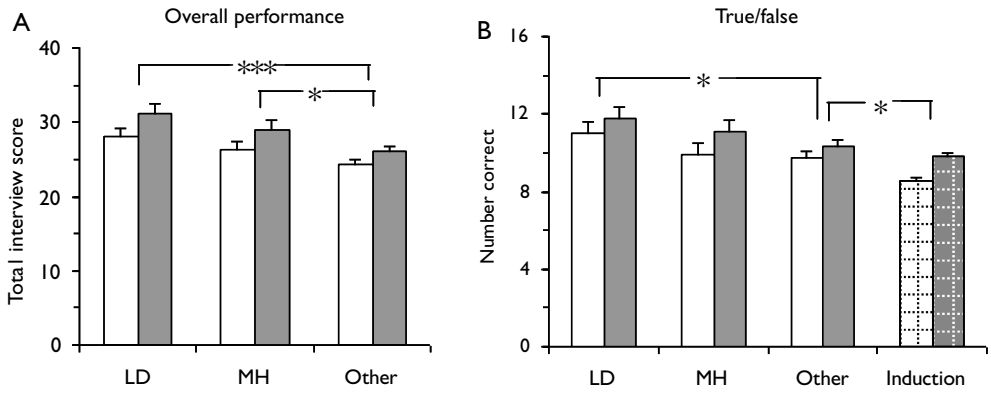

Figure 2. (A) Overall interview performance; (B) number of true/false questions answered correctly. Values are shown as mean (+SEM) scores before (open bars) and after (filled bars) MCA training, as a function of the Directorate in which participants worked. LD, learning disabilities; MH, mental health; Other, any of the other 11 directorates in the Trust. Also shown in the right panel is the performance of a separate cohort of participants who completed the true/false questionnaire before and after attendance at a brief MCA presentation as part of their Trust induction training. $^{***}p < .001$, $^{*}p < .05$.

Subsequent analyses aimed to identify the specific areas in which improvements were made following MCA training.

Capacity and best-interests assessment

The financial and heath scenarios each included four questions relevant to the assessment of mental capacity and four questions relevant to the assessment of best interests, which were summed to produce overall 'capacity' and 'best-interests' scores (Figure 1B). Training produced a marked increase in 'capacity' scores [$F(1,47) = 14.97$, $p < .001$], but had no effect on 'best-interests' scores [$F(1,47) = 0.16$, NS]. The improvements arose largely from the first question for each scenario: 'What is the first thing the multidisciplinary team would need to consider next?' (Answer: Does the person have capacity?), which was answered correctly by 84% and 90% of participants, respectively [McNemar tests: $p < .025$]; there was only a marginal improvement in the total score of the other six capacity questions [$t(48) = 2.0$, $p = .051$], none of which individually improved significantly.

Advocacy (Figure 3)

Performance improved significantly on the IMCA scenario relating to a change of long-term housing [$t(48) = 3.83$, $p < .001$], and more participants correctly identified the need for this IMCA referral (McNemar test: $p < .001$). Performance did not improve significantly on the scenario relating to serious medical treatment [$t(48) = 1.59$, NS], or on either of the non-IMCA scenarios; there was a non-significant increase in proposed IMCA referrals for the medical scenario ($p = .152$), but also for the general advocacy scenario ($p = .096$). After training, only a single participant identified the statutory duty

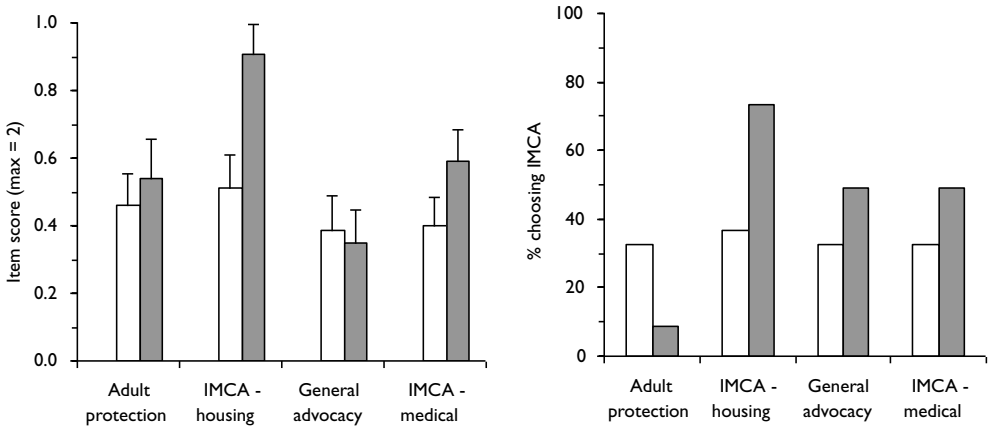

Figure 3. Performance on each of the four advocacy scenarios before (open bars) and after (filled bars) MCA training. Left: total score for each item (mean + SEM); Right: number of participants proposing referral to an IMCA.

to involve an IMCA in both scenarios, with a further five identifying the statutory nature of one of them (<10% overall).

True/false quiz (Table 1)

Significant improvements (McNemar tests) were seen on only three items, which accounted for 77% of the overall improvement, and even after training these three items were not answered well (maximum 61% correct responses). The profile of true/false scores seen post-training in the group interviewed twice ($n = 49$) was replicated almost exactly ($r = 0.97$) in the smaller group ($n = 22$) who were interviewed only once.

What do participants know after attending MCA training?

A final set of analyses provides a descriptive account of what participants' knew post-training, based on all post-training interviews ($N = 71$). True/false questions (Table 1) are identified below by question number. Seven of them were answered very well (>85% correct), five were answered moderately well, but with substantial room for improvement (50–80% correct), and four were answered very poorly (<40% correct); however, among these, Q10 was a poor question (complex, and not directly covered in the MCA), while Q16 relates to a topic [Deprivation of Liberty Safeguards (DoLS)] that is covered in a different training course.

Scope of the MCA

Only 63% of participants correctly identified that voting is not the only area that is outside the scope of the MCA (Q1). Only 54% of participants correctly stated that the MCA does not apply to the relationship scenario, and only 10% identified this as the major way in which this scenario differs from the financial and health scenarios. By contrast, all participants correctly identified that the MCA does apply to the other two scenarios.

Assessment of mental capacity

Most participants (>90%) correctly identified two of the major principles of the MCA: that incapacity must not be inferred from an unwise decision (Q3) or until steps have been taken to promote capacity (Q6); they also recognized the principle of consulting others before reaching a decision (Q4). However, there were also a number of significant limitations to participants' understanding of capacity assessment. Almost half of the participants (44%) were unaware of the two-stage test for mental capacity, which requires a 'disorder of mind or brain' to be present before commencing an assessment (Q7). Almost a third (28%) endorsed the statement that capacity decisions must be made by a specialist (Q2). And two-thirds (66%) endorsed the statement that 'In assessing capacity the outcome of the decision needs to be considered' (Q5).

While most participants correctly identified the need to assess capacity, they performed very poorly in relation to the conduct of the assessment. Most participants (93%) were able to identify the decision to be made in the health scenario, but none of them identified the decision correctly in the financial scenario and only 55% provided a partially correct answer. Participants who said they felt able to assess capacity from the information presented in these two scenarios (it was always assessed as absent) were asked to justify their decision, and scored as correct only if both the level of disability and the complexity of the problem were mentioned (since neither of these factors alone implies incapacity). Conversely, participants who they said they needed more information were asked what information they would need, and scored as correct for mentioning either understanding or retention, as well as weighing up of information (a relatively lax criterion). Only five participants (7%) responded correctly to both scenarios, with a further seven (10%) responding correctly on one scenario.

Assessment of best interests

All participants acknowledged that proxy decisions for a person who lacks capacity must be made in the person's best interest (Q9). Most (>88%) also correctly acknowledged that best-interests decisions must not be discriminatory (Q14) and should minimize restriction (Q12); and that the full range of relevant information should be taken into account in reaching the decision (Q13). However, in practice, only a half (finance scenario: 52%) to two-thirds (health scenario: 66%) of participants recognized that a best-interests decision was needed, when told 'It has been assessed that the person does not have the capacity to make the decision' and asked 'What should happen next?'

Overall, participants were very unclear about the role of the decision maker in a best-interests assessment. Most (77%) recognized that a best-interests decision does not require all concerned to be in agreement (Q11), but most (84%) also insisted that this was a team decision (Q15). Only 16% of participants correctly identified the decision maker in the financial scenario (the care manager); the proportion was higher in the health scenario (the doctor), but even here only 66% of participants responded correctly. Participants were also unclear about who should be consulted in relation to a best-interests decision. This question was scored as correct either for giving the textbook answer ('all those involved in caring for the person or interested in his welfare'), or for nominating the three groups of people who would certainly be included: family members, carers, and professionals. Only around half of the participants were scored as correct on this item (financial scenario: 40%; health scenario: 60%). And for each of the

Table 1. Performance on the true/false section of the interview[a]

		Percent correct ($n = 49$)			All post	
	T/F	Before	After	$p <$	($n = 71$)	Relevance
1. The Mental Capacity Act applies to all decisions a person might make, with the exception of voting in elections	F	57	61		***63***	Relationship scenario
2. If a capacity decision has to be made a specialist such as a psychiatrist needs to conduct the assessment	F	73	73		***72***	
3. A person must not be treated as unable to make a decision simply because they make an unwise decision	T	93	97		**97**	
4. It is essential when practical and appropriate to consult other people for their views about the person's capacity	T	92	90		**93**	Finance and health scenarios: capacity assessment
5. In assessing capacity, the outcome of the decision needs to be considered	F	30	36		34	
6. A person is not to be treated as unable to make a decision unless all practical steps to help him or her have been made and have proven to be unsuccessful	T	94	94		**94**	
7. A person is not to be treated as unable to make a decision unless it has been demonstrated that he or she has a disorder of mind or brain	T	39	61	.02	***56***	
8. An Independent Mental Capacity Advocate must be involved whenever important decisions are being made on behalf of a person who lacks capacity	F	33	51	.05	***54***	Advocacy
9. Decisions made on behalf of someone who lacks capacity must be made in his or her best interests	T	100	100		**100**	Finance and health scenarios: best-interests assessment
10. When decisions are made on behalf of someone who lacks capacity, all possible alternatives must be presented before a decision can be made	F	6	2		3	

Table 1. *Continued*

		Percent correct ($n = 49$)			All post	
	T/F	Before	After	$p <$	($n = 71$)	Relevance
11. When decisions are made on behalf of someone who lacks capacity, all those involved in the person's care should be in agreement	F	69	73		**77**	Finance and health scenarios: best-interests assessment *(continued)*
12. When decisions are made on behalf of a person who lacks capacity the less restrictive alternative must be preferred to attain the goal specified	T	78	90		**88**	
13. In assessing what is in a person's best interests, it is only necessary to consider health and welfare issues	F	98	92		**92**	
14. When decisions are made on behalf of a person who lacks capacity, assumptions must not be made about the person on the basis of age, appearance, condition, or behaviour	T	96	96		**96**	
15. A single individual must take responsibility for a decision that is made on behalf of a person who lacks capacity	T	2	20	.01	16	
16. If a person in long-term care lacks the capacity to decide for him or herself where he or she wishes to live, then a 'deprivation of liberty' assessment must be conducted	F	39	37		38	DoLS

[a]The column labelled T/F shows the correct response to each statement (True or False). The next three columns show the proportion of correct answers before and after training, and the significance of changes. The second from right column shows the proportions of correct responses across both groups of participants interviewed post-training ($N = 71$). Questions answered very well (>85% correct) are highlighted in bold; questions answered moderately well (50–80% correct) are highlighted in bold italics. The right-most column shows the relationship of the true/false questions to the other sections of the interview.

scenarios, participants identified only some of issues that would need to be taken into account.

The role of the IMCA

Only half of the participants (54%) recognized that an IMCA is not required for all important decisions that are made on behalf of a person who lacks capacity (Q8), consistent with the patchy performance recorded on the advocacy scenarios.

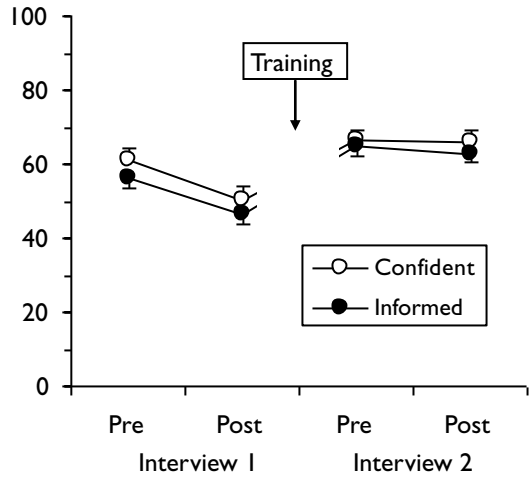

Figure 4. Participants' self-ratings (mean% ± SEM) of how well informed and confident they felt before (pre) and after (post) the pre-training (1) and post-training (2) interviews.

What insight do participants have into the state of their knowledge of MCA issues?
Participant's self-ratings of 'well informed' and 'confident' about mental capacity issues (Figure 4) decreased after the pre-training interview; after training, ratings increased and remained high post-interview [two-way interactions: informed, $F(1,48) = 6.15$, $p < .02$; confident, $F(1,48) = 12.52$, $p < .001$]. However, the post-training increase (well informed: median 31%; confident: median 33%) was significantly greater (Wilcoxon tests: $p < .001$) than the improvement in interview performance (median 11%).

The correlation between 'well-informed' ratings and how well participants subsequently performed was non-significant for the pre-training interview [$r(63) = 0.20$, NS], but increased after training [$r(70) = 0.30$, $p < .02$]. Confidence ratings showed a similar pattern (results not shown).

Discussion

What do participants bring to MCA training?
Advanced MCA training was offered to staff who had completed the basic training, so participants in the advanced training were expected to perform better – but they did not. This fact initially gave cause for significant concern. However, discussion with relevant training personnel suggested that actually, staff were choosing to attend whichever of the two modules was more conveniently timed, or had places available. The proportion of staff who had attended previous MCA training was only marginally higher for advanced training (51%) than for basic training (41%), whereas 100% previous attendance would be reported by the advanced cohort if the two courses had been taken sequentially. Because attendance was not as anticipated, we are unable to draw conclusions about retention of information from a comparison between the two training cohorts. Nevertheless, interview scores were no higher in participants who reported having attended previous MCA training relative to those who did not, consistent with the findings of earlier studies (Willner, Bridle, *et al.*, 2011; Willner, Jenkins, *et al.*, 2011), suggesting that the long-term retention of information acquired in training may be minimal.

By contrast, relevant experience did appear to enhance performance. Mental capacity knowledge was significantly higher among participants working in Learning Disabilities, where issues of mental capacity are endemic. This may to some extent reflect the fact that the three scenarios used concern individuals with learning disabilities. However, this cannot be the whole explanation, because performance was also superior in the Mental Health Directorate (which, in addition to mental health services also includes services to people with brain injury and dementia, where mental capacity problems are common). Furthermore, participants from Learning Disabilities performed better on the true/false questions, which do not include any learning disability-specific items. Finally, there was evidence of an effect of mental capacity experience to improve interview performance even after differences in client groups served were taken into account.

MCA training was promoted as mandatory for all staff. However, the participants in these training sessions were not a representative sample. Over 90% were practitioners and almost half (45%) were from the two Directorates – Learning Disabilities and Mental Health – where problems of mental capacity are routinely encountered. These two statistics strongly suggest that the participants in this training programme were largely self-selected on the basis of an interest in mental capacity. Selection bias may also account, at least in part, for the superior performance of the present sample relative to the participants surveyed as part of their induction training, which truly is mandatory. Similar to Learning Disabilities and Mental Health, the third Directorate that was well represented, Intermediate Care and Re-ablement, includes a high proportion of staff who work in the community and manage their own diaries, suggesting that the problem of non-attendance from other Directorates might in part reflect the logistical difficulties involved in releasing ward-based staff for training. Indeed, the interviewer was frequently told by managers that they were unable to release ward-based staff. In some parts of the Trust, additional MCA training events are provided locally, but this provision is inconsistent. The low take-up of training is concerning, since people who lack capacity have the same (or greater) health problems as those who do not, and could present to any medical specialty.

Do participants benefit from MCA training?

There is no question that participants learned something from their training. Furthermore, notwithstanding the earlier remarks about the apparent lack of effect of prior training experiences, the gains were retained at least until the post-training interview, 1–7 weeks later. The improvements can with confidence be ascribed to the training, rather than to information acquired in the earlier pre-training interview, because better performance was seen not only in participants who were interviewed pre- and post-training, but also in those who were interviewed only once, post-training. (There was no evidence that participants who were re-interviewed showed any recall, post-training, of the prompts that they received in the first interview.)

However, the detailed analysis of where the gains were made suggests that the benefits provided by MCA training are very limited. The main practical effect was to sensitize participants to the need to think about mental capacity: they improved markedly in their ability to recognize situations that call for a mental capacity assessment. However, there was almost no improvement in their practical ability to deal with such situations, as assessed by the other questions addressing mental capacity or best-interests assessments. Similarly, while participants showed better understanding of the role of the IMCA, only half of them correctly answered the true/false question on this topic post-training, and

they were able to identify only one of the two situations where there is a statutory duty to involve an IMCA.

These results are consistent with those of an earlier study, with a very similar methodology, in which care managers in social services departments were presented with three case-based vignettes and a set of true–false questions before and after participation in a risk-assessment training programme. The study concluded that the training '[failed] . . . to result in any comprehensive and demonstrable skill gain . . . ', and suggested that 'the pressures on care managers in terms of their workloads, combined with the limited opportunity provided on a one or two day programme . . . militate against care managers adopting changes to their current practices' (Clarke, 2002). The present evidence, albeit limited, suggests that improvements in the ability to handle mental capacity issues may require opportunities to gain practical experience, rather than, or perhaps, in addition to, a session of theory training.

What do participants know after attending MCA training?

Even after participation in a training event, there appear to be some significant gaps in participants' knowledge of mental capacity issues:

(1) The MCA does not entirely succeed in discarding the diagnostic approach to mental capacity, because it imposes a diagnostic threshold: before proceeding to a functional assessment of capacity, 'an impairment of, or a disturbance in the functioning of, the mind or brain' must first be established. This two-stage test was understood better after training, but was still widely misunderstood. This could lead to clinicians deciding inappropriately that a patient lacked capacity in the absence of any mental disorder.
(2) Even after training, over a quarter of the participants thought that a capacity decision needs to be made by a specialist, such as a psychiatrist. This failure to accept personal responsibility is likely to inhibit treatment decisions, potentially to the detriment of the patient who lacks capacity. It is also contrary to the ethos of the 'New Ways of Working' that are promoted within the NHS to increase the competencies of individual practitioners to deal with the problems that they encounter in their work (Department of Health, 2007a).
(3) The MCA protects the right to make unwise decisions (albeit that a pattern or series of unwise decisions may call a person's judgement into question), and participants appear aware of this. However, the fact that they nonetheless thought the outcome of the decision is relevant suggests that the issue is not well understood, and creates a risk that patients' rights to make an unwise decision could be over-ridden.
(4) The results of these interviews give little confidence that, faced with the need to make an assessment of mental capacity, NHS staff would know enough to carry out the assessment appropriately.
(5) In contrast to the high awareness, post-training, of situations that call for an assessment of mental capacity, many staff appeared unaware that where a person lacks capacity, they may need to take best-interests decisions. Perhaps this is seen as the responsibility of more senior colleagues, but the best-interests principle applies not only to major decisions but also to minor decisions made in the course of daily care. A study of residential care workers reported that while major decisions were made in accordance with service users' best interest, many of the everyday decisions made on behalf of service users who lack capacity were not (Dunn, Clare,

& Holland, 2008, 2009). There is no reason to expect a different ethos in medical settings (Stanley & Manthorpe, 2008).

(6) The principle of individual ownership of best-interests decisions was also poorly understood. Even after being prompted to identify a specific decision maker, many respondents continued to insist that best-interests decision making was a team responsibility. It appears that most NHS staff do not understand that the multidisciplinary team acts in an advisory capacity to the decision maker.

(7) A high proportion of participants appeared unaware that before making a best-interests decision on behalf of a patient who lacks capacity, there is a legal duty to consult 'all those involved in caring for the person or interested in his welfare'. A failure to consult appropriately could lead to clinical risks to the patient, and legal risks to the clinician and the organization, since decisions made without consultation would be open to legal challenge.

(8) Where a person who lacks capacity has no representative, there is a similar legal duty to consult an IMCA before making a best-interests decision about serious medical treatment. Somewhat surprisingly, considering that they were NHS staff, participants were clearer about the role of the IMCA in relation to housing decisions rather than treatment decisions: even after training, half of the participants appeared unaware that an IMCA must be involved (where a person is otherwise unrepresented) in decisions about serious medical treatment. While such decisions are made by senior staff, junior staff may be responsible for maintaining them, so even junior staff cannot avoid this issue in relation to their own practice.

(9) The DoLS were introduced, via an amendment to the Mental Health Act (2007), in order to deal with the implications of a European Court of Human Rights ruling on the rights of individuals who lack capacity but need to be detained for their own safety. The study did not address this issue in detail, because it is the subject of a separate training programme. However, >60% of participants misunderstood the limited scope of the DoLS.

Implications

Limited understanding of the principles of the MCA, and their practical implementation, creates risks not only to patients, but also to staff. The MCA provides protection for actions taken in connection with care or treatment, provided that there is a reasonably held belief that capacity is lacking and that the action is in the person's best interests. But staff are only protected if capacity has been assessed appropriately and the best-interests principle can be defended. The best way for staff to keep themselves safe is to understand these issues.

There was evidence that participants have some insight into their difficulties. Consistent with earlier findings (Willner, Jenkins, *et al.*, 2011), interview scores correlated with participants' self-confidence. Furthermore, confidence ratings decreased markedly following the first interview, which suggests that staff realized, when confronted with mental capacity issues, that they were not well equipped to deal with them. Ratings increased post-training (consistent with anecdotal reports that MCA training courses receive very positive feedback), but to a much greater extent than was warranted by the improvement in interview performance. Overconfidence is well known to lead to poor decision making (e.g., Barber, Odean, 2000; Kanter, 2004; Koellinger, Minniti, & Schade, 2007). It was encouraging that most participants who had experienced mental capacity issues had consulted others about how to address them. However, staff who routinely

encounter capacity problems were highly over-represented among participants in the training, and while such staff have the greatest need for MCA expertise, they are also likely to have access to consultation with knowledgeable colleagues. For most staff there is little reason to be confident that the others consulted, who most likely were close colleagues, would be any better informed. It would be appropriate to inform participants that they are likely to have learned little from the training by way of the practical skills needed to address mental capacity issues.

The main question that this study raises is whether the conventional training model is the best way to increase understanding of the principles and procedures of the MCA (or other legal innovations). We are aware of only one directly comparable study, which reached similarly pessimistic conclusions (Clarke, 2002). Other studies have emphasized the importance of basing medical training in practice settings (Burr, 2009; D'Amour, Timmons, Sheps, & Davies, 2008; Hamilton, 2005; Walker, 2007). Willner, Morris, and Fisher (2008) described a practice-based training model in which inexperienced staff worked alongside more experienced colleagues to conduct a series of actual mental capacity assessments. However, this was in a setting where capacity issues are common, and practice-based training may not be feasible in general medical settings, where capacity issues arise infrequently.

Participants made some suggestions to improve on the half-day training session. Some suggested decreasing the information load by providing the training as several shorter sessions and offering refresher courses; however, this would make attendance for ward-based staff even more difficult. Others said they would prefer training to be based on practice examples within their own specialty; but this requires a homogeneous audience, which would be even more difficult for managers to release in settings where staff are heavily overloaded. Where MCA training is mandatory, there is also the option of policing attendance and sanctioning non-attendance: but while this would improve attendance, it would not in itself increase the efficacy of the training.

Alternative approaches are suggested by the positive feature of these results, that participants come away from their training with a heightened awareness of mental capacity issues. An effective strategy might have three elements. First, awareness training is needed for all staff, aimed at ensuring that staff can identify mental capacity issues but also acknowledge that they probably will need help to deal with them. Next, staff should be signposted to electronic resources, such as the wide-ranging set of MCA training packs produced by the Department of Health (2007b), which in many Trusts have been supplemented by locally produced materials available on the Trust intranet. Third, and perhaps most important, all staff should have access to a mental capacity 'expert' who can provide guidance and support. Ideally, each Directorate within a Trust would have several MCA champions, who themselves would be supported by the MCA implementation lead officer. It is likely that, in many parts of the NHS, the necessary expertise to function as a champion might not yet be available; the possibility of providing high-level training for staff selected to take on this role, or seconding staff to services where mental capacity issues are more frequently encountered, could be considered as a way of growing local expertise.

We are not suggesting that MCA training in its conventional form should be discontinued. There are clear benefits, and it is possible that these include gains that were not picked up by the present evaluation. However, our results suggest that the knowledge and skill needed to deal with mental capacity issues, as distinct from the ability to identify issues that need attention, may be gained more from experience of actual cases than from formal training. We have proposed a strategy in which it is

accepted that the main function of formal MCA training is awareness raising, including encouragement to access available electronic resources and a local MCA 'champion'. Other structures, such as the availability of mentors, easy access to legal advice, and a local forum to discuss mental capacity practice dilemmas as they arise, may also be helpful in promoting good practice in this area.

This study was concerned with a single piece of legislation (the MCA) that applies within a single jurisdiction (England and Wales). However, it is likely that that the limitations that we have identified in the effectiveness of staff training, and the potential applicability of the alternative approaches that are proposed, may have a wider relevance for other attempts, and in other jurisdictions, to bring legislative changes to the attention of large and disparate staff groups. The results suggest that the conventional model, in which groups of health staff are brought together for a training event, may be successful in raising awareness of the new legal landscape, but may have only limited success in preparing staff to navigate it. The results also suggest that subjective feedback from participants in training may be of limited value, and highlight the need for objective evaluation of expensive staff training initiatives.

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References

Adults with Incapacity (Scotland) Act. (2005). *Office of public sector information*. London, UK.

Alonzi, A., Sheard, J., & Bateman, M. (2009). Assessing staff needs for guidance on the Mental Capacity Act, 2005. *Nursing Times*, *105*, 24–27.

Barber, B. M., & Odean, T. (2000). Trading is hazardous to your wealth: The common stock investment performance of individual investors. *The Journal of Finance*, *2*, 773–806.

Berghmans, R., Dickenson, D., & Ter Meulen, R. (2004). Mental capacity: In search of alternative perspectives. *Health Care Analysis*, *12*, 251–263.

Burr, S. (2009). Integrating teaching innovations in medical education. *British Journal of Hospital Medicine*, *70*, 104–106.

Clarke, N. (2002). Training care managers in risk assessment: Outcomes of an in-service training programme. *Social Work Education*, *21*, 461–476.

D'Amour, D., Timmons, V., Sheps, S., & Davies, B. (2008). Knowledge to action: The development of training strategies. *Health Policy*, *3*(Special Issue), 68–79.

Department of Health (2007a). *Mental health: New ways of working for everyone*. Retrieved from http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_074490

Department of Health (2007b). *Mental Capacity Act 2005: Training Materials*. Retrieved from http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_074491

Dunn, M. C., Clare, I. C. H., & Holland, A. J. (2008). Substitute decision-making for adults with intellectual disabilities living in residential care: Learning through experience. *Health Care Analysis*, *16*, 52–64.

Dunn, M. C., Clare, I. C. H., & Holland, A. J. (2009). Living a life like ours': Support worker's accounts of substitute decision-making in residential care homes for adults with intellectual disabilities. *Journal of Intellectual Disability Research*, *54*, 144–160.

Evans, K., Warner, J., & Jackson, E. (2007). How much do emergency healthcare workers know about capacity and consent? *Emergency Medicine Journal*, *24*, 391–393.

Fisher-Jeffes, L., Barton, C., & Finlay, F. (2007). Clinicians' knowledge of informed consent. *Journal of Medical Ethics*, *33*, 181–184.

Grisso, T., & Appelbaum, P. (1998). *Assessing competence to consent to treatment*. New York: Oxford University Press.

Guvver, P., Hindle, P., Harrison, J., Jain, N., & Brinsden, M. (2010). The Mental Capacity Act 2005: Review of mental capacity assessments in people with proximal femoral fracture. *Psychiatric Bulletin*, *34*, 284–286.

Hamilton, R. (2005). Nurses' knowledge and skill retention following cardiopulmonary resuscitation training: A review of the literature. *Journal of Advanced Nursing*, *51*, 288–297.

Hardy, S., & Joyce, T. (2009). The *Mental Capacity Act:* Practicalities for health and social care professionals. *Advances in Mental Health and Learning Disabilities*, *3*, 9–14.

Jackson, E., & Warner, J. (2002). How much do doctors know about consent and capacity? *Journal of the Royal Society of Medicine*, *95*, 601–603.

Johnston, C., & Liddle, J. (2007). The Mental Capacity Act 2005: A new framework for healthcare decision making. *Journal of Medical Ethics*, *33*, 94–97.

Kanter, R. M. (2004). *Confidence: How winning streaks and losing streaks begin and end*. New York: Crown Business.

Koellinger, P., Minniti, M., & Schade, C. (2007). "I think I can, I think I can": Overconfidence and entrepreneurial behaviour. *Journal of Economic Psychology*, *28*, 502–527.

Martins, C. da S., Willner, P., Brown, A., & Jenkins, R. (2010). Knowledge of advocacy options within services for people with learning disabilities. *Journal of Applied Research in Intellectual Disabilities, 24*, 274–279.

McCullough, J. (2009). (In)capacity legislation in practice. *Psychiatric Bulletin*, *33*, 20–22.

Mental Capacity Act. (2005). *Office of Public Sector Information*. London, UK.

Mental Capacity Act Code of Practice. (2007). *Department of Constitutional Affairs*. London, UK.

Mental Health Act. (2007). *Office of Public Sector Information*. London, UK.

Murphy, G. H., & Clare, I. C. H. (2003). Adults' capacity to make legal decisions. In D. Carson & R. Bull (Eds.), *Handbook of psychology in legal contexts* (2nd ed., pp. 31–66). Chichester, UK: John Wiley.

Myron, R., Gillespie, S., Swift, P., & Williamson, T. (2008). W*hose decision? Preparation for and implementation of the Mental Capacity Act in statutory and non-statutory services in England and Wales*. London, UK: Mental Health Foundation.

Richards, F., & Dale, J. (2009). The Mental Health Act 1983 and incapacity: What general hospital doctors know. *Psychiatric Bulletin*, *33*, 176–178.

Sawhney, I., Mukhopadhyay, A., & Karki, C. (2009). Mental Capacity Act 2005: Views and experiences of learning disability psychiatrists. *Psychiatric Bulletin* 33, 234–236.

Schofield, C. (2008). Mental Capacity Act 2005: What do doctors know? *Medicine, Science and Law*, *48*, 113–116.

Shah, A., Banner, M., Heginbotham, C., & Fulford, B. (2010). The early experience of old age psychiatrists in the application of the Mental Capacity Act 0205: A pilot study. *International Psychogeriatrics*, *22*, 147–157.

Stanley, N., & Manthorpe, J. (2008). Small acts of care: Exploring the potential impact of the Mental Capacity Act 2005 on day-to-day support. *Social Policy & Society*, *8*, 37–48.

Walker, R. (2007). Is it time to jump off the training bandwagon? *British Medical Journal*, *334*, 696.

Willner, P., Bridle, J., Dymond, S., & Lewis, G. (2011). What do newly-appointed health staff know about the Mental Capacity Act (2005)? *Science, Medicine and the Law, 51*, 97–101.

Willner, P., Jenkins, R., Rees, P., John, E., & Griffiths, J. (2011). Knowledge of mental capacity issues in community teams for people with intellectual disabilities. *Journal of Applied Research in Intellectual Disabilities*, *24*, 159–171.

Willner, P., Morris, L., & Fisher, S. (2008). Mental capacity is everyone's business: Use of a consultation model to support the assessment of capacity to manage direct payments. *Clinical Psychology Forum*, *190*, 44–48.

Wilson, E., Seymour, J. E., & Perkins, P. (2010). Working with the Mental Capacity Act: Findings from specialist palliative and neurological care settings. *Palliative Medicine*, *24,* 396–402.

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