

This is a pre-copyedited, author-produced version of an article accepted for publication in British Journal of Social Work following peer review. The version of record, Wayne Buckton, 'It just fundamentally reflects the best of social work': Social Worker's Practice Understandings and Experience of the Best Interests Assessor role, The British Journal of Social Work, 2022;, bcac147, is available online at: <https://doi.org/10.1093/bjsw/bcac147>.

Abstract

This paper explores narratives of professional social workers tasked with undertaking the formal para-legal role of Best Interests Assessor under the Deprivation of Liberty Safeguards (DoLS) scheme. Wholesale reform of this practice has been debated in recent years and legislative changes have passed through Parliament – the Liberty Protection Safeguards. The process and debate preceding this change was, however, marked by a relative marginalisation of accounts and critical opinions of Best Interests Assessors themselves. Semi-structured interviews were conducted with a sample group of Best Interests Assessors from a variety of social work teams within a single Local Authority. These accounts are explored using a thematic analysis underpinned by Ritzer's McDonaldization (1983) theory and Sayer's work on Contributive Justice (2008; 2011). The work considers the professional identities of the Best Interests Assessors within and beyond their employing organisation in association with social justice and human rights. Barriers and supports to practice are considered in relation to the organisational, technological and legal contexts of assessment work under the Deprivation of Liberty Safeguards. The study holds relevance for social workers and organisations in contemplating the transition to Liberty Protection Safeguards and workforce conversions to the Approved Mental Capacity Professional.

Keywords: deprivation of liberty, professional identity, social justice, social work

Teaser text

- This paper considers accounts of adult service social workers in the para-legal role of Best Interests Assessor (BIA).
- A qualitative study seeking to explore how practitioners see their role in terms of achieving social justice and human rights for those adults who lack mental capacity on matters of care and residence.
- What constrains and enables practice is charted via the organisational, technological and legal contours of assessment work under the Deprivation of Liberty Safeguards.

- The work considers what types of experience and influence form and maintain the professional identities of Best Interests Assessors in a practice that is directed to promote social justice and human rights.
- The study holds relevance for social workers and organisations in contemplating the transition to Liberty Protection Safeguards.

Introduction

In 2009, the first generation of Best Interests Assessors (BIAs) began to practice in England and Wales under Deprivation of Liberty Safeguards (DoLS). In Scotland and Northern Ireland arrangements have fallen under the Adults with Incapacity Act (Scotland) 2000 and Mental Capacity Act (NI) 2016. The BIA workforce comprises *“qualified, experienced and independent health and social care professionals who carry out a specific and bounded role within the DoLS”* (Hubbard and Stone, 2018: 23). A range of responsibilities and statutory applications underpin the breadth of BIA practice including decision-making and consultation. Responsibilities include making informed judgements around the necessity and proportionality of restrictions incumbent in care provision, whether care arrangements are in an individual’s best interests overall and the power the BIA holds to set conditions to reduce restrictions and revise care practices (Hubbard and Stone, 2018). The BIA role in Local Authorities (LA) developed a focus on the protection of Human Rights and dignities of adults who lack mental capacity to make their own decisions on the matter of care and accommodation. Inevitably, the trajectory of the role is framed by the significant backdrop of governmental fiscal austerity (West, 2013:640, Leece and Leece, 2011:206). The DoLS scheme is set to be replaced by new provisions - the Liberty Protection Safeguards (LPS) process. Subsequently, the BIA role will cease to exist, making way for the Approved Mental Capacity Professional (AMCP). This study aims to capture a particular outline of the fated BIA role through the experience and perceptions of those who have carried out its work. Through those perceptions, a linking thread from practice to social justice and human rights will be developed. The study uses a qualitative methodology, applying a thematic analysis with the use of two underpinning

explanatory theoretical frameworks – contributive justice (Sayer, 2008,2011) and McDonaldization (Ritzer, 1983).

Tensions and contradictions in capitalist divisions of labour, through interpersonal perceptions of tasks shared equitably, or not, in settings from commercial enterprise to household chores can be examined with the idea of contributive justice (Sayer, 2008:2). The scope of potential contributive injustice runs from those whom are intermittently or permanently excluded from the labour market, and thus denied opportunity to contribute to the project of labour; to those who can accumulate and exploit opportunities for fulfilling, rewarding and positively remunerating jobs. Crucially, contributive justice can be said to reflect “*the quantity or quality of the contribution made by people to some project*” (Sayer, 2011:9), and the autonomy, mental and emotional stimulation such endeavours provide. Therefore, where contributive justice exists for workers, so does the ongoing opportunity for self-actualisation (Maslow, 1943). Conversely, where contributive injustice reigns, positive self-development through work is constrained with possible far reaching import for individuals and the recipients of the goods and services they provide. This is particularly important for BIA practice, as the people who are likely to be assessed are potentially some of the most marginalised individuals in UK society (Scourfield; 2007, Whitaker; 2014). Ritzer’s theory of McDonaldization (1983) posits that rationalisation continues to pervade ever-widening spheres of life and work and can be identified in the presence and growth of routinized techniques, norms and expectations which shape and govern the practices of service production. Domains which have come to bear the mark of McDonaldization will feel the emphasis of efficiency, predictability, calculability, substitution of nonhuman for human technology and control over uncertainty (Ritzer, 1983:372). Individuals working in environments where these aims and ideas dominate, and those receiving services produced under such conditions, may experience what Ritzer terms the “*irrationality of rationality*” (1983:372). Irrationality, produced as a residual, unfocused, effect of mechanistic, managerial rational systems can result, at worst, in catastrophic de-humanising outcomes. More customarily, irrationality is found in unforeseen contradictions.

For instance, rational efficiency from an organisation's perspective can be felt as inefficient, frustrating or absurd from the perspective of service recipients.

Dustin (2009) rigorously applied Ritzer's ideas to care management in adult social work practice. This extensive work demonstrated practices, priorities and ideals have come to dominate social work as care management that can be effectively conceptualised using Ritzer's McDonaldization thesis. The themes and consequences for practice, highlighted by Dustin (2009), indicate social work practice, social policy and political direction make uneasy bedfellows. These forces are global and are identified and described under a range of terms and guises. For instance, in the United States, Schram and Silverman (2012:128-129) refer to "*neoliberal paternalism*"; an overt intention to marketise, society wide, the functions of social service organisations. Organisations dictate, through stringent control of practice, to instil in those individuals who use social services, compliance consistent with market rational behaviour and inward-looking acceptance of positions allotted to them in the lower socio-economic order. Policy that champions targets and performance indicators, disciplines social service organisations so they can be held to account over their ability to discipline clients. Schram and Silverman (2012:129) state that social service organisations are now punitive, corrective regimes for managing poverty populations and environments that quickly and effectively suppress the humanist and compassionate tendencies in the social work workforce; ironing out of the frame any recourse to ideas about social exclusion or the social dimensions of vulnerability (Wishart, 2003). In the British context of state-mediated social work with adults, Lymbery (2014b:802-5) characterises the policy of personalisation under the political conditions of austerity as solidifying and accelerating the same narrowing and regressive tendencies care management is held to embed in practice. Hingley-Jones and Ruch (2016:3) go further, arguing austerity in the UK, delivered under the economic, discursive and cognitive architecture of neo-liberal ideology has imbued social work at all levels; resulting in a "*relational austerity*" that undermines relationships from organisational level, professional supervision through to face to face practice with service users. Social work is singled out of

the public service sector as a profession in a perpetual crisis of competence (Hingley-Jones and Ruch, 2016: 6). These are the broader historical conditions of adult social work that surround the debate about BIA practice which has focused more on administrative obfuscation than the developmental contours of what has become a distinct space for social work practice.

Clearly, BIAs are not restricted to being social workers, yet social workers undoubtedly make up the majority of BIAs nationally. In a 2015 study, out of 507 BIAs contacted, 443 were qualified social workers (Goodall and Wilkins; 2015:16). Conducting DoLS assessments shares key features with broader social work practice with adults, encompassing holistic and anti-oppressive underpinnings. BIA practice is one that has the potential to reinforce social work in terms of realising human rights ideals and social justice. The International Federation of Social Work (IFSW) is explicit in these matters: “*Principles of social justice, human rights, collective responsibility and respect for diversities are central to social work*” (ifsw, 2014). Given the majority of the BIA workforce is made up of qualified, practicing social workers, it is prudent to consider social work centric assumptions and bias in proclaiming a natural affinity between the profession and BIA practice generally. However, these viewpoints are echoed to an extent across the multi-disciplinary BIA workforce composition. Hemmington et al (2019) report similar sentiments from the perspective of BIA nurses, occupational therapists and psychologists. When articulating the unique knowledge and value contribution to BIA practice from each perspective, themes included learning from social work about conceptualising and challenging restrictions on a human rights’ footing and the importance and centrality of social model understandings of mental health and illness (Hemmington, 2019: 79-85).

Fledgling predictions of how DoLS would develop reflected a belief that they would apply to the few, not the many, individuals in limited categories, primarily in residential care (Dwyer; 2010:1505). The less restrictive MCA principle would loom large, all care planning and provision would aim to reduce the likelihood of a DoL and a declaration that a DoL is occurring would ‘*depend on all circumstances of the case*’ (MoJ; 2008: 10). This statutorily prescribed approach clearly embeds DoLS as a social work practice that assimilates neatly with pre-

existing social work values and ethics, and links specifically with those values unequivocally espoused by the IFSW (2014). The requisite to provide care in a manner that takes principal account of, and promotes, individual freedoms and preferences, decisively infuses social work values across the DoLS scheme, building on the unifying legal, professional and ethical base provided by the principle MCA.

Practice Context and the role of Best Interests Assessors

In 2004, a young man with a diagnosis of autism who was unable to communicate his care needs, was detained in an English hospital under common law without presenting need for medical assessment or treatment, no due legal process had been sought or enacted by the decision-making professionals (Boyle; 2009:416). The European Court of Human Rights ruled this contravened the young man's rights under article 5 of the Human Rights Act 1998 – right to liberty and security, and concluded he had been unlawfully deprived of liberty (Khan et al; 2013:94-95). The case represented the Bournemouth Gap, facilitating legislative action in the form of The Mental Health Act 2007 (MHA2007) amended the Mental Capacity Act 2005 (MCA) with the introduction of the Deprivation of Liberty Safeguards 2007 (DoLS). DoLS implementation acknowledged, at the outset, a necessary degree of plurality and subjectivity as a consequence of the scheme becoming practice without definition in statute. The Code of Practice made clear that what constitutes a DoL is “*ultimately a legal question and only the courts can determine the law*” (MoJ; 2008:16). Thus, an implied expectation existed from origin that case law would develop to test and clarify this over time (Carpenter et al; 2013:579). The anticipated test was duly delivered in the seminal Supreme Court judgement, P v Cheshire West and Chester Council and P and Q v Surrey County Council [2014] UKSC 19, which has come to be known as *Cheshire West*.

Pre Cheshire West

Preliminary psychiatric understandings were trained on the perception that DoLS practice was overly complex and riddled with confusion requiring an obfuscating level of bureaucracy and monitoring (Varghese et al, 2012:57). Determining what constituted a DoL assumed ambiguous judgement, yet in general, BIAs “*were quite confident in their decisions*” (Carpenter et al; 2014:585), unpicking subtle circumstantial and material veracities of care in order to carve out the nature of an occurring DoL. The identifying process implicitly assumed a deal of rational judgement and familiarity with the code of practice. The code outlines a distinction between permissible restriction of liberty which can be actioned under the main MCA, and deprivation – that is, one of “*degree and intensity and not one of nature or substance*” (MoJ; 2008:17). However, Cairns et al’s (2011a& b) studies, highlighted the extent to which the ranged subjectivities of professional judgement, values, ethics and training of different professional disciplines failed to produce an applicable consensus around identifying a DoL in practice. The picture was further blurred by developing case law that served to create yet more complexity around the notion of DoL identification (Lennard, 2014:250).

Post Cheshire West

Since its inception, criticism of the DoLS has been frequent. Charges include burdensome processes, bureaucratic overload with meaning detached from people subject to DoLS assessments, their families and carers (Lennard, 2014:245-6). Detached meanings provoke concerns that DoLS practice is not seen or experienced as connected to, or fulfilling an aspiration to human rights; while the phrase ‘deprivation of liberty’ could be interpreted in a negative sense by both professionals and public (Spencer-Lane, 2015:332). Richard’s (2016) survey of 468 BIAs suggested a principle function of BIAs practice is detecting deficiencies in care for adults at risk, and by way of the DoLS process, drive through concrete changes and improvements to care provision in a variety of ways (Richards; 2016:4). This implies more questions remain regarding wide spread problems, less with DoLS, more with the consequences of care management in a national context of shrinking resources, industrial

scale privatised provision and highly pressurised budgets. Therefore, in austere times, the principles of the DoLS and the practice of the BIAs provides vital and necessary independent scrutiny of care. Hubbard (2017:9) discusses a positive residual effect of the BIA role on statutory social work practice with adults in the sense they have become the natural champions of reflective MCA practice more widely. Since Cheshire West, within local authorities, DoLS has become a departmental priority. The need to recruit and train much greater numbers of BIAs, along with the proliferation of BIA teams has combined to raise the profile of DoLS and BIAs in a way which recognises specialised knowledge and imbues an elevated professional status.

Hearings of this case through the courts led to a watershed moment for human rights and access to social justice for adults at risk who lack mental capacity. Cheshire West therefore crystallised a palpable lowering of the threshold for what constitutes a DoL and asserts The Acid Test as a matter of answering two questions: is P free to leave and is P under continuous supervision and control? These questions must be considered in the context of what freedoms should be reasonably enjoyed by any adult in a so-called free society (Whitaker; 2014;1494). The meaning and practice of skilfully and objectively determining a Deprivation of Liberty was qualitatively altered by the Cheshire West case. What was *“unlikely that any simple definition... can be applied in every case”* and the *“cumulative effect of all the restrictions imposed on the person amount to a deprivation of liberty, even if individually they would not”* (MoJ; 2008:18) is now, arguably, reducible to The Acid Test. The Acid Test has supplanted carefully calibrated professional judgement with a simple definition that can be applied in every case, implying arbitrary and routinised practice follows in its wake. Nationally, in the years following Cheshire West, DoLS applications increased in the tens of thousands. Under mounting pressure to meet statutory obligations following Cheshire West, many local authorities created specific central DoLS teams staffed with BIAs. From a resourcing perspective, Cheshire West intensified the pressure on adult social care departments in a time of exceptionally testing austerity.

Anticipated practical and process implications of LPS include a dissipating of BIA responsibilities. Best interests' decisions around deprivation of liberty for care and accommodation will fall within the remit of care management processes enacted by staff without equivalent specialist training, knowledge and experience (Hemmington et al, 2021). The AMCP role being more narrowly focused on assessing those individuals perceived to be objecting to their restrictive care arrangements. In a sharp analysis of the LPS, Griffiths (2019:2-7) describes the proposed changes meant to simplify the practice of upholding the rights of marginal populations in the following terms "*far reaching and dangerous... extraordinarily complex... opaque and illogical*". These factors pose a number of challenges for social work in upholding the underpinning values of the profession (McNicol; 2017).

Indicative overtures in the literature suggest the profession of social work is less critical of the so – called messy bureaucratic compromises the DoLS throws up. The most persistent critics hail from other disciplines. This appears to reflect a deeper practical appreciation from a social work perspective on the relative worth that DoLS practice promotes for people in terms of their human rights and social justice.

Research Design, Ethical Considerations and Limitations

Ethical permission to conduct the research and recruit participants from an employed pool of active BIAs in one LA was sought and granted. Ethics committee approval was gained from the University of Birmingham, adhering to internationally accepted ethical guidelines and relevant professional ethical guidelines. Each participant gave their written consent to participate.

One level of sampling is used in the study. From a copy of the district rota schedule, emails were sent to BIAs Attached was the study advert, participant recruitment information sheet, consent form and a copy of ethical approval. Initially, only one BIA agreed to be interviewed. However, that interview became the catalyst for the recruitment phase being ultimately

successful, with the help of the first participant, it was possible to snowball sample, recruit and interview the five BIAs which provided the data set. In total, nine BIAs were approached, four of whom either declined to participate or did not respond.

Participants had been qualified, registered practising social workers within statutory adult services for ten years or more and qualified, practising BIAs between four and ten years. Of three female and two male participants, one had only ever worked on the district rota, two had just recently left the central DoLS Team for social work positions in differing community teams, while still contributing to the BIA rota. Lastly, two were working in the central DoLS Team and had been for a minimum of the previous three years.

Semi-structured interviews were conducted individually, in private, at a time and place convenient to participants. Some pre-established questions were prepared in order to shape a conversation around the area of practice of interest. With permission, each interview was recorded on Dictaphone.

There were email exchanges and phone conversations with participants when organising the interviews and consent promoting update emails were sent out at a later stage. No intermediaries were involved so the participants' identities were kept confidential. The findings are anonymised. Nothing to distinguish or identify the participants is contained in quotes presented in the text. Records of the interviews were numbered not named. Data from the semi-structured interview phase was only ever handled or heard by the researcher. At the transcribing phase, data was fully anonymised and, when complete, the original interview recordings were erased. All transcribed documents were password protected. Records of communication between researcher and participants before and after the interviews concerning the study were deleted on completion of participation.

Thematic Analysis

Ontologically, thematic analysis offers a suitable approach, providing flexibility to situate and foreground lived experience of participants. Analysis of the data set entailed undertaking six stages of analysis presented by Braun and Clarke (2006): Becoming habituated with the data, formulation of initial codes, looking for themes, reviewing themes, defining themes and writing up.

In the following section, four principle themes are offered, distilling the most complete, consistent points of accord across the data set, prioritising the words of participants (Brown and Rutter, 2008). Analysis of BIA practice experience is framed through the conceptual lenses of contributive justice and McDonaldization.

Themes

We get held up as experts

Participants gave a sense BIA work was stepping off the treadmill of social work as constructed within statutory adult services. Accounts were understandably framed in comparison to other social work roles held in the LA. This perspective, grounded within the norms, practices, expectations and messages exchanged and understood within this particular LA, brought about several points of consensus regarding how the level of pressure on BIA work is felt differently to that of social work in adult care management teams. A perception of having more time to focus on doing the job well and having more power and independence concentrated in the BIA professional identity than in social work in adult services:

We have a lot of power to influence for the better... Certainly, I get called upon to help a lot with mental capacity assessments and I get held up as an expert.. which is a good thing because disseminating information and knowledge is the way forward really. I've never felt shackled by anything [as a BIA] I've always felt that I've got absolute control over what I do

and the decisions I make... I've never ever felt pressured to make a particular decision so I think that my professional practice is respected and that I can work in a way that is very much in the interests of service users (P1).

Inside the authority [LA] the professional status [of the BIA] is I think quite good in social work. I'd say look, someone's done social work for a while then gone to do the BIA. Because I've always thought that the profession, you know in terms of social work compared to other professions, I don't think it's up there. You know and I'm not making this up, I sometimes would rather not say I was a social worker. (P2).

The participants shared a range of experiences that shaped their views on how the BIA role is felt and valued by other stakeholders. The following quotes give a flavour of the complex and contradictory constructions of the BIA role made up of professional encounters with care home staff, medical and legal professionals:

In care homes they worry about us.. the language we use 'deprivation of liberty safeguards'. You know we're using the phrases that frighten care home managers... I think their attitude towards us [BIAs] is similar to Safeguarding Officers, we're there to find the bad stuff and to criticise them and hold that up as a bad example. Which is a shame as I think we're there to do the opposite. So they give us a certain status but I don't think they like us very much (P1).

Medical, I'm a bit critical of medical to be honest. I don't think they've got the understanding of mental capacity, never mind DoLS. "Yeah he's at home he's not safe he's sun-downing" or whatever. I've seen Consultants just write one sentence [re Mental Capacity in medical notes] you know, so many times. And I think they might see us [BIAs] as meddling (P2).

I... had the opposing Barrister, who was difficult at first, but he actually came to me and asked me how to write one of the conditions he was proposing which was surprising. And I was saying "yes of course I will help you. I think you should say this and I think you should say that". But to see him turn around so much was quite interesting. That for me was quite a pat on the back... yes it [BIA knowledge] most probably is respected in those circles a lot (P3).

Participant 4 was attuned to how their own feelings and perceptions had changed when undertaking the BIA role from different operational settings. This entailed a more positive sense of professional self when situated in a care management team and undertaking BIA work on a monthly rota basis, to moving into the Central DoLS Team and functioning in the BIA role all the time:

I found the BIA role very very satisfying really, but I don't find it that satisfying now... From a professional development point of view, I found that [BIA practice] quite empowering really... Within the supervisory body the status of the BIA is variable really, in that erm most people do the training as part of their professional development really and want to further their practice... so, to that extent it's kind of a positive thing. But I think inevitably it might well be as well that if you're only doing BIA work that it might be considered your other professional [social work] skills are waning (P4).

It's about really good care reviewing

The professional power captured above is linked with descriptions of greater, more consistent opportunities to apply such power positively, acting as a brake or a check and balance on wider problematic systemic issues generated in diverse priorities across multi-agencies. BIA

practice operates as a lever for change in the material circumstances of individuals whose lives may be arbitrarily constrained by statutory processes and underdeveloped understandings of human rights at varying levels within the care sector. Examples included hospital discharge processes understood as a paternalistic, unwieldy conveyor belt shifting people who lack mental capacity into residential settings. Furthermore, care reviews done by residential providers, along with those completed by social work colleagues, can be re-examined, unpicked and scrutinised by the BIA in the DoLS process; cementing regular and timely windows for change in a context of accelerating struggle to preserve the “*right way of doing social work*” (P3), constituting an additional vital “*safety net*” (P2).

I think DoLS assessments informs more to the forefront people’s right for independence... wishes and feelings, DoLS assessments gives a forum for that (P5).

I’ve uncovered some terrible things, things that make me think uurrghh, I can’t believe we’re doing this in this day and age, and it’s not happening now [due to BIA intervention]. But no other workers would’ve gone out because there would’ve been no reason for anyone else to have ever been involved, because only BIAs go out to specifically look at those things.... it just fundamentally reflects the best of social work because it’s absolutely person-centred (P1).

I think in every case it makes some difference... On one occasion I know it led to the district [SW Team] being involved with the family and friend and trying to resolve their dispute so that the friend could visit more often so it improved that person’s social life with somebody they knew very well. So it protects people and improves their quality of care (P3).

The human rights aspect of it is massive... Dignity, respect, you know, for the person. Definitely... Like I say about social activities you know, erm, someone er who went to the pub and that was an important part of their life. Can they put that in the care plans and make sure someone does go to the local pub for a pint or whatever" (P2).

It just says, 'I'm corporate'

Technological change was seen as a practical expression of organisational change, largely driven out of necessity to adapt to an acute and continuing era of LA budget cuts. Thus, technological change in LA delivery of adult frontline services has inflected the practical doings of the BIA role over its lifespan. In the particular organisation, Tablets and Laptop devices were rolled out to all assessment teams in adult services from 2014, framed by a particular narrative and a set of explicit expectations on practitioners. The narrative expects increasing staff productivity in terms of doing greater numbers of assessments per worker in a shorter amount of time. Practical implications include BIAs taking devices with them on visits to write up assessments in situ or on the move. Such change prompted a mixed response within the participant sample ranging from *"its just the biggest barrier isn't it. It just says 'I'm corporate'"* (P1) to *"when you go out, they [mobile devices] just work, you open them up and they connect to the internet straight away, they're amazing... technology wise they are really really good"* (P5). However, it was noted that technological change that heavily impacts the role is much wider than that which is driven by the LA:

I can tell you how unhelpful it can be.... more and more care homes now have electronic records and I find it increasingly difficult to access all information or feel that to know that I have. If you have a care plan file, I know its paper but it's all there and you can flick backwards and forwards but it's either there or it isn't. If you're given a computer screen you've got to navigate it, each computer system is slightly different to the others so that has its problems... I've been given a phone and all the care plans all the information is on this tiny little screen,

and you're scrolling up and down and trying to know have you whizzed past it have you found it. I think its inadequate. So, I find at times technology from the managing authorities a barrier to doing the job properly... And there's something about seeing handwritten notes about running records you can see if certain things are in the same handwriting. It gives you visual cues to be more inquisitive about something. Whereas if it's all typeset in the same type that difference isn't there.... And I think technology neutralises some of that. I do feel quite strongly about it, being an older person within the system I think it's a major issue. I worry about it, if I've missed a crucial piece of information there's a responsibility within that so it's actually quite uncomfortable... Potentially, potentially it could be extremely serious (P3).

As private providers driven by market forces; the participant indicates how care homes purchase their own technological solutions on the grounds of internal efficiency. However, the BIA, propelled by an obligation to uphold the rights of service users, is undermined and rendered inefficient and vulnerable by narrowly focused software packages. This detailed example of practice is shot through with frustration and anxiety of the BIA. Concern spans the legal accountability of documents generated and signed off in practice to the fear that information systems may impede the practitioners from adequately protecting and promoting the rights of individuals. The passage conveys a palpable sense of both the *substitution of nonhuman for human technology* and an *irrationality of rationality* (Ritzer, 1983) in professional practice.

Each bit of case law has a profound impact

Frequent and regular legal update training for BIAs in the LA was cited as being important in helping participants self-confidence with case law, building a tangible sense of what it relates to and how to use it appropriately in practice. Skilled analysis and professional judgement

were still core markers of the BIA professional identity. However, an unmistakable shift in focus between the pre and post Cheshire West eras of practice was noted:

It's really different in some ways.. [pre Cheshire West]... we'd be... making judgements about the impact of restrictions. And a really good example would be if somebody is one to one'd. Now, some people that have one to one support think they've got a mate, they think its great... Other people it drives them batty they've got someone with them all the time they can't get away from them. They feel really oppressed. Its, so they are like polar opposites of the same spectrum aren't they. So this person that's got a mate is not particularly deprived of their liberty in that sense whereas the other person clearly clearly is and we were making judgements about the effect that these restrictions have on the individual and that would form the basis of our assessment... Erm post Cheshire West the threshold was just reduced so low that essentially if you lacked capacity to make your own decisions about care and accommodation arrangements and you're in a hospital or a care home you are deprived of your liberty. So that so that was just a given really.. you have a a much more concrete reality in terms of what constitutes a DoL (P1).

Carefully calibrated professional judgement remains a consistent mainstay of BIA practice. Energy expended by the BIA on unpicking the cumulative impact of restrictions on the subjective experience of service users; is now trained on scrutinising the modes of care delivery and the rationale for such practices for each individual service user, promoting rights, dignity, choice and life quality to shape a protective environment that is responsive in a personalised way. A positive move away from wrestling subjectively with a remotely imposed legal objectivity; to settle on the practical, moral features of a bespoke quality of day to day lived experience, is manifest in the participant testimonies.

Discussion

Examining the field data through the two theoretical lenses enables a deeper critical reflection on the lived practice experience of the BIAs. It puts the participants' accounts in the context of the global forces shaping and hastening change in social work at practice level. It also highlights areas for reciprocal thinking, where the field testimonies can challenge, inform or modify theory as tools for describing practice (Hardy and Jobling, 2015: 538).

Individuals who are most likely to make up the populations of people who may, at some time, find themselves subject to a BIA assessment are more vulnerable to having their purposive personhood subordinated and distorted in tenuous, reductionist and self-propagating discourse that externally define identity (Scourfield; 2007:1136/40). People with highly critical health and social care needs under restrictive care are constructed through prisms of dependency and complex needs. Scourfield (2007) argues neo-liberal societies express personhood as a deliberate conflation of the notions of independence and consumer power. The underlying latent effect casts these populations as defective and inadequate consumers and implicitly leads to the exclusion of those adults at risk who lack mental capacity in many spheres. The data reflects an awareness of, and frustration with reductive professional practice replicating discourse in the instance of mental capacity being abridged to one sentence in medical notes. A political imperative that recognises rights only in terms of market autonomy overlooks a substantial portion of vital human experience. Moreover, Wishart (2003) describes a "*victim characteristics*" narrative prevalent in protection policy and practice when constructing the idea of vulnerability. Explanatory assumptions of McDonaldized theory, implied predictability and calculability, here lend themselves notably to the organisational management of incapacitous populations. However, the participant narratives construct a different experience applied at the inter-personal juncture of practice. Vulnerability, for those adults to whom DoLS may apply, must be understood within the wider context of ageism and saneism and social relations which discriminate, stereotype and set people apart as being different from dominant groups (Minichiello et al, 2000). Framed in this way, practitioner formulations of human vulnerability become less about perceived individual impairments,

though these characteristics remain key to understanding the whole person. Instead, anti-oppressive and human rights focused modalities seek to reduce limiting effects of societal discourse and structure (Wishart, 2003), as an imperative direction of practice. For the BIA, narratives indicate practice mobilising holistic conceptualisations of human rights, embodying essential properties of *dignity and respect*. Therefore, care planning systematic support for someone to visit the pub, or resolving exclusionary conflicts in a person's social network, fosters appreciation for human existence as fundamentally social (Lloyd; 2004:250-1).

As described, the idea of what is a deprivation of liberty was both conceptually and materially contested. In a legal sense, Cheshire West stabilised the concept but threw the material application into chaos nationally, thus, driving elements of McDonaldisation further into focus. Take for instance, ADASS guidance on proposed desk-top DoLS assessments (McNicoll, 2016). Here is a conception of efficiency from the perspective of financially pressurised formal bodies obligated to deliver a service. The service BIAs provide is to adults who are given a potentially disempowered status through subjectively defined mental incapacity. Yet the rhetorical spectre of desk-top assessment, absent of face to face human contact, did not break through into practice under this rationale at least. The participant consensus was clear that no suggestion, much less pressure, had been applied to the BIAs managerially or otherwise to compromise their practice, values or duty to the spirit of human rights and social justice in this manner. However, a conscious precarity of multifaceted accountability remains with the BIA through consecutive assessments. In common place practices that echo the *irrationality of rationality* (Ritzer, 1983), each organisational regime brings a plethora of negotiated barriers and interpretations be managed by the BIA, unpicking and evaluating organisation's information management and transparency through environmental or cultural edifice and bespoke software 'solutions'.

A discernible outline of practice emerges as one in which potentially dehumanising outcomes of McDonaldised approaches are held at bay with daily reassertion and renegotiation of the professional power vested in the BIAs. A small-scale battle fought and won by BIAs and their

organisations on a daily basis captures an outline of professional self-actualisation; and in the doing of BIA tasks an earnest contributive connection with the upholding of human rights and the search for social justice. While many lament the bureaucratic complexity of the DoLS scheme, this perhaps reflects a consistent pragmatism of the difficulties of realising the human rights of adults at risk under neo-liberal ideologies and conditions. The central contributive tenet of the BIA role is unpicking decisions made by others that ultimately determine the day to day freedoms and life quality of adults lacking mental capacity in care regimes, ensuring alternative, less restrictive forms of care provision are meaningfully explored, evaluated and revised. The BIA professional identity exists as a constructed and maintained experience incorporating influence from a range of perspectives. These perspectives coalesce to form a fluid sense of professional self in the context of changing practice settings and norms, alongside the disconnected priorities and values that drive fragmenting organisational and market change; a localised, often uneven expression of rationality and efficiency, and the values that underpin a BIA's relationship with and to service users. Consistently, the working perception of BIA practice, is oriented, ultimately, to the higher columns of Maslow's (1943) triangle. Protecting and fulfilling the needs of those who lack mental capacity and are deemed to require a form of restrictive care; around promoting and retaining a holistic, individual, identity in creation over the life course, by highlighting dignity, autonomy and self-esteem, thereby connecting their overarching professional purpose to the pursuit of social justice. It is this element of BIA practice that dominates identity formation and furnishes professional stability in the participants' reflections. Such perception is sustained through an accepted, necessary, bureaucratic fog of daily organisational and technological reconstitutions.

Conclusion

Acknowledging the findings do not provide scope for generalisability, this study contemplates the narrative reflections of statutory social workers in one English LA on their practice in the para-legal role of BIA under the DoLS scheme. For those adults who lack mental capacity on

matters of care and residence, the BIAs consistently frame their role as important to achieving dignity, respect, life quality, social justice and human rights for people in the context of necessary and proportionate restrictive care practices to meet identified needs. The organisational impact of the Cheshire West Judgement on workforce and practice constitutes a seismic and transformative event. BIAs have taken on and observed sometimes rapid technological changes, however notwithstanding the continuing relevance of Cheshire West, this has been bound up with, not independent of, wider drivers for change in the practicalities of assessment work in statutory adult services across the authority. Furthermore, the potential difficulties to defensible human rights focused practice posed by technological shifts are readily encountered by BIAs in assessment settings such as residential care homes. The professional identities of BIAs are formed and maintained by a range of experiences and influences. A sense of being essential to the statutory integrity of the LA, while developing expertise relevant to all colleagues tasked with MCA work, stands alongside instances of defining role specific identity in contrast to other professional stakeholders in the process, such as medics. Beyond these considerations the BIAs retained an idea their practice furthers the scope to apply social work values to enhance the safety and lived experience of service users. For social workers and organisations contemplating the transition to LPS, the findings of this study suggest the developing value of BIA practice may not be straightforwardly replicable.

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