EDITORIALS

The Mental Capacity Act: some implications for black and minority ethnic elders

The Mental Capacity Act 2005 (MCA) [1] was partially implemented in April 2007 and fully implemented from 1 October 2007 in England and Wales. Lack of decision-making capacity (DMC) is associated with cognitive impairment and dementia [2]. The proportion of adults aged 65 years and above in black and minority ethnic (BME) groups is rapidly increasing [3]. The prevalence of dementia in BME groups is either similar to or higher than the indigenous white British group [4–7]. There were 531,909 BME elders in the 2001 population census [8]. One study estimated that 11,860 of these BME elders had dementia in 2004 in the United Kingdom [9]. Therefore, the increasing number of BME elders will be assessed under the MCA. The Code of Practice [10] accompanying the MCA recognises that language, culture and religion can influence the application of the MCA. The MCA has been fully implemented for 1 month now and therefore, it is difficult to draw on personal anecdotal experience. However, many of the issues discussed below, pertaining to the MCA, have been experienced anecdotally by the authors in the implementation of the Mental Health Act, 1983, over many years.

A successful assessment of the DMC and the application of the MCA are contingent upon the assessor’s fluency in the subject’s language, subject’s fluency in English, accuracy of interpretation services and availability of appropriate vocabulary in the subject’s language for concepts discussed during the assessment. The phrase decision-making capacity, a core issue of the MCA, lacks an equivalent in some languages spoken by BME elders (e.g. Gujarati). Other issues that may be discussed during the assessment of DMC, including symptoms, diagnosis and treatments, may also lack matching vocabulary, and this has been observed for mental illness in some BME groups [11]. Many BME elders are not fluent in English [12]. Ideally, the assessor should conduct the assessment in the subject’s language, but bilingual health and social care workers are scarce [13]. Relatives, non-clinical staff, clinical staff and professional interpreters have been used for interpretation in clinical practice [13]. Lay interpreters may be biased because they are emotionally involved; they may inaccurately or inappropriately translate the questions and answers and translate their opinions rather than facts. Professional interpreters, therefore, should always be used for the purposes of the MCA [10].

Dialect, gender and ethnicity are also important in the choice of interpreters. Different dialects of the same language may be spoken by different ethnic groups. The gender of the interpreter is very important in some BME groups. For example, due to traditional cultural values, difficulties in establishing rapport and ascertaining accurate information may occur if female interpreters are not used for elderly Indian women. Similar difficulties will also occur if the ethnicity of the subject and the interpreter is not matched accurately. For example, Afghani interpreters may speak both Farsi and Pashto, but there may be difficulties if the ethnicity of the interpreter is not matched with that of the subject within the Afghani group.

The Code of Practice advocates provision of written information and other methods of communication. Many BME elders are unable to read their mother tongue, and written information will not be helpful unless a professional reader is readily available as and when the subject wishes to read the information, but this may not be a practical option. Audio tapes, CDs, video tapes and DVDs may be more appropriate mediums to provide information, but availability of technical equipment would have to be ensured.

Other cultural and religious factors are also important. For example, elders practising Hinduism and Jainism are expected to disengage from economic, social and domestic responsibility [14] and, therefore, may indicate that any decision should be made by their eldest son. Also, elderly Indian women, in accordance with traditional cultural practice, may indicate that any decision should be made by their husband. The MCA does not allow other individuals to consent on behalf of adult subjects. Therefore, this implied delegation of decision-making raises major ethical difficulties that have not been recognised or addressed in the MCA other than through lasting powers of attorney or court-appointed deputies. The issue of discrimination within the MCA arises if some BME elders could only practice their traditional cultural values through this formal mechanism. Some cultural and religious practices may lead to refusal of treatment (in some faiths blood transfusion is banned) and trigger an assessment of DMC.

The broad principles of the MCA and the guidance in the Code of Practice appear to cover many of these issues. For example, those lacking DMC on an issue could have decisions made using the best interest principle, and the determination of best interest requires consideration of the subjects’ previous wishes, feelings, beliefs and roles (including culture and religion). However, details of these applications of the MCA are buried underneath the general principles and are open to differing interpretations during the assessment of BME elders.
Policy-makers, service commissioners, service providers and assessors should be aware of these potential difficulties, and undertake measures to reduce them. Formal training in cultural sensitivity and competence is required for those involved in the application of the MCA. Professional interpreters involved with the MCA require formal training on the core concepts of the MCA. In the absence of a central mechanism or requirement to collect data on language, ethnicity and religion of subjects who have an assessment of DMC, individual health care providers, local authorities, and independent sector care homes should collect this data. This will allow monitoring of any disproportionate use of the MCA, auditing of any difficulties and identification of examples of good practice. This should be supplemented by high quality research examining the assessment of DMC and the application of the MCA in BME groups. Unless these steps are taken, BME elders may be disadvantaged by the practical application of some of the MCA’s requirements. Many of the issues pertaining to the MCA with regard to BME elders may be relevant to developing countries because such countries, particularly from the Commonwealth, often make legislative changes after such changes are enacted in the United Kingdom.

Conflict of interest

None

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References


How safe are our hospitals?

Safety is at the heart of the health-care agenda with hospitals needing to make substantial service improvements to avoid the adverse events currently affecting one in ten people admitted. Elderly people with multiple complex co-morbidities, in particular, those with poor renal, hepatic and cardiac function, may be particularly at risk. Known or hidden cognitive impairment in an older patient may be associated with adverse events due to poor compliance with