

Political Studies Association Conference

(21st-23rd March 2016, Brighton)

2015 UK Election 2

Care and the Vote

Abstract

The right to vote is seen as a pillar of modern democracies and a component of a 'good life' of social participation. In the UK that right is extended to all adults unless they have been convicted of an offence in perverting democracy or are a prisoner. However it is possible that other barriers exist to prevent people from voting. This pilot research has investigated how democratic rights have been exercised by those in residential and nursing care – homes in Leicester and Leicestershire serve as a population. Citizens in such institutions often suffer from conditions which may affect their mental capacity, as well as making them particularly vulnerable to political decisions and policy changes.

Following the 2015 general election each of the homes (n=272) was invited to take part in a telephone survey: 122 (45%) responded. Initial results suggest a significant difference in turnout exists between the population of care and nursing homes in comparison to the population average. Despite mental capacity having no bearing on voting rights, results from the survey indicate that many homes have considered residents' capacity before allowing them to vote. Other possible barriers are discussed.

The findings present significant avenues for future research. Firstly, there is a need for larger studies toward nationally representative figures. Secondly, it raises policy questions about how those in care in the UK are, or can be, enabled to vote. Finally, it has revealed that methods used for capacity testing in care and nursing homes are often improvised with little or no legal or medical foundation.

Dr. Ed Thompson¹, VC2020 Lecturer, De Montfort University

Dr. Ramanjeet Kaur, CT1 Psychiatrist, Leicestershire Partnership Trust, NHS

Mrs. Jane Scullion, Lecturer and PhD Student, De Montfort University

Prof. Rob Baggott, Professor of Public Policy, De Montfort University

¹ Corresponding Author - ethompson@dmu.ac.uk

Context

The number and proportion of elderly people has increased in the UK in the last century and future projections indicate this is likely to continue. The prevalence of dementia (a leading cause in the loss of mental capacity) is very closely related to age, with less than 1% of the population aged under 65 affected while roughly 30% of those aged over 95 suffer with it (Glover 2008). Knapp and Prince (2007) project that the numbers of dementia sufferers in need of social care are likely to rise over coming decades. This project has sought to consider the question of how care organizations are currently helping to facilitate the formal democratic rights of a growing number of people with capacity issues in residential care. Much of the recent attention in the area of voting has focussed on the concern about the engagement of young people with formal politics and voting: 2001 MORI figures from 2001 estimated that only 39% of 18 – 24 year olds voted, compared to 70% of those aged 65 (Russell *et al.* 2002). This study has moved beyond that focus to the other end of the age spectrum and attempts to inform policy makers and practitioners about the issues surrounding formal democratic participation later in life, particularly for the 291,000 65 residents aged over 65 in care homes in the UK (Office for National Statistics, 2014).

Mental Capacity and Regulation

Mental capacity can be summarised as an individual's ability to make a specific decision. The Mental Capacity Act (2005) Definition of mental capacity can be seen in Box 1.

- (1) For the purposes of this Act, a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.
- (2) It does not matter whether the impairment or disturbance is permanent or temporary.
- (3) A lack of capacity cannot be established merely by reference to—
 - (a) a person's age or appearance, or
 - (b) a condition of his, or an aspect of his behaviour, which might lead others to make unjustified assumptions about his capacity.

Box 1: Mental Capacity Act (2005) definition of mental capacity

The concept of mental capacity relates to a specific decision situated in a moment of time, it may be that an individual does not have capacity to make decisions about their last will and testament at one moment, but they can decide what they might like to eat. Similarly 24 hours later they may have mental capacity to make the decision about their will that they were

unable to yesterday. Assessment of mental capacity must take into account this specificity while seeking to determine the ability of a person to undertake the cognitive tasks that constitute decision-making. Box 2 presents one popular format for assessments – taken from the *Oxford Clinical Handbook of Psychiatry*.

Incapacity cannot be presumed on the basis of any individual patient factors (e.g. diagnosis of dementia, learning disability, brain injury, mental disorder) but must be assessed specifically for each decision. The questions to ask are – for the decision required, does the patient have the ability to:

- Make a decision?
- Understand the information relevant to the decision?
- Use or weigh that information in making that decision?
- Retain memory of the decision?
- Communicate the decision?

Box 2: Required elements of mental capacity, Semple and Smyth, 2013.

Much of the literature around the level of democratic participation by people in care has been dominated by American methods of capacity assessment. Markowitz (2007) outlined personal experiences as a public official in the United States which constructed a picture of confusion around who can and cannot vote, and how they might be aided practically and legally. The US picture is reported as one where questions of ballot integrity outweigh concerns for individual rights (Colker, 2007). *Doe v. Rowe* (2001) demonstrated for the first time the need for an assessment of mental capacity before preventing people with mental disabilities from voting, and has prompted the development of specific tools of assessment for a voting context. Empirical studies describe a picture where access appears to be unofficially restricted by staff using an ad-hoc range of methods if voter capacity is in question (Karlawish *et al.* 2008, Kohn, 2007). Investigations from Europe mainly focus on the implications of the American Competence Assessment Tool for Voting (CAT-V) if applied to the Italian (Tiraboschi *et al.* 2011) and Spanish (Irastorza *et al.* 2011) national elections. Findings from these studies indicate that:

- ‘...people with dementia are underrepresented in the polls. Many of them are denied the opportunity to vote even when retaining the mental capacity to do so’
- (Tiraboschi *et al.* 2011, p5).

Research in the United Kingdom is considerably older (Brettle, 1995; Hudson, 1997; Nabi, 2002), and examines only nursing settings. While no contemporary study exists in the United Kingdom it is reasonable to expect that care residents’ access to the vote is impaired similarly to other regions.

Compared to the US system of capacity testing immediately prior to voting, the UK Electoral Commission (2008, section 5.3) guidelines simply state that “A lack of mental capacity is not

a legal incapacity to vote"; and the Electoral Administration Act (2006, section 73(1)) "Any rule of the common law which provides that a person is subject to a legal incapacity to vote by reason of his mental state is abolished." There has been no examination of the practice of care residents' access to the vote since the new regulations in 2006. Given the increased dependence of older persons on services which are ultimately controlled by elected officials, the decline in democratic participation, and upcoming elections; voting for care residents seems to be an increasingly relevant and contemporary issue. In order to address the issues raised the researchers have investigated: **'What is the current practice of residential care and nursing homes in relation to the registration and capacity assessment of residents as voters?'**

Literature reviewed from the United Kingdom, Italy, Spain and the United States of America and has identified two dimensions to this stream of research. The first is concerned with legal aspects of the voting rights of individuals who may have diminished mental capacity – whether they should or should not be able to participate in a ballot. In the United States people who lack (or may lack, Colker, 2007) mental capacity should be prevented from voting to maintain the integrity of the election. In Europe participation of those with a disability, mental or otherwise, in voting is protected by the Human Rights Act. National guidance in the United Kingdom is clear, that anyone who wishes to vote should be able to vote. The rest of this paper will consider what happens in practice.

Methods

In the 30 days following the 2015 general election all 272 care and/or nursing homes in Leicester and Leicestershire were contacted and asked to participate in a structured telephone interview (n=272). The geographical location was selected based on its proximity to the researchers and contacts with local social care departments. 122 (99 residential and 23 nursing, 44.9% of the target population) participated; 12 homes declined to participate, the remaining 138 asked that we call back at another time on more than two occasions and were considered to be un-contactable for the purposes of the study. The responder from the home remained anonymous, but was typically the manager, assistant manager, or most senior person on duty at the time of the call. Ethics approval was granted by the University. No 'service users', patients, relatives of the aforementioned, social workers or NHS staff were contacted in the course of data collection.

Participants were asked a structured set of questions loosely based on those used in the Karlawish et al. (2008) study of voting and mental capacity in a mayoral election in Philadelphia. These questions were designed and adapted to explore the realities of voting practices at the participating home. This included voter registration, how those resident were enabled or prevented from voting (intentionally and unintentionally) and the type of actors involved in these processes.

Results

Voting Numbers

The first questions related to the number of residents in the home, whether they were registered to vote, and whether they voted. Respondents were asked to estimate where they were not sure of exact numbers. According to responders, in the homes who were able to answer all three of these questions 1036 individuals were resident, of which an estimated 798 were registered to vote, of which 243 were estimated to have voted. This reflects an estimated turnout of voting age population in these settings of 23.5% (compared with 60.5% turnout of voting age population nationally for this election), and an estimated turnout² of 30.5% (compared with 66.1% turnout nationally for this election), this data is presented in Table 1. We also asked the respondents if anyone from the home voted, 72.5% said yes, 27.5% said they did not know. While the average age of this population is unknown it can be assumed that the average age of the population of these homes is higher than the national average, and of a demographic that should be more likely to vote.

Table 1 Comparison of Sample and UK Average

	Turnout	Turnout of Voting Age Population
UK average (2015)	66.1%	60.5%
Responding residential and nursing care settings (2015)	30.5%	23.5%

The Involvement of Other Actors in Voting

An evaluation of available guidance demonstrated little in the way of advice for either those involved in democratic services or care/nursing practitioners as to roles and responsibilities in relation to this group of people. We asked a series of questions about whether the care or nursing home registered people to vote, took them to the polling station or otherwise assisted them. This was an exploratory question to identify categories for a larger study, as such quantitation data is not available. However, two points came across very strongly; firstly, the role of local authorities in maintaining residents' records of electoral rolls by sending out reminders and forms for voter registration. While this may be the case up until 2015 it is presently unclear as to how individual registration will affect the process of voter registration in these settings. Secondly, the role of families in assisting residents to vote either by accompanying them to a polling station or by completing postal votes on their behalf.

The Assessment of Mental Capacity

² Turnout is calculated based on the number of individuals who were reported as registered to vote who are also reported to have voted. Turnout of voting age population is calculated by the number of those reported at the home who also voted. This second measure explores possible differences in voter registration against the general population.

We were also interested in whether residents' mental capacity was tested prior to voting. This was not a prerequisite for allowing them to vote if they indicated that they wished to do so. 22.8% of participating homes responded that they did test capacity before people voted. In one case residents were allowed to complete the postal vote irrespective of their mental capacity to do so, if they were then assessed as lacking mental capacity for this decision the postal voting paper would be discarded by home staff.

43 of the homes interviewed suggested that they had standing assessments of mental capacity in place for all decision-making of some kind or another (e.g. a resident's mental capacity was tested when they came into the home, or periodically on a 1, 6 or 12 monthly basis). This goes against medical and legal definitions of mental capacity, in which mental capacity must relate to an individual's ability to make a specific decision at a specific time and should be assessed. In the majority of cases this determined whether residents would be allowed to vote, in some cases residents would be allowed to vote irrespective of their mental capacity (the latter is in accordance with legislation).

We then explored the practicalities of testing mental capacity in these settings. Again, the results from this section were designed to be indicative rather than quantitative. We asked who carried out the testing of mental capacity; responses included home staff (this might be nurses if the home had them), GPs, Psychiatrists, Social Workers, specific local authority mental capacity teams, in one instance the family also had a say in whether their relative had mental capacity to make a decision. The Mental Capacity Act 2005 states that a *decision-maker* can be anyone assessing mental capacity, it can therefore be a member of non-specialist care staff. Relevant guidance (Department for Constitutional Affairs, 2005) suggests that such assessments are recorded. Respondents were also asked how mental capacity was tested; responses were once again wide ranging. Some homes responded that their assessments were based on a holistic knowledge of the individuals involved (e.g. "we just know them"), others had developed tools of their own as a company (e.g. "we use the [company] capacity test") or as individuals ("we made up a questionnaire"). It was notable that none of the 122 responders explicitly referred to tests of mental capacity as relative to situated decisions, although it is possible some assessments were designed in a manner which made them specific.

The Practice of Voting

The final set of questions related to how residents were supported (or otherwise) to vote. We asked respondents how members of staff assisted residents to vote. The majority of those contacted indicated that they were prepared to support residents' complete forms (this may have included postal votes, but was not explicitly concerned with postal voting) and escorting/transporting the individual to the polling station if required. A minority indicated that they would explain parties and policies to residents if help was requested. Table 2 summarises the above results.

Table 2 Comparison with previous studies

	Brettle (1995) UK	Karlawish et al. (2008) USA (Phil.)	Present Study (2015) UK
Response	17 Nursing	31 Nursing 20 Residential	23 Nursing 99 Residential
Voting Participation	17.3%	29%	24.9%
General pop. Turnout *Turnout of voting age pop.	40% for this area	28.7%	66.1% *60.5%
Other	No need to address fitness to vote, but many did.	Need to assess mental capacity before voting, only 63% did.	No need to assess mental capacity, 22.8% did. Role of family. Registration unclear.

Conclusions

This study has attempted to shed light on voting practices in residential and nursing care settings. A summary of the literature as demonstrated that there is a lack of understanding about voting practices in the settings, and a significant difference in priorities internationally. United Kingdom and European Union law requires that those with mental disabilities are not discriminated against in their participation in public life; this includes their ability to vote. Search of relevant literature, publications and guidance has also demonstrated a significant lack of clarity around roles and responsibilities in enabling those with health and social care needs to vote.

Results from our pilot have shown significant variation in practice between service providers. A minority seem to have a good understanding of mental capacity, and mental capacity is not used to decide residents' ability to vote. In 22.8% of homes mental capacity is tested before residents vote and in the vast majority of cases if a resident is found not to have mental capacity to make this decision they are prevented from voting by the home's staff. This is reflected in turnout figures which suggest that turnout in these settings is less than half of the national average, whereas the demographic of these settings would suggest turnout might have been expected to be higher than average.

Finally, across our sample there is a considerable lack of understanding around who can assess mental capacity, and the means of assessment. Most significantly, that mental capacity is particular to a decision and that assessment must reflect this context specificity.

This pilot study has enabled refinements of our methodology, and the identification of the dual focus practices of voting and the assessment of mental capacity in a care context. Our research will continue with a statistically significant study following the EU referendum in 2016. A similar assessment of health settings (for example inpatient facilities) might provide another context for this research. We have not sought to address the question of whether those who do not possess mental capacity to make measured decisions in elections should or should not be allowed to vote. This broader question may be worthy of consideration by other researchers, particularly given the demographic context of an increasing elderly population and the prevalence of mental capacity affecting illness.

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